SB
13

<target><bill>SB 13</bill><subject>SB
13</subject><comm>HFIN26</comm></target>

Alaska State Legislature

Interim: (May - Dec.)
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Session: (Jan. - May)
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Senator Bettye Davis

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

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

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

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Background of SCHIP/Denali Kid Care

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

Why Coverage for Pregnant Women is Important In Alaska

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

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Senator Bettye Davis

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

Sponsor Statement

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

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

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

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

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

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

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

LEGAL SERVICES

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

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Juneau, Alaska 99801-1182
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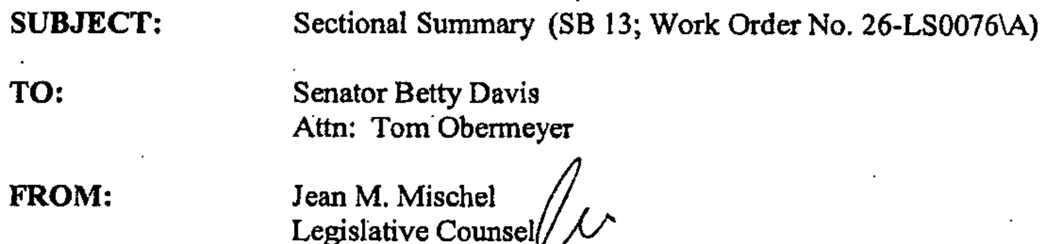
MEMORANDUM January 22, 2009



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

TO: Senator Betty Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

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

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

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

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

Section 3. Provides for an immediate effective date.

JMM:ljw
09-039.ljw

HOUSE COMMITTEE REPORT

(11)
Date Referred to Committee: March 19, 2010 — FURTHER REFERRALS:

Date of Committee Action: 4/15/10

The FINANCE Committee considered: — SENATE BILL NO. 13

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

SB 13-MEDICAL ASSISTANCE ELIGIBILITY

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* ______________________(________)
*For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR*_______ [ ] Same Title [ ] New Title

[ ] attach amendments
[ ] add new referral to ____________Committee
[ ] Letter of Intent___________Committee

List of Abbrev. for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
DHS
LWF
LAW
LEG
MVA
DNR
DPS
REV
DOT
UA

***NEW* FISCAL NOTES**
*Assigned by Chief Clerk's Office

List by Dept(s):	*FN#	Fiscal	Indet.	Zero

***PREVIOUS* FISCAL NOTES**

List by Dept(s):	FN#	Fiscal	Indet.	Zero
DHS	5	✓		
DHS	6	✓		
DHS	7	✓		

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
[signature]	Thomas	✓			
[signature]	Doogan			✓	
[signature]	Joule	✓			
[signature]	KELLY		X		
[signature]	Austerman		X		
[signature]	FOSTER	✓			
[signature]	FAIRCLOUGH			✓	
[signature]	Salmon	X			
Chair: [signature]	Stoltze			✓	
Chair: [signature]	Hawker			✓	

2930

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 5
Bill Version: SB 13
(H) Publish Date: 3/19/10

Identifier (file name): SB013-DHSS-FAFS-03-05-10
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Public Assistance
Component: Public Assistance Field Services
Sponsor: Davis
Requester: House HSS
Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	134.4		134.4	134.4	134.4	134.4	134.4
Travel							
Contractual	17.6		17.6	17.6	17.6	17.6	17.6
Supplies	1.0		1.0	1.0	1.0	1.0	1.0
Equipment	14.4						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**167.4**	**0.0**	**153.0**	**153.0**	**153.0**	**153.0**	**153.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
1002 Federal Receipts	109.2	0.0	99.5	99.5	99.5	99.5	99.5
1003 GF Match	58.2	0.0	53.5	53.5	53.5	53.5	53.5
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**167.4**	**0.0**	**153.0**	**153.0**	**153.0**	**153.0**	**153.0**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

	FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Full-time	**2.0**		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

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

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

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

(continued on Page 2)

Prepared by: Ellie Fitzjarrald, Director
Phone 907-465-5847
Division: Division of Public Assistance
Date/Time 1/4/10 12:00 PM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 3/5/2010

FISCAL NOTE #5

STATE OF ALASKA

2010 LEGISLATIVE SESSION

BILL NO. SB 13

ANALYSIS CONTINUATION

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

The cost estimates assume that 218 pregnant women and 1,277 children will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and that implementation will begin July 1, 2010. Two additional Eligibility Technician I (Range 13) positions will be needed to manage this additional work in FY2011.

Total Administrative Costs for ET I Positions:

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

Additional Cost of FY2011:
Equipment/Supply: A one-time cost of $14.4 for desktop computer, software, printer, and work stations will be needed for the new positions.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 6
Bill Version: SB 13
(H) Publish Date: 3/19/10

Identifier (file name): SB013-DHSS-BHMS-03-05-10
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Behavioral Health
Component: Behavioral Health Medicaid Services
Sponsor: Davis
Requester: House HSS
Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	467.0		507.1	550.7	598.1	649.5	705.4
Miscellaneous							
TOTAL OPERATING	**467.0**	**0.0**	**507.1**	**550.7**	**598.1**	**649.5**	**705.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	305.7		330.7	359.1	390.0	423.6	460.0
1003 GF Match	161.3		176.4	191.6	208.1	226.0	245.4
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**467.0**	**0.0**	**507.1**	**550.7**	**598.1**	**649.5**	**705.4**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

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

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

Between October 2003 and July 2007, the upper income limits for children and pregnant women were frozen at dollar amounts equivalent to 175% of the 2003 federal poverty guideline (FPG). By April 2007, those amounts corresponded to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and pregnant women equal to 175% of the federal poverty guideline for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility at that time. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 269-7827
Division: Health Care Services
Date/Time 1/20/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 3/5/2010

(Revised 11/6/2009 OMB)

ANALYSIS CONTINUATION

Between 2003 when the upper guideline was still 200% FPG, and 2006 when the statutory income amount was approaching 150% FPG, the number of individuals enrolled annually in this income category decreased by 2,553 children and 436 pregnant women. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children).

This analysis extends the projected budget impact through 2016. It assumes that implementation will occur in early FY2011, that most people affected by this bill will enroll by the end of that first year, and that enrollment and utilization will resume normal growth thereafter. The formula for federal funds has been updated to reflect the higher regular federal match percentage for 2011 only. The annual growth percentage for costs between 2011 and 2016 (8.6%) and the annual growth percentage for enrollment after 2011 (2%), are from the department's Long Term Forecast of Medicaid Spending (2006 update).

First year costs are based on estimates for the number of new enrollees and the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in the estimates.

Fund source calculations are based on the relative proportion of costs that were reimbursed at IHS, Title XIX, or Title XXI rates for these eligibility groups during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2011 and 2016. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs are expected to be matched at the enhanced rate for Title XXI services. Fund projections assume federal SCHIP allocations adequate to fully fund the additional children between 2011 and 2016.

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

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 7
Bill Version: SB 13
(H) Publish Date: 3/19/10

Identifier (file name): SB013-DHSS-MS-3-5-10
Dept. Affected: Health & Social Services
Title: Medical Assistance Eligibility
RDU: Health Care Services
Component: Medicaid Services
Sponsor: Davis
Requester: House HSS
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	2,286.0		2,482.6	2,696.1	2,928.0	3,179.8	3,453.3
Miscellaneous							
TOTAL OPERATING	**2,286.0**	**0.0**	**2,482.6**	**2,696.1**	**2,928.0**	**3,179.8**	**3,453.3**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,592.7		1,689.5	1,834.8	1,992.6	2,164.0	2,350.1
1003 GF Match	693.3		793.1	861.3	935.4	1,015.8	1,103.2
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**2,286.0**	**0.0**	**2,482.6**	**2,696.1**	**2,928.0**	**3,179.8**	**3,453.3**

Estimate of any current year (FY2010) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

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

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

Between October 2003 and July 2007, the upper income limits for children and pregnant women were frozen at dollar amounts equivalent to 175% of the 2003 federal poverty guideline (FPG). By April 2007, those amounts corresponded to about 150% of the 2007 FPG . Senate Bill 27, implemented in summer 2007, made the upper income standard for children and pregnant women equal to 175% of the federal poverty guideline for Alaska, as published annually in the federal register, and effectively raised the income level from 150% to 175% FPG. However, children and pregnant women with incomes between 176% and 200% of the prevailing FPG did not regain eligibility at that time. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Division: Health Care Services
Phone 269-7827
Date/Time 1/20/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 3/5/2010

2010 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Between 2003 when the upper guideline was still 200% FPG, and 2006 when the statutory income amount was approaching 150% FPG, the number of individuals enrolled annually in this income category decreased by 2,553 children and 436 pregnant women. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children).

