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published a judicial checklist to help judges monitor the educational progress of children under their jurisdiction (www.ncjfcj.org/content/view/full/340/322/).

The high rates of learning disabilities and other academic problems experienced by children in foster care (Blome, 1997; Evans et al., 2004) require intervention to help maintain positive educational progress for these children. Some of this intervention can come from the foster placement itself providing a stable and educationally rich environment (American Academy of Pediatrics, 2000; Downs & Williams, 2003). In the Northwest Alumni Study optimization analyses, placement history had a great effect on educational outcomes (Pecora et al., 2005a). Caseworkers should arrange for appropriate educational services, including those that may be available through the Individuals with Disabilities Education Act (IDEA). These services can help youth complete high school and thus be better prepared for life after foster care. Youth should also be supported in obtaining a high school diploma and not a GED, as high school graduates generally have better outcomes in subsequent education, employment, and income. Although half as frequent as in the Northwest study, Alaskan alumni obtained a GED at a rate three times that of the general population in the US (5%) (Pecora et al., 2005a).

Mental and physical health and substance use issues will also hamper educational advancement. Foster youth are relatively likely to suffer from health and emotional problems (Kortenkamp & Ehrle, 2002). Early and ongoing assessment and intervention are key to improving not just mental health outcomes, but also educational progress.

Alumni may not be accessing available help to continue their schooling: Of the 13 alumni who reported currently attending school, only 2 were receiving financial aid to do so. There are a variety of programs to help disadvantaged youth become ready for and attend post-secondary education and training, including TRIO (www.coenet.us/abouttrio.html) and GEAR UP (www.ed.gov/programs/gearup/index.html). In addition, there are opportunities specific to youth in foster care, such as the Education and Training Vouchers recently added to the Chafee Independent Living program and scholarships from the Orphan Foundation of America (www.orphan.org). Youth must be made aware of these possibilities well before 18. In the Northwest Alumni Study, resources at exit (specifically, money, dishes and utensils, and a driver's license) were positively related to better educational outcomes. It may be that having these resources is an indicator of overall preparedness, including a future orientation encompassing education and career. It may also indicate "more financial stability, allowing alumni to pursue their education goals" (Pecora et al., 2005a, p. 47).

Employment, Finances, and Health Insurance

Alaska is a state with a high level of seasonal employment. Official unemployment rates are higher in Alaska compared to the US average. Interviewing for the current project began in May of 2004, when the official unemployment rate in Alaska was 7.1%. Interviewing was completed in December, when the Alaska unemployment rate was 7.6%. The unemployment rate among interviewed alumni was nearly 30%. The report of high unemployment is consistent with previous reports on outcomes for foster care alumni (Courtney et al., 2001; Courtney et al., 2005). For example, the unemployment

rate in the Northwest Alumni Study, using the same interview questions, was 19.9% (Pecora et al., 2005a). The unemployment rate for Alaskan alumni also far exceeds the three highest rates among Alaska census areas at the end of 2004: 23.5% for the Aleutians East area, 20.0% for Skagway-Hoonah-Angoon (in neither of which were any alumni found to be living), and 19.2% in Wade-Hampton (in which one alumnus was living) (Robinson, 2005).

Income comparisons are also more tenuous in Alaska because of the Permanent Fund Dividend, as well as checks for Native Corporation shareholders. In addition, Alaskan residents, particularly Alaska Natives, are more likely to rely on hunting and fishing, barter, and/or family connections to survive without having a "traditional" job. This may be illustrated by the discrepancy between the 25% who reported being unemployed versus the 11% who reported that someone in their household was receiving unemployment benefits (or it may be that their benefits had run out). It is clear, however, that foster care alumni in Alaska were not doing as well financially as their peers. Although many alumni had positive social support, foster care graduates in general tend to have less than ideal social development (American Academy of Pediatrics, 2000; Downs & Caldwell, 2003; Downs & Williams, 2003; Mech, 2003) and may thus lack the connections that might help with housing, job finding, or other resources needed to live independently. The median personal income among alumni was approximately \$9,500, comparable to the Federal poverty level in 2003 for a household of one. The low income found in this study mirrors previous work (Barth, 1990; Courtney et al., 2001; Pecora et al., 2005a).

Low incomes likely impact other areas of the lives of these alumni. As with other studies of foster care alumni (such as Barth, 1990; Cook et al., 1991; Courtney et al., 2001; and Pecora et al., 2005a, 2005b), many of those fortunate enough to have a job had low-paying positions with no health benefits. In all, 39% of Alaskan alumni were without health insurance, compared to 33% in the Northwest Alumni Study, 18% of 18- to 44-year-olds nationally (as reported by Pecora et al., 2005a), and 20% of all Alaskans under 65 (Institute of Medicine, 2004). Such young people are at risk of finding themselves in even worse financial conditions—health problems are a frequent contributing factor to bankruptcies—as well as poor health outcomes.

Uninsured people are less than half as likely as people with health insurance...to have received appropriate preventive care, such as recent mammograms or Pap tests; or to have had any recent medical visits.... Evidence suggests that lack of insurance over an extended period significantly increases the risk of premature death and that death rates among hospitalized patients without health insurance are significantly higher than those with insurance (National Center for Health Statistics, 2001, pp. 11-12).

According to the Institute of Medicine (2004), approximately 18,000 excess premature deaths occur in America each year due to a lack of health insurance coverage. Poor "health due to uninsurance is estimated to cost [the nation] between \$65 and \$130 billion annually" (p. 2).

Foster youth in Alaska report low levels of preparation in the area of money management (Pope & Williams, 2005a). While the economic infrastructure within Alaska varies, at some point in their lives most adults will have a bank account or a credit card or will have to decide how to spend their dividend check. Youth need supports to pursue education and training and to start a career, but they also need training and support in dealing with what money they do have.

In addition to life skills training, connecting youth with adults is important in promoting positive outcomes in employment and financial stability. Having a network of social support can provide more tangible benefits of job leads, letters of recommendation for scholarships, a couch on which to sleep, and so on. The importance of modeling and mentoring are well established (Mannes et al., 2005; Moore & Zaff, 2002). A recent analysis of data from the 1988 Panel Study of Income Dynamics found that, from the age of 18 until 24, the average young person receives \$2,200 a year (in 1988 dollars) from their parents (Schoeni & Ross, 2003). While many foster care alumni remain in contact or even return to live with their birth parents, many do not, and the association between poverty and child removal indicates that even those who do have a good relationship with their birth parents after leaving care likely lag behind their peers in terms of financial support from parents.

Costs to Society

Criminality

Foster youth are a marginalized group. Alumni often speak of not feeling as though anyone knew what their life was like. Youth in care often feel stigmatized (Kools, 1997). At 18 or 19, they are frequently asked to live on their own, often with, as discussed, little support and little preparation. Childhood maltreatment is associated with delinquency and criminal behavior (Briere, 1992; Chalk et al., 2002; Widom, 1989). Foster youth, therefore, appear to be at high risk for engaging in criminal activity. Many do not: More than 7 in 10 Alaskan alumni interviewed reported never having spent a night in jail. Many, however, do become involved with the criminal justice system: 43% of the entire population of alumni had some interaction with the criminal justice system after leaving the Alaska foster care system (which included non-criminal holds recorded in Department of Corrections records).

Time since leaving care is, of course, an important factor in measuring prevalence of any behavior, and so comparisons with other studies must account for this time. Thus, the rate of arrest in the Wisconsin study (18%; Courtney et al., 2001) initially appears to be substantially lower than in the current population, but the young adults in that study were interviewed 12 to 18 months after leaving care, as opposed to an average of approximately 4.5 years for the Alaska alumni. (In addition, the Wisconsin proportion included only those youth interviewed and did not incorporate criminal justice records—19 of the Alaskan interviewees, or 10%, reported being arrested since leaving care.) Cook and colleagues (1991) found that 25% of their interviewees had been arrested in the 2.5 to 4 years since leaving care. While the proportion of alumni experiencing arrest in Alaska may not be substantially larger than rates found in other foster care follow-up studies, it is

apparent that adults formerly in foster care are prone to involvement with the criminal justice system.

Nearly half of those Alaskan alumni who reported spending at least one night in jail since leaving care had been jailed more than once. Nearly 11% of the sample had been jailed three or more times. Any arrest has multiple implications, for the individual's social and family relations, employment and finances, and psychology, as well as in costs incurred by society. Foster youth may benefit from positive youth development programs that have been found to reduce the rate of delinquency. (Please see the Recommendations for more information on such programs.)

Public Assistance Use

The national independent living study conducted in the late 1980s (Cook et al., 1991) examined whether the young adults in the study had been a "cost to the community" (p. 1-7). Since discharge, 12% had relied on some form of housing assistance, and 12% had utilized the services of a food bank or soup kitchen. More than one in five (21%) had received General Assistance, 34% Aid to Families with Dependent Children (AFDC), and 37% food stamps.

Foster care alumni continue to have high rates of relying on public assistance. Barth (1990) found that 47% of young adults previously in care in the San Francisco area received welfare. In the Northwest Alumni Study (Pecora et al., 2005b), nearly 18% of the individuals interviewed were currently receiving Temporary Assistance to Needy Families (TANF), more than five times the general population rate. Nearly 52% reported receiving public assistance since age 18. In the past six months, nearly 48% of Northwest alumni households had received some form of public assistance. Rates among Alaska alumni appear to be higher, with 77% of alumni reporting recent household public assistance use (including 73% of those living alone).

Foster youth appear to be a population for whom targeting interventions addressed at employment and money management (as well as many other outcomes in this report) would have great benefit. Any parent would want their child to get a job and stay off welfare. Increasing job preparation and money management skills, job finding services, assistance with completing forms, and other interventions—some large, many small—may have great benefit to society in terms of decreased use of public funds and increased tax revenue. In examining the benefit of life skills, the national independent living study (Cook et al., 1991) found that those foster care alumni who had received training in five skill areas (employment, education, consumer skills, credit management, and budgeting) had significantly better outcomes than those who had not received such training. Youth who had received all five were more likely to maintain a job, obtain necessary health care, not be a cost to the community, and have higher life satisfaction. Training in other individual skill areas had smaller effects. The Northwest study (Pecora et al., 2005a) found positive benefits for youth preparation for leaving care and educational services in all outcome areas. Thus, OCS appears to be headed in the right direction with its increased reliance on the assessments and resources available at Caseylifeskills.org and in

its growing independent living program. Assessment is only the first step, however, and should be followed by training to address areas of weakness.

RECOMMENDATIONS

The final question of the interview invited the alumni to comment on how to improve the foster care system: *What could have been done to better help you while you were in care?* In offering recommendations we have attempted to stay close to results of the study and the feedback from the study participants. Below are some of their responses to this question.

The foster care could have helped me with finding, keeping a job and helping me. They didn't really help me and I was lost and scared. I learned the most while I was on my own. They could have helped me a whole lot more; they did nothing.... That shouldn't happen again—they should give a heads-up for future kids going out on their own. Don't assume that we know what to do.

They could have listened. I could have grown up with a little bit of love; [I was] treated as an unwanted disease...

More contact with social workers in order to be able to talk to them. I wanted to let them know about things I needed and wanted.

I needed a tutor and I think that OCS should have helped me with that since I was being moved around so much.

They could have paid more attention and not placed me with unfit caregivers and not moved me around so much. This system stinks. They need to be careful of who they let raise children.

Having someone to comfort me. Someone to say, "Hey this is what you have, you need to make the best of it." Kids in foster care are scared so anything they can do to help reassure them would help. Comforting would make it easier.

Based on the outcomes described above and comments from the study participants, as well as discussions with numerous stakeholders, the following are recommended (further suggestions from stakeholders are in Appendix A):

o **Increase early intervention:**

"Early interventions are key to minimizing the long-term and permanent effects of traumatic events" (American Academy of Pediatrics, 2000, p. 1147). Even beyond the effects of trauma, early intervention efforts are recommended to minimize most of the poor outcomes described in this report. Research has shown, for example, that family support programs are more successful the younger the children are. Casey Family Programs promotes using its life skills assessment and training tools (www.caseylifeskills.org) early and often. The National Campaign to Prevent Teen

Pregnancy has highlighted research showing that interventions with young children can prevent pregnancy when those children reach adolescence. Similar results have been found for child safety, mental health, substance abuse, and delinquency outcomes. There are various model program guides that policy makers and administrators should consult:

- The Office of Juvenile Justice and Delinquency Prevention (OJJDP) highlights effective youth development programs: www.dsgonline.com/mpg_non_flash/mpg_index_flash.htm
- The joint Center for Substance Abuse Prevention-OJJDP review of family-focused programs: strengtheningfamilies.org
- The Substance Abuse and Mental Health Services Administration's (SAMHSA) registry of evidence-based programs in substance abuse and mental health: modelprograms.samhsa.gov
- The Office on Child Abuse and Neglect's 2003 review of the evidence base for family strengthening programs: nccanch.acf.hhs.gov/topics/prevention/emerging/report.pdf

Involving youth in out-of-school programs can be an important method for promoting health in a variety of areas. Such programs nurture protective factors that reduce high risk behaviors and increase current and future well-being (Mannes et al., 2005). Research shows that after school programs can reduce delinquency (Simpkins, 2003), teen pregnancy, and sexually transmitted diseases (Manlove et al., 2002), and promote the development of socialization and other skills (Simpkins, 2003), which in turn can have long-term benefits in employment and reduced use of public assistance (Cook et al., 1991). In addition, occupying a youth's time in constructive activities has obvious benefit in reducing foster parent burnout. The Harvard Family Research Project (www.gse.harvard.edu/hfrp) is an excellent resource on youth development and out-of-school programs, including program design and youth engagement.

o **Involve youth in planning:**

A number of open-ended question responses lamented the respondent's not being involved in decisions about his or her own future, and similarly being uninformed about such decisions. Previous studies have also described the effects of youth not being involved in planning their own lives (e.g., Festinger, 1983). Simply being more informed can help increase a youth's sense of predictability, while having a say can increase her or his sense of control. Such involvement is at the center of family group conferencing and other models. Person-centered planning should involve exploring and pursuing the youth's *own* goals, which in turn will further engage the youth in planning for his or her future (Krebs & Pitcoff, 2003). Adapting such a model by including adults who are important to the youth can help strengthen beneficial connections between the youth and adults who may be supportive for a good portion of the rest of the youth's life. Furthermore, surrounding the youth with concerned adults can help the youth understand the need for life skills preparation, healthy

behaviors, and so on. The Youth Advocacy Center (youthadvocacycenter.org) provides materials and training to help youth develop a desire to succeed and prepare them to reach their goals, with a focus on self-advocacy, which may help engage youth in planning their own futures.

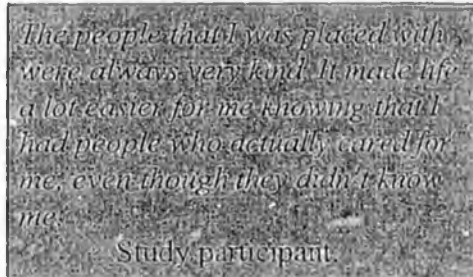
○ **Provide comprehensive assessment:**

Assessment is more than giving a test or coming up with a diagnosis. Foster children need comprehensive assessments as early as possible (American Academy of Pediatrics, 2000; Evans et al., 2004). Such an assessment should document the child's strengths, weaknesses, and needs regarding physical health, development, behavior, emotional functioning, cognitive functioning, socialization, education, and environmental issues. A comprehensive assessment can result in a detailed service and support plan, a road map for all concerned with helping the youth return to an optimal developmental path. The final purpose of assessment is communication: This assessment should be updated periodically and shared with caseworkers, foster parents, teachers, therapists, and so on. Having this collective knowledge and plan can promote placement stability, but passing on the assessment and treatment plan is especially important if a child must move to a new foster home. This helps the new caregiver understand from where the youth has come and to where she or he is going.

○ **Maximize placement stability:**

The recent Northwest Alumni Study (Pecora et al., 2005a) has strengthened previous conclusions regarding the benefits of placement stability (e.g., Festinger, 1983; McDonald et al., 1996; Newton, Litrownik, & Landsverk, 2000). A comprehensive assessment can help match youth to foster parents (American Academy of Pediatrics, 2000). Better matching can improve

relationships with foster families, which in turn results in improved outcomes during and after care (McDonald et al., 1996). Training parents in effective behavior management and therapeutic techniques, as well as other agency support, can help maintain placements. Fostering a helping and trusting relationship between youth and foster parent promotes permanency, continuity of life skills training for the youth, and maintenance of the foster parent as a source of support after leaving. If a youth does have to move, it is beneficial to have that youth remain in the same community, to help maintain social ties, and continue attending the same school, minimizing disruption of his or her educational progress and positive relationships with teachers and other school staff. As in any state, the need to recruit more foster parents almost goes without saying. Having more resource families makes matching youth and families easier, improves the odds of remaining in the same community at placement or replacement, and provides families for respite care, thus reducing incidence of foster parent burnout.



The people that I was placed with were always very kind. It made life a lot easier for me knowing that I had people who actually cared for me, even though they didn't know me.

Study participant

o **Encourage positive adult relationships:**

The development of a consistent adult relationship, a constant through the storm of foster care, can have a variety of positive effects, including socio-emotional, educational, and employment outcomes. Positive adult relationships help youth develop into psychologically healthy adults (American Academy of Pediatrics, 2000). An “available...and devoted” adult (Downs & Williams, 2003, p. 496) can be a foster parent, an elder or extended family member with whom the youth maintains contact, a dedicated caseworker, or some other mentor. These relationships can help minimize the stress of transition, provide links to jobs and other resources, and offer support and encouragement as young adults head out on their own.

On his 18th birthday, this boy's foster family actually had a cake for him that said, "Happy birthday, you're homeless." After the party, they helped him pack up everything he had in a black plastic garbage bag, and that was it.

