

SB

13

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/09

FURTHER: Finance

Date of 5-Day Notice: 2/4/09
 (in accordance with Uniform Rule 23)

DATE TURNED
 IN TO OFFICE: 2/9/09

Health and Social Services Committee considered SENATE BILL NO. 13

SB 13 MEDICAL ASSISTANCE ELIGIBILITY

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

and recommends:

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

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

NEW FISCAL NOTE(S):

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indel	Zero	FN#
DHS	2/1/09	\$			1
DHS	2/1/09	\$			2
DHS	2/4/09	\$			3

Department	Date	Fiscal	Indel	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
<i>[Signature]</i>	THOMAS	✓			
<i>[Signature]</i>	ELIE	✓			
<i>[Signature]</i>	ASKAN	K			
CHAIR: <i>[Signature]</i>	DAVIS	✓			

Alaska State Legislature

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[Senator Bettye Davis@legis.state.ak.us](mailto: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 the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL) and makes health insurance accessible to an estimated 1300 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an "enhanced" reimbursement program with up to 70% matching funds 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.

Alaska as one of the nation's richest states is only one of 7 states which funds its SCHIP program below 200% FPL. Increasing Alaska Denali KidCare to 200% FPL only brings it to the level at which it was established 10 years ago. 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, enrollment fees, or co-payments for selected services in SCHIP programs on a sliding scale of FPL.

Denali KidCare serves an estimated 7600 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 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

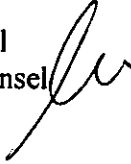
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

January 22, 2009

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

TO: Senator Betty Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel 

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

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

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

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

Section 3. Provides for an immediate effective date.

JMM:ljw
09-039.ljw

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
Sponsor: Davis Component: Behavioral Health Medicaid Services
Requester: Unknown Component Number: 2660

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
OPERATING EXPENDITURES							
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							
TOTAL OPERATING	430.0	0.0	467.0	507.1	550.7	598.1	649.5

CAPITAL EXPENDITURES							
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CHANGE IN REVENUES (
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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							
TOTAL	430.0	0.0	467.0	507.1	550.7	598.1	649.5

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
OPERATING EXPENDITURES							
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							
TOTAL OPERATING	2,105.0	0.0	2,286.0	2,482.6	2,696.1	2,928.0	3,179.8

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

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							
TOTAL	2,105.0	0.0	2,286.0	2,482.6	2,696.1	2,928.0	3,179.8

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

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
OPERATING EXPENDITURES							
Personal Services	134.4		134.4	134.4	134.4	134.4	134.4
Travel							
Contractual	17.6		17.6	17.6	17.6	17.6	17.6
Supplies	1.0		1.0	1.0	1.0	1.0	1.0
Equipment	14.4						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	167.4	0.0	153.0	153.0	153.0	153.0	153.0

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

1002 Federal Receipts	83.7		76.5	76.5	76.5	76.5	76.5
1003 GF Match	83.7		76.5	76.5	76.5	76.5	76.5
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	167.4	0.0	153.0	153.0	153.0	153.0	153.0

Estimate of any current year (FY2009) cost: 0.0

POSITIONS

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

ANALYSIS: (Attach a separate page if necessary)

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% 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

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
<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

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

- 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.

Alaska State Legislature

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

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

Suggested List to Testify

- Rod Betit – Pres/CEO ASHNA, AK State Hosp. & Nursing Home Assn. *rod.bet.it@msn.com*
- Janice Tower, Exec. Dir., AK Chapter Pediatricians
- ~~Regan Mattingly, State Affairs Coordinator, Alaska Primary Care Association~~ *Shelley Haches Gov. Affairs Dir 907-2725*
- Walter Majoros, Juneau Youth Services (Mental Health –per Caren Robinson 321-2551)
- Matt Felix – National Counsel on Drugs and Alcohol
- Pat Senner – Legis. Chair – Alaska Nurses Assn, and Covenant House
- Anchorage Neighborhood Health Clinic
- Providence Family Medicine Center in Anchorage
- Social Workers
- Others – throughout the state will call in

346-8028

*Whole crew
- by Sen
negot
- Name for child
- Not Ed for child
worked - leg of arm both
See work - work
de - term
Nurse - Phon*

*Break more (full list)
NCSL
Tan - request list
would like input - a head of this
want to know again
Kare Roberts
- number group call in
✓ w Carol + board*

Alaska State Chapter
3209 Denali Street, Suite 200
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marchofdimes.com/alaska

RECEIVED
FEB 06 2009

February 3, 2009

The Honorable Bettye Davis
State Capitol, Room 30
Juneau, AK 99801-1182

RE: Support for Senate Bill 13

Dear Senator Davis:

I am writing to you to express the support of March of Dimes for **Senate Bill 13**. The mission of March of Dimes is to improve the health of babies by preventing birth defects, premature birth and infant mortality can best be achieved if all women of childbearing age, infants and children have access to comprehensive health coverage.

Senate Bill 13 reinstates Medicaid and Denali KidCare (DKC) for children and pregnant women in Alaska up to 200% of Federal Poverty Level (FPL). This was the original eligibility level when DKC was established in 1997. The eligibility threshold was reduced and frozen at 175% FPL by the Legislature in 2003. This bill will help reinstate eligibility to many of Alaska's 19,000 uninsured children.

The Institute of Medicine has found that health coverage is the single most important factor in determining whether or not a child receives needed health services. Coverage also plays a key role in access to maternity care services for pregnant women.

Women who receive maternity care are more likely to have access to screening and diagnostic tests that can help to identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors like substance use and poor nutrition. Such care may thus help improve the health of both mothers and infants. For example, singleton infants born to mothers who received late or no prenatal care in 2004 were nearly twice as likely to be low birth weight (less than 5 1/2 pounds) as infants born to mothers who received early prenatal care — 9.9 percent compared with 5.9 percent.

In addition to pregnant women, health insurance status is the single most important influence in determining whether health care is accessible to children when they need it, according to another Institute of Medicine study. Though uninsured newborns are more likely than insured babies to be sick, they receive fewer hospital services.

march  of dimes

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Fax: (907) 276-3375

marchofdimes.com/alaska

Uninsured children are the most likely to have no usual source of medical care - 28.8 percent, compared with only 2.3 percent of privately insured youngsters and 4.6 percent of children in public insurance programs. March of Dimes is a leading nonprofit organization for maternal, infant and child health. With chapters nationwide and its premier event, March for Babies, March of Dimes works to improve the health of women, infants and children. Thank you for sponsoring Senate Bill 13.

Sincerely,



Janie Odgers
State Director

march  of dimes

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

SARAH PALIN, GOVERNOR

P.O. BOX 110608
431 N. Franklin Street, Suite 200
JUNEAU, ALASKA 99811-0608
PHONE: (907) 465-8920
FAX: (907) 465-4410
TOLL FREE: (888) 464-8920

February 9, 2009

Senator Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, Alaska 99801

Re: Support for Expanding Eligibility for Denali KidCare

Senator Davis:

The Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse appreciate your recognition of the need for quality health care for Alaska's children. An estimated 19,670 of Alaska's children live in poverty. For them, Denali KidCare is an important safety net – and the way we can insure that our children grown to be healthier and happier adults.

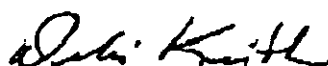
Medicaid-enrolled children who are up-to-date on their well-child checkups through age two years are 48% less likely to experience an avoidable hospitalization. Children with incomplete care are 60% more likely to visit an emergency department for any cause compared to children who are up-to-date on their well-child care. By providing regular preventative care to our children, we save on the cost and trauma of unnecessary hospitalizations.


Denali KidCare is especially important for children with serious emotional disturbances and other mental health needs. In Alaska, more than 75% of children with special health care needs who have Denali KidCare receive the mental health services they need. This is far better than the national rate for uninsured children: only 56.8% of uninsured children with special health care needs receive the necessary mental health services.

Children of families whose income exceeds the current 175% FPIG ceiling, but who still lack resources or insurance to pay for their children's health care, go without necessary health care. The costs of health care have continued to rise, and with that the number of uninsured children who go without care rises. In 2007, nearly 16% of uninsured children in the United States went without necessary care because the costs were prohibitive.

Thank you for your work, and please let us know if the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse can assist in the effort to pass this important legislation.

Sincerely,


Debi Keith, Chair
AMHB


Lonnie Walters, Chair
ABADA

Lynda Zaugg

From: Don Burrell
Sent: Monday, February 09, 2009 8:48 AM
To: Thomas Obermeyer; Lynda Zaugg
Subject: Support for SB 13 & SB 87

Karen McBride called in today at 8:42am to express her support for both SB 13 & SB 87 which will be heard in H.S.S. this afternoon.

Just passing the word along.

MCBRIDE, KAREN L
8981 RENDON DR
ANCHORAGE AK 99507
District: 30-840 Party: D Sex: F

Don Burrell Jr.
Legislative Aide
Office of Senator Bettye Davis
State Capitol Building, Rm. 30
Juneau, Alaska 99801
P 907-465-3822
F 907-465-3756
don_burrell@legis.state.ak.us

Lynda Zaugg

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, February 09, 2009 9:01 AM
To: Lynda Zaugg
Cc: Fuller, Jerry (HSS)
Subject: Senate HSS hearing today

Lynda, this is to let you know that Jerry Fuller, DHSS Medicaid director, will be calling in for today's Senate HSS hearing. He will be available for questions.

w.

Lynda Zaugg

From: Thomas Obermeyer
Sent: Monday, February 09, 2009 8:26 AM
To: Lynda Zaugg; Sen. Bettye Davis; Don Burrell
Subject: FW: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

From: Jennifer Saunders [mailto:jennifer.saunders@ncsl.org]
Sent: Monday, February 09, 2009 7:50 AM
To: Thomas Obermeyer
Cc: Martha King; Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

NCSL staff
attend via teleconf
heaven

Thomas,

Martha King and I will be on the call this afternoon to answer questions.

As we discussed on the phone on Friday, 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.

The following document summarizes these requirements and I would refer you to the summary on page 1 under the heading "Options for Premiums and Cost-sharing" and the "Important Links" on the bottom of page 2. See the document here: <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf>

Under provisions of the Deficit Reduction Act of 2005, 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.

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 (CMS) or by creating a stand-alone SCHIP program.

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

Best regards,
 Jennifer

Jennifer B. Saunders, MSW
 Research Analyst
 Health Program
 National Conference of State Legislatures
 7700 East First Place

January 26, 2009

Martha King, Group Director,
Health Programs, NCSL - Denver
303-364-7700 main line
303-364-7800 fax
303-856-1448 – direct line
E-mail: Martha.king@ncsl.org

RE: Request for:

- A) review and comments concerning Alaska Senate Bill 13 (attached), and
- B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time).
Call in number is 888-295-4546

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13**, 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) **to 200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments. You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines..

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us

Lynda Zaugg

From: Jennifer Saunders [jennifer.saunders@ncsl.org]
Sent: Thursday, February 05, 2009 10:03 AM
To: Thomas Obermeyer; Lynda Zaugg
Cc: Martha King; Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Yes, the following Kaiser report indicates that 7 states have SCHIP eligibility levels below 200 percent of the federal poverty guidelines (FPG):

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

<http://www.kff.org/medicaid/7855.cfm>

(See page 10, Figure 1.)

The 7 states are:

Alaska	175 percent FPG
Idaho	185 percent FPG
Montana	175 percent FPG
Nebraska	185 percent FPG
North Dakota	150 percent FPG
Oklahoma	185 percent FPG*
Oregon	185 percent FPG

* Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115 waiver. However, the currently proposed expansion has been scaled back to 217 percent of the federal poverty line and the future expansion of 218 percent to 300 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

Sources:

Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009

<http://statehealthfacts.org/comparemaptable.jsp?ind=203&cat=4>

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009

<http://statehealthfacts.org/comparemaptable.jsp?ind=204&cat=4>

Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?

If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
 Jennifer

Jennifer B. Saunders, MSW
 Research Analyst
 Health Program
 National Conference of State Legislatures

Lynda Zaugg

From: Rep. Les Gara
Sent: Thursday, February 05, 2009 10:46 AM
To: Rep. Les Gara
Subject: PRESS RELEASE: Affordable Medical Care For Every Alaska Child - Using New Federal Law To Benefit Alaskans

PRESS RELEASE • February 5, 2009

Alaska State Legislature

Reps. Les Gara, Scott Kawasaki & Bob Buch

Web: <http://gara.akdemocrats.org> • Contact: David Theriault • Phone: 465-2647 • Fax: 465-3518
 E-mail: representative.les.gara@legis.state.ak.us • Mail: State Capitol Bldg. Room 500, Juneau, AK 99801

GARA, WIELECHOWSKI, KAWASAKI AND BUCH CALL FOR AFFORDABLE, UNIVERSAL KIDS HEALTH COVERAGE. FEDERAL LAW SIGNED THIS WEEK HELPS STATES EXPAND CHILDREN'S HEALTH PLANS

JUNEAU – Today legislators presented a plan to provide affordable medical care to every child in Alaska. The Democratic legislators' "No Child Left Uninsured" plan follows on the heels of the children's health care expansion President Obama signed this week. Under the enhanced federal plan, states can choose to extend low cost health coverage to their children.

"Denying low cost medical care to children who need it would be failure, not leadership," said Rep. Les Gara (D-Anchorage).

"This is a cost-effective way to provide needed medical care to children of working families," said Rep. Scott Kawasaki (D-Fbks.). Rep. Bob Buch of Anchorage is the third co-sponsor.

Alaska's children's health plan ranks second worst in the nation, and roughly 10,000 Alaska children of working families receive no private or public health coverage. Current Alaska law cuts off coverage to families that earn more than 175% of the federal poverty level, or roughly \$30,000 for a single parent with one child. Alaska had a flagship state plan in the 1990's under Governor Tony Knowles.

"Private plans cost upwards of \$3,000 - \$4,000 or more for a child. That's a significant cost to parents. Roughly half of Alaska's small businesses aren't able to offer employer health insurance, leaving parents and children without medical coverage" said Gara.

In 2007, Rep. Gara and Sen. Bill Wielechowski (D-Anchorage) proposed similar legislation. The new federal law that passed this week will enable states to provide universal children's health coverage at a low cost to families, and to the state.

Under the new federal law, Alaska will qualify for federal funding that would cover 60-70 percent of the cost of this insurance. No Child Left Uninsured:

- provides no-cost coverage for families that earn up to 200% of the poverty level (\$34,000/year for a single parent with one child);
- allows families to purchase this health coverage at higher incomes up to 350% of the poverty level.
- Higher income families would be charged the full state cost of the plan.

“The Anchorage Neighborhood Health Center supports expansion of Denali KidCare that allows more parents the peace of mind in knowing they can access quality health care when they need it,” said Joan L. Fisher, Executive Director of Anchorage Neighborhood Health Center.

“American Academy of Pediatrics supports this effort to help working families. Maximizing the health of children is the basis for success in school and an active lifestyle,” said Dr. Jody Butto, a prominent Anchorage pediatrician.

For more information, contact Representative Gara (465-2647) or Scott Kawasaki (465-3466).



STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

With Congress debating the reauthorization of the State Children's Health Insurance Program (SCHIP), this *State Health Policy Briefing* seeks to inform the federal legislators and other policymakers working on reauthorizing legislation, as well as others who are concerned about the program's future, about the views of state SCHIP program directors. The brief, first published in April 2007, has been updated and is being re-issued to address changes in the policy landscape that have occurred since that time. The brief was developed by the National Academy for State Health Policy (NASHP) through a workgroup of state SCHIP directors, and was reviewed by all directors. NASHP's work with SCHIP directors, including the development of this brief, is made possible through the generous support of the David and Lucile Packard Foundation as part of broader efforts to provide assistance and report on state SCHIP programs since the program's inception.



Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

JANUARY 2009

REAUTHORIZING SCHIP: Principles, Issues And Ideas From State Directors

Updated January 2009

The State Children's Health Insurance Program (SCHIP) deservedly enjoys broad support as a successful program. That success rests on a legislative foundation enacted as a result of careful bi-partisan compromise. Title XXI of the Social Security Act established a federal-state partnership program with a delicate balance of state flexibility and core program requirements. SCHIP was created with the goal to provide health coverage for low-income uninsured children. This essential program, now serving over seven million annually, is again up for reauthorization this year.

Reauthorizing SCHIP, first published in April 2007, was developed to inform federal policymakers then working on legislation to renew SCHIP, as well as others concerned with the program's future, about the views of state SCHIP directors. The April 2007 brief built upon the 2005 report "*Perspectives on Reauthorization: SCHIP Directors Weigh In.*" The present publication updates the April 2007 brief primarily to address changes in the policy landscape that have occurred since that time. These reports have been developed by the National Academy for State Health Policy (NASHP) in conjunction with state SCHIP directors through the generous support of the David and Lucile Packard Foundation as part of broader efforts to provide assistance and report on state SCHIP programs since the program's inception.

This document describes the views of SCHIP directors on key issues at stake in the reauthorization process. The April 2007 brief was the product of a workgroup of 15 states

representing varying SCHIP program types from across the country, convened by NASHP to identify important issues, review information and recommendations from other key stakeholders, and discuss commonly held as well as differing views. The group met by phone and communicated electronically from January through March 2007. The results of the workgroup discussions were summarized in a draft brief, shared with all SCHIP programs across the country, and discussed at a March 2007 meeting attended by the majority of state programs. The April 2007 brief was finalized based on this meeting.

With SCHIP reauthorization delayed but now again on the horizon, NASHP reconvened the original workgroup in September 2008. Members of the workgroup reviewed the April 2007 brief to recommend updates. The workgroup's recommendations were discussed with all SCHIP directors attending the Annual Preconference Meeting for SCHIP directors held by NASHP in October 2008. Final revisions were subsequently recommended by the workgroup and sent to all SCHIP directors for feedback in December 2008. This revised edition of *Reauthorizing SCHIP* is the result. This updated brief reflects added emphasis on a few issues raised in the April 2007 brief as well as a small number of new issues that have surfaced since that time. These revisions address changes in federal policy after the April 2007 brief was published. While the brief does not capture all of the views of all of the states on all issues relevant to reauthorization, it does represent the views of most state SCHIP directors on issues of priority concern to them.

1. SCHIP FUNDING SHOULD BE RENEWED AND INCREASED SUBSTANTIALLY TO PROVIDE SUFFICIENT AND PREDICTABLE FUNDS FOR STATES TO EFFECTIVELY MANAGE PROGRAMS AND REDUCE THE NUMBER OF UNINSURED.

States responded to federal options in implementing programs to address state objectives. State SCHIP programs now cover over 7 million individuals annually. Most enrollees are children. But some states also provide coverage to pregnant women and parents, and a number have provided coverage to childless adults. (The Deficit Reduction Act of 2005, however, mandated that coverage of childless adults be phased out, and the Centers for Medicare and Medicaid Services (CMS) no longer approves waivers for such coverage.) Over the past decade, states have used the flexibility afforded them to cover these individuals through

different pathways and on different timetables. The structure of SCHIP – including the statutory redistribution mechanism and other federal policies, such as federal encouragement to use and approval of waivers to cover more of the uninsured – strongly influenced the decisions states made. States successfully utilized the flexibility inherent in SCHIP to initiate and build programs in ways that fit the needs of their states' children and families – both when states started up their programs and as their needs changed over time. The result today is a successful program nationwide, which reflects the diversity of state responses to federal policies and to their own residents' needs and circumstances.

State SCHIP programs have evolved to fit with the economies, health care systems, values, politics, and fiscal capacities of their states. Most states have been able to raise income eligibility for children up to at least 200 percent of the federal poverty level (FPL), although many eligible children in these states remain unenrolled. Six states, most of which are spending all of their allotted funds, have not yet been able to set eligibility levels high enough to reach children with family incomes up to that level. Over one-third of all states reach uninsured children in families with income over 200 percent FPL, or have covered parents or pregnant women with the intent of improving child coverage and health. State directors share a common vision and many common goals for coverage, access to quality care, and improved health for children and, ultimately, for everyone, but states are at different points along a number of possible pathways to achieving that vision.

Future funding needs to be substantially increased over the course of the next five years. SCHIP directors are united in concluding that SCHIP is a successful program that should be renewed with substantial additional funding that allows the program to grow and meet more of the need in the nation for health insurance coverage. The highest federal annual allotment provided in past years will not support the program today. Future funding levels need to be increased substantially to account for state success over the past decade in covering increasing numbers of children for whom private insurance is either unavailable or unaffordable and in enrolling greater proportions of those who already are eligible but not enrolled.

State directors also strongly agree that funding should be stable and predictable in order to allow them to adequately plan for program maintenance and growth. Annual appropria-

tions provided many states with more funds than they could spend in the early start up years, and insufficient funds later on as their programs expanded and matured. This funding structure, coupled with the different starting points and pacing of states in developing their programs, led some states to rely on redistributed funding, and more recently, short term federal relief for states experiencing shortfalls. The redistribution system provided little advance notice of amounts that would be available and just one year to spend the redistributed funds, making it very hard for states to plan and manage their programs effectively. The uncertainty surrounding SCHIP reauthorization in 2007, and the ultimate year-end action that provided a short-term extension of the program through March 31, 2009, rendered state planning and management of SCHIP in 2008 and 2009, much less future years, extremely difficult. Without stability in federal funding, states simply are more reluctant to conduct outreach or make program improvements requiring longer-term investment.