This analysis extends the projected budget impact through 2016. It assumes that implementation will occur in early SFY2011, that most people affected by this bill will enroll by the end of that first year, and that enrollment and utilization will resume normal growth thereafter. The formula for federal funds has been updated to reflect the higher regular federal match percentage for 2011 only. The annual growth percentage for costs between 2011 and 2016 (8.6%) and the annual growth percentage for enrollment after 2011 (2%), are from the department's Long Term Forecast of Medicaid Spending (2006 update).

First year costs are based on estimates for the number of new enrollees and the average cost per enrollee for the affected eligibility subtypes in 2008. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Fund source calculations are based on the relative proportion of costs that were reimbursed at IHS, Title XIX, or Title XXI rates for these eligibility groups during 2008 and our best estimates for federal medical assistance percentages (FMAPs) between 2011 and 2016. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs are expected to be matched at the enhanced rate for Title XXI services. Fund projections assume federal SCHIP allocations adequate to fully fund the additional children between 2011 and 2016.

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

Federal Poverty Levels for Alaska - 2009
2009 Federal Poverty Levels for Alaska

Household Size	Annual Federal Poverty Levels for Alaska - 2009									
	100%	150%	175%	200%	225%	250%	275%	300%	325%	350%
1	$13,530	$20,295	$23,678	$27,060	$30,443	$33,825	$37,208	$40,590	$43,973	$47,355
2	18,210	27,315	31,868	36,420	40,973	45,525	50,078	54,630	59,183	63,735
3	22,890	34,335	40,058	45,780	51,503	57,225	62,948	68,670	74,393	80,115
4	27,570	41,355	48,248	55,140	62,033	68,925	75,818	82,710	89,603	96,495
5	32,250	48,375	56,438	64,500	72,563	80,625	88,688	96,750	104,813	112,875
6	36,930	55,395	64,628	73,860	83,093	92,325	101,558	110,790	120,023	129,255
7	41,610	62,415	72,818	83,220	93,623	104,025	114,428	124,830	135,233	145,635
8	46,290	69,435	81,008	92,580	104,153	115,725	127,298	138,870	150,443	162,015
Each Addl.	4,680	7,020	8,190	9,360	10,530	11,700	12,870	14,040	15,210	16,380

Household Size	Monthly Federal Poverty Levels for Alaska - 2009									
	100%	150%	175%	200%	225%	250%	275%	300%	325%	350%
1	$1,128	$1,692	$1,974	$2,255	$2,537	$2,819	$3,101	$3,383	$3,665	$3,947
2	1,518	2,277	2,656	3,035	3,415	3,794	4,174	4,553	4,932	5,312
3	1,908	2,862	3,339	3,815	4,292	4,769	5,246	5,723	6,200	6,677
4	2,298	3,447	4,021	4,595	5,170	5,744	6,319	6,893	7,467	8,042
5	2,688	4,032	4,704	5,375	6,047	6,719	7,391	8,063	8,735	9,407
6	3,078	4,617	5,386	6,155	6,925	7,694	8,464	9,233	10,002	10,772
7	3,468	5,202	6,069	6,935	7,802	8,669	9,536	10,403	11,270	12,137
8	3,858	5,787	6,751	7,715	8,680	9,644	10,609	11,573	12,537	13,502
Each Addl.	390	585	683	780	878	975	1,073	1,170	1,268	1,365

Eligiblity Levels in Medicaid & CHIP[1] for Children, by State as of February 2010

State	Enacted Eligibility Levels	Implemented Eligibility Levels
Alabama	300%	300%
Alaska	175%	175%
Arizona	200%	200%
Arkansas [2]	250%	200%
California	250%	250%
Colorado	250%	205%
Connecticut	300%	300%
Delaware	200%	200%
District of Columbia	300%	300%
Florida	200%	200%
Georgia	235%	235%
Hawaii	300%	300%
Idaho	185%	185%
Illinois	300%	200% (no limit)
Indiana [3]	300%	250%
Iowa	300%	300%
Kansas [4]	250%	240%
Kentucky	200%	200%
Louisiana [5]	300%	250%
Maine	200%	200%
Maryland	300%	300%
Massachusetts	300% (400+%)	300% (400+%)
Michigan	200%	200%
Minnesota	275%	275%
Mississippi	200%	200%
Missouri	300%	300%
Montana	250%	250%
Nebraska	200%	200%
Nevada	200%	200%
New Hampshire	300%	300%
New Jersey	350%	350%
New Mexico	235%	235%
New York	400%	400%

Updated: 2/1/10

State	Enacted Eligibility Levels	Implemented Eligibility Levels
North Carolina	250%	200%
North Dakota	160%	160%
Ohio [6]	300%	200%
Oklahoma [7]	300%	185%
Oregon	300%	300%
Pennsylvania	300%	300%
Rhode Island	250%	250%
South Carolina	200%	200%
South Dakota	200%	200%
Tennessee	250%	250%
Texas	200%	200%
Utah	200%	200%
Vermont	300%	300%
Virginia	200%	200%
Washington	300%	300%
West Virginia	300%	250%
Wisconsin	300%	250% (300%)
Wyoming	200%	200%

Source: D. Cohen Ross, *et al.*, "A Foundation for Health Reform," Kaiser Commission on Medicaid and the Uninsured (December 2009); updated by the Center for Children and Families.

Notes:
1: Eligibility levels reflect the highest income eligibility level in the state using federal Medicaid/CHIP funds, without regard to income disregards or deductions. Note that Illinois, Massachusetts, and Wisconsin provide state-financed coverage to children above Medicaid/CHIP levels; eligibility for state-funded coverage is shown in parentheses.
2: Arkansas planned on implementing its expansion on July 1, 2009. The state awaits CMS approval.
3: Due to the August 17th CMS directive, Indiana submitted a CHIP state plan amendment expanding to 250% FPL (gross income); CMS aproved the limited expansion on 5/9/08. Implementation to 250% began on October 1, 2008.
4: Note that the CHIP eligibility level is 250% of the 2008 FPL (or approximately 240% of the 2009 FPL).
5: Due to the August 17th CMS directive, Louisiana submitted a CHIP state plan amendment expanding to 250% FPL (gross income) with a 12-month waiting period; CMS approved the limited expansion on 2/27/08. Implementation to 250% began on May 1, 2008.
6: Ohio planned to implement its expansion on July 1, 2009; however, funding has not yet been secured.
7: Due to the August 17th CMS directive, Oklahoma submitted a waiver amendment expanding CHIP to 250% FPL; the amendment was never approved. Since the directive has been rescinded, the state has submitted a state plan amendment to expand through premium assistance to 300%.

Updated: 2/1/10

MARK BEGICH
ALASKA

SUITE SH-825
HART BUILDING
WASHINGTON, DC 20510
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United States Senate

WASHINGTON, DC 20510

February 25, 2009

The Honorable Gary Stevens
Senate President
State Capitol, Room 111
Juneau, AK 99801-1182

The Honorable Lyman Hoffman
Co-Chairman, Senate Finance Committee
State Capitol, Room 518
Juneau, AK 99801-1182

The Honorable Bert Stedman
Co-Chairman, Senate Finance Committee
State Capitol, Room 516
Juneau, AK 99801-1182

Dear Senators Stevens, Hoffman and Stedman:

As the Alaska Senate this week resumes committee work on Denali KidCare, I urge your support of proposals to increase the number of children and pregnant women eligible for health insurance under this valuable program. One of my first acts as U.S. Senator was to vote in favor of the Children's Health Insurance Program Reauthorization Act of 2009. The measure also was supported by Senator Lisa Murkowski and Congressman Don Young. Now that Congress has reauthorized and funded the Children's Health Insurance Program (CHIP) for the next five years, it is time to give more Alaska families the chance to qualify for basic health care.

