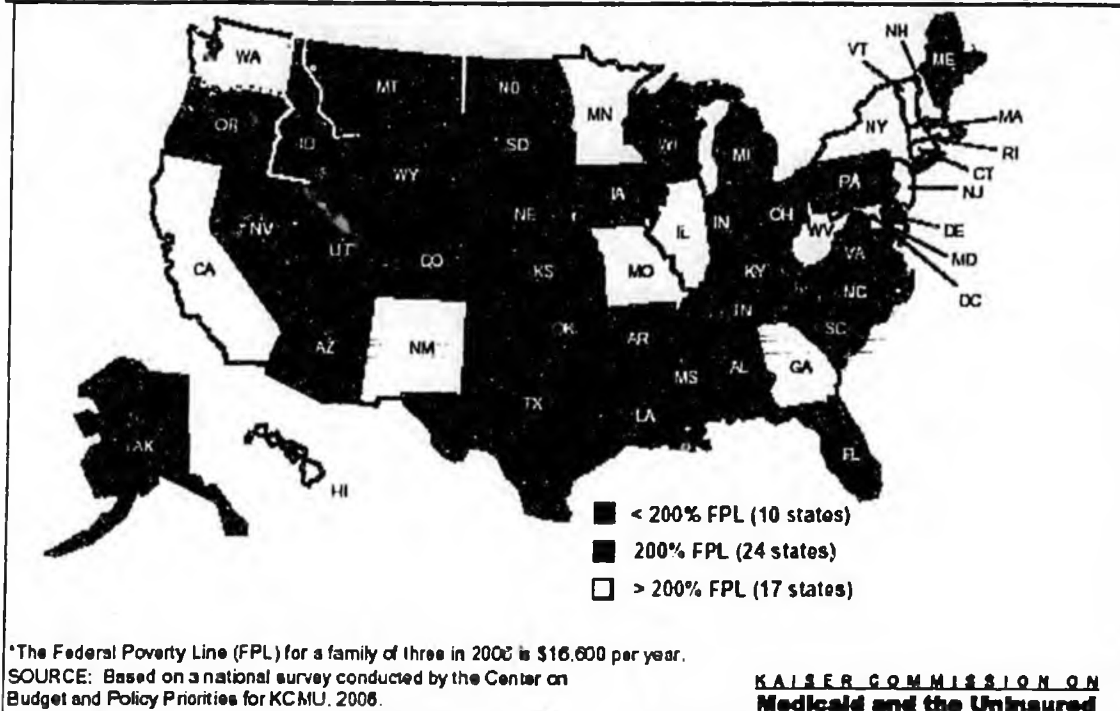
12116 HOUSE HESS

Figure 1: Children's Eligibility for Medicaid/SCHIP by Income, July 2006



MEDICAL COVERAGE UNDER DENALI KIDCARE

The Denali KidCare program provides comprehensive health care coverage for children, teens through age 18, and pregnant women who meet the eligibility criteria. Denali KidCare is actually comprised of several Medicaid eligibility categories administered by the State of Alaska. Because Denali KidCare is a Medicaid program, it covers the same services which are covered for all Medicaid recipients in Alaska.[5] Although other Medicaid recipients may be required to make a co-payment for services received, children under the age of 18 and pregnant women are not required to make a co-payment. Generally speaking, Medicaid appears to provide more extensive coverage of certain services for children than for adults. Medicaid recipients must obtain prior authorization for certain services such as orthodontia before receiving these services.[6]

The Denali Kid Care program covers regular prenatal checkups for eligible pregnant women, as well as two months of postpartum care. Nutrition services may also be covered for children and

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[5] Barbara Hale.

[6] "Alaska Medicaid Recipient Services," Alaska Department of Health and Social Services, revised April 2006, *http://www.hss.state.ak.us/dhcs/recipient_helpline.htm*, p. 16-17. We include this document, which provides more detailed information about covered services, as Attachment B.

pregnant women in certain situations.[7] Denali KidCare also covers complete physical exams for children under 21 years of age as part of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). According to the Alaska Department of Health and Social Services' Medicaid Recipient Handbook, these exams should include the following components:

- Height and weight measurement;
- Vision, hearing, and dental screening;
- Immunizations, if needed;
- Growth and development assessment;
- Age-related information about normal development, food, health, and safety;
- Time for parents, children and teens to have questions answered; and
- Referrals for dental care, vision exams, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), depending on the patient's age.

The Department recommends that children have a complete exam at the following ages:

- Birth, 2, 4, 6, 9, 12, 15, 18, and 24 months;
- 3, 4, 5, and 6 years; and
- at least every other year after age 6.[8]

The Denali KidCare program covers dental services for eligible children, including emergency, preventative, and routine dental services. Exams, x-rays, polishing, fluoride treatment, oral surgery, and sealants are covered, and orthodontia may also be covered under certain conditions. Unlike children, pregnant women who are over age 21 are eligible for only limited dental services necessary to relieve pain and infection.[9]

In addition to dental benefits, the program also provides recipients with access to certain vision services. Denali KidCare will cover one vision examination per calendar year and one pair of Medicaid approved glasses.[10]

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[7] "Alaska Medicaid Recipient Services," p. 9-10.

[8] "Alaska Medicaid Recipient Services," p. 15.

[9] "Alaska Medicaid Recipient Services," p. 5.

[10] "Alaska Medicaid Recipient Services," p. 13.

THE UNINSURED IN ALASKA

The Census Bureau appears to be the most widely used source of information about health insurance coverage in the United States. The Census Bureau collects health insurance data by surveying households as part of the Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS). The ASEC is a survey of about 78,000 households and includes detailed questions about health insurance coverage in the previous calendar year. According to the Census Bureau, this data can be used to examine state-level trends and differences; however, they point out that the usefulness of state level data may be limited by sampling errors.[11] Because the sample size in an individual state or category may be small, some analysts use multi-year averages when considering state-level data.

In 2005, the Census Bureau estimated that approximately 117,000 Alaskans, or 18 percent of the total population, were uninsured. Based on averages of data from 2003 to 2005, approximately 23,000 of the uninsured were children and 94,000 were adults. The ages of the uninsured in Alaska are roughly as follows:

- 22,700 uninsured Alaskans are 0-17;
- 21,000 uninsured Alaskans are 18-24;
- 44,000 uninsured Alaskans are 25-44;
- 27,800 uninsured Alaskans are 45-64; and
- 800 uninsured Alaskans are 65 and older.[12]

As you may know, the Census Bureau counts as part of the uninsured population those people who have access to the Indian Health Service but no other insurance. The Indian Health Service (IHS) is a federal program which provides medical assistance to eligible American Indians and Alaska Natives at IHS facilities and may pay the cost for selected health care services provided at non-IHS facilities.[13]

The Institute of Social and Economic Research (ISER) adjusted the Census Bureau's figures to separate those with IHS-only coverage from those with no coverage. The adjustment was based on the methods of the University of Minnesota's School of Medicine State Health Access Data Center. According to ISER's estimates, in 2004, 12.8 percent of Alaskans had no insurance coverage and another 4.2% had IHS coverage only. This suggests that roughly a quarter of the people that the Census Bureau considers to be uninsured in Alaska are covered by the Indian Health Service.

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[11] "Health Insurance: Overview," U.S. Census Bureau, Housing and Household Economic Statistics Division, last revised October 5, 2005, *http://www.census.gov/hhes/www/hlthins/overview.html*.

[12] "Available Data on Alaska's Uninsured," Health Planning & Systems Development Unit, Office of the Commissioner, Alaska Department of Health & Social Services, December 2006, *www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/assets/Data_Uninsured.ppt*. We include this presentation as Attachment C.

[13] "CPS Health Insurance Definitions," U.S. Census Bureau, Housing and Household Economic Statistics Division, last revised December 19, 2005, *http://www.census.gov/hhes/www/hlthins/hlthinstypes.html*.

The Institute of Social and Economic Research reports that between 2001 and 2003, on average, 53% of children in Alaska had private or employer-based health care coverage, 38.8% were coveraged through Medicaid, including Denali KidCare, or the Alaska Area Native Health Service, and the remaining 8.2% had no insurance. During that same time period, approximately 12% of children nationwide had no insurance.[14] It is likely that at least some of the children without health insurance are eligible for coverage under Denali KidCare.

According to ISER, Alaska probably has a smaller share of uninsured children because Alaska Native children are typically eligible for care through the Indian Health Service, and some children are covered by Denali KidCare. As the authors note, the uninsured generally suffer from poorer health and uninsured children are more likely to have development delays. The public bears the financial cost of having uninsured citizens in a number of ways, including government subsidies to hospitals to offset the costs of uncompensated care.[15]

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

[14] Mark Foster and Scott Goldsmith, "Alaska's $5 Billion Health Care Bill—Who's Paying?" Institute of Social and Economic Research, University of Alaska Anchorage, UA Research Summary No. 6, March 2006, p. 4. We include this document as Attachment D.

[15] Foster and Goldsmith, p. 4.

Attachment A

"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*

Household Size	Children with other Health Insurance* Monthly Income (150% FPL)	Children with no Health Insurance and Pregnant Women with or without Health Insurance ** Monthly Income
1	$1,532	$1,635
2	$2,063	$2,208
3	$2,594	$2,782
4	$3,125	$3,355
5	$3,657	$3,928
6	$4,188	$4,501
7	$4,719	$5,074
8	$5,250	$5,647
each additional	$532	$574

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

Key Points

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

Rev. 4/06

** Based on 2006 Federal Poverty Level (FPL) Guidelines for Alaska*

*** Based on 2003 Federal Poverty Level (FPL) Guidelines for Alaska frozen at the 2003 standard*

Attachment C

"Available Data on Alaska's Uninsured," Health Planning & Systems Development Unit, Office of the Commissioner, Alaska Department of Health & Social Services, December 2006, *www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/assets/Data_Uninsured.ppt.*

Available Data on Alaska's Uninsured

December 2006

Health Planning & Systems Development Unit
Office of the Commissioner
Alaska Department of Health & Social Services
Phone: 465-3091

www.hss.state.ak.us/commissioner/Healthplanning

Available Data on Alaska's Uninsured

December 2006

Health Planning & Systems Development Unit
Office of the Commissioner
Alaska Department of Health & Social Services
Phone: 465-3091

www.hss.state.ak.us/commissioner/Healthplanning

Who are the Uninsured in Alaska?

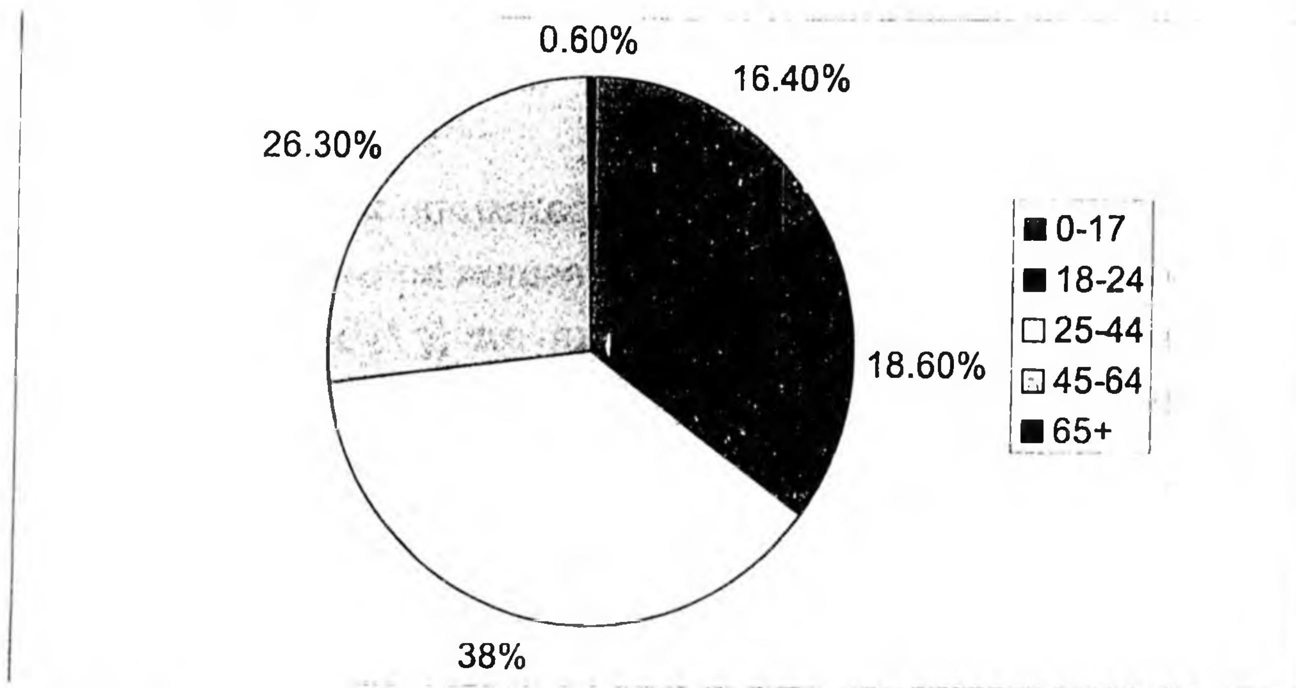
About 117,000 Alaskans (18% of the population) have been counted as uninsured in 2005.

- Young adults, males, and Alaska Natives are more likely to be uninsured.
- People who are self-employed, part-time workers, seasonal workers, and people who work for small firms are most likely to be uninsured.
- Most of the uninsured are employed; most uninsured who are not employed are children and others not in the workforce; only one in ten of the uninsured are unemployed people in the workforce.

*Current Population Survey (CPS), US Census Bureau

Age of the Uninsured in Alaska, 2003-2005 Average

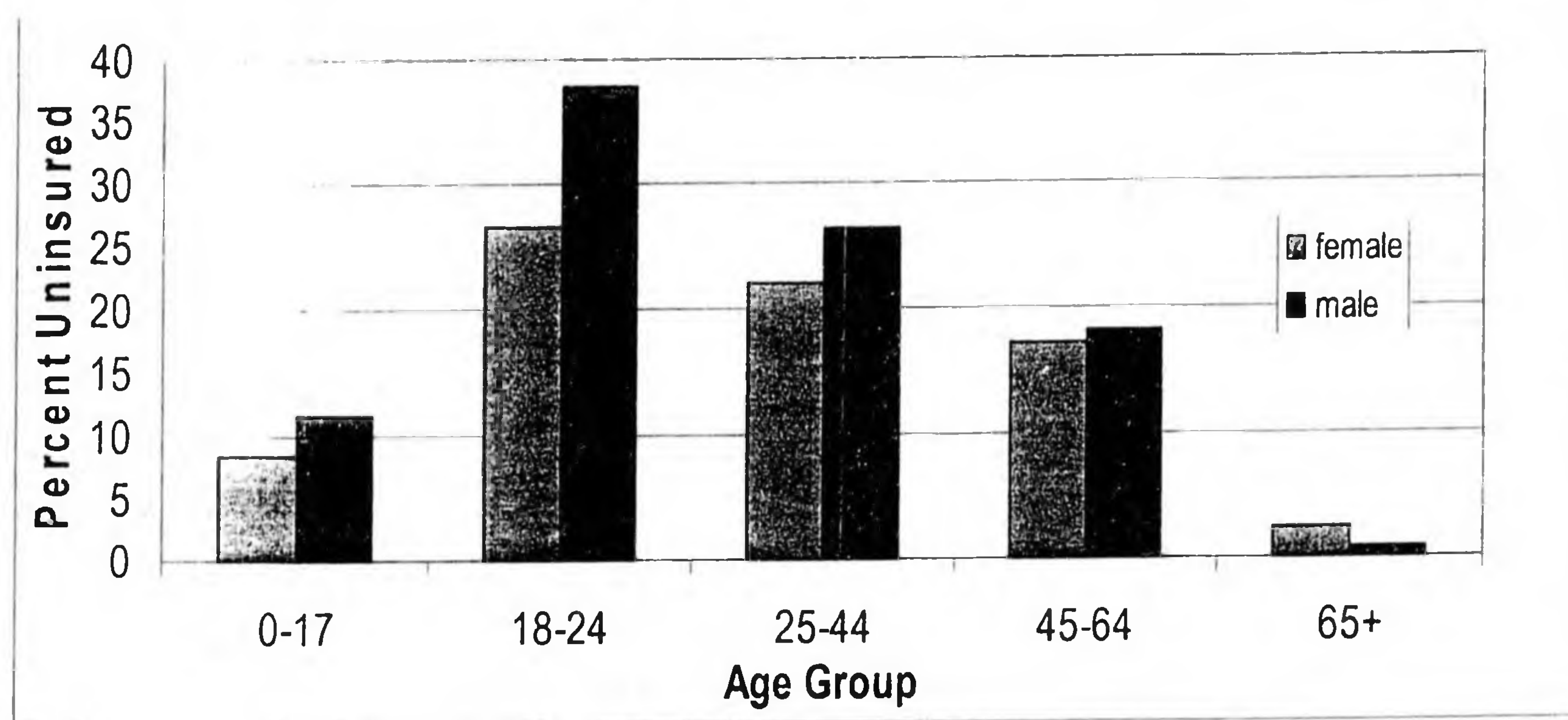
- 22,700 Uninsured Alaskans are 0-17
- 21,000 Uninsured Alaskans are 18-24
- 44,000 Uninsured Alaskans are 25-44
- 27,800 Uninsured Alaskans are 45-64
- 800 Uninsured Alaskans are 65 and older



Age and Sex of the Uninsured in Alaska, 2003-2005 average

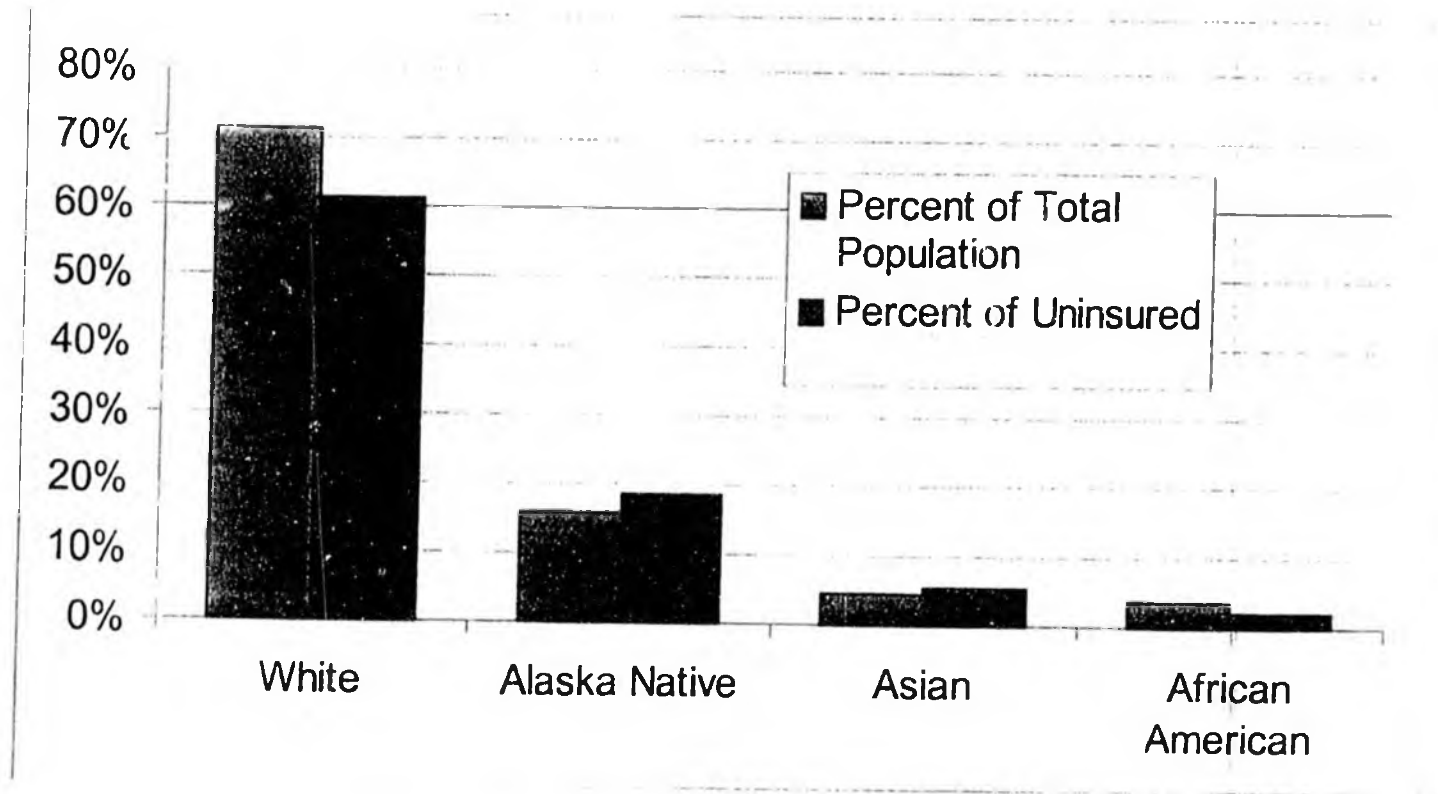
Although 18-24 year olds are about 1/5 of the uninsured, a higher proportion of 18-24 year olds (about 1/3) are uninsured than for any other age group.