Predictability, stability, and growth over time are critical for effective program management. SCHIP directors believe that the total SCHIP appropriation should increase steadily over a five-year authorization period, taking into account population growth and cost increases, including health care cost inflation.

The funding structure needs to be reconsidered. There is fairly broad agreement among state SCHIP directors that the funding formula needs to be revisited. In particular, directors are concerned that use of the number of uninsured children within the current formula can penalize states for being effective in enrolling more children. Collectively, SCHIP directors have identified a number of factors which federal policymakers might consider for inclusion in a revised formula. These potential formula factors include enrollment levels, eligible but unenrolled populations, regional differences in cost of living, and state coverage levels for children at the time of SCHIP enactment. Directors also have concerns about the use of Current Population Survey data in the formula, as these data are often inconsistent with data that many states collect. State directors urge careful analysis and consultation with states in consideration of any alternative funding formulas and data sources.

State SCHIP directors' views vary on the extent to which and how funding should be structured in covering targeted low-income children, other children needing health insur-

ance, pregnant women (whose coverage can improve child health outcomes), parents (whose coverage can boost rates of children's enrollment), or others. As noted previously, six states have not been able to set program eligibility as high as the target level of 200 percent of FPL, while many other states have been able to reach uninsured children above that level, and a number of states do or have covered parents or pregnant women. This variation again reflects the differing circumstances of states at the time of SCHIP enactment and over time, as well as prior federal encouragement and approval for covering parents, pregnant women, and others.

2. SCHIP AND MEDICAID PLAY VITAL, COMPLEMENTARY ROLES IN COVERING CHILDREN AND ADOLESCENTS, AND EACH PROGRAM NEEDS TO BE MAINTAINED AND STRENGTHENED.

SCHIP and Medicaid work in tandem. SCHIP was designed to build on Medicaid, to support states in covering uninsured children not eligible for Medicaid when SCHIP was enacted. States had the choice to implement SCHIP through a Medicaid expansion, a separate program that could work in conjunction with Medicaid to cover more uninsured children, or through a combination of both approaches. In 2005, approximately 29 million children were covered through Medicaid funding and 6.1 million children through SCHIP.

As the nation and states focused attention over the past decade on enrolling children eligible for SCHIP, policy and systems improvements were made in both Medicaid and SCHIP. As of January 2008, for example, almost all states (46) had eliminated the asset test and in-person interviews for children's eligibility in both programs. As more states have implemented separate programs, they also have worked to improve the coordination between Medicaid and SCHIP. As of January 2008, for example, the vast majority of states with a separate SCHIP program (31 of 39) used the same application for both Medicaid and SCHIP. Other common strategies to promote coordination between the two programs include: aligning eligibility criteria and employing the same staff to determine eligibility for both programs; expanding the locations at which, and technologies through which, families can apply for coverage; developing administrative verification capability; and adopting presumptive eligibility. State efforts to simplify eligibility and streamline the application process have been critical to improving enrollment in both programs.

There should be greater consistency and more options for SCHIP and Medicaid eligibility. SCHIP's successes have been built on the shoulders of the Medicaid program, and SCHIP has driven system improvements in both programs. State directors need continued flexibility to use and combine Medicaid and separate program approaches and to make the interface between them work smoothly for children and families.

State directors see elimination of inconsistent and inequitable federal eligibility rules as important to states and families. Currently, states cannot enroll uninsured children whose parents are state employees in their separate SCHIP programs, although they can enroll such children in Medicaid and they can enroll children of federal employees in both programs. States would like the eligibility rules for separate SCHIP programs aligned with those of Medicaid expansion programs to allow for consistent and equitable treatment of children of state and federal employees.

States also would like the option to cover all legal resident children. The federal welfare reform law barred coverage of such children for the first five years of their residency. Some states cover these children with state funds; other states do not. Including these children as an optional group would enable more states to cover them and promote better health for all children.

Additional flexibilities are needed to enroll or retain specific groups of children who are eligible for Medicaid, in order to make the two programs as seamless as possible for families. Fluctuations in family income mean that children frequently move between the two programs. Policies and procedures to avoid or diminish breaks in coverage are essential to ensuring that children and families maintain access to critical preventive and treatment services, and directors would like increased flexibility to ensure continuity of coverage for children whose family incomes change.

States also would like the option to give families who have children eligible for both programs the choice to enroll all children in a family in one program – either Medicaid or SCHIP – in order to keep the children together in one plan and reduce the burdens on parents. Since states get a higher federal matching rate for children enrolled in SCHIP, state directors propose that they receive the lower Medicaid match for children who are Medicaid-eligible but opt for enrollment in SCHIP. This would eliminate any financial incentive that

states might have to encourage families to choose SCHIP over Medicaid. Finally, some states have raised the possibility of having the option to cover youth up to age 21 with SCHIP funds, something that is permitted under Medicaid.

States which expand Medicaid coverage of children should have the option to use SCHIP funds or their regular Medicaid matching rate and funds. States have the option to draw down federal funds from their SCHIP allotment by expanding coverage of children under their Medicaid program or by establishing a separate program. Due to limited SCHIP funds, some states have sought to expand coverage to children under Medicaid and claim regular Medicaid federal funding at their regular federal match, thereby leaving more SCHIP funds available to cover children at incomes higher than the Medicaid levels. The Centers for Medicare and Medicaid Services (CMS), however, recently has interpreted the statute to require that states which expand Medicaid coverage of children above the level covered as of June 1997 (when SCHIP was passed), must draw down funds for such children from their SCHIP allotment. This interpretation has limited these states' ability to cover greater numbers of uninsured children. SCHIP directors believe that CMS' interpretation is inconsistent with the purpose of the program, and states should have the option to use either federal Medicaid or SCHIP funding streams in order to make most effective use of both programs in covering uninsured children.

3. THE PROGRESS THAT STATES HAVE ACHIEVED IN SIMPLIFYING ENROLLMENT FOR CHILDREN AND FAMILIES SHOULD BE SUPPORTED AND NOT HAMPERED BY FEDERAL PROGRAM REQUIREMENTS.

Simplification is a state success story. Some of the greatest state success stories in SCHIP are about the simplifications in enrollment and renewal processes for families. As noted, nearly all states have eliminated the asset test and in-person interview requirement. Over two-thirds of all states allow mail-in applications for children, and increasing numbers accept faxed applications, take applications over the phone, or are developing electronic applications and administrative verification. The majority allow families to apply at provider locations, and a growing number permit providers and other qualified entities to determine whether children are presumptively eligible for coverage, pending a complete review by the state. Most programs also have lengthened the period between renewals to the least frequent (12 months) permitted under federal law,

thereby reducing the likelihood that children will lose coverage for failing to complete required paperwork.

New documentation requirements for citizens threaten to reverse this enrollment progress. Provisions in the Deficit Reduction Act (DRA) of 2005 require citizens to prove their identity and citizenship in order to obtain Medicaid. The regulations implementing this law include the need to present original (not photocopied) documents, a provision that particularly undermines the effectiveness of mail-in applications and the elimination of the in-person interview. In many states, the new requirements have resulted in major delays, and some states have documented a significant decline in enrollment in public coverage.

These rules directly affect SCHIP Medicaid expansion programs, which must follow federal Medicaid policy. But they also have a major impact on separate SCHIP programs. As noted earlier, most states with separate programs have one application form for both SCHIP and Medicaid. This means that any new requirements attached to Medicaid affect the application process for SCHIP-eligible children, unless the state reverses progress and develops separate applications for each program. In addition, SCHIP programs must refer children potentially eligible for Medicaid to that program, so that these children are affected. Most SCHIP directors believe the citizenship documentation requirements should be rescinded or modified substantially, and should not be applied to separate SCHIP programs.

States need tools to carry out essential outreach, enrollment, and retention activities. State experience has shown that outreach, enrollment, and retention activities are integral to effective program management in achieving the goal of insuring children. Ongoing attention to these functions is critical, as the need to reach, enroll, and retain children and families is continual. Families move in and out of state; they change jobs; their incomes fluctuate; and their access to employer sponsored insurance changes. To ensure effective ongoing strategies, state programs need access to funding, research, and best practices. To effectively manage their programs within capped funding, states need the flexibility to determine when outreach should be increased, and when slowed down. While it should not come at the expense of funding for coverage, funding for outreach is critical. For this reason, state SCHIP directors recommend that outreach funding not be subject to the current 10 percent administrative cap.

Additionally, the directors seek flexibility to implement "express lane" or "auto enrollment" systems that allow enrollment in or income determinations from certain other public programs to count as proof of eligibility for SCHIP. If accompanied by assurances that such "deeming" will not be disallowed in federal audits, such a streamlined approach holds great promise for improving enrollment and retention.

State flexibility in specific areas of program design has been an important component of SCHIP's success and should be supported and enhanced.

4. STATE FLEXIBILITY WAS PART OF SCHIP'S DESIGN AND HAS CONTRIBUTED TO ITS WIDE BASE OF SUPPORT.

The state flexibility that was an integral part of the SCHIP program's design has been key to its success. States have tailored marketing, enrollment, benefits, service delivery systems and other key features of their programs to the circumstances and culture of their states. This state tailoring has led to broad based support at the state and national levels. State directors believe maintaining such flexibility is vital to the continued support and success of SCHIP.

More flexibility to coordinate with private coverage could meet more of children's needs. State SCHIP directors are very concerned with the erosion in employer-based coverage, as well as market trends toward limited-benefit health insurance products that may not address children's needs for preventive developmental services. Additionally, directors are keenly aware of substantial unmet service needs, particularly in the areas of oral health and mental health benefits. The directors would like to have more options to help families keep children and youth enrolled in the private market and have critical health needs met.

One option is providing assistance to families in paying private coverage premiums. While the SCHIP law does allow states to provide such premium assistance, numerous programmatic and administrative requirements make it very difficult to operate a successful and cost-effective program. In 2005, most of the states which had premium assistance programs paid for by SCHIP funds did so through federal waivers; no separate state SCHIP program operated a premium assistance program under a state plan.

States also would like the option to provide benefits that often are not covered for children enrolled in private plans. This could be accomplished by amending the definition of "targeted low income child" to include children with creditable but less-than-comprehensive coverage, or by allowing states to offer supplemental benefits for children with private coverage that does not include important services, such as dental, mental health, vision, hearing, or prescription drugs. Another option would be to allow states to offer supplemental benefits as a health services initiative, but as a category that is exempt from the 10 percent cap.

Flexibility to set income standards and methodologies appropriate for state circumstances should be maintained. When the federal legislation authorizing SCHIP was first enacted, only eight states provided coverage for children above the levels mandated under Medicaid (133 percent FPL for children under age 6; 100 percent FPL for children ages 6 – 18). Today, all but six states provide coverage for children in families with income up to 200 percent FPL, and over one-third of all states provide coverage at incomes above that level. The varying eligibility levels reflect variations in family income, cost of living, and health care costs across states. As experience with SCHIP has matured and the cost of health insurance has risen, states are finding that private group and individual health insurance coverage is unavailable or unaffordable even for many more moderate-income families. States also are finding that covering children at higher income levels is proving to be an effective strategy to reach eligible but unenrolled children at lower income levels.

Policies announced by CMS during 2007 and 2008, including the August 17, 2007 directive addressing substitution of public for private coverage, have created significant roadblocks to state efforts to ensure that more uninsured children have access to affordable coverage. While SCHIP directors agree that preventing substitution of coverage is a worthwhile goal, the anti-crowd out measures imposed by the August 17 directive are not grounded in an evidentiary base and were not developed in consultation with states. Most SCHIP directors believe that the August 17 directive should be rescinded; that state flexibility to adopt income standards and methods that best fit state circumstances and achieve federal program purposes should be maintained; and that states and the federal government should work together to examine and develop effective strategies for reducing crowd out of private coverage as public coverage is expanded.

5. STATES SHOULD BE SUPPORTED IN THEIR EFFORTS TO IMPROVE PROGRAM PERFORMANCE AND PROMOTE ACCESS TO QUALITY CARE.

The federal-state partnership is the foundation for program improvement. States are committed to effective program management and accountability, operating within the capped funding and program flexibility of SCHIP. The SCHIP statute provides a good framework for state reporting, and states worked cooperatively with the federal government to develop a standard reporting format which has been improved over time. States also worked with the federal government to develop core performance measures to be reported on a voluntary basis. While standard performance measures raise challenging technical and resource issues, within two years a majority of states were reporting on all four core measures. Beginning in FY 2006, states also now report on quality improvement initiatives.

States are implementing quality improvement strategies tailored to their states' systems. States also have implemented various policies to ensure that program participants have access to quality care. These strategies differ by state, and by delivery system: managed care, Primary Care Case Management (PCCM)-based, and fee-for-service. Most SCHIP programs that deliver services through managed care systems consider factors related to access and quality when selecting contractors; have contract provisions, including cultural and linguistic requirements that promote access to quality care; and monitor contractor performance to ensure that program expectations are met. Many of these programs also use program performance data to help participants make a choice of health plans, produce public reports on health plan performance, and conduct quality improvement projects. PCCM-based programs use various reimbursement and provider requirements strategies to promote access. To ensure quality, programs with PCCM-based systems may conduct enrollee surveys to assess access and quality. States with fee-for-service based systems have adopted a variety of strategies to improve quality as well – e.g., surveying participants to gather information about access and quality and promoting medical homes.

Federal oversight is overly focused on payment errors, draining state resources. Recent new federal requirements under the Payment Error Rate Measurement (PERM) system have directed limited administrative resources and state focus toward measuring errors. State directors believe that program

accountability should continue to focus on performance in reaching and enrolling eligibles, reducing numbers of uninsured, and improving access and outcomes, and not disproportionately on the burdensome and bureaucratic federal payment error measurement system.

PERM has not been implemented through a federal-state partnership approach. Methods were not developed in consultation with SCHIP directors, and have been implemented with little advance notice or technical assistance. As currently structured, PERM represents a significant administrative burden on state SCHIP programs, which is further exacerbated in the current fiscal climate. States have received conflicting and confusing guidance from the Centers for Medicare and Medicaid Services (CMS) and its Regional Offices. Auditors often are unfamiliar with program rules and policies established for SCHIP programs. Definitions of errors often are inconsistent with, and threaten to undermine, progress made in simplifying the program. The rules also do not provide adequate adjustment for services provided in a capitated versus a fee-for-service environment.

SCHIP directors believe that in implementing PERM, CMS has used a bureaucratic hammer in an area where significant problems have not been documented, and implementation has been burdensome and expensive. In the case of SCHIP, which has an administrative cost cap, the resources that must be devoted to PERM audits take away from administrative efforts in outreach, enrollment, quality measurement, and improvement. The costs of PERM audits should be 100 percent federally-funded and outside the 10 percent administrative cap. PERM reviews also should be temporarily suspended and CMS should be required to revisit the PERM implementation requirements, in consultation with state SCHIP directors, and to issue clear, uniform guidance to all states. The different incentives in capitated versus fee-for-service environments should be taken into account in the guidance. CMS also should be prohibited from requiring a uniform sampling

platform, as has been required. States included in the 2007 or 2008 reviews should not be penalized for high error rates found as a result of a faulty PERM review process.

States want assistance to strengthen measurement and improve performance and quality. State directors found the federal technical assistance for SCHIP performance measurement that was provided for several years to be very important in helping states develop and improve reporting of core performance measures. Technical assistance, which was discontinued, should be reinstated; the federal-state partnership for performance measurement needs to be renewed. The directors also believe the federal government should strengthen leadership and resources for working in partnership with states to review and develop optional new child health quality measures. These measures should be relevant to and used not only by SCHIP, but also by Medicaid and other programs which fund or provide health services for children. Currently, standard measures are not available, and federal agencies do not have a well-funded or coordinated effort in place to develop them. State SCHIP directors are ready and interested in working with other state and federal partners and experts to develop strategies to improve measurement of child health care quality.

CONCLUSION

State SCHIP directors are committed to working with federal and state policymakers, the private sector, advocates, and other key stakeholders to promote successful reauthorization of the SCHIP program. SCHIP has been resoundingly successful over the past decade in providing coverage to uninsured children, and reauthorization that provides sufficient, stable, and predictable funding and retains and expands the kinds of flexibility that have contributed to SCHIP's success is essential. For more information about state SCHIP programs, go to www.chipcentral.org, or call NASHP at 202-903-0101.

NATIONAL ACADEMY for STATE HEALTH POLICY

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Acknowledgments: This briefing, originally written by Catherine Hess to reflect the views expressed by SCHIP directors through a process described in the paper, was updated in 2009 by Sarah deLone and Catherine Hess, again working with the SCHIP directors. NASHP wishes to acknowledge the SCHIP Reauthorization Workgroup and many other SCHIP directors' contributions to the content of this briefing.

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Citation

Catherine Hess and Sarah deLone, *Reauthorizing SCHIP: Principles, Issues and Ideas from State Directors* (Portland, ME: National Academy for State Health Policy, January 2009)



NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

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

Date: January 30, 2009

Subject: State Children's Health Insurance Program (CHIP)

Thomas,

I have compiled some information regarding your questions about the State Children's Health Insurance Program and have included additional resources. At the end of this document, you will find summaries of enacted state legislation that you may find helpful. Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

-
1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review.

At least one other state has introduced legislation (as of January 27, 2009) to increase SCHIP eligibility.

North Dakota
2009 Senate Bill 2362

<http://www.legis.nd.gov/assembly/61-2009/bill-text/JAVD0300.pdf>

Directs the Department of Human Services to establish a buy-in program through which a parent/guardian whose family net income exceeds 250 percent of the federal poverty guidelines

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

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Website www.ncsl.org

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may purchase, on a sliding income scale, a plan of coverage for a child who is uninsured. The bill also would increase the net income eligibility from 150 percent to 250 percent of the federal poverty guidelines. In addition, the bill would direct the Department of Health to seek a federal waiver to increase the income eligibility level to 350 percent of the federal poverty guidelines.

The bill also would establish the children's health insurance program advisory committee.

In previous sessions, many other states have also increased eligibility levels. Please see the list of state examples at the end of this document for the links to such legislation.

In addition, you may also view this information on NCSL's Children's Health Reform webpage: <http://www.ncsl.org/programs/health/kidsins.htm>

2. Are asset tests, payments, and co-payments common, and are other matters of eligibility other than income and household size under federal poverty guidelines codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits? Are other states allowing payments of premiums or co-payments by those seeking income eligibility over 200% and not over 250% FPG?

As of January 2009, 46 states and the District of Columbia do not require an asset test for children's health coverage.

Sources:

- ◆ 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
<http://www.kff.org/medicaid/upload/7855.pdf>
Kaiser Commission on Medicaid and the Uninsured, January 2009
- ◆ See also Kaiser State Health Facts:
<http://www.statehealthfacts.org/comparetable.jsp?ind=228&cat=4>

Under provisions of the Deficit Reduction Act of 2005, 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. SCHIP programs that are Medicaid expansions are subject to the same cost sharing rules as Medicaid, but states with separate stand-alone SCHIP programs have more flexibility in imposing cost sharing.

Ten states—Alabama, Arizona, California, Delaware, Florida, Georgia, Idaho, Nevada, Tennessee, and Utah—impose premiums on children in families with income below 150 percent of the federal poverty guidelines, and they can do so because they operate separate SCHIP programs or because they have a federal waiver to do so for their Medicaid population. As of January 2008, 26 states charge premiums at an income level over 150 percent of the federal

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poverty guidelines, 29 states at 200 percent of the federal poverty guidelines and 19 states at 201 percent of the federal poverty guidelines.

Sources:

- ◆ Cost Sharing for Children and Families in Medicaid and SCHIP
http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/cost_sharing_final.pdf
Center for Children and Families, Georgetown University Health Policy Institute, September 2008
- ◆ Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008
<http://www.kff.org/medicaid/upload/7740.pdf>
Kaiser Commission on Medicaid and the Uninsured, January 2008

Additional resources:

- ◆ Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences
<http://www.kff.org/medicaid/7322.cfm>
Kaiser Commission on Medicaid and the Uninsured, May 2005
- ◆ The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings
<http://www.cbpp.org/5-31-05health2.pdf>
Center on Budget and Policy Priorities, July 7, 2005.

Please see the state examples at the end of this document for links to legislation that define cost-sharing requirements. Additional state examples can be found on NCSL's Children's Health Reform webpage: <http://www.ncsl.org/programs/health/kidsins.htm>

At least one state, **Colorado**, has cost sharing requirements, but does not specify the cost sharing structure in statute. Instead, the act directs the Colorado Health Department to design and implement a structure of premiums and co-payments. In addition, at least two states—**Louisiana and Washington**—specifically require cost sharing between 200 percent and 250 percent of the federal poverty guidelines.

3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.

The following summary describes the SCHIP eligibility guidelines that states have enacted through legislation. However, these eligibility guidelines may not be implemented in all states.

