SB

5

<TARGET><BILL>SB 5</BILL><SUBJECT>SB
5</SUBJECT><COMM>SFIN27</COMM></TARGET>

SENATE FINANCE COMMITTEE REPORT

DATE: 3/30/11

FURTHER:

DATE TURNED IN TO OFFICE: 4/11/11

Finance Committee considered SENATE BILL NO. 5

SB 5-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 **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS	X			1
DHS	X			2
DHS	X			3

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Thomas	✓			
		✓			
	Olson			✓	
	Ellis	X			
CO-CHAIR:		✓			
CO-CHAIR:	STEDMAN			✓	

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 3
Bill Version: SB 5
(S) Publish Date: 3/30/11

Identifier (file name): SB005-DHSS-PAFS-02-17-11
Title: Medical Assistance Eligibility
Sponsor: Sen. Bettye Davis, Sen. Dennis Egan
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Public Assistance
Allocation: Public Assistance Field Services
OMB Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services	187.0		187.0	187.0	187.0	187.0	187.0
Travel							
Services	19.4		19.4	19.4	19.4	19.4	19.4
Commodities	1.0		1.0	1.0	1.0	1.0	1.0
Capital Outlay	14.4						
Grants							
Miscellaneous							
TOTAL OPERATING	**221.8**	**0.0**	**207.4**	**207.4**	**207.4**	**207.4**	**207.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	144.2		134.8	134.8	134.8	134.8	134.8
1003 GF Match	77.6		72.6	72.6	72.6	72.6	72.6
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**221.8**	**0.0**	**207.4**	**207.4**	**207.4**	**207.4**	**207.4**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

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

Why this fiscal note differs from previous version:
Not applicable, initial version.

Prepared by: Ron Kreher, Acting Director
Division: Public Assistance
Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Phone (907) 465-2680
Date/Time 2/17/11 12:00 AM
Date 2/17/2011

(Revised 12/29/2010 OMB)

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 5

Analysis:

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.

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, 2011. We estimate two additional Eligibility Technician II (Range 14) positions will be needed to manage this additional work in FY2012.

Total Administrative Costs for Two ET II Positions:

Personal Services: Two Eligibility Technician II Range 14 at a cost of $187.0, including benefits, for 12 months.
Contractual: Annual cost for office space, phones, etc. will be $19.4.
Commodities: Annual cost for the office supplies will be $1.0.

Additional Cost of FY2012:
Equipment/Supply: A one-time cost of $14.4 for desktop computer, software, printer, and work stations will be needed for the new positions.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 5
(S) Publish Date: 3/30/11

Identifier (file name): SB005-DHSS-BHMS-02-17-11
Title: Medical Assistance Eligibility
Sponsor: Sen. Bettye Davis, Sen. Dennis Egan
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants	567.0		615.7	668.7	726.2	788.6	856.4
Miscellaneous							
TOTAL OPERATING	**567.0**	**0.0**	**615.7**	**668.7**	**726.2**	**788.6**	**856.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	383.6		416.5	452.3	491.2	533.4	579.3
1003 GF Match	183.4		199.2	216.4	235.0	255.2	277.1
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**567.0**	**0.0**	**615.7**	**668.7**	**726.2**	**788.6**	**856.4**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version:

Not applicable, initial version

Prepared by: Kimberly Poppe-Smart, Director — Phone 907-334-2520
Division: Health Care Services — Date/Time 2/17/11 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/17/2011
DHSS Finance & Management Services

FISCAL NOTE #2

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 5

Analysis:

Denali KidCare is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually. In 2003, DKC eligibility limits were reduced from 200% of poverty to 175% and frozen at 2003 levels. In 2007, the income limits were unfrozen, but remained at 175% of poverty. This bill would restore Denali KidCare to its original level.

Children age 18 and under at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2012, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid. Pregnant women under this income level are eligible only for regular Medicaid (50% match).

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 at 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2012 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 2010. 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 2010 and our best estimates for federal medical assistance percentages (FMAPs) between 2012 and 2017. 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 2012 and 2017.

Expenditures for the Behavioral Health Medicaid Services component were determined based on the component's share of expenses for the affected eligibility subtypes in 2010. Behavioral Health paid about 15% of the costs for affected DKC children in 2010. No charges for services for DKC pregnant women were paid by this component in 2010.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 5
(S) Publish Date: 3/30/11

Identifier (file name): SB005-DHSS-HCMS-02-17-11
Title: Medical Assistance Eligibility
Sponsor: Sen. Bettye Davis, Sen. Dennis Egan
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants	2,718.2		2,952.0	3,205.8	3,481.5	3,781.0	4,106.1
Miscellaneous							
TOTAL OPERATING	**2,718.2**	**0.0**	**2,952.0**	**3,205.8**	**3,481.5**	**3,781.0**	**4,106.1**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,897.8		2,061.1	2,238.3	2,430.8	2,639.9	2,866.9
1003 GF Match	820.4		890.9	967.5	1,050.7	1,141.1	1,239.2
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**2,718.2**	**0.0**	**2,952.0**	**3,205.8**	**3,481.5**	**3,781.0**	**4,106.1**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Kimberly Poppe-Smart, Director — Phone 907-269-7827
Division: Health Care Services — Date/Time 2/17/11 12:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/17/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE #1

STATE OF ALASKA **BILL NO.** SB 5
2011 LEGISLATIVE SESSION

Analysis:

Denali KidCare is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually. In 2003, DKC eligibility limits were reduced from 200% of poverty to 175% and frozen at 2003 levels. In 2007, the income limits were unfrozen, but remained at 175% of poverty. This bill would restore Denali KidCare to its original level.

Children age 18 and under at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2012, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid. Pregnant women under this income level are eligible only for regular Medicaid (50% match).

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 SFY2012 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 2010. 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.

Cost 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 XXI rates , Title XIX, or State General Fund only (for abortions) during 2010 and our best estimates for federal medical assistance percentages (FMAPs) between 2012 and 2017. 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 2012 and 2017.

Expenditures for the Health Care Services Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2010. Health Care Services Medicaid paid 100% of the costs for DKC pregnant women and about 85% of the costs for affected DKC children in 2010.

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
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 5 - "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Sponsor Statement

Senate Bill 5 increases and restores to original levels established 14 years ago the qualifying income eligibility standard to 200% of the Federal Poverty Level (FPL) for the State Children's Health Insurance Program (SCHIP) called Denali KidCare (DKC) in Alaska. Alaska as one of the nation's wealthiest states is only one of four states which funds its SCHIP program below 200% FPL. This bill makes health insurance accessible to an estimated 1277 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an enhanced Medicaid reimbursement program receiving up to 70% federal matching funds.

Denali KidCare serves an estimated 7900 Alaska children and remains one of the least costly medical assistance programs in the state at about $1,700 per child with full coverage, including dental care, which is about 20% of the cost of adult senior coverage. Early intervention and preventative care 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 per the Kaiser Foundation that the 24,000 uninsured children in Alaska 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.

A similar bill was overwhelmingly passed with bipartisan support by the Legislature in 2010. Governor Parnell subsequently vetoed the bill over concern that increased eligibility to Denali KidCare would require an increase in state-funded induced terminations of pregnancies. Medicaid funds 51% of all births in Alaska. In order to continue to receive federal funding for the state Medicaid program of which Denali KidCare is part, and in order to comply with state law, constitutional provisions, and Alaska Supreme Court rulings, the state must provide medical services for pregnant women including medically necessary terminations, as well as prenatal and postpartum care.

The Alaska Department of Health and Social Services (DHSS) estimated that no more than 10% or 22 more induced terminations would result with minimal expense from the increase in eligibility for Denali KidCare to 200% FPL. Induced terminations under Denali KidCare cost about $384,000 annually or less than 0.18% or 1/5 of 1% of the $217 million of the DKC budget.

While the Governor understandably is concerned about the mushrooming cost of the state Medicaid program, Denali KidCare which is about 18% of the $1.2 billion total state Medicaid budget should not be among his first cuts at the expense of Alaska's most vulnerable children and pregnant women. Increasing eligibility for DKC to 200% FPL under Senate Bill 5 is uncomplicated, manageable, and could take effect immediately with prompt implementation by DHSS.

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 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 5 "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

- State Children's Health Insurance Program (SCHIP), which is administered in Alaska through the Denali KidCare Program 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 SCHIP 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%.
- Denali KidCare provides health insurance for children up to 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 7,900 children were covered by Denali KidCare in 2009.
- 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 substantial deductible, 20% co-pay, and no vision, dental or hearing benefits.

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 fro pregnancy-related mortality and complications of childbirth (DHSS).
- The average cost of hospital care for a premature baby was $75,000 in 2001, compared with $1,300 for a healthy, full-term infant. The March of Dimes Prenatal Data Center reports that premature babies cost about $13.1 billion annually.

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 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 5 "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 Care Needs of Alaska's Uninsured Children

- The number of uninsured children in Alaska is estimated to be about 24,100 or 19% of the uninsured population (Kaiser Family Foundation, 2008-2009).
- 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.

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 24, 2011

SUBJECT: Sectional Summary (SB 5; Work Order No. 27-LS0057\B)

TO: Senator Bettye 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
11-034.ljw

LEGAL SERVICES

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

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

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

MEMORANDUM March 29, 2011

SUBJECT: Discussion points relating to medical necessity
(SB 5 (Work Order No. 27-LS0057\B))

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have provided a March 28, 2011 memorandum from the Department of Health and Social Services and comments from the Planned Parenthood of the Greater Northwest pertaining to the above-referenced bill and the concept of medical necessity as it relates to Medicaid funding of abortions.

I understand the basis for the Department of Health and Social Services memorandum relates at least indirectly to my own memorandum on the concept of medical necessity dated November 18, 2010. The department appears, however, to be interested in clarifying its own undated fact sheet presented to you that contains the following statement:

> "Medically necessary" as it applies to abortions paid for under Denali KidCare is not defined in statute or regulation, or by Court decision.

My memorandum on the subject provided a survey of the several instances in state regulation, and in federal and state court cases in which the concept is or was defined. 7 AAC 105.100(5), I pointed out, provides that the department will pay for medical assistance, including Denali KidCare and abortion services, that are

> medically necessary as determined by criteria established under 7 AAC 43 and 7 AAC 105 - 7 AAC 160 or by the standards of practice applicable to the provider.

In the same memorandum, I also explained that a statutory definition of medical necessity that was limited only to abortion services funding was vetoed in 2002, that the general relief assistance program contains a regulatory definition for abortion funding, and that a former regulatory definition (7 AAC 43.140(a)) was found to be unconstitutional by the

Alaska Supreme Court, resulting in the state's current lack of a clear definition of the phrase as it applies to medical assistance funding for abortion services. (November 18 memorandum at page 5). I also explained that although the phrase is "not clearly defined in Alaska" the regulations that pertain to all covered services and to other specified types of services provide "some guidance" (November 18 memorandum at page 8). The memorandum further described several court cases in which the concept is analyzed and described.

In this context, the March 28, 2011 memorandum from the department is confusing. While admitting that current and unrepealed (the lack of funding for one of the programs is not relevant to the existence of the regulation) definitions of the phrase exists in several sections of state regulations, the department stated that

> . . . the Department believes its previous statement that there is no statute, regulation, or court decision that defines medical necessity as it applies to abortions paid for under Denali KidCare is accurate.

My understanding of the purpose of the November 18 memorandum by my office and the discussion in committee, was to come to some agreement on the meaning of the concept of medical necessity and to discern which definition is currently applied by the department for medical assistance funding of abortions in this state and elsewhere. The department doesn't answer that question except to refer to a definition in the regulations for all medical assistance funding. So the department's position becomes quite circular.

In any event, the legislature could provide a definition in statute of the phrase "medical necessity" that allows for consideration of physical, mental, and age of a patient by a physician. In so doing, the concept must in my opinion be consistent for all reproductive services covered by medical assistance payments. The current regulatory definition in 7 AAC 105.100(5) acknowledges the applicability of standards of medical practice to covered services but confuses the issue by cross-referencing medical necessity considerations for mental health and other services that may or may not be relevant to other types of services.

Another option that would allow for an increase in income eligibility limits include raising the limit only as it pertains to persons under 19 years of age and not for pregnant women. The difficulty with that option is that the state plan combines children and pregnant women and the federal law also treats them similarly. A separation would require federal approval.

A third option, proposed by Planned Parenthood in various ways, is to introduce a separate bill to address family planning services for both men and women, including adoption services. That, of course, would also necessitate a state plan amendment and approval as well as additional funding.

As a modification of this third option, it is possible to amend the informed consent provisions for abortion under AS 18.16.060(b)(1) to require a physician's office to provide the information contained on the state website (currently it is one of two options for consent) and to amend AS 18.05.032 to provide additional information about adoption services and costs.

If I may be of further assistance, please advise.

JMM:plm
11-193.plm

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 November 18, 2010

SUBJECT: Medicaid funding of "medically necessary" abortions
(Work Order No. 27-LS0175)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have asked about the meaning of "medical necessity" as it relates to medical assistance (Medicaid) funding of abortions. State and federal statutes fail to define the phrase, although the concept forms the basis for coverage of all services under the jointly funded Medicaid program and is defined for purposes other than abortion services in regulation.

Despite a federal exclusion for most abortion services known as the "Hyde Amendment," upheld by the United States Supreme Court, the Alaska Supreme Court in 2001 specifically held that the equal protection guarantee under our state constitution requires the state to cover medically necessary abortion services, as it does for all other medical services covered under state Medicaid funding. The standard for "medical necessity" in Alaska appears to be similar for all Medicaid services and includes services that are broader than life saving services but less than elective services, as discussed below.

FEDERAL LAW DRAWS A DISTINCTION BETWEEN ABORTION SERVICES FUNDING AND OTHER TYPES OF COVERED SERVICES

The federal purpose of the Medicaid program established the medical necessity standard under 42 U.S.C.S. § 1396-1 as follows:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of *necessary medical services*, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Emphasis added.) Since 1976, Congress has prohibited, either by an amendment to the annual appropriations bill for the United States Department of Health and Human Services, or by joint resolution, the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances. The "Hyde Amendment" provides that:

> [N]one of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service.

Pub. L. 96-123.

After the passage of the Hyde Amendment, federal courts wrestled with questions about whether state and federal governments are required to pay for an indigent woman's exercise of a fundamental constitutional right when a "medically necessary" abortion is involved. In several close decisions, the U.S. Supreme Court determined that the federal constitution does not require public financial support of the right to choose an abortion in cases that do not involve rape or incest or a threat to the mother's life. Beal v. Doe, 432 U.S. 438 (1977); Maher v. Roe, 432 U.S. 464 (1977); Harris v. McRae, 448 U.S. 297 (1980); Webster v. Reproductive Health Services, 492 U.S. 490 (1989). It is instructive to note the trial court definition in the McRae case of the phrase "medically necessary" for purposes of abortion funding was "a professional judgment for the physician that may be exercised in the light of all factors--physical, emotional, psychological, familial and the woman's age--relevant to the well-being of the patient."

The federal courts ruled in these cases that governments are not required to provide money to assist in the exercise of constitutional rights; governments are only prohibited from placing obstacles in the way of exercising those rights. Withholding funding, said the federal courts, is not an obstacle to the indigent woman who seeks an abortion. Her poverty may be an obstacle, but the government did not create the poverty. She is still free to have an abortion, but not with public money. The federal courts suggested other private money might be available. In light of these federal decisions, it is clear that public funding for abortions, even when "medically necessary," is not required under the federal constitution.

ALASKA LAW REQUIRES A MORE UNIFORM BUT INEXACT STANDARD FOR STATE MEDICAID FUNDING OF ALL TYPES OF SERVICES COVERED, INCLUDING ABORTION SERVICES

In the early 1990's, the state attempted to adopt the federal distinction for funding of abortion services and disregarded the general medical necessity definition adopted in regulation for other types of services. In a direct challenge to the state regulation that provided only for public funding of abortion services to preserve the life of the mother or

in cases of rape or incest, the Alaska Supreme Court held that the state must pay for medically necessary abortions for participants in the Medicaid program as it does for other types of services. State v. Planned Parenthood of Alaska, Inc., 28 P.3d 904 (Alaska 2001). The Alaska Supreme Court determined then that the "rape, incest, and to prevent the death of the mother" restrictions of the Hyde Amendment are too narrow to satisfy the requirements of the Alaska state constitution.

