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# Alaska State Legislature

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Session: (Jan. - May)  
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Senator [Bettye Davis@legis.state.ak.us](mailto:Bettye.Davis@legis.state.ak.us)  
<http://www.akdemocrats.org>

## Office of Senator Bettye Davis

January 20, 2010

Representatives Herron and Keller, Co-Chairs, House HSS Committee

**RE: Request for Hearing for SB 13- "Denali KidCare"** – "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Dear Representatives Herron and Keller,

**Senator Davis respectfully requests a hearing concerning SB 13 before the House HSS Committee as soon as possible.** SB 13 increases and restores the income eligibility standard for Denali KidCare to 200% of the Federal Poverty Guideline Level (FPL) – the level at which it was established over 10 years ago. Per the Kaiser Commission on Medicaid and the Uninsured in December, 2009 Alaska remains only one of four states below the 200% FPL. Twenty-three states are 200-249% FPL. Twenty-four states are 250% or higher FPL, including DC.

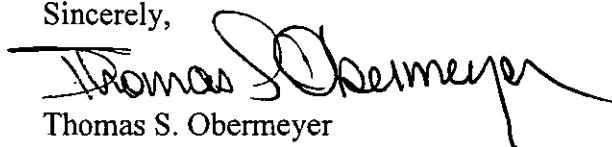
**In 2009 over 26 states increased coverage for low income children, parents, and pregnant women.** Nineteen states improved children's access to coverage by increasing eligibility, simplifying procedures, and/or eliminating premiums. The enactment of the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the infusion of fiscal relief through the American Recovery and Reinvestment Act (ARRA) in 2009 provided key federal support to help states maintain and expand coverage. Alaska was among nine states rewarded by the federal government for enrolling more uninsured children in Medicaid in 2009. On December 21, 2009 Kathleen Sebelius, Secretary of Health and Social Services, reported Alaska is receiving a \$789,000 bonus for boosting health insurance coverage for children. (See AP article, *Anchorage Daily News* attached).

**Governor Parnell indicated to Senator Davis in Fall, 2009 that he supported increasing Denali KidCare to 200% FPL.** Prompt action by the House HSS Committee will assure continued federal funding and enhanced matching funds for Denali KidCare through September, 2013.

Attached in order are the following:

1. Original Sponsor Statement
2. The most recent version of the bill
3. Sectional Analysis
4. Fiscal Notes
5. Additional Documentation

Sincerely,



Thomas S. Obermeyer  
Legislative Assistant

# Alaska State Legislature

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Senator Bettye Davis@legis.state.ak.us  
<http://www.akdemocrats.org>

## Senator Bettye Davis

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

#### **Sponsor Statement**

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

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

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

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

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

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

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

# LEGAL SERVICES

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

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

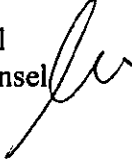
State Capitol  
Juneau, Alaska 99801-1182  
Deliveries to: 129 6th St., Rm. 329

## MEMORANDUM

January 22, 2009

**SUBJECT:** Sectional Summary (SB 13; Work Order No. 26-LS0076A)

**TO:** Senator Betty Davis  
Attn: Tom Obermeyer

**FROM:** Jean M. Mischel  
Legislative Counsel 

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

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

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

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

**Section 3.** Provides for an immediate effective date.

JMM:ljw  
09-039.ljw

# FISCAL NOTE

**STATE OF ALASKA**  
**2009 LEGISLATIVE SESSION**

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

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

**Expenditures/Revenues** (Thousands of Dollars)

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

OPERATING EXPENDITURES	Appropriation Required	Information					
	FY 2010	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	430.0	0.0	467.0	507.1	550.7	598.1	649.5
Miscellaneous							
<b>TOTAL OPERATING</b>	<b>430.0</b>	<b>0.0</b>	<b>467.0</b>	<b>507.1</b>	<b>550.7</b>	<b>598.1</b>	<b>649.5</b>

<b>CAPITAL EXPENDITURES</b>							
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<b>CHANGE IN REVENUES (</b>							
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**FUND SOURCE** (Thousands of Dollars)

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

Estimate of any current year (FY2009) cost: 0.0

**POSITIONS**

Full-time							
Part-time							
Temporary							

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

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

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner Phone 907-269-7827  
 Division Health Care Services Date/Time 1/22/08 12:00 AM  
 Approved by: Alison Elgee, Assistant Commissioner Date 2/1/2009  
Finance Management Services

## FISCAL NOTE

STATE OF ALASKA  
2009 LEGISLATIVE SESSION

BILL NO. SB013

### ANALYSIS CONTINUATION

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

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

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

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

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

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

# FISCAL NOTE

STATE OF ALASKA  
2009 LEGISLATIVE SESSION

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

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

**Expenditures/Revenues** (Thousands of Dollars)

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

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
<b>OPERATING EXPENDITURES</b>							
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	2,105.0	0.0	2,286.0	2,482.6	2,696.1	2,928.0	3,179.8
Miscellaneous							
<b>TOTAL OPERATING</b>	<b>2,105.0</b>	<b>0.0</b>	<b>2,286.0</b>	<b>2,482.6</b>	<b>2,696.1</b>	<b>2,928.0</b>	<b>3,179.8</b>

<b>CAPITAL EXPENDITURES</b>							
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<b>CHANGE IN REVENUES (</b>							
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**FUND SOURCE** (Thousands of Dollars)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1002 Federal Receipts	1,448.7	1,561.0	1,689.5	1,834.8	1,992.6	2,164.0
1003 GF Match	656.3	725.1	793.1	861.3	935.4	1,015.8
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other Interagency Receipts						
<b>TOTAL</b>	<b>2,105.0</b>	<b>0.0</b>	<b>2,286.0</b>	<b>2,482.6</b>	<b>2,928.0</b>	<b>3,179.8</b>

Estimate of any current year (FY2009) cost: 0.0

**POSITIONS**

Full-time						
Part-time						
Temporary						

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

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

Between October 2003 and July 2007, the upper income limit for these individuals was "frozen" at an amount equivalent to the 2003 federal poverty guideline (FPG). By April 2007, that income amount was calculated by the department to correspond to about 150% of the 2007 FPG. Senate Bill 27, implemented in summer 2007, made the upper income standard for children and certain pregnant and postpartum women equal to 175% of the (continued on page 2)

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

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

## FISCAL NOTE

STATE OF ALASKA  
2009 LEGISLATIVE SESSION

BILL NO. SB013

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### ANALYSIS CONTINUATION

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

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

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

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

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

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

# FISCAL NOTE

**STATE OF ALASKA**  
**2009 LEGISLATIVE SESSION**

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

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

**Expenditures/Revenues** (Thousands of Dollars)

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

	Appropriation Required	Information					
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
<b>OPERATING EXPENDITURES</b>							
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							
<b>TOTAL OPERATING</b>	<b>167.4</b>	<b>0.0</b>	<b>153.0</b>	<b>153.0</b>	<b>153.0</b>	<b>153.0</b>	<b>153.0</b>

<b>CAPITAL EXPENDITURES</b>							
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<b>CHANGE IN REVENUES (</b>							
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**FUND SOURCE** (Thousands of Dollars)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1002 Federal Receipts	83.7		76.5	76.5	76.5	76.5
1003 GF Match	83.7		76.5	76.5	76.5	76.5
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other Interagency Receipts						
<b>TOTAL</b>	<b>167.4</b>	<b>0.0</b>	<b>153.0</b>	<b>153.0</b>	<b>153.0</b>	<b>153.0</b>

Estimate of any current year (FY2009) cost: 0.0

**POSITIONS**

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Full-time	2.0		2.0	2.0	2.0	2.0
Part-time						
Temporary						

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

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

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

(continued on Page 2)

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

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

FISCAL NOTE

STATE OF ALASKA  
2009 LEGISLATIVE SESSION

BILL NO. SB 013

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ANALYSIS CONTINUATION

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

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

Total Administrative Costs for ET I Positions:

Personal Services: Two Eligibility Technician I Range 13 at a cost of \$134.4, including benefits, for 12 months.

Contractual: Annual cost for office space, phones, etc. will be \$17.6.

Commodities: Annual cost for the office supplies will be \$1.0.

Additional Cost of FY2010:

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

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Senator [Bettye Davis@legis.state.ak.us](mailto:Bettye.Davis@legis.state.ak.us)  
<http://www.akdemocrats.org>

## Senator Bettye Davis

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

### Background of SCHIP/Denali Kid Care

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

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Senator [Bettye Davis@legis.state.ak.us](mailto:Bettye_Davis@legis.state.ak.us)  
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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. They receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser, *supra*).
- Uninsured children are more likely to develop throat, eye, and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than five times as likely as insured children to have an unmet need for medical care and nine times more likely not to be examined by a regular doctor. They are also four times more likely to use emergency rooms which are much more costly than care in physicians' offices (*Pediatrics* 105, 113; "Care for Children," *New England Journal of Medicine*, 330).
- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (*Health Affairs* 23, no. 5, September-October 2004).
- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund, Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of \$65-\$130 billion annually.

## Why Coverage for Pregnant Women is Important In Alaska

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

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[Senator Bettye Davis@legis.state.ak.us](mailto:Senator.Bettye.Davis@legis.state.ak.us)  
<http://www.akdemocrats.org>

## Office of Senator Bettye Davis

April 7, 2009

Representatives Wes Keller, Co-Chair  
House HSS Committee

### RE: Request for Hearing for SB 13

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

Dear Representative Keller,


**Senator Davis respectfully requests a hearing concerning SB 13 before the House HSS Committee.** SB 13 increases and restores the maximum income eligibility standard for Denali KidCare to 200% of the Federal Poverty Guideline Level (FPL). Denali KidCare, Alaska's federal Medicaid-funded State Children's Insurance Program (SCHIP), was just reauthorized for five years by Congress and signed into law as a priority with expanded coverage by President Obama on February 4, 2009. Continued federal funding should assure enhanced matching funds at 66%-70% for Denali KidCare through FY2015.

Alaska remains only one of five states below the 200% Federal Poverty Level for the SCHIP/Denali KidCare Program. The Alaska Health Care Strategies Planning Council recommended increasing Denali KidCare to 200% FPL in its Final Report on December 23, 2007. It is our understanding that the Governor's office also supports increasing Denali KidCare to 200% FPL.

Attached in order are the following:

1. Sponsor Statement
2. The most recent version of the bill, SB 13
3. Sectional analysis
4. Fiscal Notes
5. Additional Documentation

Sincerely,

  
Thomas S. Obermeyer,  
Legislative Administrative Assistant  
465-3762



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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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kaiser  
commission on

**medicaid**  
and the **uninsured**

**A Foundation for Health Reform:**

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

**Executive Summary**

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

*and*

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

**December 2009**

THE HENRY J.  
KAISER  
FAMILY  
FOUNDATION

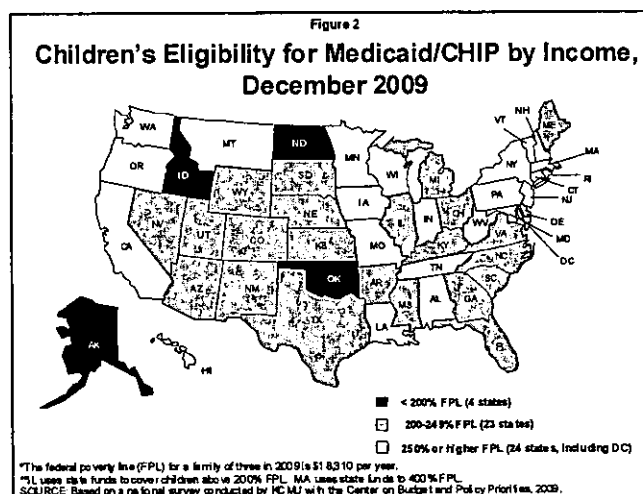
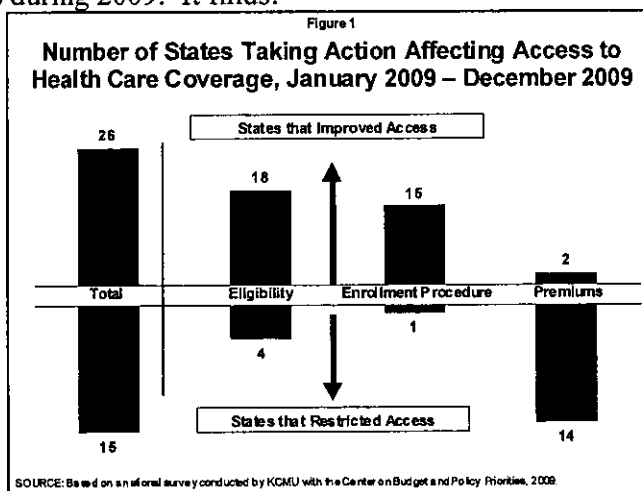
## Executive Summary

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

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

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

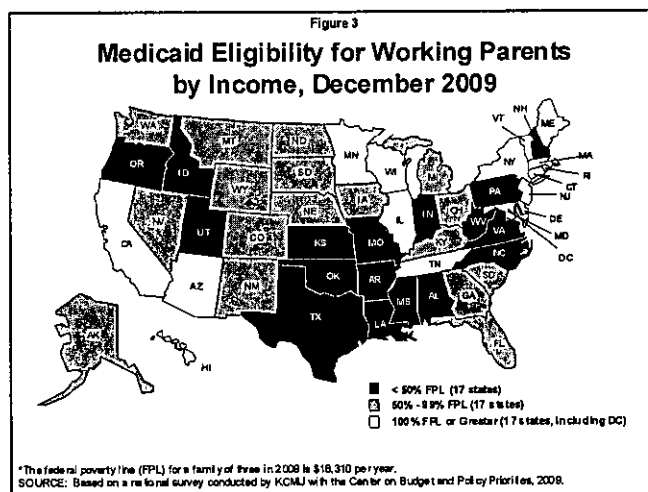
**Children were the main beneficiaries of expansions in 2009.** Nineteen states improved children's access to coverage by increasing eligibility, simplifying procedures, and/or eliminating premiums. Reflecting this progress, currently, 47 states cover children in families with income at 200 percent of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



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

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

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



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



## **An Overview of the CHIPRA Outreach and Enrollment Grants**

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

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

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

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

### **Legislative Background**

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

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

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

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

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

### **The Request for Proposal Process**

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

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

### **Key Dates**

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

### **Grant Principles**

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

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

## **Eligible Entities**

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

Eligible entities include:

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

## **Outreach and Enrollment Strategies**

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

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

## **Target Populations**

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

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

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

### **Budgets, Match and Sustainability**

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

### **Data Reporting and Evaluation**

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

### **Best Practices and Lessons Learned**

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

## Specific Requirements for Different Types of Grantees

- ***State Applicants***

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

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

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

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

- ***Non-State Applicants***

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

- ***Tribes or Tribal Entities***

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

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## News Release

FOR IMMEDIATE RELEASE  
Wednesday, September 30, 2009

Contact: HHS Press Office  
(202) 690-6343

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

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

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

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

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

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

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

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

A list of grantees by state is below.

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

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

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

###

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Last revised: November 17, 2009

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U.S. Department of Health & Human Services - 200 Independence Avenue, S.W. - Washington, D.C. 20201

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

Timely Analysis of Immediate Health Policy Issues

January 2009

Genevieve Kenney and Jennifer Pelletier

## Summary

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

## Background

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

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

## Introduction

SCHIP was designed to address gaps in health insurance coverage for children whose family incomes were too high to allow them to qualify for Medicaid but too low to afford private coverage. One of the issues that received considerable attention during the 2007 SCHIP reauthorization debate was the income level at which subsidized public coverage should be available to children through Medicaid and SCHIP.<sup>1,2</sup> On the one hand, some argued that SCHIP had drifted from its statutory intent by allowing children with incomes above 200 percent of the FPL to be covered in so many states, exposing the programs to an increased

risk that public coverage will substitute for—or crowd out—private coverage.<sup>3,4</sup> On the other hand, it was argued that private premiums had grown faster than the federal poverty level since the inception of SCHIP, which in turn was placing private insurance out of reach for a growing number of moderate-income families with incomes above 200 percent of the FPL, and that cost-of-living differences across states affect how affordable health insurance premiums are for families.<sup>5</sup> Where eligibility thresholds are set and the extent to which states have latitude over their thresholds are important because they likely affect how effective SCHIP and Medicaid will be at filling gaps in coverage for children.



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

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

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

## Data and Methods

To assess how the affordability of private health insurance coverage has been changing over the past decade, we use information on the cost of employer-sponsored insurance premiums from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). The MEPS-IC includes survey information for an average of 38,500 private sector establishments per year, going back to 1996. Response rates range from 67 percent to 81 percent, with the early years of the survey experiencing lower response rates.<sup>18</sup> The standard errors on the premium data are small, making the annual estimates of average employer-sponsored insurance premiums very precise. For example, the standard error

associated with the average total family premium in 2006 was less than 0.3 percent as large as the average premium for that year. The survey contains data on the insurance plan offered, including total premiums, employer contributions, cost sharing arrangements and information on the establishment. Data on the average premium cost for single coverage (employee only) and family coverage are available back to 1996.

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

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

We use changes in the average employer premium for family coverage as a proxy for how the costs of private insurance coverage have been changing over time. Fully capturing how the affordability of private coverage has been changing over time would ideally rely on information

on how private nongroup premiums have been changing. However, only limited information is available to estimate changes in nongroup premiums. The MEPS Household Component (MEPS-HC) contains data on nongroup premiums, which are based on small samples of respondents with nongroup family coverage, and even smaller samples that represent a family size of four.<sup>22</sup> Studies using the MEPS-HC data found that nongroup premiums for family coverage increased about 25 percent between 2002 and 2005 and by about 67 percent between 1996 and 2005.<sup>23</sup> Using the average premium growth between 2002 and 2005, we estimated the average premium cost for nongroup family coverage in 2006. While the MEPS data suggest that the nongroup premiums have not risen as fast as ESI premiums, we still found substantial growth in nongroup family premiums.<sup>24</sup>

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

## Findings

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

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

Similar growth was found in the ratio of average employee ESI costs (employee contributions to premiums and total out-of-pocket costs) to income over the period, increasing from less than 8 percent of family income in 1996 to 12 percent in 2006 for families at 200 percent of the FPL and from 5 to 8 percent for families at 300 percent of the FPL.<sup>29</sup> Because premiums paid by employers are part of an employee's total benefit package, we also examined the share of income spent on premiums after including the value of the employer's premium contribution in the family's income. The trend using this definition of family income tracks very closely to the trend using the simpler definition, increasing from 14 percent in 1996 to 24 percent in 2006 for families at 200 percent of the FPL and from 10 to 17 percent for families at 300 percent of the FPL (data not shown). Regardless of the definition used, the ratio of ESI costs to income was higher for families with incomes at 300 percent of the FPL in 2006 than it was for families with incomes at 200 percent of the FPL in 1996, the year before SCHIP was enacted.

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

Another factor determining whether available coverage is affordable for families is the cost of living, which translates into very different effective incomes for families with the same nominal income living in different areas. For example, in 2008, families living in San Francisco and Philadelphia,

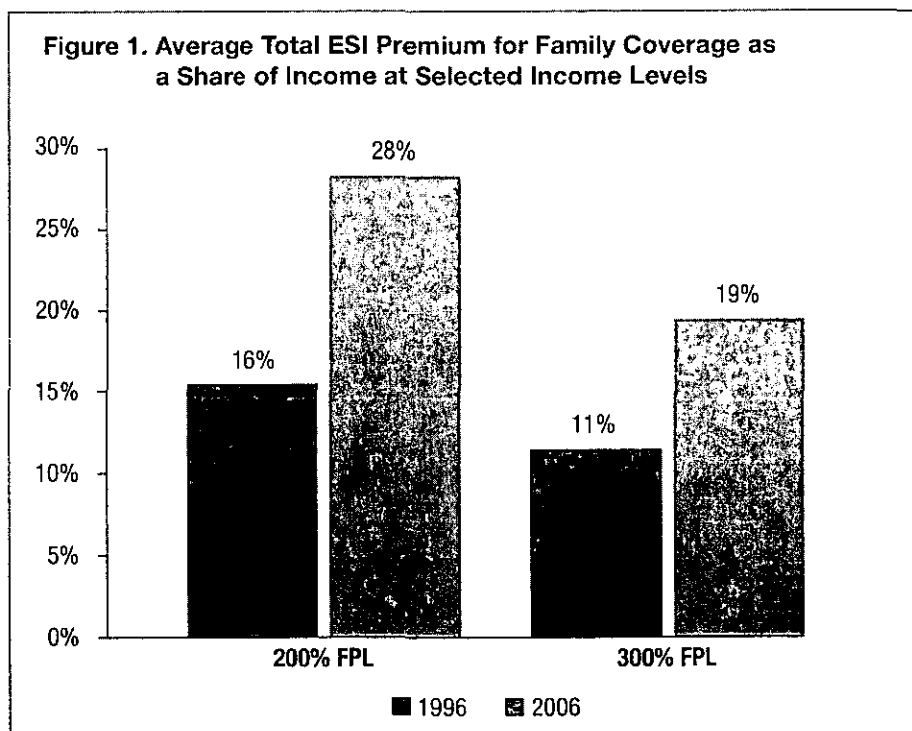
two urban areas with higher than average cost of living than the other areas included in the ACCRA index, would have to earn 2.1 and 1.5 times as much, respectively, to have the same purchasing power as families living in Douglas, Georgia, the lowest cost urban area in the study (figure 2). Consequently,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

## Discussion

Given that health care cost growth has historically exceeded general inflation rates, capping eligibility levels for public

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

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



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

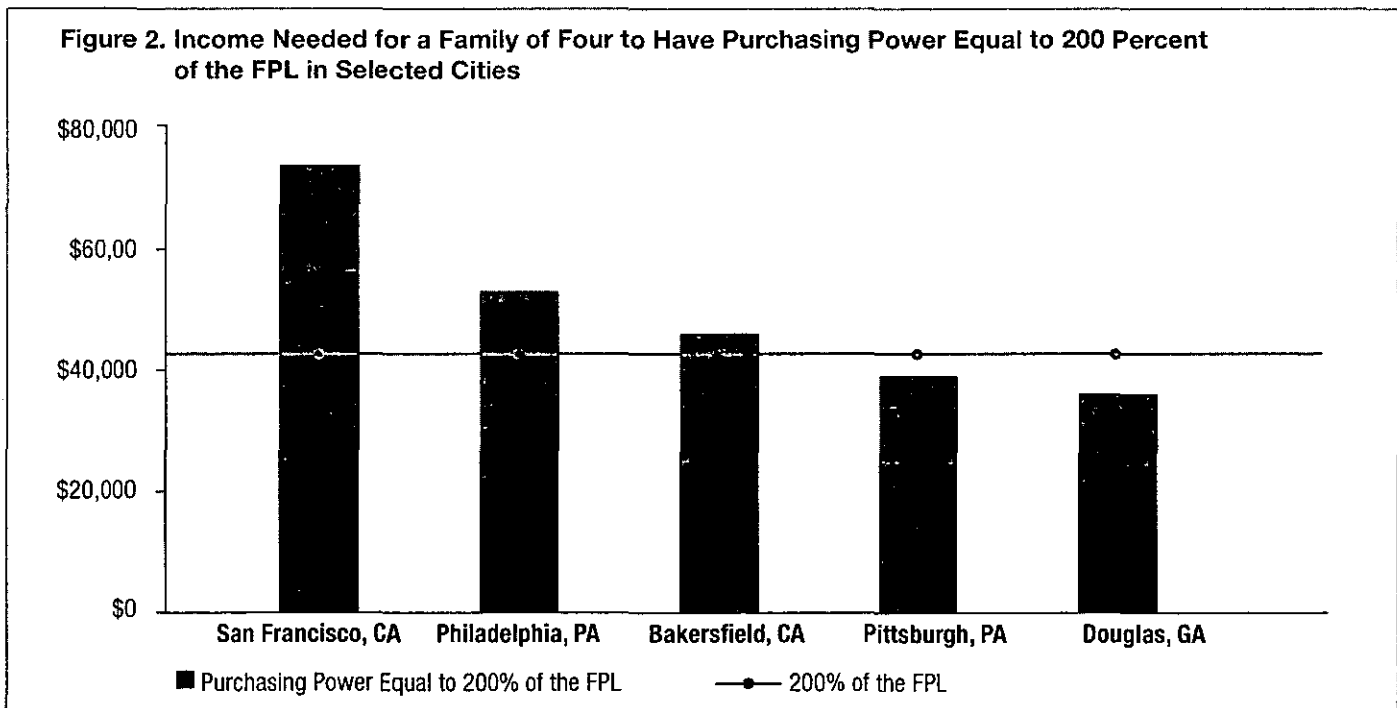
expanding eligibility to higher income levels has been shown to have positive spillover effects on the enrollment of lower-income children who were previously eligible.<sup>32</sup> At the same time however, allowing states to expand public eligibility to higher income levels increases the risks that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