John O'Toole, director of the National Center for Youth Law, relating the story of a foster care alumnus who became a lawyer at the Center, as quoted in the Seattle Post-Intelligencer, 7 April 2005.

o **Promote legal ties, such as adoption and guardianship, throughout adolescence and even into adulthood:**

Even adolescents, during a time of establishing an individual identity, need a permanent adult connection. In addition to individuals taking on this role spontaneously, formal efforts, such as the California Permanency for Youth Project (www.cpyy.org), are appearing around the country to overcome barriers to life-long connections with caring adults and promote permanency for older youth and even adult foster care alumni. Subsidized guardianship may be an especially appropriate choice of permanency options for adolescents and/or youth in kinship care placements, particularly in Native communities that might disapprove of termination of parental rights (National Abandoned Infants Assistance Resource Center [NAIARC], 2003). Guardianship can be a cost-effective choice for the State, but efforts must be made to make sure that it works financially for the child and family—for example, in some states subsidized guardianship results in a loss of eligibility for Medicaid (Riggs, 1996, as cited in NAIARC, 2003)—and that support services continue.

o **Support relationships with foster parents after youth leave foster care:**

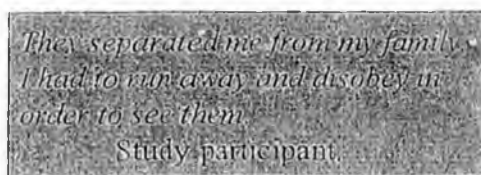
While most young people remain dependent upon their parents into their 20s, the timing of the customary emancipation itself—leaving care at 18 or 19—puts young people who grew up in foster care at risk. Furthermore, about half of young adults who were not in foster care return to live at home at least once after their initial transition to independence (Collins, 2001). In order to promote maintenance of adult connections, the State should work to remove barriers to having young people remain in the home or at least in contact after emancipation. These barriers may include licensing, insurance, and payment issues:

In a very matter-of-fact way, George explained to his worker that he had to leave this home “because the foster parents were not getting any money anymore, and they needed room for more kids.” According to the worker, he acted as if that was to be expected and that people should not feel sorry for him (Mech, 2003, p. 12).

During the course of conducting alumni studies, researchers often hear from foster parents who would like to be in contact with former foster youth, and former foster youth who would like to catch up with their former foster parents. To promote this among current and future alumni, the State could take advantage of the free service offered by Foster Care Alumni of America called FosterFind. Foster parents, youth and alumni, and others involved with foster care should be encouraged to register with this free service that will confidentially facilitate re-contact (see www.fostercarealumni.org).

o **Promote sibling contact, as appropriate:**

Optimally, sibling groups would remain intact. Siblings can provide a protective factor for adjusting to foster care and preventing placement change. The interviewed alumni often spoke of the pain and trauma of being separated from their siblings (as well as their birth parents). Even if they are not placed together, social contact among siblings should be supported. Promoting healthy relationships with birth family members can reduce a youth’s anxiety over their separation and placement, thus decreasing the probability of acting out and running away (which often involves running home). Furthermore, by helping youth



maintain these relationships, workers can increase the probability of a young person having supportive relationships upon leaving care.

o **Provide sexuality education to all foster youth:**

Foster youth appear to be relatively likely to engage in early sex, often resulting in pregnancy and/or STDs. A number of sexual and reproductive health programs have been shown to be effective in scientific evaluations in promoting delay of sexual activity, avoidance of pregnancy, and prevention of STDs. Specifically, programs that incorporate sexuality education into youth development programs as well as service learning programs (combining volunteering with classroom activities) have been shown consistently to reduce the probability of early sexual activity and pregnancy (see Manlove et al., 2002, for a review of programs, and the National Campaign to Prevent Teen Pregnancy website at www.teenpregnancy.org). Youth development programs will have added benefits in educational, employment, social, and mental and behavioral health outcomes as well. In addition to promoting such youth development and/or service learning efforts, the State can provide family planning services, including examinations, counseling and education, and contraceptives, to at-risk youth through Medicaid (with a 90% reimbursement rate). Such efforts have

been shown to result in substantial cost savings to the states as well as the prevention of hundreds of thousands of unwanted pregnancies (Gold & Richards, 2005).

o **Provide parenting support for youth who do become parents:**

Once a young person does have a child, they need support and training to avoid the poor outcomes described above. The need for training in parenting skills was also highlighted in CWEP's youth in care study (Pope & Williams, 2005a). The State is working to address the needs of at-risk parents. In particular, OCS' project with Healthy Families America should be targeted to foster youth, and connections should be made with other existing services available in many parts of Alaska, such as Early Head Start (www.acf.hhs.gov/programs/hsb/programs/ehs/ehs.htm) and Parents as Teachers (www.parentsasteachers.org). As discussed in CWEP's family preservation and support report (Pope & Williams, 2005b), programs involving parent-child activities and peer support with a goal of parent development, combined with case management, can be effective, especially when focused on teen parents with young children. Foster youth appear to be at high risk for early parenting. A home visitation program may be indicated for these young mothers and their partners. One such program, utilizing nurses and including training in health and development issues, has the added benefit of reducing the incidence of subsequent early pregnancies (Olds et al., 1999, as cited in Manlove et al., 2002). Other programs demonstrated to be effective in promoting positive parenting and preventing maltreatment and child removal include:

- Incredible Years (Carolyn Webster-Stratton, University of Washington; incredibleyears.com)
- Family Connections (University of Maryland School of Social Work)
- Strengthening Families (K.L. Kumpfer, University of Utah)
- Michigan Families First (www.michigan.gov/dhs/0,1607,7-124-5439-15373--,00.html)
- Parenting Wisely (Donald Gordon and colleagues, Ohio University; familyworksinc.com)

o **Improve mental health treatment:**

Foster children, most of whom have been maltreated, are prone to a host of psychological problems (Briere, 1992; Chalk et al., 2002; Widom, 1989). Proper assessment can help develop a treatment plan to be implemented by caseworkers, foster parents, teachers, and others, in the home and out. Proper training, for example in cognitive-behavioral interventions, will maximize the effectiveness of this plan. The Kauffman Best Practices Project conducted by the Chadwick Center on Children and Families (2004) identified three well defined and well researched practice models in treating abused children:

- Trauma-focused cognitive behavioral therapy (TF-CBT; Judith Cohen and Anthony Mannarino, Center for Child Abuse and Traumatic Loss, Allegheny General Hospital, Pittsburgh)
- Abuse-focused cognitive behavioral therapy (AF-CBT; David Kolko, University of Pittsburgh School of Medicine)
- Parent-child interaction training (PCIT; Anthony Urquiza, CAARE Center, UC-Davis)

Like any new program, there are barriers to implementing these interventions, such as funding and reimbursement issues, resistance to change, and concerns about manualized treatments. The Chadwick Center report discusses these and other barriers and offers ideas on how a state might overcome them and install one or more of these validated interventions among its mental health providers. Awareness of such interventions should then be promoted among caseworkers and resource families to help them advocate for better care for children in foster care with mental health issues.

○ **Extend foster care services:**

Intact families do not send their children off immediately after high school graduation to live alone at 18 or 19. Given the array of difficulties faced by foster children, as well as the negative short-term outcomes found in this and other studies (e.g., 30% homeless within a year of leaving care), some form of extended service is warranted. This may include allowing a youth to remain in placement, with continued support payments to the foster parent, until the youth has demonstrated the ability to successfully move out. Chafee funds are available for this option and for other services through the age of 21, even if the youth is no longer in custody. A number of states make available guardianship subsidies into the early 20s if the youth is enrolled in school (NAIARC, 2003). Although a particular youth's situation may not call for it, research has provided evidence that in general longer and later stays in foster care result in better outcomes (McDonald et al., 1996; Courtney et al., 2005). In the past, youth have not always wanted to stay beyond legal emancipation after years of being in state custody. Positive relationships with foster parents and caseworkers may encourage a youth to see the benefit of remaining in care, and encouraging school completion and further education and/or training (such as through Education and Training Vouchers, which may be used through age 22) may further convince a young person to stay. In addition, barriers to staying (and, conversely, benefits to leaving) should be addressed, such as the ability to obtain a driver's license. Full-fledged foster care may not be necessary: Continued monitoring and services (including mental health services) can provide a guiding hand and a safety net as youth enter the real world of jobs and housing. Courtney and colleagues (2005) found that young adults out of care were much more likely to suffer from economic hardships than those of the same age still in state custody, particularly such difficulties as not being able to pay rent or a utility bill, being evicted, or frequently not having enough food to eat. Mech (2003), Kroner (2001), and others have discussed the effectiveness of scattered site apartments and other supportive housing programs, and states are allowed to spend up to 30% of their Chafee funds on room

and board. Allowing a young adult to return for services will also be helpful, providing help with such difficulties as completing complicated forms (such as for health insurance or financial aid [Pecora et al., 2005a]), job or housing search, or limited financial assistance (Courtney et al., 2001). It may be possible to identify a suite of easily and cheaply provided services, including referrals, that a young person could access from a single source, as in a help-line or website. This may be a way to make a small number of Chafee dollars spread a long way, and could be done in coordination with general youth and young adult assistance efforts to provide a central information source.

o **Use the Chafee Medicaid option to extend health coverage:**

Given the health problems, poor finances, and lack of health insurance experienced by many alumni, they appear to be at risk of joining the tens of thousands of Americans who die each year due to a lack of health insurance. Continued Medicaid coverage can ensure that on-going treatment for physical or mental health needs can continue. Providing the option to remain covered by Medicaid until age 21 does not necessarily mean paying for Medicaid for all alumni until they reach 21: In combination with other efforts—improved IL training, aftercare, job programs, connections with adults, etc.—this may shorten the time it takes an alumnus to find a job with health benefits.

o **Develop a detailed transition plan with each youth:**

Youth often express anxiety over the prospect of leaving care and being on their own. Having a plan can help alleviate that anxiety. A transition plan should address “supportive relationships, community connections, education, life skills assessment and development, identity formation, housing, employment experience, physical health, and mental health” (Pecora et al., 2005a, p. 50). Youth need concrete assistance as they transition to adulthood (Courtney et al., 2001; Pecora et al., 2005a), “rather than merely information” (Courtney et al., 2001, p. 714). A plan will identify needs and resources in the community—internships and apprenticeships, job fairs, community mental health centers, free driver’s education courses, and so on—to meet those needs now and in the future. More and more transition-related resources are being developed, including:

- the TRIO (www.coenet.us/abouttrio.html) and GEAR UP education programs (www.ed.gov/programs/gearup/index.html)
- resources for starting a career, including help for youth, from the Federal Department of Labor (www.doleta.gov/jobseekers/starting_your_career.cfm)
- Chafee Education and Training Vouchers (see www.acf.hhs.gov/programs/cb/programs/etvfactsheet.htm)
- money management skills education resources such as Money Talks (www.moneytalks.ucr.edu)

- the transition and mentoring information available from Foster Care Alumni of America (www.fostercarealumni.org).

These are only examples; the current report is not intended to provide day-to-day guidance in working with youth. Ansell (2001) describes an independent living continuum, beginning with informal work (family discussions and activities), continuing to formal training, followed by supervised independent living (supported apartments, transitional living arrangements with a foster family, weekend apartment living experiences, etc.), and finally self-sufficiency (with some support, such as scholarships, support groups, or continued counseling). As discussed in the Child Welfare Evaluation Program's youth-in-care study (Pope & Williams, 2005a), a transition plan should be youth-centered, arising out of a frank conversation about where a youth wishes to live and what skills are necessary there. Youth who wish to return to rural areas, for example, may need to learn a whole new set of skills not necessary in Anchorage or Juneau. In the absence of extant training materials, such a youth will need experiences and contact with a knowledgeable mentor. The state may wish to investigate sponsoring more formal group experiential learning, such as an Alaska Native elder-lead fishing day for not only youth placed locally but also youth moved out of the area for foster care.

- **Facilitate communication across agencies, programs, roles and functions, cultures, generations, etc.:**

The benefits of assessment and thorough planning can come only if parties communicate. Thus, information must pass from professional to professional and also from caseworker to foster parent, caseworker to new caseworker (if necessary), school to school, child welfare agency to educational system, caseworker and foster parent to therapist, and so on. Similarly, working across departments will help maximize efficiency of services and access to resources, such as access to Medicaid or to developmental disability assistance. Although officially charged with the care of foster youth, OCS should not shoulder all the burden of caring for this segment of society's children and preparing them for adulthood: The rest of society needs to take some responsibility for it youth. Other agencies, both public and private, and individuals can provide employment opportunities, tutoring and mentoring, service learning programs, respite care, and other ways to care for youth, prepare them for adulthood, and connect them to the larger society. As the agency chosen by the village to raise these children, OCS should take responsibility within Alaska to coordinate services and link youth to resources, such as housing options, scholarships and training programs, parenting and child development assistance, and so on, offered by other organizations. Communication should extend beyond the state as well: As OCS learns how to overcome barriers and improve services, these lessons should be shared with other states.

- **Support caseworkers in their efforts to help youth transition to adulthood:**

Workers in Alaska often face caseloads above advised levels, often with the added complication of day-long travel to visit one child. Calls for hiring more caseworkers are frequent. Many workers, however, recognize that they might be able to do more

for the youth they serve than they are currently in the absence of certain barriers and with improved training and knowledge. For example, OCS should continue its efforts in maximizing use of not only the Ansell-Casey Life Skills Assessment but also the lesson plans that the Caseliveskills.org website can then produce, and the indicated resources available through the site, many of which are free. Training and information should include accessing the wide variety of resources, within OCS and without, that are available. Programs and resources mentioned in this report are merely a handful of those available. Only if a worker is aware of a service and of how to pay for it can youth or young adult take advantage. Worker-youth relationships can also be improved by training workers regarding adolescent-specific developmental issues and themes, so that workers are better prepared for the particular events and interactions that come with caring for a teen. OCS should work to match caseworkers (as well as foster families) with youth. Those with a professed interest in adolescents should be assigned adolescents. Those workers who, in consultation with their supervisors, declare a desire to not work with teens should have teens on their caseloads only because the younger children in their care have grown into adolescence. Matching is, of course, easier with a larger pool of workers. More available caseworkers would in turn allow each worker more time to spend with each child on their caseload, helping that child feel heard and cared for, discussing future goals, developing transition plans, monitoring progress, and otherwise providing stable, caring contact.

CONCLUSION

This report provides some of the answers to the question posed by the research team at the beginning of the study: what happens to foster care youth after they “age out” of state custody? Despite the hardships of abuse and neglect, removal from biological family, multiple moves and transitions, and ill-preparation for adult living, many Alaskan foster care alumni were thriving. Through persistence, emotional support and connections, and their own resourcefulness and that of others, they have grown into contributing members of the communities where they live. Many Alaskan alumni, however, were still struggling economically, emotionally, and physically.

The intent of this study was to provide insight into the experiences of foster care alumni with the hopes of improving the lives of current and future generations of youth who find themselves removed from their birth families and placed in state custody. This responsibility does not rest solely with the State of Alaska, but with communities, families, caregivers, tribal programs, caseworkers, residential youth facilities, schools, and even the youth themselves. Transition to adulthood is a complex phenomenon, influenced by personal and social factors as well as such societal factors as job availability, housing costs, and the availability of services (Collins, 2001). These factors cannot all be changed at once, but small changes can be effective.

Several studies have found that there are some key ingredients that, if provided to the youth early, can greatly enhance their chances of success. These are, among many others: positive, consistent adult relationships; youth participating in their own planning; early and on-going preparation for independent living; promotion of education, training, and employment; on-going connection to family members when appropriate; and allowing

youth to receive the economic and emotional benefits of remaining in care until 21. This study highlights the need to apply such efforts to youth in the child welfare system. Care, support, mentoring, training, and financial assistance will ultimately benefit foster youth, their communities, and all of us.

Recommendations related to the results of this study were discussed in the previous section, and further recommendations from stakeholders are listed in Appendices A and B. Most of these recommendations are not new. Since 1980, foster care advocates have espoused the benefits of beginning preparation for independent living when youth are 14 or 15, including

educational, prevocational, and vocational experience...; gradually moving the foster ward from traditional placements to community-based settings, such as transitional congregate apartments or scattered-site apartments; providing extensive information with respect to the range of community services available, including linkage with community contacts, transitional mentors, and a "natural-systems" support team; and helping [youth and young adults] to make decisions about educational choices, including postsecondary education, as well as employment and housing (Mech, 2003, p. 45).

Focus on transition issues for adolescents in foster care is relatively new, and OCS' efforts to date to provide improved services both before and after leaving care are to be commended. As the results of this study have demonstrated, this focus is warranted. Many efforts to improve foster care were underway when interviews for this study were begun in 2004, or have been launched even more recently. Some of these initiatives are discussed in Appendix B. Further foster care research which compares a newer cohort of alumni who have benefited from more available resources with the cohort from this study would provide insight into the success of OCS' recent endeavors.

APPENDIX A

Stakeholder Recommendations: Strategies to Improve Foster Care in Alaska

In addition to the recommendations above, various advocates of improved foster care emphasized the following strategies to improve foster care in the state:

- Increase the number and cultural diversity of resource families.
- Expand targeted recruitment of resource families to reach underrepresented cultural groups, with particular emphasis on reaching out to Alaska Native families.
- Increase the number of resource families with the capacity and expertise to provide care to adolescents.
- Expand efforts to more carefully match children's needs with the culture, style, and capabilities of foster families.
- Increase kinship care, provide support and training to families providing this care.
- Expand the use of the Team Decision Making model currently used in the Anchorage OCS office (from Family to Family by the Annie E. Casey Foundation). This process involves families and community members actively in case planning and decision-making.
- Reduce the reliance on emergency shelter care.
- Reduce the use of residential care.
- Provide more agency and respite support to resource families.
- Build academic support for foster children through working with schools and other community resources.
- Increase post-secondary education and vocational training for foster youth and alumni, including job training, job shadowing, and apprenticeships.
- Increase the number of safe, affordable transitional housing options for foster care alumni.

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APPENDIX B

Action Steps to Improve Foster Care in Alaska: Expanded Independent Living Services

The information below was provided in response to the study recommendations by the Office of Children's Services Independent Living Program as an update on services now provided to youth making the transition out of state custody.

Involve youth in planning:

Current policy and procedure requires that all youth in care age 16 and older complete a life skills assessment (the ACLSA), transition learning plan (TLP) and exit plan. Youth assess their own knowledge, skill, and abilities in five domains that score their competency in critical life skills. Based on the assessment, the youth and foster parent, social worker, or Regional Independent Living Specialist will complete a TLP. The TLP documents learning activities in which the youth and caregivers can engage to increase life skills competencies. An exit plan, along with the assessment, is completed if the youth is scheduled to exit custody or is 17 or older. The exit plan documents the youth's plans for education, housing, employment, support from and connections to adults and family members, health care and continuing independent living services available to them through OCS. Before a youth leaves custody, the youth compiles a binder in which their personal exit plan, discharge papers, medical records, birth certificate, social security, tribal membership, other official documents, and other information are contained. Also included in the binder is a list of community resources for continuing support

Provide comprehensive assessment:

For purposes of independent living, OCS requires that youth, beginning at age 15, complete the Ansell-Casey Life Skills Assessment a minimum of once a year and preferably every six months. Youth must complete the ACLSA prior to receiving individual living funds for services and/or benefits.