The Alaska constitution has been consistently interpreted to provide broader protections than the federal constitution. For instance, in Valley Hospital Ass'n v. Mat-Su Coalition for Choice, 948 P.2d 963, 969 (Alaska 1997), the Alaska Supreme Court held that "reproductive rights are fundamental . . . [and] include the right to an abortion." Later, in State v. Planned Parenthood of Alaska, Inc., 28 P.3d 904 (Alaska 2001), the Alaska Supreme Court, although basing its decision on due process considerations rather than the privacy clause used by the lower court, came to the same conclusion the lower court had. The conclusion was that if the state Department of Health and Social Services (DHSS) restricted abortion coverage for Medicaid-eligible women to only those covered by the exceptions in the Hyde Amendment, it would result in unconstitutional implementation of Medicaid in Alaska.

There is language in the Planned Parenthood of Alaska, Inc. case (cited above; see 28 P.3d at 913) strongly suggesting that the Alaska Supreme Court considers women who carry their pregnancy to term to be similarly situated with women who have an abortion (in that they are both exercising their constitutional freedom of reproductive choice). If the court continues to hold that position when faced with a renewed public abortion funding challenge, there is a possibility that the court will find that the state may not be able to burden the right to abortion services under the state Medicaid program unless a similar burden is placed on medical services to continue a pregnancy, and in the absence of comparable burdens on continuation of a pregnancy the state cannot burden the right to abortion services.

The consequence of having a more broadly interpreted right to public funding of abortions for Medicaid recipients in Alaska than what is allowed under federal law is that DHSS must cover some Medicaid abortions with 100% state money (no federal match).[1] The federal government does not prohibit states from using their own funds.

Over the years, language has appeared in Alaska budget acts that purport to prohibit DHSS from using any of its appropriated money for abortions outside the scope of the

---

[1] Alaska is reportedly not alone in using purely state funds for some Medicaid abortions that the federal government will not fund. I do not have an up-to-date list and I have not double-checked the cases cited, but the ACLU says that 17 states fund abortions outside the Hyde Amendment restrictions, 4 voluntarily and 13 under court order. I have attached the relevant information, as reported by the ACLU, excerpted from http://www.aclu.org. I cannot vouch for the accuracy of the ACLU website, but if you require further information about public funding of abortions in other states, please let the office know.

Hyde Amendment. However, DHSS has been under court order to continue to pay for medically necessary abortions and has complied with the state attorney general's advice to do so.[2]

---

[2] For instance, with regard to the 2007 fiscal year operating budget, the attorney general wrote the following:

> This year's budget, as did the prior four years' budgets, contains the following language regarding abortion funding:
>
> > No money appropriated in this appropriation may be expended for an abortion that is not a mandatory service required under AS 47.07.030(a). The money appropriated for Health and Social Services may be expended only for mandatory services required under Title XIX of the Social Security Act and for optional services offered by the state under the state plan for medical assistance that has been approved by the United States Department of Health and Human Services . . . .
>
> [citation omitted]. As we opined before, this language is intended to prevent expenditures from these appropriations for therapeutic or medically necessary abortions. DHSS, however, is under a superior court order to operate its Medicaid program in a constitutional manner by providing payment for them. That superior court order has been upheld by the Alaska Supreme Court, which specifically rejected an argument that the separation-of-powers doctrine precluded the superior court from ordering the state to pay. State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, 28 P.3d 904 (Alaska 2001). Thus, the DHSS is faced with a ruling from the state's highest court that the limit on payment for abortion services results in the operation of the Medicaid program in an unconstitutional manner, while DHSS is ostensibly without the money available to pay for services to operate the program legally. . . . Five years ago, the plaintiffs in the Planned Parenthood case asked the superior court to clarify how similar budget restrictions impacted its judgment. The superior court, three days after the supreme court affirmed the judgment, issued an opinion ordering the DHSS not to comply with the restrictions. To date, therefore, DHSS has obeyed the superior court's order and we must advise DHSS to continue to obey it; i.e., to continue to pay for these medically necessary abortions, until such time as a court reverses the order that is now in effect.

2007 Alas. AG LEXIS 21, 7 - 8.

According to DHSS, the money used for Medicaid abortions not covered by the Hyde Amendment (i.e., abortions for which the federal government will not contribute federal money), comes from the appropriation made by the legislature to DHSS for Medicaid.[3]

Other attempts to narrow the definition of "medical necessity" for purposes of abortion services funding have similarly failed. In 2002, for example, the Alaska Legislature passed and the governor vetoed a bill (SB 364, 22nd Legislature) that added a new section to AS 47.07 to provide that the state Medicaid program may only pay for medically necessary abortions and for abortions to terminate pregnancies resulting from rape or incest. The bill prescribed what is a medically necessary abortion and established requirements for submitting claims for payment for abortions. (See SB 364, attached). That bill provided as follows:

> (b) A claim for payment for a medically necessary abortion that is submitted to the department must be accompanied by a written certification by the treating physician that the abortion is medically necessary to treat a serious
>
> (1) adverse physical condition of a pregnant woman that
>
> (A) either is caused by the pregnancy or would be significantly aggravated by continuation of the pregnancy; and
>
> (B) would seriously endanger the physical health of the woman if the pregnancy were not terminated by an abortion; or
>
> (2) psychological illness of a pregnant woman who requires medication for treatment of the illness if
>
> (A) the medication required to treat the illness would be highly dangerous to the fetus; and
>
> (B) the health of the woman would be endangered if the mediation was not taken during pregnancy.

Since the bill was vetoed and the definition of "medical necessity" for purposes of abortion services funding contained in former 7 AAC 43.140(a) was held to be unconstitutional in 2001 and has recently been repealed but not reenacted, the state currently lacks a clear definition of the phrase as it applies to abortion services. The repealed regulatory definition provided that:

> (a) Payment for an abortion will, in the department's discretion, be covered under Medicaid if the physician services invoice is accompanied by certification that the (1) life of the mother would be endangered if the pregnancy were carried to term; or (2) pregnancy is the result of an act of rape or incest.

---

[3] If the physician submitting the Medicaid claim for costs associated with an abortion does not provide the information that would allow DHSS to document to the federal government that a particular abortion falls within the Hyde Amendment exceptions, then DHSS does not seek a federal match for the costs associated with that abortion.

What remains in the regulations for abortion services funding are the terms "elective" and "therapeutic" (a term that appears to be used as a substitute in the regulations for "medical necessity"), defined in 7 AAC 47.290, along with the general concept of "medically necessary" for all covered services under 7 AAC 105.100.

For general relief funding,[4] 7 AAC 47.290 provides as follows:

> . . .
> (7) "elective abortion" means a procedure, other than a therapeutic abortion, to terminate a pregnancy;
> (8) "therapeutic abortion" means the termination of a pregnancy;
> (A) certified by a physician as medically necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health; or
> (B) that resulted from actions that would constitute a crime of sexual assault under AS 11.41.410 - 11.41.425, a crime of sexual abuse of a minor under AS 11.41.434 - 11.41.440, or the crime of incest under AS 11.41.450.

For state funding under Medicaid, 7 AAC 105.100 describes "covered services" to include the general concept of "medically necessary" with cross-references to specified types of services as follows:

> The department will pay for a service only if that service
> (1) is identified as a covered service in accordance with AS 47.07, 7 AAC 43, and 7 AAC 105 - 7 AAC 160;
> (2) is provided to an individual who is eligible for Medicaid under 7 AAC 100 on the date of service;
> (3) is ordered or prescribed by a provider authorized to order or prescribe that service under applicable law;
> (4) is provided by a person who is enrolled as a Medicaid provider or rendering provider under 7 AAC 105.210, or otherwise eligible to receive payment for services under 7 AAC 43 and 7 AAC 105 - 7 AAC 160;
> *(5) is medically necessary as determined by criteria established under 7 AAC 43 and 7 AAC 105 - 7 AAC 160 or by the standards of practice applicable to the provider;*
> (6) has received prior authorization from the department, if prior authorization is required under 7 AAC 43 or 7 AAC 105 - 7 AAC 160; and

---

[4] Like the Medicaid program, the general relief program is designed to meet "medical needs." While some abortions are termed "elective" by some observers, they still meet a medical need, as determined by the physician who performs the abortion procedure. Distinguishing among types of abortions in the general relief program would infringe the same privacy and equal protection interests as courts have determined are infringed when abortion funding restrictions are imposed under the Medicaid program.

(7) is not specifically excluded as a noncovered service under 7 AAC 43 or 7 AAC 105 - 7 AAC 160.

(Emphasis added.) The phrase "medically necessary" is defined for purposes of mental health services and other purposes such as vision, hearing, and dental screening funding under Medicaid as follows:

7 AAC 43.486. Medical necessity determinations for mental health rehabilitation services

(a) The division will, in its discretion, periodically review the recipient's clinical record to determine whether the services requested are medically necessary. A medically necessary mental health rehabilitation service is a service designed to

(1) screen recipients for the presence of a mental or emotional disorder;

(2) assess the nature and extent of the mental or emotional disorder and its impact upon the recipient's ability to meet the demands of daily living, social, occupational, or educational functioning;

(3) diagnose the mental or emotional disorder;

(4) treat the mental or emotional disorder;

(5) provide rehabilitation for the mental or emotional disorder;

(6) prevent the relapse or deterioration of the recipient's condition due to the mental or emotional disorder.

(b) In making its determination as to whether the proposed services are medically necessary, the division will consider the following:

(1) the recommendations of the referring physician, mental health professional clinician, or interdisciplinary team organized under 7 AAC 43.470 that prescribed, ordered, recommended, or approved the service;

(2) the recipient's diagnosis and level of functioning;

(3) the risk of danger from the recipient to self or other individuals;

(4) the appropriateness of the level of care and the need for inpatient or residential care;

(5) whether the intervention targets specific symptoms and behavioral and social dysfunction, and logically derives from the assessments and diagnosis;

(6) whether the proposed services in the individualized treatment plan are consistent with generally accepted community-based treatments and practices for the treatment of the specific symptoms and behavioral and social dysfunction;

(7) whether the recipient agrees with the referring physician, mental health professional clinician, or interdisciplinary team under (1) of this subsection that the focus of the treatment will be the symptoms and behavioral and social dysfunction targeted for intervention;

(8) the extent to which past and current treatment has been successful in treating the symptoms and behavioral and social dysfunction;

(9) if the recipient is under 21 years of age, whether the recipient has, as indicated by the American Psychiatric Association's Diagnostic

and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, dated 2000, an Axis V Global Assessment of Functioning (GAF) rating at admission of 50 or less, or the recipient has an Axis V Global Assessment of Functioning (GAF) rating at admission of more than 50, but exhibits specific mental, behavioral, or emotional disorders that place the recipient at imminent risk for out-of-home supervision or protective custody of state or local authorities; the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, dated 2000, is adopted by reference;

(10) the extent to which a less restrictive or intrusive alternative treatment is not available;

(11) the extent to which a less expensive alternative is not available;

(12) the extent to which the units of service requested are no more than are necessary to meet the treatment or rehabilitation needs of the recipient;

(13) the extent to which the duration of services requested are no more than are necessary to reach the recipient-approved goals outlined in the individualized treatment plan;

(14) if the requested services are intended to prevent the relapse or deterioration of a mental disorder, the extent to which social functioning is improved through interventions provided as active treatment, targeted in specific therapeutic goals, and included in the individualized treatment plan;

(15) the likelihood that the recipient will benefit from any therapy provided on the same day as the recipient has received crisis intervention services.

(c) Payment for services determined not to be medically necessary under this section is subject to recovery under 7 AAC 105.260.

The limitation on abortion services funding is, as for other Medicaid covered services "medical necessity," a phrase that is not clearly defined in Alaska. The regulations that pertain to other types of covered services provide some guidance. Because the right to state funding for medically necessary abortions under the current state Medicaid program is protected by the Alaska constitution, the term "medically necessary abortion" has acquired a constitutional component of unknown scope. The relatively few Alaska cases involving abortion rights do not provide guidance as to how broadly the term "medically necessary abortion" is to be construed. There is a possibility that the Alaska courts may find that there are additional situations other than those described in the vetoed bill that fall within the scope of a medically necessary abortion and thus must be covered under the state Medicaid program.

What follows is a brief overview of how other states have handled the issue after the federal exception was rejected under those state's constitutional protections.

CASE LAW FROM STATES OTHER THAN ALASKA

Other states have dealt with the issue of state funding of abortion services in various ways. After the federal decisions of the 1970's that upheld restrictions on public abortion funding, courts in a number of states were required to analyze the issue under their own laws and constitutions to see if they supported the same conclusion. In contrast with the federal decisions, several state decisions determined that funding for abortions could not be singled out under public assistance programs. See Moe v. Sec'y of Admin. and Fin., 417 N.E.2d 387 (Mass. 1981); Comm. to Defend Reproductive Rights v. Myers, 625 P.2d 779 (Cal. 1981); Right to Choose v. Byrne, 450 A.2d 925 (N.J. 1982); Planned Parenthood Ass'n v. Dep't of Human Res., 663 P.2d 1247 (Or. App. 1983), affirmed at 687 P.2d 785 (Or. 1984); and Doe v. Maher, 515 A.2d 134 (Conn. Super. 1986); contra, Fischer v. Dep't of Pub. Welfare, 502 A.2d 114 (Pa. 1985).

Except for the Pennsylvania case, these state courts weighed the private and state interests involved with abortions and struck a different balance than the federal courts. They considered the state's desire to save money, state policies to promote childbirth, state claims that poor women can still choose to find private money to fund their abortions, state interests in protecting unborn life, and state arguments that they are not required to provide money for the exercise of constitutional rights. Most of these arguments had been successful in federal courts. Not so in the state courts of Massachusetts, California, New Jersey, Oregon, and Connecticut.

In Moe v. Secretary of Administration and Finance, supra, the highest state court in Massachusetts determined that the Massachusetts constitution afforded a greater degree of protection for the right to choose an abortion than the federal constitution.[5] In upholding the right of Medicaid recipients to have their abortions paid for, the court observed:

> [T]he Legislature need not subsidize any of the costs associated with child bearing, or with health care generally. However, once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weigh the options open to the pregnant woman by its allocation of public funds; in this area, government is not free to "achieve with carrots what [it] is forbidden to achieve with sticks." (citation omitted). We are therefore in agreement with the views expressed by Justice Brennan, writing in dissent to Harris v. McRae, [when he wrote] "In every pregnancy, [either medical procedures for its termination, or medical procedures to bring the pregnancy to term are] medically necessary, and the poverty-stricken woman depends on the Medicaid Act to pay for the expenses associated with [those] procedure[s]. But under [this restriction], the Government will fund only those procedures incidental to childbirth. By thus injecting coercive financial incentives favoring childbirth into a decision that is constitutionally

[5] Moe, 417 N.E.2d at 400.

> guaranteed to be free from governmental intrusion, [this restriction] deprives the indigent woman of her freedom to choose abortion over maternity, thereby impinging on the due process liberty right recognized in Roe v. Wade."[6]

In Committee to Defend Reproductive Rights v. Myers, supra, the highest court in California made a determination similar to Massachusetts'. The court noted that the state had no constitutional obligation to provide medical care to the poor or to fund the exercise of all constitutional rights, but held:

> Once the state furnishes medical care to poor women in general, it cannot withdraw part of that care solely because a woman exercises her constitutional right to choose to have an abortion.[7]

In Right to Choose v. Byrne, supra, the highest court in New Jersey also came to a similar conclusion, using an equal protection analysis. The court struck down a restrictive abortion funding statute, stating:

> [T]he Legislature need not fund any of the costs of medically necessary procedures pertaining to pregnancy. . . . Once it undertakes to fund medically necessary care attendant upon pregnancy, however, government must proceed in a neutral manner. Given the high priority accorded in this State to the rights of privacy and health, it is not neutral to fund services medically necessary for childbirth while refusing to fund medically necessary abortions. . . . The statute affects the right of poor pregnant women to choose between alternative necessary medical services. No compelling state interest justifies that discrimination, and the statute denies equal protection to those exercising their constitutional right to choose a medically necessary abortion.[8]

In Planned Parenthood Ass'n v. Department of Human Resources, supra, the court struck down an Oregon Medicaid regulation that would have restricted funding of abortions, saying:

> [I]t is difficult to understand the rational basis for denying one medically necessary surgical procedure to a pregnant woman solely because it involves an abortion while, at the same time, funding all other medically necessary services relating to pregnancy.[9]

---

[6] Id. at 402.

