

ALASKA LEGISLATURE COMMITTEE FILES

2007-2008

SHES

12

A. ANALYSIS OF PUBLIC NEED D

The following analyses of State Medical Board (board) activities relate to the public-need factors defined in the sunset review law at AS 44.66.050(c). These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

Determine the extent to which the board, commission, or program has operated in the public interest.

The State Medical Board, through regulation of the licensure of medical professionals, has provided the public with qualified professionals in the field of medicine. To promote continued competence, all licensees must provide proof of continuing education for license renewal and each licensee is subject to a continuing education audit.

The board adopted or revised regulations regarding professional conduct and ethical standards, professional licensure, and educational requirements. The board has issued licenses in a uniform manner and held required meetings.

Determine the extent to which the board, commission, or agency has recommended statutory changes that are generally of benefit to the public interest.

During the review period, the board continually reviewed statutes and regulations for necessary changes. No changes to statutes governing the medical board were made during the review period. The board did, however, support passage of Ch 40, SLA 2005, Sec. 2 (AS 09.55.549) which limits liability on malpractice claims.

Determine the extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service that it has provided.

The locations, dates, and times of upcoming board meetings and proposed changes in regulations were published in the *Anchorage Daily News*, as well as posted on the board's website. Adequate time was provided for interested individuals to plan to attend or to submit written comment for review.

Determine the extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices that it has adopted, and any other matter, including budgetary, resource, and personnel matters.

The board submitted annual reports for FY 03 through FY 06 in a timely manner. Additionally, the board has a financial surplus at the end of FY 06. See Exhibit 1 for details.

Exhibit 1

State Medical Board				
Schedule of License Revenues and Board Expenditures				
FY 03 - FY 06				
(Unaudited)				
	FY 06	FY 05	FY 04	FY 03
Revenue	\$405,691	\$1,818,123	\$331,850	\$1,630,349
Direct Expenses				
Personal Services	416,838	416,568	446,749	429,996
Travel	32,060	30,658	30,934	38,269
Contractual	275,050	214,586	146,593	282,043
Supplies	4,435	6,489	4,361	5,354
Equipment	-	-	-	120
Total Direct Expenses	<u>728,383</u>	<u>668,301</u>	<u>628,637</u>	<u>755,782</u>
Indirect Expense	<u>170,600</u>	<u>161,019</u>	<u>146,809</u>	<u>140,633</u>
Total Expenses	<u>898,983</u>	<u>829,320</u>	<u>775,446</u>	<u>896,415</u>
Annual Surplus (Deficit)	<u>(493,292)</u>	<u>988,803</u>	<u>(443,596)</u>	<u>733,934</u>
Beginning Cumulative Surplus (Deficit)	<u>1,087,979</u>	<u>99,176</u>	<u>542,434</u>	<u>(191,500)</u>
Unallocated Administrative Indirect Revenue	-	-	338	-
Ending Cumulative Surplus (Deficit)	<u>\$ 594,687</u>	<u>\$1,087,979</u>	<u>\$ 99,176</u>	<u>\$ 542,434</u>

The Division of Corporations, Business, and Professional Licensing (division), with input from the board, sets fees based on a two-year cycle, with the majority of the revenue collected in odd-numbered fiscal years. Based upon the financial data presented in Exhibit 1, licensing fees may need to be decreased during the next licensing period.

For multiple licensing periods, revenues have steadily risen while expenditures have remained relatively stable. These two factors combined with an increase in the number of

licensees, present the likelihood that the cumulative surplus will continue to grow in future years. Given this likely scenario, the division and the board should closely review licensing fees to ensure occupational fees are sufficiently set to avoid an operational surplus.

Determine the extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.

Public notices of proposed regulations are published in the *Anchorage Daily News* and the State of Alaska's Online Public Notice System. The board meeting minutes show that unlimited time was allotted for the scheduled public comment period. All proposed regulation changes are subject to the public participation process.

Determine the efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims' rights or the office of the ombudsman have been processed and resolved.

For the period July 2002 through June 2006, the division opened 337 investigative cases related to individuals either seeking licensure or licensed by the State Medical Board.

Approximately 43% of the cases involved complaints made by patients or other individuals of the public. Another 30% were initiated by occupational licensing staff. Board actions taken during the audit period included, but were not limited to those identified in Exhibit 2.

Exhibit 2

Discipline or Other Actions	2003	2004	2005	2006	Total
Audit Compliance	-0-	2	-0-	3	5
Education	-0-	-0-	1	-0-	1
Fine	11	14	12	14	51
Limited License ²	-0-	3	-0-	4	7
Probation	5	3	1	2	11
Reprimand	6	15	8	12	41
Revocation	-0-	3	1	-0-	4
Suspension	<u>3</u>	<u>2</u>	<u>4</u>	<u>2</u>	<u>11</u>
Total	25	42	27	37	131

The types of complaints filed included, but were not limited to:

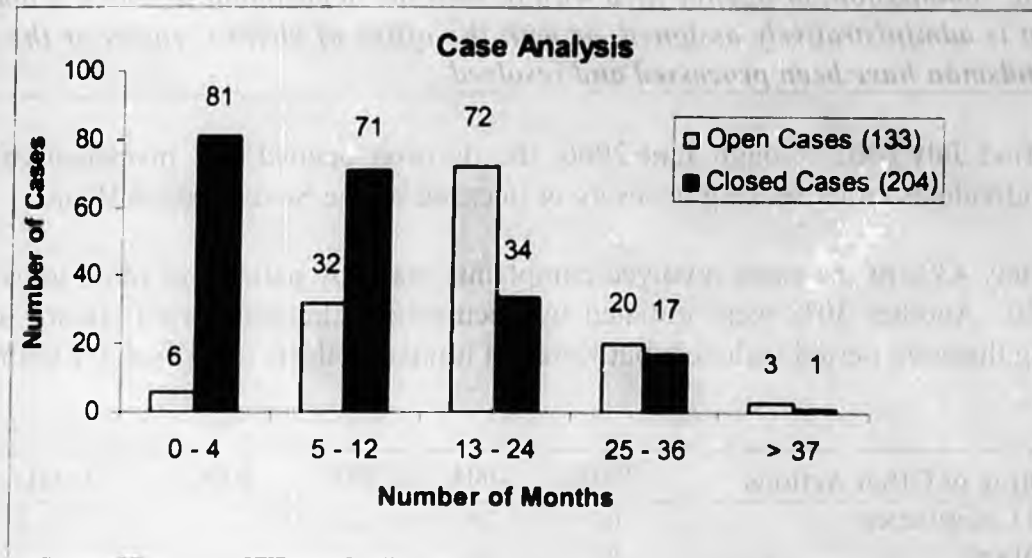
- Prescriptive practice (77)
- Negligence (71)
- Other (22)
- License application problem (20)

² License limitations may be self-imposed and, therefore, do not necessarily reflect board imposed restrictions.

