

SB

87

**TESTIMONY IN SUPPORT OF SB 87: INCREASING ALASKA
CHILD HEALTH INSURANCE**

March 12, 2007 for the Health, Education, and Social Services Committee

Honorable Senators, Representatives, and Legislative Staff:

I am George Brown, a board certified pediatrician who has practiced in Alaska since July 1965. Today I feel like Yogi Berra said, "This is like dejavu all over again". As a 20th century Alaskan, it is proper to give credit to many of my pediatric and public health friends that made Medicaid and SCHIP possible for what many families know as Denali Kid Care. One of the key and tireless promoters is Dr. Kenn Moss. We worked together in the Anchorage Native Hospital for 3 years during the time Senator Earnest Gruening represented Alaska in D.C. Thus I am reminded of Dr.Gruening's book, "Many Battles". (1)

Senator Gruening understood, as did many of the founding mothers and fathers of our beloved Alaska, that we must, like our Alaska Native friends and colleagues, take the long look. He and they understood that children are our human future. Many of the medical and scientific minds of the early 20th century understood this clearly. Dr. Emmett Holt, widely respected professor of pediatrics, wrote in 1913, "The problem of infant mortality is one of the great social and economic problems of our day. A nation may waste its forests, its water power, its mines, and to some extent its lands, but if it is to hold its own in the struggle for supremacy, its children must be conserved at any cost. On the physical, intellectual, and moral strength of the children today, the future

depends." Dr. Holt was referring to a report from the newly formed U. S. Children's Bureau. (2) The key finding of this report was the **DIRECT CONNECTION BETWEEN INFANT MORTALITY AND POVERTY**. Infant mortality rates for families with incomes over \$1250 was 60 compared to 170 for those with incomes under \$450. Measuring human infant mortality rates is rather like the warning canaries in coal mines. They are critical indicators of national values. (3) Senator Edward Kennedy testified recently – in support of finding the \$60 million to continue federal child health insurance – how the U.S. spends less for health care than all the other industrialized nations. (4) We rank 24th of 25 among industrialized nations in infant mortality. (5) While both U.S. and Alaska infant mortality rates have gradually decreased over the last 30 years, they remain higher among minority populations, that is, those families living in poverty.

There is good news, resulting directly from both state and federal support of child health insurance. From 1997 to 2003, there was a 30% reduction in the number of uninsured children. Children covered under Medicaid and SCHIP receive better health care in four key ways: 1. They have a regular source of health care (we pediatricians call it a "medical home". 2. They use preventive and primary care in cost effective ways, 3. They receive dental care, and 4. They less often miss needed care despite living in families who otherwise could not afford such care. There is a further public benefit from this state and national investment in children. Children with such access to preventive and primary care are less often hospitalized. (6)

Senator Kennedy stressed his concern for our future, echoing the prophetic words of Dr. Holt. Economic and social changes that force both parents to work just to pay for food, mortgages or rent, and heat –the basics of survival – mean such families have no health insurance. These families keep working and their children keep waiting when ill with bad coughs, asthma, or severe vomiting and diarrhea out of fear of the \$150 to \$300 Emergency Room costs. These are the working poor. They hold two critical characteristics that influence our state and national future: 1. They are the parents of millions of 3 to 10 year old children, and 2. They have no health insurance.

Senator Murkowski recently spoke of the crisis in decreasing access to health care for elderly Alaskans. Some primary care physicians refuse to take Medicare patients because they cannot afford to. (7) We are in danger of the same for Alaskan children if we do not increase SCHIP coverage to more than 200% of the poverty level. Alaska started at that level under Title XXI when SCHIP was instituted in 1997. Alaska reduced it to 175% in 2003. Our national newspaper, USA Today, is reminding the public of this looming crisis for our kids. 1.5 million will lose care if the \$60 million for the next five years is not found to continue SCHIP. They also remind us of the huge gains made in public and parent understanding of babies and children since 1913. USA Weekend just yesterday featured "15 Important Findings Parents Must Know Right Now". Such public understanding of child needs is the engine that drives parents – both Medicaid

and SCHIP eligible – to use these valuable preventive and primary care services. These are both the least expensive and longest lasting investments we can make for our children – for all children.

A superior court judge (who requested anonymity) in Fairbanks clearly describes the importance of insuring "all" children. "Each of us must come to care about everyone's children. We must recognize that the welfare of our children and grandchildren is intimately linked to the welfare of all other people's children. After all, when one of our children needs life saving surgery, someone else's child will perform it. When our children dial 911. Someone else's child will answer it. When our children need a helping hand, someone's else's will be there to lend it. If one of our children is threatened by violence, someone else's child will be responsible for the violent act. The good life for our children can be secured only if a good life is secured for all other peoples' children."

George W. Brown, MD, FAAP

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gwbrown76@yahoo.com

SOURCES:

1. Gruening, Earnest: **MANY BATTLES**, Liveright Publishing, 1973.
2. Yankauer, Alfred: "A Classic Study of Infant Mortality, 1911 – 1915", **PEDIATRICS** 94(6): 874 – 877, 1994.
3. Lindeen, Kathleen and Macfarland, Robert: "Community Parenting Centers in Colorado" **THE JOURNAL OF PSYCHOHISTORY** 21(1) 7 – 19, 1993.

4. Howard, Ed. (Moderator): "Enrolling and Keeping Kids in the SCHIP Program, Alliance for Health Reform and Robert Wood Johnson Foundation Teleconference, February 26, 2007.

5. UNICEF: CHILDREN IN POVERTY: An Overview of Child Well-being in Rich Countries. 2007

6. Ku, Leighton and Nimalendran. IMPROVING CHILDREN'S HEALTH, A Chartbook About the Roles of Medicaid and SCHIP, Center for Budget and Policy Priorities, January 2004.

7. Senator Lisa Murkowski. "Speech to Alaska State Legislature" on Gavel to Gavel, February 2007.

SENATE COMMITTEE REPORT

First Committee of Referral

DATE: 2/19/07

FURTHER: Finance

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

DATE TURNED
IN TO OFFICE: 3/13/07

Health, Education and Social Services Committee considered

SENATE BILL NO. 87

SB 87 MEDICAL ASSISTANCE ELIGIBILITY

"An Act expanding medical assistance coverage for eligible children and pregnant women; relating to cost sharing for certain recipients of medical assistance; and providing for an effective date."

and recommends:

- be replaced with SCS or CS SB 87 (HES)
- adopt previous SCS or CS _____ (_____)
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

SENATE BILL:	
<input type="checkbox"/> Same Title	
<input checked="" type="checkbox"/> New Title	
<hr/>	
HOUSE BILL:	
<input type="checkbox"/> Same Title	
<input type="checkbox"/> Technical Title Change	
<input type="checkbox"/> New Title w/ SCR # _____	

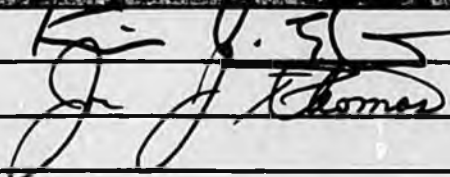
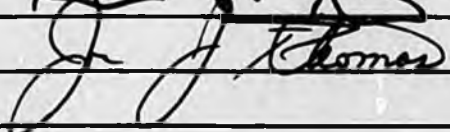
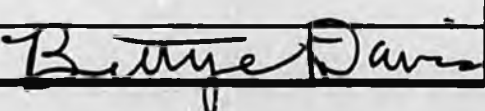
NEW FISCAL NOTE(S):

Department	Date	Fiscal Impact	Year	Year	Year
HSS/Beh. Health	3/9/07	✓			
HSS/Beh. H. Adm	3/8/07	✓			
HSS/Med. Ser	3/9/07	✓			
HSS/Med. Asst.	3/9/07	✓			
HSS/Ph. Asst	3/9/07	✓			

HSS/Info Tech 3/9/07 ✓ 6
COR 3/1/07 ✓ 7

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal Impact	Year	Year	Year	FN#

Signature	Name	Checked			
	Elton Thomas	✓			
	Thomas	✓			
CHAIR: 	Bettye Davis	✓			

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB087-DHSS-DBH1-03-09-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Behavioral Health
 Component: Behavioral Hlth Medicaid Svcs

Revision Date/Time (Note if correction): _____
 Title: MEDICAL ASSISTANCE ELIGIBILITY

Sponsor: WIELECHOWSKI
 Requester: SENATE (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						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		2,017.6	2,113.5	2,285.8	2,460.7	2,672.3
1003 GF Match		1,824.8	2,059.3	2,285.9	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)

SB87 (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: Janet Clarke
 Division: Finance and Management Services
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone: 465-1630
 Date/Time: _____
 Date: 03/09/2007

**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.

SB 87 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. SB87 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.

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FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

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 than 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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FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

We assume that enrollment for all groups covered by SB87 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 SB87 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 SB87 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	436	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	\$14,141.2
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	\$11,211.3
Medicaid Services (2077). Division of Health Care Services.	\$1,471.3	\$2,732.8	\$2,456.3	\$4,912.6	\$7,368.9**
Behavioral Health Medicaid Services (2660). Division of Behavioral Health.	\$0.0	\$1,366.4	\$1,280.8	\$2,561.6	\$3,842.4

** Health Care Services Medicaid (2077) costs are net of claim expenditures and revenue from premiums. Total Medicaid Services costs for Health Care Services 9,156.0

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB087-DHSS-DBH2-03-08-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Behavioral Health
 Component: Behavioral Health Administration

Revision Date/Time (Note if correction):
 Title: MEDICAL ASSISTANCE ELIGIBILITY

Sponsor: WIELECHOWSKI
 Requester: SENATE (HES) Component No. 2685

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						
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CHANGE IN REVENUES (0)						
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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)
 SB 87 (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: Stacy Toner, Acting Director Phone 465-2817
 Division: Division of Behavioral Health Date/Time 03/08/2007
 Approved by: Karleen Jackson, Commissioner Date 03/09/2007
 Agency: Department of Health and Social Services

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

SB 87 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 Administrative 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: SB067-DHSS-HCS1-03-08-07
 Bill Version: SB 07
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Health Care Services
 Component: Medicaid Services

Revision Date/Time (Note if correction): _____
 Title: MEDICAL ASSISTANCE ELIGIBILITY

Sponsor: WIELECHOWSKI
 Requester: SENATE (HES)

Component No. 2077

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		9,156.0	9,943.4	10,798.6	11,727.2	12,735.8
Miscellaneous						
TOTAL OPERATING	0.0	9,156.0	9,943.4	10,798.6	11,727.2	12,735.8

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		3,869.4	4,131.2	4,505.8	4,970.1	5,474.4
1003 GF Match		3,499.5	4,025.1	4,505.7	4,970.0	5,474.3
1004 GF						
1037 GF/Mental Health						
Other(SDPR--Premiums)		1,787.1	1,787.1	1,787.1	1,787.1	1,787.1
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	9,156.0	9,943.4	10,798.6	11,727.2	12,735.8

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)

SB87 (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: Janet Clarke
 Division: Finance and Management Services
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone 465-1630
 Date/Time _____
 Date 03/09/2007

**FISCAL NOTE
FN #**

**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.

SB87 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. SB87 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 \$7000. 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.