As states expand coverage to higher incomes, it is also important to consider whether their premium schedules adequately reflect the greater ability of higher-income families to afford coverage. It is important to note that past research has shown that premiums charged in public programs have a negative effect on enrollment, despite being much lower than premiums in the private insurance market, suggesting that even low amounts of cost sharing

can deter families from enrolling their children in coverage.<sup>34</sup> At the same time, however, there may be room for some states to raise premium levels, especially for moderate income children, without incurring significant enrollment declines. There is substantial variation in the premiums that states charge in their Medicaid/SCHIP programs to cover families above 200 percent of the FPL—of the eleven states that cover children in SCHIP at 300 percent of the FPL, monthly premiums range from zero in the District of Columbia to over \$100 in New Jersey and Missouri for one child.<sup>35</sup> While defining what is Affordable for families of different income levels is analytically difficult because the concept is inherently subjective, it is critical to efforts to achieve and finance universal coverage.<sup>36</sup>

Whereas 200 percent of the FPL might have been a reasonable eligibility

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



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

## Notes

- <sup>1</sup> See Kenney, G. "The Failure of SCHIP Reauthorization: What Next?" Washington, DC: The Urban Institute. 2008. <http://www.urban.org/publications/411628.html>.
- <sup>2</sup> SCHIP was established over a decade ago as part of the Balanced Budget Act of 1997. Though an optional program, all states expanded coverage under SCHIP, with an estimated 6.7 million children and 700,000 adults having coverage under SCHIP at some point during 2006. State programs vary in terms of their structure and characteristics (e.g., cost sharing arrangements and income eligibility levels), reflecting the flexibility over program design that was built into the SCHIP statute (Kenney 2008).
- <sup>3</sup> Hederman, R. "Expanding SCHIP into AMT Territory: SCHIP Plan Would Extend Welfare to Wealthy Families." Web Memo No. 1546. Washington, DC: The Heritage Foundation. July 10, 2007; Owcharenko, N. "The SCHIP Negotiations: A Backdoor Approach to Expanding Medicaid to the Middle Class?" Web Memo No. 1716. Washington, DC: The Heritage Foundation. December 3, 2007; Winfree, P. and G. D'Angelo. "SCHIP and "Crowd-Out": The High Cost of Expanding Eligibility." Web Memo No. 1627. Washington, DC: The Heritage Foundation. September 20, 2007.
- <sup>4</sup> When SCHIP was enacted in 1997, the statute designated children in low-income families (defined as less than 200 percent of the FPL) as the target population for SCHIP, but states had the flexibility to use disregards in setting their thresholds, and an explicit exception was made for states that already were covering children through prior Medicaid expansions above 150 percent of the FPL, who were allowed to cover children in SCHIP up to 50 percentage points greater than their Medicaid eligibility level (The Balanced Budget Act of 1997, PL-105-33).
- <sup>5</sup> Mann, C. and M. Odeh. "The Growing Health Insurance Affordability Gap For Children and Families." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007a; Kaiser Family Foundation. "Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level." Snapshots: Health Care Costs. Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. February 2007. <http://www.kff.org/insurance/snapshot/chcm021507oth.cfm>
- <sup>6</sup> Congressional Budget Office. "Technological Change and the Growth of Health Care Spending." A CBO Paper. Washington, DC: Congressional Budget Office. January 2008.
- <sup>7</sup> Congressional Budget Office 2008.
- <sup>8</sup> Seliger Keenan, P. "What's Driving Health Care Costs?" The Commonwealth Fund/John F. Kennedy School of Government 2004 Bipartisan Congressional Health Policy Conference Issue Brief. Washington, DC: The Commonwealth Fund. November 2004.
- <sup>9</sup> State Health Access Data Assistance Center (SHADAC). "Squeezed: How Costs for Insuring Families are Outpacing Income." University of Minnesota: State Health Access Data Assistance Center. April 2008.
- <sup>10</sup> Seliger Keenan 2004; Kaiser Family Foundation and Health Research and Educational Trust. "Employer Health Benefits 2008 Annual Survey." Washington, DC: The Kaiser Family Foundation and Health Research and Educational Trust. September 2008. <http://ehbs.kff.org/>
- <sup>11</sup> Kaiser State Health Facts. "Cost of Living Variation." Menlo Park, CA and Washington, DC: The Kaiser Family Foundation. 2008. <http://www.statehealthfacts.kff.org/comparable.jsp?ind=600&cat=1>; Jolliffe, D. "The Cost of Living and the Geographic Distribution of Poverty." Economic Research Service. Washington, DC: US Department of Agriculture. September 2006. <http://www.ers.usda.gov/publications/err26/>
- <sup>12</sup> Before 2007, states had broad latitude to set their own eligibility levels and to use income disregards to subtract costs of child care or work expenses from a family's gross income, thereby establishing eligibility based on the family's net income; states also applied "blanket" income disregards to reach children at higher income levels, as had long been permitted for Medicaid under Section 1902(r)(2) of the Social Security Act. On August 17, 2007, the Centers for Medicare and Medicaid Services issued a letter to state health officials (SHO-#07-001) restricting states' ability to cover children in families with gross income above 250 percent of the FPL. Specifically, in order to expand income eligibility above 250 percent of the FPL, the letter required states to achieve a coverage rate of 95 percent for low-income children and to ensure that the rate of employer-sponsored coverage for children had not dropped more than two percentage points in the past five years. States were also required to impose a 12-month waiting period for children coming off of other insurance before they could enroll in SCHIP and to charge the maximum amount of cost sharing allowable by law (5 percent of family income) for children in families earning more than 250 percent of the FPL (Mann, C. and M. Odeh. "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children." Georgetown Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. 2007b). Both SCHIP reauthorization bills that passed Congress but were vetoed by the president in 2007 (H.R. 976 and H.R. 3963) would have overturned the August 17th Directive. The Directive was set to take effect on August 17, 2008 for states already covering children above 250 percent of the FPL; however, CMS has applied the new rules only to states seeking to expand coverage (including New York, Ohio, Oklahoma, Louisiana, Indiana, and Wisconsin) and not to those who had already implemented coverage expansions (Associated Press, "States Won't Be Sanctioned over Kids' Health Insurance." 2008. [http://www.usatoday.com/news/health/2008-08-14-children-insurance\\_N.htm?csp=34](http://www.usatoday.com/news/health/2008-08-14-children-insurance_N.htm?csp=34)).
- <sup>13</sup> These income eligibility levels reflect those in effect as of October 2008. Several states have authorized income eligibility increases that have not yet been implemented either because of legislative delays or CMS denials of the increases (see footnote 12). In addition, four states have moved to use state-only funds to increase their income eligibility levels above the limit set in their SCHIP program. Illinois and Wisconsin use state funds to cover kids up to 300 percent of the FPL (Illinois' SCHIP eligibility level is 200 percent of the FPL; Wisconsin's is 250 percent of the FPL); Massachusetts and New York cover kids up to 400 percent of the FPL (Massachusetts' SCHIP eligibility level is 300 percent of the FPL; New York's is 250 percent of the FPL) (Georgetown Center for Children and Families. "Eligibility Levels in Medicaid & SCHIP for Children, by State as of October 1, 2008." Georgetown University Health Policy Institute. October 20, 2008).
- <sup>14</sup> Selden, T., G. Kenney, M. Pantell, and J. Ruhter. "Cost Sharing Arrangements in Medicaid and SCHIP: Implications for Out-of-Pocket Spending Burdens." Under Review.
- <sup>15</sup> Congressional Research Service. "REVISED: Estimates of SCHIP Child Enrollees up to 200% of Poverty, above 200% of Poverty, and of SCHIP Adult Enrollees, 2007." May 30, 2008. This study evaluated low-income families by their net income since that is how SCHIP eligibility is determined in most states. Some children with net income of less than 200 percent of the FPL have gross income above 200 percent of the FPL after adding back in child care and work-related expenses and other disregards.
- <sup>16</sup> When both Medicaid and SCHIP children are considered together, the proportion of enrollees who are low-income rises to 98 percent (Author's tabulation based on SCHIP enrollment as reported in Congressional Research Service 2008 and Medicaid enrollment from Georgetown Center for Children and Families, "Number of Children Ever Enrolled in Medicaid/SCHIP by Program Type and State, FY 2007." Washington, DC: Georgetown University Health Policy Institute. 2008).
- <sup>17</sup> Kenney, G., A. Cook, and J. Pelletier. "SCHIP Reauthorization: How Will Low-Income Kids Benefit under House and Senate Bills?" Washington, DC: Urban Institute. 2007. <http://www.urban.org/publications/411545.html>
- <sup>18</sup> Establishments are pre-screened over the phone, and those that offer health insurance to their employees are mailed a complete questionnaire. Those who do not offer health insurance to their employees are only asked a few questions over the phone. Establishments that do not return the questionnaire are sent a second mailing, and those that do not return the second mailing are called to complete the information over the phone.
- <sup>19</sup> Available at <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>
- <sup>20</sup> Two-hundred percent of the FPL for a family of four translates into \$31,200 in 1996 and \$40,000 in 2006. Three-hundred percent of the FPL translates into \$46,800 in 1996 and \$60,000 in 2006.
- <sup>21</sup> Data on out-of-pocket costs are based on Urban Institute tabulations of the Household Component of the 1996 and 2006 Medical Expenditure Panel Survey and include average out-of-pocket costs for families with ESI coverage for the entire survey year.

- <sup>22</sup> Examining nongroup premium growth is also important when considering coverage options for this income group because few low- and moderate-income children have access to ESI coverage. (Kenney, Cook, and Pelletier. "Prospects for Reducing Uninsured Rates Among Children: How Much Can Premium Assistance Programs Help?" Urban Institute. Forthcoming).
- <sup>23</sup> Bernard, D. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65, 1996 and 2002." Statistical Brief #72. Rockville, MD: Agency for Healthcare Research and Quality. March 2005; Bernard, D. and J. Banthoin. "Premiums in the Individual Health Insurance Market for Policyholders under Age 65: 2002 and 2005." Statistical Brief #202. Rockville, MD: Agency for Healthcare Research and Quality. April 2008.
- <sup>24</sup> Because of the small sample sizes, the nongroup premium estimates in the MEPS have large standard errors associated with them and are therefore much less precise than the ESI premium data. For example, the standard error associated with the mean nongroup family premium for 2005 was close to 10 percent of the mean, compared to a ratio of less than 0.3 percent for the mean ESI family premium in 2006 (MEPS-IC Table I.D.1(2006); Bernard and Banthoin 2008). We also looked at out-of-pocket spending when evaluating the cost of nongroup coverage but chose not to include it because the sample sizes for families of four are very small.
- <sup>25</sup> Kaiser State Health Facts (2008) provides ACCRA data on what a family of four would need to earn in select U.S. cities to have purchasing power equal to 300 percent of the FPL. Because the focus of this brief is on children currently targeted by SCHIP, the income figures were multiplied by 2/3 in order to represent purchasing power equal to 200 percent of the FPL. Mann and Odeh (2007a) used ACCRA data and a similar method to show purchasing power for a family of three at 200 percent of the FPL.
- <sup>26</sup> The index is based on the spending distribution across the six major categories of purchases listed on page 2 for consumers in the top income quintile in the Consumer Expenditure Survey. The distribution is relatively similar to the distribution for the lowest income quintile, which would represent lower-income families. The largest share of expenditures for both quintiles is due to housing costs, which represent 37 and 35 percent of total expenditures in the six categories of goods and services for the top and bottom quintiles, respectively. Because housing costs are highly variable across the country and constitute such a large share of expenditures in the index, the cost of living can vary greatly between cities. Transportation costs make up the second-largest share of expenditures (31 percent for the top quintile and 23 percent for the bottom quintile); groceries and utilities each constitute 10 percent of expenditures for the top quintile and 15 percent for the bottom quintile. Health care costs account for 8 percent of spending in the top quintile and 10 percent of spending in the bottom quintile (Urban Institute tabulations of the 2007 Consumer Expenditure Survey).
- <sup>27</sup> The standard errors associated with these estimates were \$32.33 in 2006 and \$36.06 in 1996 (MEPS-IC Table I.D.1 from 1996 and 2006).
- <sup>28</sup> For firms with large shares of low-wage workers (50 percent or more), the ratio of average employee premium to income is slightly higher than for all firms: For families at 200 percent of the FPL, the ratio is 6 percent in 1996 and 8 percent in 2006, and for families at 300 percent of the FPL, the ratio is 4 percent in 1996 and 5 percent in 2006 (data not shown). Employee contributions remained fairly constant over the period, constituting about a quarter of the total premium (data not shown).
- <sup>29</sup> The premium for 2006 was estimated using the average growth rate in the nongroup premium between 2002 and 2005. The standard errors associated with these estimates are large, \$241 in 1996, or 7.2 percent of the mean, and \$513 in 2005, or 9.2 percent of the mean.
- <sup>30</sup> Holahan, J. and A. Cook. "What Happened to the Insurance Coverage of Children and Adults in 2006?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. September 2007.
- <sup>31</sup> Smith, V. and D. Rousseau. "SCHIP Program Enrollment: June 2003 Update." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. December 2003. <http://www.kff.org/medicaid/upload/SCHIP-Program-Enrollment-June-2003-Update.pdf>; Cohen Ross, D. A. Horn, and C. Marks. "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. January 2008. <http://www.kff.org/medicaid/upload/7740.pdf>
- <sup>32</sup> Arjun, L. and J. Guyer. "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children." Georgetown Center for Children and Families. Washington, DC: Georgetown Health Policy Institute. 2008; Kenney, G., L. Blumberg, and J. Pelletier. "State Buy-In Programs: Prospects and Challenges." Washington, DC: Urban Institute. 2008.
- <sup>33</sup> Winfree and D'Angelo 2007.
- <sup>34</sup> Hadley, J., J. Reschovsky, P. Cunningham, G. Kenney, and L. Dubay. 2007. "Insurance Premiums and Insurance Coverage of Near-Poor Children." *Inquiry* 43, no. 4: 362-377; Kenney, G., J. Hadley, and F. Blavin. 2007. "The Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003." *Inquiry* 43, no. 4: 345-361; Kenney, G., R.A. Allison, J. Costich, J. Marton, and J. McFeeters. 2007. "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States." *Inquiry* 43, no. 4: 378-392.
- <sup>35</sup> The cost of enrolling two children in both Missouri and New Jersey is the same as enrolling one child (Selden et al. Under Review).
- <sup>36</sup> Blumberg, L., J. Holahan, J. Hadley, and K. Nordahl. "Setting a Standard of Affordability for Health Insurance Coverage." *Health Affairs* 26(4): w463-w473. 2007.
- <sup>37</sup> These numbers understate the extent to which coverage has become unaffordable at 300 percent of FPL, compared to coverage at 200 percent of FPL when SCHIP was signed into law. The 1996 estimates in the text represent the cost of coverage one year before the 1997 enactment of SCHIP. The 2006 estimates, by contrast, are at least three years before the potential reauthorization of SCHIP; if SCHIP is reauthorized at its earlier possible point (2009), the year most directly analogous to 1996 would be 2008. Between 2006 and 2008, premium growth continued to outstrip increases in the FPL. According to surveys by the Kaiser Family Foundation (KFF) and the Health Research & Educational Trust (HRET), average premiums for family coverage rose by 10.5 percent from 2006 to 2008 (KFF/HRET 2008. Available at <http://ehbs.kff.org/>). During that same period, the FPL rose by 6 percent. Using the recent premium increase reported by KFF/HRET to project ESI premiums for 2008, ESI family coverage in 2008 consumed an average of 30 percent of family income at 200 percent of FPL and 20 percent of family income at 300 percent of FPL. If average nongroup premiums are estimated for 2008 based on the growth rate between 2002 and 2005, nongroup premiums would have constituted 17 percent of income for families at 200 percent of the FPL and 11 percent of income for families at 300 percent of the FPL.

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

## **About the Authors and Acknowledgements**

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Medicaid Spending

- Total Medicaid Spending, FY2007
- Spending by Service, FY2007
- Spending on Acute Care, FY2007
- Spending on Long Term Care, FY2007
- Growth in Medicaid Spending, FY90-FY06
- Payments by Enrollment Group, FY2006
- Medicaid Payments per Enrollee, FY2006
- Federal Matching Rate and Multiplier
- Federal/State Share of Spending, FY2007
- Federal DSH Allotments
- Medicaid Spending by Residence, 95-04

State Medicaid Spending

- State Medicaid Spending, SFY2007

Temporary Federal Medicaid Relief

- ARRA Medicaid Grant Funds (2 Qtrs.)
- ARRA Medicaid Grant Funds (Total)
- Federal DSH Allotments under ARRA

Medicaid Budget Actions

- Medicaid Cost Containment, FY2008
- Medicaid Cost Containment, FY2009
- Positive Medicaid Policy Actions, FY2008
- Positive Medicaid Policy Actions, FY2009

Medicare Drug Benefit: Clawback Payments

- Baseline Dual Eligible Enrollment
- Baseline FFS Drug Payments for Duals
- Estimated Annual Clawback Payments
- Per-Capita Monthly Clawback Amounts

Medicaid Physician Fees

- Medicaid Fee Index, 2003
- Medicaid-to-Medicare Fee Index, 2003
- Change in Medicaid Fees, 1998-2003

Medicaid Enrollment

- Total Medicaid Enrollment, FY2006
- Medicaid Enrollment as a % of Total Pop
- Distribution by Enrollment Group, FY2006
- Monthly Medicaid Enrollment
- Monthly Medicaid Enrollment - Children
- Monthly Medicaid Enrollment - Adults
- Monthly Medicaid Enrollment % Change
- Monthly Enrollment % Change - Children
- Monthly Enrollment % Change - Adults

Children's Medicaid and SCHIP Eligibility

- Income Eligibility - Medicaid
- Income Disregards - Medicaid
- Income Eligibility - Separate SCHIP Prog
- Income Disregards - SCHIP Program

Medicaid/SCHIP Eligibility

- Income Eligibility - Parents in Medicaid
- Income Eligibility - Pregnant Women
- Income Eligibility - Other Groups
- Expansions for SSP Recipients

SSI Beneficiaries

- Total SSI Beneficiaries
- SSI Beneficiaries as % of Population
- Distribution of Total SSI by Age
- Aged SSI

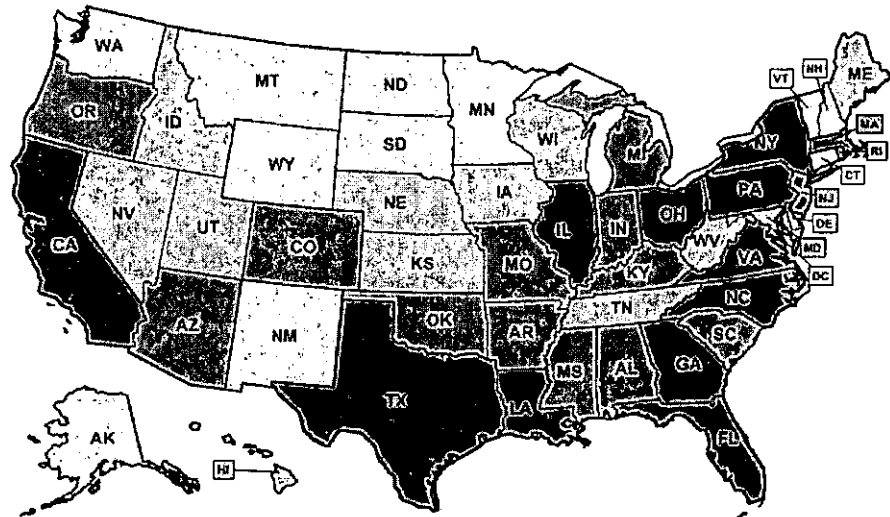
**Estimated Number of Children Enrolled in SCHIP with Family Income at or Below 200% Federal Poverty Level (FPL) and Above 200% FPL, FY2008**

Bar Graph | Table | Map | Map & Table

Rank by:  View by: # | %

Rank Order: ▲ ▼

**At or Below 200% FPL**



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

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

- Aged SSI as % of Population Ages 65+
- SSI with Disabilities
- SSI with Disabilities as % of Population
- Medicaid Medically Needy
  - Total Enrollment
  - Enrollment by Eligibility Category
  - Medically Needy Eligibility
  - Total Spending
  - Spending by Eligibility Category
  - Total per Enrollee Spending
  - Per Enrollee Spending by Eligibility Cat
- Medicaid Managed Care
  - Total Medicaid MC Enrollment
  - MC Enrollment as a % of Medicaid Enrollm
  - Dual Eligible Enrollment by MC Plan Type
  - Enrollment by Medicaid MC Plan Type
  - Medicaid Managed Care Capitation Rates
- Births Financed by Medicaid
  - Total Medicaid Births
  - As Percent of State Births
- Enrollment Practices for Pregnant Women
  - Asset Test
  - Presumptive Eligibility
- Enrollment Practices for Children
  - Joint Application: Medicaid & SCHIP
  - Face-to-Face Interview: Medicaid & SCHIP
  - Asset Test: Medicaid & SCHIP
  - Presumptive Eligibility: Medicaid/SCHIP
  - Income Verification: Medicaid/SCHIP
- Renewal Practices for Children
  - Joint Renewal: Medicaid/SCHIP
  - Face-to-Face Interview: Medicaid/SCHIP
  - 12-Mo. Continuous Eligibility: Med/SCHIP
- SCHIP
  - Federal SCHIP Spending, FY 1998-2007
  - Total SCHIP Spending, FY2007
  - Monthly SCHIP Enrollment
  - Monthly SCHIP Enrollment % Change
  - SCHIP Enrollment by FPL
  - SCHIP Program Name and Type
  - Federal Matching Rate
  - Federal SCHIP Allotments, FY2009
- Home and Community-Based Services
  - Total HCBS Waivers
  - Participants by HCBS Waiver Type
  - Expenditures by HCBS Waiver Type
  - Aged & Aged/Disabled Participants
  - Aged & Aged/Disabled HCBS Expenditures
  - Waiting Lists for HCBS Waivers, 2006
  - Waiting Lists for HCBS Waivers, 2007
  - Home Health Participants
  - Home Health Expenditures
  - Personal Care Participants
  - Personal Care Expenditures
  - Individual Budget-Based Models of LTC
- False Claims Act
  - States With a False Claims Act

Louisiana	146,373	1,490	147,863
Maine	30,947	NA	30,947
Maryland	66,602	66,262	132,864
Massachusetts	142,216	58,734	200,950
Michigan	67,763	NA	67,763
Minnesota	5,534	87	5,621
Mississippi	84,370	NA	84,370
Missouri	110,196	25,939	136,135
Montana	22,679	NA	22,679
Nebraska	48,827	NA	48,827
Nevada	38,592	NA	38,592
New Hampshire	2,891	9,345	12,236
New Jersey	112,909	38,896	151,805
New Mexico	4,270	10,674	14,944
New York	433,047	84,209	517,256
North Carolina	251,647	6	251,653
North Dakota	7,617	NA	7,617
Ohio	251,278	NA	251,278
Oklahoma	117,507	NA	117,507
Oregon	73,686	NA	73,686
Pennsylvania	219,366	37,261	256,627
Rhode Island	23,210	2,821	26,031
South Carolina	73,620	NA	73,620
South Dakota	15,277	NA	15,277
Tennessee	55,320	8,299	63,619
Texas	731,916	NA	731,916
Utah	At or Below 200% FPL	Above 200% FPL	5,492
Vermont	0	6,496	6,496
Virginia	155,289	NA	155,289
Washington	365	16,466	16,831
West Virginia	37,250	395	37,645
Wisconsin	52,940	NA	52,940
Wyoming	8,976	NA	8,976

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

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

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

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

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

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

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NATIONAL CONFERENCE of STATE LEGISLATURES

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**Joe Hackney**  
*Speaker*  
*North Carolina House of Representatives*  
*President, NCSL*

To: The Honorable Bettye Davis  
Alaska Senate

**Gary VanLandingham**  
*Director, OPPAGA*  
*Florida Legislature*  
*Staff Chair, NCSL*

From: Jennifer Saunders  
Health Program  
303-856-1440  
[Jennifer.saunders@ncsl.org](mailto:Jennifer.saunders@ncsl.org)

**William Pound**  
*Executive Director*

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)

**Denver**  
7700 East First Place  
Denver, Colorado 80230-7143  
Phone 303.364.7700 Fax 303.364.7800

**Washington**  
444 North Capital Street, N.W. Suite 515  
Washington, D.C. 20001  
Phone 202.624.5400 Fax 202.737.1069

Website [www.ncsl.org](http://www.ncsl.org)

February 11, 2009

p. 2

CRS Report for Congress, January 25, 2007

[http://assets.opencrs.com/rpts/RS22578\\_20070125.pdf](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](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



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 — Full text](#) ]

[ [Prior Poverty Guidelines and Federal Register References Since 1982](#) ]

[ [Frequently Asked Questions \(FAQs\)](#) ]

[ [Further Resources on Poverty Measurement, Poverty Lines, and Their History](#) ]

[ [Computations for the 2009 Poverty Guidelines](#) ]

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

- The poverty thresholds, and
- The poverty guidelines.