As of January 1, 2009, five states—Alaska, Idaho, Nebraska, North Dakota and Oregon—have enacted eligibility levels for children below 200 percent of the federal poverty guidelines. Forty-

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five states and the District of Columbia have enacted eligibility levels for children with a family income of 200 percent of the federal poverty guidelines or greater. Sixteen states have enacted eligibility levels for children at 200 percent of the federal poverty guidelines. Twenty-six states and the District of Columbia have enacted eligibility levels between 200 and 300 percent of the federal poverty guidelines. Three states—Massachusetts, New Jersey and New York—have enacted eligibility levels above 300 percent of the federal poverty guidelines.

These eligibility levels may not be implemented in all states due to a variety of reasons; for example, the legislation may specify an effective date that is in the future, or the state plan amendment has been denied or is under review by the Centers for Medicaid and Medicare Services. For example, in Colorado, the enacted expansion of SCHIP eligibility to 225 percent of the federal poverty guidelines is anticipated to be implemented in July 2009, but this may be delayed due to the state's budget shortfall.

For more information:

- ◆ Eligibility Levels in Medicaid & SCHIP for Children, by State as of January 1, 2009
Center for Children and Families at Georgetown University Health Policy Institute
http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/eligibility_expansions_by_state.pdf

In addition, some states effectively cover children whose family incomes are above the established eligibility limit of the state's SCHIP program by using income disregards. When determining eligibility, these states do not count certain portions of earnings from a working family's income (e.g., such as earnings used to cover the cost of child care). As of January 2008, SCHIP eligibility levels in 22 states and the District of Columbia are effectively greater than 250 percent of the federal poverty guidelines, and in 16 states eligibility levels are effectively between 200 percent and 250 percent of the guidelines. Six states have set eligibility levels at 200 percent of the federal poverty guidelines, and six are below 200 percent of the federal poverty guidelines.

Source:

- ◆ President's FY 2009 Budget and SCHIP, February 2008
<http://www.kff.org/medicaid/upload/7758.pdf>

For more information about income disregards and how states use them in Children's Medicaid and SCHIP:

- ◆ Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP
Kaiser Family Foundation, May 2008
<http://www.kff.org/medicaid/upload/7776.pdf>

See also Kaiser Family Foundation's State Health Facts:

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- ◆ Income Disregards in Children's Separate SCHIP Programs, 2008
<http://www.statehealthfacts.org/comparetable.jsp?ind=630&cat=4>
- ◆ Income Disregards in Children's Medicaid Programs, 2008
<http://www.statehealthfacts.org/comparetable.jsp?ind=627&cat=4>

4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

For more information about the SCHIP Reauthorizations bills before Congress, please visit the following NCSL webpage:

<http://www.ncsl.org/statefed/health/SCHIPreauth.htm>

House Majority Leader Hoyer has stated the House will accept the Senate version of the SCHIP reauthorization bill next week, clearing the bill for President Obama's signature.

If you have additional questions about this federal legislation, please contact the following NCSL staff:

Joy Johnson Wilson, Health Policy Director at 202-624-8689 or joy.wilson@ncsl.org
or Rachel Morgan RN, BSN, Senior Health Policy Specialist at 202-624-3569 or rachel.morgan@ncsl.org.

Additional NCSL Resources:

- ◆ SCHIP overview webpage: <http://www.ncsl.org/programs/health/chiphome.htm>
- ◆ SCHIP Frequently Asked Questions: <http://www.ncsl.org/print/health/forum/SCHIPFAQ.pdf>
- ◆ SCHIP Reauthorization: <http://www.ncsl.org/statefed/health/SCHIPreauth.htm>
- ◆ State Children's Health Reform: <http://www.ncsl.org/programs/health/kidsins.htm>
- ◆ *What's Up With SCHIP?* LegisBrief, August/September 2008:
http://www.ncsl.org/legis/lbriefs/2008/08lbaugsep_schip.pdf

State Examples of Enacted Legislation

For more information about these states, please visit NCSL's Children's Health Reform webpage at:

<http://www.ncsl.org/programs/health/kidsins.htm>

Colorado

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2008 Senate Bill 160

http://www.leg.state.co.us/clics/clics2008a/csl.nsf/fsbillcont3/EE9D222D73A97EF68725736300812716?open&file=160_enr.pdf

Increases SCHIP eligibility from 205 percent of the federal poverty guidelines to 225 percent of the federal poverty guidelines; the law allows that if funding is available, the eligibility level can be raised to 250 percent of the federal poverty guidelines. In addition the law stipulates that it is among the duties of the Health Department to design and implement a structure of premiums and co-payments.

Connecticut

2007 Senate Bill 1484

<http://www.cga.ct.gov/2007/ACT/Pa/pdf/2007PA-00185-R00SB-01484-PA.pdf>

Increased the HUSKY (SCHIP) program eligibility level from 300 percent federal poverty level to 400 percent federal poverty level.

District of Columbia

Fiscal Year 2007 Budget Support Act of 2006

<http://www.dccouncil.washington.dc.us/images/00001/20060727152635.pdf>

Expands Medicaid/SCHIP eligibility to 300 percent federal poverty guidelines. CMS approved the expansion in March and the expansion was implemented starting in June 2007.

Indiana

2008 House Bill 1678

<http://www.in.gov/legislative/bills/2007/HE/HE1678.1.html>

Increases SCHIP eligibility for children in families with incomes up to 300 percent federal poverty level. In May 2008, CMS approved the expansion of eligibility to only 250 percent federal poverty level. The expansion to increase eligibility to 250 percent of the federal poverty level was implemented beginning October 1, 2008.

Iowa

2008 House File 2539

<http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=billbook&GA=82&hbill=HF2539>

Increases SCHIP eligibility from 200 percent of the federal poverty guidelines to 300 percent of the federal poverty guidelines. Establishes cost sharing guidelines for children whose family income is 150 percent to 200 percent of the federal poverty guidelines; and for families with incomes between 200 and 300 percent of the federal poverty guidelines. The expansion is expected to be effective as of July 1, 2009.

Kansas

2008 Senate Bill 81

<http://www.kslegislature.org/bills/2008/81.pdf>

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Increases SCHIP eligibility from 200 percent of the federal poverty level to 225 percent of the federal poverty guidelines in 2009 and, finally, to 250 percent of the federal poverty guidelines in 2010, subject to appropriations. The law establishes cost sharing provisions on a sliding scale basis

Louisiana

2007 House Bill 542

<http://www.dhh.louisiana.gov/offices/miscdocs/docs-119/Act407.pdf>

Created the Louisiana Children and Youth Health Insurance Program, expanding Louisiana's SCHIP program, LaCHIP. The act aims to expand eligibility to children in families with incomes up to 300 percent federal poverty level from the former eligibility threshold of 200 percent federal poverty level. A request for approval of the plan was submitted to CMS in September 2007. In February 2008, CMS approved the expansion of eligibility to only 250 percent federal poverty level. The coverage under this expansion will be provided through the State Group Benefits program, which also provides insurance to state government employees. Families will contribute premiums (approximately \$50), co-payments and deductibles.

Montana

2007 Senate Bill 22

<http://data.opi.mt.gov/bills/2007/billpdf/SB0022.pdf>

Increased the SCHIP eligibility level for children in families with income up to 175 percent of federal poverty guidelines--from the current level of 150 percent--provided there is funding available.

New York

2007 Senate Bill 2108

The state budget included an SCHIP eligibility level increase from 250 percent of the federal poverty guidelines up to 400 percent of the federal poverty guidelines and allowed families with incomes above 400 percent to buy-in to the program for their children. Due to the August 17 directive, CMS denied New York's request for this expansion.

<http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/NYCurrentFactsheet.pdf>

2008 Senate Bill 6808

The 2009 budget was enacted and appropriated state funds for the implementation of the expansion of the Child Health Plus program to 400 percent of the federal poverty guidelines. This expansion was implemented beginning September 1, 2008.

Pennsylvania

2006 Senate Bill 1192

<http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2005&sessInd=0&billBody=S&billTyp=B&billNbr=1192&pn=1734>

Expanded CHIP coverage from 200 percent of the federal poverty guidelines to 300 percent of the federal poverty guidelines with premiums based on a sliding income scale, ranging from \$36

January 30, 2009

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to \$57 per child per month. The expansion was approved by CMS in February and the program began implementation in March 2007.

South Carolina

2007 House Bill 3620

http://www.scstatehouse.gov/sess117_2007-2008/appropriations2007/tap1b.htm

A provision in the 2007-2008 budget passed the state legislature and creates a separate State Children's Health Insurance Program, Healthy Connections Kids, that expands eligibility to children with family incomes up to 200 percent of the federal poverty level. This provision was vetoed by the Governor, but the legislature overrode the veto.

West Virginia

2006 House Bill 4021

http://www.legis.state.wv.us/Bill_Text_HTML/2006_SESSIONS/RS/BILLS/HB4021%20ENR.htm

Expanded SCHIP eligibility up to 300 percent of the federal poverty guidelines. In January 2007, the state began enrolling children with incomes up to 220 percent of the federal poverty level. Families with income between 200 and 220 percent of the federal poverty level will be required to pay premiums based on a two-tier system. Families with one child will pay a monthly premium of \$35 and families with two children or more will pay \$71 per month. Due to the failure of SCHIP reauthorization, the expansion to 300 percent of the federal poverty level was delayed.

http://www.kaisernetwork.org/Daily_reports/print_report.cfm?DR_ID=38314&dr_cat=3

An expansion from 220 percent to 250 percent of the federal poverty guidelines went into effect January 1, 2009.

<http://www.wvchip.org/chipnotes.shtml>

Wisconsin

2007 Senate Bill 40

<http://www.legis.state.wi.us/2007/data/SB-40.pdf>

Expands SCHIP eligibility to families with incomes up to 300 percent of the federal poverty guidelines. Due to the August 2007 CMS directive, state-only funds will be used to finance coverage for children with family incomes between 250 and 300 percent of the federal poverty guidelines. Under the BadgerCare Plus program, Wisconsin's SCHIP program, families with annual incomes between 200 percent and 300 percent of the federal poverty level are eligible for health coverage for their children and will be required to pay premiums (approximately \$10 to \$90.74 per month).

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148



Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
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Toll free: (800) 770-3822

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

Senator Betty 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 the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL) and makes health insurance accessible to an estimated 1300 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an "enhanced" reimbursement program with up to 70% matching funds 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.

Increasing Alaska Denali KidCare to 200% FPL only funds it to the level at which it was established 10 years ago. 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, enrollment fees, or co-payments for selected services in SCHIP programs on a sliding scale of FPL.

Denali KidCare serves an estimated 7600 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. Alaska should do its share by insuring its low income children and participating in Denali KidCare at 200% FPL under SB 13.



NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

Joe Hackney
Speaker
North Carolina House of Representatives
President, NCSL

To: The Honorable Betty Davis
Alaska Senate

Gary VanLandingham
Director, OPPAGA
Florida Legislature
Staff Chair, NCSL

From: Jennifer Saunders
Health Program
303-856-1440
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

February 11, 2009

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CRS Report for Congress, January 25, 2007

http://assets.opencrs.com/rpts/RS22578_20070125.pdf

The following document by the Centers for Medicare and Medicaid Services (CMS) also summarizes these Medicaid requirements and you may find the "Important Links" on the bottom of page 2 helpful.

See the CMS document here:

<http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf>

For more general information about cost sharing and SCHIP, please see the following CMS website:

http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp

(Scroll down to see the information under the heading "Cost Sharing.")

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

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

Best regards,
Jennifer Saunders

Thomas Obermeyer

From: Jennifer Saunders [jennifer.saunders@ncsl.org]
Sent: Thursday, February 05, 2009 10:03 AM
To: Thomas Obermeyer; Lynda Zaugg
Cc: Martha King; Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Yes, the following Kaiser report indicates that 7 states have SCHIP eligibility levels below 200 percent of the federal poverty guidelines (FPG):

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

<http://www.kff.org/medicaid/7855.cfm>

(See page 10, Figure 1.)

The 7 states are:

Alaska	175 percent FPG
Idaho	185 percent FPG
Montana	175 percent FPG
Nebraska	185 percent FPG
North Dakota	150 percent FPG
Oklahoma	185 percent FPG*
Oregon	185 percent FPG

* Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115 waiver. However, the currently proposed expansion has been scaled back to 217 percent of the federal poverty line and the future expansion of 218 percent to 300 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

Sources:

Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009

<http://statehealthfacts.org/comparemaptable.jsp?ind=203&cat=4>

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009

<http://statehealthfacts.org/comparemaptable.jsp?ind=204&cat=4>

Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?

If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
 Research Analyst
 Health Program
 National Conference of State Legislatures

7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----

From: Thomas Obermeyer

To: Jennifer Saunders

Cc: Lynda Zaugg

Sent: Wednesday, February 04, 2009 9:26 PM

Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Jennifer,

In reviewing one of your recommended web sites, the Kaiser Commission on Medicaid and the Uninsured, January 2009 reported that only 7 states, apparently including Alaska, are below 200% FPL. Can you tell me which are the other 6 states?

Tom Obermeyer
Office of Senator Davis
907-465-3762

From: Jennifer Saunders [<mailto:jennifer.saunders@ncsl.org>]

Sent: Wednesday, February 04, 2009 8:31 AM

To: Thomas Obermeyer

Subject: Fw: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Hi Thomas,

I wanted to follow up with you to check that you received the information about SCHIP that I sent you last week.

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures
7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----

From: Jennifer Saunders

To: Thomas Obermeyer
Cc: jennifer breshears ; Martha King ; Senator_Bettye_Davis@legis.state.ak.us ;
Lynda_Zaugg@legis.state.ak.us ; Don_Burrell@legis.state.ak.us
Sent: Friday, January 30, 2009 2:05 PM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time
(3:30-5:00pm Mtn time)

Thomas,

In the attached document, I have compiled some information regarding your questions about the State Children's Health Insurance Program and have included additional resources. At the end of the document, you will find summaries of enacted state legislation that you may find helpful. Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
Research Analyst
Health Program
National Conference of State Legislatures
7700 East First Place
Denver, CO 80230
303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----

From: Martha King
To: Thomas Obermeyer
Cc: jennifer saunders ; jennifer breshears
Sent: Tuesday, January 27, 2009 9:41 AM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time
(3:30-5:00pm Mtn time)

Greetings Thomas!

We're happy to provide the information you've requested in your email and to participate by phone on February 9th, if you continue to think we could be helpful. I am asking the two NCSL staff named in the cc line to work on the specifics you've asked for and we will be getting back to you as soon as possible.

In the meantime, please give our regards to Senator Davis & stay warm up there! martha

----- Original Message -----

From: Thomas Obermeyer
To: martha.king@ncsl.org
Cc: Sen. Bettye Davis ; Lynda Zaugg ; Don Burrell
Sent: Monday, January 26, 2009 2:48 PM
Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK
Time (3:30-5:00pm Mtn time)

January 26, 2009

Martha King, Group Director,
Health Programs, NCSL - Denver
303-364-7700 main line

303-364-7800 fax
303-856-1448 – direct line
E-mail: Martha.king@ncsl.org

RE: Request for:

- A) review and comments concerning Alaska Senate Bill 13 (attached), and
- B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time).
Call in number is 888-295-4546

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13**, 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) **to 200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments . You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us



United States Department of
Health & Human Services

• [Frequent Questions](#)

THE 2009 HHS POVERTY GUIDELINES

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

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

Handwritten: Bank of SB 13

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

- The poverty thresholds, and
- The poverty guidelines.

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

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

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

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

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

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

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

2009 Poverty Guidelines for Alaska

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

2009 Poverty Guidelines for Hawaii

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

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

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

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

Last Revised: January 23, 2009

[The White House | USA.Gov](http://www.whitehouse.gov)

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

2008 POVERTY LEVEL GUIDELINES									
ALASKA									
Income Guidelines as Published in the Federal Register on January 23, 2008									
ANNUAL GUIDELINES									
FAMILY SIZE	PERCENT OF POVERTY								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,000.00	15,600.00	17,290.00	17,550.00	19,500.00	22,750.00	24,050.00	26,000.00	32,500.00
2	17,500.00	21,000.00	23,275.00	23,625.00	26,250.00	30,625.00	32,375.00	35,000.00	43,750.00
3	22,000.00	26,400.00	29,260.00	29,700.00	33,000.00	38,500.00	40,700.00	44,000.00	55,000.00
4	26,500.00	31,800.00	35,245.00	35,775.00	39,750.00	46,375.00	49,025.00	53,000.00	66,250.00
5	31,000.00	37,200.00	41,230.00	41,850.00	46,500.00	54,250.00	57,350.00	62,000.00	77,500.00
6	35,500.00	42,600.00	47,215.00	47,925.00	53,250.00	62,125.00	65,675.00	71,000.00	88,750.00
7	40,000.00	48,000.00	53,200.00	54,000.00	60,000.00	70,000.00	74,000.00	80,000.00	100,000.00
8	44,500.00	53,400.00	59,185.00	60,075.00	66,750.00	77,875.00	82,325.00	89,000.00	111,250.00
For family units of more than 8 members, add \$4,500 for each additional member.									
MONTHLY GUIDELINES									
FAMILY SIZE	PERCENT OF POVERTY								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,083.33	1,300.00	1,440.83	1,462.50	1,625.00	1,895.83	2,004.17	2,166.67	2,708.33
2	1,458.33	1,750.00	1,939.58	1,968.75	2,187.50	2,552.08	2,697.92	2,916.67	3,645.83
3	1,833.33	2,200.00	2,438.33	2,475.00	2,750.00	3,208.33	3,391.67	3,666.67	4,583.33
4	2,208.33	2,650.00	2,937.08	2,981.25	3,312.50	3,864.58	4,085.42	4,416.67	5,520.83
5	2,583.33	3,100.00	3,435.83	3,487.50	3,875.00	4,520.83	4,779.17	5,166.67	6,458.33
6	2,958.33	3,550.00	3,934.58	3,993.75	4,437.50	5,177.08	5,472.92	5,916.67	7,385.83
7	3,333.33	4,000.00	4,433.33	4,500.00	5,000.00	5,833.33	6,166.67	6,666.67	8,333.33
8	3,708.33	4,450.00	4,932.08	5,006.25	5,562.50	6,489.58	6,860.42	7,416.67	9,270.83

The Alaska Health Care Strategies Planning Council
Final Report: Summary and Recommendations
December 23, 2007

What should be done about it: *More Alaskans need to be covered by efficient health insurance plans. Increasing the number of Alaskans covered by efficient health insurance will be the result of several specific actions. In the short-term, the Council recommends that the state immediately pursue and support change in the Denali KidCare program to make Alaskan children in families at 200% of the federal poverty level eligible for coverage. While there was a majority vote among Council members regarding this expansion of Denali KidCare coverage, the role of that program within an efficient and effective system of health care coverage is worthy of continued debate at the statewide level, through the recommended "Alaska Health Care Commission."*

To most effectively cover the adults and remaining children without health insurance, bringing consumerism to the forefront of Alaska's health insurance structure is important. Alaskans should have access to choices, through a wide range of health insurance options, including at the very least high deductible coverage with a strong prevention component. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. Whereas some uninsured Alaskans are not working, most are working for employers who would like to, but cannot necessarily afford to, provide health insurance coverage for their employees. Therefore, through incentives, Alaskan employers should be encouraged to offer a wide range of coverage choices, to include at a minimum, high deductible coverage.

washingtonpost.com

Senate Passes Health Insurance Bill for Children

Immigrant Clause Opens Rift

By Ceci Connolly
Washington Post Staff Writer
Friday, January 30, 2009; 9:24 AM

The Senate overwhelmingly approved legislation yesterday to provide health insurance to 11 million low-income children, a bill that would for the first time spend federal money to cover children and pregnant women who are legal immigrants.

The State Children's Health Insurance Program, which is aimed at families earning too much money to qualify for Medicaid but not enough to afford private insurance, currently covers close to 7 million youngsters at a cost of \$25 billion.

Lawmakers voted 66 to 32, largely along party lines, to renew the joint state-federal program and spend an additional \$32.8 billion to expand coverage to 4 million more children. The expansion would be paid for by raising the cigarette tax from 39 cents a pack to \$1.

The House approved similar legislation on Jan. 14, and President Obama is expected to sign a final version as early as next week.

During the presidential campaign, Obama pledged to provide coverage to every American child. Experts estimate that once the program is fully implemented about 5 million youngsters will remain uninsured.

In a statement released this morning, Obama praised the Senate's action as the "worsening economy causes families to lose their jobs and health insurance." He added, "Providing health care to more than ten million children through the Children's Health Insurance Program will serve as a down payment on my commitment to ensure that every American has access to quality, affordable health care."

Democratic lawmakers, noting that President George W. Bush twice vetoed similar legislation, praised the vote as evidence of the changing Washington landscape.

"Low-income, uninsured kids all across America have been waiting for Congress to fulfill the promise of the Children's Health Insurance Program for them," said Senate Finance Committee Chairman Max Baucus (Mont.). The program "works to get low-income, uninsured kids the doctor's visits and medicines they need to stay healthy, and approval of this bill opens the door of the doctor's office to millions of children who live without proper health care today."

But the political victory may come at a price. The rancorous debate -- on a program that once basked in bipartisan popularity -- raised doubts about whether the two parties can unite to pass broader health reform later this year, several moderate Republicans said.

