U.S., Britain ranked last in child welfare

U.N. study of wealthy nations cites economic inequality, poor family support

The Associated Press

Updated: 4:02 p.m. HT Feb 14, 2007

BERLIN - The United States and Britain ranked at the bottom of a U.N. survey of child welfare in 21 wealthy countries that assessed everything from infant mortality to whether children ate dinner with their parents or were bullied at school.

The Netherlands, followed by Sweden, Denmark and Finland, finished at the top of the rankings, while the U.S. was 20th and Britain 21st, according to the report released Wednesday by UNICEF in Germany.

One of the study's researchers, Jonathan Bradshaw, said children fared worse in the U.S. and Britain — despite high overall levels of national wealth — because of greater economic inequality and poor levels of public support for families.

"What they have in common are very high levels of inequality, very high levels of child poverty, which is also associated with inequality, and in rather different ways poorly developed services to families with children," said Bradshaw, a professor of social policy at the University of York in Britain.

"They don't invest as much in children as continental European countries do," he said, citing the lack of day care services in both countries and poorer health coverage and preventative care for children in the U.S.

U.S. officials questioned the comparisons made by the study, while Britain said it failed take into account recent social improvements.

Risky ways

The United States finished last in the health and safety category, based on infant mortality, vaccinations for childhood diseases, deaths from injuries and accidents before age 19, and whether children reported fighting in the past year or being bullied in the previous two months.

The U.S. was second to worst, behind only Hungary, for its infant mortality rate of 7 per 1,000 births. The rate, a standard indicator of children's health and prenatal care, is under 3 in Japan.

The study also gave the U.S. and Britain low marks for their higher incidences of single-parent families and risky behaviors among children, such as drinking alcohol and sexual activity.

Britain was last and the U.S. second from the bottom in the category focusing on relationships, based on the percentage of children who lived in single-parent homes or with stepparents, as well as the percentage that ate the main meal of the day with their families several times per week. That category also counted the proportion of children who said they had "kind" or "helpful" relationships with other children.

The report's authors cautioned that the focus on single-parent families "may seem unfair and insensitive" and noted that many children do well with one parent.

"But at the statistical level there is evidence to associate growing up in single-parent families with greater risk to well-being — including a greater risk of dropping out of school, of leaving home early, poorer health, low skills and of low pay," the report said.

On average, 80 percent of the children in the countries surveyed live with both parents. There were wide variations, however, from more than 90 percent in Greece and Italy to less than 70 percent in Britain and 60 percent in the U.S., where 16 percent of adolescents lived with stepfamilies.

Bob Reitemeier, chief executive of The Children's Fund charity in Britain, said the UNICEF report also showed

that less than half of British children reported good relations with their peers.

Bullying in Britain

"That really jumped off the page," he said, citing concerns about the competitive, ratings-based school environment in Britain and higher reported incidences of bullying and fighting. "The environment for these young people is quite negative."

The study ranked the countries in six categories, based on national statistics: material well-being, health and safety, education, peer and family relationships, behaviors and risks, and young people's own subjective sense of well-being. Both the U.S. and Britain were in the bottom two-thirds of five of the six categories.

Britain finished at the bottom in behaviors and risks, which considered factors such as the percentage of children who had breakfast, ate fruit regularly, exercised, were overweight, used drugs or alcohol, were sexually active or became pregnant.

Both the U.S. and British governments criticized the report.

Wade Horn, an assistant secretary at the Department of Health and Human Services, said the study's standard of measuring poverty differed from that of the United States.

Defining poverty

A family of four is defined by the U.S. as living in poverty if its combined income is less than $20,650 a year. The poverty threshold used by the report was an income of $35,000 a year for a family of four, he said.

"I think when you try to compare nations in a report like this, you tend to ignore so many other factors specific to those nations that the comparison becomes somewhat meaningless," Horn said.

State Department spokesman Paul Denig was also critical of the report and said his department first learned of the study through the media and was not asked to provide input.

Britain said the report did not take account of recent improvements to education, health and general living standards in the country. Some of the statistics also went back as far as 2001, it said.

In general, northern European countries with strong social welfare systems dominated the upper half of the rankings. Southern European countries, such as Spain, Italy and Portugal, ranked higher in terms of family support and levels of trust with friends and peers.

URL: http://www.msnbc.msn.com/id/17155848/

Alaska: Health Insurance Coverage of Children 0-18, states (2004-2005), U.S. (2005)

Health Insurance Coverage of Children 0-18, states (2004-2005), U.S. (2005) Compare

	AK #	AK %	US #	US %
Employer	96,160	49	43,934,050	56
Individual	7,210	4	3,459,740	4
Medicaid	60,210	31	20,354,580	26
Other Public	13,790	7	1,124,430	1
Uninsured	17,880	9	9,035,420	12
Total	195,240	100	77,908,220	100

Notes and Sources: Show | Hide

Notes: Percentages may not sum to 100% due to rounding effects.
For current Medicaid enrollment figures, please refer to the "Medicaid & SCHIP" section, which report administrative data from the Centers for Medicare and Medicaid Services (CMS).
For more details, see "Notes to Topics Based on the Current Population Survey (CPS)" at http://www.statehealthfacts.kff.org/methodology.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

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From Governing
February 2004

THE GOVERNMENT PERFORMANCE PROJECT

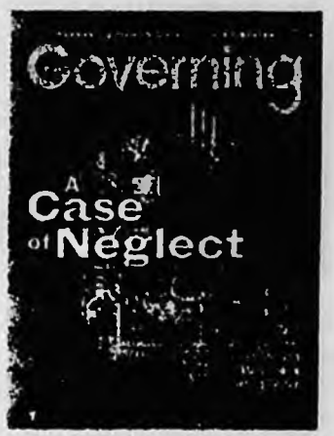
A Case of Neglect

CHILDREN'S CARE

Sudden Reversal

Diagnosis: Dramatic recent improvements in health care for poor children in America are being threatened by a new wave of cost-cutting in the states. Changes are being made that not only endanger the health of young people but are likely to lead to greater costs in future years.

Children are heavy consumers of health care, but they are the cheapest of patients. About a third of all children in America get health services through Medicaid or the State Children's Health Insurance Program (SCHIP), and that cost taxpayers an average of $1,475 for a child enrollee in 2002, compared with $12,764 for one who was elderly. The payoff from that $1,475 investment is large: 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.



The same goes for prenatal care for pregnant women. Premature babies cost about $13.1 billion annually, according to the March of Dimes Prenatal Data Center. The average premature baby racked up $75,000 in hospital fees in 2001, compared with $1,300 for a healthy full-term infant.

That's fairly well known. What's less well known is that states made remarkable progress on children's care in the few years just before the most recent budget crunch. Between 1999 and 2002, the number of children without insurance nationwide fell from 9.6 million to 7.8 million. At the upper end of performance, Iowa, Massachusetts, Minnesota, Nebraska, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont and Wisconsin all had less than 7 percent of total children uninsured.

By 2002, nearly 70 percent of all U.S. children were getting regular doctor's visits, and 83 percent of new mothers were receiving prenatal care in their first trimester — up from 76 percent in 1990. Infant deaths dropped from 9.2 out of 1,000 in 1990 to 6.9 out of 1,000 a decade later.

In recent years, improvements occurred even as the percentage of children covered by private insurance was shrinking. "Medicaid demonstrated its strength as a counter-cyclical safety net program," says Tara Straw, of the March of Dimes. "When children were losing insurance, Medicaid filled the gaps."

Elected officials realize the emotional importance of children's health to millions of Americans. No legislator ever denounces immunization or prenatal care as a waste of tax dollars. And yet — when budgets need to be cut — medical care for children often seems to be sitting in a

less than 50 percent of children covered through SCHIP stay eligible. Some are dropped from the rolls for good reasons, such as a change in family income. But a close look at eight states suggested that between 10 and 40 percent of children were "lost." One reason was that parents didn't answer renewal notices or re-submit applications.