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

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

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

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

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

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

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

### 2009 Poverty Guidelines for Alaska

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

### 2009 Poverty Guidelines for Hawaii

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

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

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

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

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

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

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

The [computations for the 2009 poverty guidelines](#) are available.

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

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Go to [Further Resources](#) on Poverty Measurement, Poverty Lines, and Their History

Go to [Frequently Asked Questions \(FAQs\)](#).

Return to the main [Poverty Guidelines, Research, and Measurement](#) page.

Last Revised: February 27, 2009

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## APPENDIX F

### 2009 HSS Poverty Guidelines for Alaska

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

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



AARP Alaska  
3601 C Street  
Suite 1420  
Anchorage, AK 99503

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

March 8, 2010

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

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

RE: SB 13 (Davis)—Support

Dear Co-Chairs Keller and Herron:

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

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

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

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

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

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

AARP requests an "AYE" vote on SB 13.

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

Thank you for your consideration.

Sincerely,

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

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

1

| 2121 Starr Avenue | Anchorage, Alaska 99501 | T 907.272.3663 | F 907.277.7368 | [www.foodbankofalaska.org](http://www.foodbankofalaska.org) |



March 5, 2010

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

Dear Representative Keller,

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

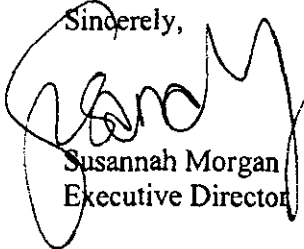
The eligibility level for Denali KidCare is currently set at 175% of federal poverty level. This means that Alaska has one of the most restrictive eligibility criteria for child health insurance programs in the nation. 48 states and the District of Columbia now cover children at or above 200% of the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

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

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

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

Sincerely,



Susannah Morgan  
Executive Director





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

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

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

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

**WHEREAS** in 2006, of the 22,868 children in Mat-Su, approximately 12.9% or 2,949 were uninsured;<sup>ii</sup>

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

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

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

**WHEREAS** 11.3% of families with related children in Mat-Su and 11.2% of families with related children in AK have lived below the poverty level in the last 12 months;<sup>vi</sup>

**WHEREAS** 37% of Mat-Su Borough School District students ages five to 17 live in households receiving Public Assistance;<sup>vii</sup>

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

**WHEREAS** the rate of uninsured children under age 18 in Alaska is increasing—from 8.4% in 2005 to 10.3% in 2006 to 11.4% in 2007 to 13.2% in 2008;<sup>viii</sup>

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

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

- 17% of Alaskan children living at or below 199% FPL had no coverage at the time of the survey versus 13.9% nationwide
- 25.1% of Alaskan children living at or below 199% FPL had periods of no coverage during the year versus 24.3% nationwide;<sup>ix</sup>

**WHEREAS** approximately 10,000 Alaskan children 18 years or younger and below 200% FPL are uninsured,<sup>x</sup> and 36,000 Alaskan children 19 years or younger and below 200% FPL rely on government health insurance to provide access to health care services;<sup>xi</sup>

**WHEREAS** Alaska has seen a 31% decline in the number of children covered by private health insurance in the past decade;<sup>xii</sup>

**WHEREAS** the cost of caring for uninsured children is passed on to other Alaskans and businesses, raising premiums and out-of-pocket expenses for everyone;<sup>xiii</sup>

**WHEREAS** uninsured children are nine times less likely to have a regular doctor, four times more likely to be taken to emergency rooms, and 25% more likely to miss school than insured children;<sup>xiv</sup>

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

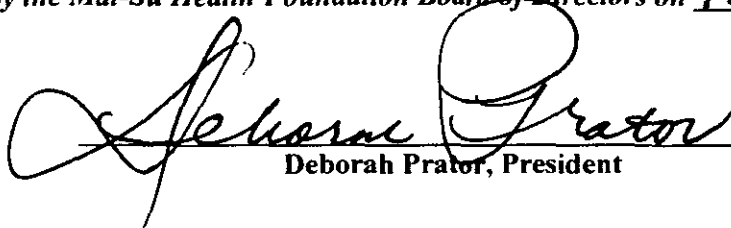
**WHEREAS** increasing Denali KidCare income eligibility levels to at least 200% FPL will increase health care access for children and families that meet this criterion;

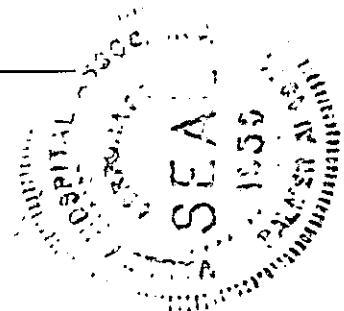
**WHEREAS** expanding the Denali KidCare income eligibility levels would result in improved public health and overall health outcomes throughout the state for Alaskan children;

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

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

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

  
Deborah Prator, President



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

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

<sup>iii</sup> Ibid.

<sup>iv</sup> Alaska Health Care Data Book, page 241. Alaska Department of Health & Social Services. November 2007.

<sup>v</sup> Ibid.

<sup>vi</sup> Ibid.

<sup>vii</sup> Ibid.

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

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

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

<sup>xi</sup> Ibid.

<sup>xii</sup> Legislative Health Care Initiatives Presentation to the Anchorage Chamber of Commerce, August 27, 2007.

<sup>xiii</sup> Ibid.

<sup>xiv</sup> Ibid.



## ALASKA ASSOCIATION OF HOMES FOR CHILDREN

February 9, 2010

Alaska Baptist Family Services  
Anchorage, AK

Alaska Children's Services  
Anchorage, AK

Alaska Family Services  
Palmer, AK

Covenant House of Alaska  
Anchorage, AK

Fairbanks Native Association  
Fairbanks, AK

Family Centered Services of Alaska  
Fairbanks, AK

Juneau Youth Services  
Juneau, AK

Kenai Peninsula Community Care  
Center  
Kenai, AK

Maniilaq Association  
Kotzebue, AK

Nome Children's Home  
Nome, AK

North Slope Borough Children's  
Services  
Barrow, AK

North Star Behavioral Health  
Systems  
Anchorage & Palmer, AK

Presbyterian Hospitality House  
Fairbanks, AK

Providence Behavioral Health  
Systems  
Anchorage, AK

Residential Youth Care  
Ketchikan, AK

The Salvation Army Booth Memorial  
Home  
Anchorage, AK

The Boys and Girls Home of Alaska  
Fairbanks, AK

Youth Advocates of Sitka  
Sitka, AK

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

Dear Representatives Herron and Keller:

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

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

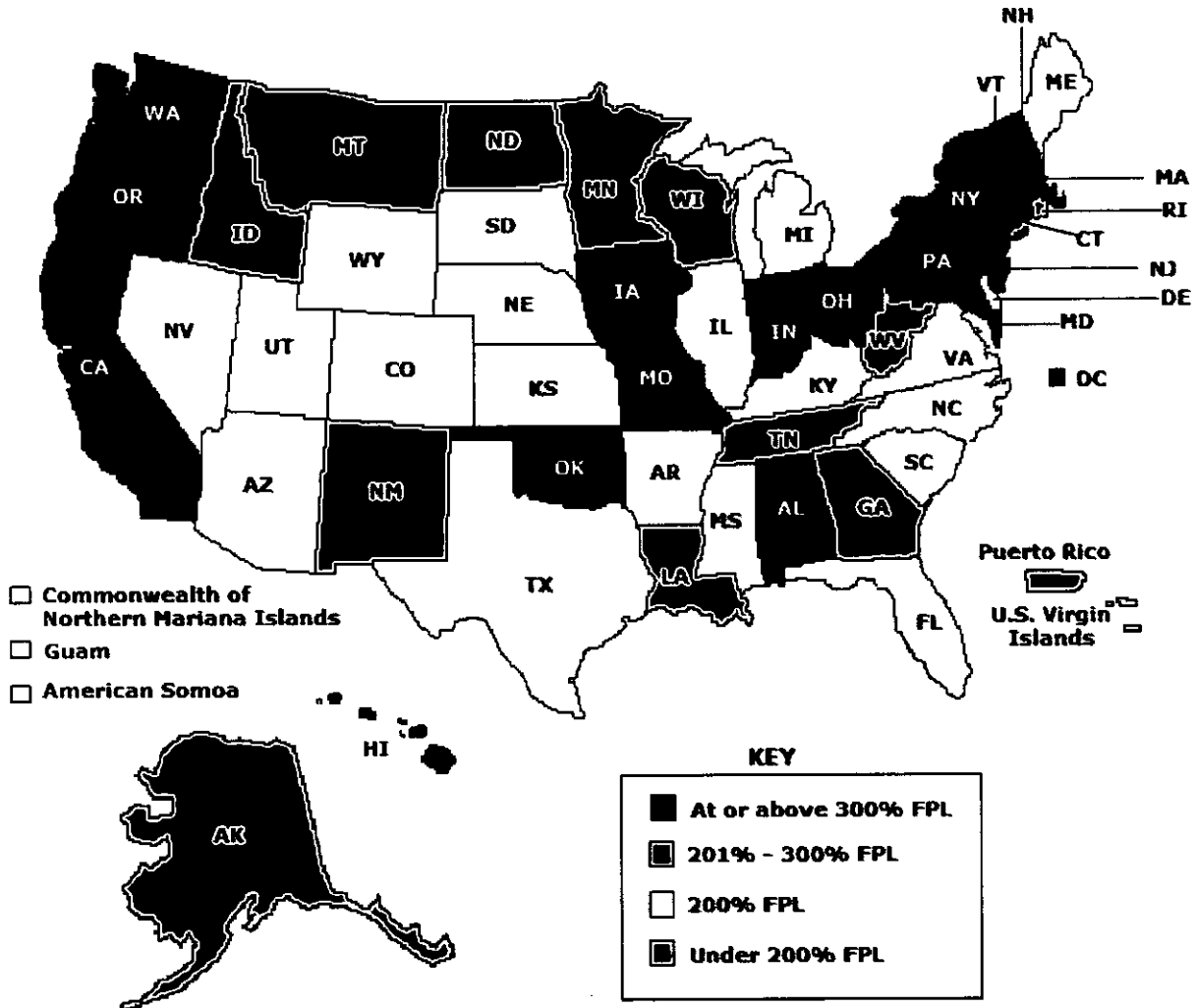
As Alaskans who consider our children as our future, we should be leading the nation in providing quality health care to them, not lagging so far behind. Let's join those states that place a greater emphasis on helping working families take care of their children! The clock is ticking. Don't make those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

Sincerely,

  
Brad Ohs, President

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

# Children's Health Insurance Program Upper Income Limits as of February 1, 2010



SB 13

Thurs 3/9/10

Testimony in Support of Senate Bill 13

March 8, 2010

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

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

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

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

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

Please support Senate Bill 13.



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



Banner Health

# Tanana Valley Clinic

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

Representative Keller,

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

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

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

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

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

Sincerely,

**J. Timothy Foote, MD**

**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.

## Table of Contents

Executive Summary.....	2
I. Introduction.....	3
II. About this Survey.....	5
III. Key Survey Findings -- Current Status of Coverage for Children and Parents....	6
IV. Key Survey Findings -- State Actions During 2008.....	8
V. Discussion.....	13
VI. List of Tables.....	17

## 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 17<sup>th</sup> 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 17<sup>th</sup> 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.<sup>1</sup> 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.<sup>2</sup>

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.<sup>3</sup> 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.<sup>4</sup>

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.<sup>5</sup> 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.<sup>6</sup>

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

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.

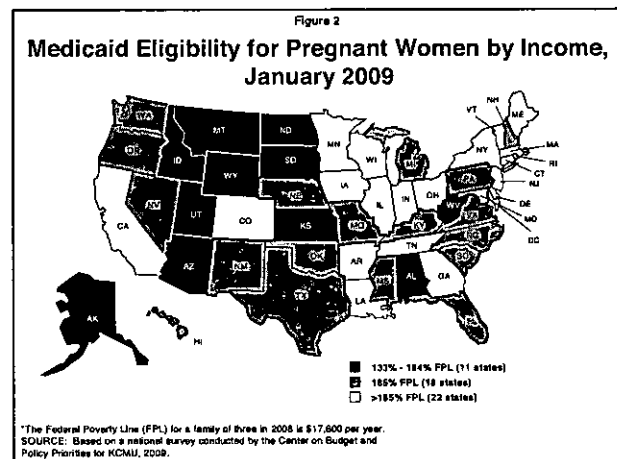
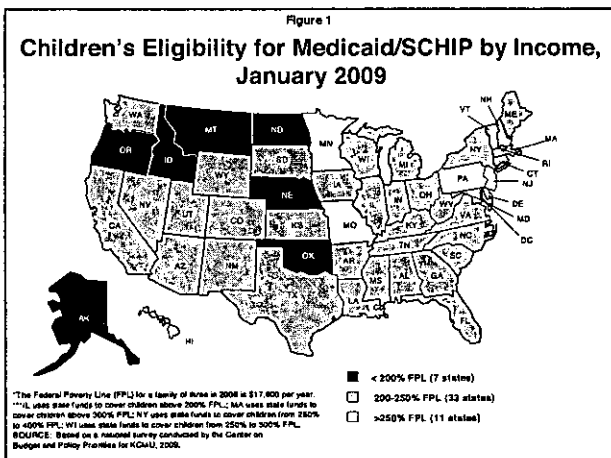
This study, the eighth annual survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, was carried out in the summer and early fall of 2008, through extensive telephone interviews with state Medicaid and SCHIP program administrators. Detailed 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:

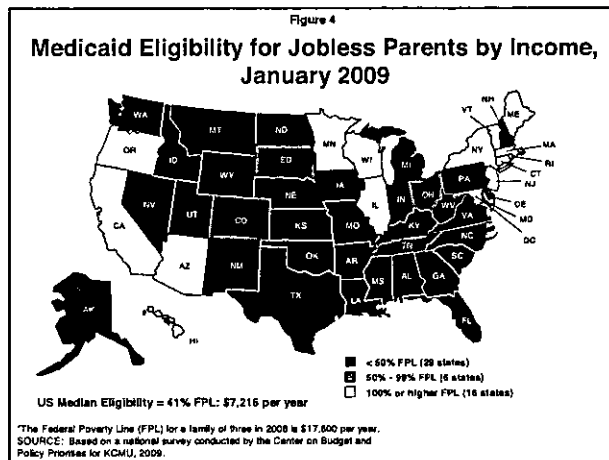
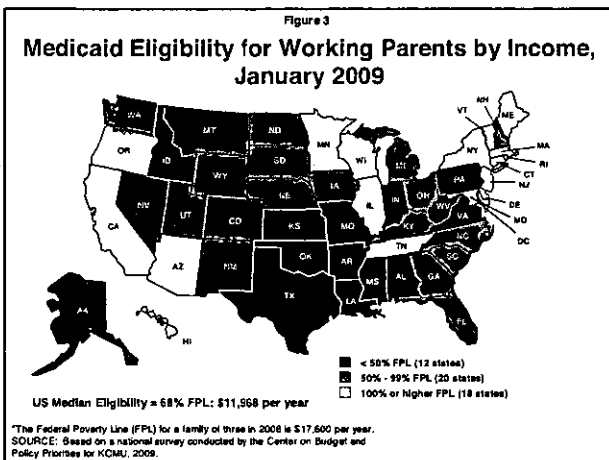
States provide health coverage for children and pregnant women under Medicaid or SCHIP as follows (Figures 1 & 2):

- 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).

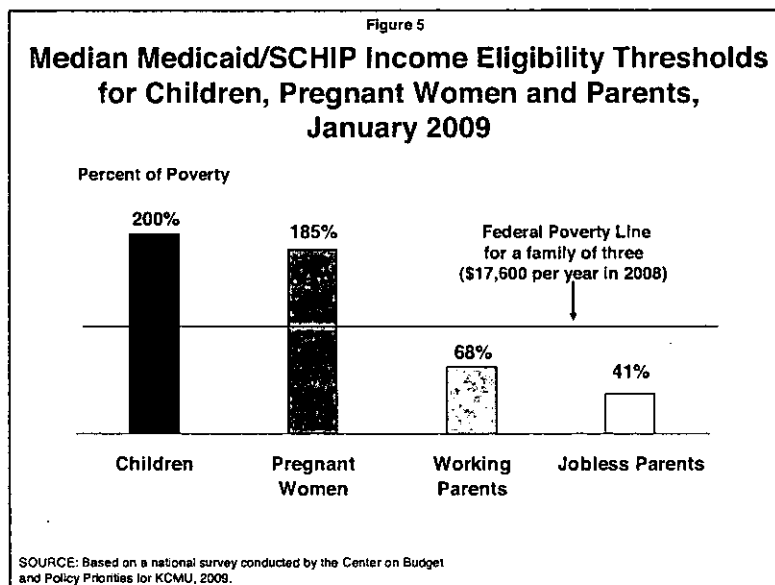


States provide health coverage for parents under Medicaid as follows (Figures 3 & 4):

- 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.



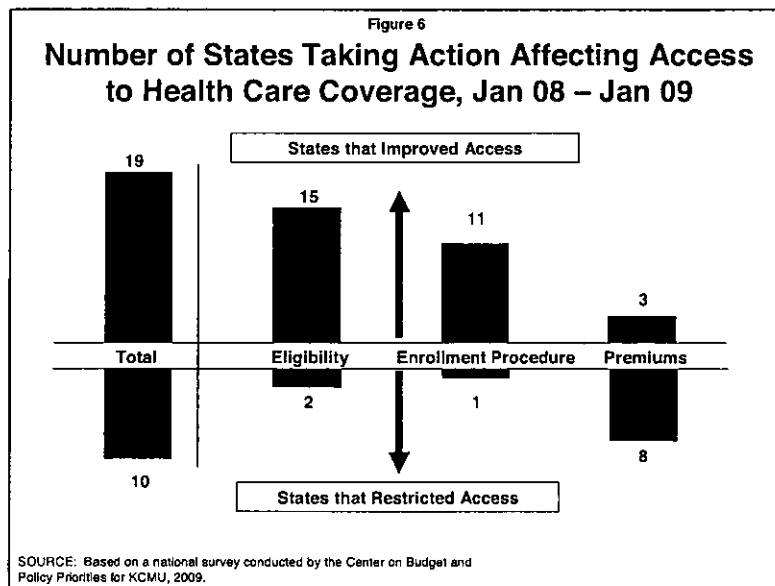
It continues to be more difficult for a low-income parent to qualify for health coverage than for a child (Figure 5). The median income at which children qualify for Medicaid or SCHIP is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working 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, LA, IN, KS, LA, MD, MT, ND, NJ, NY, OK, OR, SC, TN, WI); 11 states reduced procedural barriers (AZ, CO, LA, KY, LA, MD, MT, NV, OR, SC, UT) and three states reduced financial barriers to Medicaid and SCHIP (TN, WA, WI).



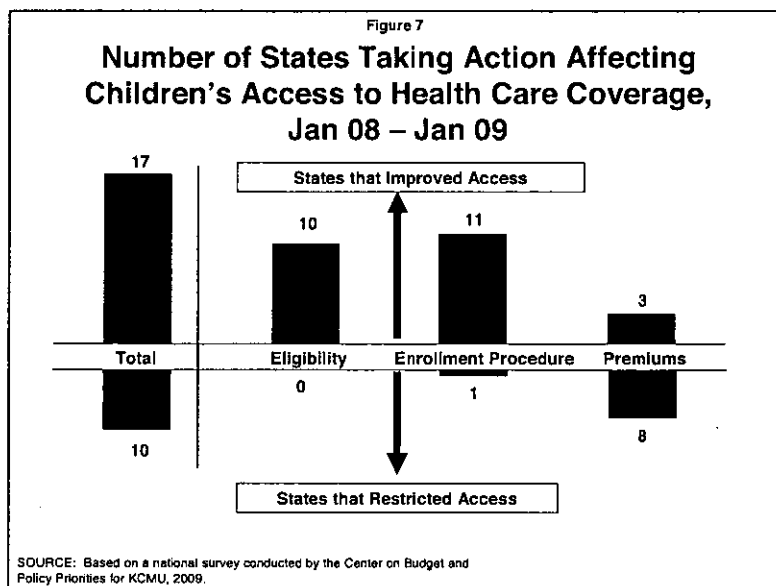
- Ten states (10 states) enacted at least one measure to restrict coverage. The most common restriction was to increase financial barriers such as new or higher premiums in SCHIP programs. Eight states (GA, LA, MN, MO, NJ, NV, PA, RI) went in this direction. Rhode Island and South Carolina restricted 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

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.<sup>7</sup>

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 17<sup>th</sup> 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 17<sup>th</sup> 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 17<sup>th</sup> 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.