- Continuing education requirements (17)
- Sexual misconduct (15)
- Falsified application (14)
- Incompetence (13)
- Patient/client abuse (15)
- Action in another state (12)
- Unlicensed practice (12)

Two hundred four (204) of the 337 investigative cases had closed as of June 30, 2006; 133 remained open. The cases are graphically depicted below.

Exhibit 3



During the review period, investigative cases remained open for longer periods of time when compared to the prior sunset audit. While the number of investigations that opened and closed did not change significantly between the prior and current audit periods,³ the length of time, or the age, of investigative cases open at the end of FY 06 was substantially different.

In the prior audit, 121 or 29% of cases remained open at the end of the review period. Of those cases, 74% had opened within the prior four months; the remaining 26% were open for a period of time exceeding four months.

The 133 open investigations at the end of FY 06 shows only 5% were opened in the prior four months; the remaining 95% were open for periods of time exceeding four months.

³ In the prior audit, 413 investigative cases were opened. Two hundred ninety-two (292) closed within the audit period; 121 remained open. Comparatively, in the current period 337 investigative cases were opened. Two hundred four (204) closed within the audit period; 133 remained open.

Further, 71% were open for longer than one year.⁴

Several factors likely contributed to the lengthy investigations in the current audit period. Specifically, multiple ongoing high profile cases which may involve litigation, implementation of a panel review process⁵ for standard-of-care cases⁶, high employee turnover, and investigator training have slowed case processing times. Individually, these factors may not have significantly slowed the investigative process; however, collectively, their impact is notable.

We have reviewed the nature and extent of complaints filed involving medical professionals. The division, in conjunction with the board, prioritized complaints in a reasonable manner. We have concern with the increase in the number of investigations that are staying open for longer periods of time. We believe the division should report to the board regarding the length of investigations to help ensure the complaints are being investigated in an efficient and timely manner.

No complaints or investigations specifically involving the actions and activities of the State Medical Board were received, or undertaken by, either the Office of the Ombudsman or the Office of Victims' Rights within the past four fiscal years.

Determine the extent to which a board or commission that regulates entry into an occupation or profession has presented qualified applicants to serve the public.

The application process for licensing appears reasonable and appropriate. The licensing process is neither unduly restrictive nor too lax. Exhibit 4 below, summarized new licenses and permits issued by the board for FY 03 through FY 06 as well as the current number of license and permit holders at the end of FY 06.

Exhibit 4

License or Permit Type	New Licenses and Permits Issued (exclusive of renewals)				Current Number of Licensees (as of June 30, 2006)
	FY 03	FY 04	FY 05	FY 06	
Physicians	235	192	237	212	2,604
Osteopaths	16	16	23	22	205
Podiatrists	1	1	2	1	21
Paramedics	36	35	42	48	334
Physician Assistants	24	34	45	37	<u>361</u>
Total					3,525

⁴ Typically in high-profile cases numerous complaints are filed against an individual. At the end of the audit period, there were more than 59 open cases related to two physicians; 43 cases have been open longer than one year.

⁵ The two-member panel review is composed of medical professionals serving on the board. Panel members are rotated monthly.

⁶ Standard-of-care is defined as the level of care, skill, and treatment which is recognized as acceptable and appropriate by reasonably prudent similar healthcare providers under similar circumstances.

Continuing medical education is required and adequately monitored by the board to promote a high level of quality performance and to help ensure the integrity of the profession. In FY 03, the continuing medical education requirement increased from 17 to 25 hours for licensing periods beginning after January 1, 2005.

Each applicant is required to satisfy the requirements for licensing. Meeting minutes reflect that the board considers each application and verifies the licensing requirements are satisfied prior to issuing a license.

Determine the extent to which state personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.

We did not find any evidence that the board was not complying with the state personnel practices, including affirmative action, in qualifying applicants. Each time the board has denied an applicant a license, the reason has been based on requirements set out in statute and regulation. The reasons for denials are stated in writing and the applicant is always informed of their rights, and the process to contest or appeal any denial of licensure.

Determine the extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interests of the public and to comply with the factors enumerated in this subsection.

Regulatory revision to 12 AAC 40.020(a) is necessary to clarify the current exam process. The regulation states the "...written examination administered twice yearly in Alaska..." does not reflect the current practice. The board has contracted with the Federation of State Medical Boards (FSMB) to administer the computerized United States Medical Licensing Examination which is available year-round at specific test sites. See Recommendation No. 1.

The board continues to be active in recommending regulatory changes, in order to better service the interest of both the public and the profession.

Determine the extent to which the board, commission, or agency has effectively attained its objectives and purposes and the efficiency with which the board, commission, or agency has operated.

Broad objectives identified by the board included:

- Continue to provide timely, complete processing of all applications submitted to the board for licensure.
- Respond promptly, objectively, and decisively to all complaints.
- Act upon disciplinary matters swiftly and in accordance with the law after obtaining complete and detailed investigation reports and advice from the Assistant Attorneys General.

- Review, draft and pursue regulatory changes in order to more clearly define existing law and to establish clear, concise requirements for applicants and practitioners.
- Maintain a presence in national organizations important to the function of the medical board.
- Send one voting delegate, one other board member, and the board's administrator to the annual FSMB conference.

The board establishes and meets its operational objectives annually.

Determine the extent to which the board, commission, or agency duplicates the activities of another governmental agency or the private sector.

The board is tasked with licensing physicians, osteopaths, podiatrists, physician assistants, and intensive care paramedics. Our review of the interactions among the State Medical Board, the Alaska State Medical Association, the American Medical Association, and other national organizations showed no overlap of duties. Licensees are not required to be members of any professional organization.

- Review, draft and pursue regulatory changes in order to provide timely funding for the law and to establish clear, concise requirements for the board and the board's staff.
- Maintain a presence in relevant organizations and forums to ensure the board's interests are represented.
- Provide strategic advice and oversight to the board and the board's staff.

The board continues to address the operational objectives outlined below.

To ensure the board's ability to fulfill its mission, the board has established the following as its primary objectives:

The board is tasked with ensuring the board's operations are efficient and effective. The board is also responsible for ensuring the board's financial health and for ensuring the board's compliance with applicable laws and regulations. The board is also responsible for ensuring the board's reputation and for ensuring the board's transparency and accountability. The board is also responsible for ensuring the board's communication and for ensuring the board's public relations. The board is also responsible for ensuring the board's human resources and for ensuring the board's information technology. The board is also responsible for ensuring the board's legal and risk management. The board is also responsible for ensuring the board's ethics and for ensuring the board's governance. The board is also responsible for ensuring the board's overall performance and for ensuring the board's success.