Males are more likely to be uninsured – The CPS reports 16% of females and nearly 20% of males are uninsured.



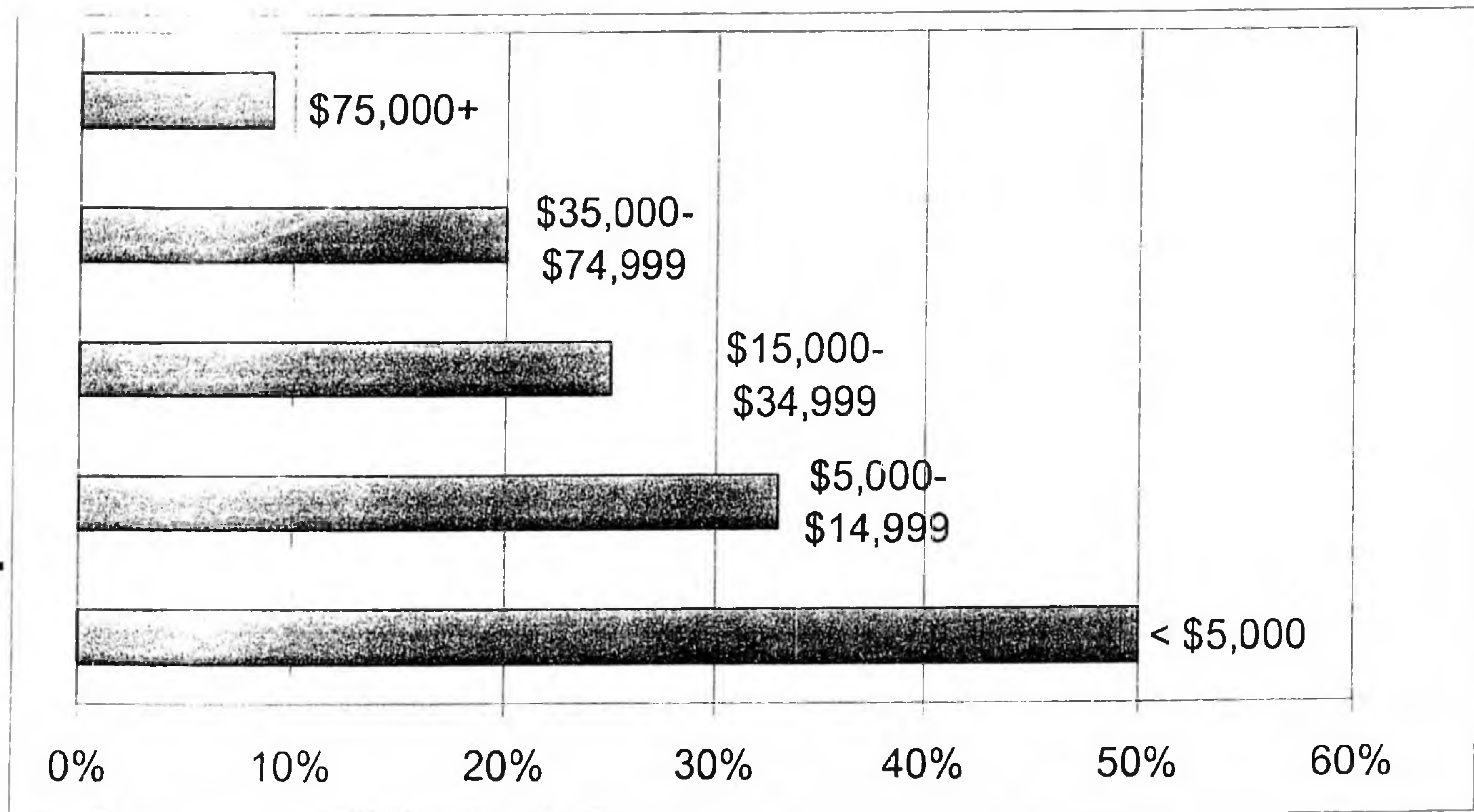
Race of the Uninsured, Alaska
2003-2005 average

Alaska Natives make up nearly 16% of the population, but account for 19% of the uninsured



Percent of Uninsured Alaskans By Household Income level

2003-2005 average

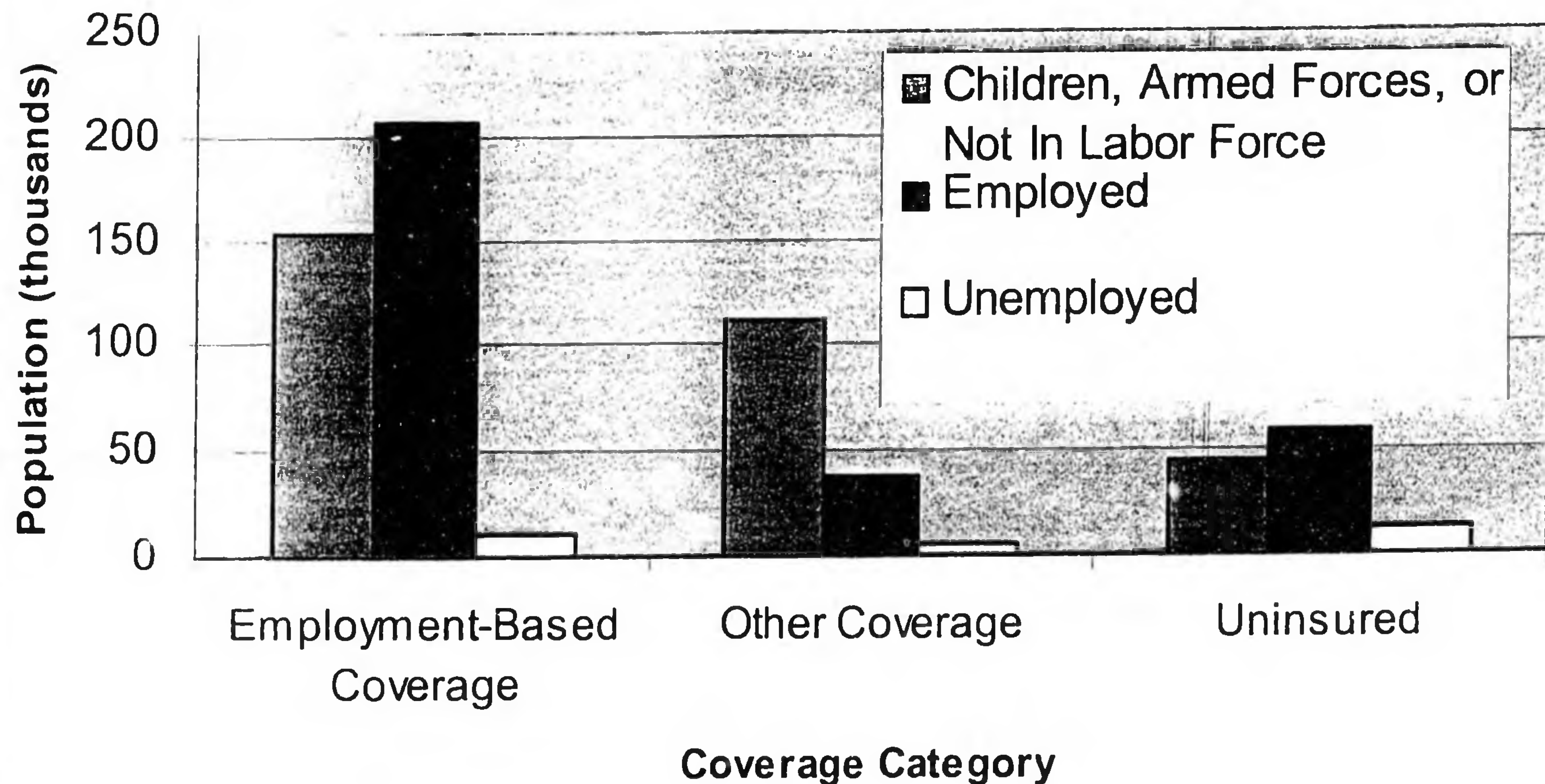


Health Insurance Coverage of Alaskans, 2003-2004

(Source: www.statehealthfacts.org, Medicaid data from CMS/USDHHS Administrative Data, other from Current Population Survey, US Bureau of the Census)

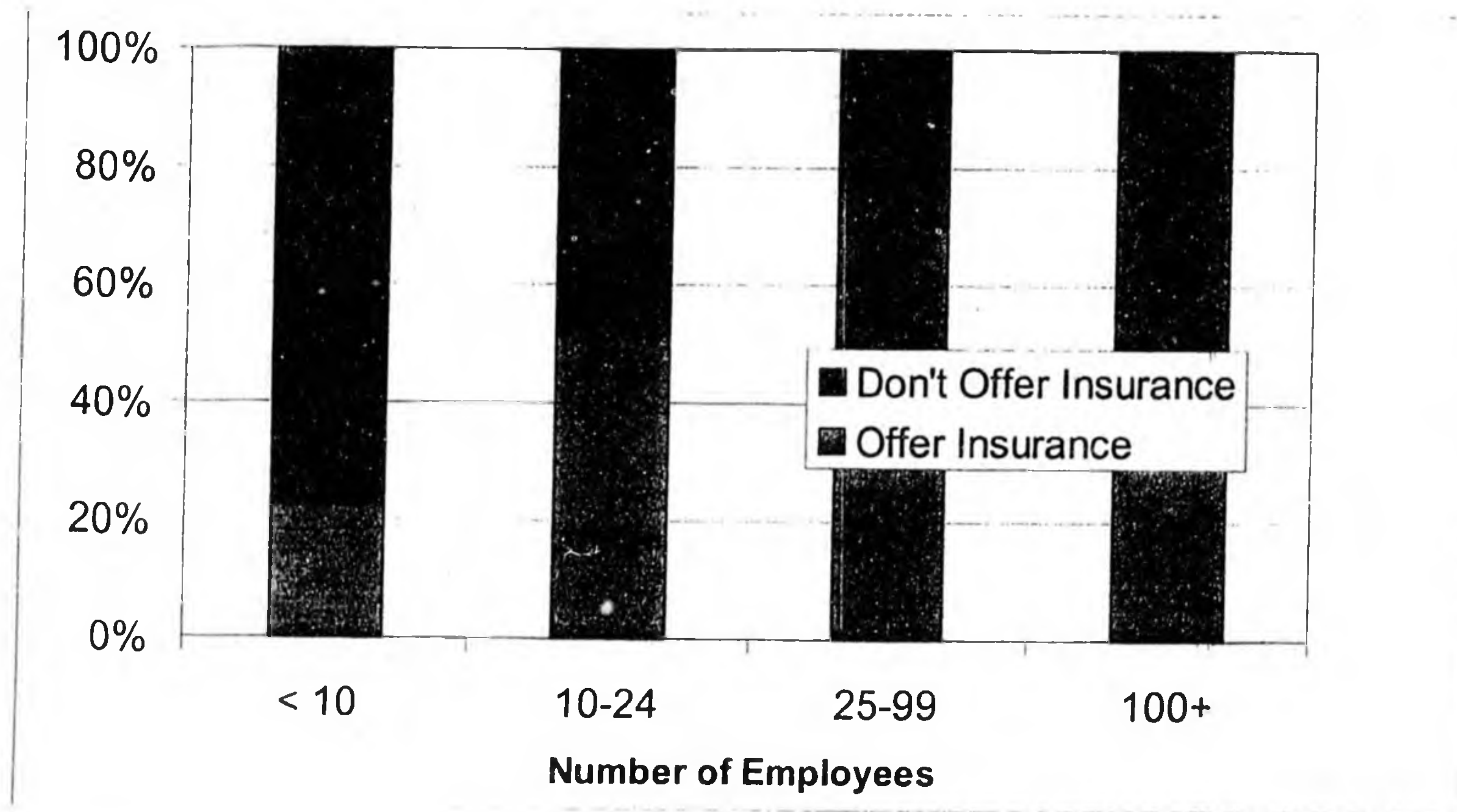
Coverage Type	Percent of Population
Employer	52%
Individual	4%
Medicaid	15%
Medicare	6%
Other Public	5%
Uninsured	**18%**
Total	100%

Health Coverage by Employment Status
(2003-2005 average)



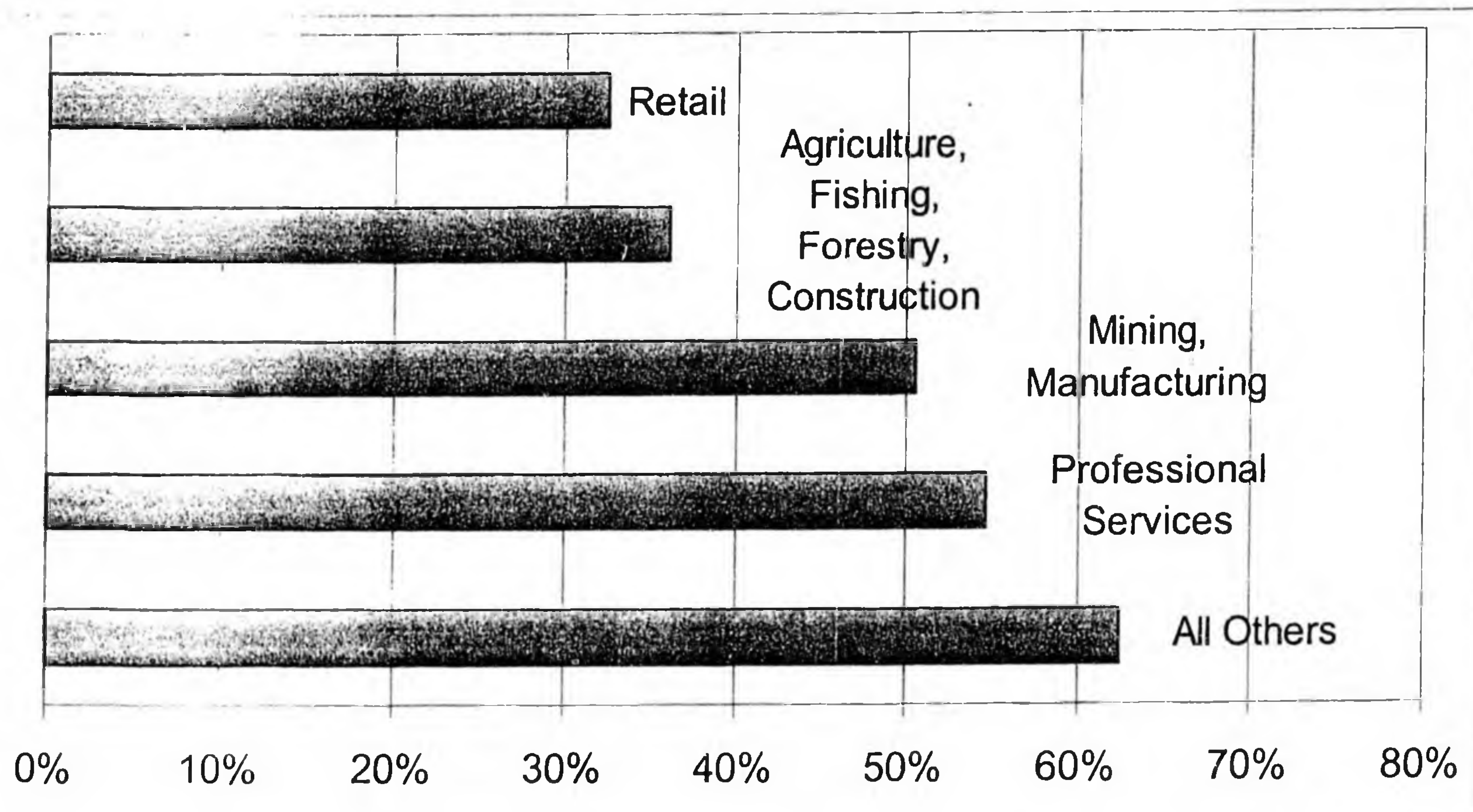
Uninsured Alaskans by Firm Size
2004

Less than one-fourth of firms with less than 10 employees offer health insurance to their employees and nearly all firms with more than 100 employees offer some type of health insurance.



Percent of Private Sector Firms Offering Health Insurance by Industry, 2004

Less than one half of all employers in Alaska offer health insurance.



Data Sources

U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2003 through 2005
(http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Agency for Healthcare Research and Policy, Medical Expenditure Panel Survey, 2004
(http://www.meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp)

Where to Find Information

For links to information about insurance, links to data and research on the uninsured, and information about the State Planning Grant:

www.hss.state.ak.us/commissioner/healthplanning/planninggrant/default.htm/

Email: infohealthplanning@health.state.ak.us

Write: Health Planning & Systems Development
PO Box 110601 Juneau AK 99811

Attachment D

Mark Foster and Scott Goldsmith, "Alaska's $5 Billion Health Care Bill—Who's Paying?" Institute of Social and Economic Research, University of Alaska Anchorage, UA Research Summary No. 6, March 2006

Alaska's $5 Billion Health Care Bill—Who's Paying?