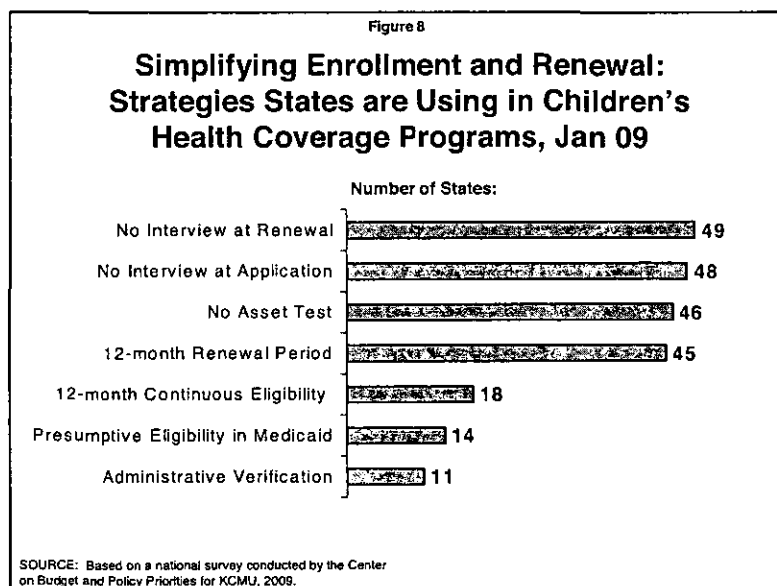
Of the ten states that expanded coverage for children, four were implementing expansions that were authorized last year, but which had been held back by the August 17<sup>th</sup> directive or by the uncertainty surrounding SCHIP reauthorization. *Louisiana* and *Indiana* increased eligibility to 250 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

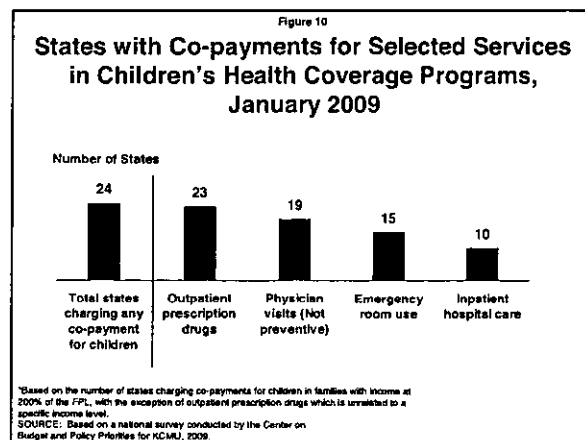
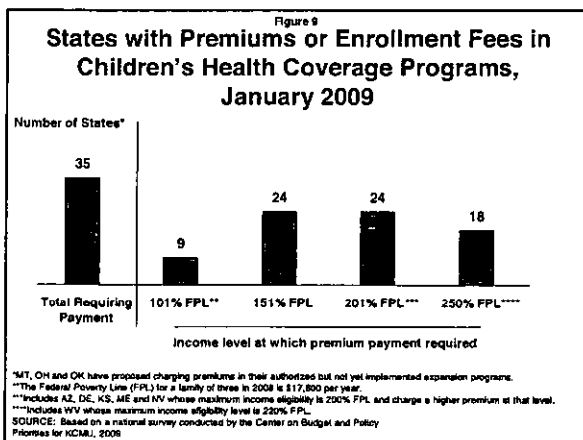
### Emergence of Online Applications

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

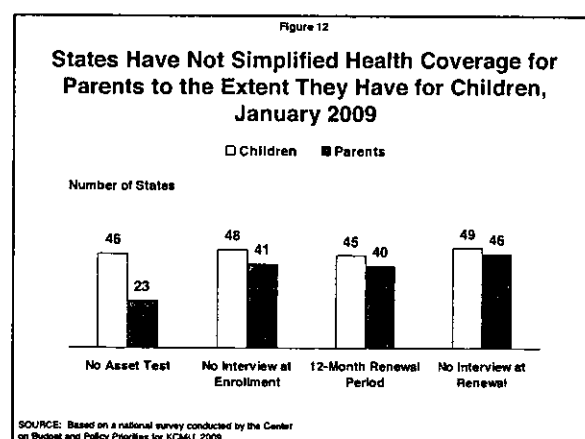
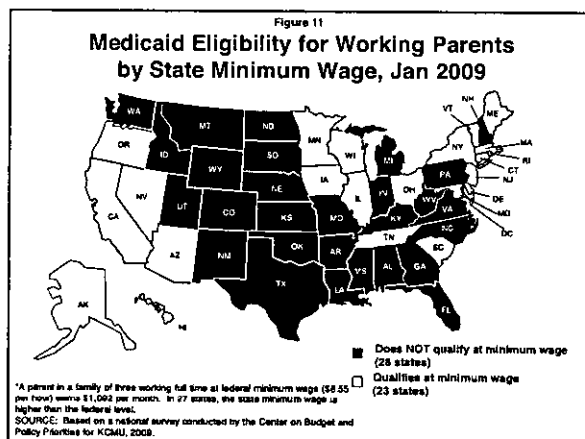
Eleven states (12 states at renewal) report using technology to streamline the enrollment and renewal process. States report conducting matches with existing databases to verify income and other information, as well as eliminating rules requiring families to submit pay stubs or other paper documentation. 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.



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.



## 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.

## **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.<sup>8</sup> 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.<sup>9</sup> 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."<sup>10</sup> Given the demands that outreach generates and the limitations created by personnel cuts, adopting simplified procedures are more important than ever. Streamlining renewal, in particular, protects the investment in outreach since it guards against eligible children and parents losing coverage unnecessarily.

## **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.

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- <sup>1</sup> Kaiser Commission on Medicaid and the Uninsured analysis of the National Health Interview Survey data.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> Elizabeth McNichol and Iris Lav, *State Budget Troubles Worsen*, Center on Budget and Policy Priorities, Washington, DC, Updated, January 14, 2009.
- <sup>5</sup> 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.
- <sup>6</sup> *Ibid.*
- <sup>7</sup> Nicholas Johnson, Phil Oliff and Jeremy Koulisch, "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.
- <sup>8</sup> 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.
- <sup>9</sup> 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.
- <sup>10</sup> Conversation with Robert D. Beardsley, Deputy Director, Medical Assistance Division, New Mexico Department of Human Services, January 12, 2009.

# STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES  
OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601  
JUNEAU, ALASKA 99811-0601  
PHONE: (907) 465-3030  
FAX: (907) 465-3068

April 15, 2009

Representative Wes Keller, Co-chairman  
House Health & Social Services Committee  
State Capitol, Room 13  
Juneau AK, 99801-1182

Representative Bob Herron, Co-chairman  
House Health & Social Services Committee  
State Capitol, Room 415  
Juneau, AK 99801-1182

*Wes* *Bob*  
Dear Representatives ~~Keller~~ and ~~Herron~~:

I am writing on behalf of the Governor to respectfully request a hearing for Senate Bill 13 in the House Health & Social Services Committee.

Senate Bill 13 increases the income level for covering children and pregnant women under Denali KidCare to 200 percent of the federal poverty guidelines, up from the current level of 175 percent.

Senate Bill 13 would allow approximately 1,277 more uninsured children and 225 pregnant women to access health insurance. Early intervention and preventative care under SB 13 will significantly improve the health of Alaska children's by addressing problems before they result in more costly conditions that must be treated later in life. Early care can also result in savings to the state and public and private sector hospital emergency rooms by reducing the need to treat indigent and uninsured patients for non-emergencies.

Although we believe there is merit in several other proposals introduced this year to implement cost sharing provisions along with an increase in eligibility, we believe that providing essential care for those up to 200 percent of poverty level is more important than pursuing those options this year.

Thank you for consideration of this request.

Sincerely,  
*William H. Hogan*

William H. Hogan  
Commissioner

cc: Gerald Gallagher, Director Governor's Legislative office  
Anna Kim, Governor special assistant  
House Health & Social Services committee members

20  
Years



**Covenant  
House  
Alaska**

Crisis Center • Community Services Center • Transitional Living

Governor Sarah Palin  
State Capitol  
Third Floor  
Juneau, AK 99801

April 9, 2009

Dear Governor Palin,

Senator Bettye Davis and Representative Les Gara introduced legislation providing transitional assistance and care for foster care youth leaving the state's care (SB 105 and HB 126). The Alaska State Legislature is currently reviewing these proposed bills.

Covenant House Alaska (CHA) provides shelter, food, healthcare and transitional living assistance to Alaska's homeless youth. CHA strongly supports SB 105 and HB 126.

The proposed legislation provides access to educational, housing and life skills support that is vital for young people to successfully transition to adulthood. Nearly 50% of CHA youth have been involved with the foster care system at some point in their lives. They arrive on our door step with a plastic bag full of a few belongings. Many of these youth survive for a few months after being released from care, but find at the young age of 18 they don't have the resources and life skills required to live completely independently on their own. After living traumatized lives, they are faced with a new trauma and a new set of dangers that homelessness presents.

This legislation is fundamentally about providing to our foster care youth the resources we would naturally provide to our own children. Youth still require assistance with educational, occupational and housing needs past the age of 18. This bill ensures that while we cannot completely erase the trauma endured by foster care children, we can lessen it. We can actively take steps to help them in a responsible, reasonable fashion.

Thank you for your consideration of this letter and the proposed legislation. Please contact me with any questions you may have.

Sincerely,

Deirdre A. Cronin  
Executive Director

Opening Doors for Homeless Youth  
Celebrating 20 years of service in the State of Alaska

Mailing: P.O. Box 104640, Anchorage, Alaska 99510-4640 • (907) 272-1255 • [www.covenanthouseak.org](http://www.covenanthouseak.org)

## Janet Ogan

---

**From:** doctorem@aol.com  
**Sent:** Wednesday, March 10, 2010 11:24 PM  
**To:** Rep. Wes Keller; Rep. Bob Herron  
**Subject:** in support of SB 13 and Denali Kidcare

March 10, 2010

Dear Representatives Keller and Herron, and members of the House HSS committee,

I am writing in support of SB 13, which has been worked over for 2 years now. SB 13 represents a classic opportunity to demonstrate the wisdom of "a stitch in time, saves nine." Helping children, single mothers and low-income workers get the health care they need BEFORE they land in the emergency department will SAVE money, not to speak of time lost at work, heart-ache, pain and suffering.

This bill is not designed to waste money on those who could actually afford premium health insurance plans. We have all heard about Medicare loopholes in which billionaires get discounted drugs. This bill is about helping people who really need the help. The federal poverty limit for a family of 4 this year is less than \$1000/month per person. This level of income, which represents many hours of hard work in a lower-paying job, may pay rent, cold weather clothing and basic food. It will not allow for opportunities for self-advancement, nor savings, nor debt reduction, in particular if one or more of the family members has health issues. Even at 200% of poverty level, many families will struggle to pay health care insurance premiums, deductibles and co-pays. As you know, the single largest line item for personal debt in the US (Alaska included) is medical bills. Some families lose their homes over choosing to provide needed, yet expensive, care for their cherished children or siblings or parents.

Alaska is the wealthiest state in the nation. Please let us help raise up people in this great country from such a level of struggle. It is shameful to refuse a small part of our \$40 billion bank account to care for our own people. Health, ultimately, is absolutely the most precious resource for every individual. Without health, any amount of money or fame is trivial. Please, invest in the health of all Alaskan people, and let Alaska lead the way in taking care of its own.

Sincerely,

Dr. Emily A. Kane  
Juneau AK

# SB 13 AMENDMENTS:

It seems to me that its unfair for the chronically disabled to be penalized when they are trying so hard to become productive members of the community. It also seems unfair to penalize working poor families by denying them extra assistance until they are able to solve their financial situation. What I would like to talk to you about is my solutions to these situations:

- Please consider raising the federal poverty rate to 200% across all programs (i.e. Childcare Assistance, Adult Public Assistance, Denali Kid Care). Through this change, not only will it allow more families to qualify for services, but also it might give them the boost they need to stabilize their current situation.
- Create an exemption process for working families that fall slightly over income limits. This would give families the ability to receive assistance and continue working. From personal experience, I know that if my family had had the benefit of just a little extra assistance we would be able to take care of our family and be productive in work, which ultimately helps the State of Alaska.
- Establish a transportation assistance fund for elders and people experiencing disabilities. When I lived in New York, the state ran a program that provided free transportation for elders and people experiencing disabilities through establishing a general transportation assistance fund to the state budget. From my research, I noticed that the Alaska Commission on Aging advocated to get this discussed during the last legislative session. Unfortunately, the proposal did not get passed. As a person who experiences issues with affording public transportation, I strongly urge you to please give their proposal more consideration. If I was able to fully access transportation, I could focus on receiving treatment to help me better handle my symptoms. As I see it, this small change will assist me on my way to achieving my goal of gainful employment and safety/security for my family.

I thank you in advance for your time and consideration in reading my letter. Please know that I welcome the opportunity to speak with you or one of your aides personally about my situation and ways I'm willing to help to create solutions to benefit all Alaskans. My contact information is listed above. Please feel free to contact me at your earliest convenience.

Sincerely,

Michael Markovich

# 764-5001

MJM7788@GMAIL.COM

# SB 13      AMendments :

## Ways to decrease spending so that the Federal Poverty Level could be raised to 200%:

- Eliminate 6 - month reviews for people already on Adult Public Assistance. The paperwork so is cumbersome for workers that cases have to be shipped to other offices to be processed. Personally, I live in Anchorage, but my paperwork is processed in the Kenai office. From my research, Alaska is one of a few states that still do 6-month reviews. The majority of other states conduct reviews yearly. Imagine the time and money saved if paperwork was reviewed yearly.
- Limit benefits for people with major criminal offences or history of chronic drug or alcohol use. When applying for benefits, ask people for proof of any criminal or substance abuse history. If they comply, ask them to sign a release so that history can be verified and case managers working with the person can provide feedback on progress. If the person is in a rehabilitation program, they should be allowed on the program as long as they are actively working on staying out of jail or getting clean and sober. People who do not comply with the program or sanctions taken if they have a "bump in the road to recovery" should be removed from the program. The way I see it, if people are actively engaged in trying to get more self-sufficient, funding spent of fighting crime and homelessness would decrease, which will reduce the crime rate, cut spending on policing the State and save the State of Alaska money overall.
- Create a buy in program for Medicaid and Child Care Assistance programs. If a person doesn't quite fit the requirements for assistance due to income (for example if he or she is financially over by a few hundred dollars) allow them the option to partial pay for Medicaid or Child Care assistance based on what they can afford. This would assist people to get medical assistance as well as childcare so that they are healthy and able to find gainful employment, which helps them create a plan for self-sufficiency. A timetable would need to be set in place to ensure that participants work towards coming off the program. People who do not show compliance in working themselves off the program would be removed from the program after a year.

Sincerely,

Michael Markovitch

# 764-5001

MSM 7788@GMAIL.COM

Fax Written Testimony

269-0229

# Alaska State Legislature

Please enter into the record my testimony to the House H&SS  
committee name

committee on SB 13 - Increase Denali KidCare dated 3/9/2010  
bill/subject

Catholic Social Services provides help & creates hope for nearly 19,000 individuals a year through a variety of social services programs that focus on self sufficiency. Many people seeking assistance at Catholic Social Services are the working poor - people that are just getting by, struggling each day to pay their bills and feed their families.

SB 13 is important legislation because it will increase the income eligibility guidelines for Denali KidCare from 175% to 200% of Alaska's federal poverty level (FPL). As you know, this change would restore eligibility to 1,300 children and 225 pregnant women.

Increasing eligibility to 200% of the federal poverty level is not only a good thing to do for Alaska's low-income families but reflects sound fiscal policy as research shows that preventive care, such as that received through Denali KidCare, has a positive return on investment. For example, children and pregnant women without access to health care are four times more likely to use expensive emergency room care for medical treatment. The federal government covers almost 65% of the entire cost of Denali KidCare. Therefore, compared to the long term expenses the State of Alaska will most likely incur if these vulnerable children and pregnant women continue to be denied access to health care, the financial expenditure associated with a return to 200% of FPL is nominal.

Thank you for giving Catholic Social Services an opportunity to speak out on this important issue! We strongly believe that Denali KidCare helps parents raise healthy kids and we are all strengthened by a healthy community.

Signed: Ellen Lawlor Krsnak *Ellen Lawlor Krsnak*  
Testifier

Catholic Social Services  
Representing (Optional)

3710 East 20<sup>th</sup> Avenue, Anchorage, AK 99508  
Address

907-222-7327  
Phone No.



Banner Health

# Tanana Valley Clinic

SB 13

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

Representative Keller,

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

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

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

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

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

Sincerely,

Timothy Foote, MD



AARP Alaska  
3601 C Street  
Suite 1420  
Anchorage, AK 99503

T 1-866-227-7447  
F 907-341-2270  
TTY 1-877-434-7598  
[www.aarp.org/ak](http://www.aarp.org/ak)

April 15, 2010

To: Members of the Alaska House of Representatives

RE: SB 13 (Davis)—Support

On behalf of the members of AARP in Alaska, we encourage you to support SB 13, authored by Senator Bettye Davis, and co-sponsored by Senators Paskvan, Ellis, Wielechowski, and French as well as Representatives Gruenberg, Tuck, Kawasaki, Crawford, Herron, Munoz, Holmes and Kerttula.

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

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

In addition, we have many retired grandparents who are raising their grandchildren. Currently there are over 5,400 grandparents responsible for raising over 8,200 young Alaskan grandchildren. Very often these grandparents are retired and dependent on Medicare for their health coverage. Denali KidCare, in many cases, is the only health insurance they can secure for their grandchildren. If these grandparents are not able to secure insurance coverage for their grandchildren, some of the children will have to leave this caring family environment and become wards of the state. We hope you realize how important Denali KidCare coverage is to these extended families that are now in one household. These grandparents are trying to provide the best care for their grandchildren. They need Denali KidCare.

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

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

AARP requests an "AYE" vote on SB 13.

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

Thank you for your consideration.

Sincerely,



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

CC: Senator Bettye Davis

# fax

**Subject:** Denali Kidcare

**Date:** April 16, 2009

**To:** *Representative Sharon Cissna*

**CC:** *Representative Bob Herron, HSS Co-Chair*  
*Representative Wes Keller, HSS Co-Chair*

**From:** *Various Anchorage Residents*

**Fax:** 465--4588 (Representative Cissna)  
465--4589 (Representative Herron)  
465—3818 (Representative Keller)

**Comments:**

*Dear Representative Cissna:  
Please share these letters with your colleagues on the  
House HSS Committee. Thank you.*

24 pages plus cover sheet

**Letter in Support of Increasing Denali KidCare Income Eligibility Levels**

Name: Katrina Letner

Address:

12254 Keystone Place  
Eagle River, AK, 99577

Phone Number: 720-7449

During the 2009 State Legislature, Senate Bill 13 and 87 have been introduced to increase the eligibility income level for Denali KidCare. These very important bills would increase Denali KidCare from 175% of Alaska's federal poverty level to 200%. These bills would allow thousands of additional Alaskan children and pregnant women to be eligible for medical assistance. Along with Governor Palin, I support an increase in Denali KidCare and encourage the Alaska State Senate to do the same. Here are my reasons why:

Providing health and dental insurance for more children  
will prevent major health issues and save money in the  
long run. Prevention is the key. Uninsured children  
are 25% more likely to miss school than insured children. Continued  
illness affects school performance and work force participation.

Thank you for taking my thoughts into consideration. If you have any questions, please call me at the above number. Please do all that you can to support these important pieces of legislation.

Katrina Letner  
Signature

03/05/2009  
Date

This letter campaign was organized by concerned local citizens and Alaskan non-profit agencies and is not affiliated with any politician, political organization or political action committee.

## Letter in Support of Increasing Denali KidCare Income Eligibility Levels

Name: Miriam Verquez Ematio

Address:

241 N Bagrow St.

Anchorage AK, 99508

Phone Number: (907) 277-6358

During the 2009 State Legislature, Senate Bill 13 and 87 have been introduced to increase the eligibility income level for Denali KidCare. These very important bills would increase Denali KidCare from 175% of Alaska's federal poverty level to 200%. These bills would allow thousands of additional Alaskan children and pregnant women to be eligible for medical assistance. Along with Governor Palin, I support an increase in Denali KidCare and encourage the Alaska State Senate to do the same. Here are my reasons why:

I am thinking that is really important for our children

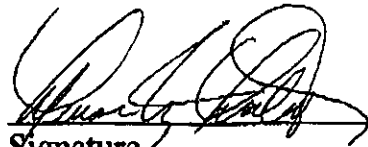
that they have health insurance, with increase of poverty

level at 200% given more chance to other children will

have this benefit. Medical bills in the State of Alaska are

so expensive many families are forced to wait until  
the child is very sick to visit a doctor and that puts child in  
health risk.

Thank you for taking my thoughts into consideration. If you have any questions, please call me at the above number. Please do all that you can to support these important pieces of legislation.

  
 Signature

2-27-09  
 Date

This letter campaign was organized by concerned local citizens and Alaskan non-profit agencies and is not affiliated with any politician, political organization or political action committee.

**Matthew Johnson**

---

**From:** Rynnieva Moss  
**Sent:** Friday, April 17, 2009 1:34 PM  
**To:** Matthew Johnson  
**Subject:** RE: A SCAN HAS ARRIVED.

The portion spent on minor girls would be Denali Kid Care. Denali Kid Care is a name Knowles gave Medicaid for children. The feds call it CHIP Children's Health Insurance Program. It is Medicaid money.

---

**From:** Matthew Johnson  
**Sent:** Friday, April 17, 2009 11:18 AM  
**To:** Rynnieva Moss  
**Subject:** RE: A SCAN HAS ARRIVED.

Would all of these dollars be funded through Denali Kid Care?

---

**From:** Rynnieva Moss  
**Sent:** Friday, April 17, 2009 11:02 AM  
**To:** Matthew Johnson  
**Subject:** FW: A SCAN HAS ARRIVED.

Look at page 3 – one-third of the way down on the page is the numbers; \$418,200 dollars for the calendar year of 2008.

---

**From:** postmaster@legis.state.ak.us [mailto:postmaster@legis.state.ak.us]  
**Sent:** Friday, April 17, 2009 11:58 AM  
**To:** Rynnieva Moss  
**Subject:** A SCAN HAS ARRIVED.



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Operated by: Planned Parenthood of the Great Northwest

Alaskan Families Can't Wait - Support Denali KidCare Today!

Please call Your Alaska State Senator today!

Take Action on this Issue
Send this message to:

- Senator Con Bunde
Senator Fred Dyson
Senator Thomas Wagoner
Your State Senator (if you live in Alaska)

Tell your Senator to Vote YES on Denali KidCare, Senate Bill 13, this Monday, April 6!

Senate Bill 13 would increase the eligibility rate for Alaska's Denali KidCare program to 200% of the Federal Poverty level and would immediately help support children and pregnant women in these hard economic times.

Health care for children and pregnant women shouldn't be hostage to other bills; there is no time for political games. Senate Bill 13 needs to move to the Senate Floor for a vote - and we need your help to get it there! Alaskan families can't wait.

Send This Message

Complete the following to send this message. If you have participated before, just type in your email address then submit the form.

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Last Name: \*
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Address Line 2:
City: \*
State: \*
--Choose a State--
ZIP: \*
Phone Number:
Fax Number:
Gender:
Male
Female
Email Preference: \*
Send me Plain Text
Send me HTML\*\*
Don't Know
Work Phone:

Please take five minutes to take action. Alaska's families are relying on you to speak up!

- 1) Call/write your local district Senator and ask her/him to support Senate Bill 13 because Alaskan Families Can't Wait!
2) Call/write to Senators Wagoner, Dyson and Bunde and urge them to vote YES on Senate Bill 13!

If you have any questions about SB 13 or need support please call the Planned Parenthood public affairs office in Anchorage: (907) 770-9716, or email: ppactionak@ppgnw.org.

Tell me more

Talking Points

Alaskan Families Can't Wait!

Talking Points:

- 1. Even in these hard economic times, a Denali KidCare income eligibility increase is good policy for the health and economics of our state -

An increase in Denali KidCare eligibility to 200% of the federal poverty level reflects sound fiscal policy as research shows that preventive care, such as that received through Denali KidCare, has a positive return on investment. For example, children and pregnant women without access to health care are four times more likely to use expensive emergency room care for medical treatment. Since the federal government covers almost 65% of the entire cost of Denali KidCare the additional financial exposure associated with a return to 200% of federal poverty level is nominal compared to the long term expenses the State of Alaska will most likely incur if these vulnerable children and pregnant women continue to be denied access to health care.

- 2. The people of Alaska and Governor Palin support this important increase -

Governor Palin has publicly committed her support of this change which would restore eligibility to 1,300 children and 225 pregnant women.

- 3. Increasing Denali KidCare to 200% of Alaska's federal poverty level simply brings it back up to its original level approved by the legislature in 1999 -

Denali KidCare was authorized by the Alaska Legislature in 1999. The program was modeled after

Political Party:

--Select--

Issue Areas:

Family Planning Funding

Contraceptive Coverage

Abortion Access

Emergency Contraception

Sex Education

Judicial Nominations

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 Check this box if you would like to receive periodic updates or action alerts

\* Required Field  
\*\* Some older email programs may not display HTML correctly.

similar programs around the country with an eligibility level set at 200% of federal poverty level. In 2004, the legislature changed the way Alaska calculated maximum eligibility for Denali KidCare; instead of basing eligibility on a percentage of federal poverty level, maximum eligibility was changed to a fixed income limit that essentially froze eligibility rates at the 2003 level. Over time, this approach has cut children of working families and pregnant women out of the program. By 2007, the maximum Denali KidCare eligibility level had essentially fallen to 153% of the federal poverty level.

Subject: -  
Please Vote YES on SB 13 - Alaskan Fa

Dear [ Decision Maker ],

(Edit Letter Below)

Alaskan families can't wait. Please vote YES on SB 13!

As an Alaskan resident and voter, I think it is critical to increase the income eligibility guidelines for Denali KidCare from 175% to 200% of Alaska's federal poverty level.

Please do not play politics with the health of Alaska's children! Vote YES on Senate Bill 13.

In these hard economic times, a Denali KidCare income eligibility increase is good policy for the health and economics of our state. Children and pregnant women without access to health care are four times more likely to use expensive emergency room care for medical treatment.