The federal legislation authorizes states to offer coverage for families earning up to 300 percent of the federal poverty level (FPL), and some already do. It is troubling that Alaska – recognized in the early days of Denali KidCare as a national leader for its outreach and signup efforts – is now at only 175 percent of FPL and one of the strictest states in the nation for eligibility.

At a minimum, I urge you and your colleagues to restore Alaska's eligibility guidelines to 200 percent. As you know, that step would return Alaska to 2003 levels and immediately qualify an estimated 1,277 additional children and 218 more pregnant women for Denali KidCare. I and many other Alaskans would celebrate that improvement. However, merely restoring the program to where it was six years ago is not exactly a huge victory for Alaska's families. We can and should do better. I support efforts to increase eligibility levels beyond 200 percent of FPL, including the possibility of an effective but equitable co-pay provision for families that can afford to buy into the program. I applaud your Senate and House colleagues on both sides of the political aisle who are working to improve Alaska's program.

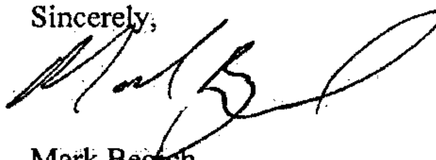
We know the need is great. According to the respected Kaiser Family Foundation, there are more than 21,000 children in Alaska without health insurance. Many are from hard-working families who make too much for regular Medicaid but not enough to afford a private health plan. This results in less preventive care, more sickness and more lost school days. Emergency room visits also increase – last-minute care that is often uncompensated and results in higher insurance premiums and medical costs for everyone.

As you deliberate, let me alleviate concerns about federal support. When President Obama signed the CHIP reauthorization bill earlier this month, he and Congress effectively joined forces to provide states with funding certainty (CHIP is now authorized through FFY2013). That continuity is especially important during these times of economic instability. If families do lose employer-provided health coverage or fall further behind in their efforts to afford private insurance, it is essential that Denali KidCare be available to cover basic health care needs. Coupled with the fact that the federal government is offering financial incentives to states that increase enrollment and will pay up to 70 percent of the total cost of the program (currently estimated at 66 percent in Alaska), this is frankly a very good deal.

Given action by Congress to reauthorize CHIP, the Legislature's obvious interest in this issue and Governor Palin's announced intent to support an expansion of Denali KidCare, it looks as if the stars are finally aligned.

Thank you for your work on this matter. Please feel free to contact me if I can be of assistance.

Sincerely,



Mark Begich
U.S. Senator

Cc: The Honorable Mike Chenault, Speaker of the House
The Honorable Mike Hawker, Co-Chairman, House Finance Committee
The Honorable Bill Stoltze, Co-Chairman, House Finance Committee
Governor Sarah Palin

SB13

Denali KidCare at 200%	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Additional Children Served	1,277	1,291	1,305	1,320	1,334	1,349
Additional Pregnant Women Served	218	220	223	225	228	230
	1,495	1,511	1,528	1,545	1,562	1,579
Annual Medicaid Program Costs (Benefits)	$ 2,535.0	$ 2,753.0	$ 2,989.7	$ 3,246.8	$ 3,526.1	$ 3,829.4
Annual Administrative Costs	$ 167.4	$ 153.0	$ 153.0	$ 153.0	$ 153.0	$ 153.0
Total Costs SB13	**$ 2,702.4**	**$ 2,906.0**	**$ 3,142.7**	**$ 3,399.8**	**$ 3,679.1**	**$ 3,982.4**
Federal Share	$ 1,841.5	$ 1,966.2	$ 2,119.7	$ 2,593.4	$ 2,482.1	$ 2,687.1
General Fund Share	$ 860.9	$ 939.9	$ 1,023.0	$ 1,106.4	$ 1,197.0	$ 1,295.3
Positions	2.0	2.0	2.0	2.0	2.0	2.0

Additional persons served is based on enrollment, allowing 1.1% annual growth for the affected eligibility groups.
Program costs (cost of benefits) are expected to grow by 6.8% per year.

Source: Department of Health and Social Services, Medicaid Budget Group

3/9/2009

United States Department of Health & Human Services

• Frequent Questions

Search

THE 2009 HHS POVERTY GUIDELINES

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

[*Federal Register* notice, January 23, 2009 (PDF - 3 pages)]
[Prior Poverty Guidelines and *Federal Register* References Since 1982]
[Frequently Asked Questions (FAQs)]
[Further Resources on Poverty Measurement, Poverty Lines, and Their History]

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

- The poverty thresholds, and
- The poverty guidelines.

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

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs. The *Federal Register* notice with the 2009 poverty guidelines (PDF - 3 pages).

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

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

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

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050

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

2009 Poverty Guidelines for Alaska

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

2009 Poverty Guidelines for Hawaii

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

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

Go to Frequently Asked Questions (FAQs).

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

Last Revised: January 23, 2009

kaiser commission on medicaid and the uninsured

Challenges of Providing Health Coverage for Children and Parents in a Recession:

A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009

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

and

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

January 2009

Acknowledgments

The authors would like to extend our deep appreciation to the many Medicaid and SCHIP officials throughout the country who participated in this survey and so generously shared their time and expertise with us. We are grateful for their willingness to explain recent program developments -- from the broadest policy change to the most detailed program rule. Their important contribution to improving the health of children and families deserves recognition and our thanks. We also would like to thank our colleagues at the Center on Budget and Policy Priorities, particularly Matthew Broaddus, for their assistance and helpful suggestions as we prepared this report. We also appreciate the assistance of the Center for Children and Families at Georgetown University's Health Policy Institute.

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Executive Summary

Medicaid and SCHIP have been instrumental in covering more low-income uninsured children over the last decade. While much progress has been made, nine million children remain uninsured. As SCHIP reauthorization approached in 2007, states were poised to move forward with efforts to cover more uninsured children. However, federal obstacles, including the Medicaid citizenship documentation requirements, the issuance of a CMS-directive on August 17th 2007 limiting state expansions, and the failure to reauthorize SCHIP have hampered progress. A temporary extension provided funds for SCHIP through March 31, 2009.

When states adopted their budgets for the fiscal year starting July 1, 2008, many were able to include funding for children's coverage expansions. Later, the severity of the unfolding fiscal crisis became clearer and state budget shortfalls are now expected to total $350 billion for the remainder of FY 2009 and through 2011. States face mounting pressure to cut Medicaid and SCHIP just as the need for coverage rises due to climbing unemployment and loss of health coverage. In the last downturn, some states implemented restrictive enrollment procedures and reported dramatic declines in children's enrollment as a result. States may soon feel pushed to take such steps. Key findings from the annual KCMU survey of state Medicaid and SCHIP policies for children and parents that were implemented or authorized between January 2008 and January 2009 in the 50 states and D.C. include:

- **States continued to make progress on improving access to health coverage, particularly for children, but several significant setbacks warn about impending problems.** One-third of states (19) increased access to health coverage, while ten states enacted at least one measure to restrict coverage. The most common restriction was imposing new or higher premiums in SCHIP, but two states also restricted eligibility. California increased the frequency of renewal, a change estimated to affect more than 260,000 children as well as large numbers of parents.

- **The economic crisis is widespread and serious healthcare cuts are looming, but the commitment to children is still strong.** States continued to enact eligibility expansions for children, and state officials in several of those states plan to go forward even though they are facing significant budget shortfalls. Federal constraints, such as the unresolved reauthorization of SCHIP and the August 17th directive, have caused some states to put expansions on hold temporarily. Others are using state funds to pay for coverage precluded by the directive.