Maximize placement stability:

Regional Independent Living Specialists (RILS) consider the youth's placement history while working directly with the youth. RILS may provide information to social workers and others when a placement change is necessary or when a placement decision is being made that may affect the youth's independent living goals and plans. In order to increase placement stability, OCS is striving to increase the number of foster families and care providers who will accept teenagers to foster and provide them with the necessary support and training to mentor youth as they prepare to live on their own.

Provide sexuality education to all foster youth:

Independent living conferences have included this topic in their curriculum.

Provide parenting supports for youth who do become parents:

All pregnant and parenting youth in custody are referred directly to OCS partner programs including WIC (Women, Infants, and Children), Infant Learning Programs,

and/or Healthy Families for parenting and pregnancy supports. Additionally, youth are referred to other financial resources including Denali KidCare, public assistance, and community-based service providers such as Passage House, a residential program for single mothers.

Encourage positive adult relationships:

As part of the exit planning process, youth identify adults with whom they have an important and positive relationship and whom they can contact if the need arises once they leave care. Through grants and collaborative agreements OCS also supports community organizations that provide mentoring and adult sponsors for youth. Additionally, OCS connects tribal youth with tribal supports and services, actively encouraging participation in tribal activities especially where elders play an important role in mentoring youth.

Promote sibling contact:

The Alaska Youth Advisory Board—Facing Foster Care in Alaska—has identified ongoing sibling contact as one of their priority areas. They have defined “sibling” as both biological siblings and foster siblings. Through the exit planning process youth may identify connections with siblings as one of the goals and the RILS can assist youth with locating siblings, resolving family issues, and making connections.

Promote legal ties, such as adoption and guardianship throughout adolescence and even into adulthood:

Five of the core members of Facing Foster Care in Alaska are young people who were adopted or entered legal guardianship as adolescents. These connections clearly demonstrate that OCS is committed to promoting permanent legal ties for youth in care.

Extend foster care services beyond 18:

Youth may remain in custody beyond age 18. Primarily youth are encouraged to remain in care beyond age 18 if they have not graduated high school. Once released from care, youth may continue to receive services and supports through OCS and the Independent Living Program up to age 23 for education and training purposes. This continuing support is mandated by Alaska statute and has been in place since the state began receiving Chafee Foster Care Independence Act funds in 2001.

Support relationships with foster parents after youth reach 18:

While the formal, subsidized relationship between foster parents and youth may end when the youth is released from custody; there is no rule that mandates they cannot remain connected. Many foster parents are receptive to this and continue to maintain connections with their foster children, including providing housing and supports for youth. For example, two former foster youth who are currently attending college with support through the OCS Independent Living Program return to their former foster homes during school breaks and vacations.

Advocate for using the Chafee Medicaid option to extend health coverage:

A request to use the Chafee Medicaid option was forwarded by the Department of Health and Social Services to the Governor's office for consideration during the 2005 legislative session. Because new Medicaid expenditures were not under consideration this year, the request will be held and considered during the 2006 legislative session.

Facilitate communication:

In 2004, the Independent Living Program was expanded to include four new Regional Independent Living Specialists (RILS) positions. There is now an Independent Living Specialist established in each of the four OCS Regional Offices. The primary goal of these Regional Specialists is to work directly with youth to develop and implement plans that specifically address the individual needs of the youth as they prepare to exit custody. The RILS are bridges between youth, social workers, foster parents, and others in the flow of information about and on behalf of the youth. Additionally, the RILS are a primary connection to community services and providers (including schools and health care professionals) who can play a significant role in helping youth transition from care. The RILS maintain open lines of communication once the youth exits care and they continue to provide case management services, funding assistance, and other supports to former foster youth.

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HB

136

ALASKA STATE LEGISLATURE

Vice Chair:
House Finance Committee

Chair:
House Finance Subcommittees for,
Department of Public Safety
Department of Law



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BILL STOLTZE

State Representative

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House Bill 136

Dental Hygienists

"An Act relating to dental hygienists."

Good oral health is essential to improving overall health and well being. However, many factors exacerbate the oral health disparity across Alaska's population, including the current structure of the oral healthcare delivery system, geographic and educational barriers, and the cost of care.

Dental Hygienists are licensed oral care health professionals who focus on preventing and treating oral diseases. They have graduated from nationally accredited dental hygiene education programs in colleges and universities, and have successfully passed a national written and state clinical examination. Given their comprehensive education and clinical preparation, dental hygienists are well prepared to deliver preventative oral health care services to the public, safely and effectively.

The provisions of House Bill 136 follow the expanded functions of dental hygienists in other states to improve access to preventative oral health care. Specifically, HB 136:

1. Allows a licensed dental hygienist to place "fillings" into a cavity prepared by a licensed dentist.
2. Authorizes a licensed dental hygienist to administer local anesthetic agents under the general supervision of a licensed dentist.
3. Permits a licensed dental hygienist to enter into a collaborative agreement with a licensed dentist in which the dentist authorizes the dental hygienist to perform certain duties stipulated under HB 136 without the supervision of the dentist.

I ask for your consideration and support of HB 136 to help improve access to oral health care in Alaska.

DISTRICT 16

BIRCHWOOD • BUTTE • CHUGIAK • EKLUTNA • FAIRVIEW LOOP
KNIK RIVER ROAD • LAZY MOUNTAIN • PALMER • PETERS CREEK

Number of Dentists and Dental Hygienists by Region

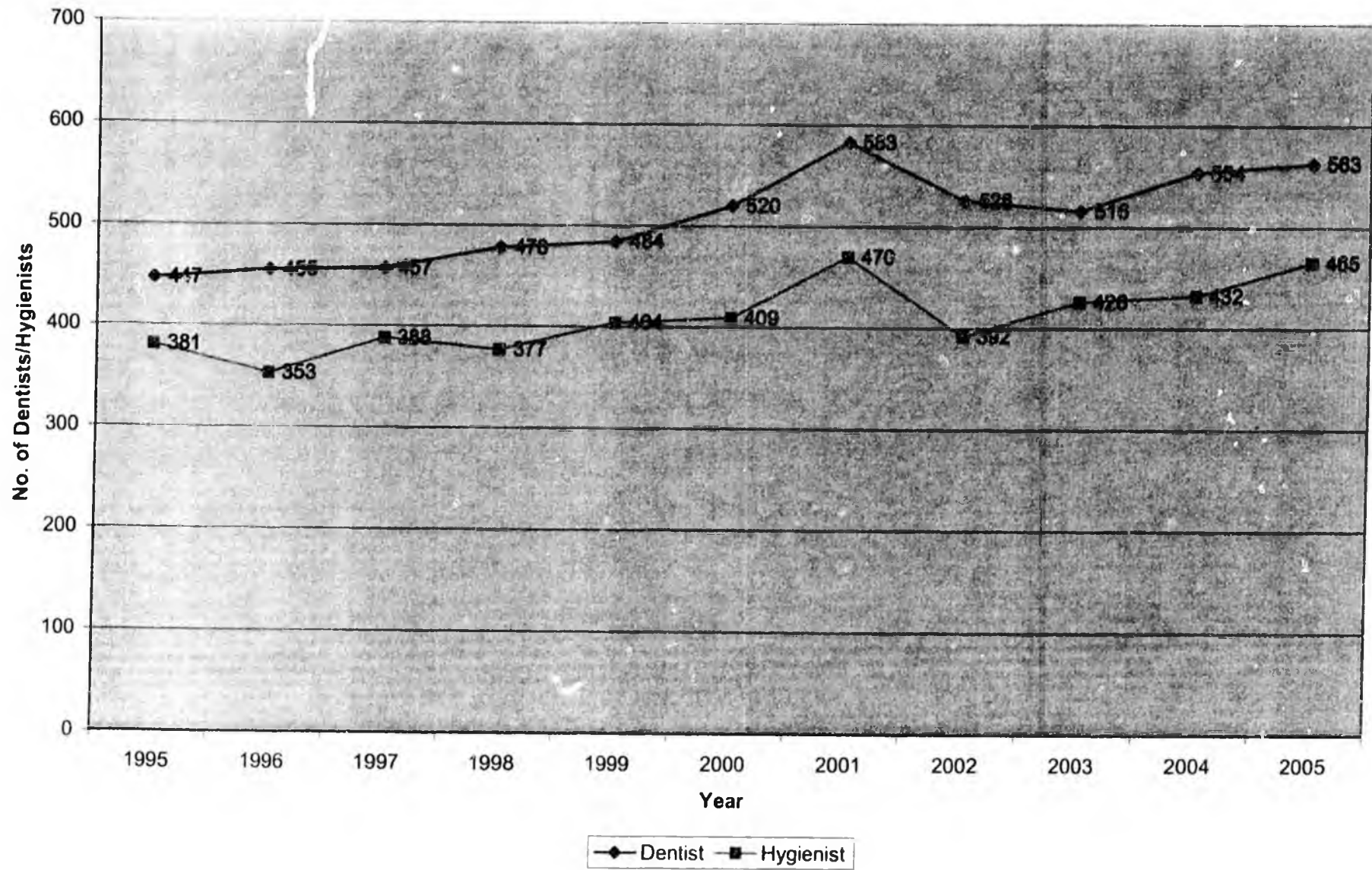
| Region | Population | No. of Dentists | No. of Hygienists | No. of Hyg/Den | No. of Hyg/10,000 |
|--------------------------------------|----------------|--------------------|----------------------|-------------------|----------------------|
| New England | | | 13,118 | 1.4 | 9.4 |
| Middle Atlantic | | | 25,976 | 0.9 | 6.6 |
| East North Central | | | 31,851 | 1.3 | 7.1 |
| West North Central | | | 9,481 | 1 | 4.9 |
| South Atlantic | | | 27,484 | 1.1 | 5.3 |
| East South Central | | | 7,998 | 1.1 | 4.7 |
| West South Central | | | 12,287 | 0.9 | 3.9 |
| Mountain | | | 10,422 | 1.2 | 5.7 |
| Pacific | | | 31,149 | 1.1 | 6.9 |
| U.S. Total | | | 169,149 | 1.1 | 6.0 |
| Alaska | 663,661 | 497 | 496 | 1.0 | 7.47 |
| Anchorage Mat-Su Region | 352,282 | 226 | 270 | 1.2 | 7.66 |
| Anchorage Municipality | 278,241 | 197 | 216 | 1.1 | 7.76 |
| Matanuska-Susitna Borough | 74,041 | 29 | 54 | 1.9 | 7.29 |
| Gulf Coast Region | 74,904 | 37 | 42 | 1.1 | 5.61 |
| Kenai Peninsula Borough | 51,224 | 27 | 29 | 1.1 | 5.66 |
| Kodiak Island Borough | 13,638 | 7 | 9 | 1.3 | 6.60 |
| Valdez-Cordova Census Area | 10,042 | 3 | 4 | 1.3 | 3.98 |
| Interior Region | 102,005 | 50 | 45 | 0.9 | 4.41 |
| Denali Borough | 1,823 | 0 | 0 | - | - |
| Fairbanks North Star Borough | 87,650 | 47 | 45 | 1.0 | 5.13 |
| Southeast Fairbanks Census Area | 6,471 | 3 | 0 | - | - |
| Yukon Koyukuk Census Area | 6,061 | 0 | 0 | - | - |
| Northern Region | 23,669 | 8 | 2 | 0.3 | 0.84 |
| Nome Census Area | 9,452 | 5 | 1 | 0.2 | 1.06 |
| North Slope Borough | 6,894 | 2 | 1 | 0.5 | 1.45 |
| Northwest Arctic Borough | 7,323 | 1 | 0 | - | - |
| Southeast Region | 70,822 | 41 | 48 | 1.2 | 6.78 |
| Haines Borough | 2,207 | 1 | 2 | 2.0 | 9.06 |
| Juneau City and Borough | 31,193 | 22 | 26 | 1.2 | 8.34 |
| Ketchikan Gateway Borough | 13,125 | 7 | 9 | 1.3 | 6.86 |
| Prince of Wales-Outer Ketchikan C.A. | 5,497 | 1 | 2 | 2.0 | 3.64 |
| Sitka City and Borough | 8,947 | 6 | 5 | 0.8 | 5.59 |
| Skagway-Hoonah-Angoon C.A. | 3,062 | 0 | 0 | - | - |
| Wrangell-Petersburg Census Area | 6,172 | 4 | 4 | 1.0 | 6.48 |
| Yakutat City and Borough | 619 | 0 | 0 | - | - |
| Southwest Region | 39,979 | 13 | 5 | 0.4 | 1.25 |
| Aleutians East Borough | 2,659 | 0 | 0 | - | - |
| Aleutians West Census Area | 5,249 | 2 | 1 | 0.5 | 1.91 |
| Bethel Census Area | 17,085 | 9 | 2 | 0.2 | 1.17 |
| Bristol Bay Borough | 1,073 | 0 | 0 | - | - |
| Dillingham Census Area | 4,792 | 2 | 2 | 1.0 | 4.17 |
| Lake and Peninsula Borough | 1,620 | 0 | 0 | - | - |
| Wade Hampton Census Area | 7,501 | 0 | 0 | - | - |
| Out-of State | | 122 | 84 | | |

Source: National data calculated using ICR, 2000 and U.S. Census Bureau

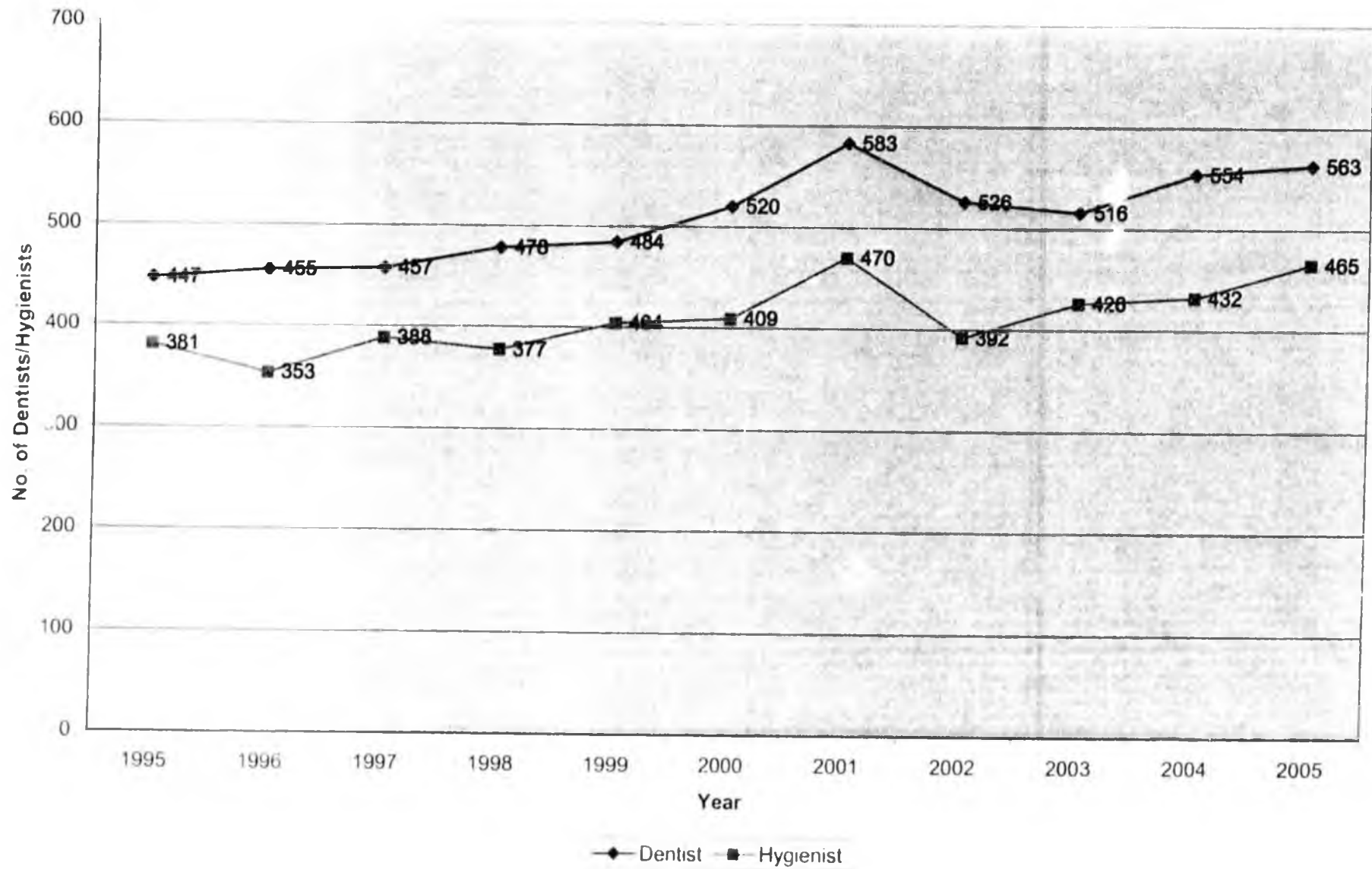
Source: State population data from ADOL&WD, 2005

Source: Dentist/Hygienist data from AK Div of Occupational Licensing, Jan 2007

Dentist & Hygienists in AK (1995 - 2005)



Dentist & Hygienists in AK (1995 - 2005)




DIRECT ACCESS STATES

For purposes of this document, direct access means that the dental hygienist can initiate treatment based on his or her assessment of patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and can maintain a provider-patient relationship.

Arizona 2004

Sec 32-1289




A dental hygienist with a written affiliated practice agreement with a dentist may assess for and perform dental hygiene services on patients under 18 years who meet certain financial criteria and are enrolled in a federal, state, county or local healthcare program

Special requirements: 5 years practice

Services: Any dental hygiene services specified in the affiliated practice agreement except root planing, local anesthesia, nitrous oxide or placing sutures.

California 1998 (*California has two different provisions for unsupervised practice)

Sec. 1774, 1775



Dental hygienists endorsed as RDHAPs (registered dental hygienist in alternative practice) may provide services without supervision for homebound persons or at schools, residential facilities, institutions and in dental health professional shortage areas if the patient has a prescription from a dentist or physician. RDHAP'S may own an alternative dental hygiene practice. Currently, there are more than 100 RDHAP's.