(continued)

**FISCAL NOTE
FN #**

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

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 than 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.

(continued)

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

We assume that enrollment for all groups covered by SB87 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 SB87 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 SB87 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.

Health Care Services Medicaid (HCS) currently pays for 2/3 of the cost of services to DKC children and all of the costs associated with DKC pregnant women. Component fund calculations for this fiscal note are based on that costs distribution (2/3 of costs of services due to added SCHIP enrollment, 2/3 of costs of services due to section 3 enrollment, and all costs of services due to additional enrolled pregnant women). Additionally, all premiums will be paid through HCS mechanisms and are therefore added to the funds analysis for this component as program receipts.

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	436	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	\$14,141.2
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	\$11,211.3
Medicaid Services (2077). Division of Health Care Services.	\$1,471.3	\$2,732.8	\$2,456.3	\$4,912.6	\$7,368.9**
Behavioral Health Medicaid Services (2660). Division of Behavioral Health.	\$0.0	\$1,366.4	\$1,280.8	\$2,561.6	\$3,842.4

** Health Care Services Medicaid (2077) costs are net of claim expenditures and revenue from premiums. Total Medicaid Services costs for Health Care Services 9,156.0

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 88067-DHSS-DHC82-03-08-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Health Care Services
 Component Medical Assistance Admin.

Revision Date/Time (Note if correction): _____
 Title MEDICAL ASSISTANCE ELIGIBILITY

Sponsor WIELECHOWSKI
 Requester SENATE (HES)

Component No. 242

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	49.0	282.3	282.3	282.3	282.3	282.3
Travel						
Contractual	106.8	135.2	135.2	135.2	135.2	135.2
Supplies	6.6	2.2				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	162.2	419.7	417.5	417.5	417.5	417.5

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	81.1	209.8	208.7	208.7	208.7	208.7
1003 GF Match	81.1	209.9	208.8	208.8	208.8	208.8
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	162.2	419.7	417.5	417.5	417.5	417.5

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	4	4	4	4	4	4
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB87 will increase recipient enrollment that in turn will cause an increase in associated appeals, by recipients and providers. The level of appeal activity is difficult to determine, but a minimum of 1 additional FTE position to process appeals would be required. Other volume related increases would be in prior authorizations and claims volume. These are not expected to cause an increase in payment to the fiscal agent under contract.

Premium collection activity would require a minimum of staffing increase, in our Accounting and Recovery section, of 3 FTE's.

Continued on page 2

Prepared by: Randall Schlapa
 Division: Health Care Services
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone 334-2461
 Date/Time 03/08/2007
 Date 03/09/2007

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

Analysis continued:

System enhancements to the MMIS will cost approximately \$100,000. These changes would accommodate the new Federal Poverty Level indicator and co-pay requirements and would be a one time cost in FY2008.

There will be increased referrals to the Department of Law for collections and appeals, this will result in approximately \$100,000 in the contractual line starting in FY2009.

Health Care Services caseload is going to increase by approximately 436 pregnant women and 1,700 cases (3,400 children).

We estimate two Accounting Technician I's, and a Medical Assistant Administrator I position will be needed to manage this additional work beginning in FY2008. In FY2009 a Medical Assistant Administrator II will be needed, most likely in our Practitioner Relations section. The new extended Medicaid program increases complexity of the eligibility determination work and results in increased contact with applicants and enrollees.

Total Administrative Costs:

The increase in Medicaid applications and caseload creates the need for two Accounting Technician I, a Medical Assistant Administrator I, and a Medical Assistant Administrator II, all located in Anchorage. These annual costs are estimated to be:

- 2 Accounting Technician I's, \$121.0 (Range 12 at a cost of \$60.5, including benefits, per position).
- 1 Medical Assistant Administrator I, \$75.7 (Range 16 at a cost of \$75.7, including benefits, per position).
- 1 Medical Assistant Administrator II, \$85.6 (Range 18 at a cost of \$85.6, including benefits, per position).

It is assumed that one quarter year's personal services funding will be needed in FY08 to hire and train staff, the two Accounting Technician I's and the one Medical Assistant Administrator I in the Accounting and Recovery section, at the cost of \$49.0, in order to be able to accept applications and make eligibility determinations effective July 1, 2008. The Medical Assistant Administrator II will be filled in FY2009.

With the additional caseload, a one time supplies cost will be incurred in FY2008, for computers and software with a cost of \$2,200 for each additional staff for a total of \$6.6 for three staff hired in FY2008 and \$2.2 in FY2009 for the 4th new position. Annual costs for office space, phones and other contractual costs are calculated at a cost of \$8,800, per additional staff for a total of \$35.2 (prorated for 1/4 year in FY2008) .

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB007-DHSS-DPA-03-09-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Public Assistance
 Component Public Assistance Field Svcs

Revision Date/Time (Note if correction): _____
 Title MEDICAL ASSISTANCE ELIGIBILITY

Sponsor WIELECHOWSKI
 Requester SENATE (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						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
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

POSITIONS	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Full-time	7	7	7	7	7	7
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB 87 (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
 Division: Public Assistance
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone 465-5847
 Date/Time 03/08/2008
 Date 03/09/2007

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

SB 87 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. SB 87 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 determining eligibility 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.

**FISCAL NOTE
FN #**

**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 Administrative 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 specified above. 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 \$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: SB087-DHSS-FMS-03-08-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Departmental Support Services
 Component Information Technology Services

Revision Date/Time (Note if correction):
 Title MEDICAL ASSISTANCE ELIGIBILITY

Sponsor WIELECHOWSKI
 Requester SENATE (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						
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CHANGE IN REVENUES (0)						
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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)

SB 87 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, Assistant Commissioner
 Division Finance and Management Services
 Approved by: Karleen Jackson, Commissioner
 Agency Department of Health and Social Services

Phone 465-1630
 Date/Time 03/08/2007
 Date 03/09/2007

**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.

FISCAL NOTE

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

Fiscal Note Number: _____
 Bill Version: SB 87
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Corrections
 Title An Act expanding medical assistance coverage RDU Administration & Operations
eligible children and pregnant women . . . Component Office of the Commissioner
 Sponsor Senators Wielechowski, Franch, Ellis, Eton, Davis
 Requester Senate Health, Education, and Social Services Component No. 694

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

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

POSITIONS

POSITIONS	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
 Passage of this legislation will not have a fiscal impact on the Department of Corrections.

Prepared by: Sharleen Griffin, Director Phone (907) 465-3339
 Division: Administrative Services Date/Time 3/1/07 12:33 PM
 Approved by: Dwayne Peoples, Deputy Commissioner Date 3/1/2007
 Agency: Department of Corrections

ALASKA STATE LEGISLATURE

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Co-chair
Joint Armed Services Committee

Member
Resources Committee
Judiciary Committee
Transportation Committee

Senator_Bill_Wielechowski@legis.state.ak.us

SENATOR BILL WIELECHOWSKI

Sponsor Statement for SB 87: No Child Left Uninsured

The intent of SB 87 is to make health insurance accessible to all children in Alaska, while asking those families who can afford it to make a substantial financial contribution towards their coverage. By ensuring that all children have access to health services, SB 87 will reduce costs to the state and its citizens over the long run.

An estimated 18,000 children in Alaska lack health insurance and the number is growing. According to the Robert Wood Johnson Foundation, the number of children covered by private health insurance has declined by 31% in the last decade. The vast majority of these children are from working families.

Uninsured children have much higher health risks than do covered children. They are more likely to develop chronic illnesses such as asthma and diabetes and to suffer from acute conditions such as eye and ear infections. While many lack a regular doctor and don't receive preventative care, they are four times more likely than insured children to use emergency rooms when medical attention is needed.

The high cost of this emergency care is often borne by other Alaskans, including businesses that purchase health insurance for their employees. For example, Providence and Alaska Regional hospitals provided \$89 million in uncompensated care in 2006. These costs are passed on to other hospital users through higher charges for medical services, which ultimately results in increased premiums. They are also passed on to government. Governor Palin has proposed a \$22.7 million increment in fiscal year 2008 to reimburse hospitals for the uncompensated care they provide. These costs could be reduced by insuring that all children have access to health insurance.

SB 87 raises the eligibility limit for participation in the Denali KidCare program to 200% of the federal poverty level (FPL), currently \$27,000/year for a single parent and child. This change puts Alaska in line with other states, 41 of which allow participation by families at or above this level. Roughly 70% of the costs of this program are currently covered by the federal government.

SB 87 would also allow families with incomes up to 350% of the FPL to buy into Denali KidCare using a sliding fee scale for premiums and a 20% co-pay. Those with the greatest means would reimburse the state roughly 90% of its costs. Participants would have to certify that they don't have access to health insurance at work.

With the "No Child Left Uninsured Act," Alaska joins states from Idaho to Illinois that are working to ensure that all children have access to health insurance. Please support this crucial legislation.

LEGAL SERVICES

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

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

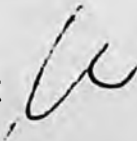
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 19, 2007

SUBJECT: Sectional Summary (Work Order No. 25-LS0595\A)

TO: Senator Bill Wielechowski
Attn: Michele Sydeman

FROM: Jean M. Mischel
Legislative Counsel 

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

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

Section 1. Provides a short title for the bill.

Section 2. Amends optional medical assistance provisions for persons under 19 years of age and for pregnant women to establish an income eligibility standard in relation to the federal poverty guideline, and deletes the specified household income limits.

Section 3. Requires the Department of Health and Social Services to administer a program to extend mandatory and optional medical assistance coverage for persons under 19 years of age whose household income is above sec. 2's limits but below a set percentile range of the federal poverty guideline, and imposes contribution and copayment amounts for the coverage.