States might conclude from this research that they should do more to educate and retain potential clients. And in the 1990s, many states did just that. But cutting back on SCHIP outreach saves substantial amounts of money, because it keeps the size of the rolls down. In both fiscal 2003 and 2004, California eliminated more than $13 million in funding to community-based organizations for outreach and application assistance as well as another $6 million a year for school-based outreach, such as media advertising and aides to help families fill out applications. Mississippi, Nebraska and Washington have recently added more rigorous documentation requirements for reporting income, while Connecticut, Indiana, Nebraska and Washington did away with the guarantee of 12 months of uninterrupted coverage.

All told, about half a million children will have lost coverage in fiscal years 2003 and 2004.

A More Direct Approach

If tightening up on eligibility sounds like a form of budget-cutting by stealth, many states are taking the more direct approach of actually freezing enrollment in their SCHIP programs. Alabama, Colorado, Florida, Maryland, Montana and Utah all have taken this path. The levels of income used to determine eligibility have not changed, but no new children are being admitted. In Florida, some 63,000 children who are eligible for SCHIP are now on waiting lists for coverage. Utah doesn't have a waiting list; it just sends people home and tells them to watch for a time when enrollment is open again.

The impact of such actions is immediate and dramatic, as was pointed out in a study of an enrollment freeze in the North Carolina SCHIP program, which took place between January and October 2001. About 34,000 children went on a waiting list. In interviews with University of North Carolina researchers, families who were wait-listed complained that they had been forced to delay medical or dental care, were unable to afford prescriptions, and in some cases had put off paying rent or utility bills.

Texas has made the most drastic cutbacks of all. Historically, the Lone Star State has been one of the weakest in children's health; an analysis of census data by the American Academy of Pediatrics puts the uninsured rate for children in Texas at 23 percent, compared with a U.S. average of 11.9 percent. This is in part a function of the state's percentage of low-income Hispanic families and a business sector with no strong tradition of employee benefits.

For a while, however, there was a serious effort to overcome these obstacles. After waiting until 2000 to implement its SCHIP program, Texas received deserved accolades for a massive expansion in which 500,000 children received new coverage through SCHIP and another 335,000 were added to the Medicaid program by 2002. Enrollment was simplified, Spanish-language outreach was initiated, and documentation requirements were eased. Medicaid officials reported a significant decline in the use of emergency rooms and county indigent care programs — settings where the uninsured often access their medical care.

But with its budget in trouble, and with a statewide aversion to new taxes, Texas has retreated. It reduced eligibility levels for pregnant women on Medicaid from 185 percent of poverty to 158 percent. It imposed asset limits and added a requirement that families on SCHIP re-enroll every six months, rather than once a year. One of the changes with the most impact is a new 90-day delay in starting coverage for children after they're determined to be eligible. This delay includes newborns as well. "It is unconscionable that crucial health care be delayed for an eligible newborn as a cost-saving measure," says Straw, of the March of Dimes. In all, the package of restrictions enacted

Natal Numbers

States ranked by rate of pre-term births, low birthweight and infant mortality (1=lowest)

STATE	% PRE-TERM BIRTHS, 2002	RANK	% LOW BIRTH-WEIGHT 2002	RANK	INFANT DEATHS (PER 1,000 LIVE BIRTHS)	RANK
Alabama	13.8%	49	9.9%	44	9.6	47
Alaska	9.8	5	6.8	1	6.1	10
Arizona	12.6	30	6.8	14	6.0	8
Arkansas	12.7	34	8.4	38	8.3	41
California	10.2	9	6.4	9	6.0	8
Colorado	12.0	26	8.0	40	6.6	18
Connecticut	10.1	7	7.8	23	6.1	10
Delaware	13.6	43	9.9	46	8.7	46
Florida	13.0	37	8.4	36	7.3	29
Georgia	12.4	29	8.9	42	8.6	43
Hawaii	12.7	46	8.3	34	6.0	8
Idaho	10.4	10	6.1	6	6.2	12
Illinois	12.6	30	8.3	32	7.7	34
Indiana	12.6	29	7.6	21	7.6	34
Iowa	11.6	21	6.6	12	6.6	18
Kansas	11.9	14	7.0	16	7.4	31
Kentucky	13.6	43	8.6	39	8.9	45
Louisiana	14.1	48	10.4	48	8.8	44
Maine	10.1	7	6.9	8	6.1	10
Maryland	12.9	36	9.0	43	8.1	39
Massachusetts	10.6	12	7.6	19	6.0	8
Michigan	11.9	25	8.0	37	8.8	44
Minnesota	9.8	6	6.3	5	6.5	17
Mississippi	12.2	50	11.2	50	10.3	49
Missouri	12.8	33	8.0	37	7.6	31
Montana	11.3	16	6.8	14	6.7	20
Nebraska	11.8	23	7.3	17	6.8	25
Nevada	13.8	47	7.8	23	6.5	17
New Hampshire	9.5	2	6.8	6	5.8	3
New Jersey	12.8	33	8.0	37	6.8	24
New Mexico	12.6	30	8.0	37	6.6	18
New York	11.4	19	7.9	24	6.6	18
North Carolina	13.3	40	9.0	43	8.6	43
North Dakota	11.3	15	6.3	5	8.8	45
Ohio	12.2	26	8.3	34	7.7	34
Oklahoma	12.6	30	8.0	37	7.5	30
Oregon	9.7	4	5.8	1	5.4	1
Pennsylvania	11.4	19	8.2	32	7.3	27
Rhode Island	11.3	15	7.9	24	6.8	25
South Carolina	14.2	47	10.0	48	8.9	46
South Dakota	11.3	15	7.3	17	7.4	31
Tennessee	13.8	46	9.2	45	8.7	46
Texas	13.3	40	7.1	22	6.9	28
Utah	10.5	11	6.1	6	4.8	2
Vermont	9.8	1	6.4	9	5.6	7
Virginia	11.8	23	7.9	24	7.6	34
Washington	9.6	3	6.9	8	6.6	18
West Virginia	13.4	43	9.0	43	7.2	27
Wisconsin	10.9	13	6.6	12	7.1	26
Wyoming	11.7	22	8.4	36	6.9	28

Source: National Center for Health Statistics, Centers for Disease Control and Prevention

Data for this graphic

children are eligible and are not clients of someone else. Referrals require heavy paperwork and in some states, including Alabama and Tennessee, unpredictable or delayed payments are a problem as well. In the American Academy of Pediatrics survey, 39.4 percent of pediatricians regarded "paperwork" as a very important reason for limiting participation in Medicaid. But this criticism also varied a good deal among the states. In Florida, Mississippi, Nevada, New Jersey and Pennsylvania, more than half the pediatricians who responded complained about a paperwork problem. In Montana, Rhode Island, Vermont and Wyoming, fewer than 20 percent did.

REMEDIES

Targeting Acccess

Cutting back on access — either by freezing enrollments or cutting reimbursement rates — is not a choice states have taken happily. But it's a choice they were willing to make as a means of bringing budgets closer to balance. Children's health is universally seen as a worthy cause, but the fact remains that SCHIP and Medicaid families are not a very strong political constituency anywhere in the country.

Still, some states are doing better than others. Despite severe budget problems, Virginia simplified its application forms in 2002, instituted a joint form for SCHIP and Medicaid, and started new outreach efforts, with Governor Mark Warner going on what he called "a road show" to community fairs and churches to encourage families to sign up their children. The result by mid-summer 2003 was an additional 50,000 children enrolled.

Illinois last year increased coverage in its SCHIP program from 150 to 185 percent of poverty, adding an additional 20,000 children. Louisiana increased eligibility levels for pregnant women to 200 percent of the poverty level, and now covers a total of 600,000 children through either Medicaid or SCHIP, nearly twice as many as it covered five years ago. "We don't have uncoordinated care anymore," says Louisiana Health Secretary David Hood. "We have a program that I hope is going to change both recipient and provider behavior."