Special Requirements: Bachelors degree equivalent, 3 years clinical practice, completion of 150 clock hour special course and exam.

Services: Those services permitted under general supervision (which include oral prophylaxis, root planing, pit and fissure sealants, charting and examination of soft tissue).

California 2002

Sec 1763 (a) 2002 Any dental hygienist may provide screening, apply fluorides and sealants without supervision in government created or administered public health programs.

- In 2006, more than 100 RDHAP's registered.
- A dental hygienist mobile practice treats 25/35 disabled patients per week.
- Direct Medicaid reimbursement allowed.



Colorado - 1987

Sec. 12-35-122.5

Unsupervised practice in all settings for all licensed dental hygienists for the oral prophylaxis and preventive and therapeutic services. The dental hygienist may also own a dental hygiene practice.

Special Requirements: None.

Services--remove deposits, accretions, and stains, curettage without anesthesia, apply fluorides and other recognized preventive agents, oral inspection and charting, topical anesthetic. However, x-rays require general supervision and local anesthesia requires direct supervision.

- **Direct Medicaid reimbursement allowed. In fiscal year 2003-04 16 independent RDH's provided 199,518 in services to 2,284 Medicaid children.**



Connecticut 1999

Section 20-126l.

Dental hygienists with 2 years experience may practice without supervision in institutions, public health facilities, group homes and schools.

Special Requirements: 2 years experience.

Services: Oral prophylaxis, remove deposits, accretions and stains, root planning, sealants, assessment and treatment planning.

- **Since 7/1/2003 hygienists have program has provided over 55,000 dental procedures – nearly 7,000 prophylaxis/fluorides, 5,800 sealants and 15,000 exams.**
- **Direct Medicaid reimbursement allowed.**

Iowa 2004

Rule 650-10.5 (153)

Dental hygienists may provide services based on standing orders and a written agreement with a dentist in schools, Head Start settings, FQHCs (Federally Qualified Health Centers), public health vans, free clinics, community centers and public health programs. As of 2005, 15 hygienists held public health permits.

Special Requirements: RDH must have 3 years clinical experience and submit annual report on number of patients/services to department of health.

Services: All dental hygiene services (except local anesthesia and nitrous) may be provided once to each patient. To perform repeat services other than assessment, screening and fluoride, dentist must examine.

- Active Public Health Supervision agreements in place between Iowa dentists and dental hygienists.
- Preliminary estimates for 2004: Over 3,100 clients received sealants, over 11,000 received screenings, 1,600 received fluoride applications, over 150 received prophylaxis, and over 5,000 received education.
- In 2006, 24 public health RDHs.

Kansas 2003

Sec. 65-1456

Dental hygienist with 1800 hours experience can obtain an extended care permit to treat patients in schools, headstart programs, state correctional institutions, local health departments, indigent care clinics, adult care homes, hospital long term units, or at the home of homebound persons on medical assistance. No prior authorization is needed, but the hygienist must have an agreement with a sponsoring dentist who will monitor his/her practice. Services permitted are the oral prophylaxis, application of fluoride, dental hygiene instruction, assessment of the patient's need for further treatment by a dentist and other services if delegated by the sponsoring dentist.

- As of April 2006, there were 41 extended care permit dental hygienists.

Maine 2001

Rule 02 313 Chap. 1. Sec. 4

A dental hygienist may practice in a public or private school, hospital or other non-traditional practice setting under a public health supervision status granted by the dental board on a case-by-case basis. The hygienist may perform all services rendered under general supervision.

The dentist should have specific standing orders and procedures to be carried out, although the dentist need not be present when the services have been provided. A written plan for referral or an agreement for follow-up shall be provided by the public health hygienist recording all conditions that should be called to the attention of the dentist. The supervising dentist shall review a summary report at the completion of the program or once a year.

Special Requirements: A dental hygienist must apply to the board to practice providing such information the board deems necessary. The board must take into consideration whether the program will fulfill an unmet need, whether a supervising dentist is available and that the appropriate public health guidelines and standards of care can be met and followed.

Services: All services that can be provided under general supervision. Dentist's diagnosis for sealants not needed in public health or school sealant programs.

- From 3/02 through 10/04, over 5,500 patients were provided care in over 400 clinics. Nearly 30 dental hygienists are involved in this particular program.
- Direct Medicaid reimbursement allowed.

Michigan 1991

Sec. 333.16625

A dental hygienist may apply to the Department of Community Health to become designated as a "grantee health agency" for a 2 year period, during which time hygienist can administer dental hygiene services to patients not assigned to a dentist as part of a program in dentally underserved populations. Dental hygienists practicing as grantee health agencies must work under the supervision of a licensed dentist for a public or nonprofit entity, school, or nursing home that employs or contacts with at least one dentist or dental hygienist and provides care to an underserved population.

Special requirements: Dental hygienists interested in attaining grantee health agency status must submit a comprehensive form outlining how the program will be carried out, providing for oversight and direction, and including information for all dental personnel involved. A dental hygienist operating as a grantee health agency must ensure that the supervising dentist is available for consultation when necessary.

Services: those permitted under general supervision.



Minnesota 2001

Section 150A. 10, subd. 1a

A dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform dental hygiene services without the patient first being examined by a licensed dentist if the dental hygienist has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

Health care facility is defined as a hospital, nursing home, home health agency, disabled/juvenile home, federal/state/local public health facility, community clinic, prison, tribal clinic school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients.

A collaborative agreement means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services may be performed without the presence of a licensed dentist and may be performed at a setting other than the usual place of practice of the dentist or dental hygienist and without the dentist's diagnosis/treatment plan unless specified in the agreement.

Special Requirements: Has been engaged in the active practice of clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years. Has documented participation in courses in infection control and medical emergencies within each continuing education cycle and maintains current certification in advanced or basic cardiac life support as recognized by the American Heart Association, the American Red Cross, or another agency that is equivalent to the American Heart Association or the American Red Cross.

Services: Removal of deposits and stains from the surfaces of the teeth, application of topical preventive and prophylactic agents, sealants, fluoride varnishes, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking x-rays and root planing. A dental hygienist can provide sealants and fluoride varnishes without the patient first being examined by a licensed dentist.

Restorative Services: a licensed dental hygienist or a registered dental assistant may perform the following restorative procedures:

- Place, contour, and adjust amalgam restorations;
 - Place, contour, and adjust glass ionomer;
 - Adapt and cement stainless steel crowns; and
 - Place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel.
- The restorative procedures may be performed only if:
- The licensed dental hygienist or the registered dental assistant has completed board-approved courses on the specific procedures which include a course that sufficiently prepares the dental hygienist or registered dental assistant to adjust the occlusion on the newly placed restoration.

- A licensed dentist has authorized the procedure to be performed.
- There are now 2 dental hygienists volunteering in a community dental clinic providing restorative and preventive services to at least 10 patients each day they volunteer.
- Direct Medicaid reimbursement allowed.

Missouri 2001



Statute 332.311.2

Dental hygienists may provide services without supervision in public health settings to Medicaid eligible children and be directly reimbursed by Medicaid.

Special Requirements: 3 years experience.

Services: Oral prophylaxis, sealants, fluorides.

- One particular dental hygienist has seen a sealant program grow from one school district to eight. Over 2,500 sealants have been placed on over 700 children.
- Direct Medicaid reimbursement allowed.
- In 2006, were 12 registered providers.



Montana 2003

Sec. 37-4-405

Dental hygienists may obtain a limited access permit from the board allowing them to practice under public health supervision in a variety of federally funded health centers and clinics, nursing homes, extended care facilities, home health agencies, group homes for the elderly, disabled, and youth, headstart programs, migrant work facilities and local and state public health facilities. Public health supervision means the hygienist can provide oral prophylaxis, fluoride, polish restorations, root plane, sealants, oral cancer screening, expose radiographs, and chart without the authorization of a dentist provided he or she follows protocols to be established by the board and refers any patients needing dental treatment.

- Program took effect in September of '04, 6 applicants so far.

New Hampshire 1993

Rule 101.11(d)

Under public health supervision dental hygienists may provide procedures authorized by a dentist in a public or private school, hospital or institution, provided the dentist reviews patient records once in a 12 month period.

Special Requirements: None.

Services: Instruction in oral hygiene, topical fluorides, oral prophylaxis, assess medical/dental history, periodontal probing/charting.

New Mexico 1999

Sec 61-5A-4D

Rule 16.5.17

Collaborative practice permits based on a written agreement between the dental hygienist and one or more consulting dentist(s), dental hygienists to treat patients according to a protocol with collaborative dentist. Dental hygienists may own or manage a collaborative dental hygiene practice in any setting. Must refer patient for dental exam yearly.

Special Requirements: 2400 hours active practice in past 18 months or 3000 hours in 2 of past 3 years.

Services: Each collaborative practice agreement must contain protocols for care. Which provide for standing orders allowing the dental hygienist to provide routine services such as preliminary assessment, x-rays, oral prophylaxis and fluoride treatment without prior authorization. Case-by-case authorization required in some procedures (as sealants and root planning).

- One collaborative practice arrangement that started in 2002, serves a patient base of 4,000 people- 1/3 of which are Medicaid eligible.
- Direct Medicaid reimbursement allowed.
- In 2006, there were 35 collaborative practice RDHs.



Nevada 1998

Statute 631.287

Dental hygienists may obtain approval to work as public health dental health hygienists in schools, community centers, hospitals, nursing homes and such other locations as the state dental health officer deems appropriate without supervision.

- **20 RDH's have gained board approval Nevada Health Centers, Inc. where some RDH's are employed, provides services in eighteen different locations in Nevada. Dental hygienists with Public Health endorsement can also screen and place sealants without a dentist present. Additional locations include Saint Mary's, Huntridge Teen Center & Lyon Co. Healthy Smiles.**
- **Direct Medicaid reimbursement allowed.**



New York 2005

Rules Sec. 61.9

That a supervising dentist be available for consultation, diagnosis and evaluation, has authorized the dental hygienist to perform the services, and exercises that degree of supervision appropriate to the circumstances." A dental hygienist can work in any setting (private or public) and perform dental hygiene duties (listed below) without a dental examination or need to refer a patient to a dentist.

Dental hygiene services allowed include removing calcareous deposits, accretions and stains, including scaling and planning of exposed root surfaces; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; placing and exposing X-ray films; performing topical anticariogenic agent applications, including but not limited to topical fluoride applications, and performing topical anesthetic applications; polishing teeth, including existing restorations; taking medical history including the measuring and recording of vital signs; charting caries and periodontal conditions as an aid to diagnosis by the dentist; applying pit and fissure sealants; and applying desensitizing agents to the teeth.

In nursing homes a hygienist can perform a complete oral examination of a resident and then determine treatment priorities; plan for continuing oral hygiene and dental care.

- **In 2005, dental hygienists have screened almost 800 children & sealed over 1500 teeth.**
- **Thousands of New York children have been treated by dental hygienists' in school based programs under general supervision.**



Oklahoma 2003

Sec. 328.34 C

A dentist may authorize in writing a dental hygienist with 2 years experience to perform services one time on a patient in a setting outside the office prior to any dentist contact/exam if the hygienist refers the patient back to the authorizing dentist.



Oregon 1997

Sec. 680.200

Rule 818-035-0065

Dental hygienists who have obtained a limited access permit (LAP'S) may initiate services for patients in a variety of limited access settings such as extended care facilities, facilities for the mentally ill or disabled, correctional facilities, schools and pre-schools, and job training centers. RDH must refer the patient annually to a licensed dentist available to treat the patient.

12 hours of CE every two years (in addition to the 24 hours required for all dental hygienists) to renew permit.

Services--All dental hygiene services, except that some (local anesthesia, pit and fissure sealants, denture relines, temporary restorations, radiographs and nitrous oxide) must be preauthorized by a dentist.

- In 2006, there was 70 LAP's.
- In the last year, LAP dental hygienists in 3 counties provided over 5,000 preventative procedures for children in Headstart, Early Headstart, WIC a public health settings.
- Several LAP hygienists throughout Oregon continue to build practices serving the elderly in foster homes and extended care facilities.
- Direct Medicaid reimbursement allowed.



Rhode Island 2006

Sec. 5-31.1-6.1

Dental hygienists working under a dentist's general supervision can initiate dental hygiene treatment to residents of nursing facilities. Dental hygienists working in nursing facilities can treat patients, regardless of whether or not the patient is a patient of record, as long as documentation of services administered is maintained and necessary referrals for follow-up treatment are made.

Special requirements: None.

Services: Initial oral health screening assessments, prophylaxis, fluoride treatments, charting, and other duties delegable under general supervision.



Texas 2001
Statute 262.1515

A dentist may delegate services without seeing the patient first to a dental hygienist practicing in a nursing facility or school based health center. The hygienist must refer the patient to a dentist following treatment. The hygienist may not perform a second set of services until the patient has been examined by a dentist.

Special Requirements: 2 years practice experience.

Services: No limitations.



Washington 1984 (Washington has two different provisions for unsupervised practice)
Sec. 18.29.056

Unsupervised practice in hospitals, nursing homes, home health agencies, group homes (for the elderly, handicapped or youth), state institutions under department of health and human services, jails, and public health facilities provided the hygienist refers patient to a dentist for dental treatment and needed care.

Special requirements: Two years clinical experience within the last five years.

Services -- removal of deposits and stains, application of topical preventive or prophylactic agents, polishing and smoothing restorations, root planing, curettage and local anesthesia. (The dental board has ruled that sealants are not included, but require general supervision).

Washington 2001
Statute 18.29.220

Dental hygienists who are school endorsed may assess for and apply sealants and fluoride varnishes in community-based sealant programs carried out in schools.

Special Requirements: Sealant/Fluoride Varnish Endorsement from Department of Health.

- Data obtained through Medicaid indicates that dental hygienists working under these provisions saw 5,653 clients in 2002; 6,799 in 2003, and 4,265 through July of '04. Specifically in terms of sealants, over 19,200 sealants have been placed since Dec. 2003.
- Direct Medicaid reimbursement allowed.

House Bill 136 – “An act relating to dental hygienists”

The Problem

- Preventable oral diseases can cause life threatening emergencies.
- Many Alaskans cannot afford oral healthcare.
- There are geographic and educational barriers preventing access to oral health care.
- The structure of Alaska's current oral healthcare delivery system contains barriers that prevent access to oral health care.

Dental Hygienists Can Help

Dental hygienists are well-prepared to deliver preventative oral health care services to the public safely and effectively.

- Dental hygienists focus on preventing and treating oral diseases.
- Dental hygienists graduate from nationally accredited dental hygiene education programs in universities, and must pass a national written and state clinical examination in order to practice.
- Dental hygienists are state-licensed oral healthcare professionals.
- Dental hygienists are key to cost-effective early intervention and education.

Provisions under HB 136

1. Anesthesia under *general* supervision

Allows a licensed dental hygienist to perform local anesthesia under general supervision. A licensed dentist would still be required to diagnose the condition to be treated prior to the hygienist performing treatment.

2. Expanded restorative function

Allows a licensed dental hygienist to place “fillings” into a cavity prepared by a licensed dentist.

3. Collaborative agreement

Allows a licensed dental hygienist to enter into a written agreement with a licensed dentist who would authorize the services to be performed by the dental hygienist without the supervision of the dentist.

HB

140

Alaska State Legislature

House of Representatives

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Representative Les Gara

House Bill 140: The No Child Left Uninsured Act Sponsor Statement

Currently, nearly 18,000 Alaskan children have no health insurance (Urban Institute and Kaiser Commission on Medicaid). In addition, due to changes in 2003, 3,440 children have lost coverage under the state's low income children's health insurance plan, Denali Kid Care. House Bill 140 is an efficient, low cost way to reverse this decline. It seeks to extend health coverage to all Alaska children. We believe universal health coverage for children is long overdue.

Currently, Alaska offers Denali Kid Care medical and dental insurance to pregnant women and children of families that earn roughly 160 percent of the federal poverty level for Alaska. Only two states (North Dakota and Montana) have lower a eligibility level. Most states provide coverage under their Medicaid programs to families earning up to 200 percent of the federal poverty guideline.

HB 140 raises the eligibility level for Denali Kid Care to 200 percent of the federal poverty guideline. It extends optional coverage to children of families that earn between 200 and 350 percent of the federal poverty guideline by offering coverage at a sliding scale fee of between \$200 and \$1,200. Families that earn above 200 percent of the federal poverty guideline would have to certify that health insurance is not offered through their work.

Currently, the federal government contributes up to 70 percent of the cost of providing this health insurance to low income children and pregnant women.

It is believed that HB 140 would serve to make health insurance available to all families that cannot afford it. At present, coverage is provided to only very low income families. HB 140 extends coverage to working families that cannot afford private insurance on their own.

We hope you will support this effort, and ask that you contact with us with any questions.

Alaska State Legislature

House of Representatives

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Representative Les Gara

House Bill 140: The No Child Left Uninsured Act Sectional Analysis

Section 1

Gives short title to the act "Leave No Child Uninsured Act"

Section 2

Deletes hard income limits to qualify for Denali Kid Care and increases the income limit to 200 percent of the federal poverty guideline (FPG) as defined by the United States Department of Health and Human Services for the state of Alaska for children aged under the age of 19 and for pregnant women.

Section 3

Adds new section (AS 47.07.022) creating extended healthcare coverage to those state residents who are under the age of 19, whose household income is between 200 and 350 percent of the FPG, and whose parent or guardian certifies the child cannot be covered under a health care policy at the parent or guardian's place of work.

Allows the department to create sliding scale contribution regulations and those regulations must: include the option of using a child's and parent's permanent fund dividend and a contribution between \$200 and \$1,200 per person for incomes between 201 and 350 of the FPG increasing progressively as incomes progress.

In addition to the sliding scale contribution, the department shall impose a co-payment of 20 percent for medical services and prescription drug costs for a person whose income is between 250 and 350 of the FPG.

Section 4

Requires the department to accept premiums or cost-sharing contributions from recipients of the extended medical coverage.

Section 5

Repeals previous cost sharing requirements for Denali Kid Care.

Section 6

Giving the department the latitude to begin to adopt regulations to implement this Act, but the regulations may not take effect before the effective dates for secs. 1-5 of this Act.