Section 4. Requires the Department of Health and Social Services to set premium and cost-sharing contributions for person under 19 years of age and who meet eligibility criteria under sec. 3.

Section 5. Repeals household income limits for cost-sharing under existing law for medical assistance coverage.

Section 6. Authorizes the Department of Health and Social Services to adopt regulations needed under the bill before the effective date of the bill.

Section 7. Provides an immediate effective date for sec. 6.

Senator Bill Wielechowski
February 19, 2007
Page 2

Section 8. Provides a July 1, 2008 effective date for secs. 1 - 5.

JMM:lmb
07-027.lmb

ALASKA STATE LEGISLATURE



Senator Bill Wielechowski

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

Representative Les Gara

State Capitol, Rm. 500
Juneau, AK 99801
(907) 465-2647

Senator_Bill_Wielechowski@legis.state.ak.us

Representative_Les_Gara@legis.state.ak.us

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.

ALASKA STATE LEGISLATURE



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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 \$89 million in uncompensated care in 2006. 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.
- 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 7,600 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.

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.

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 health 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.

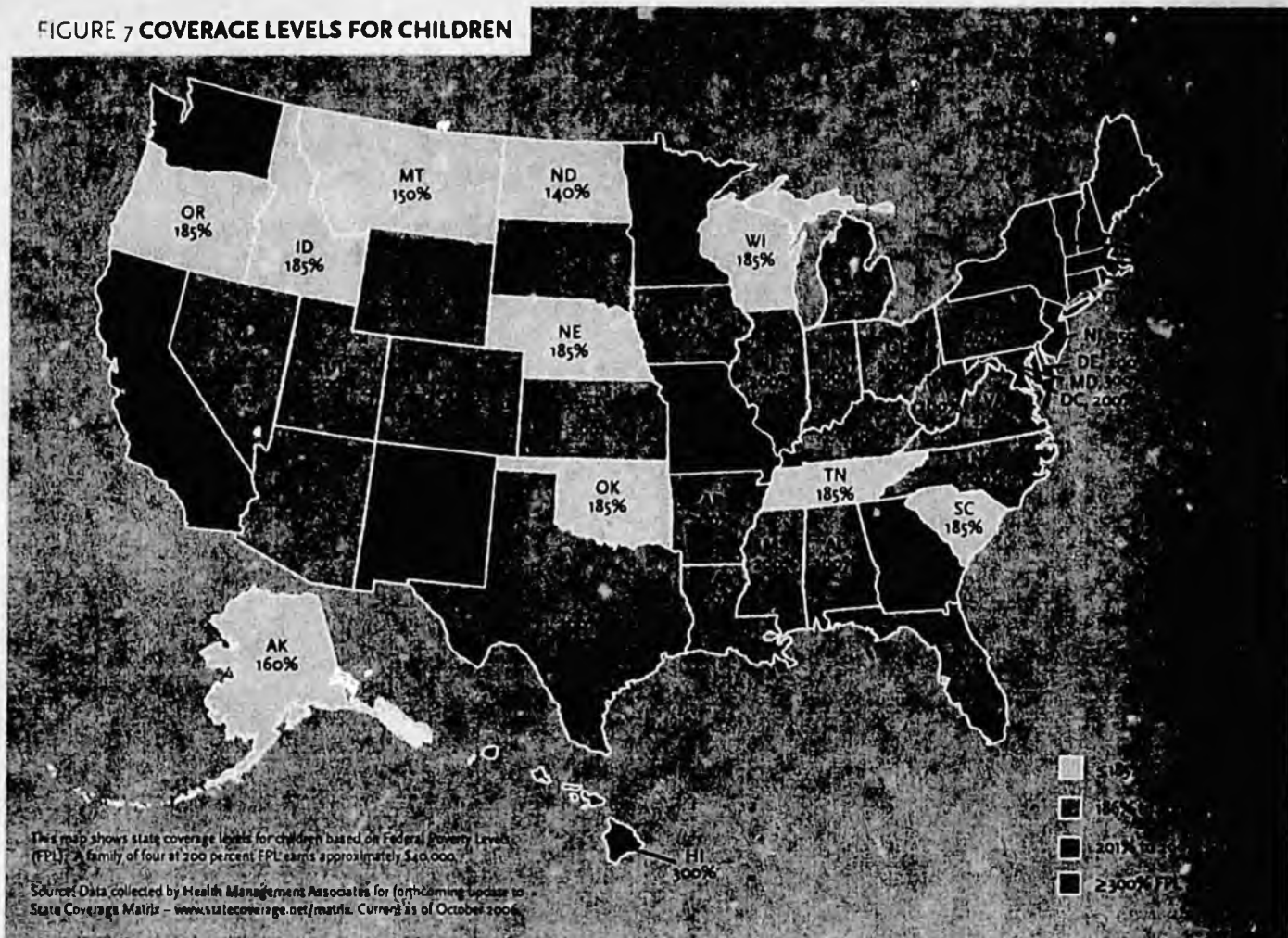
John Riley is with the clinical faculty of the University of Alaska Anchorage and is president of the Alaska Public Health Association.

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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. Employers 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.¹³ 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.



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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February 13, 2007

The Honorable Bill Wielechowski
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Dear Senator Wielechowski

The Alaska Chapter of the American Academy of Pediatrics whole heartedly supports your upcoming Bill regarding the ability of families who are at the 200-350% of poverty level to "buy-in" to Denali Kid Care. We also support Senator Davis's Bill regarding re-instating SCHIP to 200% of poverty level. This "buy-in" ability would allow access to care at an affordable cost. As you know almost 1/3 of Alaska's children are at or below 200% poverty. Many other families do not have access to insurance through their employer and private insurance in Alaska is cost prohibitive. And while the vast majority of patients enrolled with Medicaid are children they utilize only a fraction of the resources. This makes for efficient use of health care dollars. It is also well documented in the literature that preventative healthcare is cost effective and families with healthcare coverage are more likely to access preventative care and not wait until problems have reached a crisis. The American Academy of Pediatrics advocates for universal coverage of children and the more options that are available will make this a reality. Thank you for your careful consideration and advocacy for Alaska's children. If more information is required please feel free to contact me or any of our executive staff.

Sincerely yours

Jody Butto MD FAAP
AAP Alaska Chapter President

U.S., Britain ranked last in child welfare

U.N. study of wealthy nations cites economic inequality, poor family support

The Associated Press

Updated: 4:02 p.m. HT Feb 14, 2007

EERLIN - The United States and Britain ranked at the bottom of a U.N. survey of child welfare in 21 wealthy countries that assessed everything from infant mortality to whether children ate dinner with their parents or were bullied at school.

The Netherlands, followed by Sweden, Denmark and Finland, finished at the top of the rankings, while the U.S. was 20th and Britain 21st, according to the report released Wednesday by UNICEF in Germany.

One of the study's researchers, Jonathan Bradshaw, said children fared worse in the U.S. and Britain — despite high overall levels of national wealth — because of greater economic inequality and poor levels of public support for families.

"What they have in common are very high levels of inequality, very high levels of child poverty, which is also associated with inequality, and in rather different ways poorly developed services to families with children," said Bradshaw, a professor of social policy at the University of York in Britain.

"They don't invest as much in children as continental European countries do," he said, citing the lack of day care services in both countries and poorer health coverage and preventative care for children in the U.S.

U.S. officials questioned the comparisons made by the study, while Britain said it failed take into account recent social improvements.

Risky ways

The United States finished last in the health and safety category, based on infant mortality, vaccinations for childhood diseases, deaths from injuries and accidents before age 19, and whether children reported fighting in the past year or being bullied in the previous two months.

The U.S. was second to worst, behind only Hungary, for its infant mortality rate of 7 per 1,000 births. The rate, a standard indicator of children's health and prenatal care, is under 3 in Japan.

The study also gave the U.S. and Britain low marks for their higher incidences of single-parent families and risky behaviors among children, such as drinking alcohol and sexual activity.

Britain was last and the U.S. second from the bottom in the category focusing on relationships, based on the percentage of children who lived in single-parent homes or with stepparents, as well as the percentage that ate the main meal of the day with their families several times per week. That category also counted the proportion of children who said they had "kind" or "helpful" relationships with other children.

The report's authors cautioned that the focus on single-parent families "may seem unfair and insensitive" and noted that many children do well with one parent.

"But at the statistical level there is evidence to associate growing up in single-parent families with greater risk to well-being — including a greater risk of dropping out of school, of leaving home early, poorer health, low skills and of low pay," the report said.

On average, 80 percent of the children in the countries surveyed live with both parents. There were wide variations, however, from more than 90 percent in Greece and Italy to less than 70 percent in Britain and 60 percent in the U.S., where 16 percent of adolescents lived with stepfamilies.

Bob Reitemeier, chief executive of The Children's Fund charity in Britain, said the UNICEF report also showed

that less than half of British children reported good relations with their peers.

Bullying in Britain

"That really jumped off the page," he said, citing concerns about the competitive, ratings-based school environment in Britain and higher reported incidences of bullying and fighting. "The environment for these young people is quite negative."

The study ranked the countries in six categories, based on national statistics: material well-being, health and safety, education, peer and family relationships, behaviors and risks, and young people's own subjective sense of well-being. Both the U.S. and Britain were in the bottom two-thirds of five of the six categories.

Britain finished at the bottom in behaviors and risks, which considered factors such as the percentage of children who had breakfast, ate fruit regularly, exercised, were overweight, used drugs or alcohol, were sexually active or became pregnant.

Both the U.S. and British governments criticized the report.

Wade Horn, an assistant secretary at the Department of Health and Human Services, said the study's standard of measuring poverty differed from that of the United States.

Defining poverty

A family of four is defined by the U.S. as living in poverty if its combined income is less than \$20,650 a year. The poverty threshold used by the report was an income of \$35,000 a year for a family of four, he said.

"I think when you try to compare nations in a report like this, you tend to ignore so many other factors specific to those nations that the comparison becomes somewhat meaningless," Horn said.

State Department spokesman Paul Denig was also critical of the report and said his department first learned of the study through the media and was not asked to provide input.

Britain said the report did not take account of recent improvements to education, health and general living standards in the country. Some of the statistics also went back as far as 2001, it said.

In general, northern European countries with strong social welfare systems dominated the upper half of the rankings. Southern European countries, such as Spain, Italy and Portugal, ranked higher in terms of family support and levels of trust with friends and peers.