By Mark Foster and Scott Goldsmith

March 2006
UA Research Summary No. 6

Figure 1. Growth in Alaska Health-Care Spending, 1991-2005

	Total Spending	Per Person Spending
1991	$1.6 Billion	$2,884
2005	$5.3 Billion	$7,970
Change	+230%	+176%

Source: Authors' estimates

Spending for health care in Alaska topped $5 billion in 2005. Just how big is $5 billion? It is, for perspective, one-third the value of North Slope oil exports in 2005—a year of high oil prices. It's nearly one-sixth the value of everything Alaska's economy produced last year.

In 1991, health-care spending in Alaska was about $1.6 billion. Even after we take population growth into account, spending for health care increased 176% per Alaskan in 15 years. These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage.

The $5.3 billion in spending in 2005 was all for the 665,000 people who live in Alaska, but individuals didn't pay all the bills. They paid nearly 20% out of their pockets and through payroll deductions. Businesses (including non-profits) and governments paid about 30%. Of course, individual Alaskans and other Americans indirectly pay all these costs, because they buy goods and services, own businesses, and pay taxes.

What does health-care spending buy? Stays in the hospital, visits to doctors and dentists, prescription drugs, and more, as well as program administration and public health programs. Our estimates don't include capital expenditures.[1]

Who pays the bills, and how has that burden shifted as spending increased?

• *Private and government employers spent about $2 billion for employee health-care coverage in 2005.* For comparison, they paid $11.8 billion in wages in 2005. With rising costs, businesses and governments have become increasingly likely to pay health-care bills themselves—"self-insure"—rather than pay through insurance premiums.

• *Alaska households spent just over $1 billion for health care in 2005, up from $361 million in 1991.* That includes everything individual Alaskans spent—not only their out-of-pocket costs, but also what was deducted from their paychecks to help pay for health coverage through their employers.

• *Governments spent $2.2 billion for health care programs in 2005, up from $736 million in 1991.* Medicaid spending was almost $1 billion.

Health-care spending could double again by 2013, if current trends continue. Why are costs of medical care so high, and why are they increasing faster than everything else? Why have health-care costs in Alaska stayed higher than U.S. averages, even as other costs moved closer to national levels? Are we getting better care now? Who can't afford care?

We're starting to assemble data to help answer those questions. Alaskans face some hard choices about how to control costs but still have a health-care system that provides good care and is accessible to everyone. We hope to provide some useful insights.

This publication is the first step in ISER's research on the health-care industry. It starts with our new estimates of spending and of changes since 1991, when we last looked at health-care spending.[2] But cost alone is only one part of the complicated health-care story, and here we also begin looking at:

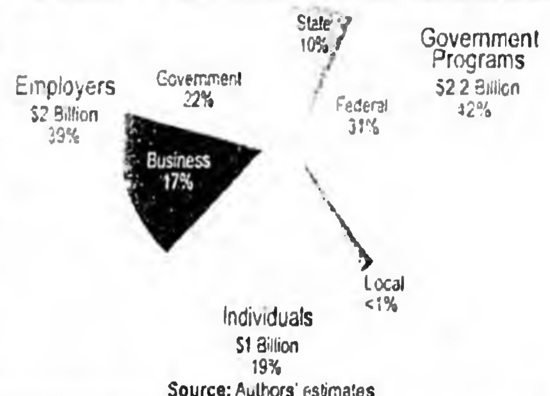
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

• Who is more likely to have health insurance provided through their jobs at a reasonable cost? Single people working for big companies.

• How does use of the health care system in the U.S. compare with use in other countries? Canadians and Australians seem to use their systems about as much.

• What is driving costs? Despite what many people think, there are no simple explanations: it's a puzzle with many pieces.

Figure 2. Who Pays The Bills?
(Total 2005 Spending: $5.3 Billion)



Source: Authors' estimates

Understanding Alaska (UA) is a special series of ISER research studies examining Alaska economic development issues. The studies are paid for by the University of Alaska Foundation. UA reports are available from ISER's offices and at: www.alaskaneconomy.uaa.alaska.edu

Organization of Summary

We first describe what health-care dollars buy—what shares go to doctors, hospitals, drugs, and other expenses. Then we look in more detail at our estimates of health-care spending in 2005 and the changes since 1991. We think our estimates are a good effort to update our previous work. But the health-care industry is complex, and tracking all the spending is difficult.

After we talk about spending, we give readers a glimpse of related health-care issues. In some cases we have no Alaska data and rely on national figures, which are still useful in illustrating important issues.

Pages 4, 5, and 6 discuss access to, use of, and benefits from the health-care system: who is uninsured; who has health-care coverage and how that coverage is provided; which patients get the costliest care; how Americans' use of medical care compares with use by people in oth r industrialized countries; and whether we've gotten healthier in exchange for more spending.

Page 7 summarizes what we know about how medical costs in Alaska differ from the U.S. average, and page 8 concludes with a discussion about the many things that may be driving health-care costs.

Keep in mind that population growth and general inflation account for part of the increase in health-care spending since 1991. Alaska's population increased from about 570,000 in 1991 to 665,000 by 2005. Also, prices for everything Americans buy also went up, by about 43% nationwide and 39% in Anchorage. But prices of medical care nearly doubled (Figure 3).

What Are We Buying?

Figure 4 shows that as of 2000, more than 70% of Alaska's health-care spending was for hospital care and visits to doctors. Prescription drugs accounted for about 9% and dental care 7%. The "other" category includes medical products, health care provided on the job and in schools, and Medicaid payments for in-home care.

Nursing home and home health care made up only 2% of health-care spending in 2000, far short of the U.S. average of 11%—and that share actually dropped between 1990 and 2000, despite fast growth in the number of Alaskans over 65. There has been a shift in how long-term care is provided in Alaska. A change in Medicaid allowed payment for in-home and assisted-living care for people who would otherwise have been cared for in nursing homes.

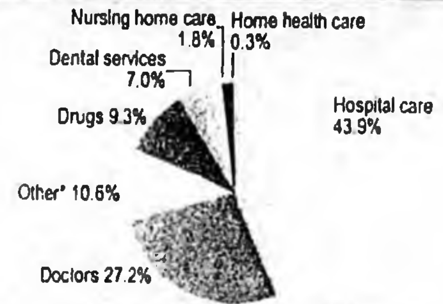
All types of health-care spending grew rapidly since 1990, but the fastest growth was in prescription drugs and the "other" category (described in the footnote to Figure 4).

How Has Spending Changed?

Table 1 details who paid for health-care in 2005. Figures 5 and 6 show changes in levels and shares of spending from 1991 to 2005.

• Growth in government spending wasn't uniform. The federal government's share of spending increased (Figure 5). Costs for Medicare and Medicaid more than quadrupled and costs for the Indian Health Service doubled.

Figure 4. What Are We Buying?
(Alaska Health Care Spending, 2000)



*Includes, among other things, durable and non-durable medical products, direct services employers provide employees, government expenditures in schools, and Medicaid payments that allow people to be cared for at home instead of in institutions.
Source: Center for Medicare and Medicaid Services

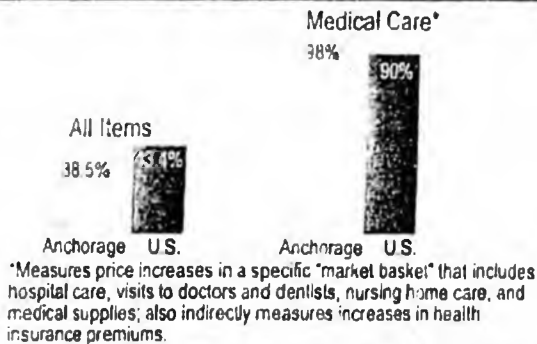
• State government's share dropped, partly because the federal government paid a bigger share of Medicaid costs in 2005 than in 1991.[3]

• Local government is the smallest government spender, but the local share of spending increased, mostly because of growing costs for employee health coverage.

• Employers saw the fastest growth. Combined spending by private and government employers increased about 290% (Figure 6).

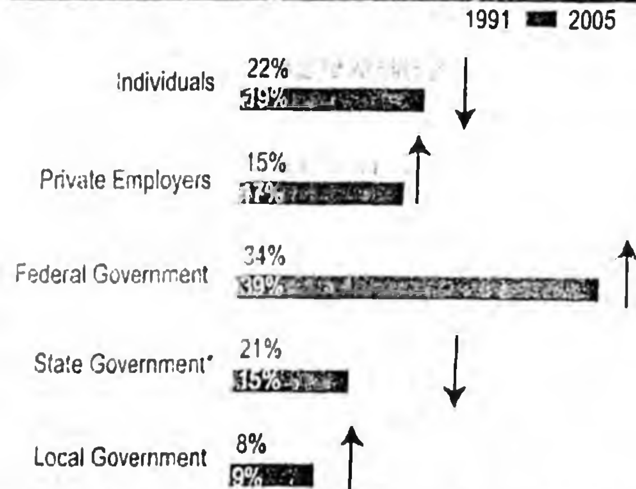
• Spending by individual Alaskans didn't go up as much—184%—but the $1 billion they spent in 2005 was still more than the $922 million businesses spent.

Figure 3. Increase in Consumer Price Index Anchorage and U.S., 1991-2005



*Measures price increases in a specific "market basket" that includes hospital care, visits to doctors and dentists, nursing home care, and medical supplies; also indirectly measures increases in health insurance premiums.
Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers, Anchorage and U.S. City Average

Figure 5. How Did Shares of Spending Change From 1991 to 2005, Among Those Who Buy Health Care?



*See endnote 3, page 8. Note: Totals may not add to 100% because of rounding.
Source: Authors' estimates

Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: $5.3 Billion)

Who Provides the Coverage?	Who Buys the Care? (In Million of Dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total
Individuals	**$1,028**					**$1,028**
Out-of-pocket costs	$431					
Individual policies	$276					
Payments for employer-based insurance	$320					
Employers (Including retiree coverage)		**$922**	**$454**	**$252**	**$411**	**$2,039**
Insurance Premiums		$303	$103	$72	$75	
Self-Insured Costs[a]		$485	$352	$180	$115	
Military Medical Costs					$221	
Worker's Compensation (medical benefits)		$134				
Government Health Programs			**$38**	**$535**	**$1,654**	**$2,227**
Medicare					$419	
Medicaid				$303	$667	
Other Public Programs						
Federal						
Indian Health Service Contracts					$401	
Veterans' Affairs					$105	
Community Health Centers					$29	
State						
Grant to local governments, private groups				$116		
API, Pioneers' Homes				$55		
Other State-Administered				$31		
Elementary and Secondary Schools			$3	$8	$33	
WAMI Medical Education				$2		
Department of Corrections				$21		
Local						
Health and hospital spending			$35			
Total Spending	**$1,028**	**$922**	**$492**	**$787**	**$1,950**	**$5,294**

[a]Many organizations that self-insure—that is, they pay some of their bills themselves—also still carry some insurance to help cover extraordinary risks.

Source: Authors' estimates Note: Totals may not sum because of rounding.

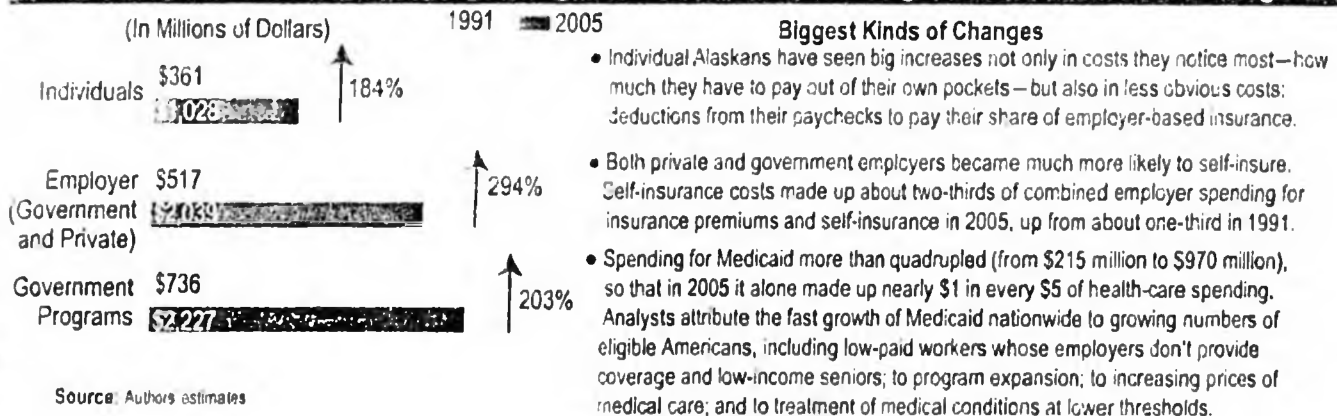


Figure 6. How Did Spending Change From 1991 to 2005, Among Those Who Provide Coverage?

Biggest Kinds of Changes

- Individual Alaskans have seen big increases not only in costs they notice most—how much they have to pay out of their own pockets—but also in less obvious costs: deductions from their paychecks to pay their share of employer-based insurance.
- Both private and government employers became much more likely to self-insure. Self-insurance costs made up about two-thirds of combined employer spending for insurance premiums and self-insurance in 2005, up from about one-third in 1991.
- Spending for Medicaid more than quadrupled (from $215 million to $970 million), so that in 2005 it alone made up nearly $1 in every $5 of health-care spending. Analysts attribute the fast growth of Medicaid nationwide to growing numbers of eligible Americans, including low-paid workers whose employers don't provide coverage and low-income seniors; to program expansion; to increasing prices of medical care; and to treatment of medical conditions at lower thresholds.

Source: Authors estimates

Health-Care Coverage

Most Alaskans—an estimated 87%—have some form of health-care coverage, either through private insurance or government programs.[4] Some people have more than one kind of coverage, so the percentages in Figure 7 add to more than 100%.

Around 64% of Alaskans are covered by private insurance, 38% by government programs, and nearly 13% have no coverage. Nationwide, 68% of people are covered by private insurance, 30% by government programs, and close to 16% have no coverage.

Alaskans are more likely to have coverage through the military (reflecting the state's large number of active-duty and retired military); the Indian Health Service (because Alaska Natives make up 20% of the population); and Medicaid (the joint federal-state program mainly for low-income and disabled people). Fewer Alaskans are covered by Medicare, because fewer are over 65.

We don't know characteristics of the 13% of Alaskans with no health-care coverage, but we know that nationwide the uninsured are most likely to be young adults and to have annual incomes below $25,000 (Figure 8).

Children in Alaska are more likely to have coverage than both adults in Alaska and children nationwide. Figure 9 shows that about 8% of children in Alaska had no coverage in 2003, compared with the U.S. average of nearly 12%.[5] The smaller share of uninsured children in Alaska is probably due to the fact that Alaska Native children are eligible for care through the Indian Health Service, and also to the Denali KidCare program, an extension of Medicaid that provides coverage for low-income children without other coverage.

It's outside the scope of this summary to describe all the ways that families, communities, and governments are affected because millions of Americans lack health insurance. But a recent report by the National Academy of Sciences broadly summarized those effects. It found that the uninsured are in worse health; that uninsured children are more likely to have development delays; that the direct costs of caring for uninsured Americans fall heavily on local communities; and that governments pay hospitals large public subsidies to offset their costs for uncompensated care.[6]

The 64% of Alaskans with private insurance either pay for that coverage themselves (through individual policies) or are covered through their jobs and share the costs with their employers. Figures 10, 11, and 12 show how the rising costs of medical care have affected health-insurance coverage for Alaskans working for private industry.

- Health insurance in Alaska was already more expensive in the 1990s and still is. In 2003, insurance premiums for family coverage at private firms were about $10,500 in Alaska and $9,200 nationwide. By 2005, those premiums had jumped to an average of $11,268 nationally (Figure 10).

- Premiums are higher in Alaska, but workers here pay a smaller share, as Figure 11 shows. As of 2003, employees at private firms in Alaska paid 11% of the premiums for single-person coverage and 17% for family coverage, compared with 17% for single-person coverage and 25% for family coverage nationwide. But employers, especially at small firms, have been shifting more insurance costs to workers. The 2005 UBA-Ingenix Health Plan Survey found that employees of businesses nationwide paid 43% of the premiums for family coverage.

Figure 7. Health-Care Coverage, Alaska and U.S.

	Private Insurance	Medicaid	Medicare	Military	IHS only*	None
Alaska	63.5%	15.3%	7.3%	11.6%	4.2%	12.8%
U.S.	68.1%	12.9%	13.7%	3.7%	N/A	15.7%

*Authors' adjustment. See endnote 4, page 8.

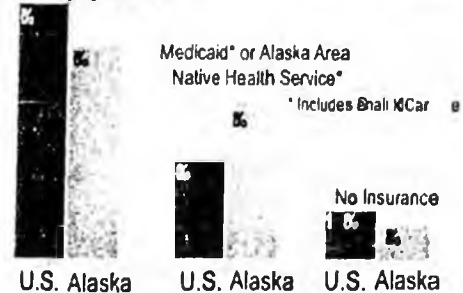
Note: Totals are more than 100% because some people have more than one coverage.
Source: U.S. Census Bureau, Current Population Survey, 2004

Figure 8. Who is Most Likely To Be Uninsured in U.S.?

By Age	Percent Uninsured
18-24	31%
65+	1%
By Annual Income	
Less than $25,000	24%
$75,000+	8.4%

Source: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the U.S.*, 2004

Figure 9. Health-Care Coverage for Children (and Under), Average



Source: American Academy of Pediatrics, adjusted U.S. Census data; see endnote 5, page 8.

Figure 10. Health Insurance Premiums for Family Coverage[a], Private Firms

	Year	Premium
Alaska	1993	$6,175
	2003	$10,564
U.S.	1993	$5,786
	2003	$9,249
	2005[b]	$11,268

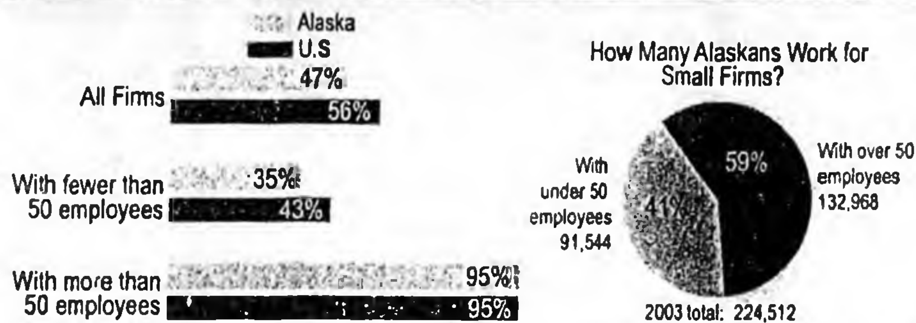
[a]Total costs shared by employer and employee. [b]Alaska figures for 2005 not available.
Sources: Medical Expenditure Panel Survey, U.S. Agency for Health Care Research and Quality, 2003; 2005 UBA/Ingenix *Health Plan Survey*

Figure 11. Share of Health Insurance Premiums Employees Pay (At Private Firms Offering Health Insurance)

		Single-Person	Family Coverage
2003[a]	Alaska	11%	17%
	U.S.	17%	25%
2005[b]	U.S.	17%	43%

[a]Reported in Medical Expenditure Panel Survey, 2003
[b]Alaska 2005 figures not available; national figures from 2005 UBA/Ingenix *Health Plan Survey*

Figure 12. Private Firms Offering Health Insurance,* Alaska and US, 2003



* Not all workers at firms that offer insurance carry that insurance. Source: Medical Expenditure Panel Survey, 2003

• Small Alaska businesses are less likely to offer insurance coverage. Only about a third of those with fewer than 50 employees offer coverage, compared with 43% nationwide (Figure 12).