Section 7

Giving sec. 6 an immediate effective date

Section 8

All other sections of this Act take effect July ., 2008.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-DBH2-03-14-07
 Bill Version: SS HB 140
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Behavioral Health
 Component: Behavioral Health Administration

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

Sponsor: GARA
 Requester: HOUSE (HES)

Component No. 2665

Expenditures/Revenues (Thousands of Dollars)

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

| OPERATING EXPENDITURES | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 |
|-------------------------------|------------|--------------|--------------|--------------|--------------|--------------|
| Personal Services | | 274.6 | 274.6 | 274.6 | 274.6 | 274.6 |
| Travel | | | | | | |
| Contractual | | 6.6 | | | | |
| Supplies | | 26.4 | 26.4 | 26.4 | 26.4 | 26.4 |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | | | | | |
| Miscellaneous | | | | | | |
| TOTAL OPERATING | 0.0 | 307.6 | 301.0 | 301.0 | 301.0 | 301.0 |
| CAPITAL EXPENDITURES | | | | | | |
| CHANGE IN REVENUES (0) | | | | | | |

FUND SOURCE (Thousands of Dollars)

| | | | | | | |
|---------------------------------------|------------|--------------|--------------|--------------|--------------|--------------|
| 1002 Federal Receipts | | 153.8 | 150.5 | 150.5 | 150.5 | 150.5 |
| 1003 GF Match | | 153.8 | 150.5 | 150.5 | 150.5 | 150.5 |
| 1004 GF | | | | | | |
| 1037 GF/Mental Health | | | | | | |
| Other(Specify Type-do not abbreviate) | | | | | | |
| Other(Specify Type-do not abbreviate) | | | | | | |
| TOTAL | 0.0 | 307.6 | 301.0 | 301.0 | 301.0 | 301.0 |

Estimate of any current year (FY2007) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

| | | | | | | |
|-----------|--|---|---|---|---|---|
| Full-time | | 3 | 3 | 3 | 3 | 3 |
| Part-time | | | | | | |
| Temporary | | | | | | |

ANALYSIS: (Attach a separate page if necessary)

SS HB140 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200 percent of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(Continued)

Prepared by: Stacey Toner, Acting Director
 Division: Behavioral Health
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone: 465-2817
 Date/Time: 03/09/2007
 Date: 03/14/2007

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

SS HB140 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201% and 350% of the prevailing FPG, and have no insurance.

This fiscal note represents the administrative costs for utilization review for youth who have been determined eligible for extended Medicaid coverage through Denali Kid Care and who are eligible for Behavioral Health Services.

Assumptions for Extended Medicaid Coverage:

We assume that 5,106 additional children will enroll in Medicaid if the SCHIP qualifying income level is increased up to 350% Federal Poverty Guidelines. Based on the current Behavioral Health proportion (or approximately 30% of the cost of SCHIP services) approximately 1,700 of these children will be eligible for extended Medicaid coverage through DKC and will utilize Behavioral Health services.

We estimate that this will increase workload for our Utilization Review Staff who facilitate wrap-around service delivery for children and adolescents at risk of institutionalization. We also anticipate it will result in increased requests for onsite Medicaid Documentation Reviews and Technical Assistance as our providers attempt to integrate more children and adolescents into their systems. We estimate 2.0 FTE (Health Facility Surveyor I, Range 18) and 1.0 FTE (Mental Health Clinician III, Range 21) positions will be needed to manage this additional work. A Health Facility Surveyor I in our Utilization Review office can manage a workload of up to 500 cases (one child per case) per month. The Mental Health Clinician III will perform utilization reviews as well as develop, oversee, and monitor FirstHealth Medicaid claims processing. Work duties of all positions include:

Medicaid program review and evaluation

- Management of Medicaid system operations and enhancement efforts
- Management of fiscal agent contract activities
- Development of program changes, operational processes, and system enhancement to implement revised regulations
- Coordination of program developments with stakeholders
- Insures compliance with state regulations and program guidelines
- Monitors services and utilization
- Development of a provider education plan
- Maintain an effective partnership with state and federal agencies
- Evaluation of the budget and development of recommendations for program changes to insure compliance with budget constraints
- Interpretation of state and federal regulations
- Analyze legislation and develop fiscal notes
- Support MMIS development and implementation efforts
- Support the RPTC demo project
- Support PERM and the Medicaid integrity program

(Continued)

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION
Total Administrative Costs:

With the additional caseload, a one time cost for computers and software will be required with a cost of \$2,200 for each additional staff for a total of \$6,600. Annual costs for office space, phones and supplies are calculated at a cost of \$8,800 per additional staff for a total of \$26,400.

For the personal services allocations of this fiscal note, the fund source calculations are derived by using standard 50% Federal /50% GF Match splits for existing positions.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-DBH1-03-14-07
 Bill Version: SS HB 140
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Behavioral Health
 Component Behavioral Hlth Medicaid Svcs

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

Sponsor GARA
 Requester HOUSE (HES) Component No. 2660

Expenditures/Revenues (Thousands of Dollars)

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

| OPERATING EXPENDITURES | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 |
|-------------------------------|------------|----------------|----------------|----------------|----------------|----------------|
| Personal Services | | | | | | |
| Travel | | | | | | |
| Contractual | | | | | | |
| Supplies | | | | | | |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | 3,842.4 | 4,172.8 | 4,531.7 | 4,921.4 | 5,344.6 |
| Miscellaneous | | | | | | |
| TOTAL OPERATING | 0.0 | 3,842.4 | 4,172.8 | 4,531.7 | 4,921.4 | 5,344.6 |
| CAPITAL EXPENDITURES | | | | | | |
| CHANGE IN REVENUES (0) | | | | | | |

| FUND SOURCE | (Thousands of Dollars) | | | | | |
|---------------------------------------|------------------------|----------------|----------------|----------------|----------------|----------------|
| 1002 Federal Receipts | | 2,017.6 | 2,113.5 | 2,265.8 | 2,460.7 | 2,672.3 |
| 1003 GF Match | | 1,824.8 | 2,059.3 | 2,265.9 | 2,460.7 | 2,672.3 |
| 1004 GF | | | | | | |
| 1037 GF/Mental Health | | | | | | |
| Other(Specify Type-do not abbreviate) | | | | | | |
| Other(Specify Type-do not abbreviate) | | | | | | |
| TOTAL | 0.0 | 3,842.4 | 4,172.8 | 4,531.7 | 4,921.4 | 5,344.6 |

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

POSITIONS

| | | | | | | |
|-----------|--|--|--|--|--|--|
| Full-time | | | | | | |
| Part-time | | | | | | |
| Temporary | | | | | | |

ANALYSIS: (Attach a separate page if necessary)

SS HB140 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200 percent of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(continued)

Prepared by: Janet Clarke Phone 465-1630
 Division Finance and Management Services Date/Time 03/12/2007
 Approved by: Karleen Jackson, Commissioner Date 03/14/2007
 Agency Department of Health and Social Services

FISCAL NOTE

FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

We assume that 436 additional pregnant women will enroll if their qualifying income is revised to 200% FPG, based on the difference between the number of pregnant women with incomes above 150% FPG that were enrolled in 2003, before the current statute took effect, and the number enrolled in 2006. The number of children expected to enroll in Medicaid if the SCHIP qualifying income level is increased to 200% FPG is estimated as the number of SCHIP children with incomes above 150% FPG that dropped from the program between 2003 and 2006 (2,553 children). This corresponds to 2,553 children per 50 point increment in the percent of FPG (50 points is approximately the difference between the current effective 154% FPG income limit for this group and 200%).

For this analysis, the annual cost per enrollee per year (CPEPY) to reinstate SCHIP children up to 200% FPG is based on the current annual cost per enrollee (\$1,387 in 2006) for uninsured children with qualifying incomes above 150% FPG. The CPEPY to reinstate DKC pregnant women up to 200% FPG is based on the current annual cost per enrollee pregnant women with incomes above 150% FPG (\$2,915 in 2006). Medicaid costs are calculated as the number of persons enrolled times the CPEPY, inflated to 2009 dollars.

SS HB140 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201 and 350% of the prevailing FPG, and have no insurance. They will be required to pay premiums to the State of Alaska ranging between \$200 and \$1200 per year (sliding scale based on qualifying income). In this analysis, we use an average \$700 annual premium for all enrollees above 200% FPG. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. SS HB140 does not impose an annual deductible.

The Deficit Reduction Act (DRA) section 6041 stipulates that co-payments cannot exceed 20% of the cost of the service claimed. Annual out-of-pocket expenses for cost sharing and premiums cannot exceed 5% of family income. We estimate that children near the 250% FPG level will reach out-of-pocket limits when costs of services approach \$7,000. Because, on average, the cost per enrollee per year is expected to be lower than the average out-of-pocket limit, the ceiling on cost sharing is not a factor in calculations for this fiscal note. On an individual basis however, some children will likely reach cost-sharing limits.3 children). This

(continued)

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Other (DRA) limitations relevant to implementation of the provisions of section 3 include:

- No co-payments for emergency services, family planning services and supplies, and preventative services.
- No premiums or co-payments for pregnant women or the terminally ill using hospice care (no cost-sharing for children that become pregnant or use hospice care)
- Providers can deny service if the enrollee is unable to pay copays
- The State cannot terminate enrollees until premiums are at least 60 days delinquent

This fiscal analysis assumes that all co-payment and premiums are paid and that all services utilized by section 3 enrollees with incomes greater than 250% FPG are subject to cost sharing.

The number of children expected to enroll in Medicaid with incomes between 201 and 350% is based on the number of children potentially eligible for every 50 point increase in the percent of FPG. We anticipate that only 50% of eligible persons will apply and we exclude native eligibles because there is no incentive for them to seek medical insurance that requires payment of premiums and co-pays when they are already covered for most medical services through the Indian Health Service. We estimate that 851 children will enroll at income levels between 201 and 250% FPG and an additional 1,702 children will enroll between 251 and 350% FPG. All 2,553 will be required to pay premiums and 1,702 will also be responsible for co-payments for services.

The cost per enrollee per year (CPEPY) to expand coverage to children with incomes between 201% and 350% FPG is estimated as the current CPEPY for all children managed through the Denali KidCare Office (uninsured SCHIP children and certain categories of both uninsured and insured children funded through Title XIX). In 2006, that CPEPY was about \$2,900. Medicaid costs are calculated as the number enrolled times the CPEPY, inflated to 2009 dollars and less 20% co-payments. Premiums are treated as SDPR and fund splits are calculated without any correction for revenue from premiums.

(continued)

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

We assume that enrollment for all groups covered by SS HB140 will be completed rapidly on implementation of this bill, and within the 2009 fiscal year. Historically SCHIP and DKC expansion efforts have resulted in rapid growth in enrollment, up to expected targets.

The 2009 total costs estimate for SS HB140 is based on a 2006 base calculation that was adjusted annually for 5% medical inflation (average of the Anchorage CPI medical care component between 2001 and 2005). Projections for 2010 through 2013 assume an annual growth rate of 8.6% based on the projected overall Medicaid program growth between 2008 and 2012 from the *Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*. Medical inflation and a low level of enrollment growth are incorporated into the annual growth percentage applied between 2010 and 2013.

Federal funds calculations use only the Title XIX federal match rate. Expenses for the additional SCHIP children enrolled under SS HB140 section 2 will be eligible for Title XXI funding, however Title XXI funding is not expected to cover all SCHIP costs after 2007 and the state's SCHIP allocation is not expected to increase enough to cover costs over the term of these fiscal note projections.

Behavioral Health Medicaid Services (DBH) currently pays for 1/3 of the cost of services to DKC children and none of the costs associated with DKC pregnant women. Component fund calculations for this fiscal note are based on that costs distribution (1/3 of costs of services due to added SCHIP enrollment and 1/3 of costs of services due to section 3 enrollment). Premiums will be processed through a different component (Health Care Services Medicaid) and are therefore excluded from the funds analysis for DBH.

The attached table provides a quick department-level summary of the possible Medicaid direct costs, cost sharing, and enrollment associated with this bill.

| 2009 Enrollment and Costs | Denali KidCare Income Standard Unfrozen | | Extended Medical Assistance Coverage | | Total |
|---------------------------------------------------------------|-----------------------------------------|------------------------------------|--------------------------------------|------------------------------------|------------|
| | Pregnant Women | SCHIP Children | Children | | |
| | 151-200% Federal Poverty Guideline | 151-200% Federal Poverty Guideline | 201-250% Federal Poverty Guideline | 251-350% Federal Poverty Guideline | |
| Annual Enrollment | 36 | 2,553 | 851 | 1,702 | 5,542 |
| Average Cost per Enrollee | \$2,915 | \$1,387 | \$2,900 | \$2,900 | na |
| Total Cost of Medicaid Services before Cost Sharing (in 000s) | \$1,471.3 | \$4,099.2 | \$2,856.9 | \$5,713.8 | \$14,141.1 |
| Annual Premiums | \$0.0 | \$0.0 | -\$255.3 | -\$1,531.8 | -\$1,787.1 |
| Annual Co-Payment | \$0.0 | \$0.0 | \$0.0 | -\$1,142.8 | -\$1,142.8 |
| Net Cost of Medicaid Services after Cost Sharing | \$1,471.3 | \$4,099.2 | \$2,601.6 | \$3,039.2 | \$11,211.2 |
| Health Care Services Medicaid | \$1,471.3 | \$2,732.8 | \$2,456.3 | \$4,912.6 | \$7,368.9 |
| Behavioral Health Medicaid | 0 | \$1,366.4 | \$1,280.8 | \$2,561.6 | \$3,842.4 |

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-DPA-03-14-07
 Bill Version: SS HB 140
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Public Assistance
 Component: Public Assistance Field Svcs

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

Sponsor: GARA
 Requester: HOUSE (HES)

Component No. 236

Expenditures/Revenues (Thousands of Dollars)

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

| OPERATING EXPENDITURES | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 |
|------------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Personal Services | 117.5 | 469.9 | 469.9 | 469.9 | 469.9 | 469.9 |
| Travel | | | | | | |
| Contractual | 14.4 | 57.4 | 57.4 | 57.4 | 57.4 | 57.4 |
| Supplies | 19.6 | 4.2 | 4.2 | 4.2 | 4.2 | 4.2 |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | | | | | |
| Miscellaneous | | | | | | |
| TOTAL OPERATING | 151.5 | 531.5 | 531.5 | 531.5 | 531.5 | 531.5 |

| | | | | | | |
|-----------------------------|--|--|--|--|--|--|
| CAPITAL EXPENDITURES | | | | | | |
|-----------------------------|--|--|--|--|--|--|

| | | | | | | |
|-------------------------------|--|--|--|--|--|--|
| CHANGE IN REVENUES (0) | | | | | | |
|-------------------------------|--|--|--|--|--|--|

FUND SOURCE (Thousands of Dollars)

| | | | | | | |
|---------------------------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| 1002 Federal Receipts | 71.2 | 249.5 | 249.5 | 249.5 | 249.5 | 249.5 |
| 1003 GF Match | 64.1 | 223.5 | 223.5 | 223.5 | 223.5 | 223.5 |
| 1004 GF | 14.3 | 51.7 | 51.7 | 51.7 | 51.7 | 51.7 |
| 1037 GF/Mental Health | | | | | | |
| Inter-Agency Receipts | 1.9 | 6.8 | 6.8 | 6.8 | 6.8 | 6.8 |
| Other(Specify Type-do not abbreviate) | | | | | | |
| TOTAL | 151.5 | 531.5 | 531.5 | 531.5 | 531.5 | 531.5 |

Estimate of any current year (FY2007) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

| | | | | | | |
|-----------|---|---|---|---|---|---|
| Full-time | 7 | 7 | 7 | 7 | 7 | 7 |
| Part-time | | | | | | |
| Temporary | | | | | | |

ANALYSIS: (Attach a separate page if necessary)

SS HB140 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200% of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(continued)

Prepared by: Ellie Fitzjarrald, Director
 Division: Public Assistance
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone 465-5847
 Date/Time 03/14/2007
 Date 03/14/2007

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

SS HB140 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201% and 350% of the prevailing FPG, and have no insurance. They will be required to pay premiums to the State of Alaska ranging between \$200 and \$1200 per year (sliding scale based on qualifying income). Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. SS HB 140 does not impose an annual deductible.

The Deficit Reduction Act (DRA) section 6041 stipulates that co-payments cannot exceed 20% of the cost of the service claimed. Annual out-of-pocket expenses for cost sharing and premiums cannot exceed 5% of family income.

This fiscal note represents the administrative costs for the eligibility determinations associated with expanding medical assistance coverage for pregnant women and children, and instituting cost sharing for certain recipients. The eligibility decision includes a finding of eligibility or ineligibility based on the household's size and monthly income at the time of application, acting on changes in a household's circumstances that are reported during the period of eligibility, and re-examining a household's eligibility every six months. This bill would also require staff to determine the amount of the household's premium payment, communicate the premium obligation to the Division of Health Care Services for collection, and confirm payment of the premium before Medicaid benefits are issued.

Assumptions for Denali Kid Care and Pregnant Women:

We assume that 436 additional pregnant women will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and 2,553 children will enroll in Medicaid if the SCHIP qualifying income level is increased to 200% FPG.

We estimate two Eligibility Technician I positions will be needed to manage this additional work. An Eligibility Technician I in our Denali Kid Care office can manage a workload of up to 1,000 cases per month, and some cases contain more than one child.

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Assumptions for Extended Medicaid Coverage:

We assume 851 children will enroll at income levels between 201% and 250% FPG and an additional 1,702 children will enroll between 251% and 350% FPG. All 2,553 will be required to pay premiums and 1,702 will also be responsible for co-payments for services.

We estimate three Eligibility Technician I positions will be needed to manage this additional work. The new extended Medicaid program increases complexity of the eligibility determination work and results in increased contact with applicants and enrollees. We assume an Eligibility Technician I will only be able to manage a caseload up to 700 cases per month.

Total Administrative Costs:

The increase in Medicaid applications and caseload creates the need for an Administrative Support Clerk, and an Eligibility Technician IV Supervisor to oversee the work of the five new Eligibility Technicians. These annual costs are estimated to be:

- 1 Administrative Clerk II \$52.5 (Range 8 at a cost of \$52.5, including benefits, per position).
- 5 Eligibility Technician I's \$336.0 (Range 14 at a cost of \$67.2, including benefits, per position).
- 1 Eligibility Technician IV \$81.4 (Range 16 at a cost of \$81.4, including benefits, per position).

With the additional caseload, a one time cost for computers and software will be required with a cost of \$2,200 for each additional staff for a total of \$15.4. Annual costs for office space, phones and supplies are calculated at a cost of \$8,800 per additional staff for a total of \$61.6.