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DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

Sarah Palin, Governor
William C. Noll, Commissioner
Rick Urien, Director

December 8, 2006

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DEC 11 2006

LEGISLATIVE AUDIT

Ms. Pat Davidson
Legislative Auditor
Legislative Budget and Audit Committee
Division of Legislative Audit
PO Box 113300
Juneau, Alaska 99811-3300

Dear Ms. Davidson,

RE: Sunset Review Audit, State Medical Board

Dear Ms. Davidson:

Thank you for the opportunity to comment on your preliminary audit findings concerning the Alaska State Medical Board. The department concurs with your findings and fully supports extension of the State Medical Board to June 30, 2013.

As mentioned in the earlier Management Letter No. 1, the department will encourage and assist the Board to comply with your Recommendation No. 1 to update its regulation 12 AAC 40.020(a) reflecting the current practice of computerized examinations offered by the Federation of State Medical Boards (FSMB).

We also appreciate your comments in paragraph 1 on page 13 recognizing that several factors contribute toward lengthy investigations. We also want to clarify that several of the investigative cases which appear to be "open" have already completed the investigation stage and remain open because of litigation. We feel it is important to note the distinction of these open cases. The Investigations Unit has no control over cases once it enters the litigation process.

Again, we appreciate the opportunity to comment on your audit findings.

Sincerely,


William C. Noll
Commissioner



February 1, 1988

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COMMUNITY AND ECONOMIC DEVELOPMENT

Mr. [Name]
[Address]
Juneau, Alaska 99801

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21. [Name]
[Address]

[Faint, illegible text, likely a letter or report body]

[Handwritten signature and name]



DEPARTMENT OF
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LEGISLATIVE AUDIT

Frank H. Murkowski, Governor
William C. Noll, Commissioner
Rick Urion, Director

Division of Corporations, Business and Professional Licensing

Alaska State Medical Board

907/269-8163 - Office

907/269-8196 - Fax

November 3, 2006

Regina M. Vose, In-Charge Auditor
Legislative Budget and Audit Committee
Post Office Box 113300
Juneau AK 99811-3300

Ms. Vose, thank you for your letter of October 9, 2006 in which you present your findings from the sunset audit for the Alaska State Medical Board.

We noted in the report that it is your recommendation that the board pursue a change regarding the administration of the physician qualification examination, regulation, 12 AAC 40.020(a). Since the Alaska board licenses very few physicians by examination, less than five percent of our applicants per year, the revision of this particular regulation has not been a high priority for the board. We do agree that it needs to be updated to conform with current practices and have initiated the process to do so.

Thank you, Ms. Vose, for your review of the medical board and we appreciate your comments.

David M. Head, MD
Chair, Alaska State Medical Board

Richard Urion, Division Director
Division of Corporations, Business, and Professional Licensing

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LEGISLATIVE AUDIT

DEPARTMENT OF
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Alaska State Medical Board

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Thank you for your letter of October 1, 2008, regarding your request for a copy of the Alaska State Medical Board's 2008 budget and audit committee report. The board has reviewed your request and will provide you with a copy of the report as soon as it is available. We appreciate your interest in the board's operations and will contact you again when the report is ready for distribution.

David M. Hadd
David M. Hadd, MD
Chair, Alaska State Medical Board

SB

87

**TESTIMONY IN SUPPORT OF SB 87: INCREASING ALASKA
CHILD HEALTH INSURANCE**

March 12, 2007 for the Health, Education, and Social Services Committee

Honorable Senators, Representatives, and Legislative Staff:

I am George Brown, a board certified pediatrician who has practiced in Alaska since July 1965. Today I feel like Yogi Berra said, "This is like dejavu all over again". As a 20th century Alaskan, it is proper to give credit to many of my pediatric and public health friends that made Medicaid and SCHIP possible for what many families know as Denali Kid Care. One of the key and tireless promoters is Dr. Kenn Moss. We worked together in the Anchorage Native Hospital for 3 years during the time Senator Earnest Gruening represented Alaska in D.C. Thus I am reminded of Dr.Gruening's book, "Many Battles". (1)

Senator Gruening understood, as did many of the founding mothers and fathers of our beloved Alaska, that we must, like our Alaska Native friends and colleagues, take the long look. He and they understood that children are our human future. Many of the medical and scientific minds of the early 20th century understood this clearly. Dr. Emmett Holt, widely respected professor of pediatrics, wrote in 1913, "The problem of infant mortality is one of the great social and economic problems of our day. A nation may waste its forests, its water power, its mines, and to some extent its lands, but if it is to hold its own in the struggle for supremacy, its children must be conserved at any cost. On the physical, intellectual, and moral strength of the children today, the future

depends." Dr. Holt was referring to a report from the newly formed U. S. Children's Bureau. (2) The key finding of this report was the **DIRECT CONNECTION BETWEEN INFANT MORTALITY AND POVERTY**. Infant mortality rates for families with incomes over \$1250 was 60 compared to 170 for those with incomes under \$450. Measuring human infant mortality rates is rather like the warning canaries in coal mines. They are critical indicators of national values. (3) Senator Edward Kennedy testified recently – in support of finding the \$60 million to continue federal child health insurance – how the U.S. spends less for health care than all the other industrialized nations. (4) We rank 24th of 25 among industrialized nations in infant mortality. (5) While both U.S. and Alaska infant mortality rates have gradually decreased over the last 30 years, they remain higher among minority populations, that is, those families living in poverty.

There is good news, resulting directly from both state and federal support of child health insurance. From 1997 to 2003, there was a 30% reduction in the number of uninsured children. Children covered under Medicaid and SCHIP receive better health care in four key ways: 1. They have a regular source of health care (we pediatricians call it a "medical home". 2. They use preventive and primary care in cost effective ways, 3. They receive dental care, and 4. They less often miss needed care despite living in families who otherwise could not afford such care. There is a further public benefit from this state and national investment in children. Children with such access to preventive and primary care are less often hospitalized. (6)

Senator Kennedy stressed his concern for our future, echoing the prophetic words of Dr. Holt. Economic and social changes that force both parents to work just to pay for food, mortgages or rent, and heat –the basics of survival – mean such families have no health insurance. These families keep working and their children keep waiting when ill with bad coughs, asthma, or severe vomiting and diarrhea out of fear of the \$150 to \$300 Emergency Room costs. These are the working poor. They hold two critical characteristics that influence our state and national future: 1. They are the parents of millions of 3 to 10 year old children, and 2. They have no health insurance.