A lot of Alaskans work for small businesses. In 2003, about 91,500 of the state's 224,500 private-industry employees worked for businesses with fewer than 50 employees. That's more than 40% of all those with jobs in private industry.

Who Costs the Most and the Least?

We've talked about the costs of health care and of health-care coverage. Now we turn to the other side of the equation: who's getting the benefits of the spending?

Health-care spending in Alaska was close to $8,000 per person in 2005. But not everyone is average. The cost of care for a few is significantly higher than average, but for many it's only a few hundred dollars a year.

As a first step toward understanding who gets the benefits of health-care spending, ISER analyzed national data on the characteristics of high- and low-cost patients. That data is from a federal panel survey—that is, a survey that follows households over time.

As Figure 13 shows, just 5% of patients nationwide account for almost half of all health-care spending in any given year, while at the other extreme 50% of patients account for just 3% of spending in a year.

A lot of Americans tend to think that the most expensive patients are probably very old, or suffering from some catastrophic illness or injury, and are possibly uninsured.

The high-cost patients are older; health-care costs do go up as people age.[7] But their average age is 57, and fewer than 40% are over 65. The average bill for high-cost patients in 2002, under $20,000, doesn't reflect major illnesses or end-of-life care. Rather, it's for a few days in the hospital for surgery, several visits to doctors, and significant spending for prescription drugs. Few of the high-cost patients—2%—are uninsured.

The low-cost patients are mostly young, averaging 28 years old. They may see a doctor or a dentist once a year, and they pay almost half their modest medicals bills out of their pockets.

Many of the low-cost group—nearly 20%—are uninsured. The share of uninsured patients in this group tracks with what the National Academy of Sciences has reported: that the uninsured often don't have any medical costs at all in a year, and among those who do, their expenses are less than half the average for people under 65.[8]

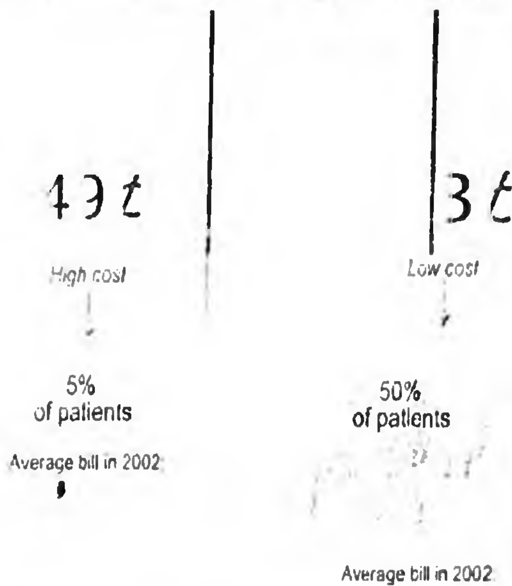
Keep in mind that it's easy to go from being a low-cost patient in one year to a much costlier one the next—a car accident, the sudden onset of an illness, or a hundred other unpredictable events can push anyone into the ranks of the high-cost patients.

Figure 13. Who Are the High-Cost and the Low-Cost Patients in the U.S.?

Distribution of Health-Care Spending on Patients, 2002

Who Are the High-Cost Patients?

- Mostly middle-aged people (average age 57), who are hospitalized for a few days, see doctors several times a year, and spend considerable money (average $3,000) on prescription drugs.
- About 40% are over 65
- They are from all income levels. A third have high incomes (family income over $80,000), and about a fifth are poor (family income under $18,000).
- Only 2% are uninsured. More than two-thirds have private insurance, and nearly a third are covered by government health programs, the most common being Medicare.
- They pay about 12% (average $2,400) of their bills out-of-pocket.



Who Are the Low-Cost Patients?

- Mostly young (average age 28), healthy people, who are likely to see a doctor and a dentist once a year and spend little (average $44) for prescription drugs.
- About 3% are over 65
- They are from all income levels, with almost the same breakdown as among high spenders: nearly a third have high incomes and about a fifth are poor.
- Nearly 20% are uninsured. About 17% are covered by government programs, most commonly Medicaid. The majority have private insurance.
- They pay about 40% (average $84) of their bills out-of-pocket.

Sources: *MEPS Statistical Brief No. 81, May 2005 and analysis of MEPS data by Stephanie Martin of ISER*

Do We Use More Medical Care?

Americans spend more on health care than anybody else. Do Americans increase health-care costs by getting more medical care than people in other developed countries? Or conversely, do countries with national health-care systems hold down costs by rationing care?

Figure 14 compares Americans with the British, Canadians, New Zealanders, and Australians on use of, access to, and satisfaction with their health-care systems. The comparison countries all have some form of national health-care system.

Overall, the comparisons show that residents of all four countries are almost equally likely to see doctors and have diagnostic tests, and that Americans are slightly more likely to take prescription drugs.

Americans are, however, more likely to skip medical tests because of cost and less likely to get appointments the same day they call. They also seem to be somewhat less satisfied with care they get from their doctors and in the emergency room.

figure 4 Use of Medical Care, US. and Selected Countries, [illegible]
(Percent of Survey Respondents)

	US.	Great Britain	New Zealand	Canada	Australia
Saw at least one doctor in previous 2 years	[illegible]%	95%	97%	95%	98%
Regularly take prescription drugs	[illegible]%	44%	39%	43%	39%
Had blood tests, x-rays, or other diagnostic tests in past 2 years	[illegible]%	71%	82%	84%	83%
Able to get doctor's appointment same day when sick	[illegible]%	41%	60%	27%	54%
Skipped medical tests, treatment or follow-up because of cost	[illegible]%	2%	20%	8%	18%
Rate regular doctor's care excellent or very good	[illegible]%	64%	74%	68%	71%
Among those who used emergency room, share who rate emergency services fair or poor	[illegible]%	23%	27%	27%	23%

Source: Commonwealth Fund International Health Policy Survey, 2004

Are We Healthier?

Another important aspect of the health-care story is what we're getting in return for the high spending. Are Alaskans healthier than in 1990?

The answer seems mixed. In 2005 the United Health Foundation ranked Alaska as among the most improved states in health outcomes since 1990. Despite that improvement, the foundation still ranks Alaska somewhere in the mid-range of states on health measures—because 15 years ago Alaska was ranked toward the bottom.[3] Figure 15 illustrates some of the improvements Alaska has made since 1990.

Rates of infectious disease (which include hepatitis, tuberculosis, and many more) went from far above the U.S. average in 1990 to significantly below by 2005. Infant mortality dropped in Alaska and throughout the country.

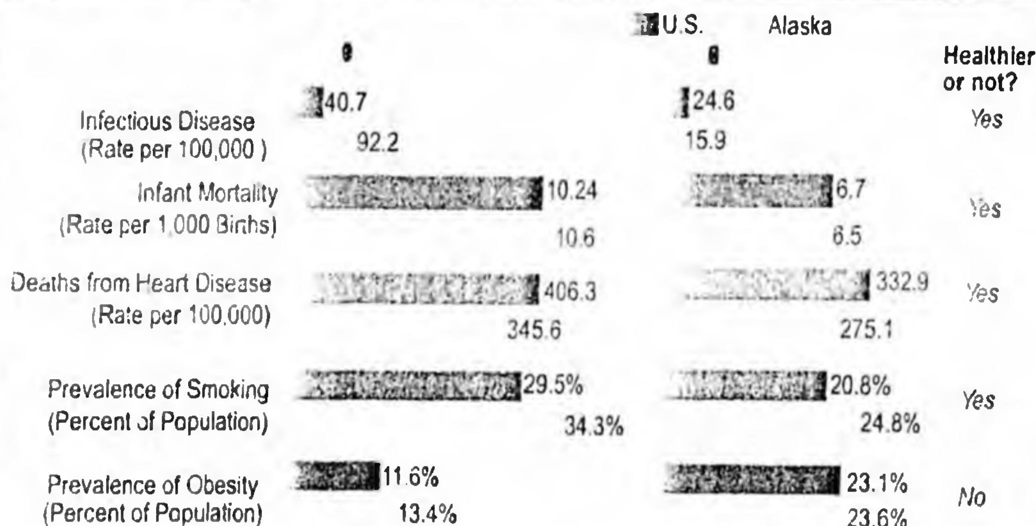
Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.[10] In Alaska and nationwide, advances in treatment and technology have also reduced infant deaths.

With improved treatments for heart disease, the rate of death from heart disease declined by 20% in Alaska since 1990, dropping slightly faster than the national rate.

Rates of smoking among Alaskans fell also, but Alaskans are still more likely to smoke than other Americans. Again, public-health campaigns to fight smoking likely contributed to the decline.

On the down side, Alaskans and other Americans are far more likely to be obese now than in 1990—and obese people are more likely to require treatment for diabetes and high blood pressure.

figure 5 Are Alaskans Healthier Now Than in [illegible]



Source: United Health Foundation, *America's Health Rankings 2005*

Alaska and U.S. Costs

Years ago, everything cost more in Alaska, and costs still remain high in remote areas. But in Anchorage and other urban places, the historically high costs of many things have moved closer to U.S. averages in recent times, as the population grew, local markets got bigger, and infrastructure and transportation improved.

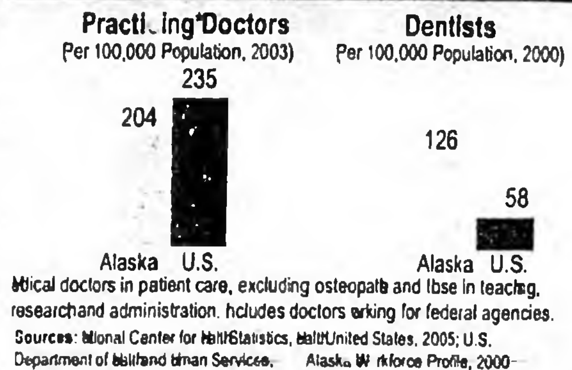
But costs of medical care haven't declined relative to U.S. averages. Overall medical costs are probably somewhere in the range of 25% higher in Alaska, but that cost difference varies quite a bit among services and procedures, and prices don't always reflect cost.

Alaska has fewer practicing doctors per capita than the nation as a whole, but about twice as many dentists—so how the supply of medical professionals may affect costs is not clear (Figure 16).

Figures 17 through 20 show some examples of cost differences, but it isn't a comprehensive picture.

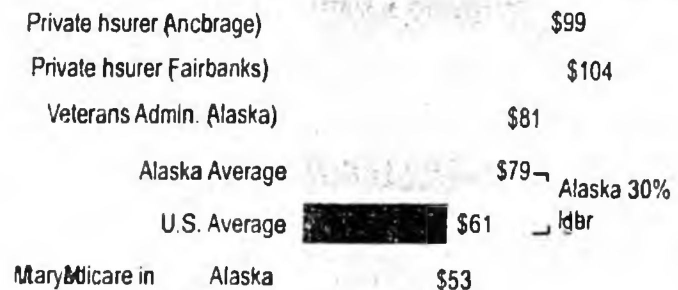
- Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).
- Average costs of a visit to a doctor's office were 30% higher in Alaska in 2001. But the average is a mix of private insurance and government payments. A private insurer in Anchorage and Fairbanks paid nearly twice as much as Medicare for an office visit in 2001, as Figure 18 shows.
- Alaskans don't use as many prescription drugs as other Americans—mostly because there are fewer Alaskans over 65—but we pay more. In 2003, the average price of retail prescriptions was 25% higher in Alaska.
- Costs of hospital care went up faster in Alaska than nationwide from 2000 to 2003—so in 2003 average expenses for a day in an Alaska hospital were 42% above the U.S. average, compared with 30% in 2000.

Figure How Do Numbers of Alaska Doctors and Dentists Compare with US. Average?



*Medical doctors in patient care, excluding osteopaths and those in teaching, research and administration. Includes doctors working for federal agencies.
Sources: National Center for Health Statistics, Health United States, 2005; U.S. Department of Health and Human Services, Alaska Workforce Profile, 2000

Figure Costs of An Office Visit, Alaska and US,
(Established Patient, 15 minutes)



*Insurance coverage for active duty and retired military personnel for medical care not available from military facilities.
Source: GAO Report GAO-01-620, May 2001

Figure How Much Higher are Medical Costs in Alaska?
Costs Paid by Private Insurer, 2000

	Percent Above U.S. Average
Medical/Surgical Procedures	18.1%
Dental Procedures	37.7%

Source: Ingenix data base; cited in Alaska Division of Medical Assistance, Health Care Cost Analysis, 2001

Figure Prescription Use and Cost, Alaska and US,

	Prescriptions Per Capita	Average Price of Retail Prescriptions	Average Cost Per Capita
United States	10.7	$52.97	$566.78
Alaska	6.3	$66.89	$421.41

Source: Kaiser Family Foundation, based on data from Verispen, LLC., Special Data Request, 2004, and U.S. Census Bureau, State Population Datasets for six Race Groups

Figure Hospital Costs, Alaska and US, and
(Expenses per In-Patient Day)

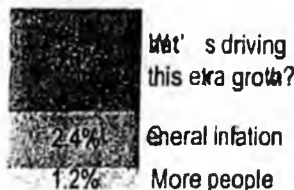
	Alaska		U.S.		Alaska as % of U.S.
2000	$1,495	Up 30%	$1,148	Up 19%	130%
2003	$1,952		$1,371		142%

Source: 2003 American Hospital Association, Annual Survey

Figure 21. What's Driving Health-Care Spending In Alaska?

Annual Growth, 1990-2005*

8.9%



*Authors' estimate

What's Driving Costs? It's a Puzzle

Spending for health care in Alaska increased an average of nearly 9% a year from 1990 to 2005—and that figure doesn't reflect the big capital costs for building hospitals and clinics in the state since 1990.

More people and general inflation together account for only about 40% of that growth. So what's driving the rest?

Just about everybody has an opinion about what's pushing up medical costs, here and nationwide. Alaska has some special conditions—mostly small markets and high costs in rural areas—but other possible contributors to high costs are common to Alaska and the rest of the country.

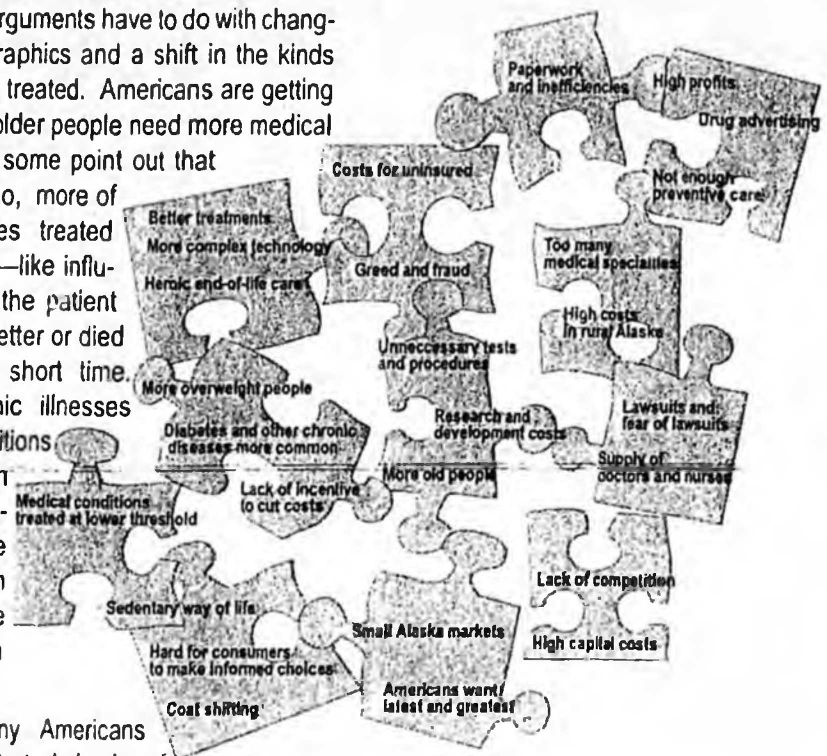
Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

Other arguments related to the delivery system are that Americans get more medical care than they need, because most of the bills are still paid by health insurance. Others believe, by contrast, that costs of caring for uninsured people are responsible.

Others blame environmental factors, especially Americans eating too much and not exercising—leading to the spread of diabetes and other conditions requiring more care.

Still others say the growth has to do with changes in treatments and technology—treating conditions at lower thresholds (like the recent drop in the cholesterol level at which doctors recommend treatment); more effective but costlier treatments and prescription drugs; and more complex technology.

Other arguments have to do with changing demographics and a shift in the kinds of illnesses treated. Americans are getting older, and older people need more medical care. Also, some point out that decades ago, more of the illnesses treated were acute—like influenza—and the patient either got better or died in a fairly short time. Now, chronic illnesses and conditions—like high blood pressure—are common and require long-term treatment.



And many Americans link high costs to behavior of drug companies, the insurance industry, the medical and legal professions, and individual Americans. Such behavior would include, for instance, insurance and drug companies making high profits; doctors overbilling government programs; and patients filing lawsuits—causing doctors to practice "defensive medicine."

Probably there are other opinions we haven't discussed here. We're not endorsing any of them, but merely pointing out that many things could be contributing to rising costs—and it's a puzzle how all the pieces fit together. We will learn more as we study Alaska's health-care system. But for now, we want to emphasize that the answer to what is driving health-care costs is not simple, and finding solutions won't be simple either.

Endnotes

1. Our estimates are based on the Center for Medicare and Medicaid Services definitions of personal health care spending. See http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage. We have also included insurance costs, to capture the expenses paid by employers and employees.

2. ISER *Research Summary* No. 53, "The Cost of Health Care in Alaska," December 1992.

3. The decline in state share is expected to ameliorate somewhat beginning in FY 2006, due to a decision by the 9th District Appellate Court to disallow the Fair Share program that enabled tribal hospitals to receive a higher reimbursement than non-tribal hospitals for uncompensated care.

4. U.S. Census Bureau figures from the Current Population Survey classify Alaskans with coverage only through the Indian Health Service as "uninsured." We have adjusted those figures, separating those with IHS-only coverage from the uninsured. The adjustment is based on methods of the University of Minnesota's School of Medicine, State Health Access Data Center.

5. Figures from the American Academy of Pediatrics for uninsured Alaska children are adjusted U.S. Census figures, separating children with IHS-coverage only from the "uninsured" category.

6. National Academy of Sciences, *Hidden Costs, Value Lost: Uninsurance in America*. Available at http://www.nap.edu/catalog/10719.html. Public subsidies for uncompensated care are illustrated in the State of Alaska's FY 2007 budget request, which includes $27 million to help Alaska hospitals pay for uncompensated care.

7. In 1999, for example, health-care spending for Americans ages 75 to 84 was seven times higher than for people 18 and under.

8. See note 6.

9. United Health Foundation, *America's Health Rankings*, 2005 edition.

10. See Chapter 3 in ISER report, *Status of Alaska Natives 2004*, May 2005.

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Denali KidCare

Let's make sure Alaska children get the medical help they need

(Published: February 21, 2007)

This one is simple. The answer is yes.