It is assumed that one quarter year's funding will be needed in FY08 to hire and train staff in order to be able to accept applications and make eligibility determinations effective July 1, 2008.

For the personal services allocations of this fiscal note, the fund source calculations are derived by using standard Random Moment Time Study averages for existing eligibility workers.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB140SS-DHSS-FMS-03-14-07
 Bill Version: SS HB 140
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Departmental Support Services
 Component: Information Technology Services

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

Sponsor: GARA
 Requester: HOUSE (HES)

Component No. 2754

Expenditures/Revenues (Thousands of Dollars)

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

| OPERATING EXPENDITURES | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 | FY 2013 |
|------------------------|--------------|-------------|-------------|-------------|-------------|-------------|
| Personal Services | 250.0 | | | | | |
| Travel | | | | | | |
| Contractual | 30.0 | 65.0 | 80.0 | 31.0 | 31.0 | 31.0 |
| Supplies | | | | | | |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | | | | | |
| Miscellaneous | | | | | | |
| TOTAL OPERATING | 280.0 | 65.0 | 80.0 | 31.0 | 31.0 | 31.0 |

| | | | | | | |
|-----------------------------|--|--|--|--|--|--|
| CAPITAL EXPENDITURES | | | | | | |
|-----------------------------|--|--|--|--|--|--|

| | | | | | | |
|-------------------------------|--|--|--|--|--|--|
| CHANGE IN REVENUES (0) | | | | | | |
|-------------------------------|--|--|--|--|--|--|

FUND SOURCE (Thousands of Dollars)

| | | | | | | |
|---------------------------------------|--------------|-------------|-------------|-------------|-------------|-------------|
| 1002 Federal Receipts | 140.0 | 32.5 | 40.0 | 15.5 | 15.5 | 15.5 |
| 1003 GF Match | 140.0 | 32.5 | 40.0 | 15.5 | 15.5 | 15.5 |
| 1004 GF | | | | | | |
| 1037 GF/Mental Health | | | | | | |
| Other(Specify Type-do not abbreviate) | | | | | | |
| Other(Specify Type-do not abbreviate) | | | | | | |
| TOTAL | 280.0 | 65.0 | 80.0 | 31.0 | 31.0 | 31.0 |

Estimate of any current year (FY2007) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

| | | | | | | |
|-----------|--|--|--|--|--|--|
| Full-time | | | | | | |
| Part-time | | | | | | |
| Temporary | | | | | | |

ANALYSIS: (Attach a separate page if necessary)

SS HB 140 will require software changes to the Eligibility Information Management system (EIS). The changes will require four positions for six months: two information system programmers working with two additional positions testing the system for Public Assistance. No new positions are requested, instead this fiscal note will provide funding for current positions. The EIS system is a highly complex and intricate system and the changes will require high level programmers to develop and re-work the software changes necessary.

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

Phone 465-1630
 Date/Time 03/09/2007
 Date 03/14/2007

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

This work will include the analysis of required software changes, programming and development to implement the changes and the necessary testing to insure accuracy. These funds are required in FY08 in order to have the system operational for a July 2008 implementation date.

The contractual costs are for producing informational brochures and media advertising for education and outreach to publicize the new eligibility standards. FY08 included \$30.0 for production and materials contracts to prepare for the July 2008 implementation date. FY09 contractual costs are for the television and radio broadcasting costs. FY10 includes both production/supply costs for new materials and broadcasting costs. FY11-13 have full materials costs and approximately 25% of the original broadcasting costs to reflect a reduction in the number of advertisements and outreach.

ALASKA STATE LEGISLATURE

Senator Bill Wielechowski

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

Senator_Bill_Wielechowski@legis.state.ak.us



Representative Les Gara

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

Representative_Les_Gara@legis.state.ak.us

A Primer on the "No Child Left Uninsured" Act

- The intent of this bill is to make health insurance accessible to all children in Alaska, while asking those families who can afford it to make a meaningful financial contribution towards their coverage.
- The bill raises the eligibility limit for participation in Denali KidCare from \$26,000/year for a single parent and child to 200% of the federal poverty level (FPL). This was the eligibility limit for the program until 2003, when SB 105 substantially lowered the limit.
- 200% of the FPL is currently \$34,000/year for a single parent and child. The FPL is adjusted annually for inflation.
- This proposal puts Alaska in line with other states, 41 of which allow participation by families at or above 200% of the FPL. Seven states set the limit at or above 300% of the FPL. Alaska currently has one of the lowest eligibility rates in the nation. Only Montana and North Dakota are lower.
- This bill would also allow families with incomes up to 350% of the FPL to buy into Denali KidCare using a sliding fee scale. Many children from working families in Alaska are unable to afford private insurance and go without coverage, which results in poorer health and greater costs in the long-run.
- Premiums for coverage would range from \$200 annually for a participants living at 201% of the FPL to \$1,200 annually. In addition, a 20% co-pay would be required for those living at 250% and greater of the FPL. Parents and/or guardians would have to certify that eligible children do not have other insurance coverage. Those with the greatest means would reimburse the state roughly 90% of program costs.
- Several states have taken steps in recent years to ensure that all children have access to health insurance. For example, in Connecticut, uninsured children from families making 300% or more of the FPL can buy into "All Kids." In Illinois, coverage is available to any child that has been uninsured for 12 months or more, with the cost determined on a sliding scale basis. Similar proposals under are under consideration in Oregon, Wisconsin, Washington, California and New Mexico, among other states.

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Falling Through the Cracks: The Unmet Health Needs of Alaska's Uninsured Children

- The number of uninsured children in Alaska is estimated to be 17,880 or 9% of the population 18 and under (Urban Institute and Kaiser Commission on Medicaid and the Uninsured).
- Over the last decade, Alaska has seen a large decline (31%) in the number of children covered by private health insurance (Robert Wood Johnson Foundation).
- Nationally, more than 80% of uninsured children are from working families (Kaiser Commission on Medicaid and the Uninsured).
- Uninsured children have much higher health risks than do covered children. They receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser Commission on Medicaid and the Uninsured).
- Uninsured children are more likely to develop viral soar throats, eye and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than 5 times as likely as insured children to have an unmet need for medical care and 9 times more likely not to have a regular doctor. They are also 4 times more likely to use emergency rooms (*Pediatrics* 105 and 113; *Care for Children, New England Journal of Medicine* 330; *The Urban Institute*).
- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (*Health Affairs* 23, no. 5, September/October 2004).
- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of \$65-\$130 billion annually.

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Impact of the Uninsured on the Broader Population

- Hospitals often serve as primary care treatment facilities for those without access to other health care. Providence and Alaska Regional Hospitals in Anchorage report providing nearly \$89 million in uncompensated care in 2004. These costs are passed on to other Alaskans, businesses and government, raising premiums and out-of-pocket expenses (Commonwealth North).
- Governor Palin has proposed a \$22.7 million increment to reimburse hospitals for the uncompensated care they provide. Of this amount, \$11.2 million would come from state general funds; the remaining would come from federal Medicaid dollars. This bill would reduce the need for this increment. *This was not in 1455 subcom. approved budget.*
- The New America Foundation estimates the average family pays an additional \$1,186 in medical costs to cover the cost of uncompensated health care. Another national study found that premiums for employer-sponsored family health coverage cost an extra \$922 in 2005 to pay for uncompensated care.
- Some \$17 billion is spent in the U.S. annually on unnecessary hospitalizations, according to a 2004 study in *Pediatrics*. The study, which surveyed parents and doctors of children admitted to the hospital, found that 13-46% of the admissions could have been avoided with better care at home or by primary care physicians.
- Nationally, individuals unable to pay medical bills are filing for bankruptcy at unprecedented rates. Between 1980 and 2001, medically driven bankruptcies increased 23 times (American Medical Association, 2005). Half of the 1.5 million American families that filed for bankruptcy in 2001 cited medical bills as the cause (Health Affairs, Feb. 2005).
- The pay-off from providing health insurance for low-income children is substantial. According to governing.com, "Immunizations, annual visits to a pediatrician, dental care, and screening for vision, hearing and developmental problems are all long-term money savers for the health care system as a whole." For example, every \$1 spent on a mumps/measles/rubella shot, saves \$26, according to Washington State Dept. of Health research.
- The National Institute of Medicine estimates that the benefit of extending insurance coverage to children is \$2,410 per year. This figure is based on the value of an individual's health over future years, physical and mental development and earning potential.

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Background on Denali KidCare

- Denali KidCare provides health insurance for children through age 18 and pregnant women who meet income guidelines. There is no cost for eligible children, teens and pregnant women. However, youth who are 18 may be required to pay a limited amount for some services.
- Denali KidCare pays for doctor's visits; eye exams and glasses; dental cleanings and fillings; hearing tests and aids; hospital care; speech, physical and mental health therapy, substance abuse treatment; lab tests; prescription drugs; and other care.
- Roughly 600 children were covered by Denali KidCare as of December 2006.
- Prior to the passage of SB 105 in 2003 (which lowered the eligibility guidelines for the program) 4,992 children with family incomes between 151% and 200% of the federal poverty level (FPL) were covered. Since passage, 3,440 fewer children with family incomes between 151% and 200% of the FPL are enrolled.
- The cost per child of providing this coverage is about \$1,700/year.
- In recent calls to private insurers, the cost of a health insurance plan for a family of 3 (pregnant woman with two children) ranged from \$8,000-\$17,000 annually. Unlike Denali KidCare, this coverage comes with a \$1,000 deductible, 20% co-pay, and no vision, dental or hearing benefits.
- **Alaska has one of the lowest program eligibility rates in the nation (160% of the FPL).** Only 2 other states (Montana and North Dakota) have lower rates. Forty-one states allow participation by families at or above 200% of the FPL. Seven have rates at or above 300% of the FPL.
- In April 2007, Alaska's eligibility rate will decline to 154% of the FPL, bumping more low-income children (perhaps as many as 1,000) off the rolls of Denali KidCare. The eligibility

rate will continue to decline relative to the federal poverty level because it is a fixed income limit that (unlike the FPL) does not rise with inflation.

- The federal government reimburses 70% of the cost of the Denali KidCare program up to the state's allocated funding level. After that, the reimbursement rate declines to 58%.
- In fiscal year 2006, the cost of Denali KidCare (also known as the State Children's Health Insurance Program) was \$25.9 million, of which \$18.2 million was paid by the federal government.

Why Coverage for Pregnant Women is Important:

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

AFV labeling cost is estimated to be \$258,400 (\$0.38 × 680,000).

Thus, the estimated total annual non-labor cost burden associated with the Rule is \$259,000 (\$205 + \$258,400), rounded.

William Blumenthal,
General Counsel.

[FR Doc. E7-952 Filed 1-23-07; 8:45 am]
BILLING CODE 6750-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

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

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

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

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

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10-105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. To speak to a person, call (301) 443-5656. To receive a Hill-Burton information package, call 1-800-638-0742 (for callers outside Maryland) or 1-800-492-0359 (for callers in Maryland). You may also visit <http://www.hrsa.gov/hillburton/default.htm>. The Division of Facilities Compliance and Recovery notes that as set by 42

CFR 124.505(b), the effective date of this update of the poverty guidelines for facilities obligated under the Hill-Burton Uncompensated Services Program is sixty days from the date of this publication.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I-864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1-800-375-5283 or visit <http://www.uscis.gov/files/form/I-864p.pdf>.

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

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

SUPPLEMENTARY INFORMATION:

Background

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

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI-U). The guidelines in this 2007 notice reflect the 3.2 percent price increase between calendar years 2005 and 2006. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. The same calculation procedure was used this year as in previous years. (Note that these 2007 guidelines are roughly equal to the poverty thresholds for calendar year 2006 which the Census Bureau expects to publish in final form in

August 2007.) The guideline figures shown represent annual income.

2007 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA¹

| Persons in family | Poverty guideline |
|-------------------|-------------------|
| 1 | \$10,210 |
| 2 | 13,690 |
| 3 | 17,170 |
| 4 | 20,650 |
| 5 | 24,130 |
| 6 | 27,610 |
| 7 | 31,090 |
| 8 | 34,570 |

For families with more than 8 persons, add \$3,480 for each additional person.

2007 POVERTY GUIDELINES FOR ALASKA

| Persons in family | Poverty guideline |
|-------------------|-------------------|
| 1 | \$12,770 |
| 2 | 17,120 |
| 3 | 21,470 |
| 4 | 25,820 |
| 5 | 30,170 |
| 6 | 34,520 |
| 7 | 38,870 |
| 8 | 43,220 |

For families with more than 8 persons, add \$4,350 for each additional person.

2007 POVERTY GUIDELINES FOR HAWAII

| Persons in family | Poverty guideline |
|-------------------|-------------------|
| 1 | \$11,750 |
| 2 | 15,750 |
| 3 | 19,750 |
| 4 | 23,750 |
| 5 | 27,750 |
| 6 | 31,750 |
| 7 | 35,750 |
| 8 | 39,750 |

For families with more than 8 persons, add \$4,000 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. (Note that the Census Bureau poverty thresholds—U.S. version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a

Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

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

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

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

Note that this notice does not provide definition of such terms as "income" or "family." This is because there is considerable variation in how different programs that use the guidelines define these terms, traceable to the different laws and regulations that govern the various programs. Therefore, questions

about how a particular program applies the poverty guidelines (e.g., Is income before or after taxes? Should a particular type of income be counted? Should a particular person be counted in the family or household unit?) should be directed to the organization that administers the program.

Dated: January 17, 2007.
 Michael O. Leavitt,
 Secretary of Health and Human Services.
 [FR Doc. 07-268 Filed 1-19-07; 8:45 am]
 BILLING CODE 4151-05-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): NIOSH Occupational Health and Safety Research, Program Announcement Number (PAR) 06-484

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

Time and Date: 8 a.m.-5 p.m., February 9, 2007 (Closed).

Place: 1750 New York Avenue, NW, Washington, DC 20006.

Status: The meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (5), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92-463.

Matters To Be Discussed: The SEP meeting will include the review, discussion, and evaluation of applications received in response to "NIOSH Occupational Health and Safety Research," PAR 06-484. The applications being reviewed include information of a confidential nature, including personal information concerning individuals associated with the applications.

Contact Person for More Information: Horace M. Stiles, DDS, PhD, MPH, Designated Federal Officer, 15111 Farm Market Road, Maypearl, Texas 76064-1802, telephone 404.498.2584.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: January 18, 2007.
 Elaine L. Baker,
 Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.
 [FR Doc. E7-987 Filed 1-23-07; 8:45 am]
 BILLING CODE 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: 45 CFR 1304 Head Start Program Performance Standards. OMB No. 0970-0148.

Description: Head Start Program Performance Standards require Head Start and Early Head Start Programs and Delegate Agencies to maintain program records. The Administration for Children and Families, Office of Head Start, is proposing to renew, without changes, the authority to require certain record keeping in all programs as provided for in 45 CFR part 1304 Head Start Program Performance Standards. These standards prescribe the services that Head Start and Early Head Start programs provide to enrolled children and their families.

Respondents: Head Start and Early Head Start grantees and delegate agencies.

ANNUAL BURDEN ESTIMATES

| Instrument | Number of respondents | Number of responses per respondent | Average burden hours per response | Total burden hours |
|--------------------------------------|-----------------------|------------------------------------|-----------------------------------|--------------------|
| Standard | 2,590 | 16 | 41.8 | 1,732,192 |
| Estimated Total Annual Burden Hours: | | | | 1,732,192 |

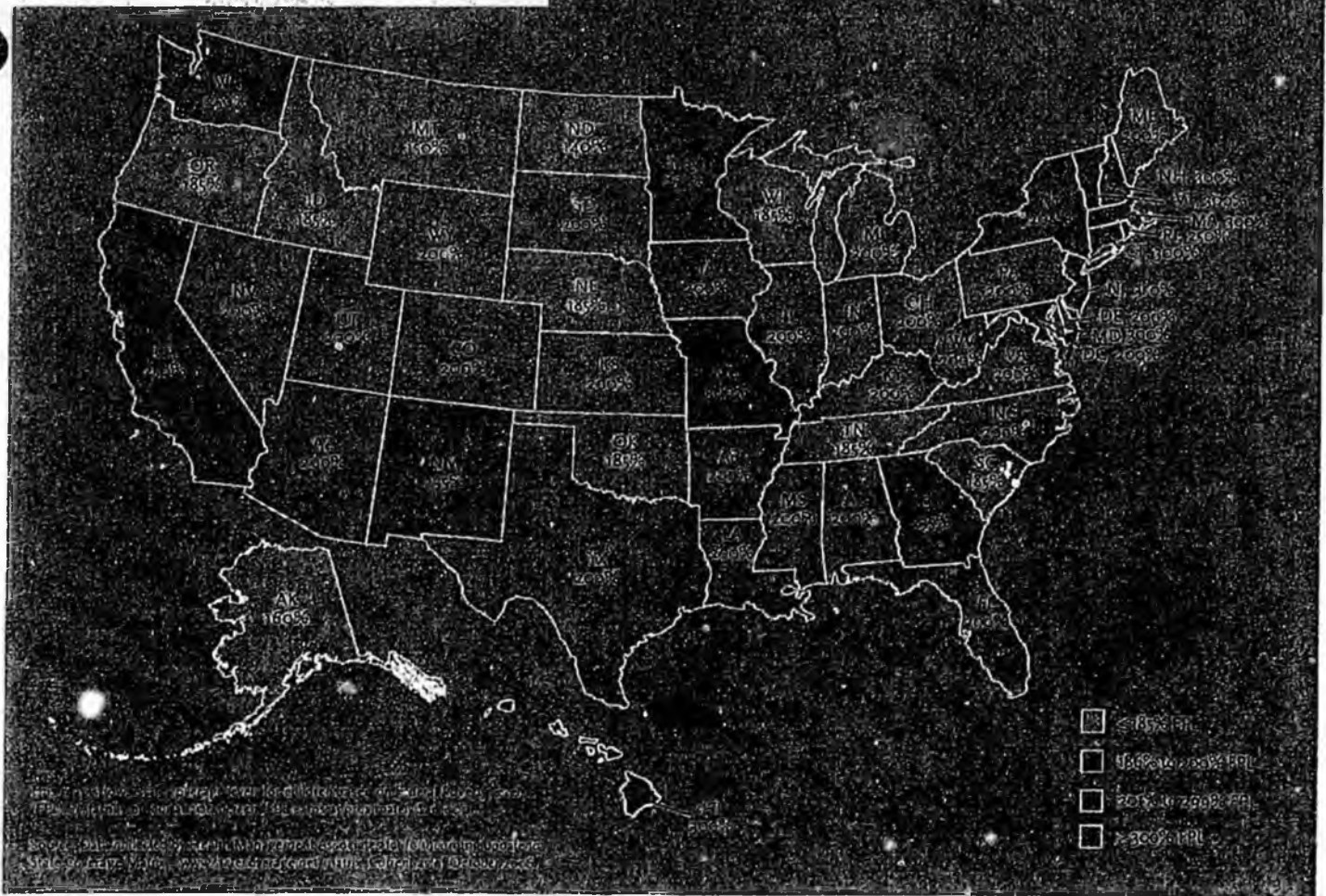
Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW, Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests

should be identified by the title of the information collection. E-mail address: infocollection@acf.hhs.gov.