A few states have revamped their organizational and management systems to ensure better access to medical care while keeping costs under control. Rhode Island stands out in this respect. Currently, about 5 percent of Rhode Island children are uninsured. The state's "Rite Care" Program covers those

Out of the Loop

Percentage of children under age 18 with health care access problems, by select characteristics, 2001

ALL CHILDREN <18	10.4%	2.4%	4.1%	5.1%	6.8%	6.7%	34.8%
FAMILY STRUCTURE							
Mother and father	9.3	2.1	3.5	4.4	6.7	6.8	12.9
Mother, no father	11.9	3.0	6.2	6.6	8.6	8.5	16.1
Father, no mother	19.2	4.0	6.4	9.9	6.1	6.1	13.6
No mother or father	18.8	3.1	7.8	10.4	6.0	3.4	12.6
POVERTY STATUS							
Poor	18.4	4.8	6.8	9.8	18.9	12.8	19.8
Near poor	16.9	4.6	7.2	7.1	8.8	11.7	18.6
Not poor	6.4	1.4	2.6	3.4	6.5	4.6	12.3
REGION							
Northeast	8.6	1.9	3.41	3.1	6.1	5.6	11.7
Midwest	8.9	2.4	3.9	3.1	7.1	6.1	12.4
South	14.8	3.2	4.4	6.1	7.0	7.1	14.1
West	14.8	2.6	5.4	7.1	6.0	7.3	14.0

Source: National Center for Health Statistics, Centers for Disease Control and Prevention

Data for this graphic

below 250 percent of the poverty level and guarantees benefits to their mothers for two years after delivery. The state's immunization rates and infant mortality rates are significantly better than the national average. One of the state's major achievements has been to narrow the gap in infant mortality between high-income and low-income families. In the 1990s in Rhode Island, the infant mortality rate for children receiving public health coverage dropped 36 percent.

One of the keys to Rhode Island's success has been an organizational structure in which a "Children's Cabinet" crosses departmental boundaries. "The nature of government is to be insular and not look across many sections of government," says John Young, the state's Medicaid director. "But that's been our effort."

Rhode Island relies heavily on a managed care approach for meeting children's health care needs. Early on, it established a consumer advisory committee to deal with concerns voiced by patient advocates about managed care, and this committee has helped to establish safeguards. The state has buttressed quality in its managed care health plans through the use of performance contracting — setting up clear expectations for what the programs are expected to accomplish and rewarding those that meet the goals.

From *Governing*'s
February 2004 issue

THE GOVERNMENT PERFORMANCE PROJECT
A Case of Neglect

Children's Care Introduction

States that Stand Out

SUCCESS STORIES

Alabama
Although sub-par in many health indicators, Alabama has a good statewide children's dentistry program. By working closely with professional dental groups, the state has been able to target the problems that keep dentists in other states from treating Medicaid patients: rejected claims, no-shows and low payment rates. Since the official kickoff of Smile Alabama in 2000, 260 providers have been added to the program, and 50,000 more children have received dental care.

Illinois, Louisiana and Virginia
Although none of these states has been a leader in child health in the past, all three made it a priority last year, countering the national trend to pull back. Illinois expanded participation in its KidCare program by 20,000. Virginia increased outreach and adopted new policies aimed at simplifying the enrollment process, and Louisiana increased low provider rates, boosted eligibility levels for pregnant women and continued to expand primary care case management.

Maine, Minnesota and Wisconsin
These states stand out in using information to improve their child health programs. Managed care organizations in Minnesota and Wisconsin are offered financial incentives for improved performance. Maine approaches individual practitioners with the same techniques, an even more difficult feat.

Massachusetts
In a poll conducted by the American Academy of Pediatrics, Bay State pediatricians complained far less than doctors in most other states about heavy paperwork, low reimbursement or unpredictable payments. The state has one of the country's highest pediatric participation rates in Medicaid, one of the lowest infant mortality rates and the highest rate of immunizations.

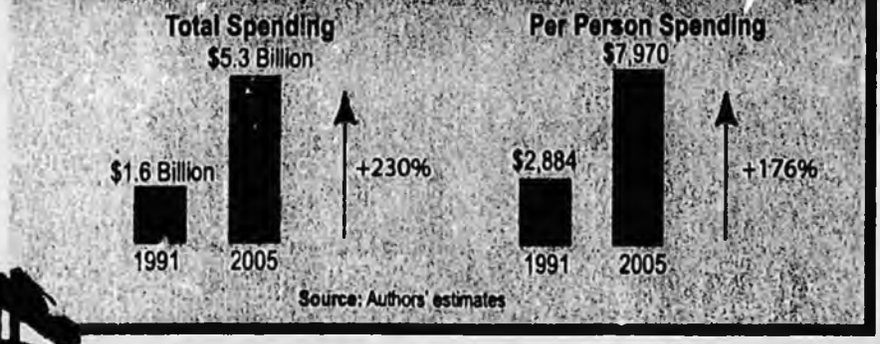
Missouri, New Hampshire, New Jersey and Vermont
These four states expanded their children's coverage well beyond that of most other states — and have so far avoided the temptation to cut back on children's

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

By Mark Foster and Scott Goldsmith

March 2006
UA Research Summary No. 6
Institute of Social and Economic Research • University of Alaska Anchorage

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



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

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

The $5.3 billion in spending in 2005 was all for the 665,000 people who live in Alaska, but individuals didn't pay all the bills. They paid nearly 20% out of their pockets and through payroll deductions. Businesses (including non-profits) and governments paid about 80%. Of course, individual Alaskans and other Americans indirectly pay all these costs, because they buy goods and services, own businesses, and pay taxes.

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

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

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

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

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

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

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

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

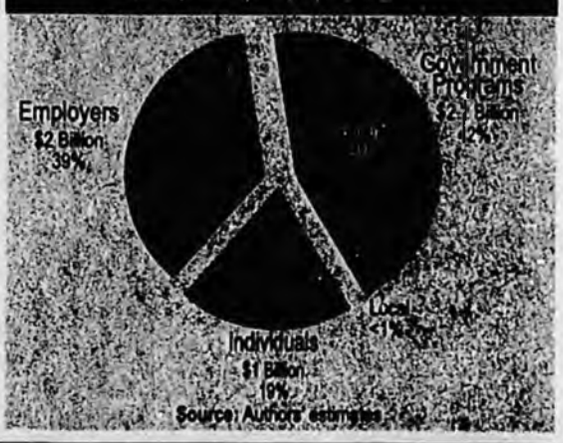
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

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

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

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

Figure 2. Who Pays The Bills?



COMMONWEALTH NORTH

Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES*

Approved by the Board of Directors on June 7, 2005
Updated July 31, 2005

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EXECUTIVE SUMMARY

Why Alaska health care issues must be addressed and solved

Health care is not a goal or end in itself. The ultimate goal of health care and of this study is health and wellness for Alaskans. Alaskans must identify and improve the aspects of health care that are under our control. Many health care issues are national, that Alaskans cannot affect. Therefore, it is even more important to address and solve issues we can do something about. Furthermore, the demographics of an aging population will put foreseeable pressure on all fronts.

ACCESS

- Approximately 110,000 Alaskans have no health insurance coverage.
- Many others have minimal or inadequate coverage.
- Thousands are turning to hospital emergency rooms as a source of primary health care, often without ability to pay.
- Adequate health care in remote areas is a significant logistical, financial and educational challenge.

QUALITY

- Based on the 2004 National Healthcare Quality Report, Alaska has low rankings in several key measures of cancer, heart disease, maternal and child health, respiratory diseases, and nursing and home health care.
- Many Alaskans are in high-risk health categories, many are not receiving adequate care.