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Alaska: Health Insurance Coverage of Children 0-18, states (2004-2005), U.S. (2005)

Health Insurance Coverage of Children 0-18, states (2004-2005), U.S. (2005) Compare 				
	AK #	AK %	US #	US %
Employer	96,160	49	43,934,050	56
Individual	7,210	4	3,459,740	4
Medicaid	60,210	31	20,354,580	26
Other Public	13,790	7	1,124,430	1
Uninsured	17,880	9	9,035,420	12
Total	195,240	100	77,908,220	100

Notes and Sources: Show | Hide

Notes: Percentages may not sum to 100% due to rounding effects.
For current Medicaid enrollment figures, please refer to the "Medicaid & SCHIP" section, which report administrative data from the Centers for Medicare and Medicaid Services (CMS).
For more details, see "Notes to Topics Based on the Current Population Survey (CPS)" at <http://www.statehealthfacts.kf.org/methodology>.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

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From Governing's February 2004 issue

**THE GOVERNMENT PERFORMANCE PROJECT
A Case of Neglect**

- **Introduction**
- **States that Stand Out**

CHILDREN'S CARE

Sudden Reversal

Diagnosis: Dramatic recent improvements in health care for poor children in America are being threatened by a new wave of cost-cutting in the states. Changes are being made that not only endanger the health of young people but are likely to lead to greater costs in future years.

Children are heavy consumers of health care, but they are the cheapest of patients. About a third of all children in America get health services through Medicaid or the State Children's Health Insurance Program (SCHIP), and that cost taxpayers an average of \$1,475 for a child enrollee in 2002, compared with \$12,764 for one who was elderly. The payoff from that \$1,475 investment is large: 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.

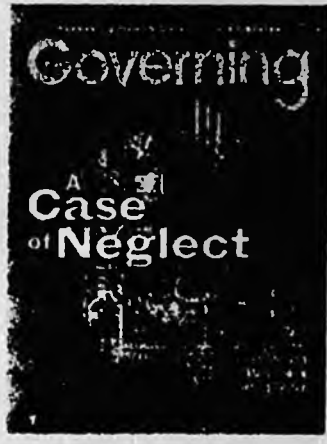
The same goes for prenatal care for pregnant women. Premature babies cost about \$13.1 billion annually, according to the March of Dimes Prenatal Data Center. The average premature baby racked up \$75,000 in hospital fees in 2001, compared with \$1,300 for a healthy full-term infant.

That's fairly well known. What's less well known is that states made remarkable progress on children's care in the few years just before the most recent budget crunch. Between 1999 and 2002, the number of children without insurance nationwide fell from 9.6 million to 7.8 million. At the upper end of performance, Iowa, Massachusetts, Minnesota, Nebraska, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont and Wisconsin all had less than 7 percent of total children uninsured.

By 2002, nearly 70 percent of all U.S. children were getting regular doctor's visits, and 83 percent of new mothers were receiving prenatal care in their first trimester — up from 76 percent in 1990. Infant deaths dropped from 9.2 out of 1,000 in 1990 to 6.9 out of 1,000 a decade later.

In recent years, improvements occurred even as the percentage of children covered by private insurance was shrinking. "Medicaid demonstrated its strength as a counter-cyclical safety net program," says Tara Straw, of the March of Dimes. "When children were losing insurance, Medicaid filled the gaps."

Elected officials realize the emotional importance of children's health to millions of Americans. No legislator ever denounces immunization or prenatal care as a waste of tax dollars. And yet — when budgets need to be cut — medical care for children often seems to be sitting in a



less than 50 percent of children covered through SCHIP stay eligible. Some are dropped from the rolls for good reasons, such as a change in family income. But a close look at eight states suggested that between 10 and 40 percent of children were "lost." One reason was that parents didn't answer renewal notices or re-submit applications.

States might conclude from this research that they should do more to educate and retain potential clients. And in the 1990s, many states did just that. But cutting back on SCHIP outreach saves substantial amounts of money, because it keeps the size of the rolls down. In both fiscal 2003 and 2004, California eliminated more than \$13 million in funding to community-based organizations for outreach and application assistance as well as another \$6 million a year for school-based outreach, such as media advertising and aides to help families fill out applications. Mississippi, Nebraska and Washington have recently added more rigorous documentation requirements for reporting income, while Connecticut, Indiana, Nebraska and Washington did away with the guarantee of 12 months of uninterrupted coverage.

All told, about half a million children will have lost coverage in fiscal years 2003 and 2004.

A More Direct Approach

If tightening up on eligibility sounds like a form of budget-cutting by stealth, many states are taking the more direct approach of actually freezing enrollment in their SCHIP programs. Alabama, Colorado, Florida, Maryland, Montana and Utah all have taken this path. The levels of income used to determine eligibility have not changed, but no new children are being admitted. In Florida, some 63,000 children who are eligible for SCHIP are now on waiting lists for coverage. Utah doesn't have a waiting list; it just sends people home and tells them to watch for a time when enrollment is open again.

The impact of such actions is immediate and dramatic, as was pointed out in a study of an enrollment freeze in the North Carolina SCHIP program, which took place between January and October 2001. About 34,000 children went on a waiting list. In interviews with University of North Carolina researchers, families who were wait-listed complained that they had been forced to delay medical or dental care, were unable to afford prescriptions, and in some cases had put off paying rent or utility bills.

Texas has made the most drastic cutbacks of all. Historically, the Lone Star State has been one of the weakest in children's health; an analysis of census data by the American Academy of Pediatrics puts the uninsured rate for children in Texas at 23 percent, compared with a U.S. average of 11.9 percent. This is in part a function of the state's percentage of low-income Hispanic families and a business sector with no strong tradition of employee benefits.

For a while, however, there was a serious effort to overcome these obstacles. After waiting until 2000 to implement its SCHIP program, Texas received deserved accolades for a massive expansion in which 500,000 children received new coverage through SCHIP and another 335,000 were added to the Medicaid program by 2002. Enrollment was simplified, Spanish-language outreach was initiated, and documentation requirements were eased. Medicaid officials reported a significant decline in the use of emergency rooms and county indigent care programs — settings where the uninsured often access their medical care.

But with its budget in trouble, and with a statewide aversion to new taxes, Texas has retreated. It reduced eligibility levels for pregnant women on Medicaid from 185 percent of poverty to 158 percent. It imposed asset limits and added a requirement that families on SCHIP re-enroll every six months, rather than once a year. One of the changes with the most impact is a new 90-day delay in starting coverage for children after they're determined to be eligible. This delay includes newborns as well. "It is unconscionable that crucial health care be delayed for an eligible newborn as a cost-saving measure," says Straw, of the March of Dimes. In all, the package of restrictions enacted

Natal Numbers

States ranked by rate of pre-term births, low birthweight and infant mortality (lowest)

STATE	% PRE-TERM BIRTHS 2002	RANK	% LOW BIRTH-WEIGHT 2002	RANK	% INFANT DEATHS (per 1,000 live births)	RANK
Alabama	18.8%	49	8.9%	46	8.4	47
Alaska	9.8	8	4.8	1	3.1	39
Arizona	12.6	30	6.6	14	6.9	36
Arkansas	12.7	35	6.6	14	6.3	41
California	10.2	9	6.4	9	6.4	40
Colorado	12.0	28	6.9	20	6.6	38
Connecticut	10.1	7	7.8	23	6.1	42
Delaware	12.6	33	9.9	44	10.7	50
Florida	12.0	27	6.4	9	7.5	39
Georgia	12.4	30	6.9	20	6.6	38
Hawaii	12.7	35	6.3	14	7.3	43
Idaho	10.4	10	6.1	10	6.1	42
Illinois	12.4	30	6.2	12	7.7	44
Indiana	12.5	29	7.0	21	7.6	45
Iowa	11.6	21	6.6	12	6.6	38
Kansas	11.0	14	7.0	21	7.4	43
Kentucky	12.6	33	6.6	14	6.9	36
Louisiana	18.1	48	10.4	49	12.0	55
Maine	10.1	7	4.3	6	6.1	42
Maryland	12.9	34	9.0	32	6.1	42
Massachusetts	10.6	12	7.6	19	6.0	43
Michigan	11.9	23	6.0	27	6.8	37
Minnesota	9.8	8	6.3	9	6.3	40
Mississippi	17.2	50	11.2	50	10.8	49
Missouri	12.0	28	6.0	27	7.4	43
Montana	11.2	18	6.8	16	6.7	39
Nebraska	11.8	22	7.2	17	6.8	37
Nevada	12.8	37	7.6	19	7.0	44
New Hampshire	9.5	2	4.9	8	5.6	46
New Jersey	12.8	37	6.0	27	6.6	38
New Mexico	12.8	37	6.0	27	6.6	38
New York	11.4	19	7.9	24	6.6	38
North Carolina	13.3	40	9.0	32	6.8	40
North Dakota	11.3	18	6.3	9	6.8	40
Ohio	12.2	26	6.3	14	7.7	44
Oklahoma	12.6	33	6.0	27	7.3	45
Oregon	9.7	4	6.8	1	6.4	39
Pennsylvania	11.7	19	6.2	12	7.2	43
Rhode Island	11.3	18	7.9	24	6.8	40
South Carolina	14.2	47	10.0	48	8.9	46
South Dakota	11.3	18	7.8	17	7.4	43
Tennessee	13.9	46	9.2	35	6.7	40
Texas	13.3	40	7.1	22	6.9	38
Utah	10.5	11	6.1	9	4.8	3
Vermont	9.8	8	4.4	9	5.8	47
Virginia	11.8	22	7.9	24	7.6	45
Washington	9.6	3	6.9	3	6.8	40
West Virginia	13.4	42	9.0	32	7.2	43
Wisconsin	10.9	13	6.6	12	7.1	44
Wyoming	11.7	22	6.4	14	6.9	36

Source: National Center for Health Statistics, Centers for Disease Control and Prevention

Data for this graphic

children are eligible and are not clients of someone else. Referrals require heavy paperwork and in some states, including Alabama and Tennessee, unpredictable or delayed payments are a problem as well. In the American Academy of Pediatrics survey, 39.4 percent of pediatricians regarded "paperwork" as a very important reason for limiting participation in Medicaid. But this criticism also varied a good deal among the states. In Florida, Mississippi, Nevada, New Jersey and Pennsylvania, more than half the pediatricians who responded complained about a paperwork problem. In Montana, Rhode Island, Vermont and Wyoming, fewer than 20 percent did.