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the Federal Register.

Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork

FIGURE 7 COVERAGE LEVELS FOR CHILDREN



premium assistance program or an individual plan. O-EPIC is funded by state general fund revenues generated by a tobacco tax, along with federal matching funds under Title XIX and employer and employee contributions.

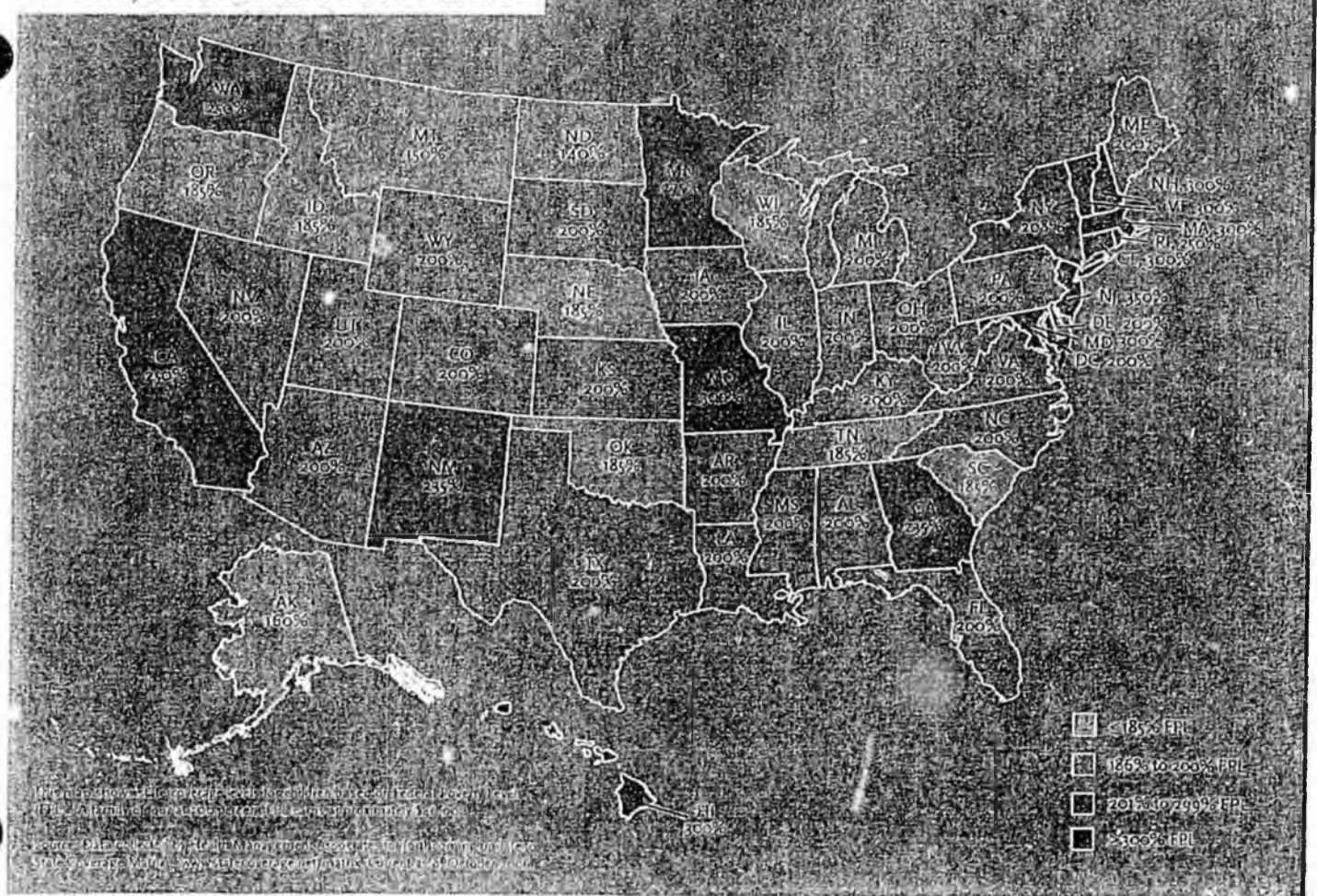
The Premium Assistance program, launched in November 2005, helps qualified employees in small businesses of 50 or fewer employees purchase health insurance coverage through their employer. The employer works with an insurance agent to choose a qualified private health plan to offer its employees. The Premium Assistance program pays 60 percent of the health insurance premium for qualified employees with incomes below 185

percent FPL and 85 percent of the premium for the qualified enrollee's spouse. Employees are expected to contribute 25 percent of the employee's premium and employees are expected to contribute up to 15 percent for themselves and 15 percent for their spouses.

The Individual Plan will be launched shortly and is designed as a safety net health plan for qualified individuals with incomes below 185 percent FPL and who are ineligible to participate in O-EPIC Premium Assistance. The Individual Plan includes self-employed individuals not eligible for small group health coverage; workers at small businesses who are either not eligible

to participate in their employer's health plan or whose employer does not offer a qualified health plan; and unemployed individuals who are currently seeking work. The Individual Plan also provides coverage to working individuals with a disability whose income exceeds the Medicaid eligibility level but is below 200 percent FPL, and who meet "ticket to work" requirements.³³ The Individual Plan provides coverage through private managed care plans that also serve the Medicaid program; however, the benefit package is less comprehensive than Medicaid or most products offered in the commercial market.

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National Conference *of* State Legislatures

Policy Brief

WHO'S COVERED AND WHO'S NOT?

THE STATE OF CHILDREN'S HEALTH INSURANCE:

A PRIMER FOR STATE LEGISLATORS

by Michelle Herman

February 2006

The fluctuating economy, steep increases in private health insurance premiums and health care costs, and changes to public insurance programs all contribute to rising numbers of uninsured U.S. residents.¹ But the trend for children is more positive. Despite the fact that the total number of uninsured citizens is growing, the number of uninsured children decreased from 1997 to 2004, from 10.8 million to just over 8.2 million uninsured children, respectively. Even with this improvement, over 11 percent of children lack health insurance coverage. Certain groups of children are over-represented in the uninsured population: poor (below the federal poverty level, or FPL) or near-poor (between 100 percent and 200 percent of the FPL) children, those who are Hispanic or who have a non-U.S. citizen parent, and adolescents are more likely to be uninsured.

There are many reasons why children do not have health coverage. Lower-income families bear financial concerns and stresses—such as securing employment and housing—that frequently push obtaining health insurance low on their list of priorities. Even in cases where employers offer insurance coverage, premiums often are too expensive for lower-income parents. Some groups may face language and cultural barriers. Parents may not know about public health care coverage options or eligibility guidelines. Complicated application processes and strict verification requirements also may create problems.

Because they administer Medicaid and the State Children's Health Insurance Program (SCHIP), states not only have great responsibility for insuring children, they also have significant flexibility in deciding who and what to cover. The number of uninsured children has not increased as in the total U.S. population, in part because public programs have expanded to cover them. In particular, SCHIP—a federal and state partnership launched in 1997—gave states new federal funds and flexibility in program design and administration. States used this flexibility to expand coverage and develop innovative enrollment and outreach strategies. The result was an increase in enrollment of children, with significant increases occurring among low-income children: as of 2004, SCHIP had enrolled almost 4 million children.² SCHIP has influenced Medicaid enrollment as well; Medicaid enrollment increased for children following SCHIP implementation, and SCHIP prompted simplification reforms in Medicaid enrollment and re-enrollment processes.³ This paper provides an overview of national children's health coverage, and what options states can use to cover uninsured kids.

WHY DO CHILDREN NEED HEALTH INSURANCE?

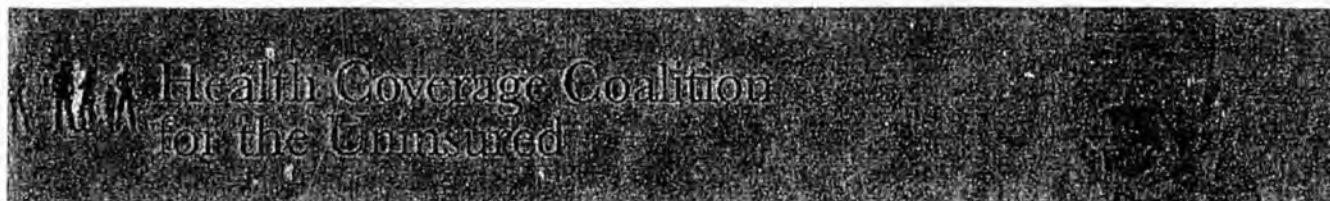
Health care experts unequivocally agree on the importance of covering children. Lack of health insurance is a substantial barrier to health care.⁴ Uninsured children have much higher health risks than do covered children. They are more likely to go without health services, may avoid or delay care when it is needed, and are less likely to receive the proper medical care for childhood illnesses such as sore throats, earaches and asthma. Children who have health insurance are more likely to have a usual place of care and reliably receive preventive and medical services. One study found that among near-poor children, 36 percent of uninsured children had an unmet medical need, compared to 9 percent of children with public insurance and 14 percent of those with private coverage.⁵ Another recent report found that almost one-third of uninsured children received no medical treatment during a one-year period between 2002 and 2003.⁶

The harmful consequences of the lack of health coverage are felt in other areas as well. As Nicole Ravenell, policy and research director at the Southern Institute on Children and Families, comments, "Health insurance is part of obtaining a good quality of life. When kids get sick or have health-related needs such as glasses, they can not concentrate in school or may miss school completely. Continued illness affects school performance and, in the long-run, can affect future workforce participation. Results from a lack of health coverage are long-term." Uninsured children face greater threats to healthy behavioral developments than do insured children, according to one study.⁷ Another study discovered that uninsured children are 25 percent more likely to miss school than insured children.⁸

Covering kids improves the health care system overall because it encourages more cost-effective service utilization and closes the gaps in health service disparities. Some studies show that covered children are more likely to seek office-based or clinic care, thus saving the higher costs that might be associated with emergency department care.⁹ Health care coverage also can reduce racial disparities. In a 2005 study, investigators compared unmet health care needs and having a usual source of care between uninsured black, white and Hispanic children before and after SCHIP enrollment. Before enrollment, white children were more likely to have a usual source of care and less likely to have unmet health care needs. After SCHIP enrollment, all three groups demonstrated improvements in access, continuity and quality of care. The preexisting disparities decreased across groups in access, unmet need and continuity of care.¹⁰

WHO'S COVERED AND WHO'S NOT?

Although the proportion of persons who are uninsured has increased in this country since 1998, the proportion of children who are uninsured slightly declined during the same period. There are 77.6 million children in the United States. As figure 1 shows, in any given year since 1997, between 8 million and 11 million children lacked health insurance.



» [America's Uninsured](#)

» [The Historic Agreement](#)

» [About the Coalition](#)

» [The Organizations Involved](#)

» [In the News](#)

America's Uninsured

According to the latest Census Bureau report, approximately 46.6 million people in the United States were uninsured in 2005 -- more than the aggregate population of 24 states plus the District of Columbia.

This number amounts to more than 15 percent of the U.S. population, or approximately one in seven Americans, and the problem is growing. Over the past two decades, the number of uninsured Americans has increased by about one million people annually, and it shows no sign of slowing down.

Being uninsured can have serious health consequences. The uninsured are often unable to receive the primary and preventive care they need -- medications to keep disease in check, mammograms and regular screenings for colon cancer, yearly visits with a primary care physician to maintain good health, and more.

The uninsured are less likely to get appropriate care when they seek it, and they have poorer health as a result. According to the Institute of Medicine, approximately 18,000 people die each year from diseases that are treatable and preventable, because they do not have health insurance.

Our nation's high number of uninsured does not merely exact a toll on those without insurance. It also impacts those who do have coverage, businesses nationwide, and the U.S. economy overall.

When the uninsured do receive health care, they often cannot afford to pay for it, so those costs are paid by others. They are passed on to privately insured people and companies offering insurance to their workers, providers who absorb costs by offering uncompensated care, and taxpayers.

A recent study found that premiums for employer-sponsored family health coverage cost an extra \$922 in 2005 to pay for uncompensated care provided to the uninsured.

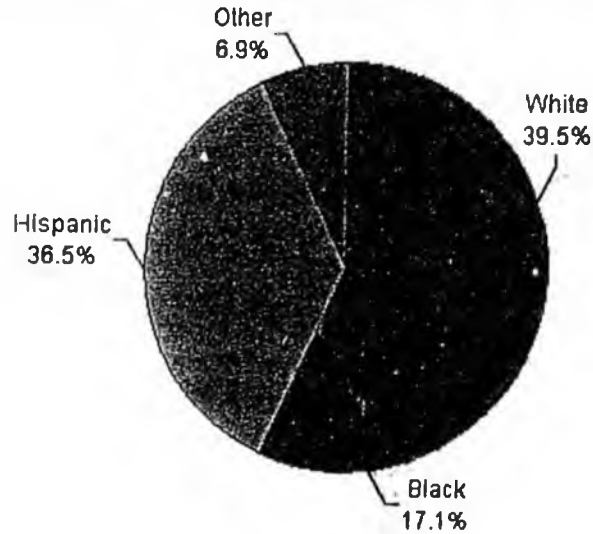
Equally troubling, with health care costs rising, even more people -- many of them from hardworking, middle-class families -- will join the ranks of the uninsured if nothing is done soon to address this problem.



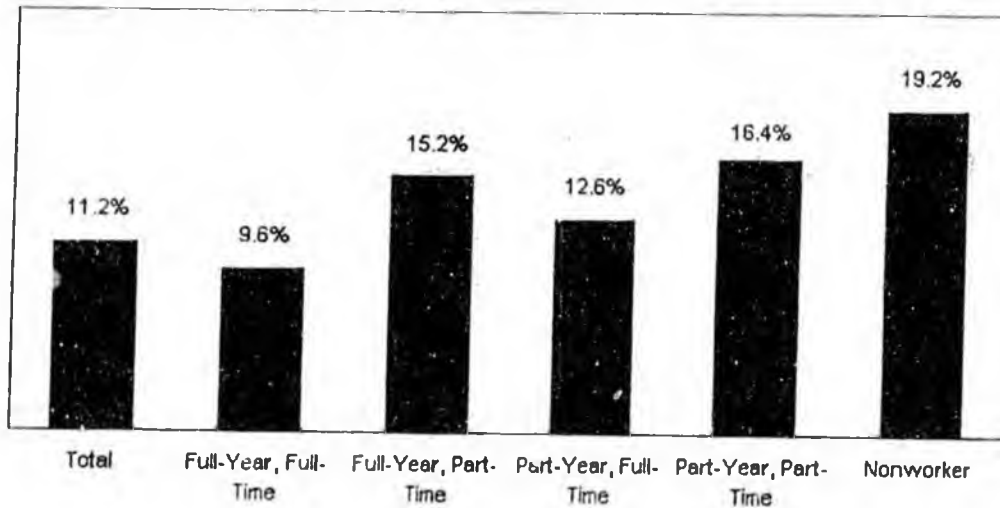
Health Coverage Coalition for the Uninsured
info@coalitionfortheuninsured.org · 202-354-6443
 ©2007, Health Coverage Coalition for the Uninsured

Fact: Nearly twenty percent of uninsured Americans – 8.3 million individuals – are children. While children are more likely to be insured than non-elderly adults, health insurance is particularly important for children. Uninsured children are more likely than insured children to lack a usual source of health care, to go without needed care and to experience worse health outcomes.

Uninsured Children by Race and Ethnic Origin, 2004

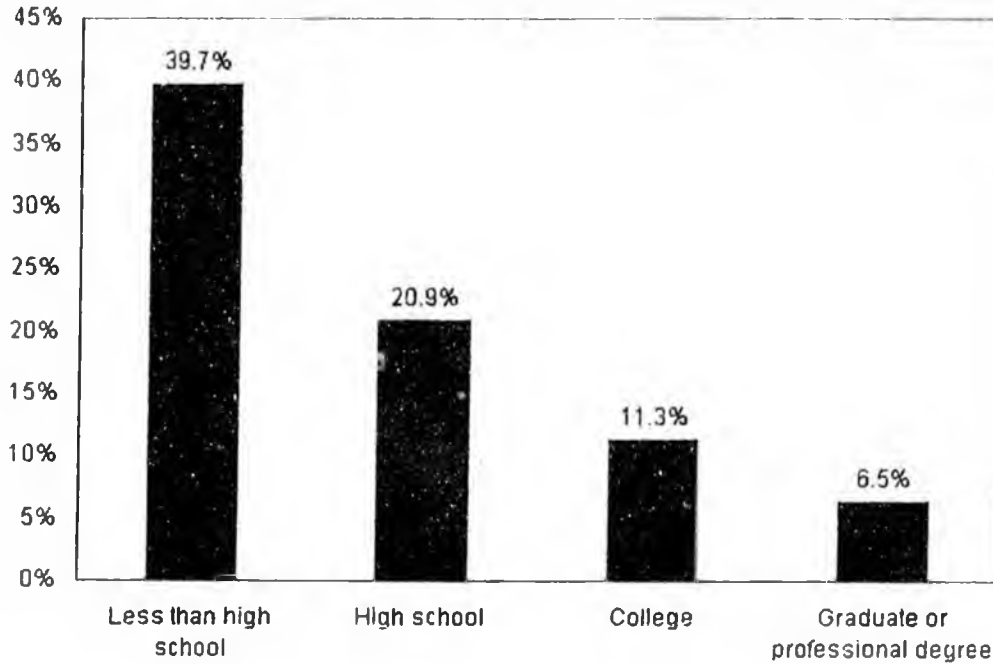


Uninsured Children by Work Status of the Family Head, 2004



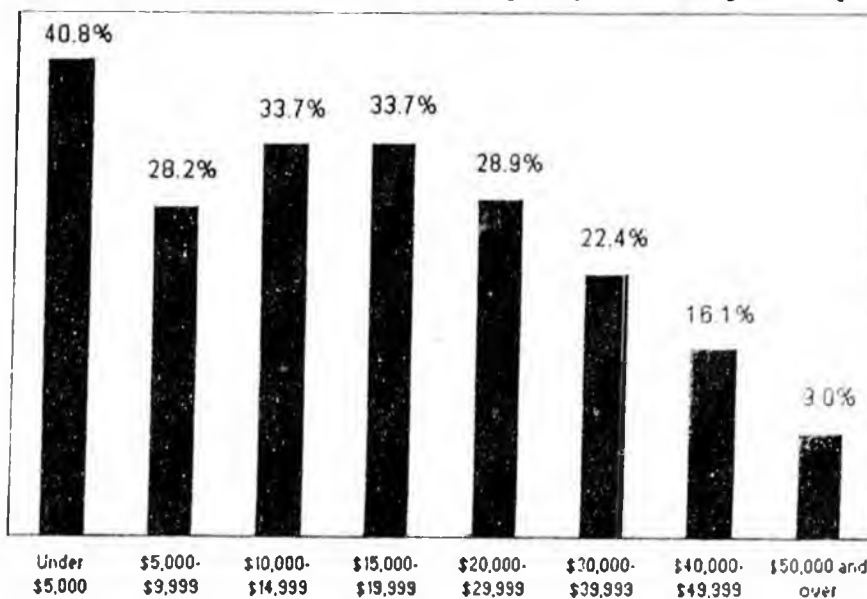
Fact: The likelihood of being insured increases as level of educational attainment rises. However, fully 40 percent of the difference in insured rates between those with no high-school diploma and those with some post-college education would disappear if the two groups were alike with respect to demographic, geographic and health status factors.