COST

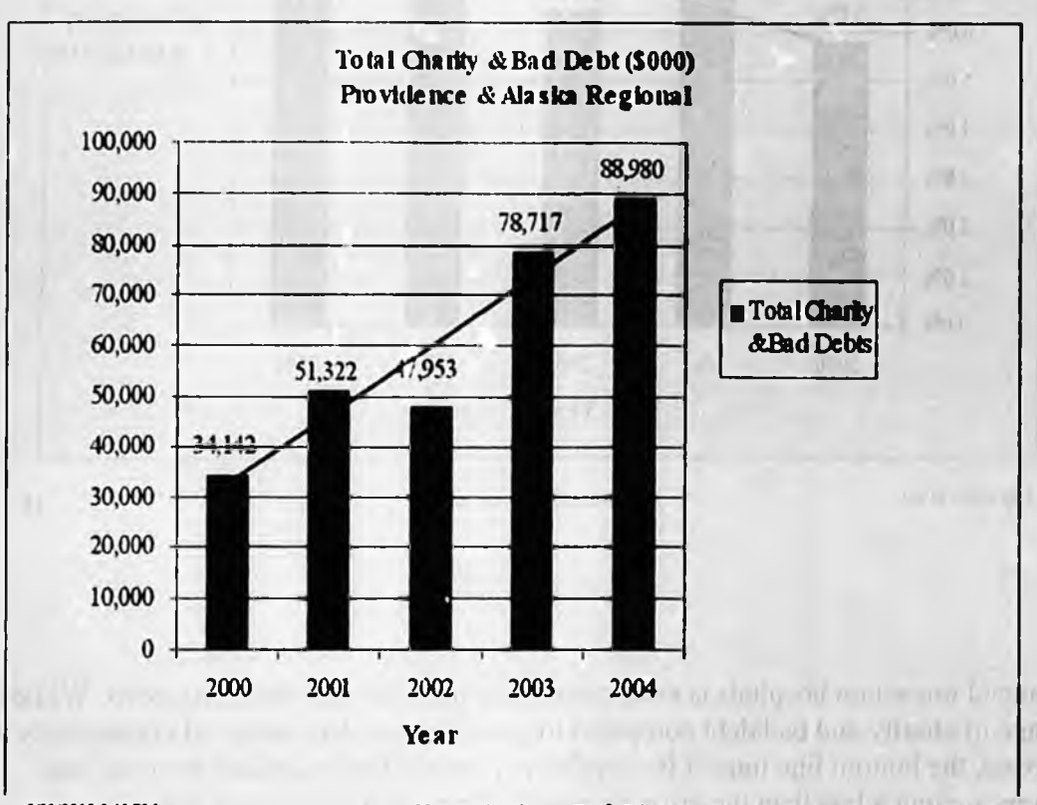
- Alaska health care costs are approximately 40% higher than Seattle (per Premera, corroborated by Providence and Alaska Regional)
- Medicaid costs to the State of Alaska are rising dramatically, to over $1 billion in 2005. It is placing a strain on the state budget.
- Health care insurance premiums are also rising dramatically, creating a significant burden on employers and employees.
- Alaska hospitals are losing tens of millions of dollars from uncollectable accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law.

What can we do?

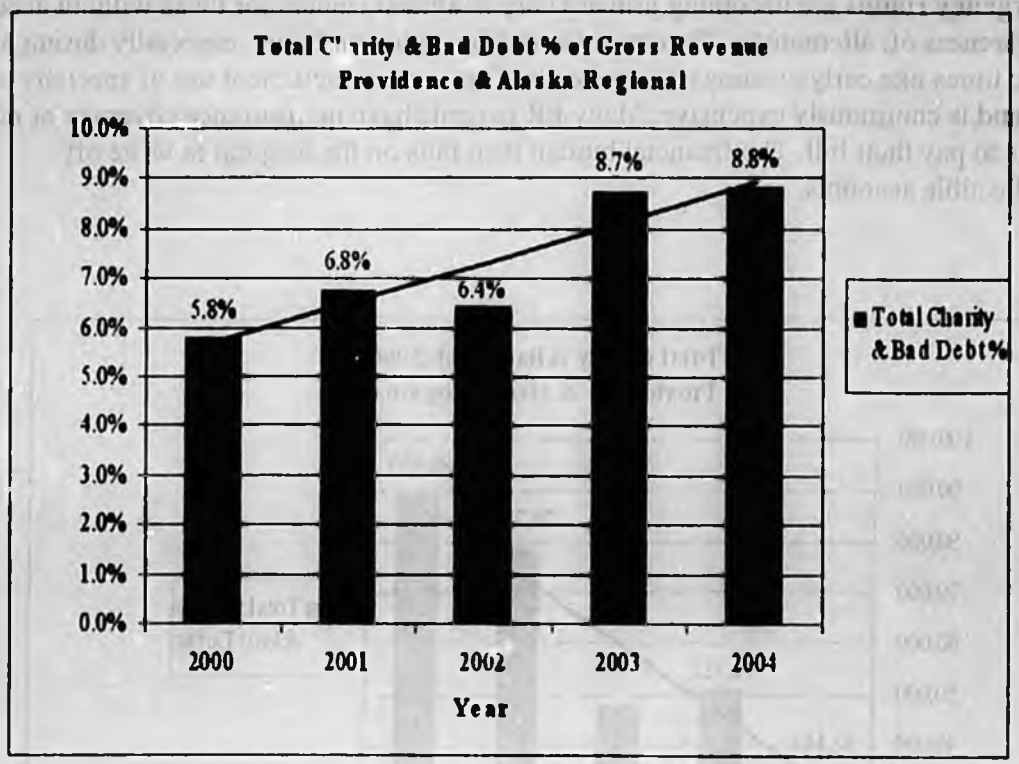
There are four major interrelated factors driving primary healthcare in Alaska today:

1. Health and wellness of the population
2. Availability of care and insurance
3. Affordability of care and insurance
4. Financial health of the stakeholders, such as employers, providers and individuals

Emergency rooms are becoming primary care treatment centers for those without access to, or awareness of, alternatives. Current waits can be up to two hours, especially during high traffic times like early evenings or weekends. This creates inefficient use of specially trained staff and is enormously expensive. Many ER patients have no insurance coverage or other means to pay their bill. The financial burden then falls on the hospital to write off uncollectible accounts.



Note: the numbers above are in thousands of dollars. E.g. 88,980 = $88,980,000



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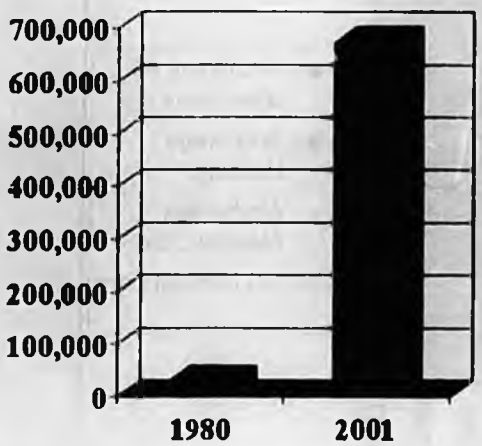
The financial impact on hospitals is even more acute than the slide above suggests. While the percentage of charity and bad debt compared to gross revenue has increased dramatically in recent years, the bottom line impact is significantly greater because actual hospital cash collections are much less than the gross revenue billings used in the chart above.

Hospitals are not the only ones affected. Individuals unable to pay medical expenses are filing for bankruptcy at staggering rates. Although Alaska data are not available, national data are noted below.

Personal Bankruptcies due to Health Care Costs-U.S.



- Between 1980 and 2001 medically driven bankruptcies increased 23 times
- 60% skipped doctors visits
- 47% skipped prescription medicines

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Source: American Medical Association 2/05 and a Harvard Law School/Medical School 2/05 studies.

70% of these debtors had some form of health insurance at the start.

Main factors cited for declaring bankruptcy were:

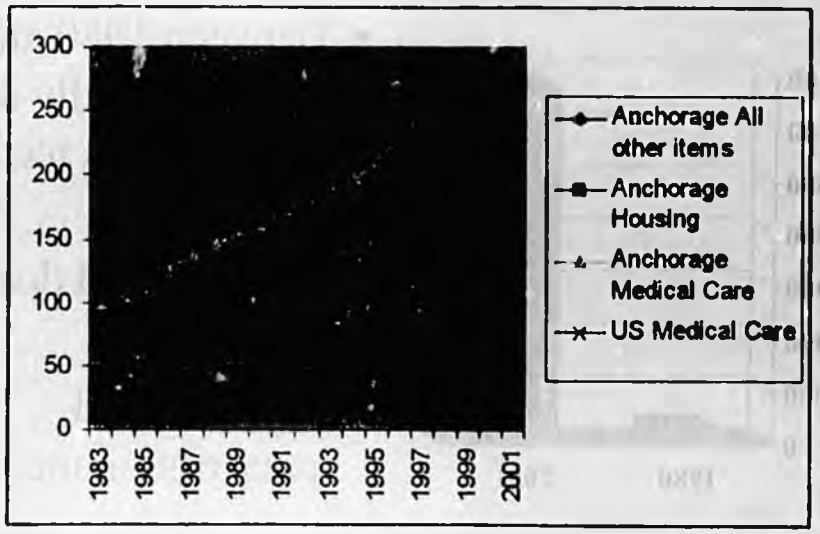
Hospital costs	42%
Prescription drug costs	21%
Doctor bills	20%

Cost: What do Alaskans pay? Why?