- **Parent coverage is still more difficult to obtain than children's coverage.** The median income at which children qualify for coverage is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working parents. However, for unemployed parents, the median income eligibility for Medicaid is just 41 percent of the federal poverty line, $601 per month for a family of three in 2008. Jobless parents who need coverage may find that unemployment payments put them over the income limit for Medicaid.

- **Outreach budgets were increased in a number of states, however, some are beginning to report that these funds are being curtailed.** Outreach, including community-based application assistance, is critical in a recession, since newly eligible families may be unfamiliar with public programs. But in light of budget shortfalls, some states expressed skepticism for conducting aggressive outreach. About half the states are using technology to implement or develop online applications and to develop more efficient enrollment and renewal systems.

As the economic crisis deepens, states will be under major pressure to contain costs. This may lead them to take steps that not only reverse coverage gains, but intensify the hardships that many families are already facing as a result of losing their jobs and their health insurance. Congress is currently considering SCHIP reauthorization and an economic recovery package that would provide additional federal Medicaid matching funds. These would help states to maintain vital coverage for low-income families, support state efforts to enroll more eligible children, and make program improvements. Strengthening Medicaid and SCHIP in these ways is an essential precursor to the larger task of enacting broad health care reform.

I. Introduction

A commitment to providing health coverage for uninsured children has inspired nationwide efforts that began in earnest with enactment of the State Children's Health Insurance Program (SCHIP) in 1997. Like Medicaid, the chief source of health coverage for low-income families, SCHIP finances coverage through a partnership between the federal and state governments. State measures to expand eligibility and adopt streamlined enrollment procedures in Medicaid and SCHIP have strengthened both of these programs, and they have been instrumental in reducing the percentage of low-income uninsured children by one-third over the last decade.[1] Notably, the number of low-income uninsured parents increased over the same period, since eligibility levels and resources for addressing their health coverage needs do not approach those related to children.

While considerable progress has been made, nine million children in the United States remain uninsured, with nearly two-thirds of them eligible for Medicaid and SCHIP. In 2007, with relatively robust state budgets and the reauthorization of SCHIP at hand, across the country, states came forward to reaffirm their commitment to closing this gap. That year, state efforts to expand children's health coverage represented the most aggressive steps forward since the early years of SCHIP. Of the 20 states that expanded eligibility for children, 12 raised or authorized raising SCHIP income limits to 300 percent of the federal poverty line, more than doubling the number of states that previously had eligibility set at this level. States also made progress on adopting simplified enrollment and renewal procedures in both Medicaid and SCHIP, emphasizing strategies that reduce paperwork and jump-start enrollment.[2]

Despite this burst of activity, efforts to advance children's coverage met unanticipated federal obstacles. The Medicaid citizenship documentation requirement, enacted in 2006 as part of the Deficit Reduction Act, sent state simplification efforts backwards by requiring U.S. citizens applying for Medicaid to present original documents proving their citizenship and identity. States reported that this new rule ushered a deep decline in the enrollment of eligible U.S. citizens, especially children.

The expected reauthorization of SCHIP also encountered roadblocks. Congress passed two versions of legislation to reauthorize SCHIP and President Bush vetoed each of them. And, on August 17, 2007, as SCHIP reauthorization was proceeding, the Centers for Medicare and Medicaid Services (CMS) issued a directive that impeded states' ability to expand coverage.[3] The year ended with these problems unresolved, meaning states were without the infusion of funds they were anticipating, and the new tools to bolster outreach and enrollment did not materialize. A temporary extension provided funds for SCHIP through March 31, 2009.

When states adopted their budgets for the state fiscal year starting July 1, 2008, they were able to include funding for children's coverage expansions. Later, the economy began to show signs of trouble, but it was not until September 2008 that the breadth and depth of the unfolding fiscal crisis became clear as financial markets collapsed and unemployment started to rise sharply. States are now facing an extremely threatening fiscal situation, with state budget shortfalls expected to total $350 billion for the remainder of FY 2009 and through 2010 and 2011.[4]

So far, most states have managed to maintain existing eligibility levels and procedural improvements. For example, despite serious financial pressures, states that enacted earlier children's coverage expansions, such as Iowa and New York, have reiterated their intentions to go forward. But, there are warning signs that this will become more and more difficult.

As in past economic downturns, states will continue to struggle with the mounting pressure to cut health coverage programs just at the time that an increasing number of people need the vital services they provide. Many states have already implemented or announced major cuts to health programs, mainly in the area of provider rates and benefits, which have a significant impact on access and the quality of care. States that have not yet expanded are likely to be deterred from increasing coverage because of the dire economic environment.

Medicaid enrollment and spending growth peaked in 2002 at the same time state revenues dropped sharply. In response, states adopted an array of cost containment strategies to control spending growth. Then federal fiscal relief was made available to states through the Jobs and Growth Tax Relief Reconciliation Act of 2003, increasing the federal share of Medicaid costs, and lifting some of the burden states were carrying. The legislation restricted states from lowering Medicaid eligibility between September 2003 and June 2004, as a condition of receiving relief funds. Thus, no state retracted Medicaid eligibility during this time period. SCHIP eligibility also remained relatively constant, with only a few states cutting back.

However, because they were still grappling with budget shortfalls, nearly half the states put in place enrollment procedures that made it more difficult for children and parents to secure and retain health coverage between April 2003 and July 2004.[5] Some states reported dramatic declines in children's enrollment as a result of these budget-driven changes, and children who were most likely *eligible* for existing programs became uninsured. For example, in Texas, SCHIP enrollment dropped by more than 149,000 children (a 29 percent decline), in large measure, due to reducing continuous coverage from 12 months to six months. Washington state also repealed the guarantee of 12 months of coverage and required parents to renew their child's eligibility every six months as well as report changes in the interim. This, along with other procedural changes, led to a dramatic caseload reduction of more than 40,000 children. In Wisconsin's BadgerCare program, establishing more rigorous documentation requirements resulted in an enrollment decline of 13,000 children and parents in just the first four months of implementation. Several states also froze SCHIP enrollment. In addition to turning away children who qualified for coverage under SCHIP, this strategy adversely affected Medicaid-eligible children not subject to the freeze. Eligible applicants' path to coverage was limited when states stopped taking joint Medicaid/SCHIP applications or because families mistakenly interpreted news reports to mean that all coverage programs were closed to new applicants.[6]

Coming out of the last economic downturn, states worked to eliminate SCHIP enrollment freezes and reverse some of the enrollment barriers they had imposed. This enabled caseloads to recover somewhat. An important lesson learned, however, is that the problematic effects of changing administrative procedures can endure if such changes send conflicting messages to prospective and current program participants.

As this report goes to press, two major developments are within reach. Congress has taken up SCHIP reauthorization once again and is working towards passing a bill that will likely be one of the first pieces of legislation to be presented to the nation's new president, Barack Obama. Next will come a significant economic recovery package that will contain substantial state fiscal relief in the form of enhanced federal matching funds for Medicaid that will reduce the share of the costs states will have to contribute for the program. Passage of both these bills would provide needed relief, as well as the support to move forward on enrolling more eligible, uninsured children. These measures would also help reinforce the federal/state partnership that is fundamental to the viability of health coverage programs. Strengthening Medicaid and SCHIP by making sure they are in a position to provide coverage to more

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low-income uninsured individuals, is also an essential precursor to the larger task of enacting broad health care reform.

II. About this Survey

This report presents the findings of a survey of eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP for children and families that were implemented or authorized between January 2008 and January 2009 in the 50 states and the District of Columbia. These policies have a large influence on how effectively Medicaid and SCHIP can deliver health coverage to the eligible children, pregnant women and parents who rely on the vital services these programs provide. They are the driving forces behind efforts to reduce the number of low-income people who lack adequate insurance but cannot afford to pay for it on their own.