"This is a very unfortunate beginning," said Sen. Charles E. Grassley (Iowa). The top Republican on the Senate Finance Committee, a stalwart supporter of the program, said he was "disgusted" by the way

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Democratic leaders handled the debate. "It does not bode well for cooperative work in the coming months," he said. But Grassley emphasized that he did not blame Baucus for the change in substance and style.

As the vote came just one day after the House passed an \$819 billion economic stimulus package without a single Republican vote, some longtime lawmakers questioned the president's ability to forge a new era of cooperation in the capital.

"If they wanted a nice signing ceremony that showed bipartisanship and carried through on the president's language, this would have been a good vehicle to do it on," said Sen. Judd Gregg (R-N.H.).

Since its creation in 1997 under a Republican-led Senate, the children's health program has received broad bipartisan support.

"Few government programs in our time have enjoyed such great success, as acknowledged by members of both parties and all bipartisan health-care experts," said Senate Majority Leader Harry M. Reid (D-Nev.).

Governors, business executives and consumer advocates lobbied for the expansion, arguing that more and more families have sought the assistance in this weakened economy.

"During this economic turmoil, it is critical that we maintain and strengthen this important lifeline to our nation's children and that we help financially strapped states respond to the growing need for affordable health-care coverage," said Cindy Mann, executive director of Georgetown University's Center for Children and Families.

In 2007, prominent Republicans such as Grassley and Sen. Orrin G. Hatch (Utah) bucked Bush to support renewal of the program.

"We carried a lot of water and took a lot of flak" for that stand, Hatch said. To push through a different version now is "not only unfair," he said, "but a slap in the face to those of us who worked so strongly with our friends on the other side."

The bill approved last night closely resembles the versions many Republicans supported in the past, countered Democrats.

GOP lawmakers objected to the new provision allowing states to enroll certain legal immigrants. Until now, many immigrants' families have been forced to wait five years for coverage.

"The bottom line is: This is a debate about children's health coverage," said Sen. Richard J. Durbin (D-Ill.). "This is not a debate about immigration."

In more than two days of debate -- in unusually personal and emotional language -- Republicans expressed a sense of betrayal that Democrats had dropped the 2007 compromise.

"We could have had 95 votes," Hatch said. "That would have sent a tremendous, tremendous message that hasn't been sent around here for a long time."

Both sides had hoped, and even predicted, that early bipartisan action on children's coverage would demonstrate that Washington's elected officials can cooperate on critical issues such as health care.

"This is on something for which there is so much agreement and something that almost no one argues about," said Helen Darling, president of the National Business Group on Health, which represents 300 large employers. "For the tough things like real national health-care reform, it unfortunately portends a really rocky road."

Compared to the daunting task of overhauling the entire U.S. health system, the debate on the children's health program should have been easy, said Sen. Olympia J. Snowe (R-Maine).

"You would have thought this issue would have been clear sailing on both sides," she said.

Karen Ignagni, president of America's Health Insurance Plans, agreed that "we're not seeing bipartisanship" but said she is optimistic that the public's overwhelming desire for improvement in the health system will force the two parties to the bargaining table. "People are talking about how to do it as opposed to whether to do it," she said.

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[Federal Register: January 23, 2009 (Volume 74, Number 14)]
[Notices]
[Page 4199-4201]
From the Federal Register Online via GPO Access [wais.access.gpo.gov]
[DOCID:fr23ja09-64]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

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

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

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

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

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10-105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland

[[Page 4200]]

20857. To speak to a staff member, please call (301) 443-5656. To receive a Hill-Burton information package, call 1-800-638-0742 (for callers outside Maryland) or 1-800-492-0359 (for callers in Maryland). You also may visit <http://www.hrsa.gov/hillburton/default.htm>. The Division of Facilities Compliance and Recovery notes that as set by 42 CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I-864, Affidavit of Support, contact U.S. Citizenship and Immigration Services

at 1-800-375-5283.

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

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

SUPPLEMENTARY INFORMATION:

Background

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

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI-U). The guidelines in this 2009 notice reflect the 3.8 percent price increase between calendar years 2007 and 2008. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2009 guidelines are roughly equal to the poverty thresholds for calendar year 2008 which the Census Bureau expects to publish in final form in August 2009.) The guideline figures shown represent annual income.

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

Poverty

Persons in family	guideline
1.....	\$13,530
2.....	18,210
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For families with more than 8 persons, add \$4,680 for each additional person.

2009 Poverty Guidelines for Hawaii

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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.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. (Note that the Census Bureau poverty thresholds--the version of the poverty measure used for statistical purposes--have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

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

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

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census

Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definitions of such terms as ``income'' or ``family.'' This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions about how a particular program applies the poverty guidelines (for example, Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program; that organization has the responsibility for making decisions about definitions of such terms as ``income'' or ``family'' (to the extent that the definition is not already contained in legislation or regulations).

[[Page 4201]]

Dated: January 16, 2009.

Michael O. Leavitt,
Secretary of Health and Human Services.
[FR Doc. E9-1510 Filed 1-22-09; 8:45 am]

BILLING CODE 4151-05-P

303-364-7800 fax
303-856-1448 – direct line
E-mail: Martha.king@ncsl.org

RE: Request for:

- A) review and comments concerning Alaska Senate Bill 13 (attached), and
- B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time).
Call in number is 888-295-4546

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13**, 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) **to 200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments. You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas.Obermeyer@legis.state.ak.us

kaiser
commission on
medicaid
and the **uninsured**

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

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

Prepared by:

Donna Cohen Ross
Center on Budget and Policy Priorities

and

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

January 2009



Acknowledgments

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

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Executive Summary

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

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

- **States continued to make progress on improving access to health coverage, particularly for children, but several significant setbacks warn about impending problems.** One-third of states (19) increased access to health coverage, while ten states enacted at least one measure to restrict coverage. The most common restriction was imposing new or higher premiums in SCHIP, but two states also restricted eligibility. California increased the frequency of renewal, a change estimated to affect more than 260,000 children as well as large numbers of parents.
- **The economic crisis is widespread and serious healthcare cuts are looming, but the commitment to children is still strong.** States continued to enact eligibility expansions for children, and state officials in several of those states plan to go forward even though they are facing significant budget shortfalls. Federal constraints, such as the unresolved reauthorization of SCHIP and the August 17th directive, have caused some states to put expansions on hold temporarily. Others are using state funds to pay for coverage precluded by the directive.
- **Parent coverage is still more difficult to obtain than children's coverage.** The median income at which children qualify for coverage is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working parents. However, for unemployed parents, the median income eligibility for Medicaid is just 41 percent of the federal poverty line, \$601 per month for a family of three in 2008. Jobless parents who need coverage may find that unemployment payments put them over the income limit for Medicaid.
- **Outreach budgets were increased in a number of states, however, some are beginning to report that these funds are being curtailed.** Outreach, including community-based application assistance, is critical in a recession, since newly eligible families may be unfamiliar with public programs. But in light of budget shortfalls, some states expressed skepticism for conducting aggressive outreach. About half the states are using technology to implement or develop online applications and to develop more efficient enrollment and renewal systems.

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

I. Introduction

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

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

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

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

When states adopted their budgets for the state fiscal year starting July 1, 2008, they were able to include funding for children's coverage expansions. Later, the economy began to show signs of trouble, but it was not until September 2008 that the breadth and depth of the unfolding fiscal crisis became clear as financial markets collapsed and unemployment started to rise sharply. States are now facing an extremely threatening fiscal situation, with state budget shortfalls expected to total \$350 billion for the remainder of FY 2009 and through 2010 and 2011.⁴

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

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

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

However, because they were still grappling with budget shortfalls, nearly half the states put in place enrollment procedures that made it more difficult for children and parents to secure and retain health coverage between April 2003 and July 2004.⁵ Some states reported dramatic declines in children's enrollment as a result of these budget-driven changes, and children who were most likely *eligible* for existing programs became uninsured. For example, in Texas, SCHIP enrollment dropped by more than 149,000 children (a 29 percent decline), in large measure, due to reducing continuous coverage from 12 months to six months. Washington state also repealed the guarantee of 12 months of coverage and required parents to renew their child's eligibility every six months as well as report changes in the interim. This, along with other procedural changes, led to a dramatic caseload reduction of more than 40,000 children. In Wisconsin's BadgerCare program, establishing more rigorous documentation requirements resulted in an enrollment decline of 13,000 children and parents in just the first four months of implementation. Several states also froze SCHIP enrollment. In addition to turning away children who qualified for coverage under SCHIP, this strategy adversely affected Medicaid-eligible children not subject to the freeze. Eligible applicants' path to coverage was limited when states stopped taking joint Medicaid/SCHIP applications or because families mistakenly interpreted news reports to mean that all coverage programs were closed to new applicants.⁶

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

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

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.

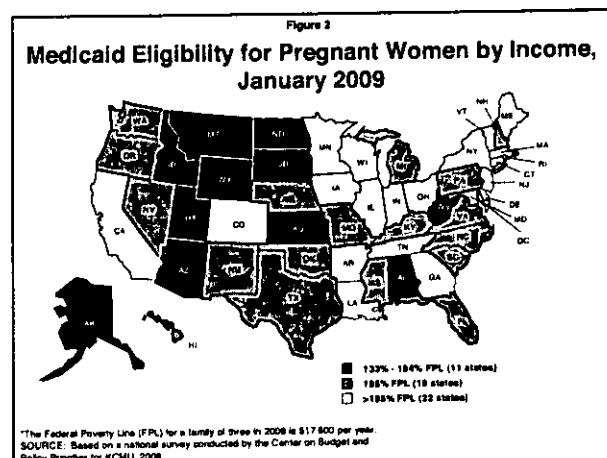
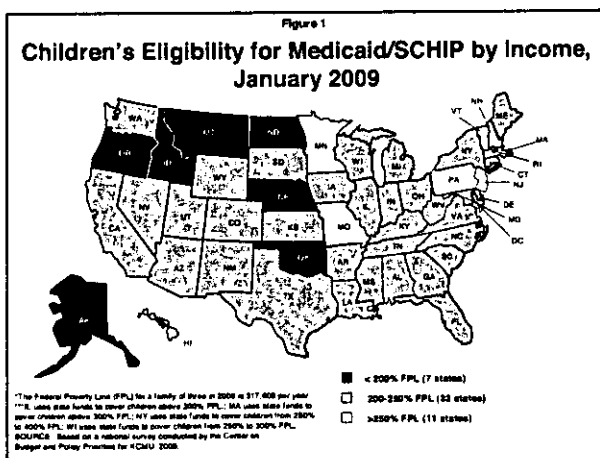
This study, the eighth annual survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, was carried out in the summer and early fall of 2008, through extensive telephone interviews with state Medicaid and SCHIP program administrators. Detailed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

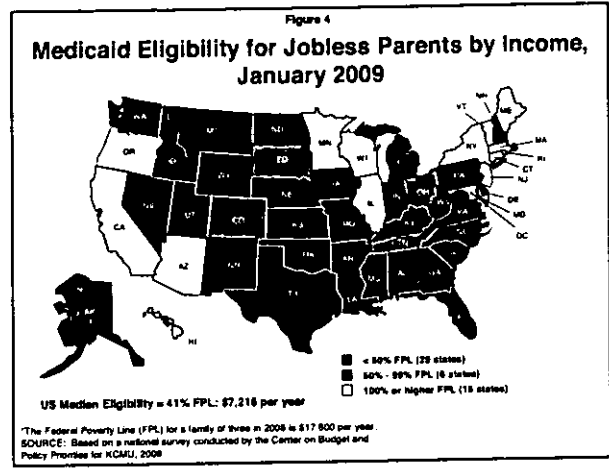
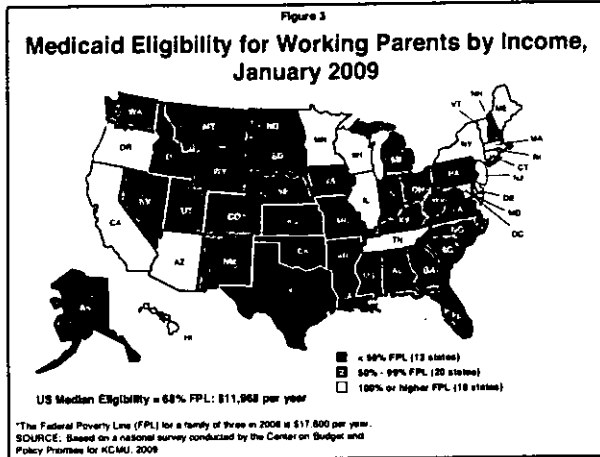
States provide health coverage for children and pregnant women under Medicaid or SCHIP as follows (Figures 1 & 2):

- 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).

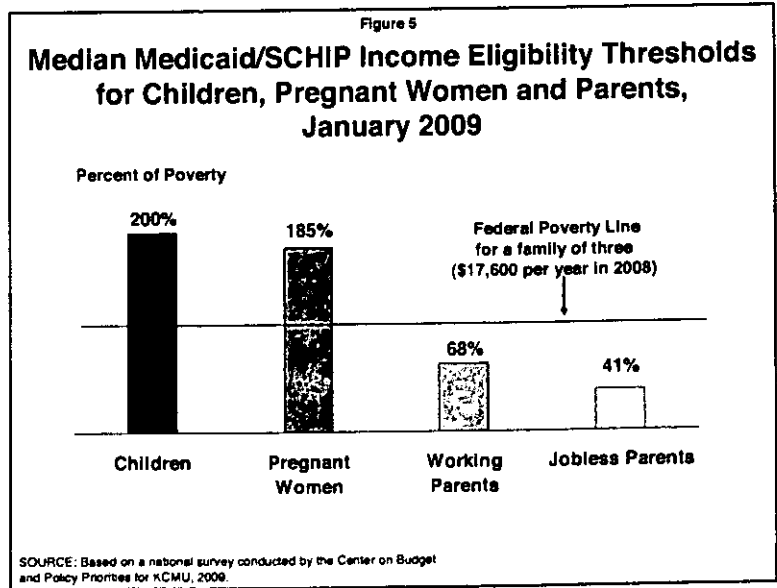


States provide health coverage for parents under Medicaid as follows (Figures 3 & 4):

- 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.



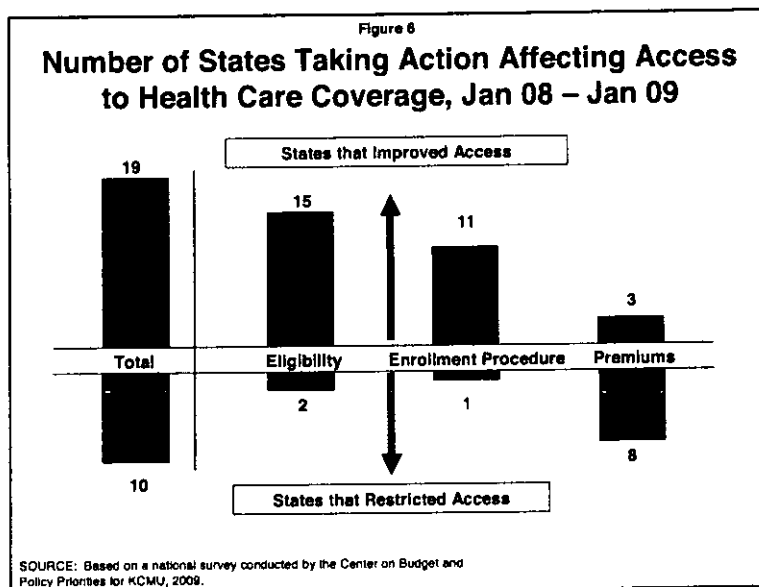
It continues to be more difficult for a low-income parent to qualify for health coverage than for a child (Figure 5). The median income at which children qualify for Medicaid or SCHIP is 200 percent of the federal poverty line, but is much lower — 68 percent of the federal poverty line — for working 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).



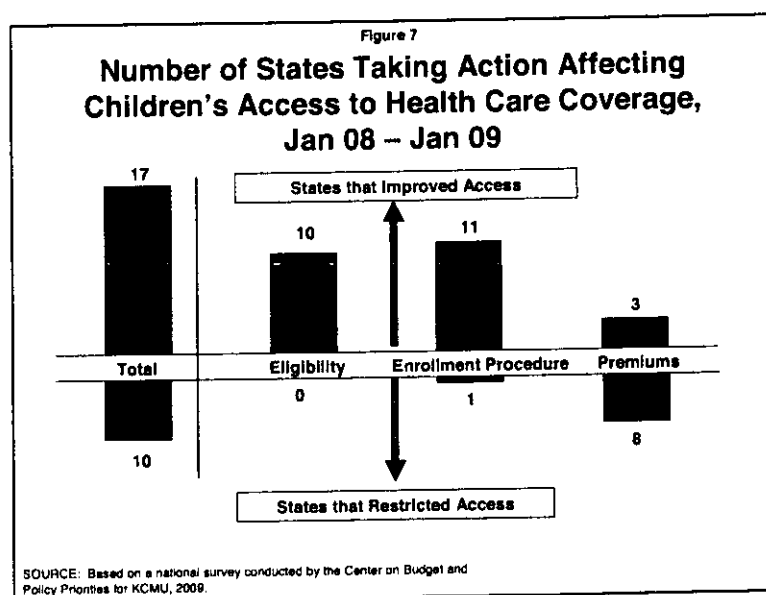
- Ten states (10 states) enacted at least one measure to restrict coverage. The most common restriction was to increase financial barriers such as new or higher premiums in SCHIP programs. Eight states (GA, LA, MN, MO, NJ, NV, PA, RI) went in this direction. Rhode Island and South Carolina restricted 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.⁷

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



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

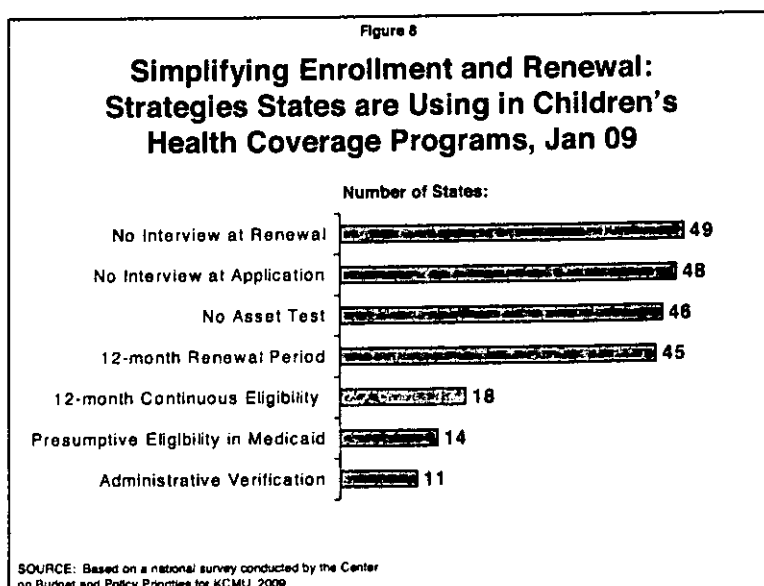
Of the ten states that expanded coverage for children, four were implementing expansions that were authorized last year, but which had been held back by the August 17th directive or by the uncertainty surrounding SCHIP reauthorization. *Louisiana* and *Indiana* increased eligibility to 250 percent of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

Iowa Children Get A Coverage Boost

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

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

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



States Explore the Use of Technology to Facilitate Enrollment

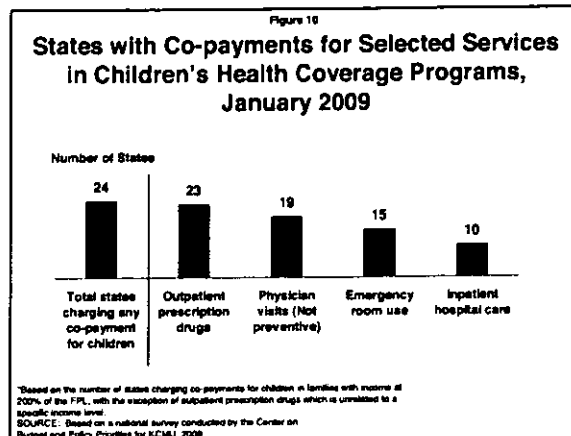
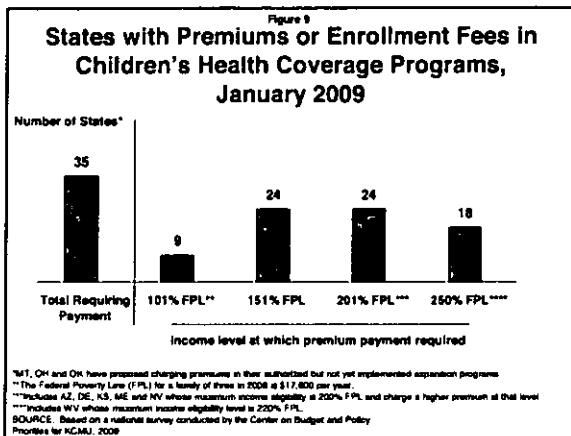
Emergence of Online Applications