[7] Myers, 625 P.2d at 798 and footnote 31 accompanying the text.

[8] Byrne, 450 A.2d at 935 - 936.

[9] Planned Parenthood, 663 P.2d at 1255.

In Doe v. Maher, supra, a Connecticut court struck down a state Medicaid regulation that prohibited funding for medically necessary abortions, saying:

> This court is unable to reconcile the mandate and logic of the United States Supreme Court in Roe v. Wade . . . with the McRae . . . decision. Medicaid reimbursement funds are made available for all the health care costs of women, including the medical costs necessary to carry the fetus to term, but not for the medically necessary abortion. Surely, this constitutes infringement on the right to an abortion. . . . In adopting the regulation, . . . the state has ceased to preserve its neutrality at least under our state constitution. . . . And since that one exception also is a subject of a woman's constitutional rights, the regulation impinges upon those constitutional rights to the same practical extent as if the state were to affirmatively rule that poor women were prohibited from obtaining an abortion.[10]

In each of the state cases quoted in this section, the state court struck down an abortion funding restriction that would have been upheld by a federal court. These cases clearly demonstrate that state courts can find independent state grounds to strike down an abortion restriction that might be upheld in federal court. Unfortunately, the cases do not provide a standard definition of "medical necessity" for purposes of all covered services.

CONCLUSION

The concept of "medical necessity" provides the baseline for Medicaid and other types of public funding of covered health care services. Under the federal law, the United States Supreme Court upheld an exemption for coverage of abortions services that was narrower than the standard for all other types of covered services. Many states, including Alaska, found an equal protection and liberty interest violation in drawing a distinction among various types of service coverage.

Current Alaska legislation and regulations defer to the treating physician to determine whether a service is medically necessary for the physician's patient under the applicable standard of practice for most covered services, including abortion services.

If I may be of further assistance, please advise.

JMM:ljw
10-418.ljw

Attachements

---

[10] Doe, 515 A.2d at 151 and 152.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

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

MEMORANDUM

DATE: March 28, 2011

TO: Senator Bettye Davis, Chair, Senate HSS Committee

FROM: Jon Sherwood, DHSS Medical Assistance Administrator

SUBJECT: Denali KidCare

Senator Davis, below is the Department's response to two issues that came up in the hearing on SB 5 on March 23, 2011.

First, we believe there may have been some confusion regarding regulations defining medical necessity as it related to abortion and the definition of therapeutic abortion. There are regulations defining therapeutic abortion at 7 AAC 47.290; however, these regulations only apply to the General Relief Medical program. This program was defunded by the Alaska Legislature in 1998. Prior to that time, abortions for Medicaid eligible women were covered under the General Relief Medical program. This defunding of the program that covered abortions for Medicaid eligible women is what triggered the court cases that currently govern state-funded abortions. Nothing in those court decisions applies the definition at 7 AAC 47.290 to the current requirement to pay for abortions nor provides a separate definition of medical necessity.

There is no specific definition of medical necessity for abortions in 7 AAC 105.100 or elsewhere in 7 AAC 105, the regulations that govern Medicaid services. Under 7 AAC 105.100(5), the general criteria for medical necessity if there is no specific definition for a service is "by the standards of practice applicable to the provider".

Given these facts, the Department believes its previous statement that there is no statute, regulation, or court decision that defines medical necessity as it applies to abortions paid for under Denali KidCare is accurate.

Second, questions arose about how the Department uses coding to determine that services are abortion-related, and if services for miscarriages or stillbirths might be included.

The Division of Health Care Services determines whether a claim is for an abortion related service based on a combination of procedure codes and diagnosis codes as follows:

If a claim comes in with one of several ICD-9 diagnosis codes related to pregnancy, the claim is pended for review. The reviewer then identifies the procedure code and determines if the procedure code - diagnosis code combination is an abortion-related service. If so, the claim is assigned a collocation code that will be charged against state funds only. In some cases, the reviewer may request medical case notes to make the final determination of whether or not the claim is for an abortion-related service.

While a multitude of procedure codes may be included in abortion-related services, use of diagnosis codes directs the reviewer to correctly exclude services related to miscarriage, stillbirths, or other circumstances not related to abortions when we identify abortion-related services.

Cc: William Streur, DHSS Commissioner

2011 POVERTY GUIDELINES

ALASKA ONLY

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	13,600.00	16,320.00	18,088.00	18,360.00	20,400.00	23,800.00	25,160.00	27,200.00	34,000.00
2	18,380.00	22,056.00	24,445.40	24,813.00	27,570.00	32,165.00	34,003.00	36,760.00	45,950.00
3	23,160.00	27,792.00	30,802.80	31,266.00	34,740.00	40,530.00	42,846.00	46,320.00	57,900.00
4	27,940.00	33,528.00	37,160.20	37,719.00	41,910.00	48,895.00	51,689.00	55,880.00	69,850.00
5	32,720.00	39,264.00	43,517.60	44,172.00	49,080.00	57,260.00	60,532.00	65,440.00	81,800.00
6	37,500.00	45,000.00	49,875.00	50,625.00	56,250.00	65,625.00	69,375.00	75,000.00	93,750.00
7	42,280.00	50,736.00	56,232.40	57,078.00	63,420.00	73,990.00	78,218.00	84,560.00	105,700.00
8	47,060.00	56,472.00	62,589.80	63,531.00	70,590.00	82,355.00	87,061.00	94,120.00	117,650.00

For family units of more than 8 members, add $4,780 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,133.33	1,360.00	1,507.33	1,530.00	1,700.00	1,983.33	2,096.67	2,266.67	2,833.33
2	1,531.67	1,838.00	2,037.12	2,067.75	2,297.50	2,680.42	2,833.58	3,063.33	3,829.17
3	1,930.00	2,316.00	2,566.90	2,605.50	2,895.00	3,377.50	3,570.50	3,860.00	4,825.00
4	2,328.33	2,794.00	3,096.68	3,143.25	3,492.50	4,074.58	4,307.42	4,656.67	5,820.83
5	2,726.67	3,272.00	3,626.47	3,681.00	4,090.00	4,771.67	5,044.33	5,453.33	6,816.67
6	3,125.00	3,750.00	4,156.25	4,218.75	4,687.50	5,468.75	5,781.25	6,250.00	7,812.50
7	3,523.33	4,228.00	4,686.03	4,756.50	5,285.00	6,165.83	6,518.17	7,046.67	8,808.33
8	3,921.67	4,706.00	5,215.82	5,294.25	5,882.50	6,862.92	7,255.08	7,843.33	9,804.17

Produced by: CMSO/DEHPG/DEEO

2011 POVERTY GUIDELINES

HAWAII ONLY

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	12,540.00	15,048.00	16,678.20	16,929.00	18,810.00	21,945.00	23,199.00	25,080.00	31,350.00
2	16,930.00	20,316.00	22,516.90	22,855.50	25,395.00	29,627.50	31,320.50	33,860.00	42,325.00
3	21,320.00	25,584.00	28,355.60	28,782.00	31,980.00	37,310.00	39,442.00	42,640.00	53,300.00
4	25,710.00	30,852.00	34,194.30	34,708.50	38,565.00	44,992.50	47,563.50	51,420.00	64,275.00
5	30,100.00	36,120.00	40,033.00	40,635.00	45,150.00	52,675.00	55,685.00	60,200.00	75,250.00
6	34,490.00	41,388.00	45,871.70	46,561.50	51,735.00	60,357.50	63,806.50	68,980.00	86,225.00
7	38,880.00	46,656.00	51,710.40	52,488.00	58,320.00	68,040.00	71,928.00	77,760.00	97,200.00
8	43,270.00	51,924.00	57,549.10	58,414.50	64,905.00	75,722.50	80,049.50	86,540.00	108,175.00

For family units of more than 8 members, add $4,390 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	1,045.00	1,254.00	1,389.85	1,410.75	1,567.50	1,828.75	1,933.25	2,090.00	2,612.50
2	1,410.83	1,693.00	1,876.41	1,904.63	2,116.25	2,468.96	2,610.04	2,821.67	3,527.08
3	1,776.67	2,132.00	2,362.97	2,398.50	2,665.00	3,109.17	3,286.83	3,553.33	4,441.67
4	2,142.50	2,571.00	2,849.53	2,892.38	3,213.75	3,749.38	3,963.63	4,285.00	5,356.25
5	2,508.33	3,010.00	3,336.08	3,386.25	3,762.50	4,389.58	4,640.42	5,016.67	6,270.83
6	2,874.17	3,449.00	3,822.64	3,880.13	4,311.25	5,029.79	5,317.21	5,748.33	7,185.42
7	3,240.00	3,888.00	4,309.20	4,374.00	4,860.00	5,670.00	5,994.00	6,480.00	8,100.00
8	3,605.83	4,327.00	4,795.76	4,867.88	5,408.75	6,310.21	6,670.79	7,211.67	9,014.58

Produced by: CMSO/DEHPG/DEEO

2011 POVERTY GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	10,890.00	13,068.00	14,483.70	14,701.50	16,335.00	19,057.50	20,146.50	21,780.00	27,225.00
2	14,710.00	17,652.00	19,564.30	19,858.50	22,065.00	25,742.50	27,213.50	29,420.00	36,775.00
3	18,530.00	22,236.00	24,644.90	25,015.50	27,795.00	32,427.50	34,280.50	37,060.00	46,325.00
4	22,350.00	26,820.00	29,725.50	30,172.50	33,525.00	39,112.50	41,347.50	44,700.00	55,875.00
5	26,170.00	31,404.00	34,806.10	35,329.50	39,255.00	45,797.50	48,414.50	52,340.00	65,425.00
6	29,990.00	35,988.00	39,886.70	40,486.50	44,985.00	52,482.50	55,481.50	59,980.00	74,975.00
7	33,810.00	40,572.00	44,967.30	45,643.50	50,715.00	59,167.50	62,548.50	67,620.00	84,525.00
8	37,630.00	45,156.00	50,047.90	50,800.50	56,445.00	65,852.50	69,615.50	75,260.00	94,075.00

For family units of more than 8 members, add $3,820 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	907.50	1,089.00	1,206.98	1,225.13	1,361.25	1,588.13	1,678.88	1,815.00	2,268.75
2	1,225.83	1,471.00	1,630.36	1,654.88	1,838.75	2,145.21	2,267.79	2,451.67	3,064.58
3	1,544.17	1,853.00	2,053.74	2,084.63	2,316.25	2,702.29	2,856.71	3,088.33	3,860.42
4	1,862.50	2,235.00	2,477.13	2,514.38	2,793.75	3,259.38	3,445.63	3,725.00	4,656.25
5	2,180.83	2,617.00	2,900.51	2,944.13	3,271.25	3,816.46	4,034.54	4,361.67	5,452.08
6	2,499.17	2,999.00	3,323.89	3,373.88	3,748.75	4,373.54	4,623.46	4,998.33	6,247.92
7	2,817.50	3,381.00	3,747.28	3,803.63	4,226.25	4,930.63	5,212.38	5,635.00	7,043.75
8	3,135.83	3,763.00	4,170.66	4,233.38	4,703.75	5,487.71	5,801.29	6,271.67	7,839.58

Produced by: CMSO/DEHPG/DEEO

Georgetown University Health Policy Institute
Center for Children and Families

To: Interested Parties
From: Tricia Brooks, Georgetown Center for Children and Families
Re: Alaskan Options for Expanding Coverage for Pregnant Women
Date: November 4, 2010

During a recent trip to Alaska to participate in the Kids First Alaska meeting on October 19, 2010 at the invitation of the All Alaska Pediatric Partnership and the Mat Su Health Care Foundation, I was asked to provide clarifying information on opportunities to expand federally supported medical coverage to pregnant women in Alaska. This memo outlines current coverage in Alaska and provides an overview of federal options and requirements for expanding coverage.

Current Coverage for Pregnant Women and Children in Alaska

Currently, Alaska provides traditional Medicaid coverage to pregnant women with income up to 175% of the Federal Poverty Level (FPL) who are citizens or immigrants lawfully residing in the U.S. for at least five years. Additionally, the state provides, as federally required, emergency medical coverage for labor and delivery services to any uninsured pregnant woman who meets the Medicaid guidelines, regardless of citizenship or immigration status.

While the purpose of this memo is to identify options for expanding coverage to pregnant women, certain options are related to coverage for children. Alaska uses its Medicaid program for covering both children and pregnant women. Currently, the State provides Medicaid coverage for children up to 150% FPL and coverage between 150% and 175% FPL for children through a Medicaid expansion funded through the Children's Health Insurance Program (CHIP) called Denali Kid Care. The CHIP-funded Medicaid expansion for children qualifies for a higher financial participation rate. In Alaska the federal participation rate for Medicaid is 50%[1] and for CHIP is 65%.

Options for Expanding Coverage for Pregnant Women with Federal Financial Participation

- *Expand Medicaid Coverage*

  Federal Requirements and Options - States with Medicaid programs are required to cover pregnant women who are citizens with income up to 133% of the federal poverty level (FPL). States may expand income eligibility through Medicaid to pregnant women who are citizens and, at the state option, lawfully-residing immigrants up to an income level approved by the federal government. States are

also required to cover labor and delivery cost of all uninsured women under emergency Medicaid services if they otherwise meet Medicaid income and asset requirements.

Alaska Options – Alaska may expand Medicaid coverage for pregnant women with incomes higher than the current limit of 175% FPL. Under this option, the state may also elect to provide coverage for lawfully residing immigrant pregnant women. An expansion of eligibility requires a Medicaid State Plan Amendment (SPA). Federal financial participation under this option is 50%.

- *Expand CHIP Coverage to Pregnant Women*

Federal Requirements and Options – The 2009 federal reauthorization of the CHIP program (CHIPRA) expanded options for states to cover pregnant women. Under CHIPRA, states may provide coverage to pregnant women who are citizens and, at the state option, lawfully residing immigrant pregnant women, through CHIP up to 300% FPL, if certain conditions are met. Among those conditions, the state must cover children under Medicaid/CHIP up to at least 200% FPL and cover pregnant women through Medicaid up to 185% FPL. Pregnant women cannot be covered at a higher income level than children.

Alaska Options – To expand coverage to pregnant women under CHIPRA, the state would first have to expand Denali Kid Care coverage to children from the current income level of 175% FPL up to at least 200% FPL or higher, depending on the proposed income limit for pregnant women. Additionally, the state would have to expand Medicaid coverage to pregnant women between 175% and 185% FPL. With those coverage levels, the state may expand coverage for pregnant women above 185% FPL drawing down the higher 65% CHIP federal match.

This option would require a Medicaid SPA to raise the income eligibility level for pregnant women to 185% FPL. Additionally, Alaska must submit a CHIP SPA to expand income eligibility for children up to 200% FPL (or higher depending on the proposed income limit for pregnant women) and to provide CHIP coverage to pregnant women above 185% FPL.

The SPA establishes what is technically a separate CHIP program for low-income pregnant women rather than a CHIP-funded Medicaid expansion program as is Denali Kid Care. However, it can be operated as a "Medicaid look-alike" program using the existing Medicaid administrative structure and health care delivery system. The expansion to pregnant women between 175% and 185% FPL would qualify for the 50% federal Medicaid match, while expanded coverage for children above 175% FPL and for pregnant women above 185% would qualify for the higher federal CHIP match of 65%.