The impact of **bad debt** on the health care system has been clearly illustrated in the preceding charts.

Increasing Cost of Medical Care in Alaska

Anchorage CPI-U for selected components 1982-2001



Source: Alaska Economic Trends June 2004

Premera, Alaska's largest health care insurer, reports that their **Alaska costs are about 40% higher than Seattle**. General observations by resource people have referenced a 40% differential overall, more in some specialties, less in others. Local hospitals have corroborated this differential. Other information points to even larger discrepancies on reimbursement rates for physicians. The Alaska Division of Medical Assistance Health Care Cost Analysis Report placed Alaska in the top five states in terms of the cost of medical and surgical procedures.

Small practices and increasing personnel costs contribute to the high cost of medicine in Alaska. Also there is general, but not substantiated, belief that the **Alaska population is too small to support HMOs**. Any discussion of managed care has been resisted by medical providers.

Dependence on "Fair Share" and other sources of federal dollars place about $800 million potentially at risk, an important share of current health care funding to Alaska. Alaska also **faces competition from other states** for willing providers. Furthermore, **reimbursement**

National Academy Of Sciences

Hidden Cost, Value Lost: Uninsurance in America

Executive Summary

The discontinuity of coverage and complete lack of health insurance among tens of millions of Americans every year entail costs for our society in

- lost health and longevity, including health deficits leading to developmental and educational losses for children;
- financial risk, uncertainty and anxiety within families with one or more uninsured members;
- financial stresses for and instability of health care providers and institutions in communities with relatively high uninsured rates that reduce the scope and amount of available health services, including public health services; and
- lost workforce productivity.

As a nation and as public law, we invest in the health of those who have health insurance, through tax subsidies and publicly sponsored coverage. About 85 percent of the U.S. population benefit from this investment. As a society, we also spend substantial public resources for health care services to the remaining 15 percent of Americans—the more than 41 million people who lack coverage every year. Despite this public spending on health services for the uninsured, those who lack coverage have worse health outcomes than do similar individuals with insurance, because dollars alone do not confer the health benefits that continuous coverage does. If all members of society bear certain risks and costs from spillover effects of uninsurance, all should realize some benefit, at least indirectly, from a public policy ensuring that everyone has coverage.

Hidden Costs, Value Lost: Uninsurance in America tallies some of the most clearly identifiable economic and social costs of uninsurance, as described in the

Committee's previous four reports. The Committee concludes that maintaining an uninsured population of 41 million results in a substantial loss of economic value that improved health would provide uninsured individuals. The Committee also believes that, as health care interventions become ever more effective in improving health and extending life, unequal access to such care, as documented in *Care Without Coverage* and *Health Insurance Is a Family Matter*, becomes increasingly unjust.

Americans devote more economic resources to health care than people in any other nation in the world, both in total dollars spent ($1.236 trillion for personal health care services in 2001) and as a percent of the gross domestic product (14 percent) (Levit et al., 2003). Access to health care is valued highly and widely throughout American society. In this report, the Committee takes a broad, societal perspective as it examines the performance of economic resources devoted to health care, health insurance, and alternative uses for these resources, which include personal resources, firms' investments, and public monies.

The societal perspective allows the Committee to evaluate our society's failure to invest in health insurance for 15 percent of the population from the standpoint of the public interest, rather than the interest of any particular individual or group within society. Practically, the societal perspective reflects the kind of aggregate, population-based information and national data sets that the Committee was able to use in its analyses. More importantly, as a matter of principle or ethical choice, the societal perspective values the interests of each individual member of society equally and allows the Committee to examine the fairness of the distribution of the costs and benefits of public policies and investments in health (Gold et al., 1996a).

WHAT ARE COSTS OF UNINSURANCE?

What do we mean by cost? This report draws on information developed within several different analytic frameworks because of the breadth of the issues encompassed by the "costs of uninsurance." When uninsured people obtain coverage, their use of health services would be expected to increase as a result of improved financial access. The majority of the costs due to being uninsured that the Committee has identified are not health services costs (that is, uncompensated care or expensive hospitalizations because of delayed treatment) but rather result from the poorer health outcomes of uninsured individuals.

Families with uninsured members bear costs resulting from the financial burdens and risks of out-of-pocket health care spending and, because children's receipt of health care in practice depends on their parents' coverage status, children in families with uninsured parents are less likely to receive adequate services.

The spillover costs of uninsurance experienced within communities result from both the poorer health of uninsured populations and the demands made on local public budgets and on providers to support care for those without coverage. Thus, this report considers both the extent and the source of resources devoted to

the care of people without health insurance and the economic cost implications of the poorer health they experience because they lack coverage.

THE VALUE LOST IN POORER HEALTH

Given the key role of health coverage in improving health outcomes, how much health is lost with a population of more than 41 million uninsured? In this report, the Committee adapts an analytic strategy that has been used to assess the value of life-saving and health-improving medical interventions, imputing a monetary value to the years of expected life that an individual is estimated to have in particular states of health (e.g., excellent, fair, poor; with controlled hypertension, or prostate cancer in remission, or no functional limitations).

The present value in money terms of the "stock" of years of life in certain expected states of health has been coined "health capital" (Grossman, 1972; Cutler and Richardson, 1997). This analytic concept of health capital is related to the approach used by government agencies that regulate public health and safety (e.g., Food and Drug Administration, Department of Transportation, Environmental Protection Agency) to evaluate and compare alternative public policies that mitigate risk and improve health. This approach involves estimating the value of averted risk as expressed by the expected number of lives saved (statistical or anonymous lives when the policy is implemented) to determine whether the benefit of reducing a particular risk or harm justifies the costs involved in adopting such a policy. The Committee has applied the analytic concept of health capital to the health risk it has been concerned with—the risk of being uninsured, compared to having coverage. Stated in the converse, the Committee has estimated the aggregate personal economic value that would be added if the entire U.S. population had health insurance coverage, compared with the status quo, which leaves 16.5 percent of the population under age 65 without coverage.

The Committee commissioned an analysis estimating the value of diminished health and longevity within the U.S. population as a result of uninsurance. Economist Elizabeth Richardson Vigdor combined information on the longevity, prevalence of health conditions, and health-related quality of life for insured and uninsured populations. The relative mortality rates for insured and uninsured populations were drawn from the Committee's earlier systematic literature review of health outcomes as a function of health insurance status and reflect a 25 percent higher mortality rate within the uninsured population (IOM, 2002a,b). Vigdor's estimates constitute a range of values for the forgone health of uninsured individuals, based on different assumptions about the relative health status of insured and uninsured populations.

Imputing a value of $160,000 to a year of life in perfect health and calculating the present value of future years with an annual discount rate of 3 percent, Vigdor estimated that the economic value of the healthier and longer life that an uninsured child or adult forgoes because he or she lacks health insurance ranges between $1,645 and $3,280 for each additional year spent without coverage

(Vigdor, 2003). This value differs for people of different ages and for men and women because of differences in underlying health status and life expectancy. These estimated benefits could be either greater or smaller if unmeasured personal characteristics were responsible for part of the measured difference in morbidity and mortality between those with and those without coverage.

The Committee's best estimate of the aggregate, annualized cost of the diminished health and shorter life spans of Americans who lack health insurance is between $65 and $130 billion for each year of health insurance forgone. These are the benefits that could be realized if extension of coverage reduced the morbidity and mortality of uninsured Americans to the levels for individuals who are comparable on measured characteristics and who have private health insurance. This estimate does not include spillover losses to society as a whole of the poorer health of the uninsured population. It accounts for the value only to those experiencing poorer health and subsumes the losses to productivity that accrue to uninsured individuals themselves.