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

Database Usage

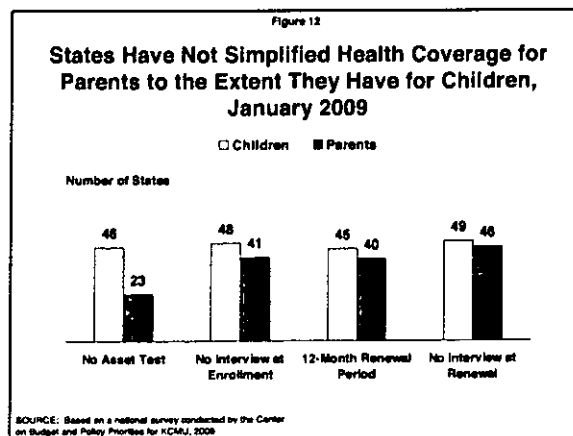
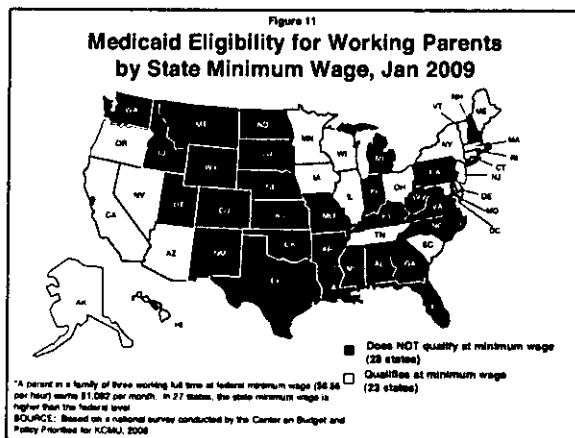
Eleven states (12 states at renewal) report using technology to streamline the enrollment and renewal process. States report conducting matches with existing databases to verify income and other information, as well as eliminating rules requiring families to submit pay stubs or other paper documentation.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

- **Outreach budgets in a number of states were increased in 2008, however, some states are beginning to report that these funds are being curtailed.** Several states reported increases in outreach funding in 2008, sometimes associated with new expansions, but also for ongoing promotional activities and community-based application assistance. In recent follow-up interviews, some state officials indicated that their outreach budgets have now been cut; others expressed skepticism for conducting aggressive outreach in light of budget shortfalls. Still others said their outreach activities would go forward, with some indicating that activities would emphasize renewal assistance so that already enrolled children do not lose coverage.
- **A few states reduced financial barriers to children's coverage, eliminating or lowering premiums for some children, while other states increased premiums (Figure 9).** *Tennessee, Washington* and *Wisconsin* either reduced premiums or eliminated them for some children. *Georgia, Minnesota, Missouri, Nevada, New Jersey, Pennsylvania* and *Rhode Island* increased premiums for children, with two of these states showing significant increases. *Minnesota* premiums increased by up to \$14 per month for some children. Premium increases in *Rhode Island*, discussed earlier, represented the most severe increases for children this year. New premiums implemented in *Louisiana*, apply to the state's new expansion group (children with incomes between 200 percent and 250 percent of the federal poverty line).
- **Co-payments for health services were adopted in one state and increased in two states (Figure 10).** Currently, 24 states charge co-payments for children's health services. *Wisconsin* adopted new co-payments, and *West Virginia* and *Utah* increased co-payments for prescription drug coverage. Only one state, *Montana* decreased co-payment amounts.



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

Premium Payment Policies Matter

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

Outreach Is Critical During Economic Downturns

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

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

¹ Kaiser Commission on Medicaid and the Uninsured analysis of the National Health Interview Survey data.

² Donna Cohen Ross, Aleya Horn and Caryn Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

³ Letter from Dennis Smith, Director for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials, August 17, 2007.

⁴ Elizabeth McNichol and Iris Lav, *State Budget Troubles Worsen*, Center on Budget and Policy Priorities, Washington, DC, Updated, January 14, 2009.

⁵ Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2004.

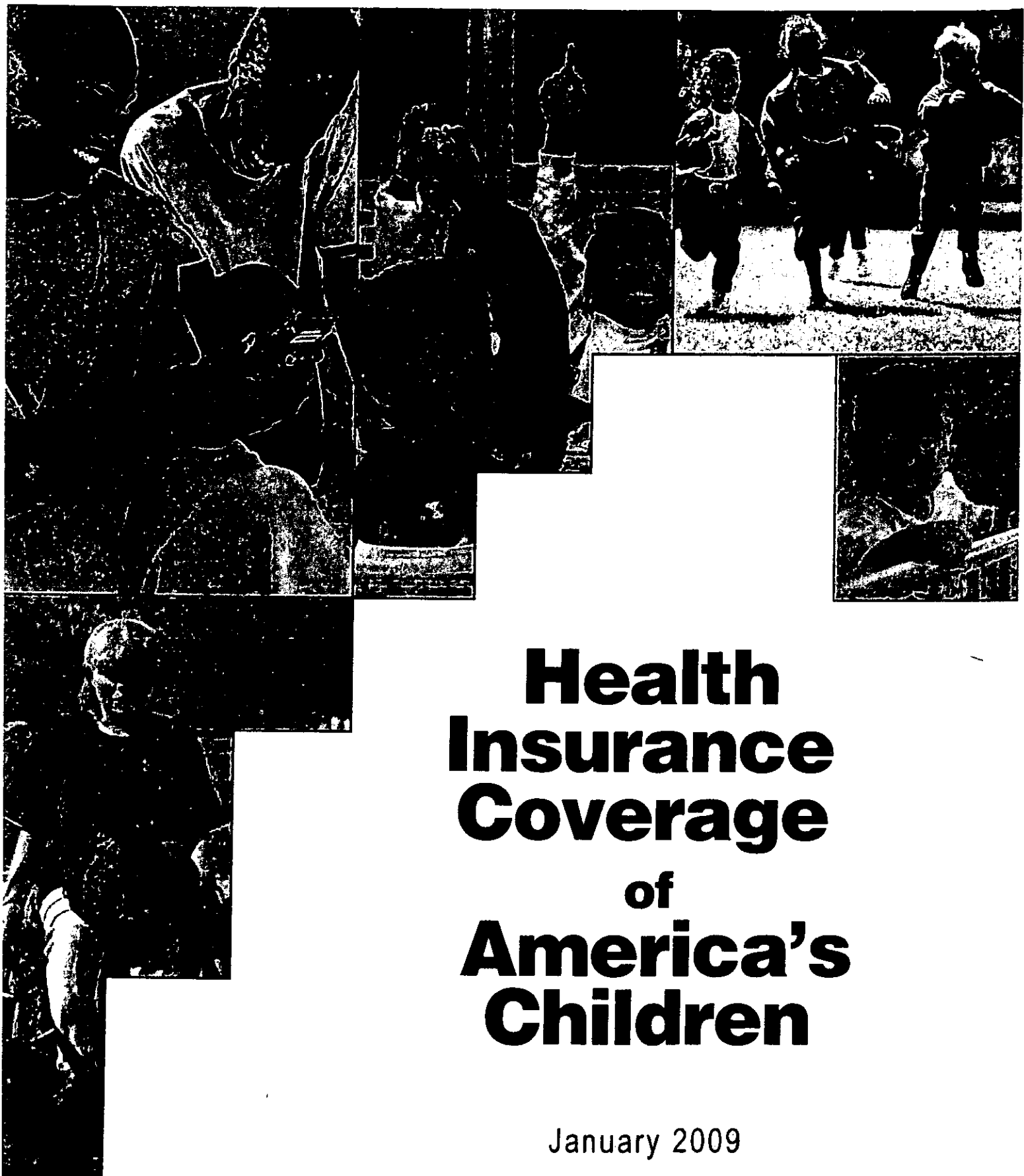
⁶ *Ibid.*

⁷ Nicholas Johnson, Phil Oliff and Jeremy Koulish, "Facing Deficits, Two-Thirds of States Are Imposing Cuts that Hurt Vulnerable Residents," Center on Budget and Policy Priorities, Washington, DC, Updated January 14, 2009.

⁸ Michael Perry, Barbara Lyons, Robin Rudowitz and Julia Paradise, "Turning to Medicaid and SCHIP in an Economic Recession: Conversations with Recent Applicants and Enrollees," Kaiser Commission on Medicaid and the Uninsured, December 2009.

⁹ Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent States Experiences," Kaiser Commission on Medicaid and the Uninsured, 2005.

¹⁰ Conversation with Robert D. Beardsley, Deputy Director, Medical Assistance Division, New Mexico Department of Human Services, January 12, 2009.



Health Insurance Coverage of America's Children

January 2009



THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

Health Insurance Coverage of America's Children

Karyn Schwartz and Jhamirah Howard
Kaiser Commission on Medicaid and the Uninsured

With

Aimee Williams and Allison Cook
The Urban Institute



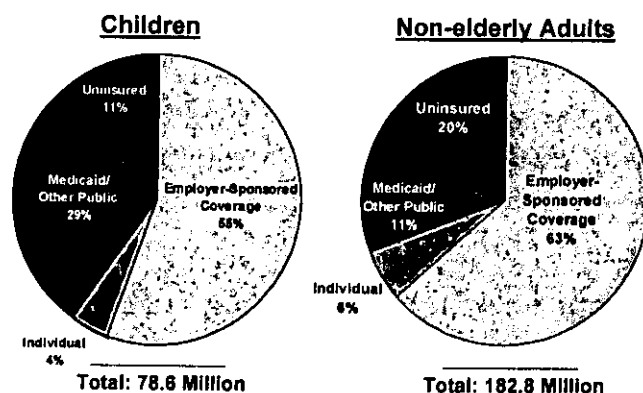
THE KAISER COMMISSION ON
Medicaid and the Uninsured

Health Insurance Coverage of America's Children 2007

**Thirty-four million—over 40% of all children—are from poor or near-poor families.
Over twenty million rely on Medicaid and SCHIP for health insurance.
Nearly nine million children were uninsured in 2007.**

There are about 79 million children in the United States and their access to health care is determined in large part by whether or not they have health insurance coverage. Uninsured children are less likely to have a medical home compared to those with health insurance. Needed care is more likely to be postponed and uninsured children are also less likely to see a physician or dentist for standard preventive care. Unhealthy children miss school and their parents miss work to care for them – just some of the consequences the nearly 9 million uninsured children in the U.S. experience.

Health Insurance Coverage of Children And Adults, 2007



Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Children are at greater risk than adults of being uninsured because as a group they are more likely to be poor. While about a third of adults under age 65 come from low-income families (incomes less than twice the poverty level, which in 2007 was about \$42,000 for a family of four) — more than 40% of children come from low-income families. However, children are much less likely than adults to be uninsured (11% vs. 20% in 2007) because of two public insurance programs: Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid and SCHIP cover all children whose family incomes are below levels set by individual states that are at or above federal minimum requirements.

Medicaid, SCHIP, and other state programs for children's coverage play an important role in providing health insurance for children. The programs cover more than 60% of all poor children (family incomes less than the poverty level) and about 40% of near-poor children (those with family incomes between one and two times the poverty level). Including higher income children with disabilities who qualify, these public programs insure more than a quarter of all children in the United States.

This chartbook provides essential facts about children's health insurance coverage today. Using the most recent Census Bureau data available (2007), it examines children's coverage by:

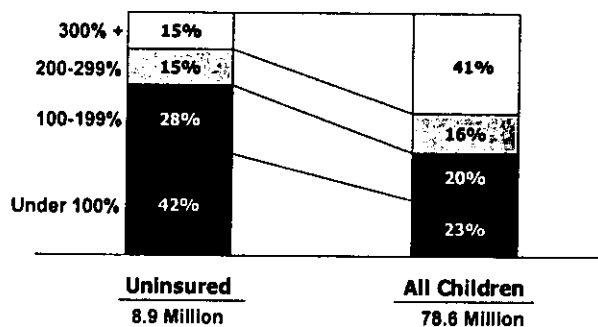
- family income
- family work status
- type of family or household
- age
- health status
- race and ethnicity
- citizenship status, and
- geographic region.

In addition to figures, each section also contains tables that provide more detailed information about family income and health insurance. For example, estimates of the share of uninsured children in families with full-time workers who are from poor, near-poor, middle-income or higher income families are included in the tables. Not all subgroups of children could be analyzed in this way however, because the survey sample size was not large enough to produce reliable estimates in all cases. Due to small sample sizes, two years of data, from 2006 and 2007, were used to analyze health coverage of children by race and ethnicity, citizenship and health status. Sample sizes were too small for Asian, American Indian, and multiracial children to analyze their health coverage by income groups. In addition, a set of state-level tables (for all children, low-income children, and uninsured rates by poverty level) can be found at the end of the chartbook.

Family Poverty Level and Health Coverage

While 43% of all children come from poor or near-poor families, more than two-thirds (70%) of uninsured children come from low-income families (less than 200% of the poverty level, e.g., about \$42,000 for a family of four in 2007). The majority of low-income children do not have private health insurance.

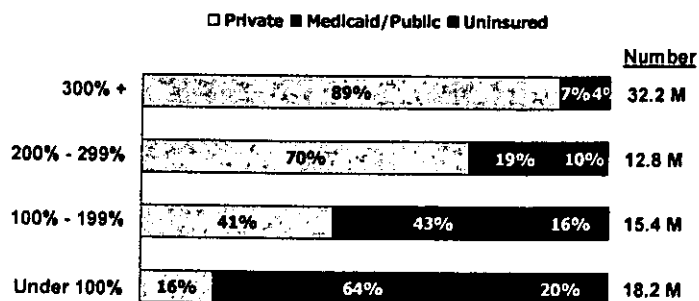
**Uninsured Children vs. All Children,
by Family Poverty Level, 2007**



The Federal Poverty Level for a family of four in 2007 was \$21,203 (according to the U.S. Census Bureau's poverty threshold). Family size and total family income are grouped by insurance eligibility. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Public insurance programs—Medicaid, SCHIP, and other state programs—are essential sources of coverage for children in this country, covering nearly two-thirds of all poor children and more than 40% of near-poor children. However, one in five poor children and 16% of near-poor children remain uninsured. Most of these low-income uninsured children are eligible for Medicaid or SCHIP, but confusion over who qualifies for these programs and an enrollment process that can be difficult to navigate have left many uninsured

**Children's Health Insurance Coverage
by Family Poverty Level, 2007**

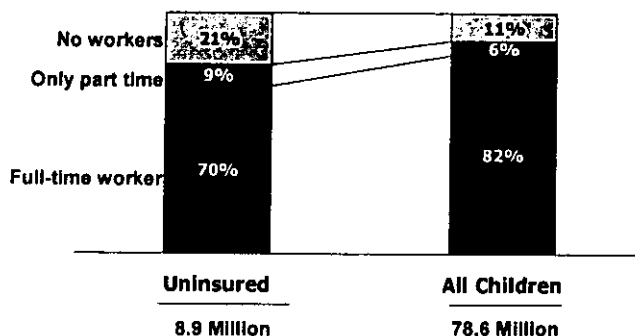


Data may not total 100% due to rounding. The Federal Poverty Level for a family of four in 2007 was \$21,203 (according to the U.S. Census Bureau's poverty threshold). Family size and total family income are grouped by insurance eligibility. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Work Status and Health Coverage

Although job-based health insurance is declining, it still covers more than half of children in this country. However, not all working families have access to, or can afford, employer-sponsored insurance. Seventy percent of uninsured children live in families where there is at least one full-time worker.

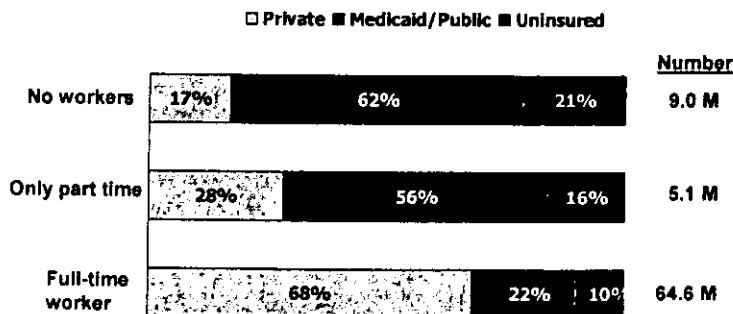
Uninsured Children vs. All Children, by Family Work Status, 2007



Data may not total 100% due to rounding. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Just over one fifth of children in families with a full-time worker are covered by Medicaid or other public insurance; leaving 10% of this large group of nearly 65 million children with no health insurance. Fewer than one-third of low-income children living in families with at least one full-time worker have employer-sponsored insurance.

Children's Health Insurance Coverage by Family Work Status, 2007



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

**Distribution of Uninsured Children in Each Poverty Category
by Family Work Status
2007**

Poverty Level	Number	Distribution	Part-time		
			1 or 2 Full-time Workers	Workers or No Workers	Total
<100%	3,718,880	41.9%	38.4%	61.6%	100.0%
100-199%	2,505,489	28.2%	90.9%	—	100.0%
200-299%	1,319,593	14.9%	94.5%	—	100.0%
300%+	1,328,125	15.0%	94.1%	—	100.0%
Total	8,872,087	100.0%	69.9%	30.1%	100.0%

**Health Insurance Coverage of Children
By Family Work Status and Family Income (Federal Poverty Levels, FPL)
2007**

Children in Families with Full-Time Workers

Poverty Level	Children of FT Workers		Distribution by Coverage Type					
	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	6,965,231	10.8%	13.2%	2.5%	62.7%	1.1%	20.5%	100.0%
100-199%	13,724,645	21.2%	38.9%	3.4%	39.9%	1.2%	16.5%	100.0%
200-299%	12,269,354	19.0%	66.9%	4.5%	16.7%	1.8%	10.2%	100.0%
300%+	31,642,412	49.0%	84.6%	4.9%	5.2%	1.3%	3.9%	100.0%
Total	64,601,642	100.00%	63.8%	4.3%	21.0%	1.3%	9.6%	100.0%

Children in Families with Only Part-Time Workers or No Workers

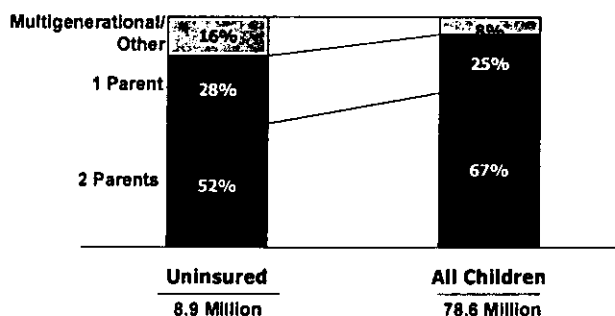
Poverty Level	Children of PT or No Workers		Distribution by Coverage Type					
	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	11,250,321	80.1%	12.3%	3.4%	62.3%	1.6%	20.4%	100.0%
100-199%	1,633,347	11.6%	—	—	53.4%	—	—	100.0%
200-299%	560,811	4.0%	—	—	—	—	—	100.0%
300%+	599,100	4.3%	—	—	—	—	—	100.0%
Total	14,043,579	100.0%	16.1%	5.1%	58.1%	1.7%	19.0%	100.0%

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Household Type and Health Coverage

Most children live in households with two parents (67%), as do over half of uninsured children. Uninsured children however, are more likely than others to live with just one parent and/or with grandparents, or other extended family members (referred to as multigenerational and other households here).

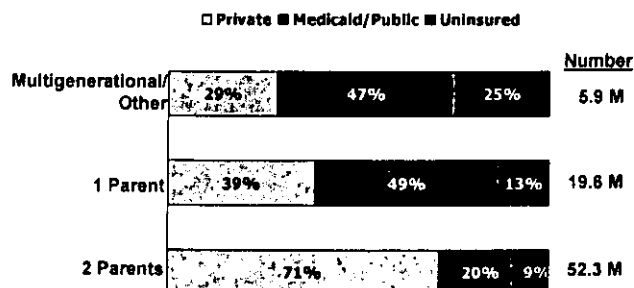
Uninsured Children vs. All Children, by Household Type, 2007



Children includes all individuals under age 19. Approximately 1% of children live in households with no adult, three-quarters of whom are 17-18 years old.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS

Children living with two parents are the most likely to have private health insurance (71%) because family incomes are generally higher and there are potentially two sources for employer-based insurance. Children living with one parent are more likely to qualify for Medicaid and SCHIP and, for them, these programs are the primary source of health insurance, covering nearly half of these children (49%). Children living with extended family are the least likely to have health coverage—25% are uninsured.