- *Expand Coverage Under the CHIP Unborn Child Option*

  Federal Requirements and Options - States may provide prenatal care, labor, and delivery services to pregnant women through the unborn child option in CHIP. Sixty days of postpartum care can also be funded if services are provided under a global capitation arrangement, which bundles payment for all prenatal, labor, delivery, and postpartum care. Through this option, coverage is provided without regard to the pregnant woman's immigration status. While it is the unborn child who is eligible, services are directed to the pregnant woman to ensure the delivery of a healthy newborn, including medical and dental services for the mother deemed necessary to promote the health of the unborn child.

  Alaska Options - The state may expand coverage under the CHIP unborn child option for the unborn child of pregnant women who do not otherwise qualify for Medicaid, as well as pregnant women above the current income limit of 175% FPL. Like the previous option, this would require a CHIP State Plan Amendment to create a separate CHIP program to establish coverage for the unborn child.

  Currently eligible children, ages 0 - 18 would continue to be covered under Denali Kid Care while the pregnant women receiving services based on the eligibility of their unborn child would be covered under the separate CHIP program. In this case, Alaska may also wish to design its CHIP unborn child coverage as a "Medicaid look-alike" program as described above. Services provided to pregnant women under the unborn child option qualify for a 65% federal financial participation in Alaska.

Summary

Several options exist for Alaska to expand coverage to pregnant women directly through Medicaid and/or CHIP. Financial participation depends on the option(s) chosen. This overview of provisions in CHIPRA to cover pregnant women may be helpful. Stakeholders may wish to review additional information provided to states by the Centers for Medicaid and Medicare (CMS) in these relevant State Health Official (SHO) letters of guidance and Q & A memos:

State Health Official Letter on the Unborn Child Option

State Health Official Letter on Lawfully Residing Children and Pregnant Women

State Health Official Letter on Covering Pregnant Women through CHIP

State Health Official Letter on Frequently Asked Questions about Covering Pregnant Women

[1] The 50% federal participation is the traditional matching rate for Alaska. During the period July 2008 through June 2011, the American Recovery and Reinvestment Act (ARRA) provides a higher match to help states deal with the increased need for services during the economic downturn.

kaiser commission on

medicaid and the uninsured

HOLDING STEADY, LOOKING AHEAD: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY RULES, ENROLLMENT AND RENEWAL PROCEDURES, AND COST SHARING PRACTICES IN MEDICAID AND CHIP, 2010-2011

EXECUTIVE SUMMARY

Prepared by:

Martha Heberlein, Tricia Brooks, and Jocelyn Guyer
Georgetown University Center for Children and Families

and

Samantha Artiga and Jessica Stephens
Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

January 2011

THE HENRY J. KAISER FAMILY FOUNDATION

Executive Summary

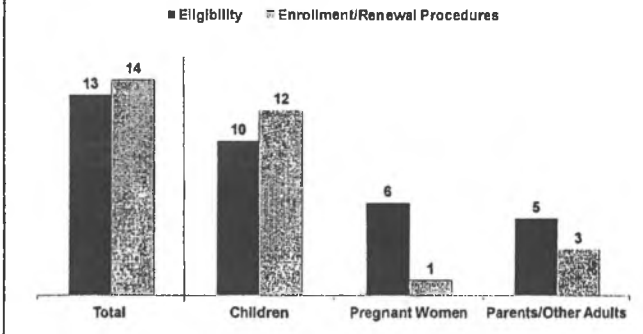
Introduction

Over the past year, as the nation's attention was focused on the country's continuing economic problems and the debate over the passage of broader health care reform, Medicaid and the Children's Health Insurance Program (CHIP) continued to play their central role of providing coverage to millions of people who otherwise lack affordable coverage options. In 2010, this role was more pronounced than ever as families losing their jobs and access to employer-based coverage turned to public programs in growing numbers. Without Medicaid and CHIP, many more individuals would have become uninsured, adding to the 50 million currently without coverage. Based on a survey of state officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, this tenth annual report provides an overview of state actions on eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and CHIP during 2010, as well as the status of coverage as of January 1, 2011, for children, parents, pregnant women, and other non-disabled adults.

As the survey findings illustrate, families could turn to Medicaid and CHIP because nearly all states "held steady" or made targeted improvements in their eligibility and enrollment rules in 2010, with a total of 13 states expanding eligibility and 14 states making improvements in enrollment and renewal procedures (Figure 1). This striking stability in public programs can be directly attributed to the federal government's decision both to provide temporary Medicaid fiscal relief to states through June 2011, and to require states to maintain their Medicaid and CHIP eligibility rules and enrollment procedures until broader health reform goes into effect.

Figure 1

Number of States Improving Access to Health Care Coverage, January 2010 – January 2011



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

During 2010, states also were starting to look ahead to implementation of the Affordable Care Act (ACA) and, in some instances, to take advantage of early options to improve Medicaid coverage. Health reform provides a broad expansion in coverage that will take effect in 2014, including extending Medicaid to a new national eligibility floor of 133 percent of the federal poverty level ($24,352 for a family of three and $14,404 for an individual in 2010). However, it is important for states to begin taking steps now to address the technological changes necessary to develop the online, consumer-friendly enrollment process envisioned under the ACA. Although there has been some progress in 2010, the survey highlights that states still have a significant amount of work to be prepared in 2014. Looking ahead, it will be important for state policymakers to continue moving forward on implementation while sustaining the gains and progress made in coverage to date.

Key Findings on Eligibility and Enrollment Procedures

Nearly all states (49, including DC) held steady or made targeted improvements in their Medicaid and CHIP eligibility rules and enrollment procedures in 2010. By doing so, they maintained the central role of Medicaid and CHIP in providing affordable coverage to children and, to a lesser extent, their parents and other adults, many of whom lost jobs and their access to employer-based coverage in the ongoing economic downturn. This stability can be directly attributed to provisions in the American Recovery and Reinvestment Act (ARRA) adopted in February 2009, that required states to maintain their Medicaid eligibility rules and enrollment procedures as a condition of receiving a significant, temporary increase in the federal Medicaid matching rate. The ACA also included a maintenance-of-effort (MOE) requirement designed to keep Medicaid coverage steady for adults until broader reform goes into effect in 2014 and for children until 2019, as well as to extend these protections to children covered by CHIP. Without the MOE requirements and enhanced federal funding, many states almost certainly would have needed to turn to cutbacks in coverage in 2010 as a result of continuing budget pressures. Two states (AZ and NJ) did make coverage reductions that were not subject to the MOE. States also made other changes such as cuts to provider reimbursement rates and benefits to reduce Medicaid spending growth in 2010.

Despite significant budget challenges, 13 states went beyond maintaining coverage to implement targeted eligibility expansions for children, pregnant women, and adults in 2010. These expansions varied in size and scope. Most of the expansions focused on providing increased coverage to uninsured children, and in a many cases, also produced some state savings by allowing the state to draw down federal matching funds for previously fully state-funded coverage.

Building on progress made over the past decade, 3 states (CO, KS, and OR) increased income eligibility in Medicaid/CHIP for children in 2010. As such, as of January 1, 2011, 25 states, including DC, cover children in families with income at least up to 250 percent of the federal poverty level ($45,775 for a family of three in 2010), although enrollment remains heavily concentrated among the lowest-income children (Figure 2). Oregon also added a buy-in program in 2010 that enables families with incomes above Medicaid and CHIP thresholds to buy into coverage.

Figure 2

Children's Eligibility for Medicaid/CHIP by Income, January 2011

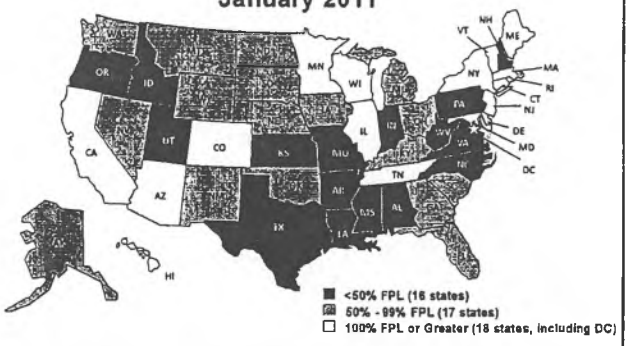
Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. IL uses state funds to cover children up to 300% of the FPL; OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

In 2010, states continued to take advantage of the option to cover lawfully-residing immigrant children and pregnant women during their first five years residing in the country. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allowed states to draw down federal funding to cover these populations without imposing a 5-year waiting period. Six (6) states (DE, MN, MT, NE, NC, and WI) adopted the option for lawfully-residing immigrant children in 2010, resulting in a total of 21 states having eliminated this barrier for children as of January 1, 2011. In 15 of these states, coverage had previously been provided to these children with state-only dollars. In addition, in 2010, 5 states (DE, MN, NE, NC, and WI) adopted this option for lawfully-residing pregnant women, bringing the total number eliminating the "five-year bar" for pregnant women to 17. In 9 of these states, coverage had previously been provided with state-only dollars.

While states have made significant progress in expanding coverage for children, eligibility for their parents continues to lag far behind. In 2010, only one state (CO) expanded Medicaid coverage for parents. As of January 1, 2011, 33 states do not cover parents up to 100 percent of the federal poverty level ($18,310 for a family of three in 2010). The median eligibility threshold for parents remains at 64 percent of the federal poverty level and 16 states limit eligibility to below 50 percent of the federal poverty level ($9,155 for a family of three in 2010). In the absence of further expansions, these restrictive eligibility levels will leave most uninsured, low-income parents without an affordable coverage option until the health reform expansion goes into effect in 2014 (Figure 3).

Figure 3

Medicaid Eligibility for Working Parents by Income, January 2011



Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid at higher income levels.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

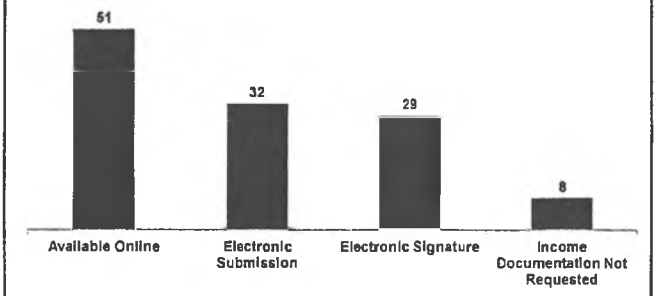
Low-income adults without dependent children remain ineligible for Medicaid in the vast majority of states. Under the ACA, Medicaid eligibility will be expanded to a minimum of 133 percent of the federal poverty level, ending the historic exclusion of non-disabled, non-pregnant adults without dependent children from the program. While this change is not required to be in effect until January 1, 2014, states have the option of moving early to cover these adults. In 2010, Connecticut and the District of Columbia took advantage of this option and moved low-income adults they had previously served through state-funded programs to Medicaid. Further, California received approval in 2010 for a waiver to continue and expand county coverage initiatives serving low-income adults. However, even with these expansions, as of January 1, 2011, only seven states (AZ, CT, DE, DC, HI, NY, and VT) provide Medicaid or Medicaid-equivalent benefits to adults without dependent children. Additional states offer more limited coverage to these adults, but in most states, low-income adults without children do not have access to public coverage regardless of their income.

States adopted improvements in their enrollment and renewal procedures in 2010 that helped to reduce burdens on families, streamline administrative processes, and achieve program efficiencies. In making these improvements, states often turned to options provided by CHIPRA. Specifically, 29 states took advantage of the CHIPRA option to more efficiently and accurately verify citizenship status by relying on an electronic data match with the Social Security Administration (SSA). A smaller, but still notable number of states, moved ahead with other simplification measures including the CHIPRA "Express Lane Eligibility" option, as well as long-standing strategies such as presumptive eligibility and continuous eligibility for children. Many appear to have done so at least in part to qualify for the Medicaid performance bonuses included in CHIPRA. These bonuses provide a financial reward and recognition to states that have implemented at least 5 of 8 simplification policies and that have reached specific enrollment targets for children in Medicaid. The Administration encouraged states in their efforts by launching the *Connecting Kids to Coverage Challenge*, a partnership of national and state organizations committed to enrolling all five million uninsured but eligible children in public programs.

States continued work to modernize their programs and begin preparing for health reform implementation by focusing on technological improvements. A number of states made program improvements such as offering applications that can be submitted online. Despite this early work, the survey findings highlight that states have a long way to go to develop the integrated, technology-driven, web-based eligibility systems for Medicaid, CHIP, and subsidized Exchange coverage that are envisioned and required under reform. For example, all states, including DC, post their Medicaid applications online, but only 32 accept the electronic submission of those applications. Among the 32 that accept electronic submission, 29 allow for the use of an electronic signature, but only 8 do not routinely ask families to submit paper documentation of information via mail or fax before checking other data sources to verify eligibility (Figure 4). In light of a rule proposed by the Administration at the end of 2010 to provide states with a 90 percent matching rate to prepare their Medicaid eligibility systems for health reform and the likelihood of additional guidance and funding opportunities in the months ahead, it can be expected that next year's survey will show more developments in this area.

Figure 4

Status of Online Applications for State Medicaid Programs, January 2011



Notes: In some states the online application is only available for children applying for coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

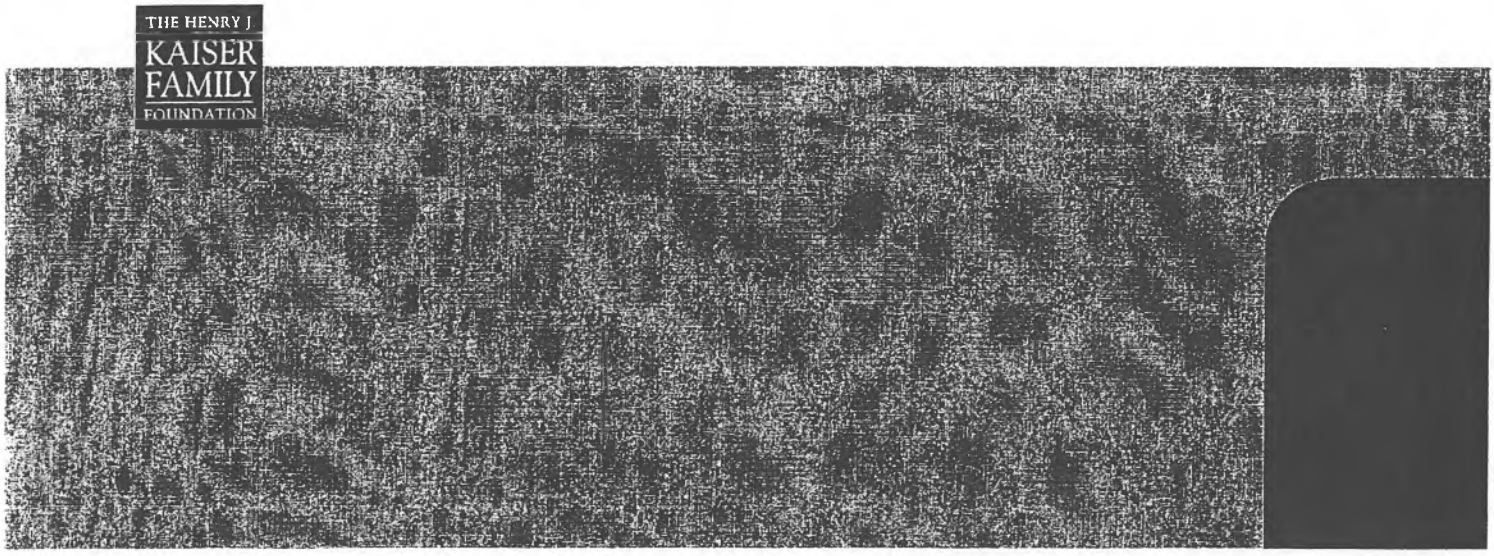
Conclusion

As implementation of broader health reform moves forward, the findings of this survey describe the foundation for coverage of low-income families and individuals through Medicaid and CHIP. These programs will play an even more substantial role in the years to come, particularly with the expansion in coverage for low-income adults. Valuable lessons can be learned from how states have streamlined and simplified their enrollment and renewal procedures in these programs, and while additional improvements will be necessary to further transform Medicaid and CHIP in order to fulfill the promise of reform, they provide a sound platform on which to begin.