Senator Murkowski recently spoke of the crisis in decreasing access to health care for elderly Alaskans. Some primary care physicians refuse to take Medicare patients because they cannot afford to. (7) We are in danger of the same for Alaskan children if we do not increase SCHIP coverage to more than 200% of the poverty level. Alaska started at that level under Title XXI when SCHIP was instituted in 1997. Alaska reduced it to 175% in 2003. Our national newspaper, USA Today, is reminding the public of this looming crisis for our kids. 1.5 million will lose care if the \$60 million for the next five years is not found to continue SCHIP. They also remind us of the huge gains made in public and parent understanding of babies and children since 1913. USA Weekend just yesterday featured "15 Important Findings Parents Must Know Right Now". Such public understanding of child needs is the engine that drives parents – both Medicaid

and SCHIP eligible – to use these valuable preventive and primary care services. These are both the least expensive and longest lasting investments we can make for our children – for all children.

A superior court judge (who requested anonymity) in Fairbanks clearly describes the importance of insuring "all" children. "Each of us must come to care about everyone's children. We must recognize that the welfare of our children and grandchildren is intimately linked to the welfare of all other people's children. After all, when one of our children needs life saving surgery, someone else's child will perform it. When our children dial 911. Someone else's child will answer it. When our children need a helping hand, someone's else's will be there to lend it. If one of our children is threatened by violence, someone else's child will be responsible for the violent act. The good life for our children can be secured only if a good life is secured for all other peoples' children."

George W. Brown, MD, FAAP

1640 Second St. Douglas, AK 99824 907 364 2726

gwbrown76@yahoo.com

SOURCES:

1. Gruening, Earnest: **MANY BATTLES**, Liveright Publishing, 1973.
2. Yankauer, Alfred: "A Classic Study of Infant Mortality, 1911 – 1915", **PEDIATRICS** 94(6): 874 – 877, 1994.
3. Lindeen, Kathleen and Macfarland, Robert: "Community Parenting Centers in Colorado" **THE JOURNAL OF PSYCHOHISTORY** 21(1) 7 – 19, 1993.

4. Howard, Ed. (Moderator): "Enrolling and Keeping Kids in the SCHIP Program, Alliance for Health Reform and Robert Wood Johnson Foundation Teleconference, February 26, 2007.

5. UNICEF: CHILDREN IN POVERTY: An Overview of Child Well-being in Rich Countries. 2007

6. Ku, Leighton and Nimalendran. IMPROVING CHILDREN'S HEALTH, A Chartbook About the Roles of Medicaid and SCHIP, Center for Budget and Policy Priorities, January 2004.

7. Senator Lisa Murkowski. "Speech to Alaska State Legislature" on Gavel to Gavel, February 2007.

SENATE COMMITTEE REPORT

First Committee of Referral

DATE: 2/19/07

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 3/13/07

Health, Education and Social Services Committee considered

SENATE BILL NO. 87

SB 87 MEDICAL ASSISTANCE ELIGIBILITY

"An Act expanding medical assistance coverage for eligible children and pregnant women; relating to cost sharing for certain recipients of medical assistance; and providing for an effective date."

and recommends:

- be replaced with SCS or CS SB 87 (HES)
- adopt previous SCS or CS _____ (_____)
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

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

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Impact	Year	EN#
HSS/Beh. Health	3/9/07	✓			
HSS/Beh. H. Adm	3/8/07	✓			
HSS/Med. Ser	3/9/07	✓			
HSS/Med. Asst.	3/9/07	✓			
HSS/Ph. Asst	3/9/07	✓			
HSS/Info Tech	3/9/07	✓			6
COR	3/1/07	✓			7

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Impact	Year	EN#

Signature	Name	Initials	Year	EN#
	Keith S...	✓		
	Thomas	✓		
CHAIR:	Davis	✓		

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB087-DHSS-DBH1-03-09-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Behavioral Health
 Component: Behavioral Hlth Medicaid Svcs

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

Sponsor: WIELECHOWSKI
 Requester: SENATE (HES)

Component No. 2660

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims		3,842.4	4,172.8	4,531.7	4,921.4	5,344.6
Miscellaneous						
TOTAL OPERATING	0.0	3,842.4	4,172.8	4,531.7	4,921.4	5,344.6

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		2,017.6	2,113.5	2,285.8	2,460.7	2,672.3
1003 GF Match		1,824.8	2,059.3	2,285.9	2,460.7	2,672.3
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	3,842.4	4,172.8	4,531.7	4,921.4	5,344.6

Estimate of any current year (FY2007) cost: _____

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB87 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200 percent of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(continued)

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

Phone: 465-1630
 Date/Time: _____
 Date: 03/09/2007

**STATE OF ALASKA
2007 LEGISLATIVE SESSION****ANALYSIS CONTINUATION**

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

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

SB 87 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201 and 350% of the prevailing FPG, and have no insurance. They will be required to pay premiums to the State of Alaska ranging between \$200 and \$1200 per year (sliding scale based on qualifying income). In this analysis, we use an average \$700 annual premium for all enrollees above 200% FPG. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. SB87 does not impose an annual deductible .

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

(continued)

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

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

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

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

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

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

(continued)

**FISCAL NOTE
FN #**

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

We assume that enrollment for all groups covered by SB87 will be completed rapidly on implementation of this bill, and within the 2009 fiscal year. Historically SCHIP and DKC expansion efforts have resulted in rapid growth in enrollment, up to expected targets.

The 2009 total costs estimate for SB87 is based on a 2006 base calculation that was adjusted annually for 5% medical inflation (average of the Anchorage CPI medical care component between 2001 and 2005). Projections for 2010 through 2013 assume an annual growth rate of 8.6% based on the projected overall Medicaid program growth between 2008 and 2012 from the *Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*. Medical inflation and a low level of enrollment growth are incorporated into the annual growth percentage applied between 2010 and 2013.

Federal funds calculations use only the Title XIX federal match rate. Expenses for the additional SCHIP children enrolled under SB87 section 2 will be eligible for Title XXI funding, however Title XXI funding is not expected to cover all SCHIP costs after 2007 and the state's SCHIP allocation is not expected to increase enough to cover costs over the term of these fiscal note projections.