Children's Health Insurance Coverage by Household Type, 2007



Data may not total 100% due to rounding. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS

**Distribution of Uninsured Children in Each Poverty Category
by Household Type
2007**

Poverty Level	Number	Distribution	Household Type			Total**
			2 Parents with Children	1 Parent with Children	Multigenerational/ Other with Children*	
<100%	3,718,880	41.9%	31.8%	32.7%	30.7%	95.1%
100-199%	2,505,489	28.2%	59.7%	30.9%	—	98.2%
200-299%	1,319,593	14.9%	70.0%	—	—	98.8%
300%+	1,328,125	15.0%	79.4%	—	—	99.1%
Total	8,872,087	100.0%	52.1%	28.3%	16.3%	97.2%

**Health Insurance Coverage of Children
By Household Type and Family Income (Federal Poverty Levels, FPL)
2007**

Children in Households with Two Parents

Poverty Level	Number	Distribution	Distribution by Coverage Type					Total
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		
<100%	5,245,365	100%	12.4%	3.1%	60.0%	2.0%	22.5%	100.0%
100-199%	8,988,262	17.2%	39.0%	3.8%	38.9%	1.6%	16.7%	100.0%
200-299%	9,431,282	18.0%	68.4%	4.2%	15.8%	1.8%	9.8%	100.0%
300%+	28,682,866	54.8%	85.5%	4.7%	4.8%	1.3%	3.7%	100.0%
Total	52,347,775	100.0%	67.1%	4.3%	18.2%	1.5%	8.9%	100.0%

Children in Households with One Parent

Poverty Level	Number	Distribution	Distribution by Coverage Type					Total
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		
<100%	8,218,291	41.9%	10.8%	2.2%	70.9%	1.2%	14.8%	100.0%
100-199%	5,409,126	27.6%	34.4%	3.7%	46.6%	0.9%	14.3%	100.0%
200-299%	2,888,233	14.7%	58.2%	7.2%	22.9%	—	10.3%	98.5%
300%+	3,114,507	15.9%	72.4%	9.5%	9.8%	1.1%	7.3%	100.0%
Total	19,630,157	100.0%	34.1%	4.5%	47.5%	1.2%	12.8%	100.0%

* Multigenerational/other households with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own (e.g. a niece living with her aunt).

** Totals do not equal 100% because approximately 3% of uninsured children live in households with no adult.

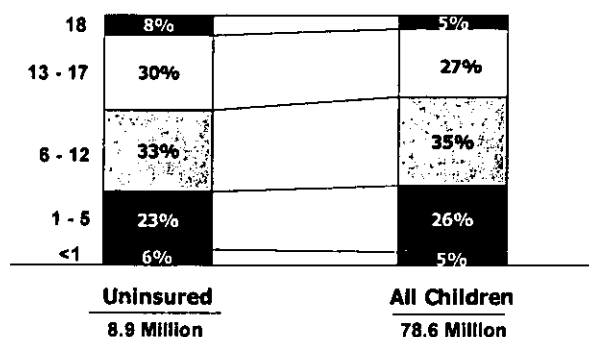
() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.

Estimates with relative standard errors greater than 30% are not provided.

Age and Health Coverage

Uninsured children span the age spectrum, but 18 year-olds are at the greatest risk of being uninsured, in part because some of them are no longer living at home and may no longer be dependents. Infants compose 6% of the uninsured, and they are particularly vulnerable to the negative effects of being uninsured given their high health care needs.

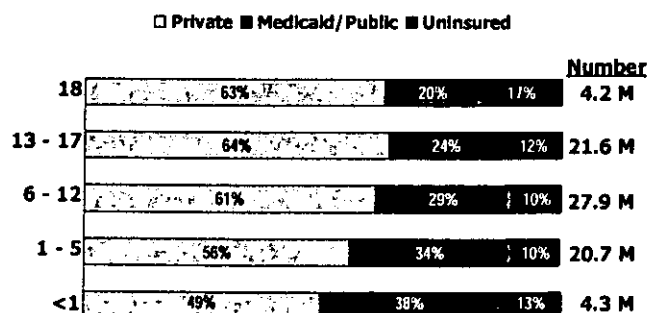
**Children
Uninsured vs. Population, by Age Group, 2007**



Data may not total 100% due to rounding. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Younger children are more likely to be insured by Medicaid or other public coverage. Were it not for Medicaid and SCHIP, the chances of being uninsured among children would be much higher, particularly among pre-schoolers and infants.

**Children's Health Insurance Coverage
by Age Group, 2007**



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

**Distribution of Uninsured Children in Each Poverty Category
by Age
2007**

Poverty Level	Number	Distribution	Age Group			Total
			0-5 Years Old	6-12 Years Old	13-18 Years Old	
<100%	3,718,880	41.9%	31.4%	29.9%	38.7%	100.0%
100-199%	2,505,489	28.2%	29.3%	35.8%	34.9%	100.0%
200-299%	1,319,593	14.9%	—	—	—	100.0%
300%+	1,328,125	15.0%	—	—	—	100.0%
Total	8,872,087	100.0%	29.5%	32.7%	37.8%	100.0%

**Health Insurance Coverage of Children
By Age and Family Income (Federal Poverty Levels, FPL)
2007**

Children 0-5 Years Old			Distribution by Coverage Type					
Poverty Level	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	6,756,102	27.1%	9.9%	1.2%	69.9%	1.8%	17.3%	100.0%
100-199%	5,039,908	20.2%	34.9%	2.2%	46.8%	1.5%	14.5%	100.0%
200-299%	3,846,182	15.4%	65.4%	3.1%	19.7%	2.2%	9.6%	100.0%
300%+	9,301,704	37.3%	85.2%	4.4%	5.8%	0.9%	3.7%	100.0%
Total	24,943,896	100.0%	51.6%	2.9%	33.6%	1.5%	10.5%	100.0%

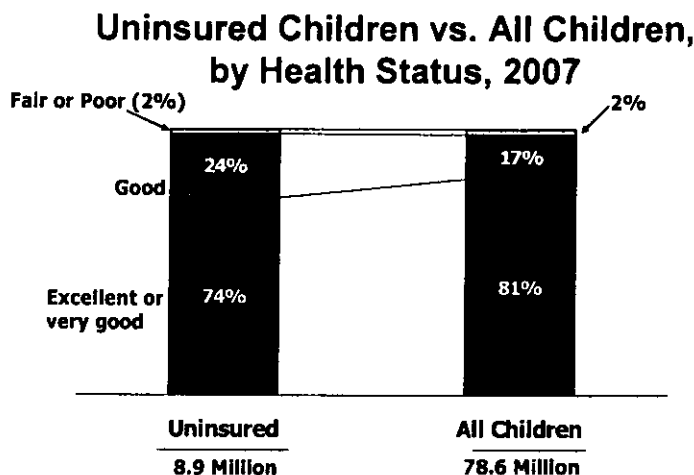
Children 6-12 Years Old			Distribution by Coverage Type					
Poverty Level	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	5,994,682	21.5%	13.6%	1.9%	64.8%	1.1%	18.6%	100.0%
100-199%	5,727,292	20.6%	39.1%	3.0%	41.0%	1.2%	15.7%	100.0%
200-299%	4,748,092	17.0%	68.7%	3.7%	16.7%	1.4%	9.5%	100.0%
300%+	11,385,104	40.9%	85.0%	4.6%	5.3%	1.3%	3.9%	100.0%
Total	27,855,170	100.0%	57.4%	3.5%	27.4%	1.2%	10.4%	100.0%

Children 13-18 Years Old			Distribution by Coverage Type					
Poverty Level	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	5,464,768	21.1%	15.0%	6.7%	50.7%	1.2%	26.3%	100.0%
100-199%	4,590,791	17.8%	37.2%	6.9%	35.7%	1.2%	19.0%	100.0%
200-299%	4,235,891	16.4%	62.3%	7.7%	16.5%	1.7%	11.8%	100.0%
300%+	11,554,704	44.7%	82.0%	6.5%	5.2%	1.7%	4.7%	100.0%
Total	25,846,154	100.0%	56.7%	6.8%	22.1%	1.5%	13.0%	100.0%

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Health Status and Health Coverage

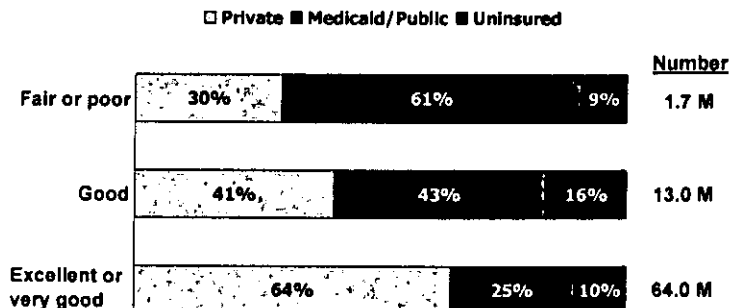
Uninsured children are somewhat less likely to be in the best health compared to all children. While 81% of all children are reported to be in excellent or very good health, only 74% of uninsured children are in such good health.



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Among children in the worst health (reported as fair or poor), the majority are covered by Medicaid and other public insurance, and just 30% are enrolled in private insurance. In contrast, nearly two-thirds of children in the best of health are insured privately, and a quarter are covered by public programs.

Children's Health Insurance Coverage by Health Status, 2007



Data may not total 100% due to rounding. Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

**Distribution of Uninsured Children in Each Poverty Category
by Health Status
2006-2007**

Poverty Level	Number	Distribution	Excellent/ Very			
			Good Health	Good Health	Fair/Poor Health	Total
<100%	3,790,701	41.4%	71.6%	25.7%	2.6%	100.0%
100-199%	2,570,213	28.1%	73.6%	24.3%	2.1%	100.0%
200-299%	1,368,470	14.9%	79.6%	19.0%	—	100.0%
300%+	1,427,698	15.6%	81.7%	17.3%	—	100.0%
Total	9,157,079	100.0%	74.9%	23.0%	2.0%	100.0%

**Health Insurance Coverage of Children
By Health Status and Family Income (Federal Poverty Levels, FPL)
2006-2007**

Children in Excellent or Very Good Health

Poverty Level	Children in Excellent or Very Good Health		Distribution by Coverage					
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		Total
<100%	12,791,998	20.0%	14.8%	3.7%	58.8%	1.5%	21.2%	100.0%
100-199%	11,834,852	18.5%	39.6%	4.1%	38.8%	1.5%	16.0%	100.0%
200-299%	10,788,851	16.9%	67.2%	5.1%	15.9%	1.8%	10.1%	100.0%
300%+	28,572,119	44.7%	85.1%	5.2%	4.4%	1.1%	4.1%	100.0%
Total	63,987,820	100.0%	59.6%	4.7%	23.6%	1.4%	10.7%	100.0%

Children in Good Health

Poverty Level	Children in Good Health		Distribution by Coverage					
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		Total
<100%	4,394,215	34.5%	9.2%	2.2%	65.5%	1.0%	22.2%	100.0%
100-199%	3,215,836	25.2%	28.7%	3.1%	47.8%	1.3%	19.4%	100.0%
200-299%	2,038,539	16.0%	57.7%	4.1%	23.3%	2.1%	12.8%	100.0%
300%+	3,090,649	24.3%	75.4%	4.3%	11.1%	1.2%	8.0%	100.0%
Total	12,737,239	100.0%	37.9%	3.2%	41.0%	1.3%	16.5%	100.0%

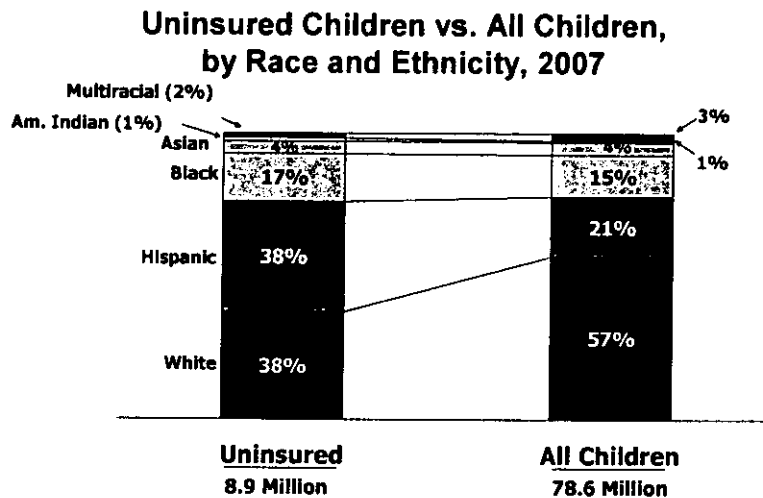
Children in Fair or Poor Health

Poverty Level	Children in Fair or Poor Health		Distribution by Coverage					
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		Total
<100%	660,784	38.9%	5.3%	—	(75.8%)	—	15.1%	100.0%
100-199%	441,960	26.0%	19.4%	—	(64.4%)	—	12.5%	100.0%
200%+	597,197	35.1%	(61.7%)	4.0%	27.4%	—	5.4%	100.0%
Total	1,699,941	100.0%	28.8%	3.1%	55.8%	1.3%	11.0%	100.0%

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Race and Health Coverage

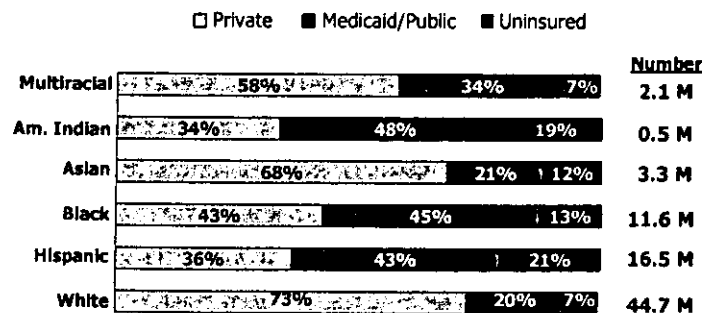
Almost 60% of all children are white in this country, but they compose only 38% of uninsured children. As a group, white children come from higher income families, which explains part of the racial and ethnic differences in health coverage. Hispanic children make up just 21% of all children, but 38% of uninsured children.



Children includes all individuals under age 19. American Indian category includes Aleutian Eskimos. Asian includes South Pacific Islander. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

The majority of white, Asian, and multiracial children have private health insurance, compared to about 40% of Black, Hispanic, and American Indian children combined. Medicaid plays a larger role for low-income groups; still, among all American Indians and Hispanics, about 20% of children are uninsured.

Children's Health Insurance Coverage by Race and Ethnicity, 2007



Children includes all individuals under age 19. American Indian category includes Aleutian Eskimos. Asian includes South Pacific Islander. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

**Distribution of Uninsured Children in Each Poverty Category
by Race
2006-2007**

Poverty Level	Number	Distribution	White, Non-Hispanic	Hispanic	Black, Non-Hispanic	Asian	American Indian	Two or More Races	Total
<100%	3,790,701	41.4%	28.6%	40.7%	23.5%	3.4%	1.6%	2.1%	100.0%
100-199%	2,570,213	28.1%	31.6%	47.3%	14.0%	4.7%	1.1%	1.4%	100.0%
200-299%	1,368,470	14.9%	45.5%	34.6%	12.6%	4.2%	1.6%	1.6%	100.0%
300%+	1,427,696	15.6%	60.7%	20.3%	10.6%	5.7%	—	2.1%	100.0%
Total	8,157,079	100.0%	37.0%	38.5%	17.2%	4.3%	1.3%	1.8%	100.0%

**Health Insurance Coverage of Children
By Race/Ethnicity and Family Income (Federal Poverty Levels, FPL)
2006-2007**

White, Non-Hispanic Children

Poverty Level	White, Non-Hispanic Children		Distribution by Coverage					
	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	6,169,827	13.8%	17.3%	5.5%	58.2%	1.5%	17.6%	100.0%
100-199%	6,921,195	15.4%	42.7%	5.6%	38.1%	1.6%	11.7%	100.0%
200-299%	7,896,296	17.6%	70.3%	5.9%	14.3%	1.6%	7.9%	100.0%
300%+	23,827,066	53.2%	85.3%	5.7%	4.3%	1.0%	3.8%	100.0%
Total	44,814,384	100.0%	66.7%	5.7%	18.7%	1.3%	7.6%	100.0%

Hispanic Children

Poverty Level	Hispanic Children		Distribution by Coverage					
	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	5,573,450	34.4%	9.1%	1.4%	60.6%	1.2%	27.7%	100.0%
100-199%	4,899,464	30.2%	25.7%	2.1%	46.6%	0.9%	24.8%	100.0%
200-299%	2,584,916	15.9%	52.8%	3.0%	23.9%	1.9%	18.3%	100.0%
300%+	3,148,811	19.4%	75.9%	3.6%	10.2%	1.0%	9.2%	100.0%
Total	16,206,641	100.0%	34.0%	2.3%	40.7%	1.2%	21.7%	100.0%

Black, Non-Hispanic Children

Poverty Level	Black, Non-Hispanic Children		Distribution by Coverage					
	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	4,819,168	41.7%	12.1%	2.3%	65.7%	1.3%	18.5%	100.0%
100-199%	2,826,679	22.8%	41.5%	2.6%	40.9%	1.4%	13.7%	100.0%
200-299%	1,677,833	14.5%	63.4%	3.0%	21.3%	2.0%	10.3%	100.0%
300%+	2,420,846	21.0%	81.4%	2.4%	7.5%	2.4%	6.3%	100.0%
Total	11,544,526	100.0%	40.8%	2.5%	41.4%	1.6%	13.7%	100.0%

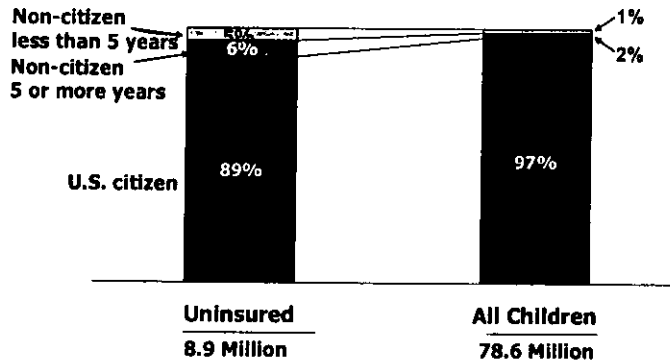
() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.

Estimates with relative standard errors greater than 30% are not provided. The sample size was too small to produce reliable estimates of health coverage by income for Asian, American Indians and multiracial children.

Citizenship and Health Coverage

Almost 90% of uninsured children are U.S. citizens. However, non-citizen children are disproportionately represented among the uninsured (11% vs. 3% of all children) in part because they are more likely to be from low-income families and many do not qualify for public coverage. The chances of being uninsured are substantially greater for non-citizen children, who are almost four times as likely to go without coverage as citizen children.

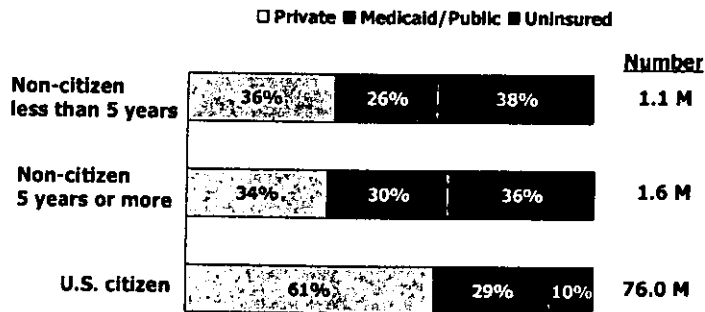
**Uninsured Children vs. All Children,
by Citizenship Status, 2007**



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Legal immigrants entering the country are only eligible for the full benefits of Medicaid after they have lived here five years unless their state chooses to provide separate coverage for legal non-citizens. Some 38% of non-citizen children who have lived in the U.S. less than five years have no health insurance.

**Children's Health Insurance Coverage by
Citizenship Status, 2007**



Children includes all individuals under age 19. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

**Distribution of Uninsured Children in Each Poverty Category
by Citizenship Status
2006-2007**

Poverty Level	Number	Distribution	U.S. Citizen	Non-citizen, Resident 5+ yrs	Non-citizen, Resident <5 yrs	Total
			<100%	3,790,701	41.4%	
100-199%	2,570,213	28.1%	88.0%	7.9%	4.1%	100.0%
200-299%	1,368,470	14.9%	90.6%	5.3%	4.1%	100.0%
300%+	1,427,696	15.6%	95.4%	2.7%	1.9%	100.0%
Total	9,157,079	100.0%	88.8%	6.6%	4.6%	100.0%

**Health Insurance Coverage of Children
By Citizenship and Family Income (Federal Poverty Levels, FPL)
2006-2007**

U.S. Citizen Children

Poverty Level	U.S. Citizen Children		Distribution by Coverage					
	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	16,809,560	22.2%	13.2%	3.3%	62.6%	1.4%	19.4%	100.0%
100-199%	14,760,010	19.5%	37.4%	4.0%	41.8%	1.5%	15.3%	100.0%
200-299%	12,667,733	16.7%	66.0%	4.9%	17.3%	1.9%	9.8%	100.0%
300%+	31,437,928	41.5%	84.2%	5.1%	5.2%	1.2%	4.3%	100.0%
Total	75,675,231	100.0%	56.3%	4.5%	27.1%	1.4%	10.7%	100.0%

Non-U.S. Citizen Children

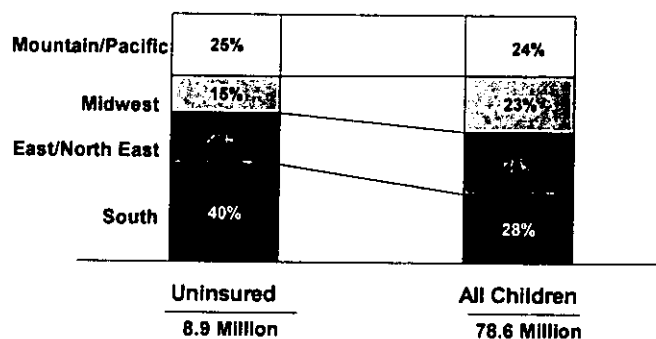
Poverty Level	Non-U.S. Citizen Children		Distribution by Coverage					
	Number	Distribution	Private		Public		Uninsured	Total
			Employer	Individual	Medicaid	Other		
<100%	1,037,436	37.7%	10.2%	3.1%	35.7%	—	50.6%	100.0%
100-199%	732,637	26.6%	22.5%	—	32.8%	—	42.2%	100.0%
200-299%	384,222	14.0%	(42.5%)	—	(19.9%)	—	(33.5%)	100.0%
300%+	595,471	21.7%	74.3%	5.2%	8.8%	—	11.0%	100.0%
Total	2,749,766	100.0%	31.9%	3.3%	26.9%	—	37.4%	100.0%

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points.
Estimates with relative standard errors greater than 30% are not provided.