Anchorage Rep. Les Gara and Sen. Bill Wielechow-ski have introduced legislation to provide children's health insurance coverage for more of Alaska's working families who currently go without.

Their bills would fortify Denali KidCare, a state and federally funded program started during the Knowles administration in 1999 and cut back by lawmakers in 2003.

Back in 1999, Alaska children and pregnant women in working families could qualify for coverage if their income was no more than 200 percent of the federal poverty level.

That provided medical, dental and vision coverage to thousands of children and pregnant women. As Rep. Gara points out, the program aimed to cover families caught in the uninsured gap between welfare and good-paying jobs with health benefits.

In 2003, shortsighted Republican lawmakers voted to scale back the program to a hard-number income limit that took no account of inflation and automatically cut children of working families out of the program over time. That has left an estimated 3,500 kids uninsured -- kids who would have been eligible under the 1999 rules. Supporters of this year's bills say an additional 1,000 will lose coverage in 2007.

As it stands now, a working Alaska family of four can't make more than $40,260 per year to qualify for the program. There are only two states with tighter qualification limits.

"That the richest state in the nation provides some of the lowest levels of care is just shameful," said Anchorage Sen. Hollis French. He's right.

Here's what this year's proposed No Child Left Uninsured Act would do:

• Restore coverage up to the old limit of 200 percent of the federal poverty line. That means eligibility would float with inflationary changes in the line. That makes sense. Right now, using 2007 federal poverty limit levels, a working family of four without insurance coverage would qualify for Denali KidCare up to a yearly income of $51,640.

• Expand the program to allow Alaska families earning from 201 percent to 350 percent of the federal poverty level to buy Denali KidCare coverage on a sliding scale -- from $200 a year at the bottom to $1,200 a year at the top. Families making more than 250 percent of the poverty level also would contribute a 20 percent co-pay for services.

The cost? That's not certain yet. The state estimates the cost of Denali KidCare at about $1,700 per child per year. With 7,600 youngsters enrolled, that comes to almost $13 million per year. Thankfully, the federal government reimburses states for 58 to 70 percent of the costs.

Several other cost factors apply, too. Families without insurance often have no choice but hospital emergency rooms for care. They can't afford to pay, but hospitals can't turn them away. Anchorage's Alaska Regional and Providence hospitals reported $89 million in unpaid emergency room costs in 2004. Burdens like that have prompted the governor to ask for $22 million in aid for Alaska hospitals.

An expanded Denali KidCare would ease that strain because more Alaskans could afford routine and preventive care. Instead of all Alaskans bearing the costs for unpaid care with higher prices, a public investment up front would reduce those bills. Each dollar spent on routine care saves many times that dollar in care for more serious afflictions.

Rep. Gara sums up the case well for Denali KidCare: "Cheaper, smarter and more moral than doing nothing."

BOTTOM LINE: The children of working Alaskans without insurance deserve health care. Let's make it happen.

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Alaska could be leader in health care

Compass: Points of view from the community

By JOHN RILEY

(Published: February 23, 2007)

Health care is a $5 billion industry in Alaska. It impacts every part of our economy and touches each of our lives. Yet there is widespread agreement that we have a dysfunctional, inefficient system. Solutions have remained elusive. The very wealth and reach of the industry can frustrate attempts to improve it.

The Commonwealth Fund has identified the five key dimensions of high-performance health systems. We can adapt these dimensions as a blueprint to transform Alaska's health care system.

The five key dimensions are: access, affordability, high-quality care, efficient care and equity. Because the five dimensions are interrelated, successful transformation requires simultaneous efforts on each. Affordability affects access. Quality and efficiency affect cost and affordability.

Where does Alaska stand? What are possible solutions?

Access: Alaska ranks in the bottom 15 percent of states, with close to 18 percent of Alaskans uninsured.

Solutions: Expand Denali KidCare to cover children and their parents up to 300 percent of the federal poverty level. Promote partnerships between the state and employers. Assure that benefits cover primary and preventive care. Consider mandated subsidized health insurance. Strengthen community heath centers. Fund workforce training to assure an adequate supply of health professionals.

Affordability: Alaska ranks 50th of the 50 states, with average health care premiums of $4,379 for employee single coverage. The majority of this cost (88 percent) is borne by employers and passed on to consumers. The cost of living increased in Anchorage by 40 percent between 1991 and 2005 while the cost of medical care increased almost 100 percent and is projected to double again by 2013. The cost of retiree health benefits is a major factor in the crisis in unfunded pension liabilities.

Solutions: The majority of health care spending is for hospital treatment of episodic high-cost complications of preventable chronic illness. Our health care must be reorganized around primary care that provides a medical home to all patients. Care must focus on behavioral change to prevent the rising epidemic of chronic disease. Alaska ranks fifth in the U.S. with 25 percent of adults who smoke. Alaska ranks fourth in the US with 62 percent of adults who are overweight or obese. New primary care payment models must exempt preventive and primary care from deductibles.

Efficiency: The U.S. spends more than twice per capita for health care as Canada and the other developed nations. The U.S. has the highest percent of national health expenditures on insurance administration and overhead at 7.3 percent.

Solutions: Encourage public-private collaboration to achieve simplification such as the Minnesota

"Smart Buy Alliance" that purchases health insurance for 70 percent of Minnesota residents. Implement performance incentives for meeting cost efficiency indicators. Increase transparency in reporting on quality and costs.

Quality: Nationwide, less than 50 percent of patients receive the recommended care for common chronic conditions. Twenty eight percent of U.S. primary care doctors use electronic medical records, or EMRs, compared to 92 percent in New Zealand and 89 percent in the United Kingdom.

Solutions: Redesign the office visit around the provision of quality care. Electronic medical records are an essential part of quality health care delivery. Leverage Alaska's health care purchasing power to provide incentives to use EMRs, to meet quality indicators and interconnect health information systems.

Equity: Nationwide, the percent of diabetics receiving recommended care is lowest for patients who are rural, poor or uninsured. African American mortality rates are significantly higher for heart disease, diabetes and infant mortality. Alaska Native infant mortality rates are almost twice that of whites.

Solutions: We must assure access to care for the poor and minorities who currently slip through our safety net systems. Patient's health care "literacy" must be assessed and care must be responsive to it.

There are innovative health care transformations in Maine, Massachusetts, Rhode Island, New York and Minnesota. A successful approach will require improving each of the five interlocking dimensions. Strategies focused on improving only one aspect of health care are unlikely to achieve the central goal of long, healthy productive lives for Alaskans. Alaska has an opportunity to become a national leader in developing a high-performance health system. Alaska's future may depend on it.

John Riley is with the clinical faculty of the University of Alaska Anchorage and is president of the Alaska Public Health Association.

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Health

U.S. approves state's Cover All Kids program

This signals the go-ahead to expand health insurance coverage to all Pennsylvania children

Friday, February 23, 2007

By Joe Fahy and Jerome L. Sherman, Pittsburgh Post-Gazette

Federal officials have cleared the way for Pennsylvania to implement its Cover All Kids program, which aims to make affordable health insurance more available to the state's uninsured young people.

"Our pledge was to ensure that every Pennsylvania child had access to health insurance coverage," Gov. Ed Rendell said in a statement yesterday. He said that because of the federal approval, announced yesterday, Pennsylvania officials can "start to make that pledge a reality."

Annie O'Neill, Post-Gazette

U.S. Sen. Bob Casey gets some pointers on how to run an electronic toy from Asa Martin, 5, in a Children's Hospital play room yesterday. Mr. Casey was at the hospital to discuss efforts to provide health insurance for the state's children.

Click photo for larger image.

The state was notified of that approval yesterday by the U.S. Centers for Medicare and Medicaid Services, said George Hoover, deputy insurance commissioner for CHIP and adultBasic programs.

The approval expands Pennsylvania's Children's Health Insurance Program, which provides coverage to young people whose families earn too much to qualify for other assistance programs such as Medicaid. Coverage is paid through state funds, with the federal government reimbursing about 68 percent of the cost.

Mr. Rendell said the approval also bodes well for "Cover All Pennsylvanians," his proposal to provide more affordable coverage for uninsured adults.

Up to now, Pennsylvania's program only received federal reimbursement for children in families whose income is up to 200 percent of the federal poverty level, about $41,300 for a four-member family, Mr. Hoover said.

The expanded program will provide federally-subsidized coverage for families that are at up to 300 percent of the poverty level, meaning income of about $61,950 for a family of four. Those families would pay sliding scale fees for the coverage based on their incomes.

Families with incomes at 200 percent of the poverty level would pay no monthly premiums; those with higher incomes up to 300 percent of the poverty level would pay premiums ranging from about $38 to $60 per child.

Families with incomes above 300 percent of the poverty level would pay about $150 a month per child.

Enrollment in the program will begin next month, Mr. Hoover said. Young people from birth to age 19 are eligible.

State officials estimate that about 133,000 Pennsylvania children are uninsured, and all but

110,000 qualified for coverage under programs that existed prior to Cover All Kids, he said.

But officials expect more families will take advantage of the coverage with the message that it is available to families of all income levels, Mr. Hoover said.

There are some exceptions. Children in families with incomes above 200 percent of the poverty level, for example, have to be uninsured for six months to qualify.

For more information, parents can call 1-800-986-5437. They also can visit www.compass.state.pa.us to apply online.

Mr. Hoover said state officials were relieved to receive federal approval of Cover All Kids. In his budget proposal, President Bush has proposed targeting the State Children's Health Insurance Program to young people at or below 200 percent of the poverty level. He also has proposed funding levels that some consider inadequate.

The federal government currently spends about $5 billion annually on SCHIP, and the president's budget proposes $4.8 billion in new money for the program over the next five years.

But the new funds won't be enough to cover rapidly rising health care costs and new programs at the state level, according to a report released yesterday by the Center on Budget and Policy Priorities.

Jeff Nelligan, director of media affairs for the Centers for Medicare and Medicaid Services, said the president's budget focuses on SCHIP's original objective of improving health insurance coverage for children in low-income families.

During a visit to Pittsburgh yesterday, U.S. Sen. Bob Casey, D-Pa., said the president's budget proposal would hamper states' efforts to provide coverage to more children.

Speaking at Children's Hospital in Oakland, Mr. Casey praised Pennsylvania's efforts to expand coverage for young people.

Joan Benso, president and chief executive officer of Pennsylvania Partnerships for Children, called the president's budget proposal "short-sighted." But she praised approval of Cover All Kids.

"We know that children who have health insurance are less likely to get preventable diseases, are less likely to use emergency room care, and are more likely to attend school," she said. "All these things save us money as taxpayers."

(Politics Editor James O'Toole contributed. Joe Fahy can be reached at jfahy@post-gazette.com or 412-263-1722. Jerome L. Sherman can be reached at jsherman@post-gazette.com or 1-202-488-3479.)

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Rep. Les Gara
State Capitol, Rm 500
Juneau, AK 99801

Fax – 907-465-3518

Dear Representative;

I whole-heartedly support your effort to expand the Denali Kid Care Program back to 200% of the poverty line. Also, allowing people to "buy in" from 200 – 300% of the poverty line is an excellent idea.
I mentioned in a previous e-mail that a co-pay, whether percentage or fixed rate per visit, would allow the program to be utilized by more people, & make it more equivalent to a private insurance plan. The children served by Denali Kid Care would not otherwise have insurance, & therefore no access to preventative health care. Furthermore, I know that a large percentage of these kids would end up obtaining their care in the Emergency Departments – like the elderly are faced with now. This just adds to everyone's health care costs.
Insurance premiums are out of reach for this financial group. As an example, I interviewed a Nurse Practitioner who works for a local health clinic, that provides her with insurance, but the premium for her one child is $450.00 per month! That's $5400.00 per year – a tremendous amount out of someone's salary. Not many people can afford this, & many children go uninsured as a result. Prisoners & people dependant on welfare have more benefits than the average worker or the elderly.
These are all hard working people, who want to provide for their families, & I feel are willing to contribute to the costs health care if it is manageable.
Denali Kid Care is money very well spent.

Thank you;

Jeff Brand, MD
2841 DeBarr Rd. Ste 32
Anchorage, AK 99508
264-1457
3/11/07

March 14, 2007

The Honorable Peggy Wilson, Chair
House Health, Education and Social Services Committee
Alaska State Capitol, Room 403
Juneau, AK 99801-1182

RE: HB 140 (Gara)–Support

Dear Chair Wilson:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health, Education and Social Services Committee to support HB 140, authored by Representative Les Gara.

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

HB 140 will return the Denali KidCare program to the former eligibility levels, index those eligibility parameters to the annual increases in the federal poverty level and, for the first time, allow uninsured families above the 200% FPL to buy into the program. We think this is an excellent plan and should provide comprehensive and preventive health coverage for many more young Alaskans and pregnant women.

AARP members understand how important health insurance is to them; we support the efforts of this bill to provide coverage to other Alaskans who need it.

AARP requests an "AYE" vote on HB 140.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866-227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

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

Thank you for your consideration.

Sincerely,

Marie Darlin

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

CC: Vice-Chair Bob Roses
Representative Anna Fairclough
Representative Mark Neuman
Representative Paul Seaton
Representative Berta Gardner
Representative Sharon Cissna
Representative Les Gara

From: Nicole Thibodeau [mailto:nicole.thibodeau@covhouse.alaska.com]
Sent: Wednesday, March 14, 2007 2:38 PM
To: Rep. Peggy Wilson; Rep. Bob Roses; Rep. Anna Fairclough; Rep. Mark Neuman; Rep. Paul Seaton; Rep. Sharon Cissna; Rep. Berta Gardner
Cc: Rep. Les Gara
Subject: *****SPAM***** Support for HB 140

Dear Members of the House HESS Committee,

Covenant House Alaska urges you to support HB 140. This bill restores funding for DenaliKidCare back to 200% of the Federal Poverty Level, allows the DHSS to charge co-pays to some families who can afford it and allows families to buy into DenaliKidCare. This bill will seriously impact two distinct groups of youth that Covenant House serves.

First, there are kids under 18 whose families cannot afford health insurance, but earn too much to qualify for DenaliKidCare. Many times children from intact families come to Covenant House not as runaways, but because their parents know that Covenant House is able to provide the basic needs; food, shelter and clothing, to these children of parents who have fallen on hard times. These are usually children with working parents whose income is great enough to disqualify them from programs such as DenaliKidCare and Medicaid, but not enough that they can support their children and pay for their basic needs.

Second, there are kids over 18, independent from their families who earn too much at minimum wage jobs to qualify for DenaliKidCare or Medicaid. This describes the majority of kids who are served by Covenant House. These kids earn too much money to qualify for government funded health insurance programs, but do not earn enough to pay for health insurance and their other basic needs expenses.

Health insurance coverage is one of the basic necessities that all children and families need to be secure, healthy and successful. The burden of health insurance and medical costs alone can drive a working family to homelessness. Research shows that children without preventative health care have much higher health risks and are four times more likely to end up in hospital emergency rooms where very expensive bills are incurred, largely at the hospital and the public's expense.

By restoring funding for DenaliKidCare back up to 200% of the Federal Poverty Level and expanding Medicaid eligibility Alaska will be making a valuable investment in its children and families. Please protect Alaska's families and children by supporting HB 140. Feel free to contact me with any questions.

Sincerely,
Nicole Thibodeau

Nicole Thibodeau

Director of Advocacy
Covenant House Alaska
609 F Street
P.O. Box 104640
Anchorage, AK 99510
Tel. 907.339.4205
Fax. 907.272.1466

From: Tom Conley [mailto:prophet@ptialaska.net]
Sent: Wednesday, March 14, 2007 11:41 AM
To: Rep. Les Gara
Subject: HB 140

Dear Les, For the last couple of years the members of the Alaska Chapter of the American
Academy of Pediatrics have been advocating for a resumption of the 200% of poverty guideline for Denali
Kid Care enrollment. While the previous limit was in force access to care fo the medically indigent and many
of the working poor was markedly improved. It is therefore very gratifying to see the introduction of HB 140 which
reinstates the 200% rule and extends "discounted" coverage to those qualifying at 200-350% of the poverty
level. It is truly saddening to see inadequate provision of medical care for children in this country and particularly
in a state like Alaska which is manifestly able to afford providing such coverage. All too often the parents of those
in the captioned income groups are unable to acquire or afford medical insurance but fail to meet the stringent
criteria necessary to qualify for medicaid. Thus their children often fail to receive preventive care in general and
early care when ill thus increasing morbidity and ultimate cost. I would urge you to give serious and favorable
consideration to HB 140 to help solve this growing problem.
Thomas L. Conley, MD, FAAP Sitka Pediatrician

Thanks for sponsoring HB 140; it is much appreciated. Tom Conley, Sitka School Board

From: Phyllis Kiehl [mailto:pkiehl@pol.net]
Sent: Saturday, March 10, 2007 12:27 PM
To: Rep. Les Gara
Subject: Re: HB 140

Thank you so much for sponsoring HB 140, the "No Child Left Uninsurec Act," supporting financial assistance for women's and children's health care coverage. At present, there are too many who cannot afford health care but do not qualify for assistance.

I am a pediatrician in Anchorage, and want to be able to provide care to those who need it, and I know that some people avoid bringing their children into the doctor's office unless they are so sick that they need emergency care. Then they end up in the ER, at increased financial cost and more ill than they might otherwise have been if they had sought care sooner.

I appreciate your support of this legislation.

Phyllis Kiehl, M.D.

STATE OF ALASKA

Sarah Palin, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

Advisory Board on Alcoholism and Drug Abuse
Alaska Mental Health Board

P.O. BOX 110608
JUNEAU, AK 99811-0608
PHONE: (907) 465-8920
FAX: 465-4410

March 14, 2007

RE: HB 140 – Eligibility for Denali KidCare
Testimony to the House HESS Committee by
Angela Salerno, Advocacy Coordinator

The Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse strongly support HB 140 and urge its passage from committee.

- **HB 140 will make health insurance accessible to more children in Alaska.** Alaska has the third lowest DKC eligibility rate in the nation. Combined with a 31% decline in the number of children covered by private health insurance in the last decade, Alaska is taking a costly risk with the health and behavioral health of its children and the well-being of families.

- **DKC covers the majority of children's behavioral health care.** Providing kids with prevention and early intervention behavioral health services are critical to their long-term mental health and the well-being of their families. In addition, access to these services will help control the mounting costs of inpatient psychiatric care.

- **DKC is a good bargain for the State of Alaska.** The federal government covers 70% of the cost of DKC. Also, those families who can afford it will make a meaningful financial contribution towards their children's health coverage.

- **DKC saves the State of Alaska money in the long run.** Children without health care get less preventative care, have much higher health risks and are four times more likely to use expensive emergency room care. Research shows that immunizations, annual visits to a doctor, dental care and screenings for vision, hearing and developmental disabilities are all long-term money savers for the health care system as a whole.

- **DKC saves all Alaskans money.** In 2004, Anchorage hospitals provided almost $89 million in uncompensated care. These costs are passed on to Alaskan business and individuals in higher insurance premiums and out of pocket health care costs.