REMEDIES

Targeting Access

Cutting back on access — either by freezing enrollments or cutting reimbursement rates — is not a choice states have taken happily. But it's a choice they were willing to make as a means of bringing budgets closer to balance. Children's health is universally seen as a worthy cause, but the fact remains that SCHIP and Medicaid families are not a very strong political constituency anywhere in the country.

Still, some states are doing better than others. Despite severe budget problems, Virginia simplified its application forms in 2002, instituted a joint form for SCHIP and Medicaid, and started new outreach efforts, with Governor Mark Warner going on what he called "a road show" to community fairs and churches to encourage families to sign up their children. The result by mid-summer 2003 was an additional 50,000 children enrolled.

Illinois last year increased coverage in its SCHIP program from 150 to 185 percent of poverty, adding an additional 20,000 children. Louisiana increased eligibility levels for pregnant women to 200 percent of the poverty level, and now covers a total of 600,000 children through either Medicaid or SCHIP, nearly twice as many as it covered five years ago. "We don't have uncoordinated care anymore," says Louisiana Health Secretary David Hood. "We have a program that I hope is going to change both recipient and provider behavior."

A few states have revamped their organizational and management systems to ensure better access to medical care while keeping costs under control. Rhode Island stands out in this respect. Currently, about 5 percent of Rhode Island children are uninsured. The state's "Rite Care" Program covers those

Out of the Loop

Percentage of children under age 18 with health care access problems, by select characteristics, 2001

	NO HEALTH INSURANCE COVERAGE	LIMITED MEDICAL NEED	DELAYED FAMILY ACCESS TO CARE	NO USUAL PLACE OF CARE	STOPPED RECENTLY PAST YEAR	UNMET DENTAL NEED	UNMET VISION NEED
ALL CHILDREN <18	18.4%	2.4%	4.1%	8.1%	8.0%	6.7%	14.8%
FAMILY STRUCTURE							
Mother and father	9.3	2.1	3.3	2.4	6.7	6.3	14.9
Mother, no father	11.9	2.9	4.2	6.4	10.6	10.3	18.1
Father, no mother	19.2	4.0	6.4	9.9	6.1	4.1	13.4
No mother or father	18.8	3.1	7.0	10.2	6.0	3.4	12.4
POVERTY STATUS							
Poor	18.4	4.0	6.0	9.8	10.0	12.0	19.8
Near poor	12.9	4.6	7.3	7.1	6.3	11.7	18.2
Not poor	4.4	1.4	2.3	2.4	6.5	4.8	12.3
REGION							
Northwest	12.4	1.9	3.4	1.1	6.1	6.1	11.7
Midwest	13.7	2.4	3.9	1.7	7.1	6.1	12.4
South	18.8	3.3	5.4	1.1	7.0	6.1	12.4
West	16.0	2.4	2.4	6.8	6.0	7.3	14.0

Source: National Center for Health Statistics, Centers for Disease Control and Prevention

Data for this graphic

below 250 percent of the poverty level and guarantees benefits to their mothers for two years after delivery. The state's immunization rates and infant mortality rates are significantly better than the national average. One of the state's major achievements has been to narrow the gap in infant mortality between high-income and low-income families. In the 1990s in Rhode Island, the infant mortality rate for children receiving public health coverage dropped 36 percent.

One of the keys to Rhode Island's success has been an organizational structure in which a "Children's Cabinet" crosses departmental boundaries. "The nature of government is to be insular and not look across many sections of government," says John Young, the state's Medicaid director. "But that's been our effort."

Rhode Island relies heavily on a managed care approach for meeting children's health care needs. Early on, it established a consumer advisory committee to deal with concerns voiced by patient advocates about managed care, and this committee has helped to establish safeguards. The state has buttressed quality in its managed care health plans through the use of performance contracting — setting up clear expectations for what the programs are expected to accomplish and rewarding those that meet the goals.

From *Governing's*
February 2004 Issue

THE GOVERNMENT PERFORMANCE PROJECT A Case of Neglect

Children's Care Introduction

States that Stand Out

SUCCESS STORIES

Alabama

Although sub-par in many health indicators, Alabama has a good statewide children's dentistry program. By working closely with professional dental groups, the state has been able to target the problems that keep dentists in other states from treating Medicaid patients: rejected claims, no-shows and low payment rates. Since the official kickoff of Smile Alabama in 2000, 260 providers have been added to the program, and 50,000 more children have received dental care.

Illinois, Louisiana and Virginia

Although none of these states has been a leader in child health in the past, all three made it a priority last year, countering the national trend to pull back. Illinois expanded participation in its KidCare program by 20,000. Virginia increased outreach and adopted new policies aimed at simplifying the enrollment process, and Louisiana increased low provider rates, boosted eligibility levels for pregnant women and continued to expand primary care case management.

Maine, Minnesota and Wisconsin

These states stand out in using information to improve their child health programs. Managed care organizations in Minnesota and Wisconsin are offered financial incentives for improved performance. Maine approaches individual practitioners with the same techniques, an even more difficult feat.

Massachusetts

In a poll conducted by the American Academy of Pediatrics, Bay State pediatricians complained far less than doctors in most other states about heavy paperwork, low reimbursement or unpredictable payments. The state has one of the country's highest pediatric participation rates in Medicaid, one of the lowest infant mortality rates and the highest rate of immunizations.

Missouri, New Hampshire, New Jersey and Vermont

These four states expanded their children's coverage well beyond that of most other states — and have so far avoided the temptation to cut back on children's

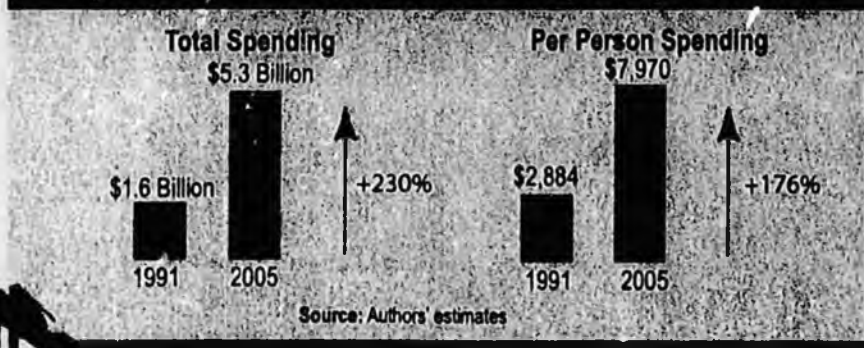
By Mark Foster and Scott Goldsmith

March 2006

UA Research Summary No. 6

Institute of Social and Economic Research • University of Alaska Anchorage

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



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 80%. 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?



COMMONWEALTH NORTH

Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES*

Approved by the Board of Directors on June 7, 2005
Updated July 31, 2005

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EXECUTIVE SUMMARY

Why Alaska health care issues must be addressed and solved

Health care is not a goal or end in itself. The ultimate goal of health care and of this study is health and wellness for Alaskans. Alaskans must identify and improve the aspects of health care that are under our control. Many health care issues are national, that Alaskans cannot affect. Therefore, it is even more important to address and solve issues we can do something about. Furthermore, the demographics of an aging population will put foreseeable pressure on all fronts.

ACCESS

- Approximately 110,000 Alaskans have no health insurance coverage.
- Many others have minimal or inadequate coverage.
- Thousands are turning to hospital emergency rooms as a source of primary health care, often without ability to pay.
- Adequate health care in remote areas is a significant logistical, financial and educational challenge.

QUALITY

- Based on the 2004 National Healthcare Quality Report, Alaska has low rankings in several key measures of cancer, heart disease, maternal and child health, respiratory diseases, and nursing and home health care.
- Many Alaskans are in high-risk health categories, many are not receiving adequate care.

COST

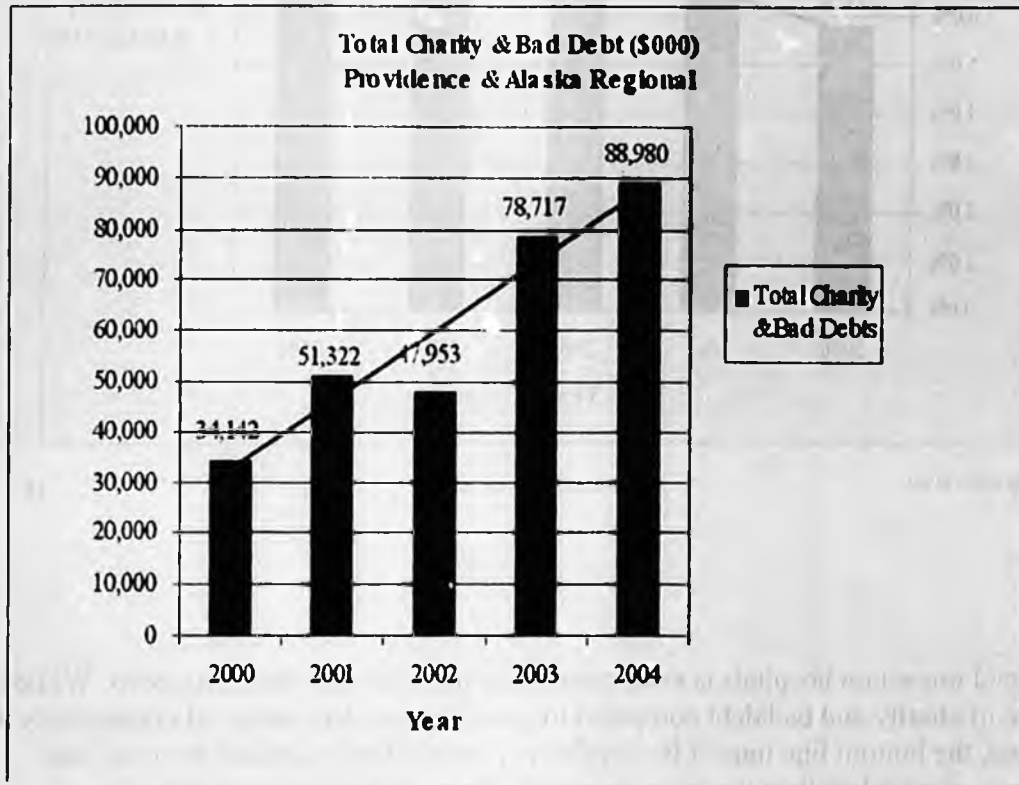
- Alaska health care costs are approximately 40% higher than Seattle (per Premera, corroborated by Providence and Alaska Regional)
- Medicaid costs to the State of Alaska are rising dramatically, to over \$1 billion in 2005. It is placing a strain on the state budget.
- Health care insurance premiums are also rising dramatically, creating a significant burden on employers and employees.
- Alaska hospitals are losing tens of millions of dollars from uncollectable accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law.