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

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

2009 Enrollment and Costs	Denali KidCare Income Standard Unfrozen		Extended Medical Assistance Coverage		Total
	Pregnant Women	SCHIP Children	Children		
	151-200% Federal Poverty Guideline	151-200% Federal Poverty Guideline	201-250% Federal Poverty Guideline	251-350% Federal Poverty Guideline	
Annual Enrollment	436	2,553	851	1,702	5,542
Average Cost per Enrollee	\$2,915	\$1,387	\$2,900	\$2,900	na
Total Cost of Medicaid Services before Cost Sharing (in 000s)	\$1,471.3	\$4,099.2	\$2,856.9	\$5,713.8	\$14,141.2
Annual Premiums	\$0.0	\$0.0	-\$255.3	-\$1,531.8	-\$1,787.1
Annual Co-Payments	\$0.0	\$0.0	\$0.0	-\$1,142.8	-\$1,142.8
Net Cost of Medicaid Services after Cost Sharing	\$1,471.3	\$4,099.2	\$2,601.6	\$3,039.2	\$11,211.3
Medicaid Services (2077). Division of Health Care Services.	\$1,471.3	\$2,732.8	\$2,456.3	\$4,912.6	\$7,368.9**
Behavioral Health Medicaid Services (2660). Division of Behavioral Health.	\$0.0	\$1,366.4	\$1,280.8	\$2,561.6	\$3,842.4

** Health Care Services Medicaid (2077) costs are net of claim expenditures and revenue from premiums. Total Medicaid Services costs for Health Care Services 9,156.0

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB087-DHSS-DBH2-03-08-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Behavioral Health
 Component Behavioral Health Administration

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

Sponsor WIELECHOWSKI

Requester SENATE (HES)

Component No. 2685

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services		274.6	274.6	274.6	274.6	274.6
Travel						
Contractual		6.6				
Supplies		26.4	26.4	26.4	26.4	26.4
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	307.6	301.0	301.0	301.0	301.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2007) cost: _____

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

POSITIONS

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

ANALYSIS: (Attach a separate page if necessary)

SB 87 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200 percent of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(Continued)

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

Phone 465-2817
 Date/Time 03/08/2007
 Date 03/09/2007

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

SB 87 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201% and 350% of the prevailing FPG, and have no insurance.

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

Assumptions for Extended Medicaid Coverage:

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

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

Medicaid program review and evaluation

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

(Continued)

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

Total Administrative Costs:

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

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

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB067-DHSS-HCS1-03-08-07
 Bill Version: SB 07
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Health Care Services
 Component Medicaid Services

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

Sponsor WIELECHOWSKI
 Requester SENATE (HES)

Component No. 2077

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		9,156.0	9,943.4	10,798.6	11,727.2	12,735.8
Miscellaneous						
TOTAL OPERATING	0.0	9,156.0	9,943.4	10,798.6	11,727.2	12,735.8

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		3,869.4	4,131.2	4,505.8	4,970.1	5,474.4
1003 GF Match		3,499.5	4,025.1	4,505.7	4,970.0	5,474.3
1004 GF						
1037 GF/Mental Health						
Other(SDPR--Premiums)		1,787.1	1,787.1	1,787.1	1,787.1	1,787.1
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	9,156.0	9,943.4	10,798.6	11,727.2	12,735.8

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:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB87 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200 percent of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(continued)

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

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

**FISCAL NOTE
FN #**

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

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

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

SB87 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201 and 350% of the prevailing FPG, and have no insurance. They will be required to pay premiums to the State of Alaska ranging between \$200 and \$1200 per year (sliding scale based on qualifying income). In this analysis, we use an average \$700 annual premium for all enrollees above 200% FPG. Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. SB87 does not impose an annual deductible.

The Deficit Reduction Act (DRA) section 6041 stipulates that co-payments cannot exceed 20% of the cost of the service claimed. Annual out-of-pocket expenses for cost sharing and premiums cannot exceed 5% of family income. We estimate that children near the 250% FPG level will reach out-of-pocket limits when costs of services approach \$7000. Because, on average, the cost per enrollee per year is expected to be lower than the average out-of-pocket limit, the ceiling on cost sharing is not a factor in calculations for this fiscal note. On an individual basis however, some children will likely reach cost-sharing limits.

(continued)

**FISCAL NOTE
FN #**

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

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

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

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

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

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

(continued)

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

We assume that enrollment for all groups covered by SB87 will be completed rapidly on implementation of this bill, and within the 2009 fiscal year. Historically SCHIP and DKC expansion efforts have resulted in rapid growth in enrollment, up to expected targets.

The 2009 total costs estimate for SB87 is based on a 2006 base calculation that was adjusted annually for 5% medical inflation (average of the Anchorage CPI medical care component between 2001 and 2005). Projections for 2010 through 2013 assume an annual growth rate of 8.6% based on the projected overall Medicaid program growth between 2008 and 2012 from the *Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*. Medical inflation and a low level of enrollment growth are incorporated into the annual growth percentage applied between 2010 and 2013.

Federal funds calculations use only the Title XIX federal match rate. Expenses for the additional SCHIP children enrolled under SB87 section 2 will be eligible for Title XXI funding, however Title XXI funding is not expected to cover all SCHIP costs after 2007 and the state's SCHIP allocation is not expected to increase enough to cover costs over the term of these fiscal note projections.

Health Care Services Medicaid (HCS) currently pays for 2/3 of the cost of services to DKC children and all of the costs associated with DKC pregnant women. Component fund calculations for this fiscal note are based on that costs distribution (2/3 of costs of services due to added SCHIP enrollment, 2/3 of costs of services due to section 3 enrollment, and all costs of services due to additional enrolled pregnant women). Additionally, all premiums will be paid through HCS mechanisms and are therefore added to the funds analysis for this component as program receipts.

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

2009 Enrollment and Costs	Denali KidCare Income Standard Unfrozen		Extended Medical Assistance Coverage		Total
	Pregnant Women	SCHIP Children	Children		
	151-200% Federal Poverty Guideline	151-200% Federal Poverty Guideline	201-250% Federal Poverty Guideline	251-350% Federal Poverty Guideline	
Annual Enrollment	436	2,553	851	1,702	5,542
Average Cost per Enrollee	\$2,915	\$1,387	\$2,900	\$2,900	na
Total Cost of Medicaid Services before Cost Sharing (in 000s)	\$1,471.3	\$4,099.2	\$2,856.9	\$5,713.8	\$14,141.2
Annual Premiums	\$0.0	\$0.0	-\$255.3	-\$1,531.8	-\$1,787.1
Annual Co-Payments	\$0.0	\$0.0	\$0.0	-\$1,142.8	-\$1,142.8
Net Cost of Medicaid Services after Cost Sharing	\$1,471.3	\$4,099.2	\$2,601.6	\$3,039.2	\$11,211.3
Medicaid Services (2077). Division of Health Care Services.	\$1,471.3	\$2,732.8	\$2,456.3	\$4,912.6	\$7,368.9**
Behavioral Health Medicaid Services (2660). Division of Behavioral Health.	\$0.0	\$1,366.4	\$1,280.8	\$2,561.6	\$3,842.4

** Health Care Services Medicaid (2077) costs are net of claim expenditures and revenue from premiums. Total Medicaid Services costs for Health Care Services 9,156.0

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 88067-DHSS-DHC82-03-08-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Health Care Services
 Component Medical Assistance Admin.