Sincerely,  
[Your name]  
[Your address]

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# STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER  
FINANCE AND MANAGEMENT SERVICES

SARAH PALIN, GOVERNOR

P.O. Box 110601  
Juneau, AK 99811-0601  
Phone: (907) 465-1630  
Fax: (907) 465-2499

February 24, 2009

The Honorable Reggie Joule, Chair  
House Finance Sub-Committee  
State Capitol, Room 502  
Juneau, AK 99801-1182

Dear Representative Joule:

In response to your questions on February 23, 2009 from the House Finance Sub-committee closeout hearing, please see our response below:

➤ *What does the childhood obesity initiative buy? Is it possible to do something for less?*

See Attachment A for an overview of the childhood obesity initiative and five major program components:

- community coalitions, \$42,600
- obesity prevention media campaign, \$190,000
- development and training, \$235,500
- data gathering and evaluation pilot program, \$69,000
- program management and staff, \$386,000

➤ *Describe the program impact of reducing the subsidized adoption and guardian assistance increment by 50%?*

The OCS incremental request is to increase existing adoption subsidy levels using the foster care base rates that went into effect July 1, 2008 as the cap for negotiated rates. The request included retroactive adjustments back to FY 2006 which captures most of the adoptions in the pipeline. While this is the approach that provides the majority of adoptive parents equitable subsidies, statute does not require retroactive adjustments. The statute does, however, require departmental review of the appropriateness of subsidy amounts upon request of the person caring for the child.

If a 50% general fund reduction is required, retroactive adjustments would begin January 1, 2007 rather than July 1, 2005. All subsidies negotiated from January 1, 2007 through June 30, 2008 would be retroactively adjusted. This results in a 703.6 GFM reduction to the current request.

- ***Sexual Offender increment added by the Sub-committee – What information does the department have to show that the McLaughlin Youth facility program actually works?***

Evidence that the McLaughlin Youth Center (MYC) Sex Offender Treatment program is effective was recently provided in a study of the program conducted by Tonie Quaintance, a PhD candidate in the Clinical-Community Psychology Program at the University of Alaska-Anchorage. In her 2008 report (see Attachment b) Ms. Quaintance found that the overall recidivism rate for 107 juvenile sex offenders released over the past 9 years was 17.8%--significantly lower than the state average of 29% recidivism for all juvenile offenders released from juvenile institutions statewide in FY05. Most significantly, 0 of the 107 juveniles had committed another sex offense. Recidivism was defined as offenses that resulted in a new juvenile adjudication or adult conviction, or a probation violation resulting in a new institutional order.

While there may be elements of the MYC program that could be used to inform and improve sex offender management around the state, it would be difficult to replicate the MYC Sex Offender Treatment program in rural areas. A more effective approach would be to deploy the "Village-based Sex Offender Treatment Program" that served the small, remote communities around Nome between 1997-2005 and was recognized by the National Partnership for Juvenile Services as a "Promising Practice" (see Attachment C). In this culturally sensitive and community-based approach to juvenile sex offender management, a team of 8-20 people in a community agree to support a juvenile while a clinician would provide on-site, intensive sex offender management every 3 weeks. The juvenile is expected to complete a curriculum in sex offender treatment while also learning social skills, respect, and empathy from local team members. The youth's juvenile probation officer facilitates meetings, reviews progress, and works with the team to determine consequences for any violations the youth commits while on probation supervision.

This program demonstrated preliminary success in the Norton Sound region but ended when the local clinician position was not funded due to budget constraints. The first step in returning this program to rural areas would be to enlist the services of a mental health clinician skilled in juvenile sex offender management and consistently available to rural areas. Such individuals could be employed by the Division of Juvenile Justice, local or regional health providers, or could work on a contractual basis as needed.

- ***Please clarify DJJ's front line staffing needs from last year to this year. Why are they being presented differently than in the past, what has changed? What is the impact of no new staffing increments in FY2010?***

The division's front-line staffing request has shifted as planning has moved from a 4-year period to a 10-year period. In FY09 DJJ was presenting their 2<sup>nd</sup> year staffing needs within a 4-year plan, as requested by Representative Hawker. In FY2010, while DJJ was preparing its 3<sup>rd</sup>-year requests in this 4-year plan, the department was directed to develop a 10-year plan. This required the division to adjust its 4-year plan to fit a much longer framework, which may explain why the request is being presented differently from the past. Several DJJ facilities are still staffed at levels below what is recommended both nationally and by the state's own calculation to ensure safety and security for both workers and residents. The staffing shortfall has been temporarily covered by using overtime and non-perms. Funding for these expenses has only been made possibly due

to the vacancy factor built into the budget, and delaying recruitment by a minimum of 30 days to cover those expenses.

When overtime and non-perms are used to cover shifts on a regular basis an unsafe situation is created by having either overworked or tired staff monitor the youth activities. Inexperienced individuals there are basically tasked with maintaining order, similar to a substitute teacher; little work in rehabilitation and restoration can be accomplished by these temporary, fill-in workers. Having an adequate number of permanent staff ensure that we are able to provide a safe and consistent environment that has a well developed structure and plan for these youth that ensures that they learn to behave safely around others, learn the discipline and self-control needed to complete school work and resist negative peer influences, and ultimately take responsibility for themselves so that they are able to succeed once they are released back to the community.

- *Please provide information on the number of abortions and amount paid by state and those paid by Medicaid for the second half of FY08 and first half of FY09.*

The state paid \$418.2 general funds for abortions or abortion-related Medicaid services incurred in the last half of FY2008 and the first half of FY2009 for 783 individuals based on claims paid in calendar year 2008. This isn't necessarily the number of abortions performed, but rather the number of individuals receiving abortions or abortion-related services. There were no abortions paid by federal Medicaid during that period.

- *A significant portion of DPA's General Relief Assistance (GRA) funds go to funeral and burial expenses of indignant deceased persons in Alaska. Please provide detailed information about these costs. For instance, what exactly does the state pay for in this regard?*

Expense	Annual Total	Monthly Average	Percent of Total	Average Pmt
Rent	\$115.1	\$9.6	8.0%	\$160.90
Burial	\$1,266.4	\$105.5	88.1%	\$2,125.22
Utilities	\$44.2	\$3.7	3.1%	\$288.75
Misc.	\$11.0	\$.9	0.8%	\$315.64

The GRA program pays for limited assistance for the burial of indigent persons. A maximum of \$1,250 can be paid for basic funeral and burial services which include:

- preparation and embalming,
- an inexpensive casket,
- a chapel service at the funeral providers place of business,
- use of a hearse, and
- use of funeral provider's facilities and equipment.

Payment of other burial related services (above the \$1,250 allowed for basic services) may also be allowed. These include:

- a cemetery plot where the deceased is going to be buried,
- the cost of opening and closing the grave,
- the cost of cremation if requested by next of kin,
- the cost of hermetic scaler, oversized casket, clothing, extraordinarily lengthy storage,

- the cost of transporting the deceased from the place of death to the place of burial payment,
- a processing fee of 10% for a funeral provider pays directly to a cemetery or a transportation vendor for any of the items listed above.

The chart below shows the 10 year history of burial costs only of the General Relief Assistance.

Burial Costs - 10 Year History

Fiscal Year	Annual Total	Monthly Average	Total FY Caseload	Average Payment
FY1996	\$541,782	\$45,149	353	\$1,534.79
FY1997	\$563,428	\$46,952	361	\$1,560.74
FY1998	\$578,691	\$48,224	354	\$1,634.72
FY1999	\$593,177	\$49,431	347	\$1,709.44
FY2000	\$645,067	\$53,756	387	\$1,666.84
FY2001	\$707,820	\$58,985	402	\$1,760.75
FY2002	\$832,412	\$69,368	448	\$1,858.06
FY2003	\$907,686	\$75,641	508	\$1,786.78
FY2004	\$969,390	\$80,783	475	\$2,040.82
FY2005	\$1,041,913	\$86,826	524	\$1,988.38
FY2006	\$1,029,992	\$85,833	505	\$2,039.59

The GRA program is a last resort. Assistance is granted only if there are not other resources available (including relatives) to meet the persons need for burial costs, or when the court has ordered the burial of an unclaimed body. The department advises families of the obligation to repay funeral and burial costs and sometimes receives payment from the family or estate. The applicable statute is AS 47.25.230.

- *The Legislature has assumed a lower case load for the senior benefits program in FY2010 and reduced funding an additional (\$933.0). Please review projections and let us know the impact of this reduction.*

The Senior Benefits Program component request of \$19,859.4 for FY2010 includes the total costs to administer this program. Unlike many of our other budget components, it includes the personnel costs to determine eligibility and provide benefits (\$697.1), as well as the cost for the benefit payments (\$19,162.3). The benefit cost reflects the \$500.0 decrement already proposed by the Department. We project benefits for FY2010 will total an estimated \$18,926.4, which leaves a small balance to cover unanticipated increases to benefit costs. The projection for FY2010 provides for an estimated 6% increase in the caseload from FY2009, which will result from increased program outreach and growth in the population age 65 and over.

We assume that a reduction in funding of an additional \$933.0 would need to be taken from the program benefits line, so that staff could be retained to administer the program. Such a reduction would result in our inability to pay benefits for all of FY2010. Following is a chart illustrating the effect on benefits if this reduction were to occur:

Benefit projections with additional  
proposed decrement of (\$933.0)

	Monthly Cost	Running Balance
	Beginning Balance	\$18,229.3
July	\$1,553.3	\$16,676.0
Aug	\$1,562.7	\$15,113.3
Sep	\$1,570.5	\$13,542.8
Oct	\$1,576.8	\$11,966.1
Nov	\$1,583.1	\$10,383.0
Dec	\$1,589.4	\$8,793.6
Jan	\$1,594.2	\$7,199.4
Feb	\$1,597.4	\$5,602.1
Mar	\$1,599.0	\$4,003.1
Apr	\$1,600.6	\$2,402.6
May	\$1,602.2	\$800.4
Jun	\$1,603.8	(\$803.4)

- *For the Bring The Kids Home program, what is the impact of postponing increments? What is the base level funding already in the budget?*

BTKH has implemented performance measures to monitor progress. These measures verify the decreasing utilization and cost of out-of-state RPTC care. Between FY 2007 and 2008 Out-of-State Medicaid expenditures for Residential Psychiatric Treatment Centers decreased by \$9.89 million. In-State RPTC Medicaid expenditures essentially remained at 2007 levels. However, Alaska still spent a total of \$47.7 M on RPTC care (in-state + out-of-state) for 847 children. A large amount of Medicaid resources continue to support the most restrictive level of treatment for a small number of children with severe emotional disturbances. The BTKH goal is to serve children and families earlier, and in less intensive programs.

The BTKH funding strategy relies on investing Alaska Mental Health Trust funds and State General funds into the in-state services and supports needed to keep children from moving into out-of-state residential psychiatric treatment centers. This will reduce the cost of out-of-state residential care and allow those resources to support an in-state continuum of care. This moves funding from intensive services for a few children to less intensive services for a larger number of children and families.

BTKH success to date reflects the development of some of the required in-state services: enough for *some* kids and in *some* locations. It also reflects the development of in-state RPTC care. However, BTKH has not yet established the basic building blocks needed to make the system sustainable, to serve children statewide, and to build the services to keep children out of RPTC care. The additional BTKH funding requested for FY2010 is for basic building blocks required for a system that serves fewer children in residential care.

Funding these BTKH increments will develop:

- Flexible services that reach into the home first to keep kids and families intact
- Immediate access to services – or treatment on demand - when the child and family reach out
- Strong families and healthy communities
- Resilient children

#### I. BTKH Community BH Outpatient Services

FY09 base GF =

\$1,000,000	“BTKH Outpx & Emergency Services & Training”
\$250,000	“BTKH Home & Community-Based Start-Up Grants”

This funding is developing community-based and in-home service capacity in new areas of the State and is addressing gaps that result in children moving into residential care. As noted above, this goal is only partially accomplished. Without additional funding we anticipate increased use of residential care resources, for the children who are remaining in Alaska. While in-state RPTC may help to address this issue, long-term success depends upon our ability to divert more children from residential placements.

Remaining gaps include services for children with severe emotional disturbances who have difficult presentations: children who are suicidal, aggressive, psychotic, or are frequent runaways. These children require programs with specific training and expertise to be stabilized in a home or community setting. Many agencies in Alaska still have limited capacity to serve children with these presentations. BTKH data continues to show that children with these challenges move into out-of-state care.

Another gap is in training and expertise for children with both a developmental disability and a severe emotional disturbance (SED): children with autism disorders, traumatic brain injury, fetal alcohol spectrum disorders, and an SED. These children may not benefit from traditional mental health counseling and lack of appropriate services often precipitates a negative spiral resulting in movement into acute or residential care. Unless the residential care is specifically tailored to their needs, it may also fail.

DHSS can remediate some of these gaps through technical assistance, training and support (see BTKH Technical Assistance, below), however new programs require start-up funding to hire and train staff, ramp up service delivery, implement Medicaid billing, and implement new programs. Between FY06 and FY009 BTKH outpatient grants went to 22 agencies working in the following communities/regions:

- Anchorage
- Fairbanks - Interior
- MatSu - Wasilla
- Juneau - Southeast
- Seward
- Kenai Peninsula
- Bethel Area
- Kotzebue
- Prince of Wales Island
- Sitka

- Ketchikan
- Metlakatla

These agencies developed expertise and expanded services to additional children and families or to children with more challenging needs. BTKH grants are all targeted towards children with severe emotional disturbance and towards those children who will move from a community setting into a more restrictive level of care.

Each year, the BTKH solicitation is targeted toward specific geographic areas, towards the populations of children who continue to be underserved, and towards best practices to maintain children in-state. Below are examples of activities that BTKH Community BH outpatient funds support:

- Metlakatla Indian Community developed mental health services and Medicaid billing capacity. MIC was able to serve more than 40 children with severe emotional disturbances in FY08 rather than having those children leave the village to seek care elsewhere.
- Central Peninsula General Hospital developed mental health services and Medicaid billing capacity in a new outpatient support program for adolescents with co-occurring SA and MH disorders. The target population was youth at highest risk of movement into more restrictive care. In FY08 the program served more than 36 children, at least three of these children would otherwise have moved into an RPTC.
- Family Centered Services of Alaska developed respite and crisis respite care in Fairbanks in order to support children to remain in community placements. In FY08 the program served 100 children. At least two of these children were diverted from an acute care setting. Movement into an acute setting generally requires that the child be flown from Fairbanks to the Alaska Psychiatric Institute or Northstar Hospital in Anchorage. Most children who move into out-of-state care do so from acute care settings.
- Denali Family Services in Anchorage developed intensive wraparound services for sexually reactive children. The program started in March of FY08 and served 4 children in its first quarter of operation. It will serve more children per quarter in FY09. This is a population of children for whom in-state services are extremely limited.
- DHSS has applied for a FY2010 Federal grant that will provide up to \$1.5 M in Federal dollars per year for six years. If the federal funding is awarded, we intend to use BTKH grant funding to match it and to sustain the system that is developed through the grant. The project would target families involved in multiple systems (juvenile justice, developmental disabilities, children's services), with children who experience both severe emotional disturbances AND problems at school. These are families who will otherwise impact multiple state systems and funding streams.

## II. BTKH Individualized Services Agreements (ISA) FY09 base GF = \$950K

The individualized services funding is used to divert children from moving into residential care, and to help children to move out of residential care. Without additional funding, the ISA funding can only be used to divert children within the fairly narrow existing parameters, and at the current level of service.

During FY08, individualized service agreements supported 196 recipients to remain in community placements. This general funding is only used for services for which there is no other funding source and which are identified in a treatment plan developed by the child's individualized treatment team and signed off on by a master's level clinician. During FY08 and FY09 several areas were identified for which additional funding is required. These include:

- Immediate need - Expanding to additional MH providers: As the resource becomes better understood, its use is expanding. Some providers are using ISA funding appropriately to divert children from residential care, others are not. For FY08, 23 providers signed on to coordinate ISA services.
- However, during the first and second quarters of FY09 there were no ISA used in the entire Northern Region. Unfortunately, this was not because children from the Northern Region were not moving into residential care. During the same time period there were only 17 children from the entire Interior Region who used ISA. There is a continued need for outreach and training around use of ISA which will expand the need for funding. In addition, DHSS continues to develop management strategies to make ISA funding accessible and easy for providers to use but to also ensure that the funding is appropriately used when other funds are not available and when it will help create/salvage a non-residential placement for a child with a severe emotional disturbance.
- Immediate need - Diverting children in the services of the Office of Children's Services or Division of Juvenile Justice: During FY08 and FY09 DHSS began piloting use of ISA for children with a severe emotional disturbance at risk of movement into residential care or moving out of residential care who involved with juvenile justice or protective services. This strategy has been highly effective at building transitions for children with mental health disorders moving back into the community from a juvenile justice setting. These children are at very high risk for recidivism to residential care or a justice setting. The strategy has also been effective to maintain foster care placements and to help children with severe emotional disturbances remain in their homes/communities.
- Immediate need - Diverting children with a primary diagnosis of substance abuse: Currently, ISA can only be used for children with a primary diagnosis of severe emotional disturbance. However, children with primary diagnoses of substance abuse often have a co-occurring severe emotional/behavioral disorder and also move into residential mental health services. It would be strategic to expand ISA funding to this population in order to reduce the use of residential care.
- Possible strategy - Diverting additional populations of children: Several other populations of children also move into MH residential care when a co-occurring severe emotional/behavioral disorder is identified and when community-based services fail. These include children with a primary diagnosis of an autistic disorder, a fetal alcohol spectrum disorder or a traumatic brain injury. It may be strategic to identify when an ISA could stop this progression.

### III. BTKH Technical Assistance

No current funding

This funding is necessary to help in-state providers improve business practices (such as expanding Medicaid billing) and to train in and implement clinical best practices in order to improve outcomes. In-state providers must expand their capacity to treat children with complex

needs. There continue to be populations of children for whom in-state services are still extremely scarce. These include services for very difficult presentations such as suicidal ideation/attempts, extreme aggressiveness or psychotic symptoms. There also continue to be significant differences in the capacity of providers to use Medicaid effectively to deliver in-home and community services. Without these services children cannot be safely diverted from RPTC.

During FY2009, DHSS used BTKH funding to begin training for children's mental health workers in Brief Strategic Family Therapy, wraparound and other best practices for serving children in their family setting. This FY2010 funding request will support continued training for practices such as BSFT. It will also support training and support to providers to improve business practices and become sustainable via Medicaid and existing grant funding. To date, DHSS has not requested a single additional position to oversee the BTKH grant program (described below). To date, this grant program has been absorbed by existing staff. The funding capacity within DHSS to provide or contract technical assistance MUST be increased in order to support providers to expand capacity.

#### IV. BTKH EARLY CHILDHOOD MENTAL HEALTH

**We need a qualified early childhood mental health workforce and early childhood professionals who can support positive social emotional development.**

Alaska is plagued by a lack of mental health practitioners experienced in early childhood mental health (ECMH) issues and intervention. Parents, teachers, child care providers, mental health clinicians, health providers and others often lack the training necessary to meet the needs of young children with mental health and social emotional concerns.

Two of the approaches we are taking to bring up workforce expertise in this area are:

- 1) A "Learning Network" for mental health clinicians and early interventionists, and
- 2) ECMH Consultation for wider array of professionals working with young children

The budget request was to continue and expand the work of both of these approaches.

##### Early Childhood MH Learning Network:

**No current funding through BTKH – limited funding through Federal ECCS and Title V.**

The budget request was to enhance a training and support network for early childhood mental health clinicians and other ECMH specialists. It included a position for an ECMH Leader/Coordinator with a high level of expertise in early childhood mental health, a statewide network of part-time early childhood mental health trainers, travel, training costs, monthly "Learning Network" conference calls and the annual Early Childhood Mental Health Institute.

**If this cannot be funded in its entirety, at a minimum it would be helpful to support continuation of the monthly "Learning Network" conference calls (\$15,000) and the Early Childhood Mental Health Institute (\$27,700).**

##### ECCS Grant - Mental Health Consultation:

FY09 base GF = \$0

FY09 MHTAAR = \$75K "Early Childhood Comprehensive Systems Grant" (MH Consultation)

This budget request was to continue and expand ECMH consultation to early care and learning providers, Infant Learning Providers, and others who work with young children. Specific skills are needed to identify mental health problems and to serve children with these issues in their natural environments. The goal is to help young children remain in stable settings with qualified

and nurturing caregivers and prevent the development of serious emotional disturbance (SED). The current funding (\$75,000) is being used to support two ECMH consultation projects. The expanded funding request for FY' 10 was to bring on additional projects in other areas of the state.

**If this cannot be fully funded, we request minimum funding to continue the FY09 projects (\$75,000).**

#### FROM THE EXPERTS:

The following points are taken from: *Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life, Working Paper 6*, developed by the National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University,

- The foundations of many mental health problems that endure through adulthood are established early in life. Early mental health problems disrupt the typical pattern of developing brain architecture and impair emerging capacity for learning and relating to others.
- There are indications that early intervention can have a profound positive effect on the trajectory of emotional or behavioral problems as well as improve outcomes for children with serious disorders, be they psychological or genetic in origin.
- Persistent poverty, threatening neighborhoods, and very poor child care conditions elevate the risk of serious mental health problems

#### WHAT SCIENCE TELLS US:

- Significant adversity early in life can damage the architecture of the developing brain and increase the likelihood of significant mental health problems that may emerge either early or years later.
- Much impairment in mental health arises as a result of the interaction between a child's genetic predisposition and his or her exposure to significant environmental adversity.
- **The behaviors and characteristics associated with mental health problems in the earliest years of life are often different from those seen in older children and adults with psychological difficulties.**
- **If young children are not provided appropriate help, emotional difficulties that emerge early in life can become more serious disorders over time.**
- Some individuals demonstrate remarkable resilience in the face of early, persistent maltreatment, trauma, and emotional harm, but there are limits to the capacity of young children to recover psychologically from such adversity.
- Serious developmental disabilities can also be associated with significant mental health impairments that are affected by experience and amenable to intervention.
- The powerful influences of early relationship illustrate how much the emotional well-being of young children is directly tied to the emotional functioning of their caregivers and the families in which they live.

- For many providers of child health services and early care and education who are faced with children who present problematic behavior, the question of "when to worry" is paramount, yet little evidence exists to answer that question definitively.

#### POPULAR MISREPRESENTATIONS OF SCIENCE:

- **Contrary to popular belief, young children can and do experience serious emotional problems that are comparable in severity to what we observe in older children and adults, and can have lasting effects.**
- Contrary to popular belief, young children living in highly disadvantaged environments can be protected from serious emotional or behavioral consequences.

#### THE SCIENCE-POLICY GAP:

- **Professionals who are regularly involved in the lives of infants, toddlers, and preschoolers often lack the knowledge and skills that would help them identify the early signs of mental health problems as well as fully understand the consequences of family difficulties and parent mental health problems for young children's development.**
- In most communities, mental health services for young children and their families are often limited, of uneven quality, and difficult to access, and there are few well-trained professionals with expertise in early childhood mental health.
- There has been a dramatic increase in the use of psychoactive drugs for young children with behavioral or mental health problems, despite the fact that neither the efficacy nor safety or many of these medications has been studied specifically in children at these early ages.

#### IMPLICATIONS FOR POLICY AND PROGRAMS:

- Because young children's emotional well-being is tied so closely to the emotional status of their parents and non-family caregivers, the emotional and behavioral needs of infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships.
- Therapeutic help for a young child with emotional or behavioral problems can be provided through a combination of home- and center-based services involving parents, extended family members, home visitors, providers of early care and education, and/or mental health professionals
- Mental health services for adults who are parents of young children would have broader impact if they routinely included attention to the needs of the children as well.
- **Physicians and providers of early care and education would be better equipped to understand and manage the behavioral problems of young children if they had more appropriate professional training in this area and easier access to child mental health professionals when they are needed.**
- A better coordinated infrastructure for funding mental health services for young children could provide a more stable and efficient vehicle for assuring access to effective prevention and treatment programs.
- Cultural differences in attitudes and beliefs about behavior and mental health require sensitivity and respect for diversity as well as specialized intervention skills.