This study, the eighth annual survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, was carried out in the summer and early fall of 2008, through extensive telephone interviews with state Medicaid and SCHIP program administrators. Detailed follow-up interviews proceeded through the end of the year. The findings reflect policies and procedures in effect in the states in January 2009, as well as coverage expansions that were authorized, but were not implemented, by states during the survey period.

III. Key Survey Findings – Current Status of Coverage for Children and Parents

States continue to make progress on improving access to health coverage for low-income families. As of January 2009, income eligibility levels are as follows:

States provide health coverage for children and pregnant women under Medicaid or SCHIP as follows (Figures 1 & 2):

- 44 states, including DC, cover children in families with income at 200% FPL or higher. ($35,200 for a family of three in 2008).
- 33 states cover children in families with income between 200% and 250% FPL. (200%: $35,200 for a family of three in 2008; 250% FPL: $44,000 for a family of three in 2008).
- 19 states, including D.C., cover children in families with income at 250% FPL or higher. 10 of these states cover children in families with income at 300% FPL or higher. ($52,800 per year for a family of three in 2008).
- 40 states, including DC, cover pregnant women with income 185% FPL or higher. ($32,560 for a family of three in 2008).

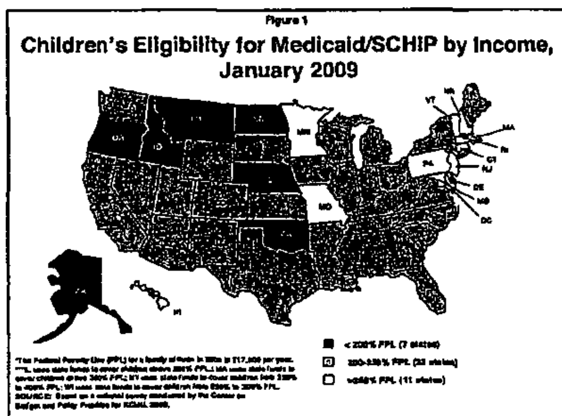
Figure 1
Children's Eligibility for Medicaid/SCHIP by Income, January 2009

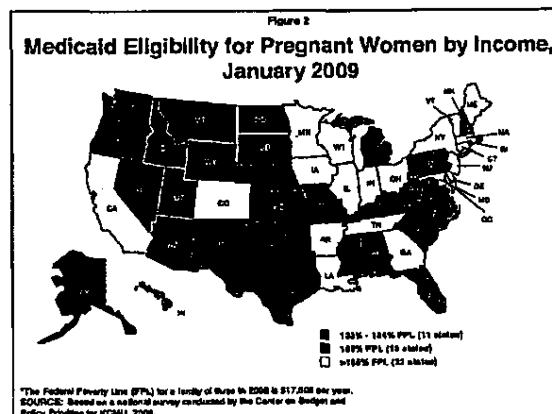
Figure 2
Medicaid Eligibility for Pregnant Women by Income, January 2009

States provide health coverage for parents under Medicaid as follows (Figures 3 & 4):

- In 12 states, family income must be less than half the federal poverty line for a working parent to qualify for Medicaid ($8,700 per year for a family of three in 2008).
- In 29 states, family income must be less than half the federal poverty line for a jobless parent to qualify for Medicaid ($8,700 per year for a family of three in 2008).
- 18 states, including the District of Columbia, cover parents in families with income at 100 percent of the federal poverty line or higher ($17,600 per year for a family of three in 2008).
- In 28 states, a parent in a family of three, working full-time at the minimum wage, earning on average, $1,092 per month, cannot qualify for Medicaid.

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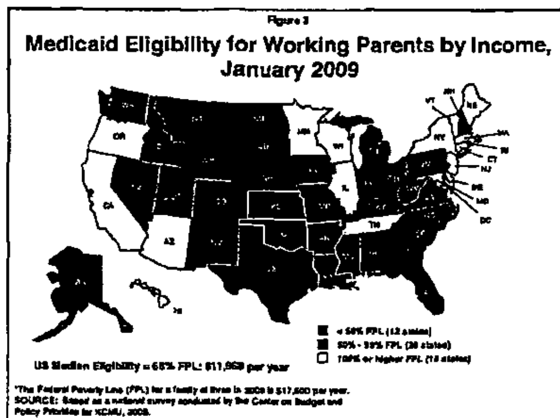
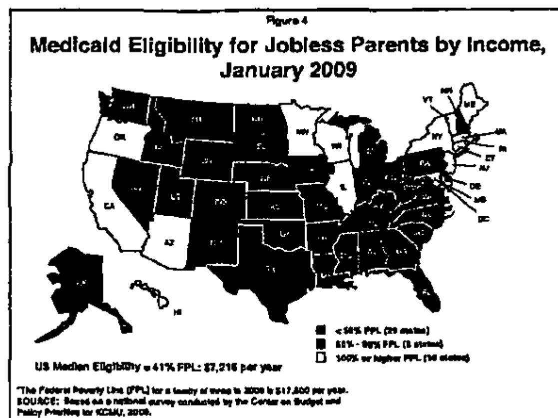
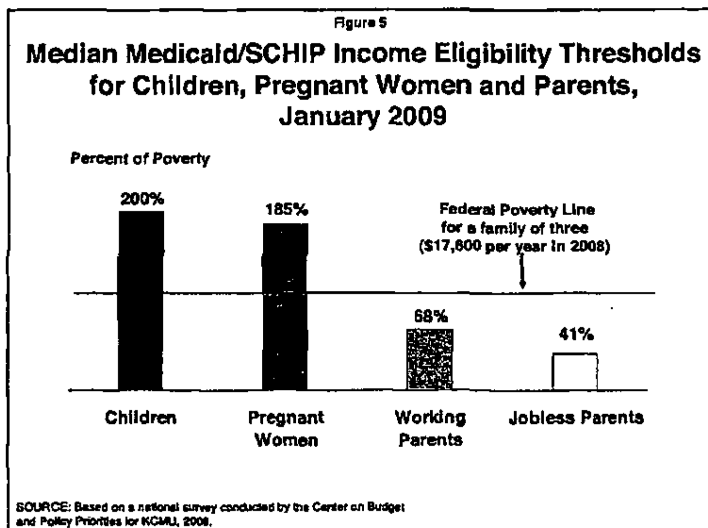




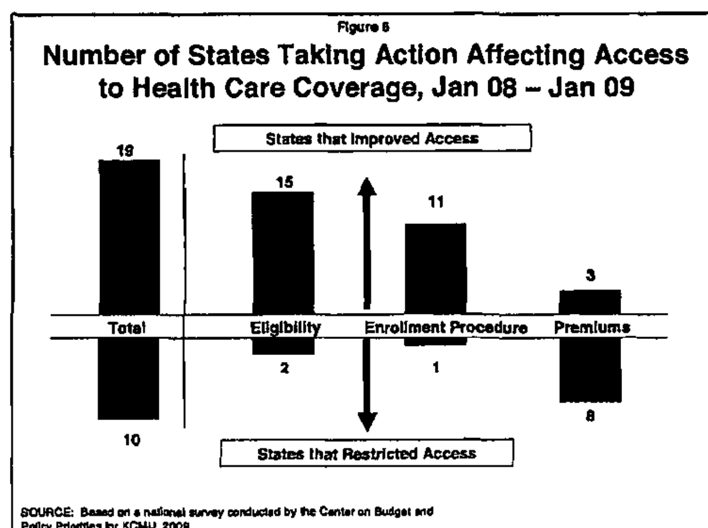
It continues to be more difficult for a low-income parent to qualify for health coverage than for a child (Figure 5). The median income at which children qualify for Medicaid or SCHIP is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working parents. For jobless parents, the median income eligibility for Medicaid is just 41 percent of the federal poverty line, $601 per month for a family of three in 2008. In an economic downturn, this low income limit can take a serious toll on families. For many individuals who have lost their jobs and also their health insurance, COBRA coverage is likely to be prohibitively expensive or may not be available, and parents may turn to public programs for coverage. However, they may find that the unemployment compensation payments they receive put them over the income limit for Medicaid. (Since unemployment compensation is unearned income, "earnings disregards" that are designed to help working families qualify do not apply.) Jobless parents may eventually become eligible, but in the interim they are subject to health risks and financial exposure that can have deleterious consequences for themselves and their families.