Looking ahead, states face the challenge of implementing reform while at the same time dealing with significant budget pressures due to the nation's continuing economic problems and the corresponding increased need for Medicaid and CHIP. To continue forward progress on reform and keep the foundation solid, it will be important to focus on sustaining the coverage gains and progress made to date even in the face of these challenges. Health reform has the potential to markedly reduce the number of uninsured and provides states new opportunities to modernize, streamline, and continue to improve their Medicaid programs. While some of the most significant changes in health reform do not go into effect until 2014, it is important for states to lay the groundwork now. In 2010, there were initial signs of state Medicaid agencies preparing for health reform implementation, but more activity can be expected in 2011.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/kcmu

This publication (#8130-ES) is available on the Kaiser Family Foundation's website at www.kff.org.



FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

NOVEMBER 2010

Access to Abortion Coverage and Health Reform

The Patient Protection and Affordable Care Act (ACA) will make significant changes to health coverage for women, expanding their access to coverage and broadening the health benefits that many will receive. Coverage for abortion services, however, was addressed separately under health reform. As result, the extent of abortion coverage that women will receive once ACA is fully implemented in 2014 will depend largely on policies enacted at the state level as well as choices that plans and consumers will make in terms of coverage of abortion services. This brief summarizes the major insurance coverage provisions of the ACA that are relevant for women of reproductive age, reviews current federal and state policies on abortion coverage and how they may be modified under health reform, and discusses the potential impact of the federal legislation on women's access to abortion coverage.

How does the Patient Protection and Affordable Care Act affect overall coverage for women of reproductive age?

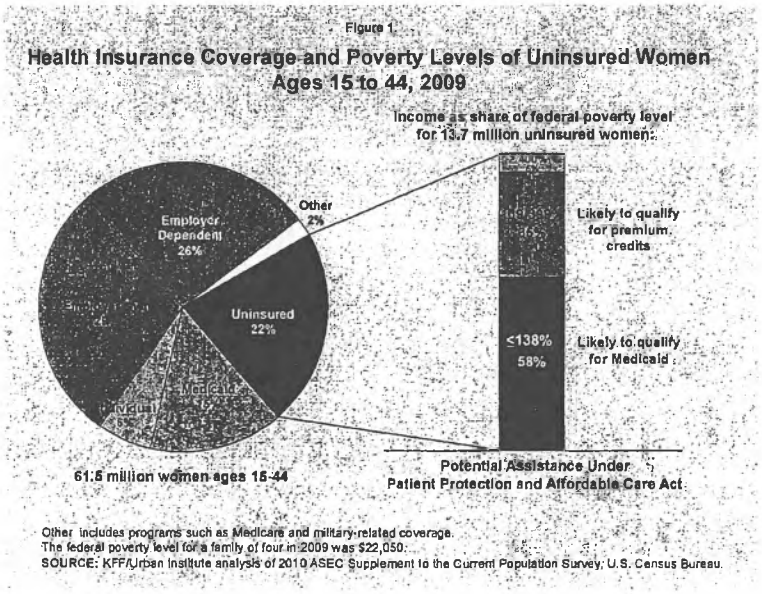
Signed into law on March 23, 2010, the ACA is a federal law aimed at ensuring that almost all U.S. citizens and legal residents have health insurance by requiring that most individuals obtain a minimum level of insurance coverage by 2014. This is to be achieved through a combination of public and private insurance expansions. By 2014, Medicaid will be available to cover many more of the nation's poorest uninsured, employers will be more likely to offer affordable coverage to their employees, and small businesses and other uninsured individuals will have access to state-based exchanges that will offer a variety of plans from which they can purchase insurance. The scope of benefits, including abortion, covered under these different avenues will vary.

The ACA will expand health care coverage to many of the nation's uninsured by extending Medicaid eligibility to all qualifying individuals with incomes up to 138% of the federal poverty level (FPL).[1] Uninsured individuals with incomes above 138% FPL will be able to purchase coverage in new state-based insurance exchanges that will act as marketplaces, open to all qualifying, uninsured individuals and small businesses with up to 100 employees. These state-based exchanges are to offer multiple insurance plans that uninsured individuals can choose from to purchase coverage. To help with the costs of insurance, the federal government will provide subsidies (in the form of premium credits) to eligible individuals and families with incomes from 139% to 399% FPL or if their share of premiums exceeds 9.5% of their income.[2]

It is estimated that 13.7 million women ages 15 to 44 are uninsured currently, 93% of whom would qualify for federal assistance under the health reform law, based on their income. The act would potentially extend Medicaid to 58% or 8 million women, and an estimated 4.8 million women (35%) would qualify for federal premium credits[3] to purchase coverage as shown in Figure 1.

Figure 1

Health Insurance Coverage and Poverty Levels of Uninsured Women Ages 15 to 44, 2009



Other includes programs such as Medicare and military-related coverage.
The federal poverty level for a family of four in 2009 was $22,050.
SOURCE: KFF/Urban Institute analysis of 2010 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

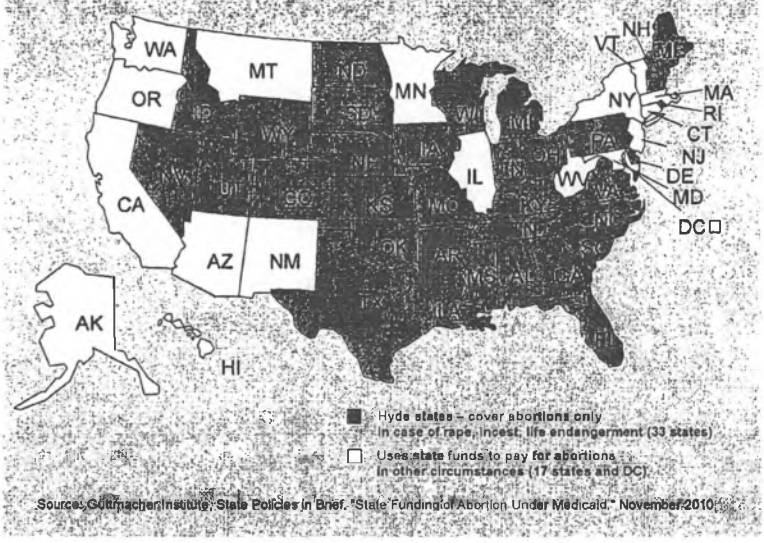
What are current federal and state laws regarding abortion coverage and financing?

Federal law bans the use of any federal funds for abortion, except when the pregnancy is a result of rape, incest, or if it is determined to endanger the woman's life. In effect since 1977, this rule known as the Hyde Amendment is not a permanent law; rather it has been attached annually to Congressional appropriations bills, and has been approved every year by the Congress. The Hyde Amendment initially affected only funding for abortions under Medicaid, but over the years, its reach broadened to limit federal funds for abortion for federal employees, women in the Indian Health Service, and in the military.

State level policies also have a large impact on abortion coverage, particularly since states are responsible for operation of Medicaid programs. The Medicaid program serves millions of low-income women and is a major payor of reproductive health services. It is estimated that two-thirds of adult women on Medicaid are in their reproductive years.[4] As discussed earlier, the federal Hyde Amendment restricts state Medicaid programs from using federal funds to cover abortions beyond the cases of life endangerment, rape, or incest. However, if a state chooses to, it can use its own funds to cover abortions in certain other circumstances, and states will continue to have this option under health reform. Currently, 17 states and the District of Columbia use state-only funds to cover abortions beyond the federal limitations for women on Medicaid.[5] In the other 33 states, Medicaid programs do not pay for any abortions beyond the Hyde restrictions (Figure 2). Currently, in these 33 states, an estimated 4.6 million women ages 15 to 44 are uninsured and have incomes less than 138% FPL, and would meet the income eligibility criteria to qualify for Medicaid under health reform (Table 2).[6]

Figure 2

Abortion Financing Under Medicaid, 2010



Source: Guttmacher Institute, State Policies in Brief, "State Funding of Abortion Under Medicaid," November 2010

States also have authority over the scope of benefits for public employees. Currently, 13 states restrict abortion coverage in insurance plans for public employees. These restrictions range from states that provide coverage only under the Hyde limits to states that prohibit coverage for all abortions, regardless of circumstances.[7] States also regulate benefits covered by private insurance plans. Currently, at least four states (Idaho, Kentucky, Missouri, and North Dakota) prohibit private insurance coverage for abortions except in the case of rape, incest, or to save the woman's life. These states allow insurers to sell riders for abortion coverage, but there is little evidence about their availability and no documentation of their cost or impact on access.

How will abortion coverage be handled by Medicaid and plans in the exchanges under health reform?

Medicaid: The ACA reinforces current federal restrictions, limiting federal funds to be spent on abortions only to cases when the pregnancy endangers the life of the woman or results from rape or incest. This will not change for Medicaid under health reform; state Medicaid programs will continue to have the option to cover other medically necessary abortions using only state funds and no federal funds. President Obama issued an executive order as part of health reform that restated the federal limits specifically for Medicaid and community health centers.[8]

Plans in the Exchange: Plans participating in state-based exchanges will be required to cover a minimum set of services, defined as "essential health benefits, and the ACA explicitly prohibits states from including abortion in any essential benefits package. Therefore, no state or insurer offering a plan in an exchange will be required to offer abortion coverage, and each exchange must include at least one plan that does not cover abortions beyond those permitted by current federal law. Furthermore, states can bar all plans participating in the state exchanges from covering abortions, which at least five states (Arizona, Louisiana, Mississippi, Missouri, and Tennessee) have already elected to do since the health reform law's passage.[9]

If the state does not bar coverage of abortions, private insurers can offer a plan that covers abortions beyond the federal limitations within an exchange. The ACA outlines a methodology for states to follow to ensure that no federal funds are used towards coverage for abortions beyond Hyde. Any plan that covers abortions beyond Hyde limitations must estimate the actuarial value of such coverage by taking into account the cost of the abortion benefit (valued at least $1 per enrollee per month). This estimate cannot take into account any savings that might be achieved as a result of the abortions. Furthermore, plans that receive federal subsidies (it is believed that all plans in the exchanges will receive at least some federal subsidies) would have to collect two premium payments from all enrollees, including men and women of all ages. One payment would be for the value of the abortion benefit and the other payment would be for all other services. The funds would be deposited in separate allocation accounts, overseen and managed by state health insurance commissioners. Both the federal Office of Management and Budget and the Department of Health and Human Services are expected to publish guidelines in 2010 that states must follow to ensure that exchanges are adhering to these requirements.[10] The health reform law prohibits plans in the exchanges from discriminating against any provider because of "unwillingness" to provide abortions. It does not preempt other current state policies regarding abortion, such as parental notification and waiting period laws.

Currently, most (55%) women of reproductive age are covered through employer-sponsored plans from their own job or their husbands. Many of these plans do cover abortion currently and will be allowed to continue once health reform is fully implemented. Table 1 summarizes the ACA's major provisions on abortion coverage.

Table 1: Summary of Abortion Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)

Benefit Design	Prohibits abortion coverage from being required as part of the federally established essential benefits package. States can prohibit coverage for any abortions by all plans in their state-based exchange. At least one plan within a state exchange must not cover abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest). Private Plans: Can provide a plan in the exchanges that covers abortions beyond those permitted by federal law as long as they comply with requirement to segregate federal funds. All states' Pre-existing Condition Insurance Plans cannot cover abortions beyond those permitted by federal law.
Financing	Prohibit federal subsidies (for premiums or cost sharing) from being used to purchase a health plan in the exchanges that includes coverage for abortions beyond those permitted by federal law. In order to segregate funds, plans that choose to offer coverage for abortions beyond Hyde limitations must estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at least $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Any exchange plan that covers abortions and includes enrollees that receive federal subsidies must collect two separate premium payments from all enrollees – one payment for value of abortion benefit and one payment for all other covered services.
State Role	Law will have no effect on state laws regarding coverage, funding or procedural requirements on abortions, such as parental notification/consent laws. States can use state-only funds to pay for "medically necessary" abortions beyond federal requirements under Medicaid or to pay for abortion coverage in plans offered in an exchange. States can prohibit plans in new exchanges from covering any abortions. State-level health insurance commissioners will monitor and oversee payment segregation requirements for the purchase of plans within their respective exchanges.
Discrimination/ Protection	Prohibit plans participating in the exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

How much does an abortion cost?

The ACA's complex combination of restrictions means that under health reform, many currently uninsured women will obtain coverage either through Medicaid or an exchange; however, many of these women will not be covered for abortions and will have to pay out-of-pocket if they seek one. The cost of an abortion varies depending on factors such as location, facility, timing, and type of procedure. A clinic-based abortion at 10 weeks' gestation is estimated to cost between $400 and $550, whereas an abortion at 20-21 weeks' gestation is estimated to cost $1,250-$1,800 or more.[11] Though the vast majority (~90%) of abortions are performed early in pregnancy, the costs could still be economically challenging for many low-income women.[12]

What is the impact of the federal abortion provisions on women in high-risk pools?

The new health insurance exchanges will become operational in 2014. Prior to that time, some uninsured individuals will be able to buy coverage in new state-based, federally subsidized high-risk pools. Separate from states' currently operating high-risk pools, these new federally funded, Pre-existing Condition Insurance Plans (PCIP) will be open to individuals who have been uninsured for at least six months with existing health conditions, and will provide temporary coverage until exchanges become fully operational in 2014. States can operate the PCIPs or request the federal government to operate them, but all are financed with federal funds.

In July 2010, the Department of Health and Human Services issued a federal directive prohibiting all of these new PCIPs from covering abortions, effectively extending the Hyde Amendment to these plans as well.[13] Women who enroll in these temporary high-risk pools will not be able to use their own private dollars to purchase abortion coverage. Since many women eligible for PCIPs have more health problems than average, they could be more likely to encounter medical complications should they become pregnant. It is estimated that an additional 200,000 to 400,000 individuals are expected to enroll in the temporary PCIPs.[14] This order does not preempt states' policies on abortion coverage in their existing high-risk pools, nor does it prohibit women from paying a provider directly should they seek an abortion.

* * * * *

As a result of health reform, many more women will gain health insurance coverage. The decisions that the federal government, states, insurance companies, and policymakers will make over the next few years will determine the extent of abortion coverage that will be available to women across the nation once health reform is fully implemented in 2014.