What can we do?

There are four major interrelated factors driving primary healthcare in Alaska today:

1. Health and wellness of the population
2. Availability of care and insurance
3. Affordability of care and insurance
4. Financial health of the stakeholders, such as employers, providers and individuals

Emergency rooms are becoming primary care treatment centers for those without access to, or awareness of, alternatives. Current waits can be up to two hours, especially during high traffic times like early evenings or weekends. This creates inefficient use of specially trained staff and is enormously expensive. Many ER patients have no insurance coverage or other means to pay their bill. The financial burden then falls on the hospital to write off uncollectible accounts.

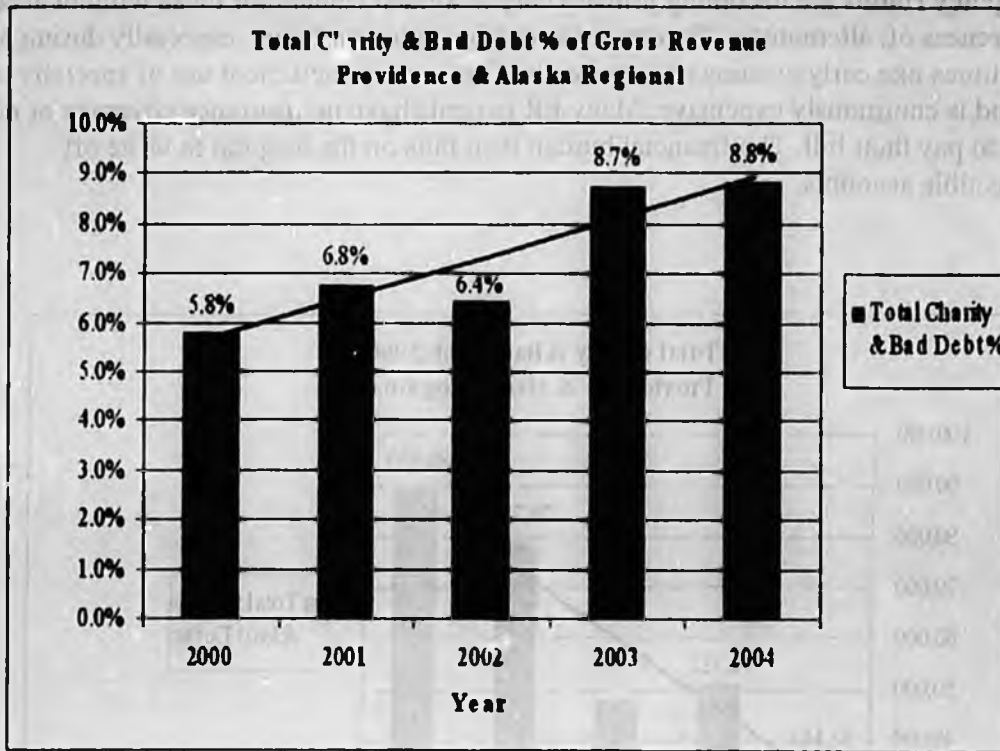


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Note: the numbers above are in thousands of dollars. E.g. 88,980 = \$88,980,000



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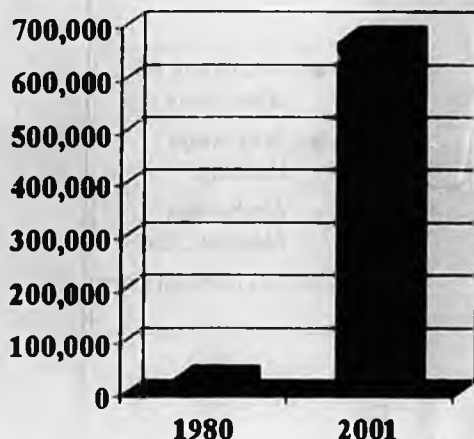
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The financial impact on hospitals is even more acute than the slide above suggests. While the percentage of charity and bad debt compared to gross revenue has increased dramatically in recent years, the bottom line impact is significantly greater because actual hospital cash collections are much less than the gross revenue billings used in the chart above.

Hospitals are not the only ones affected. Individuals unable to pay medical expenses are filing for bankruptcy at staggering rates. Although Alaska data are not available, national data are noted below.

Personal Bankruptcies due to Health Care Costs-U.S.



- Between 1980 and 2001 medically driven bankruptcies increased 23 times
- 60% skipped doctors visits
- 47% skipped prescription medicines

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Source: American Medical Association 2/05 and a Harvard Law School/Medical School 2/05 studies.

70% of these debtors had some form of health insurance at the start.

Main factors cited for declaring bankruptcy were:

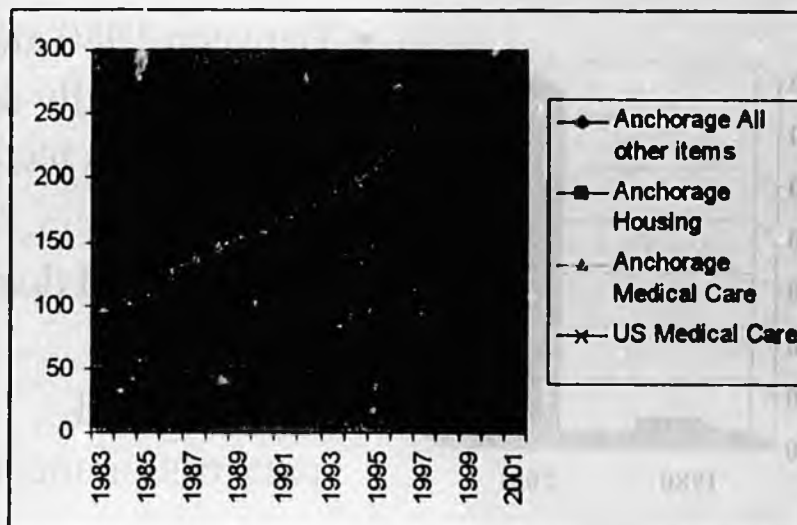
Hospital costs	42%
Prescription drug costs	21%
Doctor bills	20%

Cost: What do Alaskans pay? Why?

The impact of **bad debt** on the health care system has been clearly illustrated in the preceding charts.

Increasing Cost of Medical Care in Alaska

Anchorage CPI-U for selected components 1982-2001



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Source: Alaska Economic Trends June 2004

27



Premera, Alaska's largest health care insurer, reports that their **Alaska costs are about 40% higher than Seattle**. General observations by resource people have referenced a 40% differential overall, more in some specialties, less in others. Local hospitals have corroborated this differential. Other information points to even larger discrepancies on reimbursement rates for physicians. The Alaska Division of Medical Assistance Health Care Cost Analysis Report placed Alaska in the top five states in terms of the cost of medical and surgical procedures.

Small practices and increasing personnel costs contribute to the high cost of medicine in Alaska. Also there is general, but not substantiated, belief that the **Alaska population is too small to support HMOs**. Any discussion of managed care has been resisted by medical providers.

Dependence on "Fair Share" and other sources of federal dollars place about \$800 million potentially at risk, an important share of current health care funding to Alaska. Alaska also faces competition from other states for willing providers. Furthermore, reimbursement

National Academy Of Sciences

Hidden Cost, Value Lost: Uninsurance in America

Executive Summary

The discontinuity of coverage and complete lack of health insurance among tens of millions of Americans every year entail costs for our society in

- lost health and longevity, including health deficits leading to developmental and educational losses for children;
- financial risk, uncertainty and anxiety within families with one or more uninsured members;
- financial stresses for and instability of health care providers and institutions in communities with relatively high uninsured rates that reduce the scope and amount of available health services, including public health services; and
- lost workforce productivity.

As a nation and as public law, we invest in the health of those who have health insurance, through tax subsidies and publicly sponsored coverage. About 85 percent of the U.S. population benefit from this investment. As a society, we also spend substantial public resources for health care services to the remaining 15 percent of Americans—the more than 41 million people who lack coverage every year. Despite this public spending on health services for the uninsured, those who lack coverage have worse health outcomes than do similar individuals with insurance, because dollars alone do not confer the health benefits that continuous coverage does. If all members of society bear certain risks and costs from spillover effects of uninsurance, all should realize some benefit, at least indirectly, from a public policy ensuring that everyone has coverage.

Hidden Costs, Value Lost: Uninsurance in America tallies some of the most clearly identifiable economic and social costs of uninsurance, as described in the

Committee's previous four reports. The Committee concludes that maintaining an uninsured population of 41 million results in a substantial loss of economic value that improved health would provide uninsured individuals. The Committee also believes that, as health care interventions become ever more effective in improving health and extending life, unequal access to such care, as documented in *Care Without Coverage* and *Health Insurance Is a Family Matter*, becomes increasingly unjust.

Americans devote more economic resources to health care than people in any other nation in the world, both in total dollars spent (\$1.236 trillion for personal health care services in 2001) and as a percent of the gross domestic product (14 percent) (Levit et al., 2003). Access to health care is valued highly and widely throughout American society. In this report, the Committee takes a broad, societal perspective as it examines the performance of economic resources devoted to health care, health insurance, and alternative uses for these resources, which include personal resources, firms' investments, and public monies.

The societal perspective allows the Committee to evaluate our society's failure to invest in health insurance for 15 percent of the population from the standpoint of the public interest, rather than the interest of any particular individual or group within society. Practically, the societal perspective reflects the kind of aggregate, population-based information and national data sets that the Committee was able to use in its analyses. More importantly, as a matter of principle or ethical choice, the societal perspective values the interests of each individual member of society equally and allows the Committee to examine the fairness of the distribution of the costs and benefits of public policies and investments in health (Gold et al., 1996a).

WHAT ARE COSTS OF UNINSURANCE?

What do we mean by cost? This report draws on information developed within several different analytic frameworks because of the breadth of the issues encompassed by the "costs of uninsurance." When uninsured people obtain coverage, their use of health services would be expected to increase as a result of improved financial access. The majority of the costs due to being uninsured that the Committee has identified are not health services costs (that is, uncompensated care or expensive hospitalizations because of delayed treatment) but rather result from the poorer health outcomes of uninsured individuals.