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

Sponsor WIELECHOWSKI
 Requester SENATE (HES)

Component No. 242

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	49.0	282.3	282.3	282.3	282.3	282.3
Travel						
Contractual	106.8	135.2	135.2	135.2	135.2	135.2
Supplies	6.6	2.2				
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	162.2	419.7	417.5	417.5	417.5	417.5

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	81.1	209.8	208.7	208.7	208.7	208.7
1003 GF Match	81.1	209.9	208.8	208.8	208.8	208.8
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	162.2	419.7	417.5	417.5	417.5	417.5

Estimate of any current year (FY2007) cost: _____

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

POSITIONS

Full-time	4	4	4	4	4	4
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB87 will increase recipient enrollment that in turn will cause an increase in associated appeals, by recipients and providers. The level of appeal activity is difficult to determine, but a minimum of 1 additional FTE position to process appeals would be required. Other volume related increases would be in prior authorizations and claims volume. These are not expected to cause an increase in payment to the fiscal agent under contract.

Premium collection activity would require a minimum of staffing increase, in our Accounting and Recovery section, of 3 FTE's.

Continued on page 2

Prepared by: Randall Schlapa
 Division: Health Care Services
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone 334-2461
 Date/Time 03/08/2007
 Date 03/09/2007

FISCAL NOTE

FN #

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

Analysis continued:

System enhancements to the MMIS will cost approximately \$100,000. These changes would accommodate the new Federal Poverty Level indicator and co-pay requirements and would be a one time cost in FY2008.

There will be increased referrals to the Department of Law for collections and appeals, this will result in approximately \$100,000 in the contractual line starting in FY2009.

Health Care Services caseload is going to increase by approximately 436 pregnant women and 1,700 cases (3,400 children).

We estimate two Accounting Technician I's, and a Medical Assistant Administrator I position will be needed to manage this additional work beginning in FY2008. In FY2009 a Medical Assistant Administrator II will be needed, most likely in our Practitioner Relations section. The new extended Medicaid program increases complexity of the eligibility determination work and results in increased contact with applicants and enrollees.

Total Administrative Costs:

The increase in Medicaid applications and caseload creates the need for two Accounting Technician I, a Medical Assistant Administrator I, and a Medical Assistant Administrator II, all located in Anchorage. These annual costs are estimated to be:

- 2 Accounting Technician I's, \$121.0 (Range 12 at a cost of \$60.5, including benefits, per position).
- 1 Medical Assistant Administrator I, \$75.7 (Range 16 at a cost of \$75.7, including benefits, per position).
- 1 Medical Assistant Administrator II, \$85.6 (Range 18 at a cost of \$85.6, including benefits, per position).

It is assumed that one quarter year's personal services funding will be needed in FY08 to hire and train staff, the two Accounting Technician I's and the one Medical Assistant Administrator I in the Accounting and Recovery section, at the cost of \$49.0, in order to be able to accept applications and make eligibility determinations effective July 1, 2008. The Medical Assistant Administrator II will be filled in FY2009.

With the additional caseload, a one time supplies cost will be incurred in FY2008, for computers and software with a cost of \$2,200 for each additional staff for a total of \$6.6 for three staff hired in FY2008 and \$2.2 in FY2009 for the 4th new position. Annual costs for office space, phones and other contractual costs are calculated at a cost of \$8,800, per additional staff for a total of \$35.2 (prorated for 1/4 year in FY2008) .

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB007-DHSS-DPA-03-09-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Public Assistance
 Component: Public Assistance Field Svcs

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

Sponsor: WIELECHOWSKI
 Requester: SENATE (HES)

Component No. 236

Expenditures/Revenues (Thousands of Dollars)

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

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

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES (0)						
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FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1002 Federal Receipts	71.2	249.5	249.5	249.5	249.5	249.5
1003 GF Match	64.1	223.5	223.5	223.5	223.5	223.5
1004 GF	14.3	51.7	51.7	51.7	51.7	51.7
1037 GF/Mental Health						
Inter-Agency Receipts	1.9	6.8	6.8	6.8	6.8	6.8
Other(Specify Type-do not abbreviate)						
TOTAL	151.5	531.5	531.5	531.5	531.5	531.5

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

POSITIONS

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

ANALYSIS: (Attach a separate page if necessary)
 SB 87 (section 2, AS 47.07.020(b)) resets the upper income limit for Denali KidCare (DKC) pregnant women and for uninsured children under the Title XXI State Children's Health Insurance Program (SCHIP) to 200% of the prevailing federal poverty guideline (FPG) for Alaska. Currently the qualifying income limit for these children and pregnant women is set in statute at 175% of the 2003 FPG (effectively, about 154% of the current FPG). Enrollees in these categories do not pay premiums or co-pays and are eligible for all mandatory and optional services provided through the state's Medicaid State Plan.

(continued)

Prepared by: Ellie Fitzjarrald, Director Phone 465-5847
 Division: Public Assistance Date/Time 03/08/2008
 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

SB 87 also creates a new group of Medicaid eligible children in higher qualifying income categories (section 3, AS 47.07.022). To qualify, children must be under 19, between 201% and 350% of the prevailing FPG, and have no insurance. They will be required to pay premiums to the State of Alaska ranging between \$200 and \$1200 per year (sliding scale based on qualifying income). Those above 250% FPG will also be responsible for co-payments equal to 20% of the cost of service, payable to the provider at the time of service. SB 87 does not impose an annual deductible.

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

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

Assumptions for Denali Kid Care and Pregnant Women:

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

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

**FISCAL NOTE
FN #**

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

ANALYSIS CONTINUATION

Assumptions for Extended Medicaid Coverage:

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

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

Total Administrative Costs:

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

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

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

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

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

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB087-DHSS-FMS-03-08-07
 Bill Version: SB 87
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU Departmental Support Services
 Component Information Technology Services

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

Sponsor WIELECHOWSKI
 Requester SENATE (HES)

Component No. 2754

Expenditures/Revenues (Thousands of Dollars)

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

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

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

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

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2007) cost: _____

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

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB 87 will require software changes to the Eligibility Information Management system (EIS). The changes will require four positions for six months: two information system programmers working with two additional positions testing the system for Public Assistance. No new positions are requested, instead this fiscal note will provide funding for current positions. The EIS system is a highly complex and intricate system and the changes will require high level programmers to develop and re-work the software changes necessary.

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

Phone 465-1630
 Date/Time 03/08/2007
 Date 03/09/2007

**STATE OF ALASKA
2007 LEGISLATIVE SESSION****ANALYSIS CONTINUATION**

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

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

FISCAL NOTE

**STATE OF ALASKA
2007 LEGISLATIVE SESSION**

Fiscal Note Number: _____
 Bill Version: SB 87
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Corrections
 Title An Act expanding medical assistance coverage RDU Administration & Operations
eligible children and pregnant women . . . Component Office of the Commissioner
 Sponsor Senators Wielechowski, Franch, Ellis, Eton, Davis
 Requester Senate Health, Education, and Social Services Component No. 694

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						
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						
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 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Passage of this legislation will not have a fiscal impact on the Department of Corrections.