Table 2: State Level Estimates of Percent of Uninsured Women Ages 15-44 Likely to Qualify for Federal Assistance under the Patient Protection and Affordable Care Act

		Uninsured Women, 2008-2009		Percent of Currently Uninsured Women Ages 15-44 Potentially Eligible for Federal Assistance in 2014	
	Total Number of Women Ages 15-44 in State	Number	Percent of Total Women in State	Likely to Qualify for Medicaid **	Likely to Qualify for Premium Credits in the Exchanges ***
Alabama*	941,940	193,965	21%	63%	32%
Alaska	138,624	34,647	25%	49%	43%
Arizona	1,290,755	302,354	23%	58%	34%
Arkansas*	556,616	161,324	29%	57%	39%
California	7,712,611	1,909,644	25%	58%	36%
Colorado*	1,020,305	213,345	21%	57%	37%
Connecticut	683,718	91,238	13%	48%	41%
Delaware	174,875	28,325	16%	50%	40%
District of Columbia	149,583	17,640	12%	58%	32%
Florida*	3,439,595	1,000,591	29%	54%	38%
Georgia*	2,060,710	516,501	25%	64%	31%
Hawaii	243,668	25,898	11%	60%	28%
Idaho*	300,011	67,734	23%	59%	36%
Illinois	2,652,361	469,469	18%	54%	39%
Indiana*	1,263,857	253,215	20%	60%	36%
Iowa*	572,244	94,251	16%	52%	40%
Kansas*	546,268	97,788	18%	69%	26%
Kentucky*	859,623	208,348	24%	65%	32%
Louisiana*	923,220	232,129	25%	63%	31%
Maine*	244,584	29,488	12%	45%	44%
Maryland	1,172,744	196,542	17%	53%	41%
Massachusetts	1,353,253	90,192	7%	--	--
Michigan*	1,956,538	355,014	18%	58%	34%
Minnesota	1,030,700	125,338	12%	46%	47%
Mississippi*	593,878	138,132	23%	64%	31%
Missouri*	1,173,596	218,902	19%	53%	40%
Montana	181,434	38,227	21%	51%	39%
Nebraska*	351,675	52,110	15%	58%	38%
Nevada*	520,000	133,246	26%	50%	42%
New Hampshire*	256,892	37,572	15%	40%	48%
New Jersey	1,726,605	329,250	19%	53%	36%
New Mexico	396,222	122,328	31%	66%	28%
New York	4,035,744	708,705	18%	50%	40%
North Carolina*	1,893,856	425,668	22%	64%	31%
North Dakota*	124,975	16,977	14%	52%	46%
Ohio*	2,248,979	350,501	16%	58%	37%
Oklahoma*	722,740	167,708	23%	53%	42%
Oregon	751,120	160,498	21%	58%	36%
Pennsylvania*	2,393,581	327,877	14%	55%	37%
Rhode Island*	214,038	34,393	16%	59%	35%
South Carolina*	902,532	199,945	22%	60%	32%
South Dakota*	151,360	27,366	18%	59%	36%
Tennessee*	1,257,375	246,435	20%	56%	41%
Texas*	5,133,199	1,781,564	35%	58%	37%
Utah*	599,794	106,561	18%	53%	37%
Vermont	118,214	14,618	12%	39%	47%
Virginia*	1,593,387	273,285	17%	47%	45%
Washington	1,335,218	220,188	16%	53%	42%
West Virginia	342,321	80,517	24%	56%	37%
Wisconsin*	1,092,394	120,614	11%	56%	39%
Wyoming*	104,779	20,313	19%	45%	47%

Notes: The federal poverty level (FPL) for a family of four in 2009 was $22,050.
* State does not provide funds for abortions beyond restrictions in federal Hyde Amendment.
** Percent of women ages 15-44 who are currently uninsured with incomes <138% of the federal poverty level.
*** Percent of women ages 15-44 who are currently uninsured with incomes 139-399% of the federal poverty level.
-- Sample size insufficient to make reliable estimate.
Source: Kaiser Family Foundation/Urban Institute estimates of ASEC supplement to March 2009 and March 2010 Current Population Surveys, U.S. Census Bureau.

ENDNOTES

[1] Legislation extends Medicaid coverage to all individuals with incomes up to 133% of the poverty level (FPL) and includes a provision to disregard first 5% of income, effectively extending Medicaid to all individuals with incomes up to 138% FPL.

[2] Congressional Budget Office, *Letter to Congressman John Dingell Regarding H.R. 3962*, November 6, 2009.

[3] Note that undocumented individuals will not have access to coverage through Medicaid or exchanges, regardless of ability to pay for coverage.

[4] Kaiser Family Foundation, *Medicaid's Role for Women*, 2007.

[5] Guttmacher Institute, State Policies in Brief, November 1, 2010.

[6] Kaiser Family Foundation/Urban Institute analysis of 2009, 2010 ASEC supplements to Current Population Survey, Bureau of the Census.

[7] Guttmacher Institute, *State Policies in Brief*, September 1, 2010.

[8] The White House Office of the Press Secretary, *Executive Order – Patient Protection and Affordable Care Act's Consistency with Longstanding Restrictions o the Use of Federal Funds for Abortion*, March 24, 2010. Available at www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst.

[9] Cohen, S. Insurance Coverage of Abortion: The Battle to Date and the Battle to Come, *Guttmacher Policy Review*, Fall 2010.

[10] Kaiser Health News, *Text: The President's Executive Order on Abortion Funding and The Health Bill*, Kaiser Family Foundation, March 25, 2010. Available at: www.kaiserhealthnews.org/Stories/2010/March/24/text-Obama-abortion-executive-order.aspx.

[11] Personal communication with Stephanie Poggi, National Network of Abortion Funds, November 13, 2009.

[12] Guttmacher Institute. *An Overview of Abortion in the United States*, January 2008.

[13] U.S. Health and Human Services, *Statement of HHS Spokeswoman Jenny Backus on the Pre-Existing Condition Insurance Plan Policy*, July 14, 2010.

[14] U.S. Health and Human Services, *HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan*, July 1, 2010. Available at: www.hhs.gov/news/press/2010pres/07/20100701a.html.

This brief was prepared by Usha Ranji, Alina Salganicoff, and Tina Park of the Kaiser Family Foundation.

This publication (#8021) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION www.kff.org

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SHO # 09-006
CHIPRA #2

May 11, 2009

Dear State Health Official:

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, ensures that States are able to provide necessary health coverage for low-income uninsured children eligible under the Children's Health Insurance Program (CHIP). Section 111 of CHIPRA adds a new section 2112 to the Social Security Act (the Act) which gives States the option to provide necessary prenatal, delivery, and postpartum care to low-income uninsured pregnant women through an amendment to its State child health plan (CHIP plan) (as described in section 2112). This letter provides general information concerning the new option and guidance on amending your CHIP plan to reflect the coverage of pregnant women, should your State wish to take advantage of this option.

Background

Prior to CHIPRA, States could provide services to pregnant women either through a Section 1115 demonstration program or under the CHIP State plan by covering unborn children. CHIPRA allows States to continue providing coverage through these two options or through a new option of covering pregnant women under the CHIP plan. This letter outlines the differences between options to assist States in adopting coverage for pregnant women.

Continuation of Existing Section 1115 Pregnant Women Demonstrations

The CHIPRA allows States to continue existing section 1115 demonstrations that provide coverage for pregnant women with title XXI funds. These States may continue demonstrations or modify their CHIP plans to include pregnant women as described below.

Continuation of Coverage for Unborn Children Under the CHIP Plan

States will continue to have the option of considering an unborn child to be a targeted low-income child and therefore eligible for coverage under CHIP, if other applicable eligibility criteria are met. This permits States to provide health care services to promote healthy pregnancies, regardless of the mother's eligibility status. States may continue to pay for pregnancy and delivery services through a bundled payment or global fee method, under which a single payment is made for prenatal care, labor, delivery, and postpartum care.

New Option to Cover Targeted Low-Income Pregnant Women Under the CHIP Plan

The CHIPRA also allows States the option of providing health care coverage for uninsured, low-income pregnant women under the CHIP plan. Under this option, the pregnant woman is eligible for coverage, rather than the unborn child.

States that choose to cover pregnant women under the CHIP plan are eligible to receive enhanced Federal Medical Assistance Payments (FMAP) for such expenditures and have the option of providing presumptive eligibility to pregnant women.

As established in CHIPRA (Section 111), in order to cover pregnant women through the State plan option under CHIP, States must meet the following criteria:

- States may only provide coverage under the CHIP plan for pregnant women who were not eligible under the Medicaid State plan as of July 1, 2008;
- States must cover pregnant women under Medicaid up to the minimum income level of 185 percent of the Federal poverty level (FPL). Any State that currently does not provide Medicaid coverage for pregnant women up to this income level, can only claim regular FMAP for pregnant women covered under a Medicaid expansion whose family income is at or below 185 percent of the FPL;
- States may not establish a higher income eligibility level for pregnant women than the State's eligibility level for targeted low-income children;
- States must cover children under 19 years of age under Medicaid or CHIP, up to a minimum income level of 200 percent of the FPL;
- States must not apply an effective income level for pregnant women under CHIP that is lower than the Medicaid effective income level and cannot cover higher income pregnant women without covering lower income pregnant women;
- States must not apply any preexisting condition exclusion or waiting period for CHIP coverage of pregnant women;
- States must not impose any cap or limitation on the enrollment of targeted low-income children, and must not have any waiting list or any procedures designed to delay applications for enrollment; and
- States may not require enrollee cost sharing for preventive or pregnancy-related services.

Benefits

States have the flexibility to offer coverage that meets the requirements of section 2103 of the CHIP statute under the new CHIP option for pregnant women, including in most cases, benefits during a 60-day postpartum period.

Coverage of Both the Unborn Child and Pregnant Women

States may opt to cover both the unborn child and pregnant women under the CHIP plan. If States elect both options, we want to emphasize that States will need to uniquely identify

enrollees so that there is no duplication of payment for services. Eligibility under either category is subject to screening for Medicaid eligibility, and payment is not available under CHIP for services that would be covered under Medicaid.

Submitting a CHIP Plan Amendment

States wishing to adopt any of the options described above and be eligible for funds under title XXI, must submit a CHIP plan amendment, which must be approved by the Secretary. States adopting such an expansion will be able to amend their CHIP plan by submitting the enclosed addendum to the CHIP plan and budget form. The addendum sections correspond to the relevant sections in your current State Child Health Plan Template.

States that have implemented CHIP through a Medicaid expansion program, but wish to extend coverage to unborn children and/or pregnant women under a separate child health program, may do so by submitting the same CHIP plan amendment above. Such States would then continue to cover children from birth through age 18 under Medicaid expansion programs, and would operate separate CHIP programs only for pregnant women and/or unborn children.

To incorporate either of these provisions into the CHIP plan, the State, through the appropriate State official, should submit these pages electronically to both the Centers for Medicare & Medicaid Services (CMS) Central and Regional Offices. Once approved, these pages will be added to the current State Child Health Plan as an addendum describing coverage for pregnant women. Before submitting such an amendment, please review the current approved CHIP plan to determine if it is necessary to amend additional sections simultaneously (e.g., if a new benefit package is being adopted, if cost sharing is being modified just for this eligibility group, if different service delivery type is being used, if different enrollee protections apply, or if the State has not previously implemented a separate child health program). Note that if a State does not choose to use the same benefit type and package of services for pregnant women or unborn children, the State needs to submit a revised section 6 of the State plan with its amendment. Questions or assistance may be provided by your Central Office or Regional Office project officer.

In addition to offering the option of covering targeted low-income pregnant women under the CHIP plan, CHIPRA requires that children born to a woman receiving pregnancy-related assistance shall be deemed on the date of the child's birth to have applied for coverage under CHIP or Medicaid, and shall be found eligible for the appropriate program, and until the child reaches age one (as described in section 2112(e) of the Act). During this deemed eligibility period, the new law stipulates that the child health or medical assistance eligibility identification number of the mother shall also serve as the identification of the child. Additionally, during this period, all claims shall be submitted and paid for the child under the mother's identification number (unless the State issues a separate identification number for the child before the child reaches age one).

Draft State plan template pages to implement these options are enclosed. CMS is in the process of obtaining the required Office of Management and Budget (OMB) clearance under the Paperwork Reduction Act for the State plan amendment (SPA) templates. Given that States may need considerable time to complete these templates, CMS is sharing in draft the SPA template at

this time. Until such time when this SPA template is assigned an OMB clearance number, States are not obligated to respond.

It is well established that access to prenatal services and care throughout a mother's pregnancy improves health outcomes for both the mother and child. Therefore, we encourage States to consider these options to establish eligibility for this vulnerable population.

Sincerely,

/s/

Jackie Garner
Acting Director
Center for Medicaid and State Operations

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Barbara Levine
Director of Policy and Programs
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

From: Desiree Compton [dcompton@unitedwaymatsu.org]
Sent: Monday, April 04, 2011 3:35 PM
To: Sen. Lyman Hoffman; Sen. Bert Stedman; Sen. Donny Olson; Sen. Dennis Egan; Sen. Joe Thomas; Sen. Johnny Ellis; Sen. Lesil McGuire
Cc: Mary.Grisco@elmendorf.af.mil
Subject: FW: SB 5, DKC eligibility, Friday April 8th, 9AM Senate Finance

Dear Senate Finance Committee,

The purpose of this correspondence is to ask that you please support Sentate Bill 5 to increase Denali KidCare eligibility back to 200%. United Way of Mat-Su believes that every child should have health coverage and there are an estimated 18,000 uninsured children in Alaska.

I understand the concerns about funds being used to pay for abortions. Personally, I am a pro-life advocate who seeks to reduce the prevalence of abortions; furthermore, I completely disagree with legislation that uses tax money to fund abortions. I had my son when I was 19 years old and a major reason why I chose to raise him (rather than choose adoption) was that I was able to get him medical coverage through Denali Kid Care. In my opinion, the benefits of increased childcare for children in our state outweigh the costs associated with a minor percentage of these funds being used to fund abortions. I also speculate that the decision to veto the bill could will not reduce the prevalence of abortions and could potentially have the opposite effect as less women would qualify for health care coverage during their pregnancy for their child; thus, they may feel that abortion is the only affordable option. If the end goal is reduced prevalence's of abortion, I would advise that you attend to issues around informed consent to ensure that women are being adequately informed about their options and have had sufficient time in counseling to process their options prior to making a final decision. If a woman has made the decision to terminate her pregnancy, a lack of public funding for the operation is hardly a deterrent compared to the idea of completing a pregnancy and raising a child with no medical coverage. If this bill passes more pregnant women get a chance to deliver a healthy child through covered prenatal appointments and treatment.

Over 80% of the children receiving Denali Kid Care are from working families, but their employers either can't afford or simply don't provide employee health insurance Many of the parents in these families work more than one job. A simple examination of the numbers demonstrates that a family of four (Mat-Su's average family size) with an income of $55,140 a year (200%) with usual expenses cannot afford to purchase stand-alone health insurance for their kids. Denali Kid Care is an Alaskan solution that supports families, and helps parents raise healthy kids.

Children and teens covered by Denali KidCare receive a full range of prevention and treatment services, including doctor's visits, health check-ups and screenings, vision exams and eyeglasses, dental check-ups, cleanings and fillings, hearing tests and hearing aids, hospital care, speech therapy, physical therapy, mental health therapy, substance abuse treatment, laboratory tests, prescription drugs and medical transportation. Medicaid-enrolled children who are up-to-date on their well-child check-ups through 2 years of age are 48% less likely to experience an avoidable hospitalization. Children with incomplete care are 60% more likely to visit an emergency room compared to children who are up-to-date on their well-child care.

The bottom line is that increased federal support for state programs like Denali KidCare improves Alaska's ability to provide better health for more of Alaska's children. I urge you to pass this bill; furthermore, I would like to recommend that our legislators look into ideas such as regulating the services covered by Denali Kid Care, instituting co-pays and assets tests, and other ideas during the interim when there is adequate time for analyses and good discussions.

Sincerely,

Desiree Compton, MS
Community Impact Director
United Way Mat-Su
124 W. Swanson, Suite C
Wasilla, AK 99654
907.373.5818 (p)
907.376.0635 (f)

www.unitedwaymatsu.org

Our Vision

"A community where compassion, generosity and stewardship are intrinsic values."

Our Core Purpose

Positive Community Impact

Our Core Values

Integrity, Self-reliance, Leadership, Stewardship, Collaboration

Addendum to State Child Health Plan Describing Coverage of Pregnant Women

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements. (Section 2101)

1.1 The State will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); or

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); or

1.1.3. ☐ A combination of both of the above.

1.2 ☐ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☐ Please provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR Part 80, Part 84, and Part 91, and 28 CFR Part 35. (42 CFR 457.130)

1.4 ☐ Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date:

Implementation date:

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination. (Section 2102 (a)(1)-(3) and Section 2105)(c)(7)(A)-(B))

2.2. Describe the current State efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102(a)(2) and 42 CFR 457.80(b))

2.2.1. The steps the State is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and State-only child health insurance):

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102(b)(1)(A), 42 CFR 457.305(a), and 457.320(a))

4.1.1. ☐ Geographic area served by the Plan:

4.1.2. ☐ Age:

4.1.3. ☐ Income:

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☐ Residency (as long as residency requirement is not based on length of time in State) :

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☐ Access to or coverage under other health coverage:

4.1.8. ☐ Duration of eligibility:

4.1.9. ☐ Other standards (identify and describe):

4.1-P. ☐ The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. ***Please describe the population of pregnant women that the State proposes to cover in this section. Please include any criteria, such as the above categories (e.g., income and resources) that will be applied to this population. Please use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction).***

4.2. The State assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. ***Please confirm that this applies to pregnant women as well as targeted low-income children.***

4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition. ***Please confirm that this applies to pregnant women as well as targeted low-income children.***

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102(b)(2) and 42 CFR 457.350)

4.3.1 Describe the State's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7) and 42 CFR 457.305(b))

☐ Check here if this section does not apply to your State.