IV. Key Survey Findings – State Actions During 2008

Overall, states continued to make progress on improving access to health coverage, but a few setbacks warn about impending problems (Figure 6).

- **More than one-third of the states (19 states) took steps to increase access to health coverage for low-income children, pregnant women and parents.** Fifteen(15) states authorized or implemented coverage expansions *(CO, IA, IN, KS, LA, MD, MT, ND, NJ, NY, OK, OR, SC, TN, WI)*; 11 states reduced procedural barriers *(AZ, CO, IA, KY, LA, MD, MT, NV, OR, SC, UT)* and three states reduced financial barriers to Medicaid and SCHIP *(TN, WA, WI)*.



- **Ten states (10 states) enacted at least one measure to restrict coverage.** The most common restriction was to increase financial barriers such as new or higher premiums in SCHIP programs. Eight states *(GA, LA, MN, MO, NJ, NV, PA, RI)* went in this direction. *Rhode Island* and *South Carolina* restricted eligibility, the former cutting income eligibility for parents, and the latter establishing a three-month waiting period in its new separate SCHIP program, during which children must remain uninsured before they can enroll. *California*, increased the frequency with which parents and children are required to renew coverage.

  The actions taken by *Rhode Island* and *California*, among the first states to feel the effects of the economic downturn, raise concerns about where other states could be headed if their fiscal pressures go unaddressed. The premium increases in *Rhode Island* are steep, coming at a time when families are likely to be financially strapped. Premiums of $45 per child per month are now required for children in families with incomes as low as 133 percent of the federal poverty line ($23,467 for a family of three in 2008), as compared to the previous starting point, 150 percent of the federal poverty line. Premiums for other children range from $86 per month to $114 per month, representing an increase of up to $29 per month for some.

  California's retraction of 12-month continuous eligibility for children withdraws the guarantee of full-year coverage, which is critical for children with ongoing medical needs. In addition, the state will

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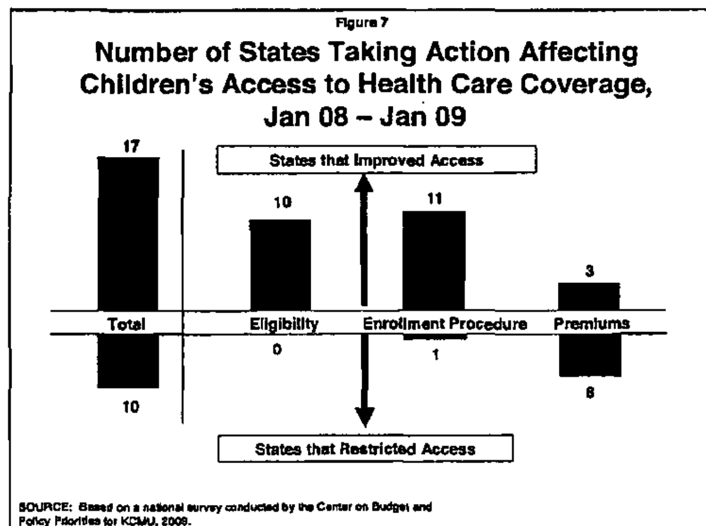
now require children and parents on Medicaid to comply with a semi-annual reporting procedure that is likely to cause otherwise avoidable gaps in coverage for eligible families. It will also create unnecessary and costly administrative burdens, since eligible families dropped from the program are likely to reapply within a short period of time. These changes could result in more than 260,000 children losing coverage by 2011. A large number of parents would be affected as well.[7]

The economic crisis is widespread, and serious health care and other cuts are looming, but states are demonstrating a steadfast commitment to covering children (Figure 7). States continued to enact eligibility expansions for children, and state officials in several of those states, such as *Iowa* and *New York*, plan to go forward even though they are facing significant budget shortfalls. Federal constraints that have dampened states' ability to expand, such as the unresolved reauthorization of SCHIP and the August 17th directive, have caused several states to put expansions on hold or scale back temporarily. Others, such as *Wisconsin* and *New York*, are using state funds to pay for children whose coverage is precluded by the August 17th directive.



- **One-third of the states (17 states) increased access to coverage for children.** Ten (10) states implemented or authorized eligibility expansions for children. *Iowa* and *Montana* raised children's coverage (scheduled to begin later this year), to 300 percent of the federal poverty line and 250 percent of the federal poverty line, respectively; *Kansas* implemented a children's coverage expansion to 250 percent of the federal poverty line. If the August 17th directive remains in place, these states will be subject to the strict conditions it imposes. Eligibility increases were also implemented, but to more modest levels in *Colorado, North Dakota* and *South Carolina*. *New York* adopted the option to allow children leaving foster care upon reaching age 18 to keep their Medicaid coverage.

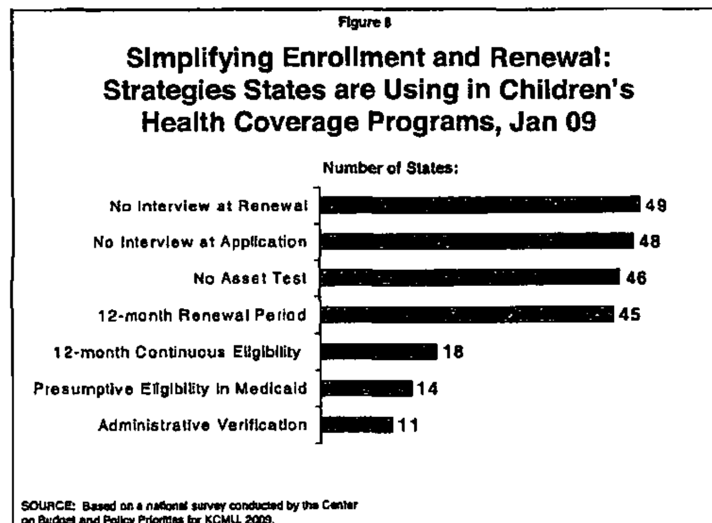
  Of the ten states that expanded coverage for children, four were implementing expansions that were authorized last year, but which had been held back by the August 17th directive or by the uncertainty surrounding SCHIP reauthorization. *Louisiana* and *Indiana* increased eligibility to 250 percent of the federal poverty line, rather than 300 percent. *Wisconsin* and *New York* chose to move forward with their full expansions, funding coverage over 250 percent of the federal poverty line with state funds only. *Illinois* has been funding its expansion using state dollars. Planned expansions in five additional states (*NC, OH, OK, WA,* and *WV*) remain stalled.

Iowa Children Get A Coverage Boost

Buoyed by a groundswell of public support for covering children, Iowa Governor Chet Culver, along with state legislators, remain strong in their pledge to expand health insurance to more of the state's uninsured children. In the last legislative session, state legislators passed an expansion of hawk-i, the state's SCHIP program, to 300 percent of the federal poverty line, which will be implemented in July 2009, and cover an estimated 5,000 new children. Program improvements have already proceeded. The state now guarantees children a full 12 months of continuous coverage and is pursuing ways to ease premium payment policies. For example, families new to the program will not have to pay premiums for the first two months of enrollment. Outreach is expected to go forward as well, but may possibly be scaled back. Like many other states, Iowa is in a severe budget crunch, with an expected shortfall of more than $600 million in the coming year. Major spending cuts are being planned, but it appears that the children's coverage expansion will go forward. Senate Majority Leader, Mike Gronstal (D) stated recently, "We committed to providing access to affordable coverage to every kid in the state of Iowa. I'm not interested in backing up on that commitment."

* "Health Promises Persist: Iowa lawmakers reconcile health care goals, budget" The Hawkeye, January 15, 2009.