Prepared by: Sharleen Griffin, Director Phone (907) 465-3339
 Division Administrative Services Date/Time 3/1/07 12:33 PM
 Approved by: Dwayne Peoples, Deputy Commissioner Date 3/1/2007
 Agency Department of Corrections

ALASKA STATE LEGISLATURE

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Co-chair
Joint Armed Services Committee

Member
Resources Committee
Judiciary Committee
Transportation Committee

Senator_Bill_Wielechowski@legis.state.ak.us

SENATOR BILL WIELECHOWSKI

Sponsor Statement for SB 87: No Child Left Uninsured

The intent of SB 87 is to make health insurance accessible to all children in Alaska, while asking those families who can afford it to make a substantial financial contribution towards their coverage. By ensuring that all children have access to health services, SB 87 will reduce costs to the state and its citizens over the long run.

An estimated 18,000 children in Alaska lack health insurance and the number is growing. According to the Robert Wood Johnson Foundation, the number of children covered by private health insurance has declined by 31% in the last decade. The vast majority of these children are from working families.

Uninsured children have much higher health risks than do covered children. They are more likely to develop chronic illnesses such as asthma and diabetes and to suffer from acute conditions such as eye and ear infections. While many lack a regular doctor and don't receive preventative care, they are four times more likely than insured children to use emergency rooms when medical attention is needed.

The high cost of this emergency care is often borne by other Alaskans, including businesses that purchase health insurance for their employees. For example, Providence and Alaska Regional hospitals provided \$89 million in uncompensated care in 2006. These costs are passed on to other hospital users through higher charges for medical services, which ultimately results in increased premiums. They are also passed on to government. Governor Palin has proposed a \$22.7 million increment in fiscal year 2008 to reimburse hospitals for the uncompensated care they provide. These costs could be reduced by insuring that all children have access to health insurance.

SB 87 raises the eligibility limit for participation in the Denali KidCare program to 200% of the federal poverty level (FPL), currently \$27,000/year for a single parent and child. This change puts Alaska in line with other states, 41 of which allow participation by families at or above this level. Roughly 70% of the costs of this program are currently covered by the federal government.

SB 87 would also allow families with incomes up to 350% of the FPL to buy into Denali KidCare using a sliding fee scale for premiums and a 20% co-pay. Those with the greatest means would reimburse the state roughly 90% of its costs. Participants would have to certify that they don't have access to health insurance at work.

With the "No Child Left Uninsured Act," Alaska joins states from Idaho to Illinois that are working to ensure that all children have access to health insurance. Please support this crucial legislation.

LEGAL SERVICES

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

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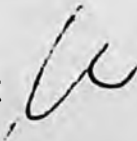
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Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

February 19, 2007

SUBJECT: Sectional Summary (Work Order No. 25-LS0595\A)

TO: Senator Bill Wielechowski
Attn: Michele Sydeman

FROM: Jean M. Mischel
Legislative Counsel 

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

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

Section 1. Provides a short title for the bill.

Section 2. Amends optional medical assistance provisions for persons under 19 years of age and for pregnant women to establish an income eligibility standard in relation to the federal poverty guideline, and deletes the specified household income limits.

Section 3. Requires the Department of Health and Social Services to administer a program to extend mandatory and optional medical assistance coverage for persons under 19 years of age whose household income is above sec. 2's limits but below a set percentile range of the federal poverty guideline, and imposes contribution and copayment amounts for the coverage.

Section 4. Requires the Department of Health and Social Services to set premium and cost-sharing contributions for person under 19 years of age and who meet eligibility criteria under sec. 3.

Section 5. Repeals household income limits for cost-sharing under existing law for medical assistance coverage.

Section 6. Authorizes the Department of Health and Social Services to adopt regulations needed under the bill before the effective date of the bill.

Section 7. Provides an immediate effective date for sec. 6.

Senator Bill Wielechowski
February 19, 2007
Page 2

Section 8. Provides a July 1, 2008 effective date for secs. 1 - 5.

JMM:lmb
07-027.lmb

ALASKA STATE LEGISLATURE



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(907) 465-2435

Representative Les Gara

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A Primer on the “No Child Left Uninsured” Act

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

ALASKA STATE LEGISLATURE

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

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

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Impact of the Uninsured on the Broader Population

- Hospitals often serve as primary care treatment facilities for those without access to other health care. Providence and Alaska Regional Hospitals in Anchorage report providing \$89 million in uncompensated care in 2006. These costs are passed on to other Alaskans, businesses and government, raising premiums and out-of-pocket expenses (Commonwealth North).
- Governor Palin has proposed a \$22.7 million increment to reimburse hospitals for the uncompensated care they provide. Of this amount, \$11.2 million would come from state general funds; the remaining would come from federal Medicaid dollars. This bill would reduce the need for this increment.
- The New America Foundation estimates the average family pays an additional \$1,186 in medical costs to cover the cost of uncompensated health care. Another national study found that premiums for employer-sponsored family health coverage cost an extra \$922 in 2005 to pay for uncompensated care.
- Some \$17 billion is spent in the U.S. annually on unnecessary hospitalizations, according to a 2004 study in *Pediatrics*. The study, which surveyed parents and doctors of children admitted to the hospital, found that 13-46% of the admissions could have been avoided with better care at home or by primary care physicians.
- Nationally, individuals unable to pay medical bills are filing for bankruptcy at unprecedented rates. Between 1980 and 2001, medically driven bankruptcies increased 23 times (American Medical Association, 2005). Half of the 1.5 million American families that filed for bankruptcy in 2001 cited medical bills as the cause (Health Affairs, Feb. 2005).
- The pay-off from providing health insurance for low-income children is substantial. According to governing.com, "Immunizations, annual visits to a pediatrician, dental care, and screening for vision, hearing and developmental problems are all long-term money savers for the health care system as a whole." For example, every \$1 spent on a mumps/measles/rubella shot, saves \$26, according to Washington State Dept. of Health research.
- The National Institute of Medicine estimates that the benefit of extending insurance coverage to children is \$2,410 per year. This figure is based on the value of an individual's health over future years, physical and mental development and earning potential.