Please note that this box should be checked as related to children because States may not have an enrollment cap or waiting list for children and cover pregnant women.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a State health benefits plan) are furnished child health assistance under the State child health plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B), 42 CFR 457.310(b), 42 CFR 457.350(a)(1), and 457.80(c)(3))

Please confirm that the State does not apply a waiting period for pregnant women.

Section 8. Cost Sharing and Payment. (Section 2103(e))

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) ***Please indicate if this applies for pregnant women also.***

8.1.1. ☐ YES

8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge, and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A), 42 CFR 457.505(a), 457.510(b) and (c), and 457.515(a) and (c))

8.2.1. Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

Please include a statement that no cost sharing will be charged for pregnancy-related services.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c) and 42 CFR 457.120(a) and (b))

9.9.1 Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required at 42 CFR section 457.125. (Section 2107(c) and 42 CFR 457.120(c))

States should provide notice and consultation with Tribes on proposed pregnant women expansions.

9.10. Provide a 1-year projected budget. (Section 2107(d) and 42 CFR 457.140)

The budget must describe:

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Please include a separate budget line to indicate the cost of providing coverage to pregnant women.

MAT-SU HEALTH FOUNDATION

950 E. Bogard Road, Suite 218 • Wasilla, AK 99654
Phone: (907) 352-2863 • Fax: (907) 352-2865
www.matsuhealthfoundation.org

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

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

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

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

WHEREAS in 2006, of the 22,868 children in Mat-Su, approximately 12.9% or 2,949 were uninsured;[ii]

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

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

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

WHEREAS 11.3% of families with related children in Mat-Su and 11.2% of families with related children in AK have lived below the poverty level in the last 12 months;[vi]

WHEREAS 37% of Mat-Su Borough School District students ages five to 17 live in households receiving Public Assistance;[vii]

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

WHEREAS the rate of uninsured children under age 18 in Alaska is increasing—from 8.4% in 2005 to 10.3% in 2006 to 11.4% in 2007 to 13.2% in 2008;[viii]

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

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

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

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

WHEREAS Alaska has seen a 31% decline in the number of children covered by private health insurance in the past decade; [xii]

WHEREAS the cost of caring for uninsured children is passed on to other Alaskans and businesses, raising premiums and out-of-pocket expenses for everyone;[xiii]

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

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

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

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

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

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

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

Deborah Prator

Deborah Prator, President

[i]Matanuska-Susitna Borough. Alaska Department of Labor, Division of Research & Analysis. http://laborstats.alaska.gov/cgi/databrowsing/localAreaProfileQSResults.asp?geogArea=0204000170&population=census+data=Population&B1=View+Report.

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

[iii] Ibid.

[iv] Alaska Health Care Data Book, page 241. Alaska Department of Health & Social Services. November 2007.
[v]Ibid.

[vi] Ibid.

[vii] Ibid.

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

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

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

[xi] Ibid.

[xii] Legislative Health Care Initiatives Presentation to the Anchorage Chamber of Commerce, August 27, 2007.

[xiii] Ibid.

[xiv] Ibid.

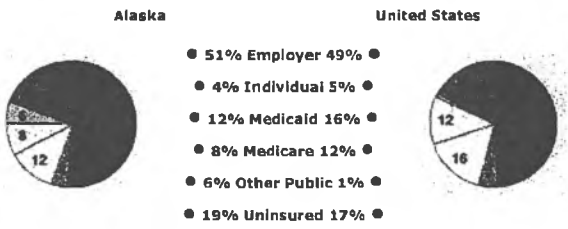
Alaska & United States

State Medicaid Fact Sheets

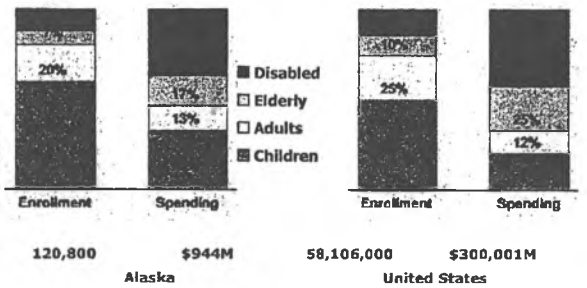
Total Residents, 2008-2009

AK: 666,900 US: 303,343,300

Distribution by Insurance Status, 2008-2009



Medicaid Enrollment and Spending by Group, FY2007



	Number		Percent		Notes
	AK	US	AK	US	
Demographic Profile, 2008-2009					
Total Residents	666,900	303,343,300	-	-	
Income					
Poor Residents (below 100% FPL)	117,700	60,939,000	18	20	% of total residents
Residents (100-138% FPL)	48,000	22,851,100	7	8	% of total residents
Median Annual Income	$63,505	$49,945	-	-	
Age					
Children (0-18)	194,300	79,305,700	29	26	% of total residents
Poor Children	43,900	21,472,200	23	27	% of total children
Adults (19-64)	416,100	185,424,200	62	61	% of total residents
Poor Adults	66,100	34,149,200	16	18	% of total adults
Elderly (65+)	56,400	38,613,300	8	13	% of total residents
Poor Elderly	7,700	5,317,700	14	14	% of total elderly
Distribution by Race/Ethnicity					
White	472,600	196,769,100	71	65	% of total residents
Black	24,400	36,795,300	4	12	% of total residents
Hispanic	27,800	48,828,900	4	16	% of total residents
Other	142,200	20,949,900	21	7	% of total residents
Non-Citizen	24,800	21,578,800	4	7	% of total residents
Population Living in Non-Metropolitan Areas	205,300	48,866,200	31	16	% of total residents
Health Insurance Coverage of Nonelderly, 2008-2009					
Medicaid	76,700	44,144,600	13	17	% of nonelderly
Children	46,500	26,325,400	61	60	% of Medicaid
Adults	30,100	17,819,200	39	40	% of Medicaid
Uninsured	125,800	49,997,900	21	19	% of nonelderly
Children	24,100	8,284,500	19	17	% of uninsured
Adults	101,700	41,713,400	81	83	% of uninsured
Nonelderly (below 100% FPL)	47,200	19,831,900	37	40	% of uninsured
Nonelderly (100-138% FPL)	10,800	6,060,700	9	12	% of uninsured
Nonelderly (139-250% FPL)	35,800	12,877,100	28	26	% uninsured
Nonelderly (251-399% FPL)	19,400	6,476,400	15	13	% of uninsured
Nonelderly (400%+ FPL)	12,600	4,751,900	10	10	% of uninsured
Employer Sponsored Insurance	341,700	149,690,000	56	57	% of nonelderly

Individual Insurance	23,300	13,767,100	4	5	% of nonelderly
Other Public	43,000	7,130,200	7	3	% of nonelderly
Percentage Point Change Among Nonelderly 0-64 by Coverage Type, 2008-2009					
Uninsured	-	-	-2.4	1.5	% point change
Medicaid	-	-	1.0	1.7	% point change
Employer-Sponsored	-	-	2.4	-3.2	% point change
Individually Purchased	-	-	-2.0	-0.1	% point change
Medicaid Enrollment					
Total Enrollment, FY2007	120,800	58,106,000	-	-	% of total residents
Children	72,900	28,754,500	60.3	49.5	% of Medicaid enrollees
Adults	24,500	14,627,000	20.3	25.2	% of Medicaid enrollees
Elderly	8,500	5,934,900	7.0	10.2	% of Medicaid enrollees
Disabled	14,900	8,789,500	12.3	15.1	% of Medicaid enrollees
% Enrolled in Managed Care, 2009	-	-	0.0	71.7	% of Medicaid enrollees
Medicaid Expenditures					
Total Medicaid Spending, FY2008	$890,169,313	$338,791,482,443	-	-	Including DSH
Disproportionate Share Hospital Payments (DSH)	$15,580,779	$17,738,530,492	1.8	5.2	% of total spending
Acute Care	$532,601,181	$206,255,691,313	59.8	60.9	% of total spending
Rx Drugs	$50,424,021	$15,274,195,878	9.5	7.4	% of acute care spending
Long Term Care (LTC)	$341,987,353	$114,797,260,638	38.4	33.9	% of total spending
Nursing Home	$74,009,055	$49,639,456,902	21.6	43.2	% of LTC spending
Home/Personal Care	$212,808,098	$47,762,519,611	62.2	41.6	% of LTC spending
Per Enrollee Medicaid Spending, FY2007					
Total	$7,815	$5,163	-	-	
Children	$4,261	$2,135	32.4	18.6	% of total spending
Adults	$5,108	$2,541	13.3	11.9	% of total spending
Elderly	$19,143	$12,499	17.4	24.3	% of total spending
Disabled	$23,194	$14,481	35.7	40.9	% of total spending
Other Medicaid Spending Measures					
Federal Contribution per State Dollar, FY2010	1.66	1.28	62.46	56.20	
General Fund Spending on Medicaid, SFY2008	$408	$111,711	7.9	16.3	% of general fund spending
Medicaid Eligibility Levels by Annual Income and FPL, 2011					
Pregnant Women	-	-	175	-	% of federal poverty level
Infants	-	-	150	-	% of federal poverty level
Children 1-5	-	-	150	-	% of federal poverty level
Children 6-19	-	-	150	-	% of federal poverty level
Working Parents	-	-	81	-	
Medicaid and Medicare Dual Eligibles					
Total Dual Eligible Enrollment, 2007	13,020	8,896,020	100	100	
Total Dual Eligible Spending in Millions, 2007	$255	$120,520	100	100	
Total Medicare Enrollment, 2010	64,797	46,589,141	9	15	% of total residents
Estimated Annual "Clawback" Payment, 2006	$17,202,153	$6,605,675,559	-	-	
CHIP					
Eligibility Income Level for Family of 3, 2011	-	-	-	-	% of federal poverty level
Change in CHIP Enrollment, June 2008-09	-	-	-0.3	2.7	% growth, 2008-2009
Total CHIP Spending, FY2007	$21,611,463	$10,046,523,960	-	-	

Other Options

Compare AK **to** US 60

- **View Sources and Notes**
- **Download Fact Sheets for all 50 states and D.C. (104 page PDF/3.6MB)**
- **View states with the lowest and highest values.**
- **Click on any topic above to jump directly to Statehealthfacts.org.**
- **Return to the Medicaid Fact Sheets home page.**

- View Children's Health Fact Sheets.

adn.com
Anchorage Daily News

Print Page Close Window

KidCare funded 664 'medically necessary' abortions in '09

DENALI KIDCARE: Physicians determine what is "medically necessary."

By SEAN COCKERHAM
scockerham@adn.com

(06/18/10 11:47:08)

The Alaska Department of Health and Social Services says 664 abortions were funded last year through Denali KidCare, the state health care program for low-income children and pregnant women.

Gov. Sean Parnell this month vetoed money to expand Denali KidCare to serve more Alaskans, saying he did it because some of the money pays for abortions.

Parnell said at the time that Denali KidCare funded "hundreds" of abortions. Anchorage Democratic Sen. Bettye Davis had disputed that, saying she'd previously spoken to the state health department and that a "very small number" of abortions are funded through Denali KidCare.

The health department couldn't answer for nearly two weeks exactly how many abortions were actually funded through the program. But a department spokeswoman sent out the figures Thursday showing Denali KidCare had paid for between 636 and 689 abortions every year for the past five years.

Last year's 664 is a substantial portion of the total abortions received by Alaskans. The Bureau of Vital Statistics reports 1,875 abortions in Alaska as a whole last year, although that doesn't count Alaskans who had the procedure performed out of state.

Davis didn't return a phone call Thursday seeking comment. But others were not ready to accept the state's numbers at face value.

"I am waiting for clarification about those numbers, but the bottom line is this -- Denali KidCare only pays for medically necessary abortions," said Hollis French, a Democratic state senator who is running against Parnell for governor. "Standing between a woman and her doctor is irresponsible, particularly when the stance also includes denying 1,200 children access to affordable medical care."

Denali KidCare is required to fund "medically necessary" abortions because of a 2001 Alaska Supreme Court ruling. The court ruled that "if the state undertakes to fund medically necessary services for poor Alaskans, it may not exclude from that program women who medically require abortions."

The state does not define what is "medically necessary," leaving that to the treating physician.

"I've been doing this for thirty-some years, not just abortions but health care. And early on I learned that only a physician can determine medical necessity," Bill Streur, deputy commissioner of the state health department, said earlier this month.

Jim Minnery, president of the anti-abortion group Alaska Family Council, said on Thursday that the

definition of "medically necessary" needs to be tightened.

He questioned how many abortions funded by Denali KidCare are related to the health of the mother, saying doctors are free to determine it's "medically necessary" to have an abortion if the birth would interfere with the mother's work or education.

Clover Simon, vice president of Planned Parenthood of Alaska, which provides abortions, said there was a court order during the 2001 case over state-funded abortions that set out what "medically necessary" is about. She said the term refers to "abortions certified by a physician to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services, in his or her professional judgment."

The state health department said $384,000 out of Denali KidCare's $217 million budget went to pay for "abortion related services." That's 0.18 percent of the total.

It adds up to about $580 for each abortion. The state and Planned Parenthood said that figure sounds about right, noting that the reimbursement to physicians through Denali KidCare is less than it would be with private insurance.

There were 55,754 Alaskans enrolled in Denali KidCare last year to receive help from the state with their health care costs, including 7,947 pregnant women.

The $3 million that Parnell vetoed would have allowed 1,300 more children and 218 more pregnant women on Denali KidCare, according to state estimates.

The money would have expanded eligibility of the program to cover households with income up to 200 percent of the federal poverty level, a threshold that's about $55,150 for a family of four. Proponents of the expansion said most states fund at that level while Alaska is currently at about 175 percent.

Ethan Berkowitz, another Democrat running against Parnell for governor, has said the issue is about health care and not abortion. If the issue for Parnell was really abortion he would have opposed all the Denali KidCare money, Berkowitz said, instead of just saying people can get health services if they are up to 175 percent of the poverty line but not between 175 and 200 percent.

Parnell spokeswoman Sharon Leighow said the governor had nothing to add Thursday to what he said when he vetoed the money. Parnell said he was acting to "make sure we don't expand state government funding of abortions here in Alaska."

Find Sean Cockerham online at adn.com/contact/scockerham or call him at 257-4344.

Print Page Close Window

adn.com
Anchorage Daily News

Print Page Close Window

Parnell cites abortion in KidCare funds veto

CUTS: Governor axes over $300 million in state spending.

By SEAN COCKERHAM
scockerham@adn.com

(06/04/10 14:34:15)

Gov. Sean Parnell vetoed more than $300 million in state spending Thursday, including money for renewable energy and to expand Denali KidCare for low-income children and pregnant women.

Parnell vetoed nearly $3 million aimed at letting more Alaskans have health care costs covered under Denali KidCare. It's an increase he supported when it overwhelmingly passed the Legislature. But the governor said he reversed his position after recently finding out some Denali Kid Care money goes to fund abortions.

"My intention here today is to make sure we don't expand state government funding of abortions here in Alaska," Parnell said in announcing the veto.

His administration could not say how much Denali KidCare money is going to fund abortions, and critics of the decision say he's denying help to more than 1,000 children.

The Denali KidCare veto was the only significant cut Parnell made to the $8 billion budget that funds state agencies and services. But the governor axed $300 million from the separate $3.1 billion state budget for construction and maintenance projects, which is among the largest capital budgets the state has seen. The Legislature approved the budgets before adjourning for the year in April.

Parnell vetoed money for about 150 projects throughout the state, from roads to sewers to a new house for polar bears Ahpun and Louie at the Alaska Zoo. In many cases the governor reduced funding for projects instead of zeroing them out. He halved the $50 million intended for renewable energy grants, saying most of the money appropriated in the past for such projects still hasn't been spent. He cut $250,000 of the $1 million for deferred maintenance at the governor's mansion.

His veto of Denali KidCare money drew by far the strongest reaction, with Democrats saying it was outrageous. Anchorage Democratic Sen. Bettye Davis, who sponsored the Denali Kid Care money, said it would have allowed 1,300 children and 225 pregnant women to receive care.