Families with uninsured members bear costs resulting from the financial burdens and risks of out-of-pocket health care spending and, because children's receipt of health care in practice depends on their parents' coverage status, children in families with uninsured parents are less likely to receive adequate services.

The spillover costs of uninsurance experienced within communities result from both the poorer health of uninsured populations and the demands made on local public budgets and on providers to support care for those without coverage. Thus, this report considers both the extent and the source of resources devoted to

the care of people without health insurance and the economic cost implications of the poorer health they experience because they lack coverage.

THE VALUE LOST IN POORER HEALTH

Given the key role of health coverage in improving health outcomes, how much health is lost with a population of more than 41 million uninsured? In this report, the Committee adapts an analytic strategy that has been used to assess the value of life-saving and health-improving medical interventions, imputing a monetary value to the years of expected life that an individual is estimated to have in particular states of health (e.g., excellent, fair, poor; with controlled hypertension, or prostate cancer in remission, or no functional limitations).

The present value in money terms of the "stock" of years of life in certain expected states of health has been coined "health capital" (Grossman, 1972; Cutler and Richardson, 1997). This analytic concept of health capital is related to the approach used by government agencies that regulate public health and safety (e.g., Food and Drug Administration, Department of Transportation, Environmental Protection Agency) to evaluate and compare alternative public policies that mitigate risk and improve health. This approach involves estimating the value of averted risk as expressed by the expected number of lives saved (statistical or anonymous lives when the policy is implemented) to determine whether the benefit of reducing a particular risk or harm justifies the costs involved in adopting such a policy. The Committee has applied the analytic concept of health capital to the health risk it has been concerned with—the risk of being uninsured, compared to having coverage. Stated in the converse, the Committee has estimated the aggregate personal economic value that would be added if the entire U.S. population had health insurance coverage, compared with the status quo, which leaves 16.5 percent of the population under age 65 without coverage.

The Committee commissioned an analysis estimating the value of diminished health and longevity within the U.S. population as a result of uninsurance. Economist Elizabeth Richardson Vigdor combined information on the longevity, prevalence of health conditions, and health-related quality of life for insured and uninsured populations. The relative mortality rates for insured and uninsured populations were drawn from the Committee's earlier systematic literature review of health outcomes as a function of health insurance status and reflect a 25 percent higher mortality rate within the uninsured population (IOM, 2002a,b). Vigdor's estimates constitute a range of values for the forgone health of uninsured individuals, based on different assumptions about the relative health status of insured and uninsured populations.

Imputing a value of \$160,000 to a year of life in perfect health and calculating the present value of future years with an annual discount rate of 3 percent, Vigdor estimated that the economic value of the healthier and longer life that an uninsured child or adult forgoes because he or she lacks health insurance ranges between \$1,645 and \$3,280 for each additional year spent without coverage

(Vigdor, 2003). This value differs for people of different ages and for men and women because of differences in underlying health status and life expectancy. These estimated benefits could be either greater or smaller if unmeasured personal characteristics were responsible for part of the measured difference in morbidity and mortality between those with and those without coverage.

The Committee's best estimate of the aggregate, annualized cost of the diminished health and shorter life spans of Americans who lack health insurance is between \$65 and \$130 billion for each year of health insurance forgone. These are the benefits that could be realized if extension of coverage reduced the morbidity and mortality of uninsured Americans to the levels for individuals who are comparable on measured characteristics and who have private health insurance. This estimate does not include spillover losses to society as a whole of the poorer health of the uninsured population. It accounts for the value only to those experiencing poorer health and subsumes the losses to productivity that accrue to uninsured individuals themselves.

These estimates constitute an initial effort to develop an integrated and coherent framework for evaluating a number of economic costs attributable to the lack of health insurance; they are not definitive but suggest the direction that further research and analysis might take. Figure ES.1 illustrates the costs of uninsurance that the Committee has documented in its work to date. The bracket to the left of the pyramid shows the costs that are captured in the estimate of the economic value of forgone health by those who lack coverage, and the costs that are additional to that estimate.

HEALTH CARE COSTS OF THE UNINSURED

In its analysis of the costs of health care now used by those who lack health coverage, the Committee finds that

- Uninsured children and adults are less likely to incur any health care expenses in a year and, on average, incur health care costs well below half of average spending for services by all those under age 65.
- People who lack health insurance for an entire year have out-of-pocket expenditures comparable, in absolute dollar amounts, to those of people with private coverage. Uninsured individuals pay for a higher proportion of the total costs of care rendered to them out of pocket, however, compared to insured individuals under age 65 (35 percent, compared with 20 percent), and they also have much lower family incomes. Out-of-pocket spending for health care by the uninsured is more likely to consume a substantial portion of family income than out-of-pocket spending by those with any kind of insurance coverage.
- The total cost of health care services used by individuals who are

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EXECUTIVE SUMMARY

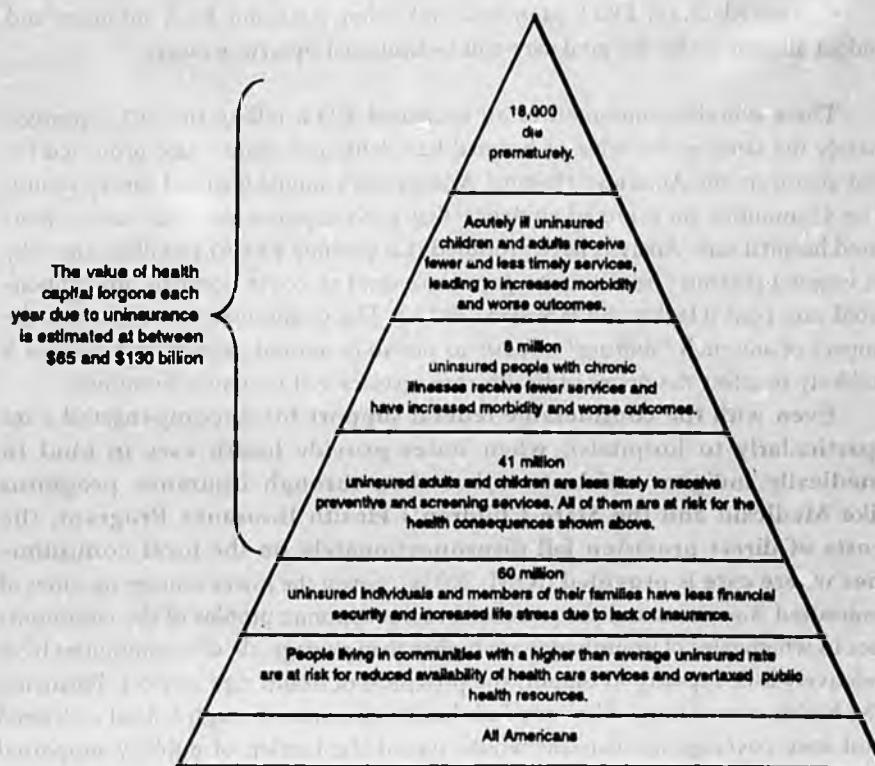


FIGURE ES.1 Consequences of uninsurance.

uninsured for either part of or the entire year is estimated to be \$98.9 billion for 2001.

- The best available estimate of the value of uncompensated health care services provided to persons who lack health insurance for some or all of a year is roughly \$35 billion annually, about 2.8 percent of total national spending for personal health care services.

The direct costs of uncompensated care provided to uninsured people are largely borne by those who pay taxes. Public support from the federal, state, and local governments accounts for between 75 and 85 percent of the total value of uncompensated care estimated to be provided to uninsured people each year (Hadley and Holahan, 2003a). Public subsidies to hospitals are paid through

- federal Medicaid and Medicare disproportionate share hospital (DSH) payments and other financing mechanisms, and

- state Medicaid DSH payments and other state and local subsidies and budget allocations for hospital care and institutional operating costs.

These subsidies amounted to an estimated \$23.6 billion in 2001, approximately the same as the value of hospital bad debts and charity care projected for that year from the American Hospital Association's annual financial survey results. The Committee finds mixed evidence that private payers subsidize uncompensated hospital care. Analysts have proposed that possibly \$1.6 to \$3 billion annually in hospital revenues from private payers are used to cover hospitals' uncompensated care costs (Hadley and Holahan, 2003a). The Committee concludes that the impact of any such "shifting" of costs to privately insured patients and insurers is unlikely to affect the prices of health care services and insurance premiums.

Even with the considerable federal support for uncompensated care (particularly to hospitals), when states provide health care in kind to medically indigent residents rather than through insurance programs like Medicaid and the State Children's Health Insurance Program, the costs of direct provision fall disproportionately on the local communities where care is provided (IOM, 2003a). Given the lower average incomes of uninsured Americans and the associated socioeconomic profiles of the communities in which rates of uninsurance are higher than average, these communities have relatively little capacity to support the provision of health care services. Financing the health care of those who now lack health insurance through federal or federal and state coverage mechanisms would spread the burden of publicly supported care over a broader tax base than that which supports uncompensated care for those without coverage.

QUALITY OF LIFE AND SECURITY FOR FAMILIES

Uninsured individuals and families bear the burden of increased financial risk and uncertainty as a consequence of being uninsured. Although the estimated monetary value of the potential financial losses that those without coverage bear is relatively small (compared to the full cost of their services) because of uncompensated care, the psychological and behavioral implications of living with financial and health risks and uncertainty may be significant. The Committee estimates that the financial risk borne by those without coverage has an economic cost of \$1.6 to \$3.2 billion. This would be the value, to those now lacking coverage, of the financial protection provided by health insurance.

Even in families in which all members are insured, the concern about losing coverage remains genuine. One, some, or all members can lose health insurance at some point, because of lifecycle events such as leaving school or retiring or because of economic conditions that result in the loss of income or workplace benefits, such as becoming unemployed or changing jobs. This lack of social and economic security, experienced by virtually all Americans except for those who

have gained Medicare coverage on a permanent basis (i.e., those over age 65 or with end-stage renal disease), is truly a hidden cost of our patchwork approach to health insurance.

OTHER COSTS OF UNINSURANCE

Developmental Losses for Children

Uninsured children are at greater risk than children with health insurance of suffering delays in development that may affect their educational achievements and prospects later in life. Good health and meeting developmental milestones in infancy and childhood affect individuals' educational attainment, earning capacity, and long-term health. The Committee's estimate of health capital forgone by uninsured children and adults that was presented earlier subsumes these developmental losses. The Committee includes its review of studies and earlier findings regarding worse health outcomes among uninsured children to provide an empirical underpinning to its approach to estimating health capital losses resulting from the lack of health insurance.