These estimates constitute an initial effort to develop an integrated and coherent framework for evaluating a number of economic costs attributable to the lack of health insurance; they are not definitive but suggest the direction that further research and analysis might take. Figure ES.1 illustrates the costs of uninsurance that the Committee has documented in its work to date. The bracket to the left of the pyramid shows the costs that are captured in the estimate of the economic value of forgone health by those who lack coverage, and the costs that are additional to that estimate.

HEALTH CARE COSTS OF THE UNINSURED

In its analysis of the costs of health care now used by those who lack health coverage, the Committee finds that

- **Uninsured children and adults are less likely to incur any health care expenses in a year and, on average, incur health care costs well below half of average spending for services by all those under age 65.**
- **People who lack health insurance for an entire year have out-of-pocket expenditures comparable, in absolute dollar amounts, to those of people with private coverage. Uninsured individuals pay for a higher proportion of the total costs of care rendered to them out of pocket, however, compared to insured individuals under age 65 (35 percent, compared with 20 percent), and they also have much lower family incomes. Out-of-pocket spending for health care by the uninsured is more likely to consume a substantial portion of family income than out-of-pocket spending by those with any kind of insurance coverage.**
- **The total cost of health care services used by individuals who are**

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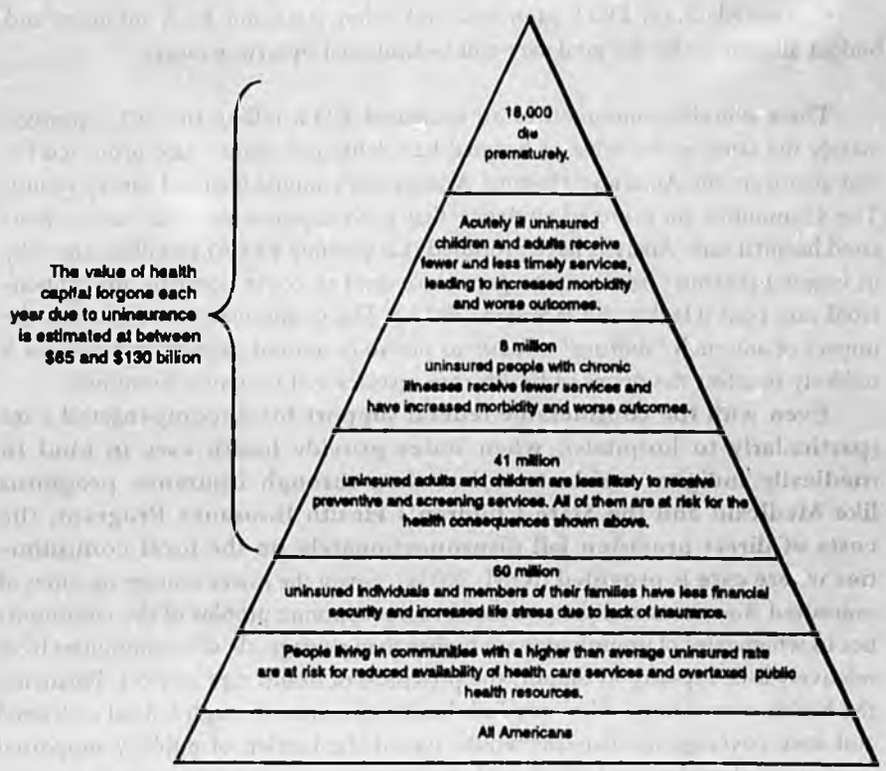

FIGURE ES.1 Consequences of uninsurance.

uninsured for either part of or the entire year is estimated to be $98.9 billion for 2001.

- **The best available estimate of the value of uncompensated health care services provided to persons who lack health insurance for some or all of a year is roughly $35 billion annually, about 2.8 percent of total national spending for personal health care services.**

The direct costs of uncompensated care provided to uninsured people are largely borne by those who pay taxes. Public support from the federal, state, and local governments accounts for between 75 and 85 percent of the total value of uncompensated care estimated to be provided to uninsured people each year (Hadley and Holahan, 2003a). Public subsidies to hospitals are paid through

- federal Medicaid and Medicare disproportionate share hospital (DSH) payments and other financing mechanisms, and

• state Medicaid DSH payments and other state and local subsidies and budget allocations for hospital care and institutional operating costs.

These subsidies amounted to an estimated $23.6 billion in 2001, approximately the same as the value of hospital bad debts and charity care projected for that year from the American Hospital Association's annual financial survey results. The Committee finds mixed evidence that private payers subsidize uncompensated hospital care. Analysts have proposed that possibly $1.6 to $3 billion annually in hospital revenues from private payers are used to cover hospitals' uncompensated care costs (Hadley and Holahan, 2003a). The Committee concludes that the impact of any such "shifting" of costs to privately insured patients and insurers is unlikely to affect the prices of health care services and insurance premiums.

Even with the considerable federal support for uncompensated care (particularly to hospitals), when states provide health care in kind to medically indigent residents rather than through insurance programs like Medicaid and the State Children's Health Insurance Program, the costs of direct provision fall disproportionately on the local communities where care is provided (IOM, 2003a). Given the lower average incomes of uninsured Americans and the associated socioeconomic profiles of the communities in which rates of uninsurance are higher than average, these communities have relatively little capacity to support the provision of health care services. Financing the health care of those who now lack health insurance through federal or federal and state coverage mechanisms would spread the burden of publicly supported care over a broader tax base than that which supports uncompensated care for those without coverage.

QUALITY OF LIFE AND SECURITY FOR FAMILIES

Uninsured individuals and families bear the burden of increased financial risk and uncertainty as a consequence of being uninsured. Although the estimated monetary value of the potential financial losses that those without coverage bear is relatively small (compared to the full cost of their services) because of uncompensated care, the psychological and behavioral implications of living with financial and health risks and uncertainty may be significant. The Committee estimates that the financial risk borne by those without coverage has an economic cost of $1.6 to $3.2 billion. This would be the value, to those now lacking coverage, of the financial protection provided by health insurance.

Even in families in which all members are insured, the concern about losing coverage remains genuine. One, some, or all members can lose health insurance at some point, because of lifecycle events such as leaving school or retiring or because of economic conditions that result in the loss of income or workplace benefits, such as becoming unemployed or changing jobs. This lack of social and economic security, experienced by virtually all Americans except for those who

have gained Medicare coverage on a permanent basis (i.e., those over age 65 or with end-stage renal disease), is truly a hidden cost of our patchwork approach to health insurance.

OTHER COSTS OF UNINSURANCE

Developmental Losses for Children

Uninsured children are at greater risk than children with health insurance of suffering delays in development that may affect their educational achievements and prospects later in life. Good health and meeting developmental milestones in infancy and childhood affect individuals' educational attainment, earning capacity, and long-term health. The Committee's estimate of health capital forgone by uninsured children and adults that was presented earlier subsumes these developmental losses. The Committee includes its review of studies and earlier findings regarding worse health outcomes among uninsured children to provide an empirical underpinning to its approach to estimating health capital losses resulting from the lack of health insurance.

Costs to Public Programs

The Committee considered other costs that are attributable to uninsurance without attempting to quantify them. Although the costs of morbidity and productivity losses associated with individual health conditions have been estimated, there is no body of research with which to investigate these effects as a function of health insurance status in a systematic way. Thus the Committee has identified public program and workforce impacts of health insurance status that can be inferred from related evidence about the effects of health status on disability and productivity and the effects of health insurance on health status, largely based on the Committee's reports *Care Without Coverage* and *Health Insurance Is a Family Matter.*

Based on its findings and conclusions about health outcomes as a function of health insurance status in its earlier reports, the Committee concludes that public programs, including Medicare, Social Security Disability Insurance, and the criminal justice system almost certainly have higher budgetary costs than they would if the U.S. population in its entirety had health insurance up to age 65. It is not possible, however, to estimate the extent to which such program costs are increased as a result of worse health due to lack of health insurance.