- **Eleven (11) states took steps to reduce procedural barriers to coverage for children (Figure 8).** *Arizona, Kentucky,* and *Utah* no longer require families to participate in face-to-face interviews to obtain health coverage for their children, and *Colorado* adopted "administrative verification and renewal," meaning the state no longer requires families to provide paper documentation of their income and eligibility workers use existing databases to verify the information families provide on the application. *Maryland, Montana, Louisiana, South Carolina* and *Utah* have revised their applications to allow parents to apply using the same simplified forms that are used for children, a change that benefits both children and parents. *Iowa, North Dakota* and *Oregon* now guarantee 12 months of continuous eligibility, considered to be one of the most effective tools for keeping children covered for as long as they qualify. One serious setback, the changes to the renewal procedures in *California,* was discussed earlier.



States Explore the Use of Technology to Facilitate Enrollment

Emergence of Online Applications

About half the states reported that they are implementing, or are in the process of designing, on-line applications. Several of these states also report allowing the use of electronic signatures, so that a follow-up signature page does not have to be printed and mailed in. (Other states appear unsure about the permissibility of electronic signatures and point to the lack of clear federal guidance on this subject.) Some states at the forefront of using on-line applications also report that their applications currently interface with existing eligibility systems (or will in the future), so that information from the on-line application does not have to be re-entered by eligibility workers and an eligibility determination can move forward more rapidly.

Database Usage

Eleven states (12 states at renewal) report using technology to streamline the enrollment and renewal process. States report conducting matches with existing databases to verify income and other information, as well as eliminating rules requiring families to submit pay stubs or other paper documentation. This procedure is referred to as "administrative verification and renewal." Many states also are conducting data matches with their Vital Records departments to help families comply with the Medicaid citizenship documentation requirement, however, the technological capacity to do this efficiently varies considerably. Finally, states are exploring the use of technology to target outreach, for example, by conducting data matches with existing databases to identify children and parents who are likely to qualify for health coverage but who are not enrolled. States report using matches with food stamp databases for this purpose, and have expressed interest in using state tax system databases.

- **Outreach budgets in a number of states were increased in 2008, however, some states are beginning to report that these funds are being curtailed.** Several states reported increases in outreach funding in 2008, sometimes associated with new expansions, but also for ongoing promotional activities and community-based application assistance. In recent follow-up interviews, some state officials indicated that their outreach budgets have now been cut; others expressed skepticism for conducting aggressive outreach in light of budget shortfalls. Still others said their outreach activities would go forward, with some indicating that activities would emphasize renewal assistance so that already enrolled children do not lose coverage.

- **A few states reduced financial barriers to children's coverage, eliminating or lowering premiums for some children, while other states increased premiums (Figure 9).** *Tennessee, Washington* and *Wisconsin* either reduced premiums or eliminated them for some children. *Georgia, Minnesota, Missouri, Nevada, New Jersey, Pennsylvania* and *Rhode Island* increased premiums for children, with two of these states showing significant increases. *Minnesota* premiums increased by up to $14 per month for some children. Premium increases in *Rhode Island*, discussed earlier, represented the most severe increases for children this year. New premiums implemented in *Louisiana*, apply to the state's new expansion group (children with incomes between 200 percent and 250 percent of the federal poverty line).

- **Co-payments for health services were adopted in one state and increased in two states (Figure 10).** Currently, 24 states charge co-payments for children's health services. *Wisconsin* adopted new co-payments, and *West Virginia* and *Utah* increased co-payments for prescription drug coverage. Only one state, *Montana* decreased co-payment amounts.

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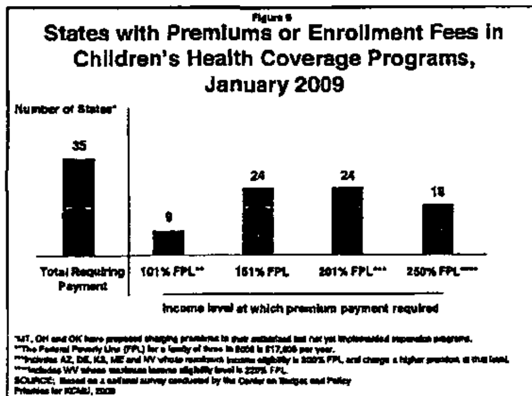
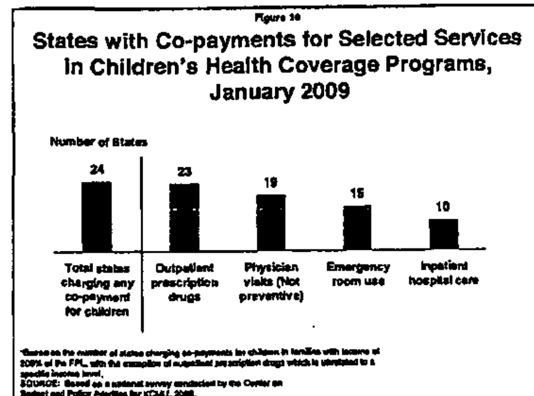
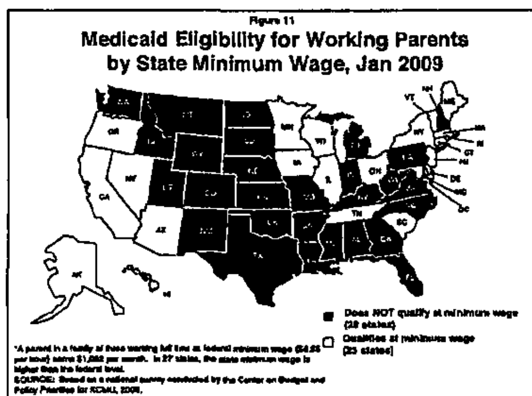
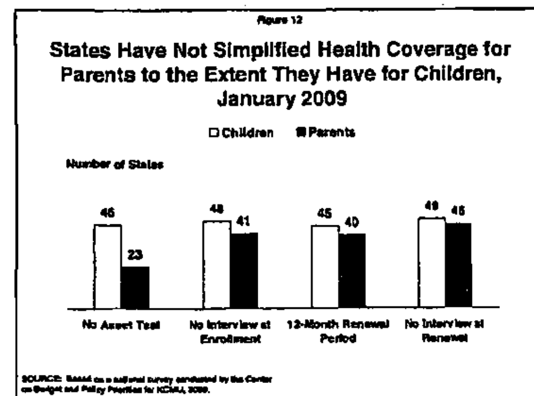




Low-income parents applying for Medicaid coverage continue to face substantially restricted income eligibility and access as compared to their children (Figure 11 and 12).

- **A few states took steps to boost coverage and simplify procedures for parents.** Three states — *New Jersey, Maryland,* and *Wisconsin* — implemented parent coverage expansions. Still, in 28 states, parents working full time at minimum wage cannot qualify for Medicaid. One state, *Rhode Island*, cut parent coverage. *Maryland* also stopped counting assets in determining eligibility for parents, a step that fewer than half the states have taken. Given the restrictive income eligibility levels for parents in most states, the majority of parents applying are not likely to have substantial bank accounts, multiple vehicles of significant value, or other resources that would disqualify them. The burdensome and intrusive paperwork associated with proving that one does not exceed the asset limit often deters eligible parents from completing the application process. Other measures were implemented to reduce procedural barriers for parents, including eliminating interviews and reducing the frequency of renewal (*AZ, MD, UT),* but these practices are still more prevalent in children's coverage programs.





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Maryland Expands Medicaid Eligibility for Low-Income Parents

Access to health coverage increased measurably for thousands of low-income Maryland parents this year when an income eligibility expansion and a package of procedural improvements were implemented on July 1, 2008. The state boosted parent eligibility from about 30 percent of the federal poverty line to 116 percent. The state also eliminated the asset test and no longer requires parents to have a face-to-face interview at the Medicaid office. This streamlined the process for parents and also aligned procedures for parents and children to a greater extent so that they can apply using the same simplified application form. Since its implementation, 29,682 adults have enrolled as a result of the expansion.