Costs to Public Programs

The Committee considered other costs that are attributable to uninsurance without attempting to quantify them. Although the costs of morbidity and productivity losses associated with individual health conditions have been estimated, there is no body of research with which to investigate these effects as a function of health insurance status in a systematic way. Thus the Committee has identified public program and workforce impacts of health insurance status that can be inferred from related evidence about the effects of health status on disability and productivity and the effects of health insurance on health status, largely based on the Committee's reports *Care Without Coverage* and *Health Insurance Is a Family Matter*.

Based on its findings and conclusions about health outcomes as a function of health insurance status in its earlier reports, the Committee concludes that public programs, including Medicare, Social Security Disability Insurance, and the criminal justice system almost certainly have higher budgetary costs than they would if the U.S. population in its entirety had health insurance up to age 65. It is not possible, however, to estimate the extent to which such program costs are increased as a result of worse health due to lack of health insurance.

As calculated for this study, the value of healthy years of life forgone by those without health insurance does not include any health and longevity impacts that occur after age 65, when Medicare covers virtually the entire population. The Committee's conservative assumption in estimating the value of health lost likely underestimates the health benefits enjoyed by individuals who would gain addi-

tional health and longevity after age 65 if they had health insurance continuously prior to that age. It is also likely to underestimate the potentially reduced costs to the Medicare program of financing services for persons with pent-up demand for care or health "deficits" as a result of having been without coverage previously. For example, individuals who have poorly controlled hypertension or diabetes or undetected high cholesterol because of irregular or no medical attention to their condition enter the Medicare program with more comorbidities and worse health status than do persons whose conditions have been treated over time.

Likewise, increasing disability among the working-age population (even as the disability rate has decreased over the past two decades for those older than 65), suggests that health and functional status improvements that health insurance provides could reduce disability insurance claims.

In the case of serious mental illness, for example, there can be substantial spillover costs of uninsurance to society. More than 3 million adults in the United States have either schizophrenia or bipolar disorder (manic-depressive disease), which can involve psychosis and aberrant behavior. Fully 20 percent of the adults with one of these conditions who do not reside in institutions lack health insurance. Although being insured is no guarantee that mental health services are a covered benefit or that one will be treated appropriately for mental health problems, persons with either public or private health insurance are more likely to receive some care for their condition than are those without any coverage. Between 600,000 and 700,000 persons with severe mental illness are jailed each year. Ironically, contact with the criminal justice system increases the chances that someone with a severe mental illness will receive specialty mental health services. The costs of less effective treatment resulting from lack of health insurance likely contribute to the costs of incarcerating people with serious mental illness.

Workforce Participation, Productivity, and Employers

Illness and functional limitations impair people's abilities to work and consequently impose the costs of forgone income and productive effort on those who are sick and disabled, their families, and potentially on their employers as well. The costs for employers of productivity losses on the job for workers with particular illnesses have been increasingly well studied within the past decade. The impact that providing workers with health insurance has on workplace productivity, however, is less well documented. What evidence exists suggests that, although workers' health status may improve as a result of having coverage, individual employers probably do not lose financially, on net, as a result of impaired productivity on the job if they do not currently offer their workers health insurance benefits. Any systemic, regional, or national losses of productivity or productive capacity as a result of uninsurance among nearly one-fifth of the working-age population cannot be measured with the data now available.

Costs for Communities

Not only those who lack coverage but others in their communities may experience reduced access to and availability of primary care, specialty, and hospital services resulting from relatively high rates of uninsurance that imperil the financial stability and viability of health care providers and institutions. Communities that have higher than average rates of uninsurance are more likely to experience reduced availability of hospital-based services and critical community benefits such as emergency services and advanced trauma care (IOM, 2003a; Gaskin and Needleman, 2003; Needleman and Gaskin, 2003).

In addition, population health resources and programs, including disease surveillance, communicable disease control, emergency preparedness, and community immunization levels, have been undermined by the competing demands for public dollars for personal health care services for those without coverage. Because uninsured individuals and families are much less likely than are those who have coverage to have a regular health care provider, they are not well integrated into systems of care. Consequently, population-level disease surveillance and health monitoring is reduced in communities with large uninsured populations.

THE COST OF THE HEALTH CARE THAT UNINSURED PEOPLE WOULD USE IF THEY HAD COVERAGE

In order to evaluate fairly the cost of the better health that uninsured Americans could be expected to achieve if they had health insurance, the Committee reviewed estimates of the value of the additional health services that would be provided to the uninsured once they became insured. Estimates of the incremental costs of health services that the population that now lacks insurance could be expected to use if they gained coverage range from \$34 to \$69 billion (in 2001 dollars). These estimates should not be construed as the costs of any particular plan to reform health care financing to provide health insurance to those now without it. This range of estimates, derived from three independent analyses, assumes no other structural changes in the systems of health services delivery or finance, scope of benefits, or provider payment (Long and Marquis, 1994; Hadley and Holahan, 2003b; Miller et al., 2003). The ultimate cost of any reform will depend on the specific features of the approach taken. These estimated costs amount to 2.8–5.6 percent of national spending for personal health care services in 2001, equivalent to roughly half of the 8.7 percent increase in personal health care spending between 2000 and 2001.

COSTS AND BENEFITS CONSIDERED TOGETHER

Table ES.1 summarizes the Committee's estimates of the amounts and sources of payment for the health care currently provided to uninsured Americans, the

TABLE ES.1 Estimates of Current Annual Cost of Health Care Services for Full- and Part-Year Uninsured Individuals, Projected Incremental Annual Costs of Services If Insured, and Economic Value Gained by Uninsured Individuals If Insured, Annualized

	Billions \$, estimated for 2001
Current cost of care for full- and part-year uninsured	98.9
Amount paid out of pocket by full- and part-year uninsured	26.4
Insurance payments (for part-year uninsured only) and workers' compensation	
Private	24.2
Public	13.8
Uncompensated care	34.5
Projected annual costs of additional utilization with coverage	34-69
Benefits of insuring the uninsured	
Aggregate value of health capital forgone by the uninsured, annualized	65-130
Aggregate annual value of risk borne by uninsured	1.6-3.2

SOURCES: Hadley and Holahan, 2003a,b; Vigdor, 2003.

projected cost of the additional health care that the presently uninsured population would receive if insured, and the aggregate, annualized economic value of lost health and financial security that those who lack coverage forgo, despite the substantial health care expenditures made on their behalf.

The next step in the Committee's analysis is to consider the potential benefits of providing the uninsured with coverage in conjunction with the new economic costs of the additional health services that would improve their health. In order to do this, both the average per capita gain in health due to an additional year of health insurance for the uninsured population and the average per capita annual cost of the additional health services that the uninsured population would use if they had coverage must be made comparable. Because the estimate of the value of health gained with an additional year of coverage is calculated as a discounted present value of the gain for a cohort of uninsured people over the course of their lives (with a range of \$1,645 to \$3,280 as presented earlier), the estimate of the annual cost of the additional health care that the uninsured would use if insured also must be calculated as the present value for an uninsured cohort over the course of their lives.

Using the projected annual cost of the additional utilization by those without coverage from Hadley and Holahan (2003b), the Committee estimated that the discounted present value of the cost of an additional year of health insurance ranges from \$1,004 to \$1,866, depending on whether the incremental service costs

are based on the cost of public or private health insurance. The range of estimated benefits from the incremental coverage (\$1,645 to \$3,280) is higher than the range of estimated incremental service costs (\$1,004 to \$1,866) and, for most values within each range, results in a benefit-cost ratio of at least one.

REALIZING SOCIAL VALUES AND IDEALS

Finally, the Committee reflected on several other benefits that our national community and local communities within the United States might gain if health insurance coverage were extended throughout the population. Economic goods that can be valued in monetary terms are not the only kinds of goods that we value having. Providing certain important goods like health care to all members of society has its own value (Walzer, 1983; Coate, 1995). In addressing normative questions, the Committee has attempted to start from values that are widely endorsed throughout American society, such as equality of opportunity, and then to make judgments about whether public policy and economic practices in health care accord with a reasonable characterization of those values. The Committee does not attempt to make a freestanding argument about objective morality but rather claims that collective actions can express or achieve existing social norms and ideals.

Because health care relieves pain and suffering and enhances our ability to function and achieve over the course of a lifetime, making sure that everyone in society has adequate access to this good is a matter of fairness and social decency (Daniels, 1985; Sen, 1993). A commitment to equal opportunity obligates us as a society to ensure that all Americans have sufficient access to health care such that they are not disadvantaged in pursuing the career and other opportunities offered by American society.

Health insurance contributes essentially to obtaining the kind and quality of health care that can express the equality and dignity of every person. Despite the absence of an explicit Constitutional or statutory right to health care (beyond access to emergency care in hospitals, required by the Emergency Medical Treatment and Labor Act), disparities in access to and the quality of health care of the kind that prevail between insured and uninsured Americans contravene widely accepted, democratic cultural and political norms of equal consideration and equal opportunity. The increasing effectiveness of medical interventions in improving health and survival (Cutler and Richardson, 1997; Murphy and Topel, 1999; Heidenreich and McClellan, 2003) make considerations of equity in access to effective care through health insurance more urgent.

Uninsurance in America not only has hidden costs, it represents lost opportunities to more fully realize important social and political ideals that account for our nation's political stability and vitality (Dionne, 1998; NASI, 1999). Extending the social benefit of health insurance would help us make our implicit and explicit democratic political commitments of equal opportunity and mutual concern and respect more meaningful and concrete.



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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.



FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB 87
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Corrections
 Title An Act expanding medical assistance coverage RDU Administration & Operations
eligible children and pregnant women . . . Component Office of the Commissioner
 Sponsor Senators Wielechowski, French, Ellis, Elton, Davis
 Requester Senate Health, Education, and Social Services Component No. 694

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

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

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Passage of this legislation will not have a fiscal impact on the Department of Corrections.

Prepared by: Sharleen Griffin, Director Phone (907) 465-3339
 Division Administrative Services Date/Time 3/1/07 12:33 PM
 Approved by: Dwyane Peoples, Deputy Commissioner Date 3/1/2007
 Agency Department of Corrections



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