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Background on Denali KidCare

- Denali KidCare provides health insurance for children through age 18 and pregnant women who meet income guidelines. There is no cost for eligible children, teens and pregnant women. However, youth who are 18 may be required to pay a limited amount for some services.
- Denali KidCare pays for doctor's visits; eye exams and glasses; dental cleanings and fillings; hearing tests and aids; hospital care; speech, physical and mental health therapy; substance abuse treatment; lab tests; prescription drugs; and other care.
- Roughly 7,600 children were covered by Denali KidCare as of December 2006.
- Prior to the passage of SB 105 in 2003 (which lowered the eligibility guidelines for the program) 4,992 children with family incomes between 151% and 200% of the federal poverty level (FPL) were covered. Since passage, 3,440 fewer children with family incomes between 151% and 200% of the FPL are enrolled.
- The cost per child of providing this coverage is about \$1,700/year.
- In recent calls to private insurers, the cost of a health insurance plan for a family of 3 (pregnant woman with two children) ranged from \$8,000-\$17,000 annually. Unlike Denali KidCare, this coverage comes with a \$1,000 deductible, 20% co-pay, and no vision, dental or hearing benefits.
- **Alaska has one of the lowest program eligibility rates in the nation (160% of the FPL).** Only 2 other states (Montana and North Dakota) have lower rates. Forty-one states allow participation by families at or above 200% of the FPL. Seven have rates at or above 300% of the FPL.
- In April 2007, Alaska's eligibility rate will decline to 154% of the FPL, bumping more low-income children (perhaps as many as 1,000) off the rolls of Denali KidCare. The eligibility

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

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

Why Coverage for Pregnant Women is Important:

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

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.

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 health 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.

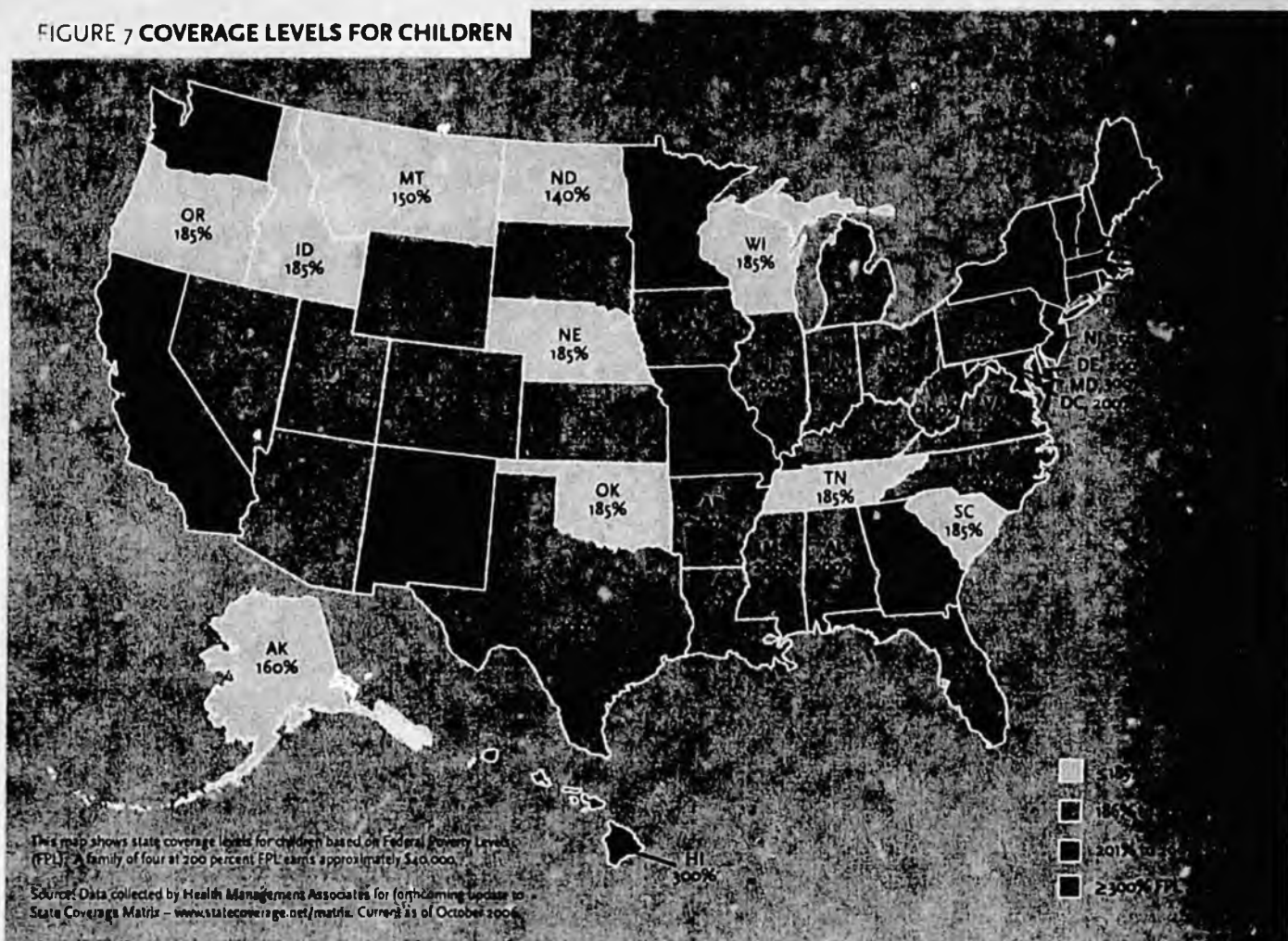
John Riley is with the clinical faculty of the University of Alaska Anchorage and is president of the Alaska Public Health Association.

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FIGURE 7 **COVERAGE LEVELS FOR CHILDREN**



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

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

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

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

to participate in their employer's health plan or whose employer does not offer a qualified health plan; and unemployed individuals who are currently seeking work. The Individual Plan also provides coverage to working individuals with a disability whose income exceeds the Medicaid eligibility level but is below 200 percent FPL, and who meet "ticket to work" requirements.¹³ The Individual Plan provides coverage through private managed care plans that also serve the Medicaid program; however, the benefit package is less comprehensive than Medicaid or most products offered in the commercial market.



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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February 13, 2007

The Honorable Bill Wielechowski
Alaska State Senate
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Juneau, AK 99801-1182
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Dear Senator Wielechowski

The Alaska Chapter of the American Academy of Pediatrics whole heartedly supports your upcoming Bill regarding the ability of families who are at the 200-350% of poverty level to "buy-in" to Denali Kid Care. We also support Senator Davis's Bill regarding re-instating SCHIP to 200% of poverty level. This "buy-in" ability would allow access to care at an affordable cost. As you know almost 1/3 of Alaska's children are at or below 200% poverty. Many other families do not have access to insurance through their employer and private insurance in Alaska is cost prohibitive. And while the vast majority of patients enrolled with Medicaid are children they utilize only a fraction of the resources. This makes for efficient use of health care dollars. It is also well documented in the literature that preventative healthcare is cost effective and families with healthcare coverage are more likely to access preventative care and not wait until problems have reached a crisis. The American Academy of Pediatrics advocates for universal coverage of children and the more options that are available will make this a reality. Thank you for your careful consideration and advocacy for Alaska's children. If more information is required please feel free to contact me or any of our executive staff.

Sincerely yours

Jody Butto MD FAAP
AAP Alaska Chapter President