To achieve this early success, a logical first step was to identify children already in Medicaid whose family income is below 116 percent of the federal poverty line and enroll the parents when they renew their child's coverage. Traditional outreach efforts including TV, print and radio publicity, as well as activities with the Baltimore Ravens football team, also have done much to inform families about the new coverage opportunity. In addition, the Medicaid and revenue agencies coordinated on a new initiative that used the tax system to identify 150,000 people who were potentially eligible. They were sent a letter from the state Comptroller inviting them to call a toll-free number for an application. Between December 1 and December 12, 2008, nearly 1,800 hotline callers were sent applications. Others obtained applications on-line and through other avenues.

Enrollment continues to increase and the recession is apparently a driving force: there were more approvals of parents in the expansion group during the first two weeks in December than there have been since it was implemented in July and state officials say they are seeing people who previously had secure jobs and are seeking help, perhaps for the first time. The budget is tight in Maryland, but in two rounds of cuts, the expansion has not been targeted.

*Conversations with Maryland State Officials, January 2009.

- **Income eligibility for pregnant women remained stable with nearly half the states covering pregnant women at 185 percent of the federal poverty line.** Two states, *Tennessee* and *Wisconsin*, increased eligibility for pregnant women to 250 percent and 300 percent of the federal poverty line respectively. *Oklahoma* and *Oregon* both adopted the option to use SCHIP funds to cover unborn children of pregnant women.

V. Discussion

Recession Jeopardizes States' Ability to Maintain and Advance Coverage for Low-Income Children and Parents

States have made substantial progress in reducing barriers to health coverage for low-income children and families. They continued to do so during the first half of 2008 by further expanding eligibility and streamlining enrollment and renewal procedures. Now, as the economic crisis deepens, states will be under major pressure to contain costs. This may lead them to take steps that would not only reverse critical coverage gains, but would intensify the hardships so many families are already facing as a result of losing their jobs and their health insurance. In the last economic downturn, federal fiscal relief was successful in helping states address budget shortfalls, avoid deeper Medicaid cuts, and preserve eligibility, which was a condition of receiving enhanced federal funds. However, to deal with tight budgets, many states made procedural changes to their programs which blocked eligible children and parents from obtaining coverage at a time when they could least afford health care on their own.

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Easing Eligibility and Simplifying Procedures Are Especially Important During an Economic Downturn

Individuals who have lost health coverage due to unemployment need a smooth path to Medicaid and SCHIP.[8] Any period of time without insurance could cause ongoing medical conditions to escalate if it is not possible for families to find or pay for needed medication or other treatment on their own. Parents who are recently unemployed may find that the unemployment compensation payments they receive put them over the income limit for Medicaid. States can choose to disregard these payments or a portion of them in determining eligibility for jobless parents. States can eliminate their SCHIP waiting periods or at least ensure that a job-loss exemption is available. Minimizing documentation requirements and rescinding face-to-face interviews also are important since complicated, burdensome forms and procedures often discourage families from completing the process. Enrolling children for a full 12 months and simplifying renewal helps ensure beneficiaries remain covered for as long as they qualify. In addition to protecting children and families, taking such steps also saves administrative costs by reducing the workload on eligibility workers. Eligibility staff may have been cut at the same time application volume has increased.

Premium Payment Policies Matter

It also is important to ensure that unreasonable out-of-pocket costs do not keep eligible children from obtaining coverage and needed care. When a family has lost income or a job, it will be more difficult to keep up with premium payments on top of regular living expenses. Numerous studies show that premiums for low-income individuals can depress enrollment in health coverage programs.[9] Similarly, burdensome co-payments can be an obstacle to getting needed care or medication. Programs should also avoid imposing strict payment timeframes after which children are disenrolled from SCHIP, as well as lock-out periods that bar children from returning to SCHIP if the lack of a premium payment forces them to lose coverage.

Outreach Is Critical During Economic Downturns

In tight budget times, it may appear sensible to cut outreach funds as states seek ways to contain the costs associated with expanding caseloads. Conducting outreach may also seem counterintuitive when hiring freezes and lay-offs mean there are fewer eligibility workers to process a larger volume of applications. However, families that previously had stable jobs with health insurance are likely to have little or no experience navigating the public benefits system. They may not know where to turn for help when they become jobless, nor are they likely to know much about Medicaid and SCHIP or realize that they may qualify. Community-based organizations and institutions can play a vital role in alerting families to the availability of free or low-cost coverage and in assisting families with application procedures.

States are attempting to balance these competing pressures. For example, although New Mexico has had to make significant cuts to its Medicaid budget, the state will continue to reach out and enroll more uninsured children, a goal Governor Richardson has prioritized. A state Medicaid official explained that, while available funding will continue to be used for outreach, "the state does not have funds to do anything very aggressive or costly. It's difficult to justify spending on outreach when we're cutting elsewhere, however we will conduct some data matches to identify eligible but unenrolled children."[10] Given the demands that outreach generates and the limitations created by personnel cuts, adopting simplified procedures are more important that ever. Streamlining renewal, in particular, protects the investment in outreach since it guards against eligible children and parents losing coverage unnecessarily.

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Federal Legislation May Provide Needed Help for States

Two major pieces of legislation are being considered in Congress as this report is being written. Both are critical to addressing the challenges states are facing as they report mounting deficits and also attempt to assist the growing demand for health coverage among families that are suffering the effects of the weakening economy. The first is reauthorization and extension of SCHIP legislation, which is currently operating with temporary funding through March 2009. This legislation would provide the additional funds to maintain coverage for children currently enrolled and cover additional uninsured children. It would also provide bonus payments designed to encourage states to enroll more eligible children under Medicaid.

The second piece of legislation is the economic recovery package. In this recession, with substantial state deficits, one form of assistance the federal government could provide is an increase in the federal share of financial assistance for the Medicaid program (FMAP). The amount of funding for the enhanced FMAP, the duration of the relief, the distribution of the funds across states, and the conditions or maintenance of effort requirements related to eligibility are critical issues in the design of a recovery package. In 2003, one of the conditions for states receiving an increased FMAP was that they were prohibited from reducing eligibility levels in order to qualify for this financial assistance. Congress could also consider requiring states to maintain enrollment procedures to qualify for federal assistance and additional provisions to extend temporary Medicaid coverage to individuals affected by the economic downturn.

The SCHIP reauthorization and economic recovery plan could provide an essential boost that would enable states to sustain the coverage gains they have achieved and give families hard-hit by the recession the confidence that assistance with health coverage will be available.

[1] Kaiser Commission on Medicaid and the Uninsured analysis of the National Health Interview Survey data.
[2] Donna Cohen Ross, Aleya Horn and Caryn Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.
[3] Letter from Dennis Smith, Director for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials, August 17, 2007.
[4] Elizabeth McNichol and Iris Lav, *State Budget Troubles Worsen*, Center on Budget and Policy Priorities, Washington, DC, *Updated*, January 14, 2009.
[5] Donna Cohen Ross and Laura Cox, Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2004.
[6] *Ibid.*
[7] Nicholas Johnson, Phil Oliff and Jeremy Koulish, "Facing Deficits, Two-Thirds of States Are Imposing Cuts that Hurt Vulnerable Residents," Center on Budget and Policy Priorities, Washington, DC, Updated January 14, 2009.
[8] Michael Perry, Barbara Lyons, Robin Rudowitz and Julia Paradise, "Turning to Medicaid and SCHIP in an Economic Recession: Conversations with Recent Applicants and Enrollees," Kaiser Commission on Medicaid and the Uninsured, December 2009.
[9] Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent States Experiences," Kaiser Commission on Medicaid and the Uninsured, 2005.
[10] Conversation with Robert D. Beardsley, Deputy Director, Medical Assistance Division, New Mexico Department of Human Services, January 12, 2009.

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To: The Honorable Bettye Davis
Alaska Senate

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

Date: February 11, 2009

Subject: SCHIP Cost Sharing Rules

Senator Davis,

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

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

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

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

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

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

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

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

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

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

Best regards,
Jennifer Saunders

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Alaska rewarded for kids' health insurance

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

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

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

The amounts totaled $72.6 million in this fiscal year.

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