- *For the therapeutic court increment of \$653.0 GF, exactly what is being maintained and what is being enhanced? What services would be eliminated if this increment is not received?*

This increment will continue funding the Anchorage Alcohol Safety Action Program (ASAP) at its current level of service, providing direct services to clients for screening, referral, monitoring and supervision of Anchorage-based clients. All clients are referred to ASAP through the Anchorage court system; referrals are made to both the misdemeanor ASAP program and the felony Therapeutic Court ASAP program. All adult ASAP services in the Anchorage area are provided by DHSS, Behavioral Health staff, housed at the Boney Court House (space is provided free of charge by the Alaska Court System, in support of the ASAP program). ASAP services are identified as a critical component of a comprehensive program for treatment of alcohol and other drugs as defined in AS 47.37.045(210); AS 47.37.130 (5) and as a critical court referral for services as identified in AS 28.035.028(f) and AS 28.035.030(h).

#### Background

In FY07 and FY08, Behavioral Health received \$750,000 per year in grant funds from the Alaska Highway Traffic Safety Office (AHTSO) at the Department of Transportation. Among other things, these funds supported 3.5 Adult Probation Officer positions and 4 administrative positions in the Anchorage ASAP office.

In FY09, we were informed by DOT that we would not receive an award because they had changed their focus for the use of the federal funds. After much discussion and negotiation, we eventually received a reduced award of \$400,000 with the understanding that these grant funds will end effective September 30, 2009.

Prior to Fiscal year 2007 when we first received these DOT grant funds, all ASAP positions were covered by state alcohol tax funds, receipt supported services (generated by ASAP fees) and limited state general funds. In an effort to maintain our ASAP program at full staffing, DOT grant funds were applied for to provide more stability than receipt supported services funds, which fluctuate depending on client payments. At the time we applied for funding, there was no indication the focus of these funds would change in the next three years.

#### Program Overview

The Alcohol Safety Action Program (ASAP) including the Therapeutic Courts operate as neutral links between the justice and the health care delivery systems and are responsible for service to Adult, Juvenile and all of the different Therapeutic Court's program participants who have alcohol or drug related offenses. The ASAP program operates in eleven communities (Anchorage, Kenai, Homer, Wasilla, Dillingham, Fairbanks, Ketchikan, Kotzebue, Juneau, Kodiak, and Seward). All programs except for the Anchorage Adult ASAP program are offered by community-based agencies with funding from Behavioral Health. Due to the size of the Anchorage Court, referral and education/treatment system, the Anchorage Adult program is operated by Behavioral Health with a coordinated, cross-discipline service system in place to meet the large volume of referrals to ASAP. The FY10 increment of \$653,000 is to maintain Adult ASAP services in the Anchorage community.

Individuals referred for ASAP services include both first time offenders (most often misdemeanants) and repeat offenders (more often felony-level offenses). As an example the Alaska Division of Motor Vehicles reported 5888 Drinking Under the Influence (DUI) offenses in 2008. Of the 5888 DUI offenders, 4047 were first time offenders and had not yet participated in an ASAP program. Most first time offenders are referred to ASAP for services as are many repeat offenders. In 2008, 44% or 2,582 of these DUI offenses were committed in Anchorage.

#### Impact

The requested increment enables the ASAP Probation Officers to screen, refer, monitor and supervise 5,552 new Adult ASAP cases, 8,000 open and ongoing cases, and the over 200 Therapeutic Court participants that require a much higher level of management and supervision each year. Without this increment to support 3.5 ASAP Probation Officers we will lose the ability to screen, refer, monitor and supervise 60% or 3,331 of our 5552 new Adult cases per quarter and about 4,800 of our 8,000 other open cases per year. Of the 2,582 Anchorage DUI offenders reported by DMV, the ASAP office would only be able to serve 1,032 of those DUI offenders, leaving 1,549 DUI offenders without the intervention that ASAP offers, leaving them ill-equipped to make the informed choices and behavioral changes that might prevent further contact with the justice system, the treatment system, and damage to the offender, their family and their community (e.g. continued driving under the influence of alcohol, alcohol-related violence, alcohol-related accidents, etc.). Without these funds the Anchorage Adult ASAP office will be left with two (2) ASAP Probation Officer, 2.5 ASAP Therapeutic Court Probation Officers and one (1) administrative support staff person.

Without the requested increment about 40 of our most vulnerable offenders with mental health disabilities or substance addictions would not have the opportunity to participate in the Therapeutic Courts, a proven effective and cost saving program. According to a recent study, researchers found that the Therapeutic Court participants were 13% less likely to be re-arrested, 34% less likely to be re-convicted and 24% less likely to be re-incarcerated than those offenders with substance abuse or mental health issues that were not afforded the opportunity to participate in a Therapeutic Court (Rhodes et al., 2006)<sup>1</sup>. Because each Therapeutic Court is staffed by a single Probation Officer, without the requested increment we lose the ability to serve one Therapeutic Court project such as the Mental Health, Felony DUI or Felony Drug Courts entirely, decreasing that population's opportunity for a proven and effective intervention.

Without this increment four (4) of the five (5) ASAP administrative positions will be eliminated, further impacting our ability to provide timely and adequate client services. Our support staff assist all ASAP and the Therapeutic Courts activities; the loss of these funds will immediately decrease by 80% our ability to bill clients and generate revenue that helps sustain our programming. This loss will decrease by 80% our ability to research prior client offenses through local and national databases to inform and help direct the client's optimum intervention. It will decrease our ability to send assessment and treatment assignment information to clients, request client's treatment status reports from providers, communicate client's treatment status with the courts, and maintain records of clients, all of which must be done in a timely manner for the program to be effective and successful. In reality, the one remaining administrative support staff would only be available for reception duties—answering the phone and greeting clients who

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<sup>1</sup> Rhodes, W., Kling, R., & Shively, M. (2006). *Suffolk County Court Evaluation*. Cambridge, MA: Abt Associates.

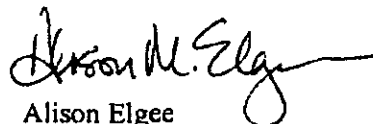
come for appointments. All support activities identified above would become the responsibility of the remaining Adult Probation Officers, in addition to their direct client services.

Currently Anchorage ASAP clients are screened and referred to an education or treatment program within 30-60 days after their offense, depending on how quickly they come into the ASAP office. With the projected reduction in Probation Officers and support staff, services for offenders would be delayed to 240-360 days from the time they come to the ASAP office. Clients would be placed on a "wait list" until staff could process their paperwork and schedule appointments for assessment and referrals. Without the assistance of the administrative staff to inform, gather and disburse the client's past criminal and treatment history to providers and the courts, create and maintain files, answer questions for clients and family members, this process will be greatly hampered, less effective, and greatly decrease the number of clients served.

Substance use, abuse and dependency is a critical social problem in Alaska, with heavy and binge drinking responsible for much of the criminal behavior, health care emergencies, preventable accidents, injuries and deaths that we experience. ASAP provides an opportunity to reach referred individuals early, before the addiction and disease of alcoholism have taken control. ASAP provides early intervention, education, treatment and consequences for adults who are in the early stages of alcohol dependency. Without this program, many of these individuals will continue to enter and re-enter the criminal justice revolving door, ever increasing the damage of alcohol use to themselves, their families and their communities. Data indicates that participating in the ASAP and Therapeutic Court programs reduce both criminal and substance use recidivism. In a 2007 legislative audit of the ASAP program 9% of ASAP clients were reported receiving a new alcohol/drug criminal offense within 42 months after their initial offense compared to the 1999 study that report 35% of ASAP clients received new alcohol/drug criminal offenses within 36 months of their initial offense. It is clear this program works and increases the health and well-being on our citizens and our communities.

If you have additional questions regarding this issue, please contact me at 465-1630.

Sincerely,



Alison Elgee  
Assistant Commissioner

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Representative John Coghill, Capitol Building, Room 214  
Representative Nancy Dahlstrom, Capitol Building, Room 411  
Representative Bob Herron, Capitol Building, Room 415  
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## Health Care News



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## COMMENTARY

## Expanding SCHIP Beyond Poor Is Wrong Approach

By Grace-Marie Turner

Few issues generate more political  
emotion than the need to provide  
health insurance for children.

It is much less expensive to cover  
children than adults, and healthy chil-  
dren have the best chance of becoming  
healthy adults. But that does not mean  
the government must provide the insur-  
ance.

Nonetheless, the new Congress is  
poised to act on President Barack  
Obama's campaign promise to provide  
government-run coverage for children.  
With the State Children's Health Insur-  
ance Program (SCHIP) due to expire  
March 31, Congress is expected to use  
renewal of the program as a vehicle to  
require all children have health insur-  
ance.

### Pushing Past the Poor

But expanding SCHIP to cover all chil-  
dren would be a mistake, for four rea-  
sons.

First, Congress should make sure  
poorer, uninsured children are covered  
first. At least two-thirds of the nation's  
uninsured children already are eli-  
gible for SCHIP or Medicaid but aren't  
enrolled. If SCHIP were expanded to  
cover children in higher-income families,  
their parents would rush to the head of  
the line to get the taxpayer-subsidized  
coverage. When a "free" government  
plan is offered, it's nearly impossible  
to resist. Poorer children would be left  
behind as states focused on enrolling  
higher-income kids.

Second, expanding the program  
would "crowd out" the private insur-  
ance many higher-income kids already  
have. Hawaii offers proof. Earlier this  
year, the state created a new taxpayer-  
financed program to fill the gap between  
private and public insurance in an effort  
to provide universal coverage for chil-  
dren. But state officials found families  
were dropping private coverage to enroll  
their children in the government plan.

When Gov. Linda Lingle saw the  
data, she pulled the plug on funding.  
With Hawaii facing budget shortfalls,  
she said it was unwise to spend public  
money to replace private coverage chil-  
dren already had.

Third, putting many millions of chil-  
dren on a government program will  
quickly lead to restrictions on access to  
care. A young boy died in Baltimore not  
long ago from an untreated tooth infec-  
tion, even though he was enrolled in  
SCHIP. The boy's mother couldn't find

a dentist to see him. Situations like that  
happen because the program's reim-  
bursement rates are so low that few den-  
tists can afford to take SCHIP patients.

In Massachusetts's move toward uni-  
versal health coverage, more people  
have insurance, but they are finding  
physicians' practices are often filled,  
with waits for a new patient appoint-

"A young boy died in  
Baltimore not long ago  
from an untreated tooth  
infection, even though he  
was enrolled in SCHIP. The  
boy's mother couldn't find a  
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[T]he program's reimburse-  
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"If SCHIP were expanded  
to cover children in higher-  
income families, ... [p]oorer  
children would be left behind  
as states focused on enrolling  
higher-income kids."

ment at 100 days and counting. Putting  
more children on SCHIP will add to the  
program's financial pressures, making it  
harder for poorer kids to get care.

Finally, government insurance means  
politicians and bureaucrats, not parents,  
make decisions about the care children  
receive and what services will or won't  
be covered.

### A Better Way

There is a better way to help the unin-  
sured become insured.

Lower- and moderate-income unin-  
sured families, not just children, need  
help to afford health insurance. But right  
now, the deck is stacked against them.  
They make too much money to qualify  
for public programs, such as Medicaid,  
but don't have good, higher-paying jobs  
that come with health insurance.

They need help in purchasing policies,  
and that help could be provided through  
refundable tax credits, which enable  
people to get the money even if they owe  
little or nothing in taxes.

Also, 12 million more people would be  
able to buy affordable health insurance  
if Congress were to allow people to buy  
insurance across state lines. And market  
fixes could help people with preexisting  
conditions get private insurance.

### Providing Powerful Incentives

None of these reforms requires turning  
our health care system upside down or  
turning it over to the government, and  
all would provide powerful incentives  
for families with children to get health  
insurance they can own and keep with  
them.

So when the debate over universal  
coverage for children begins tugging at  
the nation's heartstrings this year, it  
will be wise to consider the costs and  
consequences and look at alternatives  
that put parents, instead of politicians,  
in charge of choosing the right health  
care for children.

Grace-Marie Turner ([galen@galen.org](mailto:galen@galen.org))  
is president of the Galen Institute.

# U.S. House Votes to Expand SCHIP Program

Continued from page 1

the maximum income allowed for enrollment, and more than 10 percent of the 6 million enrollees nationwide were over the age of 18, according to the Department of Health and Human Services (HHS). SCHIP and Medicaid together now insure 45 percent of all children in America, according to HHS.

### Funding in Doubt

"This coverage is critical [and] it is fully paid for," said then-President-elect Barack Obama in a statement. Congressional estimates put the cost of the program's expansion at \$32.3 billion, but others say it will be higher and the expansion, funded by an increase of 61 cents per pack in the federal cigarette tax, is not "fully paid for."

Supporters of the legislation are overlooking the problem created by using a tobacco tax increase as the sole funding source, said Rep. Dave Camp (R-MI), ranking Republican on the House Ways and Means Committee.

"The problem is that the percentage of Americans who smoke has been dropping for decades. Research and logic both show that raising the prices of cigarettes will lead to less smoking, and less smoking will lead to less and less money being collected by the federal government to pay for an expansion of SCHIP," Camp said.

A study conducted by The Heritage Foundation concluded 22.4 million non-smoking Americans will have to begin consuming tobacco products in order for the SCHIP expansion to maintain its funding level.

### Hurting the Working Poor

Experts say the use of a tobacco tax to fund the SCHIP expansion will place a greater burden on those the program was designed to help.

According to the Centers for Disease Control and Prevention, undereducated and lower-income Americans are more likely to smoke than their better-paid, more highly educated peers. "Given such data," said Camp, "it is hard to imagine a more regressive policy, disproportionately targeting such disadvantaged groups for higher taxes."

"At a time when the last thing we need is an even weaker small business community," said Grover Norquist, president of Americans for Tax Reform, "a tax increase on tobacco products will not only hurt consumers and scapegoat a segment of the American population for using a legal product, but will also hurt small businesses, many of which often lean on tobacco sales to stay in business. "Furthermore," said Norquist, "such

"Research and logic both show that raising the prices of cigarettes will lead to less smoking, and less smoking will lead to less and less money being collected by the federal government to pay for an expansion of SCHIP."

DAVE CAMP, U.S. REPRESENTATIVE - MICHIGAN



a tax increase follows the absurd rationale of discouraging a behavior on the one hand while at the same time relying on its continuance as a revenue stream. Funding an expansion of SCHIP on an already-declining revenue stream is irresponsible and dangerous policy."

### State-Level Failures

Experts say legislators should have paid

### INTERNET INFO

House Resolution 2: <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.2>

closer attention to recent state-level attempts to expand taxpayer-funded programs, which have been derailed by soaring costs and a "crowding-out" of private health insurers.

Grace-Marie Turner, president of the Galen Institute, cited "Hawaii's hard-learned lesson in health care economics," referring to the Aloha State's Keiki Care program established in 2008 to provide coverage to children whose parents couldn't afford private insurance but whose income was too great to qualify for other public programs.

"Hawaii officials learned that, if you offer people insurance for free, they'll quickly drop other coverage to enroll.

After seven months of operation, during which 85 percent of Keiki enrollees were former private policyholders, [Gov. Linda Lingle (R)] was forced to eliminate the program altogether," Turner noted.

"People who were already able to afford health care began to stop paying for it so they could get it for free," said Dr. Kenny Fink of Hawaii's Department of Human Services in a release.

### Unpopular Program

Congress attempted to expand SCHIP in 2007, but legislation was twice vetoed by then-President George W. Bush, who objected to relaxing the program's eligibility requirements when nearly two-thirds of the nation's uninsured children were already eligible to enroll.

In addition, according to the Centers for Medicare and Medicaid Services (CMS), 42 percent of that eligible uninsured population were actually enrolled in a state SCHIP or Medicaid program in 2007, but declined to renew their enrollment—an indication that SCHIP and other taxpayer-funded programs were not as popular as their proponents claim.

### Reform Efforts Rebuffed

In 2008 CMS, at Bush's behest, issued a directive tightening SCHIP eligibility requirements, forcing states to limit the program to children whose family income was 2.5 times the federal poverty level or less. Families making \$44,000 per year or more were to be removed from the SCHIP rolls and held out of the program until their state had enrolled 95 percent of its eligible uninsured in the program.

Bush rescinded the directive after pressure from state governments wishing to continue offering SCHIP benefits to people ineligible under federal guidelines.

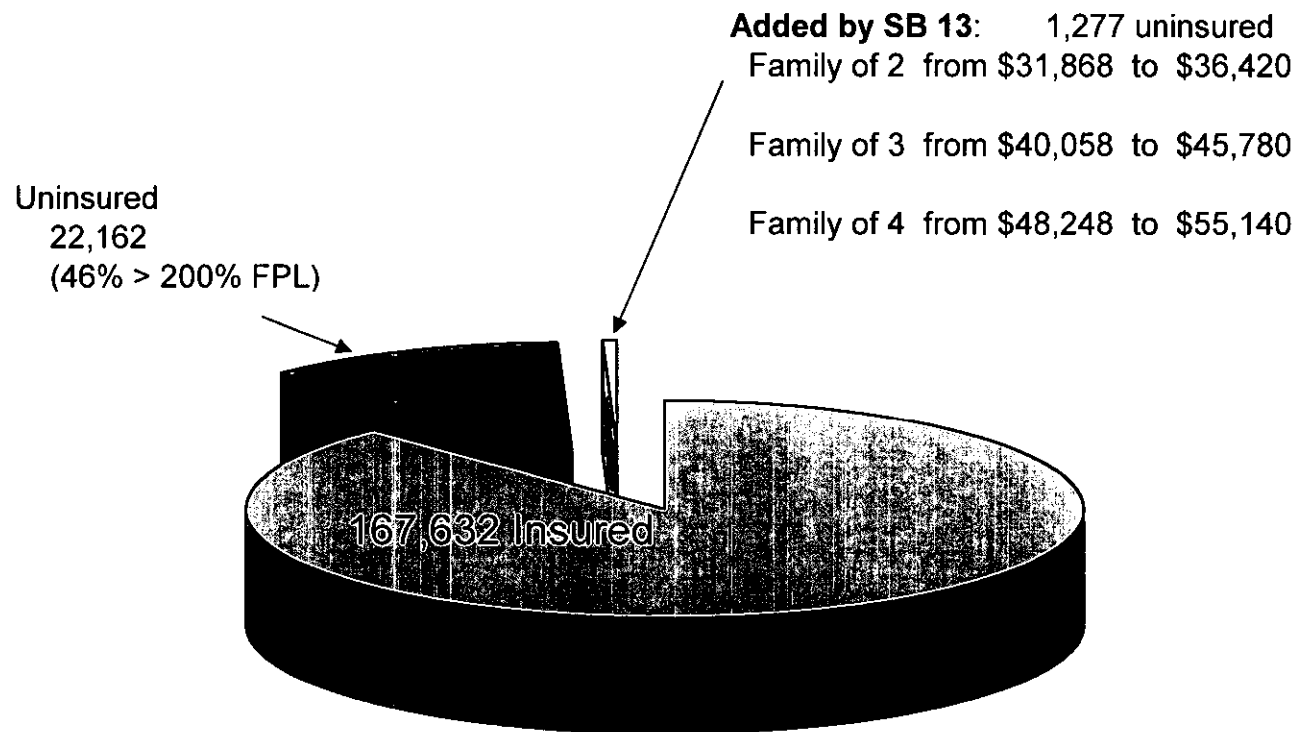
At press time, the SCHIP resolution was still pending in the Senate. Congressional observers expect the House version of the measure ultimately to be signed into law by President Obama.

Jeff Emanuel ([jmanuel@heartland.org](mailto:jmanuel@heartland.org)) is research fellow for health care policy at The Heartland Institute and managing editor of Health Care News.

### INTERNET INFO

"22 Million New Smokers Needed: Funding SCHIP With a Tobacco Tax," The Heritage Foundation: <http://www.heritage.org/Research/HealthCare/wm1548.cfm>

# Children in Alaska



# Income Guidelines (effective March 2009)



Household Size	Children with other Health Insurance	Children with no Health Insurance and Pregnant Women with or without Health Insurance
	Monthly Income (150% FPG)*	Monthly Income (175% FPG)*
1	1,692	1,974
2	2,277	2,656
3	2,862	3,339
4	3,447	4,021
5	4,032	4,704
6	4,617	5,386
7	5,202	6,069
8	5,787	6,751
each additional	585	683

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

## Key Points

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

# STATE OF ALASKA

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## ANSWERS TO HOUSE HSS COMMITTEE QUESTIONS ON SB 13 Prepared by: Dept. of Health and Social Services 3-16-2010

### Answers to 3/10/10 email from Rep. Keller:

**How many of the projected 1300 children projected to be qualified with SB 13 are already insured?**

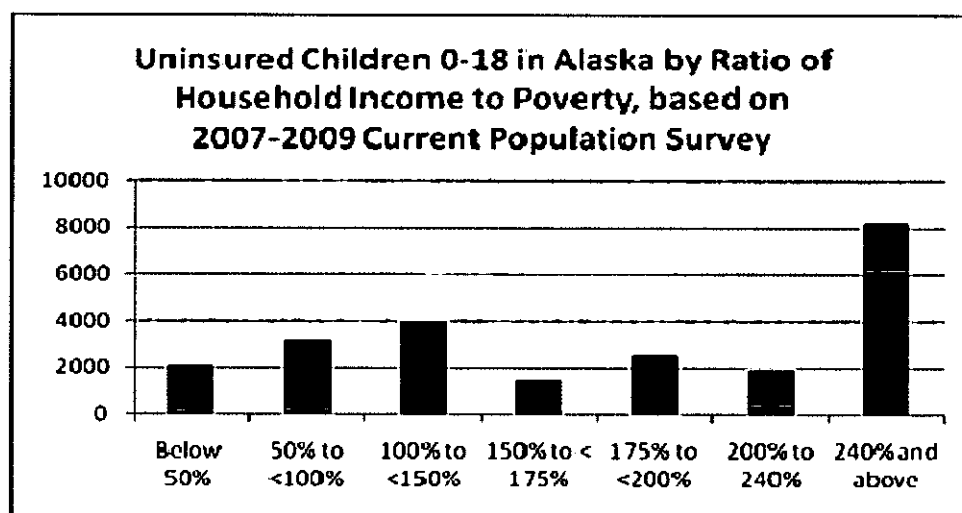
All 1300 children covered under SB13 would be uninsured at the time of application. A child cannot be insured under another plan as a condition of eligibility for Denali KidCare. It is possible that a child could obtain insurance at some point during his/her year of eligibility, but the child would be found ineligible at the annual renewal.

**Can you put together a "bell curve" that puts number of Alaska children on the vertical axis and the income level (before dividends) on the horizontal? If that cannot be done, please replace the number of children with the number of Alaska households and provide the average number of children per household in Alaska. I would like to provide a 'visual' to the committee of the children addressed by SB 13 including a vertical line at 175% and a vertical line at 200%. Please include the table that is used to build the graph --- or just send us the table so we can build the bell curve.**

We are unable to provide the specific information that you requested, although we do have information that addresses the questions you raise. Below is a table of insured and uninsured children through age 18 broken out by income as a percentage of poverty. The income measured includes the PFD. It should also be noted that the source survey does not use the same income calculation and household composition rules that Medicaid uses in determining eligibility. We have also provided two graphic representations of the data.