HB

148

SARAH PALIN
GOVERNOR
GOVERNOR@GOV.STATE.AK.US

P.O. BOX 110001
JUNEAU, ALASKA 99811-0001
(907) 465-3500
FAX (907) 465-3532
WWW.GOV.STATE.AK.US

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

February 20, 2007

The Honorable John Harris
Speaker of the House
Alaska State Legislature
State Capitol, Room 208
Juneau, AK 99801-1182

Dear Speaker Harris:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to the senior care program.

The bill would extend the sunset date of the existing senior care program from June 30, 2007, to June 30, 2012, to allow continuation of program benefits to needy seniors.

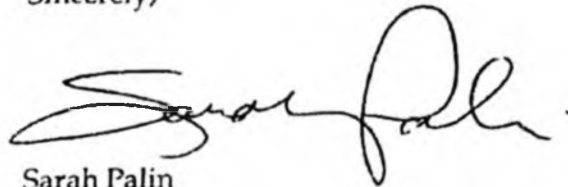
This bill also would make two changes to the eligibility requirements for the program. First, the income limitation would be altered. The current income standards are "frozen" by setting eligibility at a specific monetary amount in state law that was equal to 135 percent of the 2005 federal poverty income guidelines. The 2005 limits have caused some seniors to become ineligible for the program because of cost-of-living adjustments that are made to retirement and pension income, such as Social Security benefits, which are not automatically adjusted under the current statutory language. The change made by the bill would result in income standards that are flexible enough to correspond to changing federal poverty guidelines. Second, the bill would provide that an individual who is receiving a longevity bonus payment would not be eligible for benefits under the senior care program. It is my intent to see the longevity bonus program reinstated in the Fiscal Year 2008 budget for those qualifying seniors who were prematurely cut from the program in the Fiscal Year 2004 budget. However, seniors who qualify for the longevity bonus will have to decide whether to obtain assistance from one or the other program.

The Department of Health and Social Services has found that there is only low-level usage of the prescription drug option, despite extensive outreach efforts encouraging seniors to enroll. Additionally, survey information indicates that many

seniors have other health insurance coverage available. Because of these factors, the bill also would eliminate the prescription drug benefit portion of the program.

The senior care program finances important benefits for needy older Alaskans, to help them meet basic necessities, including food and housing. I urge your prompt and favorable action on this measure.

Sincerely,



Sarah Palin
Governor

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 148
(H) Publish Date: 2/21/07

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: REAUTHORIZE SENIOR CARE
RDU: Public Assistance
Component: SeniorCare

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: GOVERNOR
Component No. 2760

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	(5,377.2)	(5,282.2)	(5,187.1)	(5,090.6)	(4,992.7)	(12,634.8)
Miscellaneous						
TOTAL OPERATING	**(5,377.2)**	**(5,282.2)**	**(5,187.1)**	**(5,090.6)**	**(4,992.7)**	**(12,634.8)**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	(2,994.4)	(2,899.4)	(2,804.3)	(2,707.8)	(2,609.9)	(10,252.0)
1037 GF/Mental Health						
11189 Senior Care	(2,382.8)	(2,382.8)	(2,382.8)	(2,382.8)	(2,382.8)	(2,382.8)
Other(Specify Type-do not abbreviate)						
TOTAL	**(5,377.2)**	**(5,282.2)**	**(5,187.1)**	**(5,090.6)**	**(4,992.7)**	**(12,634.8)**

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: X

POSITIONS

Full-time						
Part-time						
Temporary						

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

The Senior Care program helps low-income seniors over age 65 remain independent in the community by providng an income supplement to help meet their basic needs, such as food and housing. This bill authorizes the continuation of the Senior Care program for an additional five years from July 1, 2007 through June 30, 2012. It eliminates the program's prescription drug benefit, of which there has been very low use, and changes the program's income eligibility standards. Currently, the amount of annual income seniors can have to qualify for the program is limited to 135 percent of the 2005 federal poverty guidelines for Alaska. This bill increases the income limits each year to keep pace with the annual increases in the federal poverty guidelines for Alaska and the modest cost-of-living adjustments given to senior's income such as Social Security retirement benefits.

Prepared by: Ellie Fitzjarrald, Acting Director — Phone 465-5847
Division: Public Assistance — Date/Time 02/12/2007
Approved by: Karleen Jackson, Commissioner — Date 02/20/2007
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE
FN # 1 - HB 148

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Assumptions

* The Alaska Longevity Bonus (ALB) Program will be reopened and funded in FY08. Some seniors who formerly received the ALB will choose to get ALB and not be eligible for Senior Care.
* The income qualifying standards for the Senior Care program will be tied to 135% of the annual Federal Poverty Guidelines for Alaska, which increase each year.
* In FY08, an additional 300 seniors will qualify for Senior Care under the higher income limits.
* 2,303 former ALB recipients will choose to get ALB in FY08, and become ineligible for Senior Care.
* For FY09 through FY12, the number of seniors receiving help from the Senior Care Program will grow at a rate of 1.3%/year (based on 6-year average rate of growth in the old age component of APA program).

FY	Caseload	1.3% Growth	Revised Caseload	Less ALB	Total	Cost Total x 120 x 12
FY08*	7,343		7,343	(2,303)	5,040	$7,257.6
FY09	5,040	66	5,106		5,106	$7,352.6
FY10	5,106	66	5,172		5,172	$7,447.7
FY11	5,172	67	5,239		5,239	$7,544.2
FY12	5,239	68	5,307		5,307	$7,642.1

The FY08 Governor's budget for the Senior Care component grants line is $12,634.8. The projected cost for FY08 with the proposed changes is $7,257.6 (see above), for an anticipated savings of $5,377.2 in FY08. The projected savings in future years is calculated from the FY08 Governor's budget funding level and does not represent additional savings in future years, but rather indicates increasing costs each year due to additional recipients.

Administration

There are no additional administrative costs for operating the Senior Care Program. These costs are included in the Governor's FY08 budget.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB148-DHSS-DPA-REV-03-08-0
Bill Version: HB 148
( ) Publish Date:

Revision Date/Time (Note if correction): March 8, 2007
Dept. Affected: Health & Social Services
Title: REAUTHORIZE SENIOR CARE
RDU: Public Assistance
Component: SeniorCare
Sponsor: (RLS) BY REQUEST OF THE GOVERNOR
Requester: HOUSE (HES)
Component No. 2760

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	308.7	308.7	308.7	308.7	308.7	
Travel	6.5	6.5	6.5	6.5	6.5	
Contractual	126.5	126.5	126.5	126.5	126.5	
Supplies	29.0	29.0	29.0	29.0	29.0	
Equipment						
Land & Structures						
Grants & Claims	10,573.9	10,711.4	10,850.6	10,991.7	11,134.6	
Miscellaneous						
TOTAL OPERATING	**11,044.6**	**11,182.1**	**11,321.3**	**11,462.4**	**11,605.3**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1002 Federal Receipts						
1003 GF Match						
1004 GF	11,044.6	11,182.1	11,321.3	11,462.4	11,605.3	
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**11,044.6**	**11,182.1**	**11,321.3**	**11,462.4**	**11,605.3**	**0.0**

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

POSITIONS	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Full-time	4	4	4	4	4	4
Part-time						
Temporary						

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

This bill authorizes the continuation of the SeniorCare program for an additional five years from July 1, 2007 through June 30, 2012. It continues to provide a cash benefit to eligible seniors age 65 or older. It eliminates the program's prescription drug benefit, which has seen low usage, and changes the program's income eligibility standards. The bill increases the income level to 135% of the federal poverty guideline that is adjusted each year. The current program freezes the income level at 135% of the federal poverty guideline for 2005.

(continued)

Prepared by: Ellie Fitzjarrald, Director — Phone 465-5847
Division: Public Assistance — Date/Time 03/08/2007
Approved by: Karleen Jackson, Commissioner — Date 03/09/2007
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Benefit Costs

This fiscal note assumes the SeniorCare program is reauthorized effective July 1, 2007 and includes the increase in the income limit to 135% of the federal poverty level for 2007. We assume that in the first year 300 additional individuals will become eligible for SeniorCare due to this increase. The table below displays the projected caseload including 1.3% annual growth and cost of benefits.

Caseload Cost Projections for SeniorCare				
FY	Caseload	1.3% Growth	Revised Caseload	Cost Total x 120 x 12
FY08	7343		7343	$10,573.9
FY09	7343	95	7438	$10,711.4
FY10	7438	97	7535	$10,850.6
FY11	7535	98	7633	$10,991.7
FY12	7633	99	7732	$11,134.6

Administrative Costs

We assume that the four positions currently administering the SeniorCare program will continue. They include 1 Administrative Clerk II (Range 8); 2 Eligibility Technician I's (Range 14), and 1 Eligibility Technician III Lead Worker (Range 15). These positions are responsible for the initial and ongoing determination of eligibility, processing claims, and serving as a liaison with the Social Security Administration to facilitate recipient enrollment in Medicare Part D. Below are the costs associated with these positions:

Personal Services (4 positions): $308.7
Travel (to support employee training, marketing, outreach): $6.5
Contractual (for information technology, telecommunication, postage, printing, and building lease costs): $86.5
Additional Contractual to provide outreach to inform seniors of the program's availability and benefits, and to make referrals to other programs as appropriate: $40.0
Supplies (training materials and office supplies): $29.0

All costs will be zeroed out on June 30, 2012 (FY2013) to reflect the sunset of the program.

State of Alaska
DEPARTMENT OF HEALTH & SOCIAL SERVICES

Sarah Palin, Governor

Karleen Jackson
Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

FACT SHEET

Sherry Hill
Communications Officer
/Legislative Liaison
907-465-1618
FAX: 907-465-3068
www.hss.state.ak.us

February 21, 2007

SeniorCare Program

Governor Sarah Palin's 2007 legislation:

- **Extend the SeniorCare program for 5 years:** Governor Palin's legislation will continue the $120 SeniorCare monthly cash supplement for low-income seniors for five years — through June 30, 2012. This provides continued income support to low income seniors and will allow time to evaluate the fiscal impact of SeniorCare, and potentially the continued phase out of the Alaska Longevity Bonus program.

- **Change the income eligibility:** Governor Palin's legislation ties the eligibility to 135 percent of the annual federal poverty income guidelines for Alaska. This would set the program qualifications in 2007 at an income of $17,240 for a single senior and $23,112 for a couple. The asset qualification requirements would remain the same: these seniors can qualify with liquid assets of up to $6,000 for an individual and $9,000 for a couple.

  Currently, the program's eligibility is frozen at 135 percent of the 2005 federal poverty level. The 2005 limits have caused some seniors to become ineligible for the program because of cost of living adjustments that are given to retirement and pension income, such as Social Security benefits.

- **Eligible sen ›‹s will be provided a choice between enrolling in SeniorCare or the Alaska Longevity Bonus:** If seniors receiving SeniorCare previously received the Alaska Longevity Bonus, they will have a choice between receiving SeniorCare or the Alaska Longevity Bonus, should the Longevity Bonus be funded by the Alaska legislature.
  - DHSS estimates that if the Alaska Longevity Bonus program is reinstated, that about 5,000 Alaska seniors will continue to receive SeniorCare, the remainder would choose to receive the Longevity Bonus.

- **End the Prescription Drug Benefit.** The SeniorCare prescription drug payment assistance, which has had very small enrollment, will end. A recent survey by the Department of Health and Social Services found that many seniors have other insurance coverage.

  In January 2006, the SeniorCare program expanded with the Prescription Drug Payment Assistance component aimed at helping qualified seniors pay insurance premiums and deductibles. The program was expected to serve 4,000 seniors but never topped the 200 mark. In December 2006, DHSS surveyed seniors about SeniorCare. The survey found many seniors have other insurance coverage. DHSS estimates one-third of the prescription drug program beneficiaries are former Alaska Longevity Bonus recipients who would be able to reapply for the Alaska Longevity Bonus if it is reinstated.

- more -

SeniorCare History

- In 2003, the SeniorCare program began offering $120 monthly cash assistance to low-income seniors. Last year the SeniorCare Cash program served about 7,000 out of about 45,000 senior Alaskans.

- The current eligibility level for SeniorCare is frozen at 135 percent of 2005 poverty levels ($16,133/single, $17,240/couple). Some seniors have become ineligible for the program as cost-of-living adjustments cause retirement and pension income, such as Social Security benefits, to rise with the federal poverty level.

Contact: Jeff Kasper, (907) 465-8194, Cell (907) 321-3158
Sarana Schell, (907) 269-8041, Cell (907) 240-7462

- ### -

SeniorCare Program Proposal Comparison

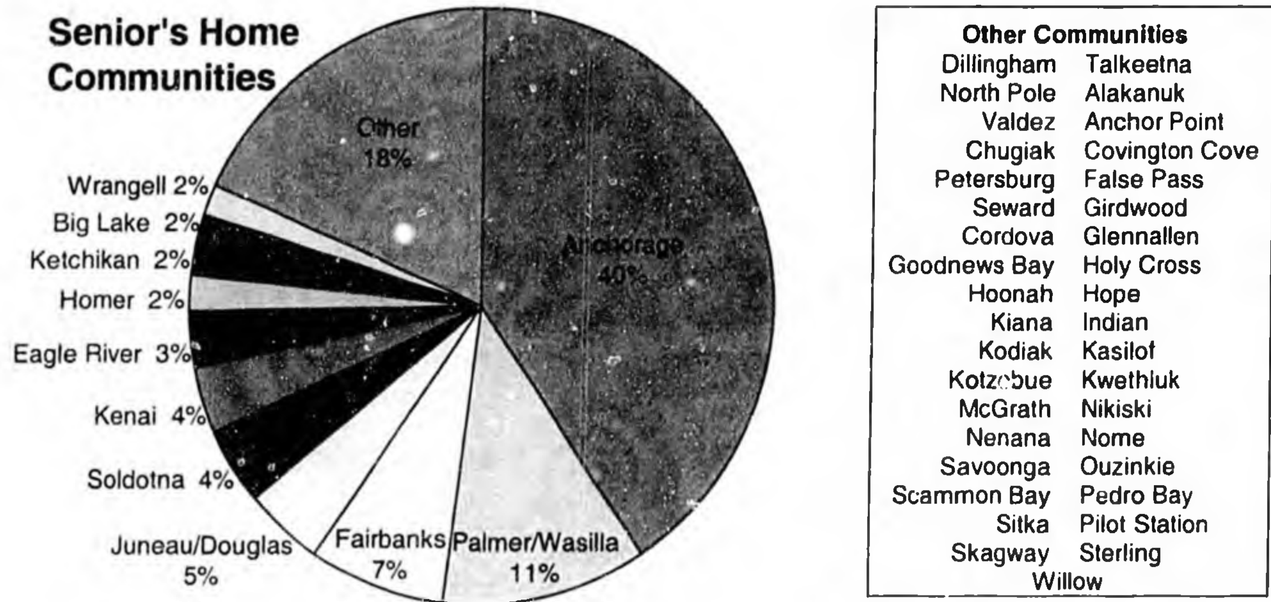
SeniorCare Proposals	Current SeniorCare Program	SB 90/HB 148 Governor's Proposal	SB 4 Senator Olson
Monthly Payment	Cash - $120/month Prescription Drug - $670/year	$120/Month	$150/Month
Annual Income Limit	Cash • $16,133 for individuals • $21,641 for couples (135% of 2005 federal poverty guidelines. Income limits frozen at 2005 levels.) Prescription Drug • $20,913 for individuals • $28,053 for couples (175% of 2005 federal poverty guidelines)	Cash • $17,240 Individual • $23,112 Couple (135% of 2007 federal poverty guidelines. Income limits will increase each year to keep pace with annual increases in federal poverty guidelines for Alaska.) Prescription Drug Benefit Ended	Cash • $16,133 Individual • $21,641 Couple (135% of 2005 federal poverty guidelines. Income limits frozen at 2005 levels.) Prescription Drug Benefit Ended
Dual Eligibility for SeniorCare & AK Longevity Bonus	Yes	No	Is not intended to provide dual eligibility
Projected Average Monthly Caseload in FY08	Cash 7,043 Prescription Drug 140	Cash 5,040	Cash 4,835 – if receipt of ALB and SeniorCare is not allowed
Estimated Benefit Payments for FY08	Cash $10,141.9 Prescription Drug $93.8	Cash $7,257.6	Cash $8,703.0 – if receipt of ALB and SeniorCare is not allowed
Sunset Date	June 30, 2007	Extends program 5 years to June 30, 2012	No expiration date

Updated 2/22/07

- Additionally, the SeniorCare drug program may have served too narrow of a population to be as useful as originally intended and may have been confusing with the concurrent start up of the Medicare Part D program.

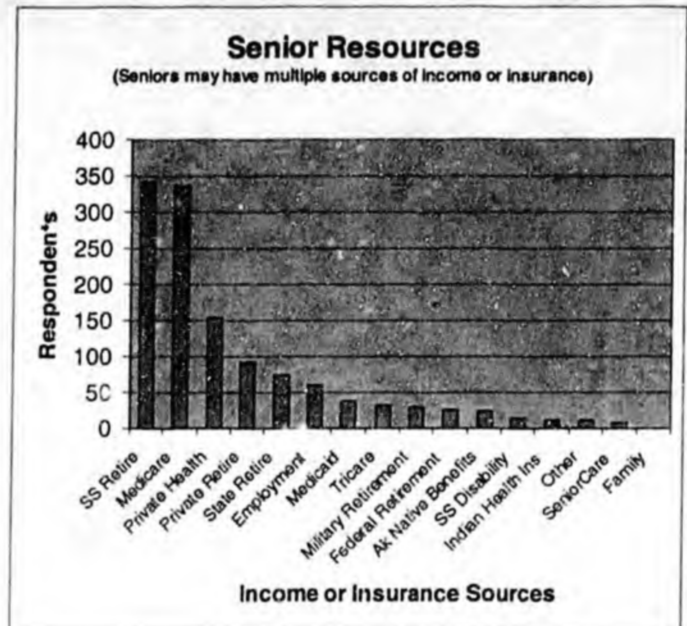
- Lastly, the SeniorCare cash program appears to be very accessible to low income seniors who most need it.

- The following information graphically represents the array of communities represented by Senior citizens that responded to the survey. The chart lists those communities included in the "other" category.