As calculated for this study, the value of healthy years of life forgone by those without health insurance does not include any health and longevity impacts that occur after age 65, when Medicare covers virtually the entire population. The Committee's conservative assumption in estimating the value of health lost likely underestimates the health benefits enjoyed by individuals who would gain addi-

tional health and longevity after age 65 if they had health insurance continuously prior to that age. It is also likely to underestimate the potentially reduced costs to the Medicare program of financing services for persons with pent-up demand for care or health "deficits" as a result of having been without coverage previously. For example, individuals who have poorly controlled hypertension or diabetes or undetected high cholesterol because of irregular or no medical attention to their condition enter the Medicare program with more comorbidities and worse health status than do persons whose conditions have been treated over time.

Likewise, increasing disability among the working-age population (even as the disability rate has decreased over the past two decades for those older than 65), suggests that health and functional status improvements that health insurance provides could reduce disability insurance claims.

In the case of serious mental illness, for example, there can be substantial spillover costs of uninsurance to society. More than 3 million adults in the United States have either schizophrenia or bipolar disorder (manic-depressive disease), which can involve psychosis and aberrant behavior. Fully 20 percent of the adults with one of these conditions who do not reside in institutions lack health insurance. Although being insured is no guarantee that mental health services are a covered benefit or that one will be treated appropriately for mental health problems, persons with either public or private health insurance are more likely to receive some care for their condition than are those without any coverage. Between 600,000 and 700,000 persons with severe mental illness are jailed each year. Ironically, contact with the criminal justice system increases the chances that someone with a severe mental illness will receive specialty mental health services. The costs of less effective treatment resulting from lack of health insurance likely contribute to the costs of incarcerating people with serious mental illness.

Workforce Participation, Productivity, and Employers

Illness and functional limitations impair people's abilities to work and consequently impose the costs of forgone income and productive effort on those who are sick and disabled, their families, and potentially on their employers as well. The costs for employers of productivity losses on the job for workers with particular illnesses have been increasingly well studied within the past decade. The impact that providing workers with health insurance has on workplace productivity, however, is less well documented. What evidence exists suggests that, although workers' health status may improve as a result of having coverage, individual employers probably do not lose financially, on net, as a result of impaired productivity on the job if they do not currently offer their workers health insurance benefits. Any systemic, regional, or national losses of productivity or productive capacity as a result of uninsurance among nearly one-fifth of the working-age population cannot be measured with the data now available.

Costs for Communities

Not only those who lack coverage but others in their communities may experience reduced access to and availability of primary care, specialty, and hospital services resulting from relatively high rates of uninsurance that imperil the financial stability and viability of health care providers and institutions. Communities that have higher than average rates of uninsurance are more likely to experience reduced availability of hospital-based services and critical community benefits such as emergency services and advanced trauma care (IOM, 2003a; Gaskin and Needleman, 2003; Needleman and Gaskin, 2003).

In addition, population health resources and programs, including disease surveillance, communicable disease control, emergency preparedness, and community immunization levels, have been undermined by the competing demands for public dollars for personal health care services for those without coverage. Because uninsured individuals and families are much less likely than are those who have coverage to have a regular health care provider, they are not well integrated into systems of care. Consequently, population-level disease surveillance and health monitoring is reduced in communities with large uninsured populations.

THE COST OF THE HEALTH CARE THAT UNINSURED PEOPLE WOULD USE IF THEY HAD COVERAGE

In order to evaluate fairly the cost of the better health that uninsured Americans could be expected to achieve if they had health insurance, the Committee reviewed estimates of the value of the additional health services that would be provided to the uninsured once they became insured. **Estimates of the incremental costs of health services that the population that now lacks insurance could be expected to use if they gained coverage range from $34 to $69 billion (in 2001 dollars).** These estimates should not be construed as the costs of any particular plan to reform health care financing to provide health insurance to those now without it. This range of estimates, derived from three independent analyses, assumes no other structural changes in the systems of health services delivery or finance, scope of benefits, or provider payment (Long and Marquis, 1994; Hadley and Holahan, 2003b; Miller et al., 2003). The ultimate cost of any reform will depend on the specific features of the approach taken. These estimated costs amount to 2.8–5.6 percent of national spending for personal health care services in 2001, equivalent to roughly half of the 8.7 percent increase in personal health care spending between 2000 and 2001.

COSTS AND BENEFITS CONSIDERED TOGETHER

Table ES.1 summarizes the Committee's estimates of the amounts and sources of payment for the health care currently provided to uninsured Americans, the

TABLE ES.1 Estimates of Current Annual Cost of Health Care Services for Full- and Part-Year Uninsured Individuals, Projected Incremental Annual Costs of Services If Insured, and Economic Value Gained by Uninsured Individuals If Insured, Annualized

	Billions $, estimated for 2001
Current cost of care for full- and part-year uninsured	98.9
Amount paid out of pocket by full- and part-year uninsured	26.4
Insurance payments (for part-year uninsured only) and workers' compensation	
Private	24.2
Public	13.8
Uncompensated care	34.5
Projected annual costs of additional utilization with coverage	34–69
Benefits of insuring the uninsured	
Aggregate value of health capital forgone by the uninsured, annualized	65–130
Aggregate annual value of risk borne by uninsured	1.6–3.2

SOURCES: Hadley and Holahan, 2003a,b; Vigdor, 2003.

projected cost of the additional health care that the presently uninsured population would receive if insured, and the aggregate, annualized economic value of lost health and financial security that those who lack coverage forgo, despite the substantial health care expenditures made on their behalf.

The next step in the Committee's analysis is to consider the potential benefits of providing the uninsured with coverage in conjunction with the new economic costs of the additional health services that would improve their health. In order to do this, both the average per capita gain in health due to an additional year of health insurance for the uninsured population and the average per capita annual cost of the additional health services that the uninsured population would use if they had coverage must be made comparable. Because the estimate of the value of health gained with an additional year of coverage is calculated as a discounted present value of the gain for a cohort of uninsured people over the course of their lives (with a range of $1,645 to $3,280 as presented earlier), the estimate of the annual cost of the additional health care that the uninsured would use if insured also must be calculated as the present value for an uninsured cohort over the course of their lives.

Using the projected annual cost of the additional utilization by those without coverage from Hadley and Holahan (2003b), the Committee estimated that the discounted present value of the cost of an additional year of health insurance ranges from $1,004 to $1,866, depending on whether the incremental service costs

are based on the cost of public or private health insurance. The range of estimated benefits from the incremental coverage ($1,645 to $3,280) is higher than the range of estimated incremental service costs ($1,004 to $1,866) and, for most values within each range, results in a benefit-cost ratio of at least one.

REALIZING SOCIAL VALUES AND IDEALS

Finally, the Committee reflected on several other benefits that our national community and local communities within the United States might gain if health insurance coverage were extended throughout the population. Economic goods that can be valued in monetary terms are not the only kinds of goods that we value having. Providing certain important goods like health care to all members of society has its own value (Walzer, 1983; Coate, 1995). In addressing normative questions, the Committee has attempted to start from values that are widely endorsed throughout American society, such as equality of opportunity, and then to make judgments about whether public policy and economic practices in health care accord with a reasonable characterization of those values. The Committee does not attempt to make a freestanding argument about objective morality but rather claims that collective actions can express or achieve existing social norms and ideals.

Because health care relieves pain and suffering and enhances our ability to function and achieve over the course of a lifetime, making sure that everyone in society has adequate access to this good is a matter of fairness and social decency (Daniels, 1985; Sen, 1993). A commitment to equal opportunity obligates us as a society to ensure that all Americans have sufficient access to health care such that they are not disadvantaged in pursuing the career and other opportunities offered by American society.

Health insurance contributes essentially to obtaining the kind and quality of health care that can express the equality and dignity of every person. Despite the absence of an explicit Constitutional or statutory right to health care (beyond access to emergency care in hospitals, required by the Emergency Medical Treatment and Labor Act), disparities in access to and the quality of health care of the kind that prevail between insured and uninsured Americans contravene widely accepted, democratic cultural and political norms of equal consideration and equal opportunity. The increasing effectiveness of medical interventions in improving health and survival (Cutler and Richardson, 1997; Murphy and Topel, 1999; Heidenreich and McClellan, 2003) make considerations of equity in access to effective care through health insurance more urgent.