**Uninsured and Insured Alaska Children through age 18, estimates based on U.S. Bureau of the Census Current Population Survey administered in 2007, 2008 and 2009 (Note: PFD amounts are included in household income)**

<b>Income-to-Poverty Ratio in 2006 to 2008 (using the federal poverty guidelines for Alaska)</b>	<b>Insured</b>	<b>Uninsured</b>
Below 50%	8498	2101
50% to <100%	12509	3172
100% to <150%	23477	3971
150% to < 175%	6615	1461
175% to <200%	11217	2598
200% to 240%	13083	1894
240% and above	92233	8242



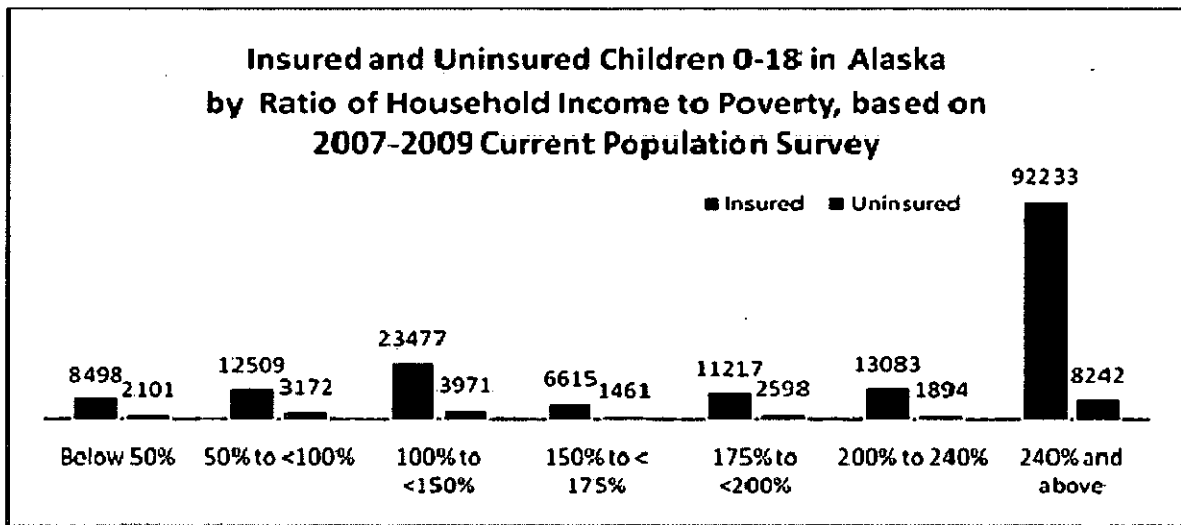


Table and Charts prepared by Health Planning & Systems Development, Div. of Health Care Services, AKDHSS ajr 3/10/2010

**Matt Johnson's questions:**

**1. Of the 1,277 kids who would be eligible for DKC under an increase to 200%, how many are currently on regular Medicaid?**

The fiscal note represents our expectations for the net impacts on the program. All of the kids we project adding under SB 13 would be net increases to the CHIP categories. We always have people coming and going and moving between regular Medicaid and CHIP. We do not assume that we would see a net decrease in the regular Medicaid categories, though there may be individual cases where children move from one category to another. We don't anticipate reducing any spending under regular Medicaid categories, so there would be no net savings.

**2. Is the ADN article reporting 11,000 more children enrolled in Medicaid in the last 18 months accurate?**

Children's enrollment from July 2008 to January 2010 went from 58,028 to 69,117, for a total increase of 11,089. It changes from month to month.

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*Please deliver to Matt @ HHS asap.  
Re SB 13 / A.S*

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1 of 10 DOCUMENTS

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\*\*\* CURRENT THROUGH PL 111-144, APPROVED 3/2/2010 \*\*\*

TITLE 42. THE PUBLIC HEALTH AND WELFARE  
 CHAPTER 7. SOCIAL SECURITY ACT  
 TITLE XXI. STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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42 USCS § 1397cc

§ 1397cc. Coverage requirements for children's health insurance

(a) Required scope of health insurance coverage. The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) [42 USCS § 1397aa(a)] shall consist, consistent with paragraphs (5), (6), and (7) of subsection (c), of any of the following:

(1) Benchmark coverage. Health benefits coverage that is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b). ?

(2) Benchmark-equivalent coverage. Health benefits coverage that meets the following requirements:

(A) Inclusion of basic services. The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

(B) Aggregate actuarial value equivalent to benchmark package. The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

(C) Substantial actuarial value for additional services included in benchmark package. With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

(3) Existing comprehensive State-based coverage. Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

(4) Secretary-approved coverage. Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

(b) Benchmark benefit packages. The benchmark benefit packages are as follows:

(1) FEHBP-equivalent children's health insurance coverage. The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

(2) State employee coverage. A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(3) Coverage offered through HMO. The health insurance coverage plan that--

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act [42 USCS § 300gg-91(b)(3)]), and

(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

## 42 USCS § 1397cc

(c) Categories of services; determination of actuarial value of coverage.

(1) Categories of basic services. For purposes of this section, the categories of basic services described in this paragraph are as follows:

- (A) Inpatient and outpatient hospital services.
- (B) Physicians' surgical and medical services.
- (C) Laboratory an-ray services.
- (D) Well-baby and well-child care, including age-appropriate immunizations.

(2) Categories of additional services. For purposes of this section, the categories of additional services described in this paragraph are as follows:

- (A) Coverage of prescription drugs.
- (B) Vision services.
- (C) Hearing services.
- (D) [Redesignated]

(3) Treatment of other categories. Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

(4) Determination of actuarial value. The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared--

- (A) by an individual who is a member of the American Academy of Actuaries;
- (B) using generally accepted actuarial principles and methodologies;
- (C) using a standardized set of utilization and price factors;
- (D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;
- (E) applying the same principles and factors in comparing the value of different coverage (or categories of services);
- (F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- (G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(5) Dental benefits.

(A) In general. The child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

(B) Permitting use of dental benchmark plans by certain states. A State may elect to meet the requirement of subparagraph (A) through dental coverage that is equivalent to a benchmark dental benefit package described in subparagraph (C).

(C) Benchmark dental benefit packages. The benchmark dental benefit packages are as follows:

(i) FEHBP children's dental coverage. A dental benefits plan under chapter 89A of title 5, United States Code [5 USCS §§ 895] et seq., that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(ii) State employee dependent dental coverage. A dental benefits plan that is offered and generally available to State employees in the State involved and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

(iii) Coverage offered through commercial dental plan. A dental benefits plan that has the largest insured commercial, non-medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.

(6) Mental health services parity.

(A) In general. In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of

## 42 USCS § 1397cc

the Public Health Service Act [42 USCS § 300gg-5(a)] in the same manner as such requirements apply to a group health plan.

(B) Deemed compliance. To the extent that a State child health plan includes coverage with respect to an individual described in section 1905(a)(4)(B) [42 USCS § 1396d(a)(4)(B)] and covered under the State plan under section 1902(a)(10)(A) [42 USCS § 1396(a)(10)(A)] of the services described in section 1905(a)(4)(B) [42 USCS § 1396d(a)(4)(B)] (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r) [42 USCS § 1396d(r)]) and provided in accordance with section 1902(a)(43) [42 USCS § 1396(a)(43)], such plan shall be deemed to satisfy the requirements of subparagraph (A).

(7) Construction on prohibited coverage. Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title [42 USCS §§ 1397aa et seq.], notwithstanding that any benchmark benefit package includes coverage for such an item or service.

(8) Availability of coverage for items and services furnished through school-based health centers. Nothing in this title [42 USCS §§ 1397aa et seq.] shall be construed as limiting a State's ability to provide child health assistance for covered items and services that are furnished through school-based health centers (as defined in section 2110(c)(9) [42 USCS § 1397j(c)(9)]).

(d) Description of existing comprehensive State-based coverage.

(1) In general. A program described in this paragraph is a child health coverage program that--

(A) includes coverage of a range of benefits;

(B) is administered or overseen by the State and receives funds from the State;

(C) is offered in New York, Florida, or Pennsylvania; and

(D) was offered as of the date of the enactment of this title [enacted Aug. 5, 1997].

(2) Modifications. A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of--

(A) the actuarial value of the coverage under the program as of the date of the enactment of this title [enacted Aug. 5, 1997], or

(B) the actuarial value described in subsection (a)(2)(B), evaluated as of the time of the modification.

(c) Cost-sharing.

(1) Description; general conditions.

(A) Description. A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) Protection for lower income children. The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

(2) No cost sharing on benefits for preventive services or pregnancy-related assistance. The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D) or for pregnancy-related assistance.

(3) Limitations on premiums and cost-sharing.

(A) Children in families with income below 150 percent of poverty line. In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose--

(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) [42 USCS § 1396o(b)(1)] (with respect to individuals described in such section); and

(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3) [42 USCS § 1396o(a)(3)], with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

(B) Other children. For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted

## 42 USCS § 1397cc

low-income children in a family under this title [42 USCS §§ 1397aa et seq.] may not exceed 5 percent of such family's income for the year involved.

(C) Premium grace period. The State child health plan--

(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice--

(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term "new coverage period" means the month immediately following the last month for which the premium has been paid.

(4) Relation to medicaid requirements. Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2) [42 USCS § 1397aa(a)(2)].

(f) Application of certain requirements.

(1) Restriction on application of preexisting condition exclusions.

(A) In general. Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

(B) Group health plans and group health insurance coverage. If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 USCS §§ 1181 et seq.] and title XXVII of the Public Health Service Act [42 USCS §§ 300gg et seq.].

(2) Compliance with other requirements. Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act [42 USCS § 300gg-51] insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(3) Compliance with managed care requirements. The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 [42 USCS § 1396u-2] (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX [42 USCS §§ 1396 et seq.].

**HISTORY:**

(Aug. 14, 1935, ch 531, Title XXI, § 2103, as added Aug. 5, 1997, P.L. 105-33, Title IV, Subtitle J, Ch 1, § 4901(a), 111 Stat. 554.)

(As amended Feb. 4, 2009, P.L. 111-3, Title I, Subtitle B, § 111(b)(1), Title IV, § 403(a), Title V, §§ 501(a)(1), 502, 504(a), 505(a), 123 Stat. 28, 84, 85, 89, 90.)

**HISTORY; ANCILLARY LAWS AND DIRECTIVES****Amendments:**

2009. Act Feb. 4, 2009 (effective on 4/1/2009, and applicable to child health assistance and medical assistance provided on or after that date, as provided by § 3(a) of such Act, which appears as 42 USCS § 1396 note), in subsec. (a), in the introductory matter, inserted ", (6)."; and, in subsec. (c), in para. (2), deleted subpara. (B) which read: "(B) Mental health services.", and redesignated subparas. (C) and (D) as subparas. (B) and (C), respectively, and added paras. (6) and (8); in subsec. (e)(2), in the heading, inserted "or pregnancy-related assistance", and, in the text, inserted "or for pregnancy-related assistance".

# Compilation of the Social Security Laws

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## STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING



Sec. 1916A. [42 U.S.C. 1396o-1] (a)(1) In general.— Notwithstanding sections 1916 and 1902 (a)(10)(B), but subject to paragraph (2), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c) and non-emergency services furnished in a hospital emergency department for which cost sharing may be imposed under subsection (e)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) subsection (g) or (i) of section 1916.

(2) Exemption for individuals with family income not exceeding 100 percent of the poverty line.—

(A) In general.—Paragraph (1) and subsection (d) shall not apply, and sections 1916 and 1902 (a)(10)(B) shall continue to apply, in the case of an individual whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved.

(B) Limit on aggregate cost sharing.—To the extent cost sharing under subsections (c) and (e) or under section 1916 is imposed against individuals described in subparagraph (A), the limitation under subsection (b)(1)(B)(ii) on the total aggregate amount of cost sharing shall apply to such cost sharing for all individuals in a family described in subparagraph (A) in the same manner as such limitations apply to cost sharing and families described in subsection (b) (1)(B)(ii).

(3) Definitions.—In this section:

(A) Premium.—The term “premium” includes any enrollment fee or similar charge.

(B) Cost sharing.—The term “cost sharing” includes any deduction, copayment, or similar charge.

(b) Limitations on Exercise of Authority.—

(1) Individuals with family income between 100 and 150 percent of the poverty line.—In the

case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved—

(A) no premium may be imposed under the plan; and

(B) with respect to cost sharing—

(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

(2) Individuals with family income above 150 percent of the poverty line.—In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved—

(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

(3) Additional limitations.—

(A) Premiums.—No premiums shall be imposed under this section with respect to the following:

(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom child welfare services are being made available under part B of title IV on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

(ii) Pregnant women.

(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(v) Women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

(vi) Disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc).

(B) Cost sharing.—Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom child welfare services are being made available under part B of title IV on the basis of being a child in foster care or and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(vi) Emergency services (as defined by the Secretary for purposes of section 1916(a)(2)(D)).

(vii) Family planning services and supplies described in section 1905(a)(4)(C).

(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

(ix) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc).

(C) Construction.—Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a).

(4) Determinations of family income.—In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this title.

(5) Poverty line defined.—For purposes of this section, the term "poverty line" has the meaning given such term in section 673(2) of the Community Services Block Grant Act<sup>[109]</sup> (42 U.S.C.

9902(2)), including any revision required by such section.

(6) Construction.—Nothing in this section shall be construed—

(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

(C) as affecting any such waiver of requirements in effect under this title before the date of the enactment of this section with regard to the imposition of premiums and cost sharing.

(c) Special Rules for Cost Sharing for Prescription Drugs.—

(1) In general.—In order to encourage beneficiaries to use drugs (in this subsection referred to as “preferred drugs”) identified by the State as the most (or more) cost effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may—

(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under section 1916, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not be imposed under subsection (a) due to the application of subsection (b) (3)(B).

(2) Limitations.—

(A) By income group.—In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed—

(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under section 1916); or

(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

(B) Limitation to nominal for exempt populations.—In the case of an individual who is not subject to cost sharing under subsection (a) due to the application of paragraph (1)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under section 1916).

(C) Continued application of aggregate cap.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing under subsection (a)(2)(B) or applied under paragraph (1) or (2) of subsection (b), as the case may be.

(3) Waiver.—In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

(4) Exclusion authority.—Nothing in this subsection shall be construed as preventing a State from excluding specified drugs or classes of drugs from the application of paragraph (1).

(d) Enforceability of Premiums and Other Cost Sharing.—

(1) Premiums.—Notwithstanding section 1916(c)(3) and section 1902(a)(10)(B), a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(2) Cost sharing.—Notwithstanding section 1916(e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this title for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.

(e) State Option for Permitting Hospitals To Impose Cost Sharing for Non-Emergency Care Furnished in an Emergency Department.—

(1) In general.—Notwithstanding section 1916 and section 1902(a)(1) or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this title, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

(A) Access to non-emergency room provider.—The individual has actually available and accessible (as such terms are applied by the Secretary under section 1916(b)(3)) an alternate non-emergency services provider with respect to such services.

(B) Notice.—The hospital must inform the beneficiary after receiving an appropriate medical screening examination under section 1867 and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

(i) The hospital may require the payment of the State specified cost sharing before the service can be provided.

(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

(iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).

(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

(2) Limitations.—

(A) Individuals with family income between 100 and 150 percent of the poverty line.—In the case of an individual described in subsection (b)(1) who is not described in subparagraph (B), the cost sharing imposed under this subsection may not exceed twice the amount determined to be nominal under section 1916, subject to the percent of income limitation otherwise applicable under subsection (b)(1)(B)(ii).

(B) Application to exempt populations.—In the case of an individual described in subsection (a)(2)(A) or who is not subject to cost sharing under subsection (b)(3)(B) with respect to non-emergency services described in paragraph (1), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under section 1916) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

(C) Continued application of aggregate cap; relation to other cost sharing.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing under subsection (a)(2)(B) or applied under paragraph (1) or (2) of subsection (b), as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a) or section 1916.

(3) Construction.—Nothing in this section shall be construed—

(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867; or

(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

(4) Definitions.—For purposes of this subsection:

(A) Non-emergency services.—The term “non-emergency services” means any care or services furnished in an emergency department of a hospital that do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1867.

(B) Alternate non-emergency services provider.—The term “alternative non-emergency services provider” means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this title.

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[109] See Vol. II, P.L. 97-35, §673(2).



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# ALASKA STATE LEGISLATURE

## State Representative Bob Herron

Official Business



State Capitol  
Juneau, Alaska  
99801-1182

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### MEMORANDUM

**TO:** House Health & Social Services Committee

**FROM:** Representative Herron

**DATE:** March 10, 2009

**RE:** SB 13 – Medical Assistance Eligibility

A handwritten signature in black ink, appearing to read "Bob Herron".

For your reference, I have attached the report "Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations." Mathematica Policy Research, Inc completed this report in 2003 as background for Congress.

There are a range of different methods used by States when implementing SCHIP programs including: premiums, copayments, deductibles, and enrollment fees. According to this report, Alaska utilized copayments to charge 18 year olds 5% of the outpatient hospital visit.

I want to emphasize that Table IV.1 is an old snapshot of the various ways states have used cost sharing as a way to control the cost and utilization of services provided under the SCHIP program.

Contract No.: 500-96-0016(03)  
MPR Reference No.: 8644-100

**MATHEMATICA**  
Policy Research, Inc.

**Implementation of the  
State Children's  
Health Insurance  
Program:  
Synthesis of State  
Evaluations**

*Background for the  
Report to Congress*

*March 2003*

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7500 Security Boulevard  
Baltimore, MD 21244

Project Officer:

Rosemarie Hakim

Submitted by:

Mathematica Policy Research, Inc.  
50 Church Street, 4th Floor  
Cambridge, MA 02138  
(617) 491-7900

Project Director:

Margo Rosenbach

TABLE IV.1  
COST-SHARING FEATURES OF SCHIP PROGRAMS

States	Type of Program	Cost Sharing				
		No Cost Sharing	Premium <sup>a</sup>	Copayments	Deductibles	Enrollment Fee
TOTAL		22	21	22	1	3
Alabama	COMBO		✓	✓ <sup>b</sup>		
Alaska <sup>c</sup>	M-SCHIP			✓		
Arizona <sup>f</sup>	S-SCHIP			✓		
Arkansas	M-SCHIP	✓				
California <sup>g</sup>	COMBO		✓ <sup>c</sup>	✓ <sup>c</sup>		
Colorado <sup>h</sup>	S-SCHIP		✓	✓		
Connecticut	COMBO		✓ <sup>c</sup>	✓ <sup>c</sup>		
Delaware	S-SCHIP		✓	✓		
District of Columbia	M-SCHIP	✓				
Florida <sup>i</sup>	COMBO		✓ <sup>c</sup>	✓		
Georgia	S-SCHIP		✓			
Hawaii	M-SCHIP	✓				
Idaho	M-SCHIP	✓				
Illinois <sup>j</sup>	COMBO		✓ <sup>c</sup>	✓		
Indiana	COMBO	✓				
Iowa	COMBO		✓ <sup>c</sup>	✓		
Kansas	S-SCHIP		✓			
Kentucky	COMBO	✓				
Louisiana	M-SCHIP	✓				
Maine	COMBO		✓ <sup>c</sup>			
Maryland	M-SCHIP	✓				
Massachusetts <sup>k</sup>	COMBO		✓ <sup>c</sup>	✓	✓	
Michigan	COMBO		✓ <sup>c</sup>			
Minnesota	M-SCHIP	✓				
Mississippi <sup>l</sup>	COMBO			✓		
Missouri <sup>m</sup>	M-SCHIP		✓	✓		
Montana <sup>n</sup>	S-SCHIP			✓		✓
Nebraska	M-SCHIP	✓				
Nevada	S-SCHIP		✓			
New Hampshire	COMBO		✓ <sup>c</sup>	✓		
New Jersey <sup>o</sup>	COMBO		✓ <sup>c</sup>	✓		
New Mexico <sup>p</sup>	M-SCHIP			✓		
New York	COMBO		✓ <sup>c</sup>			
North Carolina <sup>q</sup>	S-SCHIP			✓		✓
North Dakota	COMBO	✓				
Ohio	M-SCHIP	✓				
Oklahoma	M-SCHIP	✓				
Oregon	S-SCHIP	✓				
Pennsylvania	S-SCHIP	✓				
Rhode Island <sup>r</sup>	M-SCHIP		✓	✓		

*only applies to 18 year olds and they are charged 5% of the outpatient hospital visit*

Table IV.1 (Continued)

States	Type of Program	Cost Sharing				
		No Cost Sharing	Premium <sup>a</sup>	Copayments	Deductibles	Enrollment Fee
South Carolina	M-SCHIP	✓				
South Dakota	COMBO	✓				
Tennessee	M-SCHIP	✓				
Texas	COMBO	✓				
Utah <sup>a</sup>	S-SCHIP			✓		
Vermont	S-SCHIP					✓
Virginia	S-SCHIP	✓				
Washington <sup>b</sup>	S-SCHIP		✓	✓		
West Virginia	S-SCHIP	✓				
Wisconsin <sup>c</sup>	M-SCHIP		✓	✓		
Wyoming	S-SCHIP	✓				

SOURCE: Mathematica Policy Research analysis of the title XXI State Evaluations, Sections 3.2.1, 3.3.1, and 3.3.7 of the State Evaluation Framework.

NOTE: The type of SCHIP program is as of March 31, 2001. The state evaluations generally present program characteristics as of September 30, 1999.

<sup>a</sup> For detailed premium information, see Table IV.2.

<sup>b</sup> In the Alabama S-SCHIP program, children between 100 and 150 percent of poverty have no cost sharing. For children between 151 and 200 percent of poverty there is no deductible and a \$5 copay on some services in addition to a \$50 per year premium with a premium maximum of \$150 per family per year. In the M-SCHIP program, only 18 year olds are subject to copayments.

<sup>c</sup> Applies only to S-SCHIP program.

<sup>d</sup> Applies to both S-SCHIP and M-SCHIP program.

<sup>e</sup> In Alaska, only 18 year olds are subject to copayments.

<sup>f</sup> Arizona applies copays only to emergency room use.

<sup>g</sup> California's S-SCHIP program has a cap on copays of \$250 per family per year.

<sup>h</sup> In Colorado's S-SCHIP program, copayments vary by income. There are no copayments for families with income under 101 percent of poverty. Families between 101 and 150 percent of poverty pay a smaller copay than families between 151 and 185 percent of poverty.

<sup>i</sup> Florida has three S-SCHIP programs: Healthy Kids, CMS, and MediKids. Healthy Kids is the only program with copayments.

<sup>j</sup> In Illinois, the annual copayment maximum per family is \$100. Families with children who are American Indian or Alaska Natives do not pay premiums or copays. S-SCHIP cost sharing varies based on program: KidCare Share covers children greater than 133 to 150 percent of poverty; KidCare Premium covers children between 151 and 185 percent of poverty. Copayments vary by service and income level; premiums vary by income level.

<sup>k</sup> Massachusetts has three S-SCHIP programs: Family Assistance Direct Coverage (FADC), Family Assistance Premium Assistance (FAPA), and CommonHealth (CH). CH has no cost sharing. FADC has no copayments, although it does have premiums. FAPA has premiums; copayments are in accordance with the individual ESI policy, subject to limitations under title XXI.

<sup>l</sup> In Mississippi, there are no cost-sharing requirements for families with income below 150 percent of poverty or for American Indian/Native Alaskan children. Families in the S-SCHIP program, with incomes between 150 and 175 percent of poverty have copays on certain services and pay a maximum out of pocket of \$800 per calendar year. Families with incomes between 176 percent and 200 percent of poverty have higher copays on certain services and pay a maximum out of pocket of \$950 per calendar year. There is no copay for preventive services.

<sup>m</sup> Families with incomes between 226 and 300 percent of poverty must pay a premium for the Missouri M-SCHIP program. Copayments also vary by income: families with incomes between 186 and 225 percent pay smaller copayments than families with incomes between 226 and 300 percent of poverty.

<sup>n</sup> Montana S-SCHIP has copayments for those with family incomes greater than 100 percent of poverty.

<sup>o</sup> New Jersey has three S-SCHIP programs: Plans B, C and D. Plan B offers coverage to children in families with gross incomes between 133 and 150 percent of poverty; Plan C covers children between 151 and 200 percent of poverty; and Plan D covers children between 201 and 350 percent of poverty. Only Plans C and D have any form of cost sharing.

<sup>p</sup> In New Mexico M-SCHIP, copayments only apply to those between 185 and 235 percent of poverty.

<sup>q</sup> In North Carolina, copayments only apply to those with incomes greater than 151 percent of poverty.

<sup>r</sup> In Rhode Island, cost sharing is only for families with income in excess of 185 percent of poverty if they elected a coinsurance rather than a premium option.

<sup>s</sup> In Utah, cost sharing varies by plan. Plan A applies to enrollees at or below 150 percent of poverty. Plan B enrollees have family incomes between 151 and 200 percent of poverty. Plan B has higher copayments than Plan A (although Plan A cost sharing applies only to those between 101 and 150 percent of poverty).

<sup>t</sup> Washington has no cost sharing for American Indians/Native Alaskans. Annual maximum out-of-pocket costs are \$300 for one child, \$600 for two children, and \$900 for three or more children.

<sup>u</sup> Wisconsin copayments are only for non-pregnant adults in Medicaid FFS.

To: Mr. WES KILLER 465-3818

FROM: [unclear] [unclear]  
[unclear] [unclear]

URGENT - Before you proceed -  
please call - we suspect  
[unclear] [unclear] at  
at least 2000 FPL!