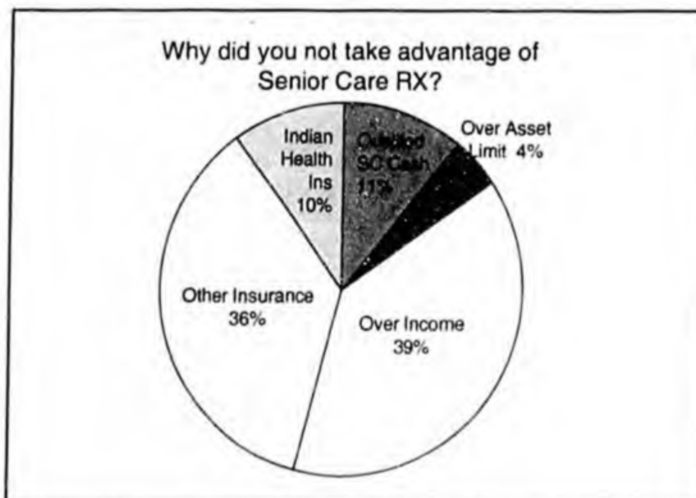


Contact: Sherry Hill, (907) 465-1618, Cell (907) 321-2838
Jeff Kasper, (907) 465-8194, Cell (907) 321-3158

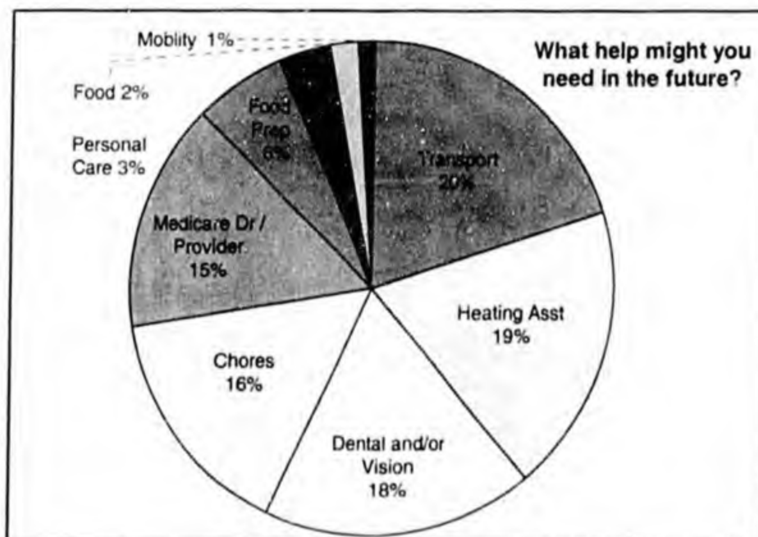
-- More --



- Of the two thirds that had not heard of the program, a surprisingly high 74 percent were employed and/or enjoyed multiple sources of retirement income (Social Security and State, Federal, Military and private retirement).



- While 99 percent of those surveyed had enrolled in the Senior Care drug program, those that responded to this question reported that they were over the income threshold for the program (39 percent), had other drug insurance coverage (36 percent), had Indian Health Service coverage (10 percent), had already qualified for SeniorCare cash (11 percent) or were over the asset limit (4 percent).



- When asked if seniors had inquired about receiving any services in the last two years, a surprising 87 percent said they'd not sought assistance and 87 percent also indicated that they lived near family or friends who could help if needed. 20 percent of respondents indicated a need for transportation assistance, 19 percent were concerned with heating assistance, 18 percent suggested dental and/or vision coverage and 16 percent would like assistance with chores.

- The survey indicates that Alaska's seniors continue to strive to remain independent and would like more services oriented toward continued independence.

-- More --

State of Alaska
DEPARTMENT OF HEALTH & SOCIAL SERVICES
Sarah Palin, Governor

Karleen Jackson
Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601
FACT SHEET

Sherry Hill
Communications Officer
/Legislative Liaison
907-465-1618
FAX: 907-465-3068
www.hss.state.ak.us

January 2007

SeniorCare Survey of Alaska's Seniors

Background

In 2003, the state implemented SeniorCare (cash) program that provides $120 a month to low-income seniors. In January 2006, the program was expanded to include a SeniorCare drug (RX) program to help low income seniors with Medicare Part D premium and deductible payments.

Last year, the SeniorCare cash program was anticipated to serve 7,000 of Alaska's over 40,000 seniors and ultimately served an average of about 7,000 seniors each month. The SeniorCare RX program was anticipated to serve 4,000 seniors but never topped the 200 mark, prompting questions about why the program was not being used. Note that the SeniorCare RX program was launched around the same time as Medicare Part D and the federal ExtraHelp program.

To promote the SeniorCare drug program, DHSS launched two advertising campaigns (Nov. 2005 – Jan. 2006 and Nov. 2006 – Jan. 2007) coupled with extensive outreach programs by SeniorCare office information staff who offered numerous presentations around the state. It is likely that many of the survey respondents were not aware of the program because they also did not participate in Medicare Part D, and therefore did not pay attention to the outreach efforts.

In December 2006 DHSS launched a survey of seniors to glean advice and input on the SeniorCare program, particularly the SeniorCare drug rug program, which had been underutilized based on DHSS estimates. The Department's contractor surveyed 386 Alaskan Seniors, a randomly selected, statistically valid percentage of Alaska's senior population in communities across the state from Kwethluk to Hoonah to the Mat-Su. The survey intentionally excluded those on multiple assistance programs as these seniors.

SeniorCare Survey Outcomes:

- Surveyors commented that seniors frequently expressed their delight at being asked their opinions and appreciation that the administration valued their input.

- Despite a lengt y and comprehensive SeniorCare marketing campaign in 2005 and 2006, only one third of survey participants had heard of the program.

-- More --

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

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

February 22, 2007

Honorable Peggy Wilson, Chair
House Health, Education, and
Social Services Committee
Alaska State Capitol; Rm. 403
Juneau, AK 99801

Dear Representative Wilson,

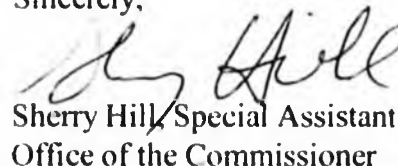
The Department of Health and Social Services respectfully requests a hearing in the House Health, Education, and Social Services Committee on House Bill 148 "An Act relating to the senior care program; and providing for an effective date."

This bill is necessary to extend the senior care program which will otherwise sunset on June 30, 2007. The bill also makes significant changes to eligibility for the program.

A copy of Governor Palin's transmittal letter providing additional information on the bill and the associated fiscal note should be on file with the committee.

Your favorable consideration of this request will be appreciated.

Sincerely,



Sherry Hill, Special Assistant
Office of the Commissioner

cc: John Bitney, Legislative Director
Office of the Governor

Ellie Fitzjarrald, Director
Division of Public Assistance

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
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DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

March 9, 2007

The Honorable Peggy Wilson, Chair
Health, Education and Social Services Committee
House of Representatives
State Capitol, Room 403

Dear Representative Wilson:

The letter is being provided to you in response to your March 6, 2007 request regarding the Senior Care Program.

- ***Please provide the citation for the asset limit for SeniorCare***

The asset limits for the Senior Care Program are not set in state statute. AS 47.45.300 (b) gives the Department the authority to adopt regulations governing administration of the program.

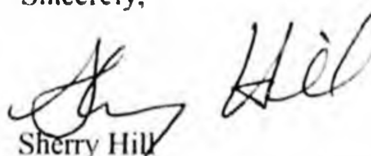
As you are aware, the Senior Care Program has been reauthorized several times. The asset rules for the Senior Care Program were established under the original Alaska Senior Assistance Program and are located in the Alaska Administrative Code at 7 AAC 47.815.

7 AAC 47.815 describes the asset limit for the case benefit as $4,000 for an individual and $6,000 for a couple. The Department has not yet modified the regulations to reflect the 2005 policy decision, and the asset limits in 7 AAC 47.815 do not reflect current policy. The intent of the 2005 Legislature was to increase this asset limit to $6,000 for an individual and $9,000 for a couple, and these higher asset limits are currently being used in determining whether seniors qualify for the cash benefit.

- ***Please provide a revised fiscal note based on HB 148 alone, showing the true costs of the Senior Care Program.***

We are in the process of developing a new fiscal note for HB 148 to reflect the total costs for the Senior Care Program, and removing the assumptions about former Alaska Longevity Bonus recipients. The revised fiscal note should be available by close of business today.

Sincerely,



Sherry Hill
Special Assistant to the Commissioner

cc: Karleen K. Jackson, Ph.D., Commissioner
Janet Clarke, Assistant Commissioner, FMS

Ellie Fitzjarrald, Director, DPA
Representative Roses, Capitol Building, Room 416
Representative Fairclough, Capitol Building, Room 411
Representative Neuman, Capitol Building, Room 432
Representative Seaton, Capitol Building, Room 102
Representative Cissna, Capitol Building, Room 420
Representative Gardner, Capitol Building, Room 422

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB148-DHSS-DPA-REV-03-08-0
Bill Version: HB 148
( ) Publish Date:

Revision Date/Time (Note if correction): March 8, 2007
Dept. Affected: Health & Social Services
Title: REAUTHORIZE SENIOR CARE
RDU: Public Assistance
Component: SeniorCare
Sponsor: (RLS) BY REQUEST OF THE GOVERNOR
Requester: HOUSE (HES)
Component No. 2760

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	308.7	308.7	308.7	308.7	308.7	
Travel	6	6.5	6.5	6.5	6.5	
Contractual	126.5	126.5	126.5	126.5	126.5	
Supplies	29.0	29.0	29.0	29.0	29.0	
Equipment						
Land & Structures						
Grants & Claims	10,573.9	10,711.4	10,850.6	10,991.7	11,134.6	
Miscellaneous						
TOTAL OPERATING	**11,044.6**	**11,182.1**	**11,321.3**	**11,462.4**	**11,605.3**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1002 Federal Receipts						
1003 GF Match						
1004 GF	11,044.6	11,182.1	11,321.3	11,462.4	11,605.3	
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**11,044.6**	**11,182.1**	**11,321.3**	**11,462.4**	**11,605.3**	**0.0**

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Full-time	4	4	4	4	4	4
Part-time						
Temporary						

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

This bill authorizes the continuation of the SeniorCare program for an additional five years from July 1, 2007 through June 30, 2012. It continues to provide a cash benefit to eligible seniors age 65 or older. It eliminates the program's prescription drug benefit, which has seen low usage, and changes the program's income eligibility standards. The bill increases the income level to 135% of the federal poverty guideline that is adjusted each year. The current program freezes the income level at 135% of the federal poverty guideline for 2005.

(continued)

Prepared by: Ellie Fitzjarrald, Director
Phone 465-5847
Division: Public Assistance
Date/Time 03/08/2007
Approved by: Karleen Jackson, Commissioner
Date 03/09/2007
Agency: Department of Health and Social Services

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Benefit Costs

This fiscal note assumes the SeniorCare program is reauthorized effective July 1, 2007 and includes the increase in the income limit to 135% of the federal poverty level for 2007. We assume that in the first year 300 additional individuals will become eligible for SeniorCare due to this increase. The table below displays the projected caseload including 1.3% annual growth and cost of benefits.

Caseload Cost Projections for SeniorCare				
FY	Caseload	1.3% Growth	Revised Caseload	Cost Total x 120 x 12
FY08	7343		7343	$10,573.9
FY09	7343	95	7438	$10,711.4
FY10	7438	97	7535	$10,850.6
FY11	7535	98	7633	$10,991.7
FY12	7633	99	7732	$11,134.6

Administrative Costs

We assume that the four positions currently administering the SeniorCare program will continue. They include 1 Administrative Clerk II (Range 8); 2 Eligibility Technician I's (Range 14), and 1 Eligibility Technician III Lead Worker (Range 15). These positions are responsible for the initial and ongoing determination of eligibility, processing claims, and serving as a liaison with the Social Security Administration to facilitate recipient enrollment in Medicare Part D. Below are the costs associated with these positions:

Personal Services (4 positions): $308.7
Travel (to support employee training, marketing, outreach): $6.5
Contractual (for information technology, telecommunication, postage, printing, and building lease costs): $86.5
Additional Contractual to provide outreach to inform seniors of the program's availability and benefits, and to make referrals to other programs as appropriate: $40.0
Supplies (training materials and office supplies): $29.0

All costs will be zeroed out on June 30, 2012 (FY2013) to reflect the sunset of the program.

HB
157

Chair, Judiciary
Labor & Commerce
Oil & Gas
Military & Veteran Affairs
1292 Sadler Way, Suite 324
Fairbanks, Alaska 99701
Phone: (907) 452-1088
Fax: (907) 452-1146

Alaska State Legislature
House of Representatives

While in Session
State Capitol, Room 118
Juneau, Alaska 99801-1182
(907) 465- 3004
Fax: (907) 465-2070
Toll Free: (877) 465-3004

Representative Jay Ramras
District 10

House Bill 157 Sponsor Statement

"An Act relating to charter school funding."

Charter schools are a valuable alternative form of education for students in Alaska. House Bill 157 supports the development of charter schools across the state by providing for an "incubation" period of two years during which a charter school can establish a strong base of students. Ordinarily a charter school must meet a minimum average daily membership, or ADM, in order to be counted as a separate school and therefore receive full funding by the state. House Bill 157 waives the ADM requirement for the first two years and thus provides full funding to new charter schools who are attempting to establish themselves.

House Bill 157 also lowers the current required ADM for charter schools from 150 students to 100 students. Lowering the ADM will give charter schools that operate in small communities a smaller more attainable goal of enrollment. Currently, if a charter school falls below the minimum ADM, it is counted as the largest school in the district, and therefore receives the lowest level of funding. The results of this cut in funding can be catastrophic.

House Bill 157 supports charter schools and their mission to provide students in Alaska with the best educational opportunity to suit their learning needs. Please join me in supporting charter schools by supporting House Bill 157.

Representative_Jay_Ramras@legis.state.ak.us

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB157-EED-ESS-3-27-07
Bill Version: HB157
() Publish Date:

Revision Date/Time (Note if correction):
Title: An Act relating to charter school funding.
Sponsor: Representative Ramras
Requester: Health, Education & Social Svc, Finance

Dept. Affected: Education & Early Development
RDU: K-12 Support
Component: Foundation Program
Component No. 141

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	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2007) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

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

This would provide a school size adjustment and additional funding for those Charter Schools that have an Average Daily Membership [ADM] of at least 100. In addition, this legislation would allow new charter schools to go through the school size table independently regardless of ADM count for the first two years of service.

The FY2008 Projections do not have any Charter Schools that would qualify for this adjustment. Future years funding cannot be determined because the ADM variables and if there are new Charter Schools are unknown.

Prepared by: Eddy Jeans, Director
Division: School Finance
Phone: 465-8679
Date/Time: 3/27/07 8:10 AM

Approved by: Barbara Thompson, Deputy Commissioner
Agency: Education & Early Development
Date: 3/27/2007

(Revised 9/7/2005 OMB)

Department of Education & Early Development
Prepared 3/27/07

Prepared by School Finance

CHARTER SCHOOLS
FY2008

District	Charter School	FY08 ADM	FY07 ADM
ANCHORAGE	Aquarian Charter	355.00	351.10
ANCHORAGE	Highland Tech Charter	269.00	266.35
MAT-SU	Academy Charter School	228.00	228.00
ANCHORAGE	Alaska Native Charter (*NEW FY08*)	200.00	
KENAI	Kaleidoscope Charter School	196.00	159.00
FAIRBANKS	Star of the North Secondary School (charter)	195.00	194.93
KETCHIKAN	Ketchikan Charter School	190.00	188.90
KENAI	Aurora Borealis Charter (soldotna)	183.00	178.00
MAT-SU	Midnight Sun Charter School	173.00	163.00
ANCHORAGE	Winterberry Charter	165.00	160.25
ANCHORAGE	Eagle Academy Charter	163.00	164.00
KENAI	Soldotna Montessori Charter	159.00	161.00
FAIRBANKS	Chinook Montessori Charter School	155.00	155.00
LOWER KUSKOKWIM	Ayaprun Elitnaurvik Yup'ik Immersion (bethel)	155.00	142.60
ANCHORAGE	Rielke Schule Charter (*NEW FY08*)	151.00	
KETCHIKAN	Tongass School of Arts & Sciences Charter	151.00	151.00
FAIRBANKS	Effie Kokrin Charter	150.00	97.65
KENAI	Fireweed Academy Charter (Homer)	90.00	66.00
JUNEAU	Juneau Community Charter School	68.00	67.65
NOME	Anvil City Science Academy	44.00	43.50

Charter School Statutes

Sec. 14.17.905. Facilities constituting a school.

(a) For purposes of this chapter, the determination of the number of schools in a district is subject to the following:

(1) a community with an ADM of at least 10, but not more than 100, shall be counted as one school;

(2) a community with an ADM of at least 101, but not more than 425, shall be counted as

(A) one elementary school, which includes those students in grades kindergarten through six; and

(B) one secondary school, which includes students in grades seven through 12;

(3) in a community with an ADM of greater than 425, each facility that is administered as a separate school shall be counted as one school, except that each alternative school with an ADM of less than 200 shall be counted as a part of the school in the district with the highest ADM.

(b) Notwithstanding (a)(3) of this section, a charter school shall be counted as a separate school if the charter school has an ADM of at least 150 students.

Sec. 14.17.990. Definitions.

In this chapter, unless the context requires otherwise,

(1) "ADM or average daily membership" means the aggregate number of full-time equivalent students enrolled in a school district during the student count period for which a determination is being made, divided by the actual number of days that school is in session for the student count period for which the determination is being made;

(2) "district" means a city or borough school district or a regional educational attendance area;

(3) "district adjusted ADM" means the number resulting from the calculations under AS 14.17.410 (b)(1);

(4) "district ADM" means the sum of the ADMs in a district;

(5) "eligible federal impact aid" means the amount of federal impact aid received by a district as of March 1 of the fiscal year as a result of an application submitted in the preceding fiscal year, including advance payments and adjustments received since March 1 of the preceding fiscal year from prior year applications, under 20 U.S.C. 7701 - 7714, except payments received under 20 U.S.C. 7703(f)(2)(B), to the extent the state may consider that aid as local resources under federal law;

(6) "local contribution" means appropriations and the value of in-kind services made by a district;

(7) "taxable real and personal property" means all real and personal property taxable under the laws of the state.

Sec. 14.17.450. School size factor.

(a) For purposes of calculating a school's ADM to determine state aid, the ADM of each school in a district shall be computed by applying the following formula:

If the student count The adjusted student count is

in a school is The number of

At least But less than Base Multiplier students in

excess of

10 - 20 39.6

20 - 30 39.6 + (1.62 x 20)

30 - 75 55.8 + (1.49 x 30)

75 - 150 122.85 + (1.27 x 75)

150 - 250 218.1 + (1.08 x 150)

250 - 400 326.1 + (0.97 x 250)

400 - 750 471.6 + (0.92 x 400)

750 or over 793.6 + (0.84 x 750).

(b) If the ADM in a school is less than 10, those students shall be included in the ADM of the school in that district with the lowest ADM as determined by the most recent student count data for that district.