Ethan Berkowitz, one of Parnell's Democratic opponents for governor, called the decision cold-hearted. "If you want to be tough, you don't be tough by slapping kids around," he said.

Hollis French, a Democratic state senator who is also running against Parnell, said the decision was depriving hundreds of children of coverage "because you're afraid a few women might make a choice you don't agree with." The courts made it clear the state has to pay for "medically necessary" abortions for poor women and the program doesn't fund elective abortions, he said.

Officials with AARP Alaska and the Central Council of Tlingit and Haida Head Start program said the governor's veto will hurt people struggling to raise children.

Parnell said he wanted to offer the health care to more women and children. But he said he couldn't bring himself to do it after recently discovering Denali Kid Care also funded abortions. Parnell said he couldn't believe it when he found out.

"I want to be able to provide those services. But if your governor doesn't stand for life and liberty, as he understands it in his conscience, then you don't have a governor," Parnell said.

Parnell said there are "hundreds of abortions being paid for by these funds." But state Sen. Davis said that's not true and only a "very small number" of abortions are funded. She said that's what the Alaska Department of Health and Social Services, which administers the program, told her when she inquired last year.

The Department of Health and Social Services was not answering any questions about it Thursday, even after Parnell referred reporters to the agency when he was asked how much Denali KidCare money is going for abortions. The agency said it could not answer that question, nor could it say how many abortions were funded or how it made the decisions on which abortions it should pay for.

Agency spokeswoman Cathy Stadem said the answers had to be run past the governor's office and she hoped to give them the next day. "Everything is having to be vetted through (the Alaska Department of Law) and through the governor's office," she said.

The $2.9 million Parnell vetoed would have expanded eligibility of the Denali KidCare program to cover households with income up to 200 percent of the federal poverty level, a threshold that's about $55,150 for a family of four. Proponents said most states fund at that level while Alaska is currently at about 175 percent.

BUILDING PROJECTS AXED

Sitka Republican Sen. Bert Stedman said he didn't realize Denali Kid Care money went to abortions and understands Parnell's reasoning on the veto. But Stedman said there was no financial reason for Parnell to chop hundreds of millions of dollars from the state budget for construction and maintenance projects.

"It's a political decision, not a financial one," said Stedman, who helped craft the budget.

The state has $12 billion in cash reserves on top of the Alaska Permanent Fund, Stedman said, and if the projects aren't funded now, they might never happen.

Parnell said the state has a surplus from high oil prices but it's not going to last forever. He said the amount of spending he approved will create jobs but not break the bank.

"These vetoes for the most part don't represent projects I do not like. They represent projects I think should be deferred to another time because of the fiscal situation," the governor said.

Ralph Samuels, a Republican running for governor, criticized Parnell for not cutting more. He said Parnell didn't do nearly enough at a time when oil production is declining.

There were about $70 million in road and drainage money vetoes in Anchorage. The mayor's office said nearly $10 million more was axed from the budget in planned upgrades for the Loussac Library, Sullivan Arena, the Ben Boeke and Dempsey Anderson ice arenas, and recreation centers in Spenard and Fairview.

But Anchorage Mayor Dan Sullivan said "a healthy list of road, public safety and other priority

projects remains, and will lead to a robust level of economic activity for Anchorage."

Parnell cut the biggest project in the budget for the Mat-Su Borough. He vetoed $22 million of the $57 million that the Legislature appropriated for work toward an extension of the Alaska Railroad from north of Willow to Port MacKenzie. Mat-Su Economic Development Director David Hanson said the remaining money will go to design and engineer the route, buy right of way and begin construction.

Mat-Su borough officials said they were mostly happy with the $137 million in projects they kept.

Find Sean Cockerham online at adn.com/contact/scockerham or call 257-4344. Daily News reporter Rindi White contributed to this story.

Print Page Close Window

adn.com
Anchorage Daily News

Print Page Close Window

Scenarios show emergency room visit is no cure-all for many children

COMPASS: ***Other points of view***

By SEN. BETTYE DAVIS

(07/23/10 21:23:29)

While stories of the governor's veto of Senate Bill 13 and the funding for the expansion of the state's Denali KidCare program fade from the media, just under 1,300 children and over 200 pregnant women will be faced with the daily reality of not having basic insurance coverage. That is why I sponsored this legislation, and that is where my interest in this remains.

Some may argue that they still have the ability to seek treatment at an emergency room. While that is true, let's look at some scenarios that Denali KidCare would cover with a less costly visit to a doctor's office.

Try taking your 6-month-old to an emergency room for checkups that include hearing or vision tests, immunizations and other various well-baby screenings instead of a pediatrician's office. They can't help you with that at the emergency room.

Perhaps while talking to your 2-year-old child, you notice he can only imitate speech or actions but doesn't produce words or phrases spontaneously. Without speech language therapy, his speech could fall further behind his peers' as he grows older. You can't get speech therapy in an emergency room.

We all know smart children who seem to lose interest or can't follow things in class, who we later learn couldn't see the visuals the teacher used because they didn't know they needed glasses. You can't get glasses in an emergency room.

How about not being able to eat or concentrate during school or at home because of a toothache? The emergency room doesn't offer dental checkups, cleanings and fillings.

Your 14-year-old breaks her leg while engaged in sports and goes to the emergency room for treatment. In this instance she will no doubt receive outstanding care, but what about follow-up physical therapy? You can't get that in an emergency room.

There are many other great services offered through Denali KidCare, such as mental health therapy, substance abuse treatment, chiropractic services, foot doctor's services and the fundamentally important but many times forgotten medical transportation services. I haven't even touched upon the prenatal services available to pregnant women that are critical to the wellbeing of the mother and birth of a healthy child.

Let me make it clear that I believe that we have some of the most highly trained, caring and compassionate professionals staffing our emergency rooms statewide and I am highly supportive of them. But an emergency room is designed for just what it pronounces itself to be: a place to treat people during emergencies. While either a doctor or an emergency room visit for your child can provide you with laboratory tests, prescription drugs or, in a worst-case scenario, hospitalization for a major traumatic event, the costs for these services could easily be a financial nightmare for any family. If the family cannot pay most or any of the bills, those costs are spread throughout the health care system to

those with insurance, whose premiums go up accordingly. And if those services are done exclusively at an emergency room, the costs are even higher.

So while some individuals want to take this valuable program and use it as a touchstone for their opinions on government spending or philosophical battles, I remain focused on helping to bring health care to those who have no real interest in politics but just need assistance to see a doctor. For those women and children, the fact that the veto of SB 13 is no longer headline news doesn't change their needs.

Sen. Bettye Davis, an Anchorage Democrat, has represented District K in the state Senate since 2001.

Print Page Close Window

Senate Bill 5 and Denali Kid Care Expansion

March 21, 2011

The Alaska Chapter of the American Academy of Pediatrics is in support of SB 5 and expansion of Denali Kid Care to 200% FPL.

Every child has medical needs that cannot be ignored. Denying coverage to a family in poverty does not change this fact. Alaska's huge size and minimally developed wilderness present a challenge in medically caring for its children. Denali KidCare (DKC) is the only means for many of these children to have access to local primary care, and when needed, the ability to reach specialty care in Anchorage. The federal government pays 64% of the cost of the State Children's Health Insurance Program (SCHIP/DKC) for non-Alaska Native children and 100% for Alaska Native children. Alaska has some of the most stringent eligibility requirements in the United States, 175% Federal Poverty Limit, placing us at 48th out of the 50 states in covering our poorest children. Senate Bill 13 was overwhelmingly passed with bipartisan support during the last legislative session. It expands DKC back to 200% of the Federal Poverty Line, its original level when instituted in 1998, and more in line with the rest of the United States. The cost of this expansion is estimated to add less than $1M to the annual State budget. Many legislators from both parties, including Governor Parnell, publically pledged support for this bill and claimed to recognize the importance of taking care of the basic health needs of our children. Suddenly, the Governor, who is a former finance committee chairman, reversed his support claiming he did not understand DKC funding and the potential for covering selective abortion services. The Alaska Department of Health and Social Services reports that 0.18% of DKC funding went to abortion related services last year. The service is permissible if deemed a medical necessity.

Prior to last year, expansion of children's healthcare was never once an abortion issue until Governor Parnell faced re-election and the republican primary. The Governor vetoed DKC expansion arguing that it was morally wrong to spend state funds on a medical plan with an abortion benefit. The Governor and his family are covered under the state workers plan called AlaskaCare (Wells Fargo Insurance Services). A call to the AlaskaCare benefits line reveals "abortion services are a covered benefit for employees and their dependents when deemed medically indicated." It appears the Governor is unconcerned with state funds paying for a healthcare plan with an abortion benefit, if the plan is for himself, his family, administration and staff. For Governor Parnell to claim that DKC expansion is an abortion bill simply does not ring true. Nearly every healthcare plan in the state has an allowance for some sort of abortion service, including the Governor's own. If the Governor truly believes that state funding should not be used towards a plan with abortion services, then he has the opportunity to take a stand with himself, his own family, his staff and administration. Not with the poor and vulnerable.

Alaska ranks at the bottom of the country in regards to domestic violence, rape and once again, children's healthcare coverage. This is not an abortion issue. It is an issue of social justice, of doing what is right. As a State, we cab do better.

M. David Bomalaski, MD, FAAP
Legislative Representative
Alaska Chapter of the American Academy of Pediatrics

Jody L. Butto, MD, FAAP
President
Alaska Chapter of the American Academy of Pediatrics

RECEIVED

MAR 14 ...

March of Dimes Foundation
Alaska Chapter
3209 Denali Street, Suite 200
Anchorage, AK 99503
Telephone (907) 276-4111
Fax (907) 276-3375

March 9, 2011

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

RE: Support for Senate Bill 5 pending in the House Health and Social Services Committee

Dear Senator Davis:

I am writing to you to express the support of March of Dimes for **Senate Bill 5.** The mission of March of Dimes to improve maternal and child health 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 5 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 24,000 uninsured children as well as provide maternity coverage for several of Alaska's 34,000 women of childbearing age who have no health insurance.

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.

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. **I urge you bring Senate Bill 5 before the House Health and Social Services Committee for a vote and ensure passage of this important piece of legislation.**

Sincerely,

Janie Odgers
State Director

Main Office
130 Seward St #209
Juneau, Alaska 99801
Phone: (907) 586-3650
Fax: (907) 463-4493
www.andvsa.org

ANDVSA
Alaska Network on Domestic Violence & Sexual Assault

Pro Bono Office
PO Box 6631
Sitka, Alaska 99835
Phone: (907) 747-7545
Fax: (907)747-7547

February 4, 2011

Senator Bettye Davis
State Capitol, Room 30
Juneau, AK 99801

Re: Letter of Support for SB 5

Dear Senator Davis:

On behalf of our member programs that provide safety and resources for women and children throughout Alaska, and the women and children for whose safety we advocate, thank you for introducing SB 5. The Alaska Network on Domestic Violence and Sexual Assault fully supports SB5. An increase in the maximum income Medicaid eligibility requirements to 200% of the Federal Poverty Level will provide many additional women and children critical and oftentimes lifesaving medical services.

It is common for instances of abuse to be first detected by medical providers, who then refer women and children to appropriate services in their communities. In this regard, access to regular medical care is one of our first screening and referral tools. But beyond increasing knowledge of and referrals to community resources, an increase in Medicaid eligibility will allow women to make safe choices. When women know they have the resources to adequately provide for their children, they are more likely to take steps to leave abusive situations. An increase to the maximum eligibility requirement will afford such security to scores of working mothers.

The Network is in full support of SB 5. Thank you for advocating for women and children in our state, and if I may be of any assistance or provide you any information, please let me know,

Sincerely,

Peggy Brown
Executive Director

cc: Lisa Mariotti, Policy Director

Theda S. Pittman
PO Box 241513
Anchorage, AK 99524

907-222-5974
tspittman@oci.net

March 24, 2011

The Honorable Kevin Meyer
Alaska State Senate

Dear Senator Meyer,

With respect to the following:

1) potential expansion of insurance coverage under Denali KidCare;

2) the fact that there is no statutory definition of 'medically necessary'; and

3) your quoted comment that it's one thing for a woman to have an abortion if her life is in danger and another if she feels having a baby will leave her depressed, I ask you to consider the following.

It is an incredible insult to women to suggest they are not capable of selecting a competent doctor and that said doctor is not competent to determine whether a given procedure is medically necessary.

As you certainly know, there is already a lot of incomprehensible language in our statutes; I shudder to think of the outcome should there be an effort to reduce something so complex as medical necessity to a laundry list of conditions that are the only things that merit insurance coverage. How detailed do you think such a list should be?

For example, common sense (which is not so common after all) might conclude that plastic surgery for breast reduction is not medically necessary. I suggest that absent some competence in medicine and knowledge of the specifics of a given case, such a conclusion would be foolish.

I know a woman whose breasts were so disproportionately large for her small body frame, that she suffered debilitating pain in her shoulders and back. Plastic surgery was indeed medically necessary and having the surgery freed her of a condition that was seriously undermining her ability to work and to care for her family.

I'm confident that intelligent men who genuinely care about health care can come to understand that abortion is a subject best left to a woman, her doctor, her spiritual advisor and any others that she personally invites to assist her with a decision.

A careful reading of Roe v. Wade will inform one that it does not sanction abortion without limitations. The time and money and anguish that has taken place since its passage because people have used laws and courts in an effort to impose their personal views on the rest of us is total nonsense. That much maligned decision is both clear and excellent public policy.

Please work to eliminate the demeaning of women and doctors when considering decisions related to women's reproductive health.

Yes, there are quack doctors and yes, there are women who – for a variety of reasons may have an abortion when a condom or a morning after pill might have help avoid that situation altogether.

But in a society where some people consider using contraception as on a level with murder, it seems clear that this subject will require calm, thoughtful, educated discussion rather than the present efforts across the states to return women to the subservient position some think they deserve simply because they are women.

Respectfully,

Theda Pittman

Cc: Senator Bettye Davis

Juneau Youth Services, Inc.

907.789.7610
907.789.2106 Fax

P.O. Box 32839
Juneau, AK 99803

March 7, 2011

Senator Bettye Davis, Chair
Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

Re: Support for SB 5

Dear Senator Davis,

I am writing on behalf of both Juneau Youth Services and the Alaska Association of Homes for Children. Thank you for once again introducing legislation (SB 5) to raise the eligibility threshold for Denali KidCare from 175% to 200% of the Federal Poverty Level (FPL).

As you know, Alaska is one of the strictest states in the country when it comes to eligibility for Children's Medicaid (Denali KidCare). The estimate last year was that raising the eligibility criteria to 200% of the FPL would result in an additional 1,200 children and 200 pregnant women being covered under Denali KidCare. With a high rate of federal matching funds, this increase could take place with a minimal increment in state operating funds.

It is important to recognize that Denali KidCare is a major funding source for children's behavioral health and residential services in Alaska. Approximately 75% of the children and youth served by Juneau Youth Services access these services through Medicaid/Denali KidCare. Denali KidCare is also a major factor in ensuring that Alaska's children and youth receive services as close to their home communities as possible.

Raising the threshold for Denali KidCare is a wise investment in the health and wellbeing of Alaska's children. Thank you for your leadership on this critical issue.

Sincerely,

Walter Majoros

Walter Majoros
Executive Director

Doniece Gott

From: Emily Kane [DoctorEm@aol.com]
Sent: Monday, April 04, 2011 11:33 PM
To: Senate Finance Committee
Cc: Thomas Obermeyer
Subject: SB 5

I support SB 5.

Investing in kids' health gives the biggest bang for the healthcare buck. For example, preventing one case of childhood obesity and subsequent diabetes could save Medicaid $5 million over that kid's lifetime. Diabetes is hugely expensive what with chronic medication, dialysis, amputations, and blindness.

Treating as many children as need medical and preventive care as possible leads to healthier moms and healthier families as well.

Many middle class families can't afford private health insurance.

What is the point of all of our oil money if we don't take care of our children?

Please insist on SB 5 passing this month.

Sincerely,

Dr Emily A Kane
www.DrEmilyAKane.com
www.AKANP.org
www.naturopathic.org