Page 7 - includes this cover.

To the Member of the House, Health and Social Services Comm.

Please pass SB 13 out of your committee so that it might pass the full House and Senate and become law. I'm fortunate enough to have health insurance through my job so that my three kids can receive adequate health care without putting me into debt. I have friends, families that are on the fringe of the current income requirement of 175% of the poverty line. By providing Seneca KidCare health insurance to kids whose parents earn up to 200% of the poverty line, the state will allow families of moderate means the ability to see that their kids receive adequate health care. We will join 46 other states that have an income threshold of 200% or higher, and we will provide health care to kids at a very reasonable cost to their state. After all, the federal government matches <sup>every</sup> around 20 cents of state monies with 70 cents.

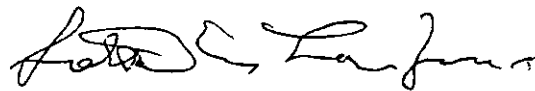
In these rough economic times, please help more working families provide health care to their children.

Sincerely, Greg Bidwell of Anchorage Alaska  
3301 Paradise Street 99508

To the Members of the House Health and Social Services  
Comm.,

I ask you to pass SB13, funding for children, for  
the benefit of Alaskan children, and Alaska people,  
~~our~~ our children are our investment of our past.

Sincerely,  
RICHARD LYNKY JUNIOR  
3722 PARSONS AVE  
ANCHORAGE, AK. 99508



4/19/09

To the Members of the House Health and Social Services Comm

Please support the Denali KidCare Program  
to 200% of the Federal Poverty Line.

Health insurance is a basic human  
right to which I believe all, especially  
children, are entitled.

Sincerely,

CLIFFORD MARVIN

201 EAST 16<sup>th</sup> AVENUE

ANCHORAGE AK 99501



House Health and Social Services Committee  
Juneau, AK.

Dear Committee Members:

1. I urge you to pass the bill which covers health care for Alaskan Children. We must restore the standard which existed Twelve years ago when the Denali Kid Care Program was based at 200% of the Federal Poverty Level.
2. It is distressing that Alaska is one of our wealthiest states but we are one of only five states which funds this program below this level.
3. Early intervention and preventive care are essential for the well being of our children and will yield substantial savings to state, and private sector health based institutions.
4. Thank you for your cooperation and I look forward to seeing your support of this bill.

Lane M. Garrett  
3701 Winterset DR  
Anchorage, 99508

4/19/09.

Dear Members of the House Health +  
Social Services Committee —

I am writing to urge you to please pass  
House Bill 61 - which covers health care for  
Alaskan children whose families are at the  
200% of federal poverty level.

It amazes me that our state is one  
of the most wealthy, yet 45 states  
do better than we do re: covering children's  
health care needs.

Families at this level of poverty are  
stretched, stressed + vulnerable; if health  
care takes a back seat - family fall  
apart. It is crazy to think we cannot  
help support a basic need as this.

Again I urge you to support this  
house bill - our state needs a  
better future for ~~you~~ our children to  
be a part of.

Thank you,

Sincerely,

Maureen Johnson, OT

CONCEPTIONAL AMENDMENT #

OFFERED IN THE HOUSE  
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 4, line 23

2 Delete all material and insert:

3 **\*\* Sec .3.** This Act takes effect immediately under AS 01.10.070 (d) provided the uncodified  
4 law of the State of Alaska is amended by adding a new section to read:

5 CONTINGENT EFFECT; PAYMENT INTO CONSTITUTIONAL BUDGET

6 RESERVE FUND. AS 47.07.030(b)(13) and (14), as amended by sec, 1 of this Act, and AS  
7 47.07.042(d), as amended by sec. 2 of this Act, take effect only if

8 (1) on June 30, 2010, money is not owed to the budget reserve fund (art. IX, sec.  
9 17, Constitution of the State of Alaska); or

10 (2) money is owed to the constitutional budget reserve fund on June 30, 2010 and  
11 the following provision or a substantially similar provision becomes law before January 1,  
12 2011:

13 The amount necessary for full repayment of the amounts owed the budget reserve  
14 fund (art. IX, sec. 17, Constitution of the State of Alaska) as of June 30, 2010, estimated  
15 to be \$401,617,000, is appropriated from the general fund to the budget reserve fund (art.  
16 IX, sec. 17, Constitution of the State of Alaska)."

# ALASKA STATE LEGISLATURE

**Interim:**

600 East Railroad Avenue  
Wasilla, Alaska 99654  
Phone: (907) 373-1842  
Fax: (907) 373-4729



**Session:**

State Capitol Building  
Juneau, Alaska 99801-1182  
Phone: (907) 465-2186  
Fax: (907) 465-3818


## REPRESENTATIVE WES KELLER DISTRICT 14

### Fax

To: Legis. Legal

Fax #: 465-2029

Number of pages including cover: 3

Fm: Jim Pound 

Cc:

Date: February 23, 2010, 8:23 AM

Re: Amendments to SB 13 (26-LS0076\A)

---

Please prepare the attached amendments for the above referenced bill. Representative Keller will introduce them in the House Health and Social Services Committee.

Thank you

The information contained in this fax is **CONFIDENTIAL** and/or privileged. This fax is intended to be reviewed initially by only the individual named above. If the reader of this transmittal page is not the intended recipient or a representative of the intended recipient, you are hereby notified that any **review, dissemination, or copying** of this fax or the information contained herein is **prohibited**. If you have received this fax in error, please immediately notify the sender by telephone and return this fax to the sender at the above address.

Thank you

E-Mail: [Representative Wes Keller@legis.state.ak.us](mailto:Representative_Wes_Keller@legis.state.ak.us)  
Call Juneau Toll free: (800) 468-2186  
Website: [www.akrepublicans.org/keller/](http://www.akrepublicans.org/keller/)

BILL VERSION: SB 13

CURRENT STATUS: (H) HSS  
THEN FIN

SPONSOR(s): SENATOR(S) DAVIS, Ellis, Paskvan, Wielechowski, French REPRESENTATIVE(S) Gruenberg

SHORT TITLE: MEDICAL ASSISTANCE  
ELIGIBILITY

STATUS DATE: 04/07/09

### Conceptional Amendment 1

AS 47.07.020(b) is amended to read:

02 (13) persons under 19 years of age who are not covered under (a) of  
03 this section and whose household income does not exceed 210 [200] [175] percent of the  
04 federal poverty line as defined by the United States Department of Health and Human  
05 Services and revised under 42 U.S.C. 9902(2);

06 (14) pregnant women who are not covered under (a) of this section and  
07 whose household income does not exceed 210 [200] [175] percent of the federal poverty line  
08 as defined by the United States Department of Health and Human Services and revised  
09 under 42 U.S.C. 9902(2);

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

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

13 (d) In addition to the requirements established under (a) and (b) of this section,  
14 the department may require premiums or cost-sharing contributions from recipients  
15 who are eligible for benefits under AS 47.07.020(b)(13) and whose household income  
16 is between [150] 185 and 210 [175] percent of the federal poverty line. If the department  
17 requires premiums or cost-sharing contributions under this subsection, the department

18 (1) shall adopt in regulation a sliding scale for those premiums, [or]  
19 contributions, or co-pay based on household income;

20 (a) 185.1% to 190% co-pay of 10%

21 (b) 190.1% to 195% co-pay of 20%

22 (c) 195.1% to 200% co-pay of 30%

23 (d) 200.1% to 205% co-pay of 40%

24 (e) 205.1% to 210% co-pay of 50%

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

26 (3) shall implement a system by which the department or its designee  
27 collects those premiums, [or] contributions, or co-pays.

## Conceptional Amendment 2

01 \* **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

02 CONTINGENT EFFECT. AS 47.07.020(b)(13 & 14), and 47.07.042(d),  
03 added in secs. 2, of this Act, take effect only if, before July 1, 2011, the United States  
04 Department of Health and Human Services has approved the changes and provided sufficient  
05 funding for the changes.

06 \* **Sec. 6.** If AS 47.07.020(b)(16), 47.07.020(o), and 47.07.042(g), added in secs. 2, 3, and 4  
07 of this Act, take effect, they take effect on the date that the revisor of statutes receives notice  
08 from the commissioner of health and social services that the United States Department of  
09 Health and Human Services has approved the changes and provided sufficient funding for the  
10 additions.

# 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

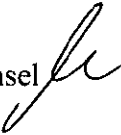
State Capitol  
Juneau, Alaska 99801-1182  
Deliveries to: 129 6th St., Rm. 329

## MEMORANDUM

March 16, 2010

**SUBJECT:** Title change necessitated by adding co-payment provisions  
(SB 13; Work Order No. 26-LS0076\A.9)

**TO:** Representative Wes Keller  
Chair of the House Health and Social Services Committee  
Attn: Matthew Johnson

**FROM:** Jean M. Mischel  
Legislative Counsel 

As in amendment A.5 of the above bill, the addition of copayment provisions modifies the Senate-passed bill to add new material that necessitates a change in the bill title. This is a bill title change in the measure's second ("other") house. The limitation of Uniform Rule 41(b) applies:

(b) An amendment to a bill introduced in the other house is not in order if the amendment requires a change of the bill title other than a clerical or technical change.

In submitting the committee report for SB 13, the House Finance Committee should also introduce a companion concurrent resolution waiving the application of the appropriate uniform rules in order to accommodate the amendments and the related bill title addition.

If I may be of further assistance, please advise.

JMM:lmb  
10-007.lmb

Enclosure

**AMENDMENT**

OFFERED IN THE HOUSE  
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 1, line 1, following "requirements":

2 Insert "**and cost-sharing**"

3

4 Page 4, line 3:

5 Delete "**200**"

6 Insert "**210**"

7

8 Page 4, line 7:

9 Delete "**200**"

10 Insert "**210**"

11

12 Page 4, line 16:

13 Delete "150 and **200**"

14 Insert "**185** [150] and **210**"

15

16 Page 4, lines 18 - 19:

17 Delete "those premiums or contributions based on household income"

18 Insert "**copayments based on household income as follows:**

19 **(A) at least 185 percent but not more than 190 percent, a**  
20 **copayment of 10 percent of the cost of services;**

21 **(B) more than 190 percent but not more than 195 percent, a**  
22 **copayment of 20 percent of the cost of services;**

23 **(C) more than 195 percent but not more than 200 percent, a**

1                   copayment of 30 percent of the cost of services;

2                                   (D) more than 200 percent but not more than 205 percent, a  
3                   copayment of 40 percent of the cost of services;

4                                   (E) more than 205 percent but not more than 210 percent, a  
5                   copayment of 50 percent of the cost of services

6                   [THOSE PREMIUMS OR CONTRIBUTIONS BASED ON HOUSEHOLD  
7                   INCOME]"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: SB 13

1 Page 4, line 23:

2 Delete all material and insert:

3 **\*\* Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to  
4 read:

5 CONTINGENT EFFECT; NOTIFICATION OF FEDERAL APPROVAL. (a)  
6 AS 47.07.020(b)(13), as amended by sec. 1 of this Act, takes effect only if, before July 1,  
7 2011, the United States Department of Health and Human Services has approved the change  
8 and included sufficient funding in the federal budget to provide for the change in the fiscal  
9 year immediately following the passage of this Act by the Alaska State Legislature.

10 (b) AS 47.07.020(b)(14), as amended by sec. 1 of this Act, takes effect only if, before  
11 July 1, 2011, the United States Department of Health and Human Services has approved the  
12 change and included sufficient funding in the federal budget to provide for the change in the  
13 fiscal year immediately following the passage of this Act by the Alaska State Legislature.

14 (c) AS 47.07.042(d), as amended by sec. 2 of this Act, takes effect only if, before  
15 July 1, 2011, the United States Department of Health and Human Services has approved the  
16 change and included sufficient funding in the federal budget to provide for the change in the  
17 fiscal year immediately following the passage of this Act by the Alaska State Legislature.

18 (d) The commissioner of health and social services shall notify the revisor of statutes  
19 of the federal approval and funding provided for in (a) - (c) of this section.

20 **\* Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to  
21 read:

22 CONTINGENT EFFECTIVE DATES. (a) If AS 47.07.020(b)(13), as amended by  
23 sec. 1 of this Act, takes effect under sec. 3(a) of this Act, it takes effect on the day after the

1 day that the revisor of statutes receives notice from the commissioner of health and social  
2 services that the United States Department of Health and Human Services has approved the  
3 change and provided sufficient federal funding to provide for the change as provided in sec.  
4 3(a) of this Act.

5 (b) If AS 47.07.020(b)(14), as amended by sec. 1 of this Act, takes effect under sec.  
6 3(b) of this Act, it takes effect on the day after the day that the revisor of statutes receives  
7 notice from the commissioner of health and social services that the United States Department  
8 of Health and Human Services has approved the change and provided sufficient federal  
9 funding to provide for the change as provided in sec. 3(b) of this Act.

10 (c) If AS 47.07.042(d), as amended by sec. 2 of this Act, takes effect under sec. 3(c)  
11 of this Act, it takes effect on the day after the day that the revisor of statutes receives notice  
12 from the commissioner of health and social services that the United States Department of  
13 Health and Human Services has approved the change and provided sufficient federal funding  
14 to provide for the change as provided in sec. 3(c) of this Act."

AMENDMENT

OFFERED IN THE HOUSE  
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 1, line 1, following "requirements":

2 Insert "and cost-sharing"

3

4 Page 4, line 3:

5 Delete "200"

6 Insert "185"

7

8 Page 4, line 11, following "42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII)":

9 Insert ";

10 (16) persons under 19 years of age who are not covered under (a)  
11 of this section

12 (A) who pay a premium under AS 47.07.042(g);

13 (B) whose household income is more than 185 and not more  
14 than 210 percent of the federal poverty line as defined by the United  
15 States Department of Health and Human Services and revised under 42  
16 U.S.C. 9902(2);

17 (C) whose assets do not exceed the maximum value  
18 established by the United States Department of Health and Human  
19 Services under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act);  
20 and

21 (D) who apply annually on a form approved by the  
22 department"

23

1 Page 4, line 16:

2 Delete "200"

3 Insert "185"

4

5 Page 4, following line 22:

6 Insert new bill sections to read:

7 **\*\* Sec. 3.** AS 47.07.042 is amended by adding a new subsection to read:

8 (g) In addition to the requirements established under (a) and (b) of this section,  
9 the department shall require annual premiums from recipients who are eligible for  
10 benefits under AS 47.07.020(b)(16) and whose household income is more than 185  
11 and not more than 210 percent of the federal poverty line. The department shall

12 (1) adopt in regulation a sliding scale, providing for a premium that

13 (A) is not less than two percent of the recipient's household  
14 income; and

15 (B) meets the maximums allowed under federal law; and

16 (2) implement a system for collection of the premium.

17 **\* Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to  
18 read:

19 CONTINGENT EFFECT. AS 47.07.020(b)(16), added by sec. 1 of this Act, and  
20 AS 47.07.042(g), added by sec. 3 of this Act, take effect only if, before July 1, 2011, the  
21 United States Department of Health and Human Services has approved the changes and  
22 provided sufficient funding for the changes.

23 **\* Sec. 5.** If AS 47.07.020(b)(16), added by sec. 1 of this Act, and AS 47.07.042(g), added  
24 by sec. 3 of this Act, take effect, they take effect on the date that the revisor of statutes  
25 receives notice from the commissioner of health and social services that the United States  
26 Department of Health and Human Services has approved the changes and provided sufficient  
27 funding for the additions."

28

29 Renumber the following bill section accordingly.

30

31 Page 4, line 23:

- 1 Delete "This"
- 2 Insert "Except as provided in secs. 4 and 5 of this Act, this"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: SB 13

1 Page 1, line 1, following "**requirements**":

2       Insert "**and cost-sharing**"

3

4 Page 4, line 3:

5       Delete "200"

6       Insert "210"

7

8 Page 4, line 14:

9       Delete "may"

10       Insert "**shall** [MAY]"

11

12 Page 4, line 16:

13       Delete "150 and 200"

14       Insert "185 [150] and 210"

# 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

March 17, 2010

**SUBJECT:** Descriptive Title (SB 13; Work Order No. 26-LS0076\A.11)

**TO:** Representative Wes Keller  
Co-chair of the House Health and Social Services Committee  
Attn: Matthew Johnson

**FROM:** Jean M. Mischel  
Legislative Counsel 

As we discussed by telephone and as presented in a previous memorandum on this subject, the addition of specific cost-sharing requirements for medical assistance recipients by the above-referenced amendment may not be clear from the title of the bill, which only refers to eligibility requirements. Sec. 3, added by this amendment, requires the addition of premium payments by some medical assistance recipients. While the amendment at page one inserts a new category of eligibility relating to those recipients and the premium requirement is linked to eligibility, the payment of the premium may not be made until eligibility is first determined on the basis of income.

The bill title without the amendment may also be misleading in the sense that the cost sharing limits are amended by sec. 2 on the basis of the income adjustments made for eligibility.

If I may be of further assistance, please advise.

JMM:lmb  
10-008.lmb

Enclosure

**AMENDMENT**

OFFERED IN THE HOUSE  
TO: SB 13

BY REPRESENTATIVE KELLER

1 Page 4, line 3:

2 Delete "200"

3 Insert "185"

4

5 Page 4, line 11, following "42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII)":

6 Insert ";

7

**(16) persons under 19 years of age who are not covered under (a)**

8

**of this section**

9

**(A) who pay a premium under AS 47.07.042(g);**

10

**(B) whose household income is more than 185 and not more**

11

**than 210 percent of the federal poverty line as defined by the United**

12

**States Department of Health and Human Services and revised under 42**

13

**U.S.C. 9902(2); and**

14

**(C) who apply annually on a form approved by the**

15

**department"**

16

17 Page 4, line 16:

18 Delete "200"

19 Insert "185"

20

21 Page 4, following line 22:

22 Insert new bill sections to read:

23 "\* **Sec. 3.** AS 47.07.042 is amended by adding a new subsection to read:

1 (g) In addition to the requirements established under (a) and (b) of this section,  
 2 the department shall require annual premiums from recipients who are eligible for  
 3 benefits under AS 47.07.020(b)(16) and whose household income is more than 185  
 4 and not more than 210 percent of the federal poverty line. The department shall

5 (1) adopt in regulation a sliding scale, providing for a premium that

6 (A) is not less than two percent of the recipient's household  
 7 income; and

8 (B) meets the maximums allowed under federal law; and

9 (2) implement a system for collection of the premium.

10 \* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to  
 11 read:

12 CONTINGENT EFFECT. AS 47.07.020(b)(16), added by sec. 1 of this Act, and  
 13 AS 47.07.042(g), added by sec. 3 of this Act, take effect only if, before July 1, 2011, the  
 14 United States Department of Health and Human Services has approved the changes and  
 15 provided sufficient funding for the changes.

16 \* **Sec. 5.** If AS 47.07.020(b)(16), added by sec. 1 of this Act, and AS 47.07.042(g), added  
 17 by sec. 3 of this Act, take effect, they take effect on the date that the revisor of statutes  
 18 receives notice from the commissioner of health and social services that the United States  
 19 Department of Health and Human Services has approved the changes and provided sufficient  
 20 funding for the additions."

21  
 22 Renumber the following bill section accordingly.

23  
 24 Page 4, line 23:

25 Delete "This"

26 Insert "Except as provided in secs. 4 and 5 of this Act, this"

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE KELLER

TO: SB 13

1 Page 4, line 3:

2 Delete "200"

3 Insert "210"

4

5 Page 4, line 14:

6 Delete "may"

7 Insert "shall [MAY]"

8

9 Page 4, line 16:

10 Delete "150 and 200"

11 Insert "185 [150] and 210"

12

13 Page 4, lines 16 - 17:

14 Delete "if the department requires premiums or cost-sharing contributions under this  
15 subsection, the"

16 Insert "The [IF THE DEPARTMENT REQUIRES PREMIUMS OR COST-  
17 SHARING CONTRIBUTIONS UNDER THIS SUBSECTION, THE]"

26-LS0076\S  
Mischel  
4/13/09

**HOUSE CS FOR SENATE BILL NO. 13(HSS)**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTY-SIXTH LEGISLATURE - FIRST SESSION**

**BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE**

**Offered:**  
**Referred:**

**Sponsor(s): SENATORS DAVIS, Ellis, Paskvan, Wielechowski, French**  
**REPRESENTATIVE Gruenberg**

**A BILL**

**FOR AN ACT ENTITLED**

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

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

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

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

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

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

15 (3) persons under 21 years of age who are under supervision of the  
16 department, for whom maintenance is being paid in whole or in part from public

1 funds, and who are in foster homes or private child-care institutions;

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

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

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

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

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

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

26 (10) persons under 21 years of age not covered under (a) of this section  
27 who the department has determined cannot be placed for adoption without medical  
28 assistance because of a special need for medical or rehabilitative care and who the  
29 department has determined are hard-to-place children eligible for subsidy under  
30 AS 25.23.190 - 25.23.210;

31 (11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title

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

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

6 (B) the department has determined that

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

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

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

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

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

20 (12) disabled persons, as described in 42 U.S.C.  
21 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under  
22 applicable federal regulations or guidelines, is less than 250 percent of the official  
23 poverty line applicable to a family of that size according to the United States  
24 Department of Health and Human Services, and who, but for earnings in excess of the  
25 limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be  
26 individuals with respect to whom a supplemental security income is being paid under  
27 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is  
28 not eligible under another provision of this section shall pay a premium or other cost-  
29 sharing charges according to a sliding fee scale that is based on income as established  
30 by the department in regulations;

31 (13) persons under 19 years of age who are not covered under (a) of

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

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

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

10 \* Sec. 2. AS 47.07.042 is amended by adding a new subsection to read:

11 (g) In addition to the requirements established under (a) and (b) of this section,  
12 the department shall require annual premiums from recipients who are eligible for  
13 benefits under AS 47.07.020(b)(13) and (14) and whose household income is more  
14 than 175 percent of the federal poverty line. The department shall

15 (1) adopt in regulation a sliding scale, providing for a premium that

16 (A) is not less than two percent of the recipient's household  
17 income; and

18 (B) meets the maximums allowed under federal law; and

19 (2) implement a system for collection of the premium.

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

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6 optional groups of persons for whom the state may claim federal financial  
7 participation are eligible for medical assistance:

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

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

15 (3) persons under 21 years of age who are under supervision of the  
16 department, for whom maintenance is being paid in whole or in part from public

1 funds, and who are in foster homes or private child-care institutions;

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

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

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

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

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

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

26 (10) persons under 21 years of age not covered under (a) of this section  
27 who the department has determined cannot be placed for adoption without medical  
28 assistance because of a special need for medical or rehabilitative care and who the  
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1 XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom  
2 a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title  
3 XVI, Social Security Act) because they meet all of the following criteria:

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

6 (B) the department has determined that

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

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

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

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

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

20 (12) disabled persons, as described in 42 U.S.C.  
21 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under  
22 applicable federal regulations or guidelines, is less than 250 percent of the official  
23 poverty line applicable to a family of that size according to the United States  
24 Department of Health and Human Services, and who, but for earnings in excess of the  
25 limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be  
26 individuals with respect to whom a supplemental security income is being paid under  
27 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is  
28 not eligible under another provision of this section shall pay a premium or other cost-  
29 sharing charges according to a sliding fee scale that is based on income as established  
30 by the department in regulations;

31 (13) persons under 19 years of age who are not covered under (a) of

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

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

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

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

11 (d) In addition to the requirements established under (a) and (b) of this section,  
12 the department **shall** [MAY] require premiums or cost-sharing contributions from  
13 recipients who are eligible for benefits under AS 47.07.020(b)(13) **and (14)** and  
14 whose household income is between 150 and 200 [175] percent of the federal poverty  
15 line. **The department shall** [IF THE DEPARTMENT REQUIRES PREMIUMS OR  
16 COST-SHARING CONTRIBUTIONS UNDER THIS SUBSECTION, THE  
17 DEPARTMENT]

18 (1) [SHALL] adopt in regulation a sliding scale for those premiums or  
19 contributions based on household income **that** [;]

20 (i) [(2)] may not exceed the maximums allowed under  
21 federal law; and

22 (ii) **may not be less than two percent of the**  
23 **recipient's household income; and**

24 (2) [(3) SHALL] implement a system by which the department or its  
25 designee collects those premiums or contributions.

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