Percentage Uninsured Among Nonelderly Adults by Education, 2004



Fact: Only 9 percent of people in families with income over \$50,000 per year are uninsured, compared to 40.8 percent of people with family income below \$5,000.

Percentage Uninsured Among the Nonelderly Population by Family Income, 2004



INSTITUTE OF MEDICINE

Shaping the Future for Health

HIDDEN COSTS, VALUE LOST UNINSURANCE IN AMERICA

Americans value health care highly, as demonstrated by our society's substantial investment in it. Our nation invests in the health of its people by directly providing health insurance for some (e.g., Medicare for people over age 65) and by offering tax subsidies to support health insurance for others. About 85 percent of the U.S. population benefits from these financial supports for health insurance. At the same time, 41 million people lack coverage every year.

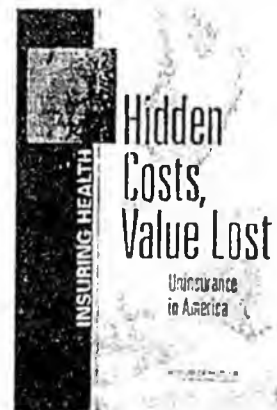
The federal, state, and local governments spend substantial sums—about \$30 billion annually—to compensate hospitals and clinics for services provided to the uninsured. Doctors donate services valued at another \$5 billion. Despite these efforts, uninsured Americans are more likely to have poorer health and die prematurely than those who are insured.

WHAT DOES THE LACK OF HEALTH INSURANCE COST SOCIETY?

In its fifth report, *Hidden Costs, Value Lost: Uninsurance in America*, the IOM Committee on the Consequences of Uninsurance tallies some of the economic and social losses to the country of maintaining so many people without health insurance. It also explores the potential economic and societal benefits that could be realized if everyone had health insurance on a continuous basis, as people over age 65 currently do with Medicare.

When people lack health coverage, society's costs are substantial:

- The uninsured lose their health and die prematurely. Uninsured children lose the opportunity for normal development and educational achievement when preventable health conditions go untreated.
- Families lose peace of mind because they live with the uncertainty and anxiety of the medical and financial consequences of a serious illness or injury.
- Communities are at risk of losing health care capacity because high rates of uninsurance result in hospitals reducing services, health providers moving out of the community, and cuts in public health programs like communicable disease surveillance. These consequences can affect everyone, not just those who are uninsured.
- The economic vitality of the country is diminished by productivity lost as a result of the poorer health and premature death or disability of uninsured workers.

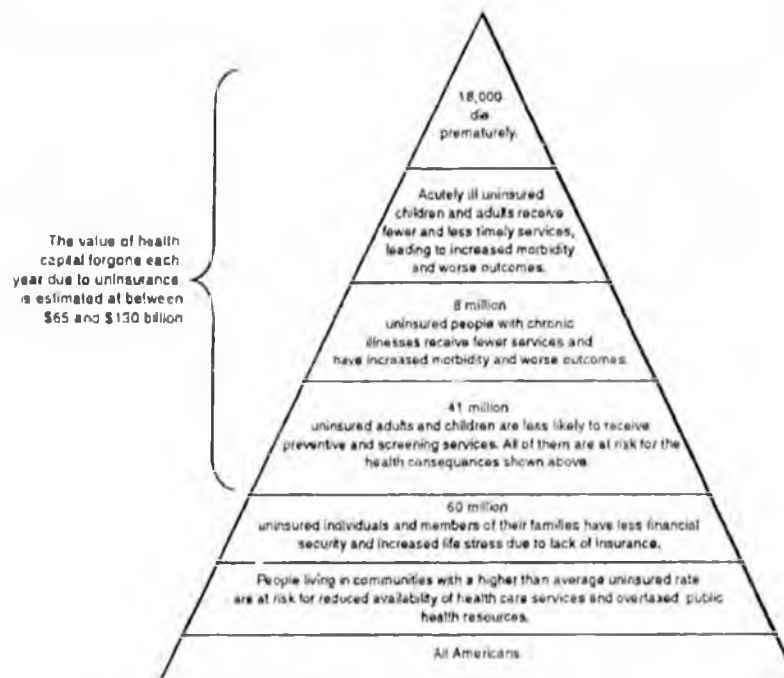


Health care accounts for roughly 14 percent of the nation's annual gross domestic product (GDP).

Forty-one million people are uninsured each year. 80 million Americans experience some period without coverage over 2 years.

- Medicare, Social Security Disability, and the criminal justice system probably cost more than they would if everyone had health insurance up to age 65. For example, when an uninsured woman with diabetes turns 65 years old and gains Medicare, her condition is likely to be worse and require more intensive treatment than if she had previously been insured. Similarly, uninsured persons who are mentally ill often do not get appropriate treatment and may end up in the criminal justice system at significant but potentially avoidable costs.

The costs to society of having a large uninsured population are not primarily due to the costs of providing health services free of charge to those without coverage. Most of the cost is in the form of poorer health for the uninsured because they frequently receive too little care, too late. The pyramid illustrates the extent of loss of life, acute and chronic illness, and the pool of uninsured people who are at risk for poorer health and shorter lives. The potential economic value to be gained in better health outcomes from continuous coverage for all Americans is estimated to be between \$65 to \$130 billion each year, assuming the uninsured will use health care as do those who now have health insurance. It includes, but is not limited to, higher expected lifetime earnings due to improved productivity and educational and developmental outcomes.



HOW IS A VALUE PLACED ON HEALTH AND A LONGER LIFE?

The healthy years that someone expects to have over the course of a lifetime can be thought of as that person's "stock" of "health capital." The differences in health status and length of life between uninsured and otherwise similar people with health insurance represents the value of health capital lost from poorer health over the lifetime by those who lack coverage.

The range in expected annual benefits (\$65-\$130 billion) of insuring the uninsured comes from different assumptions about the extent to which the disparities in health status between the insured and uninsured would be eliminated by gaining coverage. To

develop these estimates, the Committee adopted an analytic strategy for placing an economic value on life and health similar to that used by public agencies such as the Environmental Protection Agency and the Department of Transportation. When agencies responsible for public health and safety regulate exposures and risks—for example, by setting fuel emissions standards and requiring seat belts and air bags in cars—they implicitly establish the value of these interventions in terms of the improved health and lives extended throughout society.

The lack of health insurance across the United States can be thought of as imposing a risk to the health and longevity of the American population. Likewise, the cost of insuring everyone continuously can be thought of in terms of the value of improved health outcomes gained as a result. The Committee's analysis of the economic benefits of insuring the uninsured is consistent with the approaches used by regulatory agencies in their quantitative analyses of costs and benefits.

HOW MUCH IS NOW SPENT ON HEALTH SERVICES FOR THE UNINSURED?

People who were uninsured for part or all of 2001 received health care services valued at about \$99 billion. This total includes the amount the uninsured paid out of their own pocket, any insurance payments made if they were insured for part of the year, any worker's compensation payments for health care and any charity care received.

Uninsured children and adults are less likely to incur health expenses in a year because they are less likely to seek care than are those with health insurance. When they do receive services, the uninsured are often charged a higher price and pay a higher portion of the total cost themselves than people with coverage. For those who are uninsured for part rather than the whole year, private and public health insurance pays more than half the annual costs of services used. Still, being uninsured just for a short time can put a person at risk for poorer health outcomes and financial losses.

The burden of uncompensated (charity) care amounted to \$35 billion in 2001 and is largely borne by taxpayers. The public supports 75 to 85 percent of this care through federal, state and local government programs. For example, public dollars subsidize the hospital in your community when patients are not able to pay their bills.

WILL PEOPLE WHO ARE UNINSURED USE MORE HEALTH CARE IF THEY GAIN COVERAGE?

Yes; total health costs for those who now lack coverage would be expected to increase from the \$99 billion they now incur by an estimated \$34 to \$69 billion each year. This additional spending includes more appropriate use of health care that can improve health. In the absence of action to expand coverage, we can expect the existing gap in health outcomes to widen as health care interventions become ever more effective in improving health and extending life. Existing disparities between insured and uninsured people in their access to effective care will become increasingly inequitable.

IS IT WORTH IT FOR THE COUNTRY TO MAKE SURE EVERYONE HAS COVERAGE?

First, health insurance for those Americans who now lack it would likely yield dividends in terms of improved health of between \$65 and \$130 billion annually. Second, knowing health insurance is assured would reduce the stress and uncertainty about future medical care needs and financial demands for all of us. The prospect of losing insurance is a very real fear for most Americans. If having health insurance were a certainty, families' fears would be alleviated about whether they can afford health care and also meet other basic needs like buying groceries and paying the rent. Third, if everyone had cover-

Ninety-nine billion dollars are now spent on health care services for the uninsured.

The uninsured use fewer services and have poorer health outcomes than the insured.

uring the uninsured could yield \$65-\$130 billion in better health each year.

age, the continued viability of community health services and facilities would be more secure because of the greater financial stability of insurance-based financing.

The Committee concludes that the estimated benefits across society in healthy years of life gained by providing health insurance coverage are likely greater than the additional social costs of providing coverage to those who now lack it. Current disparities in access to and the quality of health care between uninsured and insured Americans do not reflect the ethical commitments to equality of opportunity and respect for all members of society that underpin American democracy. We are not getting the best return on our considerable national investment in health because public policies allow tens of millions of Americans to remain uninsured. It is time to insure everyone.

~ ~ ~

For More Information...

Visit the Committee's website at www.iom.edu/uninsured.

Copies of *Hidden Costs, Value Lost: Uninsurance in America* are available for sale from the National Academies Press; call (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area), or visit the NAP home page at www.nap.edu.

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* Indicates served from September 2000 to December 2002.

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LEGISLATIVE RESEARCH REPORT

FEBRUARY 15, 2007



REPORT NUMBER 07.092

DENALI KIDCARE AND THE UNINSURED

PREPARED FOR REPRESENTATIVE LES GARA

BY BECKY TAYLOR, LEGISLATIVE ANALYST

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You asked a number of questions about the Denali KidCare program and the number of uninsured Alaskans. Specifically, you wished to know what the federal poverty guidelines are for Alaska and whether these guidelines are used to establish eligibility for the Denali KidCare program. You also wished to know what types of medical care are covered by the Denali KidCare program. Additionally, you were interested in the number of uninsured children and adults in Alaska and how many of these uninsured Alaskans have access to the Indian Health Service.

ELIGIBILITY FOR DENALI KIDCARE

Denali KidCare is an expansion of Alaska's Medicaid program and is funded in part by federal dollars from the State Children's Health Insurance Program (SCHIP). Denali KidCare provides health insurance coverage to eligible children and teens through 18 years of age and to eligible pregnant women. Eligibility is based on family income level and the size of the household. There are two different sets of income guidelines for the Denali KidCare program, one which applies to children who have other health insurance and another which applies to uninsured children and all pregnant women.

Income limits for *children with other health insurance* are calculated at 150 percent of the federal poverty guidelines for Alaska. As such, income limits for households with children who have other insurance change when these guidelines change.¹ Table 1 displays the 2007 federal poverty guidelines for Alaska and other states.

| Persons in Family or Household | Annual Income | | |
|--------------------------------|-------------------------------|----------|----------|
| | 48 Contiguous States and D.C. | Hawaii | Alaska |
| 1 | \$10,210 | \$11,750 | \$12,770 |
| 2 | \$13,690 | \$15,750 | \$17,120 |
| 3 | \$17,170 | \$19,750 | \$21,470 |
| 4 | \$20,650 | \$23,750 | \$25,820 |
| 5 | \$24,130 | \$27,750 | \$30,170 |
| 6 | \$27,610 | \$31,750 | \$34,520 |
| 7 | \$31,090 | \$35,750 | \$38,870 |
| 8 | \$34,570 | \$39,750 | \$43,220 |
| For each additional person add | \$3,480 | \$4,000 | \$4,350 |

Source: *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148, U.S. Department of Health and Human Services, <http://aspe.hhs.gov/poverty/07poverty.shtml>.

In 2003, state legislation reduced the household income limits for *uninsured children and all pregnant women* from 200 percent of the federal poverty guidelines for Alaska to 175 percent of the guidelines and *converted* that percentage into dollar amounts.² As a result of this change, fewer children and pregnant women were eligible for Denali KidCare.

The federal poverty guidelines typically increase over time, so the income limits, which are fixed at 175 percent of the 2003 guidelines, are only about 160 percent of the 2006 guidelines and 155 percent of the 2007 guidelines. If the federal poverty guidelines continue to increase, Alaska's income guidelines for Denali KidCare will continue to fall as a percentage of the federal poverty guidelines. Table 2, on the following page, compares the income limits for *uninsured children and all pregnant women* to the 2007 federal poverty guidelines and also includes estimates of what the 2007 income limits will be for *children with other health insurance*.

¹ "Income Guidelines," Denali KidCare, Division of Health Care Services, Alaska Department of Health and Social Services, April 2006, <http://www.hss.state.ak.us/dhcs/DenaliKidCare/povlev.htm>. This document is based on the 2006 federal poverty guidelines for Alaska and will be adjusted in the spring of 2007 to reflect the 2007 federal poverty guidelines. We include this document as Attachment A.

² Chapter 34 SLA 2003 modified AS 47 07.020 (b) (13) and (14).

Table 2: Estimated 2007 Denali KidCare Income Guidelines

| Household Size | 2007 Federal Poverty Guidelines for Alaska | Children with Other Health Insurance ^(a) | | Uninsured Children and All Pregnant Women ^(b) | | Percent of the 2007 Federal Guidelines |
|----------------|--------------------------------------------|-----------------------------------------------------|----------|----------------------------------------------------------|----------|----------------------------------------|
| | | Monthly | Yearly | Monthly | Yearly | |
| 1 | \$12,770 | \$1,596 | \$19,155 | \$1,635 | \$19,620 | 154% |
| 2 | \$17,120 | \$2,140 | \$25,680 | \$2,208 | \$26,496 | 155% |
| 3 | \$21,470 | \$2,684 | \$32,205 | \$2,782 | \$33,384 | 155% |
| 4 | \$25,820 | \$3,228 | \$38,730 | \$3,355 | \$40,260 | 156% |
| 5 | \$30,170 | \$3,771 | \$45,255 | \$3,928 | \$47,136 | 156% |
| 6 | \$34,520 | \$4,315 | \$51,780 | \$4,501 | \$54,012 | 156% |
| 7 | \$38,870 | \$4,859 | \$58,305 | \$5,074 | \$60,888 | 157% |
| 8 | \$43,220 | \$5,403 | \$64,830 | \$5,647 | \$67,764 | 157% |

Notes: We estimate the 2007 income guidelines based on how these guidelines have been determined in the past. The Department of Health and Social Services has not yet released 2007 income guidelines for the Denali KidCare program.

(a) The monthly income limit for children with other health insurance is 150 percent of the federal poverty guidelines for Alaska. These income limits change when the federal poverty guidelines change.

(b) In 2003, the monthly income limits for uninsured children and all pregnant women were fixed in AS 47.27.020 (b)(13) and (14). These income limits do not change when the federal poverty guidelines change.

Sources: Federal Poverty Guidelines *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148, U.S. Department of Health and Human Services, <http://aspe.hhs.gov/poverty/07poverty.shtml>.

"Income Guidelines," Denali KidCare, Division of Health Care Services, Alaska Department of Health and Social Services, April 2006, http://www.hss.state.ak.us/dhcs/DenaliKidCare/pov_lev.htm.

Alaska's income guidelines are more restrictive than those in most other states. About forty states cover children from families with household incomes up to or above 200 percent of the federal poverty guidelines under Medicaid and/or their State Children's Health Insurance Program (SCHIP). States can use federal SCHIP funds either to expand their Medicaid program, which Alaska has done, or to create a separate SCHIP program, or to adopt a combination approach.³ Figure 1, on the following page, displays the income eligibility criteria for Medicaid/SCHIP coverage for children in other states.⁴

³ Barbara Hale, Medical Assistance Administrator/SCHIP Coordinator for Alaska, points out that the SCHIP program is scheduled for reauthorization at the federal level in 2007 and that changes in the federal funding structure may impact Alaska's program. Personal communication from Barbara Hale, Medical Assistance Administrator/SCHIP Coordinator, Division of Health Care Services, Alaska Department of Health and Human Services. Ms. Hale can be reached at (907) 465-5833.

⁴ This figure is taken from "State Children's Health Insurance Program (SCHIP) at a Glance," Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, January 2007, <http://www.kff.org/medicaid/7610.cfm>.