Region and Health Coverage

Health insurance coverage varies by region, and even by state, depending on the share of families with low incomes, the nature of employment in the area, and the inclusiveness of state Medicaid and SCHIP programs. While fewer than 30% of all children live in ten southern states, about 40% of uninsured children live there.

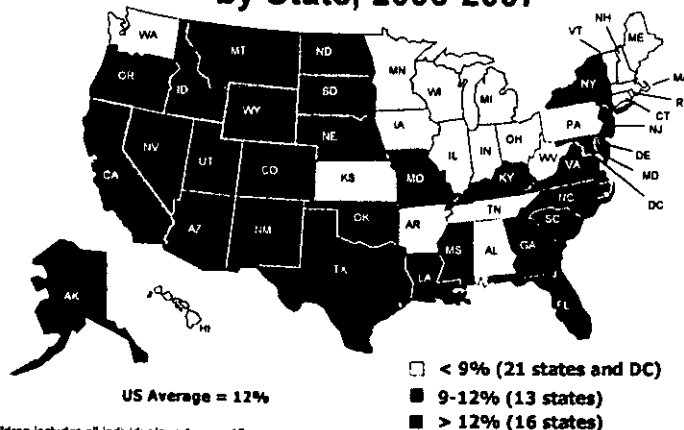
Children Uninsured vs. Population, by Region, 2007



Children includes all individuals under age 19. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

More than one in ten children nationally are uninsured, but the chances of being uninsured range widely across the states—from a low of 5% (MA, WI) to a high of 22% in Texas. Among the states in which children's uninsured rates exceed the national average, all but one is in the southern and western regions.

Uninsured Rates for Children under 19, by State, 2006-2007



Children includes all individuals under age 19.
SOURCE: KCMU/Urban Institute analysis of 2007 and 2008 ASEC Supplements to the CPS. Two-year pooled estimates for states and the US (2006-2007).

**Distribution of Uninsured Children in Each Poverty Category
by Region
2007**

Poverty Level	Number	Distribution	Region				Total
			South	East/ North East	Midwest	Mountain/ Pacific	
<100%	3,718,880	41.9%	40.7%	21.7%	—	23.1%	100.0%
100-199%	2,505,489	28.2%	39.0%	18.9%	15.6%	26.5%	100.0%
200-299%	1,319,593	14.9%	—	—	—	—	100.0%
300%+	1,328,125	15.0%	—	—	—	—	100.0%
Total	8,872,087	100.0%	39.6%	20.8%	15.1%	24.5%	100.0%

**Health Insurance Coverage of Children
By Region and Family Income (Federal Poverty Levels, FPL)
2007**

Children in Southern States

Poverty Level	Number	Distribution	Distribution by Coverage					
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		
<100%	8,045,890	27.9%	11.5%	2.5%	58.8%	2.2%	25.0%	100.0%
100-199%	4,402,674	20.3%	35.2%	3.0%	38.2%	1.5%	22.2%	100.0%
200-299%	3,405,479	15.7%	57.8%	5.0%	18.0%	2.5%	16.8%	100.0%
300%+	7,788,172	38.0%	80.8%	4.8%	6.8%	1.8%	5.8%	100.0%
Total	21,640,215	100.0%	48.5%	3.8%	29.5%	1.9%	16.3%	100.0%

Children in East/North East States

Poverty Level	Number	Distribution	Distribution by Coverage					
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		
<100%	4,189,983	21.2%	13.2%	—	63.5%	—	19.3%	100.0%
100-199%	3,518,820	17.8%	38.9%	3.8%	42.7%	1.2%	13.4%	100.0%
200-299%	3,158,662	15.9%	88.5%	3.9%	18.2%	1.9%	7.5%	100.0%
300%+	8,932,565	45.1%	88.1%	4.2%	4.7%	1.4%	3.6%	100.0%
Total	19,798,030	100.0%	59.5%	3.9%	26.1%	1.3%	9.3%	100.0%

Children in Midwestern States

Poverty Level	Number	Distribution	Distribution by Coverage					
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		
<100%	3,812,341	20.9%	—	—	69.8%	—	—	100.0%
100-199%	3,419,703	18.7%	40.3%	4.6%	42.6%	1.1%	11.4%	100.0%
200-299%	3,178,191	17.4%	74.4%	5.4%	14.2%	0.6%	5.4%	100.0%
300%+	7,829,977	42.9%	86.9%	4.7%	4.6%	0.7%	3.0%	100.0%
Total	18,240,212	100.0%	60.4%	4.4%	27.0%	0.8%	7.3%	100.0%

Children in Mountain/Pacific States

Poverty Level	Number	Distribution	Distribution by Coverage					
			Private		Public		Uninsured	
			Employer	Individual	Medicaid	Other		
<100%	4,187,338	22.0%	13.7%	—	60.0%	—	20.6%	100.0%
100-199%	4,018,795	21.2%	35.1%	4.4%	42.5%	1.5%	16.6%	100.0%
200-299%	3,089,833	16.3%	62.2%	5.2%	19.7%	1.9%	11.1%	100.0%
300%+	7,692,799	40.6%	81.9%	7.1%	5.6%	1.3%	4.0%	100.0%
Total	18,966,765	100.0%	53.8%	5.6%	27.7%	1.4%	11.5%	100.0%

U.S. Regions were defined as:

South: AL, AR, FL, GA, LA, MS, OK, SC, TN, TX

East/ North East: CT, DE, DC, ME, MD, MA, NH, NJ, NY, NC, PA, RI, VT, VA, WV

Midwest: IL, IN, IA, KS, KY, MI, MN, MO, NE, ND, OH, SD, WI

Mountain/ Pacific States: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

STATE TABLES

Table 1: Health Insurance Coverage of Children by State, 2006-2007

Table 2: Health Insurance Coverage of Low-Income Children by State, 2006-2007

Table 3: Uninsured Rates Among Children by Poverty Level and State, 2006-2007

Table 1
Health Insurance Coverage of Children
by State, 2006-2007

	Children (thousands) ^a	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Individual	Medicaid	Other ^b	
United States	78,425	55.4%	4.4%	27.1%	1.4%	11.7%
Alabama	1,187	60.5%	2.5%	28.0%	---	7.7%
Alaska	192	54.1%	3.5%	23.6%	7.6%	11.2%
Arizona	1,769	48.9%	3.3%	31.1%	---	15.9%
Arkansas	742	42.6%	4.2%	43.8%	---	8.4%
California	10,036	49.7%	6.1%	30.7%	1.2%	12.3%
Colorado	1,260	61.5%	6.7%	15.5%	2.5%	13.8%
Connecticut	872	66.8%	3.2%	23.0%	---	6.3%
Delaware	220	63.7%	2.7%	22.0%	---	10.0%
District of Columbia	119	45.6%	---	44.0%	---	7.6%
Florida	4,332	50.7%	5.2%	23.3%	1.3%	19.5%
Georgia	2,604	52.6%	2.7%	29.3%	2.9%	12.5%
Hawaii	307	62.5%	2.6%	23.3%	5.7%	5.8%
Idaho	433	56.4%	6.2%	23.7%	1.6%	12.2%
Illinois	3,362	61.8%	3.6%	25.5%	0.7%	8.3%
Indiana	1,686	64.0%	3.5%	25.5%	---	6.7%
Iowa	750	62.1%	5.9%	26.0%	---	5.5%
Kansas	742	55.9%	6.3%	28.0%	2.0%	7.7%
Kentucky	1,068	53.6%	4.4%	31.3%	---	9.4%
Louisiana	1,149	45.2%	5.1%	34.8%	---	14.5%
Maine	301	57.2%	4.4%	31.4%	---	5.6%
Maryland	1,457	65.4%	4.1%	19.0%	---	10.4%
Massachusetts	1,549	67.3%	3.3%	24.1%	---	5.1%
Michigan	2,579	61.6%	4.2%	27.7%	---	5.9%
Minnesota	1,327	67.2%	5.2%	20.0%	---	7.2%
Mississippi	823	41.2%	4.5%	36.7%	---	16.2%
Missouri	1,491	53.8%	6.0%	29.7%	---	9.8%
Montana	231	49.5%	7.2%	28.1%	---	13.8%
Nebraska	472	62.6%	5.9%	19.3%	1.9%	10.4%
Nevada	689	63.3%	4.7%	14.5%	---	16.8%
New Hampshire	317	71.5%	4.2%	16.6%	---	7.1%
New Jersey	2,209	66.4%	3.5%	16.4%	---	13.3%
New Mexico	539	40.6%	3.7%	36.7%	2.3%	16.6%
New York	4,744	55.9%	2.7%	32.3%	---	9.0%
North Carolina	2,340	49.6%	5.0%	29.7%	2.4%	13.3%
North Dakota	156	60.1%	8.0%	20.7%	2.1%	9.1%
Ohio	2,948	60.3%	3.8%	27.9%	---	7.5%
Oklahoma	971	46.5%	4.2%	32.4%	3.6%	13.3%
Oregon	916	55.4%	7.6%	23.3%	---	12.8%
Pennsylvania	2,917	62.4%	4.4%	25.3%	---	7.7%
Rhode Island	252	60.1%	2.9%	29.1%	---	6.6%
South Carolina	1,108	52.7%	3.9%	28.9%	---	13.1%
South Dakota	207	57.2%	7.4%	24.2%	2.5%	8.8%
Tennessee	1,553	51.8%	5.0%	31.7%	3.4%	8.1%
Texas	6,989	45.1%	3.8%	27.3%	2.0%	21.8%
Utah	861	61.2%	7.1%	18.0%	---	13.1%
Vermont	138	51.6%	2.9%	36.0%	---	8.5%
Virginia	1,939	61.1%	3.6%	19.1%	5.5%	10.7%
Washington	1,623	60.9%	4.4%	24.8%	2.7%	7.1%
West Virginia	422	52.7%	---	38.2%	---	6.6%
Wisconsin	1,393	64.6%	4.1%	25.3%	---	5.2%
Wyoming	132	59.0%	6.7%	22.3%	2.8%	9.2%

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 2
Health Insurance Coverage of Low-Income Children
(Less than 200% of Poverty) by State, 2006-2007

	Low-Income Children (thousands) ^a	% of Children with Low Incomes ^c	Percent Distribution by Coverage Type				Uninsured
			Private		Public		
			Employer	Individual	Medicaid	Other ^p	
United States	33,340	42.5%	24.1%	3.6%	51.9%	1.4%	19.1%
Alabama	539	45.4%	(29.2%)	---	(52.9%)	---	13.2%
Alaska	63	32.7%	(21.2%)	---	(52.6%)	7.3%	(17.3%)
Arizona	899	50.8%	23.3%	---	51.1%	---	23.2%
Arkansas	416	56.0%	18.9%	3.0%	65.3%	---	11.5%
California	4,587	45.7%	20.0%	4.7%	54.7%	1.4%	19.2%
Colorado	441	35.0%	(29.1%)	---	(34.8%)	---	(29.9%)
Connecticut	269	30.9%	(26.3%)	---	(56.3%)	---	12.9%
Delaware	86	39.0%	(34.1%)	---	(44.2%)	---	17.5%
District of Columbia	69	57.8%	(19.9%)	---	(68.0%)	---	9.5%
Florida	1,890	43.6%	24.3%	4.6%	39.0%	---	31.1%
Georgia	1,140	43.8%	21.9%	---	52.3%	3.0%	21.8%
Hawaii	122	39.6%	(38.7%)	---	(45.9%)	---	10.5%
Idaho	186	43.1%	(31.0%)	3.9%	(46.0%)	---	17.3%
Illinois	1,290	38.4%	26.9%	3.0%	54.0%	---	14.9%
Indiana	655	38.9%	29.2%	3.7%	(56.8%)	---	10.2%
Iowa	270	36.0%	(26.7%)	---	(58.6%)	---	8.8%
Kansas	310	41.7%	(23.0%)	4.4%	(57.5%)	---	12.9%
Kentucky	508	47.6%	22.7%	3.8%	(57.9%)	---	14.1%
Louisiana	554	48.3%	15.3%	---	(60.3%)	---	21.1%
Maine	110	36.5%	(20.3%)	---	(65.8%)	---	8.3%
Maryland	457	31.3%	(28.1%)	---	(45.4%)	---	(23.0%)
Massachusetts	514	33.2%	(26.3%)	5.2%	(58.2%)	---	9.7%
Michigan	1,022	39.6%	28.9%	4.1%	56.5%	---	9.3%
Minnesota	413	31.1%	(30.5%)	---	(48.6%)	---	16.5%
Mississippi	466	56.6%	14.9%	4.7%	54.7%	---	24.8%
Missouri	673	45.1%	24.3%	4.5%	(54.8%)	---	15.6%
Montana	98	42.3%	(20.4%)	---	(53.3%)	---	(20.7%)
Nebraska	161	34.2%	(27.1%)	5.9%	(46.4%)	---	(19.1%)
Nevada	298	43.3%	(38.4%)	---	(29.0%)	---	(29.2%)
New Hampshire	70	22.0%	---	---	---	---	(15.3%)
New Jersey	686	31.0%	27.9%	2.7%	(40.5%)	---	27.7%
New Mexico	252	46.7%	13.2%	---	(60.0%)	---	(23.0%)
New York	2,059	43.4%	25.6%	2.9%	58.1%	---	13.2%
North Carolina	1,090	46.6%	22.1%	3.5%	54.0%	---	19.3%
North Dakota	61	39.0%	(28.6%)	7.5%	(42.7%)	---	(18.2%)
Ohio	1,208	41.0%	26.6%	2.6%	58.2%	---	12.2%
Oklahoma	500	51.5%	22.4%	3.9%	(53.9%)	---	16.9%
Oregon	377	41.1%	(26.8%)	5.8%	(46.2%)	---	(20.4%)
Pennsylvania	1,129	38.7%	27.8%	4.3%	53.2%	---	14.1%
Rhode Island	90	35.5%	(24.9%)	---	(61.9%)	---	10.9%
South Carolina	527	47.5%	24.6%	---	(52.6%)	---	18.1%
South Dakota	76	36.9%	(22.1%)	7.6%	(54.0%)	---	13.7%
Tennessee	753	48.5%	26.4%	3.5%	56.8%	3.3%	10.0%
Texas	3,547	50.8%	18.0%	2.5%	45.7%	2.2%	31.5%
Utah	333	38.7%	(37.5%)	4.5%	35.9%	---	21.6%
Vermont	44	32.1%	(16.4%)	---	(67.3%)	---	(13.4%)
Virginia	739	38.1%	29.4%	3.1%	42.9%	4.7%	20.0%
Washington	551	34.0%	(28.0%)	---	(54.9%)	---	10.2%
West Virginia	207	49.1%	23.1%	---	(65.9%)	---	7.5%
Wisconsin	490	35.2%	(27.6%)	4.2%	(57.9%)	---	9.1%
Wyoming	47	35.6%	(30.7%)	7.1%	(45.8%)	---	13.0%

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table 3
Uninsured Rates Among Children
by Poverty Level and State, 2006-2007

	Children (thousands) ^a	Percent Uninsured Within Poverty Levels			
		All Levels ^c	<200% FPL	200-399% FPL	400%+ FPL
United States	78,425	11.7%	19.1%	8.7%	3.6%
Alabama	1,187	7.7%	13.2%	---	---
Alaska	192	11.2%	(17.3%)	9.0%	7.4%
Arizona	1,769	15.9%	23.2%	12.9%	---
Arkansas	742	8.4%	11.5%	---	---
California	10,036	12.3%	19.2%	9.0%	4.1%
Colorado	1,260	13.8%	(29.9%)	7.0%	---
Connecticut	872	6.3%	12.9%	---	---
Delaware	220	10.0%	17.5%	7.5%	---
District of Columbia	119	7.6%	9.5%	---	---
Florida	4,332	19.5%	31.1%	14.9%	5.4%
Georgia	2,604	12.5%	21.8%	6.8%	4.0%
Hawaii	307	5.8%	10.5%	---	---
Idaho	433	12.2%	17.3%	11.2%	---
Illinois	3,362	8.3%	14.9%	5.8%	2.7%
Indiana	1,686	6.7%	10.2%	5.2%	---
Iowa	750	5.5%	8.8%	---	---
Kansas	742	7.7%	12.9%	6.1%	---
Kentucky	1,068	9.4%	14.1%	7.5%	---
Louisiana	1,149	14.5%	21.1%	7.1%	9.5%
Maine	301	5.6%	8.3%	---	---
Maryland	1,457	10.4%	(23.0%)	7.7%	---
Massachusetts	1,549	5.1%	9.7%	---	---
Michigan	2,579	5.9%	9.3%	4.9%	---
Minnesota	1,327	7.2%	16.5%	4.9%	---
Mississippi	823	16.2%	24.8%	---	---
Missouri	1,491	9.8%	15.6%	6.1%	---
Montana	231	13.8%	(20.7%)	8.8%	---
Nebraska	472	10.4%	(19.1%)	7.4%	---
Nevada	689	16.8%	(29.2%)	9.8%	---
New Hampshire	317	7.1%	(15.3%)	7.4%	---
New Jersey	2,209	13.3%	27.7%	11.5%	4.0%
New Mexico	539	16.6%	(23.0%)	(15.1%)	---
New York	4,744	9.0%	13.2%	8.0%	3.4%
North Carolina	2,340	13.3%	19.3%	10.7%	4.6%
North Dakota	156	9.1%	(18.2%)	---	---
Ohio	2,948	7.5%	12.2%	5.9%	---
Oklahoma	971	13.3%	16.9%	11.6%	---
Oregon	916	12.8%	(20.4%)	8.6%	---
Pennsylvania	2,917	7.7%	14.1%	5.3%	---
Rhode Island	252	6.6%	10.9%	---	---
South Carolina	1,108	13.1%	18.1%	10.2%	---
South Dakota	207	8.8%	13.7%	7.2%	---
Tennessee	1,553	8.1%	10.0%	8.1%	---
Texas	6,989	21.8%	31.5%	17.5%	5.2%
Utah	861	13.1%	21.6%	10.9%	---
Vermont	138	8.5%	(13.4%)	7.3%	---
Virginia	1,939	10.7%	20.0%	6.4%	4.0%
Washington	1,623	7.1%	10.2%	6.7%	4.5%
West Virginia	422	6.6%	7.5%	6.0%	---
Wisconsin	1,393	5.2%	9.1%	4.4%	---
Wyoming	132	9.2%	13.0%	9.4%	---

() = Estimate has a large 95% confidence interval of +/- 5.0 - 7.9 percentage points. Estimates with relative standard errors greater than 30% are not provided.

Table Endnotes

The term family as used in family income, family poverty levels, and family work status, is defined as a health insurance unit (those who are eligible as a group for "family" coverage in a health plan) throughout this report.

- ^a Children includes all individuals under age 19.
- ^b Other includes other public insurance (mostly Medicare and military-related, e.g., Veterans Administration and TRICARE). SCHIP is included in Medicaid.
- ^c The 2007 federal poverty level for a family of four was \$21,203.



THE KAISER COMMISSION ON
Medicaid and the Uninsured

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This report (#7609-02) is available on the Kaiser Family Foundation's website at www.kff.org.

Lynda Zaugg

From: Jennifer Saunders [jennifer.saunders@ncsl.org]
Sent: Wednesday, February 11, 2009 9:27 AM
To: Lynda Zaugg; Thomas Obermeyer; Sen. Bettye Davis
Cc: Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)
Attachments: SCHIP Cost Sharing Rules 2-10-09.doc

Senator Davis, .

We enjoyed listening to your Health and Social Services committee meeting on Monday regarding Senate Bill 13 and Senate Bill 87.

The attached memo is intended to answer the question posed about the SCHIP cost-sharing rules.

Please let me know if you have additional questions or need additional information.