CHARTER SCHOOLS
FY2008

District	Charter School	FY08 ADM	FY07 ADM
ANCHORAGE	Aquarian Charter	355.00	351.10
ANCHORAGE	Highland Tech Charter	269.00	266.35
MAT-SU	Academy Charter School	228.00	228.00
ANCHORAGE	Alaska Native Charter (*NEW FY08*)	200.00	
KENAI	Kaleidoscope Charter School	196.00	159.00
FAIRBANKS	Effie Kokrin Charter	195.00	97.65
KETCHIKAN	Ketchikan Charter School	190.00	188.90
KENAI	Aurora Borealis Charter (soldotna)	183.00	178.00
MAT-SU	Midnight Sun Charter School	173.00	163.00
ANCHORAGE	Winterberry Charter	165.00	160.25
ANCHORAGE	Eagle Academy Charter	163.00	164.00
KENAI	Soldotna Montessori Charter	159.00	161.00
FAIRBANKS	Chinook Montessori Charter School	155.00	155.00
LOWER KUSKOKWIM	Ayaprun Elitnaurvik Yup'ik Immersion (bethel)	155.00	142.60
ANCHORAGE	Rielke Schule Charter (*NEW FY08*)	151.00	
KETCHIKAN	Tongass School of Arts & Sciences Charter	151.00	151.00
FAIRBANKS	Star of the North Secondary School (charter)	150.00	194.93
KENAI	Fireweed Academy Charter (Homer)	90.00	66.00
JUNEAU	Juneau Community Charter School	68.00	67.65
NOME	Anvil City Science Academy	44.00	43.50

CHARTER SCHOOLS
FY2008

District Name/School	
ANCHORAGE	**ADM**
Frontier Charter (Correspond)	n/a
Aquarian Charter	355.00
Family Partnership Charter School (corresp)	n/a
Winterberry Charter	165.00
Eagle Academy Charter	163.00
Highland Tech Charter	269.00
Alaska Native Charter (NEW FY08)	*200.00*
Rielke Schule Charter (NEW FY08)	*151.00*
DELTA GREELY	
Delta Cyber charter School (corresp.)	n/a
FAIRBANKS	
Chinook Montessori Charter School	155.00
Star of the North Secondary School (charter)	150.00
Effie Kokrin Charter	195.00
JUNEAU	
Juneau Community Charter School	68.00
KENAI	
Aurora Borealis Charter (soldotna)	183.00
Kaleidoscope Charter School	196.00
Fireweed Academy Charter (Homer)	90.00
Soldotna Montessori Charter	159.00
KETCHIKAN	
Tongass School of Arts & Sciences Charter	151.00
Ketchikan Charter School	190.00
LOWER KUSKOKWIM	
Ayaprun Elitnaurvik Yup'ik Immersion (bethel)	155.00
MAT-SU	
Academy Charter School	228.00
Midnight Sun Charter School	173.00
Twindley Bridge Charter School (corresp)	n/a
NOME	
Anvil City Science Academy	44.00

TOTAL OF 24 CHARTER SCHOOLS PROJECTED FOR FY2008

Charter Schools

Charter School Contacts

Stacy McKeown - *email*
Program Manager
PH: (907) 465-8689
Fax: (907) 465-2713

Kristina Monson - *email*
Grants Administrator
PH: (907) 465-2930
Fax: (907) 465-6760

Anchorage Schools
Aquarian Charter School
1705 W 32nd Ave
Anchorage, AK 99517
Phone: (907) 742-4900
Fax: (907) 742-4919
Susan Forbes - *email*
School Profile

Anchorage Schools
Eagle Academy Charter School
10901 Mausel St Suite 101
Eagle River, AK 99577
Phone: (907) 742-3025
Fax: (907) 742-3035
Mary Meade - *email*
School Profile

Anchorage Schools
Family Partnership Charter School
401 E Fireweed Lane, Suite 100
Anchorage, AK 99503
Phone: (907) 742-3700
Fax: (907) 742-3710
Reed Whitmore - *email*
School Profile

Anchorage Schools
Frontier Charter School
400 W Northern Lights Blvd, Suite 9
Anchorage, AK 99503
Phone: (907) 742-1180
Fax: (907) 742-1188
Tim Scott - *email*
School Profile

Anchorage Schools
Highland Tech High
5530 E Northern Lights, Suite 1
Anchorage, AK 99504
Phone: (907) 742-1700
Fax: (907) 742-1711
Mark Standley - *email*
School Profile

Anchorage Schools
Winterberry Public School
508 W 2nd Ave
Anchorage, AK 99501
Phone: (907) 742-4980
Fax: (907) 742-4985
Shanna Mall - *email*
School Profile

Delta-Greely Schools
Delta Cyber Charter School
PO Box 1672
Delta Junction, AK 99737
Phone: (907) 895-1043, 877-895-1043
Fax: (907) 895-5[illegible]08
Michael Opp - *email*
School Profile

Fairbanks North Star Borough Schools
Chinook Montessori Charter School
3002 International Street
Fairbanks, AK 99701
Phone: (907) 452-5020
Fax: (907) 452-5048
Barb Smith - *email*
School Profile

Fairbanks North Star Borough Schools
Effie Kokrine Charter School
601 Loftus Road
Fairbanks, AK 99709
Phone: (907) 474-0958
Fax: (907) 479-2104
Eleanor Laughlin - *email*
School Profile

Fairbanks North Star Borough Schools
Star of the North Secondary School
29[illegible]5 Monk Court
North Pole, AK 99705
Phone: (907) 490-9025
Fax: (907) 490-9021
Annemarie Keep-Barnes - *email*
School Profile

Juneau Borough Schools
Juneau Community Charter School
10014 Crazy Horse Dr
Juneau, AK 99801
Phone: (907) 586-2526
Fax: (907) 586-3543
Carol Valentine - *email*
School Profile

Kenai Peninsula Borough Schools
Aurora Borealis Charter School
705 Frontage Rd, Suite A
Kenai, AK 99611
Phone: (907) 283-0292
Fax: (907) 283-0293
Larry Nauta - *email*
School Profile

Kenai Peninsula Borough Schools
Fireweed Academy
PO Box 474
Homer, AK 99603
Phone: (907) 235-9728
Fax: (907) 235-8561
Kiki Abrahamson - *email*
School Profile

Kenai Peninsula Borough Schools
Kaleidoscope School of Arts & Sciences
549 N Forest Dr
Kenai, AK 99611
Phone: (907) 283-0804
Fax: (907) 283-3786
Mick Wykis - *email*
School Profile

Kenai Peninsula Borough Schools
Soldotna Montessori Charter School
16[illegible] Park Street
Soldotna, AK 99669
Phone: (907) 260-9221
Fax: (907) 260-9032
Mary Jo Sanders - *email*
School Profile

Ketchikan Gateway Borough Schools
Ketchikan Charter School
410 Schoenbar Road
Ketchikan, AK 99901
Phone: (907) 225-8568
Fax: (907) 247-8568
Margaret Spink - *email*
School Profile

Ketchikan Gateway Borough Schools
Tongass School of Arts & Sciences
410 Schoenbar Rd, Suite 202
Ketchikan, AK 99901
Phone: (907) 225-5720
Fax: (907) 225-8822
Karla Miller - *email*
School Profile

Lower Kuskokwim Schools
Ayaprun Elitnaurvik
PO Box 1468
Bethel, AK 99559
Phone: (907) 543-1645
Fax: (907) 543-1647
Agatha John-Shields - *email*
School Profile

Mat-Su Borough Schools
Academy Charter School
801 East Arctic
Palmer, AK 99645
Phone: (907) 746-2358
Fax: (907) 746-2368
Barbara Gerard - *email*

Mat-Su Borough Schools
Midnight Sun Family Learning Center
7362 W Parks #714
Wasilla, AK 99654
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George Hronkin - *email*

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School Profile	School Profile	School Profile
Nome Public Schools **Anvil City Science Academy** PO Box 131 Nome, AK 99762 Phone: (907) 443-6207 Fax: (907) 443-5144 **Todd Hindman** - *email* **School Profile**	**Yukon-Koyukuk Schools** **Alyeska Central School** 3141 Channel Drive #100 Juneau, AK 99801 Phone: (907) 888-290-3752, 586-1566 Fax: (907) 586-8106 **Patrick Doyle** - *email* **School Profile**	

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Charter Schools in Alaska

Alaska Department of
EDUCATION
& EARLY DEVELOPMENT

Questions and Answers about Charter Schools

A summary:

The Alaska Legislature passed the Charter School Act in 1995. Governor Knowles signed the bill into law. House Bill 101 amended the existing Alaska statute for charter schools and was signed into law July 1, 2001. The major changes of the amendment are: length of charter was changed to a maximum of ten (10) years, total number of allowable charter schools to operate within the state set at 60, and the geographical restrictions on number of total schools per region or district was dropped.

Both the local school board and the State Board of Education must approve a charter school application before the school can begin operation. If a local school board denies an application, there is no appeal to a higher authority.

Q: How many charter schools can operate in Alaska?
A: The Legislature allowed for the creation of up to 60 charter schools statewide with no geographical restrictions.

Q: Are charter school personnel subject to the school district's labor agreements?
A: Charter school teachers and other employees are subject to the same collective bargaining agreements of the school district in which the charter school operates. The only exception is when the district and the bargaining unit representing a teacher or other employee agree to an exemption.

Q: What are the possibilities for waivers from state regulations?
A: Regulation 4 AAC 03.091 allows local school boards to seek waivers from certain state regulations. Not allowed are waivers to regulations that are required by a specific state or federal law or a regulation necessary to assure health and safety standards. The request to waive a regulation needs to come from the local school board and be approved by the State Board of Education.

Q: Have schools been able to waive the standardized achievement test requirements?
A: Student testing is required by state regulation, not by statute, except the High School Graduation Requirement Exam, which is state statute. Waivers are allowed, under specified circumstances.

Q: Can a charter school require local school districts to charge students and parents for such items as uniforms, lab fees, transportation fees and textbooks?
A: We know of no law prohibiting school districts from setting and collecting these fees. Note, however, that AS 14.03.080, which entitles school age children to a

public education without tuition, must be considered.

Q: Can the school district disallow a student, particularly a special education student, from enrolling in a charter school if the school believes the student will not benefit from the educational style or methods used?
A: A charter school may be designed to serve two broad categories of students: (1) students within an age group or grade level, or (2) students who will benefit from a particular teaching method or curriculum. These are very broad criteria that can be further defined in the charter school contract. Civil rights laws disfavor discrimination against students with disabilities.

Q: Can a charter school be a statewide program, such as a correspondence school, or a boarding school specializing in technology, math or science?
A: Yes. Nothing in the Charter School Act prohibits these types of charter schools. However, the local school board that starts a boarding charter school would have to provide funding for the boarding part of the operation as well as the academic program.

Q: Could a year round school-without-walls, community-based education program be a charter school?
A: Yes.

Q: Can a school-within-school program be a charter school?
A: Yes. A charter school can be operated in an existing school district facility or in a facility not currently being used as a public school. The only stipulation set by the Charter School Act is that the school superintendent must determine that the facility meets standards for health and safety.

Q: Do charter school teachers have to come from a school district's approved hire list?
A: The state does not require school districts to maintain a hire list. For those that do, this is a local decision.

Q: How does a charter school get its funding?
A: Funding for a charter school will be not less than the amount generated by the students enrolled in the charter school. That amount will be determined in the same manner as it would be for a student enrolled in another public school in the same school district.

Q: Can the school district keep any of the funding generated by the charter school to pay for services that the school district's central office provides the charter school?
A: Yes, but only an amount determined by the Department of Education and only for indirect (overhead) costs.

Q: Is the district liable for any accidents that may happen to students or staff in a charter school?
A: Charter schools are public schools. A school district is liable for a charter school to the extent that it is liable for other public schools in its jurisdiction.

Q: Who would have the authority to expel students?
A: Under 4 AAC 06.060, a superintendent or principal may suspend a student from school, but only the local school board may expel a student.

Q: What happens when the district cannot negotiate exceptions to the collective bargaining agreement for charter school teachers? Is there a waiver for that?
A: Teachers in a charter school are subject to the district's negotiated agreement unless the district and the teacher's bargaining unit agree otherwise. The act provides no waiver to this provision.

Q: Who evaluates the charter school teachers? Is it the charter school principal, the central office administrators, or both?
A: Charter school teachers need to be evaluated in an equivalent manner as all other teachers in the district. However, in a charter school that does not employ a principal, the district, in cooperation with the charter school, will designate a school district administrator to conduct the evaluation.

Q: Who hires the charter school principal?
A: The principal is hired by the charter school's academic policy committee. The charter school principal selects, appoints and supervises charter school employees. Remember, the Charter School Act does not require a charter school to have a principal. Other administrative structures are allowed.

Q: Who evaluates the charter school principal?
A: Assuming the charter school hires a principal, the academic policy committee is responsible for conducting the evaluation.

Q: Does the school superintendent have the authority to fire the principal?
A: The Charter School Act gives the authority to hire a principal to the academic policy committee. The authority to hire brings with it the authority to fire.

Q: Can the local school board close the charter school.
A: Yes. The charter school contract must contain a clause that allows the local school board to terminate the contract if the charter school fails to meet its educational or financial goals or for other good cause.

Q: Will the district assume tenure responsibility for the charter school teacher?
A: To the extent required by state law, yes.

Q: Can an existing public school use the Charter School Act to secede from a school district?
A: No. A charter school is a public school and operates under contract to the local school board.

Q: Can a school district with a single site use the Charter School Act to secede from Alaska's education system?
A: No. A single site school district can use the Charter School Act to meet the needs of its students. A contract must be worked out between the school board and the charter school. A community conceivably could support a charter school idea that is a radical departure from what is currently offered in public schools. However, the district still would be responsible for educating students who do not choose to attend the charter school.

Q: How are students selected for charter schools?

A: A charter school can be designated to serve students within a certain age group or grade level and students who will benefit from a particular teaching method or curriculum. The charter school and local school board need to define the age groups or grade levels and who will benefit from the program. All eligible students may apply to the charter school.

Q: What happens if the number of students who apply exceeds the charter school's capacity to serve them?
A: If the number of applications exceeds the charter school's capacity, then the school and local school board need to try to find additional space and teachers to accommodate the students. Failing that, students are selected by random drawing in a lottery.

Q: Does a charter school discriminate de facto against minority students because access to the school would be impossible for some due to distance and other geographical barriers? Would it have to provide a boarding school?
A: No. Alaska Statute 14.03.080(a) entitles every child of school age to attend a public school within the school district boundaries in which the child is a resident. The State of Alaska does not provide funding to any school district to offer a boarding school, nor is any school district required to offer a boarding option.

Q: Can a local school board require that a charter school principal have a "Type B" Administrative Certificate?
A: The local school board may set a standard requiring such employees to possess a Type B administrator certificate.

Q: What about the timing of charter school approval by a local school board? Will funds be available in mid year, or should the charter school wait until the beginning of the next year to start up?
A: Fiscally, it would be much more advantageous for the charter school to wait until the beginning of the next school year to start up. The ADM (average daily membership) is officially done the first 20 school days in October and the foundation formula funding is based on these ADM figures.

Q: Can religious schools be charter schools?
A: The Charter School Act requires a charter school to be nonsectarian. This is the same rule that applies to all public schools.

Q: Will the state provide additional funding to a school district that starts a charter school?
A: No, House Bill 101, the "Charter School Grant Program" AS 14.03.263, has been repealed.

Q: Must charter schools maintain the same records for students and staff required of regular public schools?
A: The charter school must keep the records specified in the Charter School Act. If not otherwise required by the state or federal government, other records required of regular schools may be waived by the local school board. The charter school is subject to the same auditing requirements as regular public schools.

Q: Where can someone interested in starting a charter school get an application?

A: The state application is available on-line at
http://www.eed.state.ak.us/forms/forms1.html#charterschools
and is called: "Charter Schools Application." This application follows Alaska Charter School Statutes AS 14.03.250-290 and state regulations 4 AAC 33.110.

District applications can be obtained from local school district central offices.

Do you have a comment or a question that was not answered here? Please **E-mail the Webmaster**

Return to the Alaska Department of Education home page

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT

520 Fifth Avenue Fairbanks, Alaska 99701-4756 (907) 452-2000
www.northstar.k12.ak.us

March 1, 2007

The Honorable Jay Ramras
House of Representatives
State Capitol, Room 104
Juneau, AK 99801-1182

Dear Representative Ramras:

It is a pleasure to support HB 157 "An Act Relating to Charter School Funding." The enactment of this bill will greatly benefit school districts and ultimately our students. Allowing charter schools two years to build capacity will make a significant difference in their success. As with a business, it usually takes at least two years to build a viable program.

Changing the separate school ADM requirement from 150 to 100 will allow school districts to provide more alternatives for our students. With this change, unique specialized programs will have a better opportunity to flourish. The 150-student requirement created a catastrophic funding threshold for some worthwhile charter schools.

Thank you for introducing this beneficial legislation. Thank you for your dedicated service to our community.

Sincerely,

Ann Shortt, Ed.D.,
Superintendent of Schools

F•N•A
Fairbanks Native Association

March 2, 2007

Representative Jay Ramras
State Capitol, Room 118
Juneau, Alaska 99801-1182

Dear Representative Ramras,

I am writing to thank you for introducing HB 157, an "act relating to charter school funding." As you know, Fairbanks Native Association (FNA) is the legal financial sponsor of the Effie Kokrine Charter School here in Fairbanks. As such, FNA has an obvious vested interest in the school's continuing success. But beyond the administrative level, we have a deeper, more vital interest in insuring the educational success of all Alaska's children. HB 157, by recognizing that funding for a charter school based on 100 students is a more realistic and sustainable number than the current requirement of 150 students, will help our children achieve that success.

In Fairbanks, where three of the 23 charter schools in Alaska are located, we see first hand the value charter schools offer parents as they search for the best educational opportunity to meet their children's needs. We see an atmosphere where children are safe, where students thrive and academic success is an integral part of the school's daily culture. At Effie Kokrine we also see a new, unique program that pairs that academic success with Native culture and provides a welcome, respectful, and exciting model to the community.

At the same time, new programs and new ideas, important though they are, can be difficult to establish. HB 157 recognizes that situation and allows new charter schools two years to meet the 100 student threshold. After two years, with enrollment at 100 students or greater and funding levels set to the small school standard, charter schools will be able to hire teachers, provide infrastructure, purchase instructional material and provide support staff to best meet the needs and challenges of all Alaska's students.

Thank you again for introducing HB 157 and for your support for educational choice, and charter schools in Alaska.

Sincerely,

Shirley L. Lee
Executive Director

cc: Dr. Ann Shortt, Superintendent, Fairbanks North Star Borough School District
Eleanor Laughlin, Principal, Effie Kokrine Charter School
FNA Education Committee

201 First Avenue, Suite 200 ♦ Fairbanks, AK 99701 ♦ (907) 452-1648 Fax 456-4148

Emily Stancliff

From: Sharon McConnell Gillis [gilliss@doyon.com]
Sent: Thursday, March 01, 2007 9:43 AM
To: Rep. Jay Ramras
Subject: HB 157 Charter Schools

Good Morning Jay:

As the Executive Director of Doyon Foundation I want to thank you for introducing HB 157 which would assist Charter Schools. Doyon Foundation was honored to be one of the organizations that established the Effie Kokrine Charter School in Fairbanks and we are hopeful that the bill will pass. Schools like Effie are unique and need time to get established. We appreciate your work on this matter.

Sincerely,

Sharon McConnell Gillis

Executive Director

Doyon Foundation

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907-459-2050

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www.doyonfoundation.com

Emily Stancliff

From: Stephanie Allison [slacpa@acsalaska.net]
Sent: Thursday, March 01, 2007 2:07 PM
To: Rep. Jay Ramras
Subject: *****SPAM***** HB 157

Representative Ramras,

I'm very interested in HB 157. As a Montessori parent I believe the Montessori program in Juneau would function better as a charter, however it is difficult to "grow" the program to 150 ADM within the school district, since the district has MANY other priorities.

I'd be happy to provide testimony on the benefits of smaller learning communities, as a parent and as a representative of Great Alaska Schools (AKA Alaska Kids Count).

Thank you for your time,

Stephanie L. Allison, CPA
slacpa@acsalaska.net
723-3092 (wk)s
790-6407 (fax)