Best regards,
Jennifer

Jennifer B. Saunders, MSW
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----- Original Message -----

From: [Jennifer Saunders](mailto:jennifer.saunders@ncsl.org)
To: [Thomas Obermeyer](mailto:thomas.obermeyer@ncsl.org)
Cc: [Martha King](mailto:martha.king@ncsl.org) ; [Jennifer Breshears](mailto:jennifer.breshears@ncsl.org)
Sent: Monday, February 09, 2009 11:54 AM
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

In addition, you may be interested to know that the legislation signed by President Obama to reauthorize SCHIP last week includes a provision that requires states who wish to cover low-income pregnant women under SCHIP must also cover children in families with incomes up to 200 percent of the federal poverty guidelines.

Please see the link to the full text of this legislation (HR 2).
http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009_schip_reauth/chipra2009.pdf

I have also copy and pasted this information below.

Best regards,

Jennifer

Subtitle B—Focus on Low-Income Children
and Pregnant Women

**SEC. 111. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN
UNDER CHIP THROUGH A STATE PLAN AMENDMENT.**

(a) **IN GENERAL.**—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 112(a), is amended by adding at the end the following new section:

“SEC. 2112. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN THROUGH A STATE PLAN AMENDMENT.

“(a) IN GENERAL.—Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 2102 to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.

“(b) CONDITIONS.—A State may only elect the option under subsection (a) if the following conditions are satisfied:

“(1) MINIMUM INCOME ELIGIBILITY LEVELS FOR PREGNANT WOMEN AND CHILDREN.—The State has established an income eligibility level—

“(A) for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (I)(1)(A) of section 1902 that is at least 185 percent (or such higher percent as the State has in effect with regard to pregnant women under this title) of the poverty line applicable to a family of the size involved, but in no case lower than the percent in effect under any such subsection as of July 1, 2008; and

“(B) for children under 19 years of age under this title (or title XIX) that is at least 200 percent of the poverty line applicable to a family of the size involved.

“(2) NO CHIP INCOME ELIGIBILITY LEVEL FOR PREGNANT WOMEN LOWER THAN THE STATE’S MEDICAID LEVEL.—The State does not apply an effective income level for pregnant women under the State plan amendment that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (I)(1)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.

“(3) NO COVERAGE FOR HIGHER INCOME PREGNANT WOMEN WITHOUT COVERING LOWER INCOME PREGNANT WOMEN.—The State does not provide coverage for pregnant women with higher family income without covering pregnant women with a lower family income.

“(4) APPLICATION OF REQUIREMENTS FOR COVERAGE OF TARGETED LOW-INCOME CHILDREN.—The State provides pregnancy-related assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the State provides child health assistance for targeted low-income children under the State child health plan, and in addition to providing child health assistance for such women.

“(5) NO PREEXISTING CONDITION EXCLUSION OR WAITING PERIOD.—The State does not apply any exclusion of benefits

H. R. 2—20
for pregnancy-related assistance based on any preexisting condition or any waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) for receipt of such assistance.

"(6) APPLICATION OF COST-SHARING PROTECTION.—The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 2103(e) and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.

"(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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----- Original Message -----

From: Jennifer Saunders

To: Thomas Obermeyer

Cc: Martha King ; Jennifer Breshears

Sent: Monday, February 09, 2009 9:50 AM

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Martha King and I will be on the call this afternoon to answer questions.

As we discussed on the phone on Friday, 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.

The following document summarizes these requirements and I would refer you to the summary on page 1 under the heading "Options for Premiums and Cost-sharing" and the "Important Links" on the bottom of page 2. See the document here: <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf>

Under provisions of the Deficit Reduction Act of 2005, 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.

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 (CMS) or by creating a stand-alone SCHIP program.

For more information about cost sharing and SCHIP, please see the following CMS website:

http://www.cms.hhs.gov/MedicaidGenInfo/05_SCHIP%20Information.asp

(Scroll down to see the information under the heading "Cost Sharing.")

Best regards,
Jennifer

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----- Original Message -----

From: Jennifer Saunders

To: [Thomas Obermeyer](mailto:Thomas.Obermeyer@legis.state.ak.us) ; [Lynda Zaugg@legis.state.ak.us](mailto:Lynda.Zaugg@legis.state.ak.us)

Cc: [Martha King](mailto:Martha.King@legis.state.ak.us) ; [Jennifer Breshears](mailto:Jennifer.Breshears@legis.state.ak.us)

Sent: Thursday, February 05, 2009 12:02 PM

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Yes, the following Kaiser report indicates that 7 states have SCHIP eligibility levels below 200 percent of the federal poverty guidelines (FPG):

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

<http://www.kff.org/medicaid/7855.cfm>

(See page 10, Figure 1.)

The 7 states are:

Alaska	175 percent FPG
Idaho	185 percent FPG
Montana	175 percent FPG
Nebraska	185 percent FPG
North Dakota	150 percent FPG
Oklahoma	185 percent FPG*
Oregon	185 percent FPG

* Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115 waiver. However, the currently proposed expansion has been scaled back to 217 percent of the federal poverty line and the future expansion of 218 percent to 300 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

Sources:

Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009

<http://statehealthfacts.org/comparemappable.jsp?ind=203&cat=4>

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009

<http://statehealthfacts.org/comparemappable.jsp?ind=204&cat=4>

Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?
If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

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----- Original Message -----

From: Thomas Obermeyer

To: Jennifer Saunders

Cc: Lynda Zaugg

Sent: Wednesday, February 04, 2009 9:26 PM

Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK
Time (3:30-5:00pm Mtn time)

Jennifer,

In reviewing one of your recommended web sites, the Kaiser Commission on Medicaid and the Uninsured, January 2009 reported that only 7 states, apparently including Alaska, are below 200% FPL. Can you tell me which are the other 6 states?

Tom Obermeyer
Office of Senator Davis
907-465-3762

From: Jennifer Saunders [<mailto:jennifer.saunders@ncsl.org>]

Sent: Wednesday, February 04, 2009 8:31 AM

To: Thomas Obermeyer

Subject: Fw: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK
Time (3:30-5:00pm Mtn time)

Hi Thomas,

I wanted to follow up with you to check that you received the information about SCHIP that I sent you last week.

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

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----- Original Message -----

From: Jennifer Saunders

To: Thomas Obermeyer

Cc: jennifer.breshears ; Martha King ; Senator_Bettye_Davis@legis.state.ak.us ;
Lynda_Zaugg@legis.state.ak.us ; Don_Burrell@legis.state.ak.us

Sent: Friday, January 30, 2009 2:05 PM

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK
Time (3:30-5:00pm Mtn time)

Thomas,

In the attached document, I have compiled some information regarding your questions about the State Children's Health Insurance Program and have included additional resources. At the end of the document, you will find summaries of enacted state legislation that you may find helpful. Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
Jennifer

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----- Original Message -----

From: Martha King

To: Thomas Obermeyer

Cc: jennifer.saunders ; jennifer.breshears

Sent: Tuesday, January 27, 2009 9:41 AM

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK
Time (3:30-5:00pm Mtn time)

Greetings Thomas!

We're happy to provide the information you've requested in your email and to participate by phone on February 9th, if you continue to think we could be helpful. I am asking the two NCSL staff named in the cc line to work on the specifics you've asked for and we will be getting back to you as soon as possible.
In the meantime, please give our regards to Senator Davis & stay warm up there! martha

----- Original Message -----

From: Thomas Obermeyer

To: martha.king@ncsl.org

Cc: Sen. Bettye Davis ; Lynda Zaugg ; Don Burrell

Sent: Monday, January 26, 2009 2:48 PM

Subject: RE: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

January 26, 2009

Martha King, Group Director,
Health Programs, NCSL - Denver
303-364-7700 main line
303-364-7800 fax
303-856-1448 - direct line
E-mail: Martha.king@ncsl.org

RE: Request for:

- A) review and comments concerning Alaska Senate Bill 13 (attached), and
- B) request for NCSL staff to testify at Senate HESS hearing concerning SB 13, Denali KidCare, Alaska SCHIP program February 9, 2009 at 1:30-3:00 pm (3:30-5:00 pm Mountain/Denver time). **Call in number is 888-295-4546**

Dear Ms. King,

Please read the attached **Alaska Senate Bill No. 13**, 26th Legislature, sponsored by Senator Bettye Davis, regarding **increasing income eligibility** under the Denali KidCare -State Children's Health Insurance Program (SCHIP) to **200% Federal Poverty Guidelines (FPG)**. It was raised to 175% last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments. You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
3. Please provide an update, if possible, concerning the number of other states currently at or over 200% FPG, and the number of states over 300% FPG.
4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us

Thomas Obermeyer

From: Jennifer Saunders [jennifer.saunders@ncsl.org]
Sent: Monday, February 09, 2009 9:54 AM
To: Thomas Obermeyer
Cc: Martha King; Jennifer Breshears
Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

In addition, you may be interested to know that the legislation signed by President Obama to reauthorize SCHIP last week includes a provision that requires states who wish to cover low-income pregnant women under SCHIP must also cover children in families with incomes up to 200 percent of the federal poverty guidelines.

Please see the link to the full text of this legislation (HR 2).

http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009_schip_reauth/chipra2009.pdf

I have also copy and pasted this information below.

Best regards,
 Jennifer

Subtitle B—Focus on Low-Income Children
 and Pregnant Women

**SEC. 111. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN
 UNDER CHIP THROUGH A STATE PLAN AMENDMENT.**

(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 112(a), is amended by adding at the end the following new section:

**“SEC. 2112. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT
 WOMEN THROUGH A STATE PLAN AMENDMENT.**

“(a) IN GENERAL.—Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 2102 to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.

“(b) CONDITIONS.—A State may only elect the option under subsection (a) if the following conditions are satisfied:

“(1) MINIMUM INCOME ELIGIBILITY LEVELS FOR PREGNANT WOMEN AND CHILDREN.—The State has established an income eligibility level—

“(A) for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (I)(1)(A) of section 1902 that is at least 185 percent (or such higher percent as the State has in effect with regard to pregnant women under this title) of the poverty line applicable to a family of the size involved, but in no case lower than the percent in effect under any such subsection as of July 1, 2008; and

“(B) for children under 19 years of age under this title (or title XIX) that is at least 200 percent of the poverty line applicable to a family of the size involved.

“(2) NO CHIP INCOME ELIGIBILITY LEVEL FOR PREGNANT WOMEN LOWER THAN THE STATE'S MEDICAID LEVEL.—The State does not apply an effective income level for pregnant women

under the State plan amendment that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (I)(1)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.

“(3) NO COVERAGE FOR HIGHER INCOME PREGNANT WOMEN WITHOUT COVERING LOWER INCOME PREGNANT WOMEN.—The State does not provide coverage for pregnant women with higher family income without covering pregnant women with a lower family income.

“(4) APPLICATION OF REQUIREMENTS FOR COVERAGE OF TARGETED LOW-INCOME CHILDREN.—The State provides pregnancy-related assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the State provides child health assistance for targeted low-income children under the State child health plan, and in addition to providing child health assistance for such women.

“(5) NO PREEXISTING CONDITION EXCLUSION OR WAITING PERIOD.—The State does not apply any exclusion of benefits H. R. 2—20

for pregnancy-related assistance based on any preexisting condition or any waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) for receipt of such assistance.

“(6) APPLICATION OF COST-SHARING PROTECTION.—The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 2103(e) and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.

“(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

Jennifer B. Saunders, MSW
 Research Analyst
 Health Program
 National Conference of State Legislatures
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 Denver, CO 80230
 303.856.1440
jennifer.saunders@ncsl.org

www.ncsl.org

----- Original Message -----

From: [Jennifer Saunders](#)

To: [Thomas Obermeyer](#)

Cc: [Martha King](#) ; [Jennifer Breshears](#)

Sent: Monday, February 09, 2009 9:50 AM

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

last year under SB 27, 25th Legislature.

Senator Davis, Chair, Senate HESS Committee (and Vice-Chair NCSL Health Committee) is considering an amendment at hearing to extend optional coverage to applicants over 200% FPG not to exceed 250% FPG with provisions of premiums or co-payments . You will note that there is no asset test in the bill.

Your comments in return e-mail to me as soon as possible before the hearing would be particularly helpful in the following areas:

1. Please let me know if other states are drafting similar bills, and if one or another state has particularly clear or comprehensive language to review, and
2. if asset tests, payments, and co-payments are common, and if other matters of eligibility other than income and household size under federal poverty guidelines are codified in statutes or are limited to and found in administrative codes, regulations, department or agency directives, and/or just in signed or unsworn applications for benefits.
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4. Please also comment regarding the SCHIP Bills running through Congress. An Associated Press Article appeared today, January 26, 2009, in the *Juneau Empire*, page A6, "Kids' health care bill angers Republicans" -because, among other things, there appears to be no income limit in the legislation, only reduced Medicaid reimbursement rates if states move higher than three times the federal poverty guidelines.

Please have NCSL staff call in to the hearing teleconference line on February 9, 2009 noted above at 888-295-4546 to testify and/or field questions.

Sincerely,

Thomas S. Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
907-465-3822 office
907-465-3762 direct line
907-465-3756 fax
Thomas_Obermeyer@legis.state.ak.us



Sponsor Statement

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

SB 13 increases and restores the qualifying income eligibility standard for the Denali KidCare Program to 200% of the Federal Poverty Line (FPL) to its original levels 12 years ago. As you know, Alaska is one of the nation's wealthiest states yet Alaska is only one of 5 states that still funds our SCHIP program below 200% FPL. SB 13 makes health insurance accessible to approximately 1,277 uninsured children and 225 pregnant women in Alaska.

Denali KidCare is an "enhanced" reimbursement program with 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 and President Obama signed into law on February 4, 2009. This reauthorization expanded the coverage to 4 million additional children and is re-authorized through 2013.

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

- 45 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 7,900 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.

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. Early intervention and preventative care under SB 13 will greatly increase Alaska children's health and yield substantial savings to the state, public and private sector hospitals, emergency rooms which are required to admit indigent and uninsured patients for non-emergency treatment.

There are still an estimated 18,000 uninsured children in Alaska. This is 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. Alaska should do its share and take advantage of available federal matching funds by insuring its low income children and pregnant women up to and including 200% FPL under SB 13.

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----- Original Message -----

From: Jennifer Saunders

To: Thomas Obermeyer ; Lynda Zaugg@legis.state.ak.us

Cc: Martha King ; Jennifer Breshears

Sent: Thursday, February 05, 2009 12:02 PM

Subject: Re: SB 13, Denali KidCare/SCHIP program - Senate HESS Hearing Feb 9, 2009 1:30-3:00 AK Time (3:30-5:00pm Mtn time)

Thomas,

Yes, the following Kaiser report indicates that 7 states have SCHIP eligibility levels below 200 percent of the federal poverty guidelines (FPG):

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

<http://www.kff.org/medicaid/7855.cfm>

(See page 10, Figure 1.)

The 7 states are:

Alaska	175 percent FPG
Idaho	185 percent FPG
Montana	175 percent FPG
Nebraska	185 percent FPG
North Dakota	150 percent FPG
Oklahoma	185 percent FPG*
Oregon	185 percent FPG

* Oklahoma passed legislation to increase the income eligibility guideline to 300 percent of the federal poverty line under its current section 1115 waiver. However, the currently proposed expansion has been scaled back to 217 percent of the federal poverty line and the future expansion of 218 percent to 300 percent of the federal poverty line is pending further CMS guidance and SCHIP reauthorization.

Sources:

Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009

<http://statehealthfacts.org/comparemaptable.jsp?ind=203&cat=4>

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009

<http://statehealthfacts.org/comparemaptable.jsp?ind=204&cat=4>

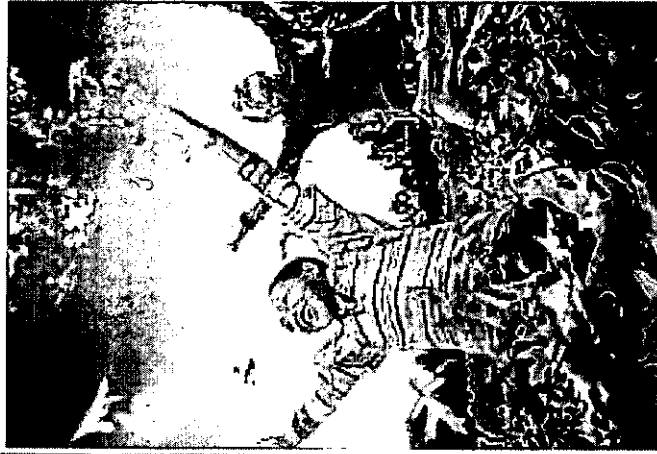
Would you still like for NCSL to participate by phone in the Senate HESS hearing concerning SB 13 on February 9, 2009?

If yes, what are you expecting from us (a presentation, or just being available to answer questions, etc.)?

Please feel free to contact me if you would like any additional information or if you have any additional questions.

Best regards,
 Jennifer

Alaska's Citizen Review Panel



Our focus areas today will be:

- To provide a brief overview of the Citizen Review Panel & to highlight our activities since last year
- To share with you what we hear about the Office of Children's Services
- To ask you to help improve the situation



Mandate for the Group

The Citizen Review Panel is mandated by state and federal law. The CRP was created through the federal Child Abuse Prevention & Treatment Act (CAPTA); Keeping Children & Families Safe Act of 2003 and through Alaska statute Sec. 47.14.205.



CRP Vision

To enable the Office of Children's Services to implement its policies and procedures in a culturally sensitive and consistent manner across the state.



Who are we?

The CRP is composed of volunteer members who are broadly representative of the state, including members who have expertise in the prevention and treatment of child abuse and neglect. The group chooses its own members.



Current members

- Fred VanWallinga,
Willow (Chair)
- Carol Olson,
Anchorage (Vice-
Chair)
- Pamela Dupras,
Kodiak
- Dana Hallett,
Soldotna
- Art Hansen,
Fairbanks
- Susan Heuer,
Anchorage
- Kristin Hull, Wasilla
- Ralph Taylor,
Anchorage (currently
deployed with the
Alaska National
Guard)



CRP Duties

Evaluate Office of Children's Services (OCS) compliance with federal and state laws, examine the policies, procedures and practices of OCS, and, where appropriate, evaluate specific cases of child abuse or neglect.



CRP Duties (continued)

The CRP must also:

- Maintain confidentiality
- Conduct public outreach
- Produce an annual report
- Meet at least quarterly



Our focus for the past year

- Potential for additional 5th service region
- Improving situation in Copper River Basin



What we've been doing

- Holding monthly teleconferences
- Produced an annual report
- Attended the Alaska Native Indian Child Welfare Summit
- Attended national Citizen Review Panel conference in Minnesota
- Meeting in-person quarterly



What else we've been doing

- Meeting with OCS partner agencies
- Meeting with OCS staff from Director Sandoval to line workers
- Participated in the federal Child and Family Services Review
- Met with UA staff responsible for OCS training
- Meeting with the Commissioner and Legislators



A couple more things we did

- Attended the Family to Family Conference
- Attended the Community Care Conference
- Heard from concerned citizens
- Received training on safety assessment



Where some of us have been

- Aniak
- Bethel
- Copper Center
- Dillingham
- Fairbanks
- Glennallen
- Juneau
- King Salmon
- Naknek
- St. Mary's
- Unalaska



We've met with...

- Counseling center staff
- District attorneys
- Foster parents
- Health aides & public health nurses
- ICWA workers
- Local police departments
- OCS staff
- School principals, nurses & counselors
- State troopers
- Tribal representatives
- WIC workers



OCS is improving due to...

- Key personnel changes
- System changes—safety assessment, expanded training, ORCA programming improvements
- Increased collaboration with partnering state agencies (DJJ, Dept. of Law, etc.)



OCS is improving due to...

- Continued and increased financial support from Legislature during past couple fiscal years
- Responsive to outside recommendations (ACTION for Children, CRP, federal audit)



Issues of concern

- Hiring freeze
- Region 5
- Many solutions to problems are beyond the control of OCS, Director lacks discretion
- Standardization



Issues of concern

- Hiring freeze

OCS is public safety like the Troopers in as much as they have a protective function

In rural areas, workers are already stretched, further unfillable vacancies with no end in sight will directly affect child safety

Increased risk of current workers leaving due to work overload



Issues of concern

- Region 5
 - Last year we strongly advocated for Region 5 based on Bethel community support
 - SCRO has 13 offices, next largest region has 7
 - OCS costed-out Region 5 for \$1.5 million, but the region was not in the Governor's budget



Issues of concern

- Region 5
 - Bethel OCS and community partners continue to support this idea, but other communities have concerns
 - Over the next year, the CRP will intensively survey all Southwestern Alaska field offices and community partners
 - We continue to think that a smaller more culturally focused region is in the best interest of children



Issues of concern

- Many solutions to problems are beyond the control of OCS, Director lacks discretionary powers



Issues of concern

- Standardization of supports for employees varies between state agencies
 - Housing
 - Internet



We'd like your help to address these concerns

- Support the exemption of OCS from hiring freeze and issuance of immediate variances
- Investigate and resolve the lack of standardization between state agencies



Benefits of CRP

- Seven volunteer members all contributing a minimum of 250 active hours annually
- We're the eyes and ears of the public for the Legislature and OCS
- Unique function of identifying and advocating for ancillary services that OCS cannot request
- Jointly we can achieve a vastly improved child protection system for the children of Alaska



Alaska's Citizen Review Panel



For more
information,
please visit our
website
www.crpalaska.org