Uninsurance in America not only has hidden costs, it represents lost opportunities to more fully realize important social and political ideals that account for our nation's political stability and vitality (Dionne, 1998; NASI, 1999). Extending the social benefit of health insurance would help us make our implicit and explicit democratic political commitments of equal opportunity and mutual concern and respect more meaningful and concrete.

National Conference *of* State Legislatures

Policy Brief

WHO'S COVERED AND WHO'S NOT?

THE STATE OF CHILDREN'S HEALTH INSURANCE: A PRIMER FOR STATE LEGISLATORS

by Michelle Herman

February 2006

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

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

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

WHY DO CHILDREN NEED HEALTH INSURANCE?

Health care experts unequivocally agree on the importance of covering children. Lack of health insurance is a substantial barrier to health care.[4] Uninsured children have much higher health risks than do covered children. They are more likely to go without health services, may avoid or delay care when it is needed, and are less likely to receive the proper medical care for childhood illnesses such as sore throats, earaches and asthma. Children who have health insurance are more likely to have a usual place of care and reliably receive preventive and medical services. One study found that among near-poor children, 36 percent of uninsured children had an unmet medical need, compared to 9 percent of children with public insurance and 14 percent of those with private coverage.[5] Another recent report found that almost one-third of uninsured children received no medical treatment during a one-year period between 2002 and 2003.[6]

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

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

WHO'S COVERED AND WHO'S NOT?

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

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 eligible children and pregnant women . . .
RDU: Administration & Operations
Component: Office of the Commissioner
Sponsor: Senators Wielechowski, French, Ellis, Elton, 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: Dwyane Peeples, Deputy Commissioner
Date 3/1/2007
Agency: Department of Corrections

(Revised 9/18/2006 OMB)

National Conference *of* State Legislatures

Policy Brief

WHO'S COVERED AND WHO'S NOT?

THE STATE OF CHILDREN'S HEALTH INSURANCE: A PRIMER FOR STATE LEGISLATORS

by Michelle Herman February 2006

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

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

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

WHY DO CHILDREN NEED HEALTH INSURANCE?

Health care experts unequivocally agree on the importance of covering children. Lack of health insurance is a substantial barrier to health care.[4] Uninsured children have much higher health risks than do covered children. They are more likely to go without health services, may avoid or delay care when it is needed, and are less likely to receive the proper medical care for childhood illnesses such as sore throats, earaches and asthma. Children who have health insurance are more likely to have a usual place of care and reliably receive preventive and medical services. One study found that among near-poor children, 36 percent of uninsured children had an unmet medical need, compared to 9 percent of children with public insurance and 14 percent of those with private coverage.[5] Another recent report found that almost one-third of uninsured children received no medical treatment during a one-year period between 2002 and 2003.[6]

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

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

WHO'S COVERED AND WHO'S NOT?

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

SB

90

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/21/07

FURTHER: Finance

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

DATE TURNED IN TO OFFICE: 3/7/07

Health, Education and Social Services Committee considered

SENATE BILL NO. 90

SB 90 SENIOR CARE

"An Act relating to the senior care program; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Fiscal	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Fiscal	Zero	FN#
HSS	2/12/07	✓			

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Jo J Thomas	Thomas	✓			
Robert Ruedrich	Coulter-F	✓			
CHAIR: Betty Davis	DAVIS	✓			

Senior CARE Rx

SeniorCare Program Proposal Comparison

SeniorCare Proposals	Current SeniorCare Program	SB 90/HB 148 Governor's Proposal	SB 4 Senator Olson
Monthly Payment	Cash - $120 / month Prescription Drug - $670 / year	Cash - $120 / Month	Cash - $150 / Month
Annual Income Limit	Cash *Income Threshold* • $16,133 for individuals • $21,641 for couples (135% of 2005 federal poverty guidelines. Income limits frozen at 2005 levels.) *Asset Limits* • $6,000 Individual • $9,000 Couple Prescription Drug • $20,913 for individuals • $28,053 for couples (175% of 2005 federal poverty guidelines)	Cash *Income Threshold* • $17,240 Individual • $23,112 Couple (135% of 2007 federal poverty guidelines. Income limits will increase each year to keep pace with annual increases in federal poverty guidelines for Alaska.) *Asset Limits* • $6,000 Individual • $9,000 Couple Prescription Drug Benefit Ended	Cash *Income Threshold* • $16,133 Individual • $21,641 Couple (135% of 2005 federal poverty guidelines. Income limits frozen at 2005 levels.) *Asset Limits* • $6,000 Individual • $9,000 Couple Prescription Drug Benefit Ended
Dual Eligibility SeniorCare & Longevity Bonus	Yes	No	Is not intended to provide dual eligibility
FY08 Projected Average Monthly Caseload	Cash 7,043 Prescription Drug 140	Cash 5,040	Cash 4,835 – if receipt of ALB and SeniorCare is not allowed
Estimated Benefit Payments for FY08	Cash $10,141.9 Prescription Drug $93.8	Cash $7,257.6	Cash $8,703.0 – if receipt of ALB and SeniorCare is not allowed
Sunset Date	June 30, 2007	Extends program 5 years to June 30, 2012	No expiration date

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STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

February 20, 2007

The Honorable Lyda Green
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Dear President Green:

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

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

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

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

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

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

Sincerely,

Sarah Palin
Governor

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 90
(S) Publish Date: 2/21/07
Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):
Title: REAUTHORIZE SENIOR CARE
RDU: Public Assistance
Component: SeniorCare

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR
Requester: GOVERNOR
Component No.: 2760

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	(5,377.2)	(5,282.2)	(5,187.1)	(5,090.6)	(4,992.7)	(12,634.8)
Miscellaneous						
TOTAL OPERATING	(5,377.2)	(5,282.2)	(5,187.1)	(5,090.6)	(4,992.7)	(12,634.8)
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

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

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

POSITIONS

Full-time						
Part-time						
Temporary						

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

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

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

(Revised 9/7/2005 OMB)

STATE OF ALASKA **BILL NO. SB 90**
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

Assumptions

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

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

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

Administration

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

FOR IMMEDIATE RELEASE 07-034

Governor Palin Outlines Continued Support for Alaska Seniors

February 21, 2007, Juneau, Alaska — Governor Sarah Palin introduced legislation today to continue support for low-income older Alaskans by extending the Alaska SeniorCare Program. Without passage of this legislation, the program will end June 30, 2007.

"We must support our seniors," Governor Palin said. "I'm pleased to present a plan that continues this important assistance to Alaska seniors, and helps keep pace with cost-of-living changes."

The SeniorCare program was created in 2003 to help low-income Alaska seniors with monthly cash payments of $120. The program was expanded in 2005 to help cover prescription drug costs. Currently, nearly 7,000 Alaskans are enrolled in the SeniorCare cash assistance program and about 140 receive prescription support.

Governor Palin's legislation will continue the $120 SeniorCare monthly cash payment to low-income seniors for five years and will tie eligibility to the annual federal poverty income guidelines for Alaska. Currently, the program's eligibility is frozen at 135 percent of the 2005 federal poverty level.

About 2,500 seniors enrolled in SeniorCare previously were enrolled in the Alaska Longevity Bonus Program. If seniors receiving SeniorCare previously received the Alaska Longevity Bonus, they will be given a choice between receiving SeniorCare or the Alaska Longevity Bonus, should both be supported by the Alaska legislature.

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

###

The Governor's comments regarding SeniorCare can be found on the Governor's feed at 3:30 p.m.

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

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

FACT SHEET

Sherry Hill
Communications Officer
/Legislative Liaison
907-465-1618
FAX: 907-465-3068
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February 21, 2007

SeniorCare Program

Governor Sarah Palin's 2007 legislation:

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

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

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

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

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

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

- more -

SeniorCare History

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

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

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

- ##### -

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

Karleen Jackson
Commissioner
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FACT SHEET

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January 2007

SeniorCare Survey of Alaska's Seniors

Background

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

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

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

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

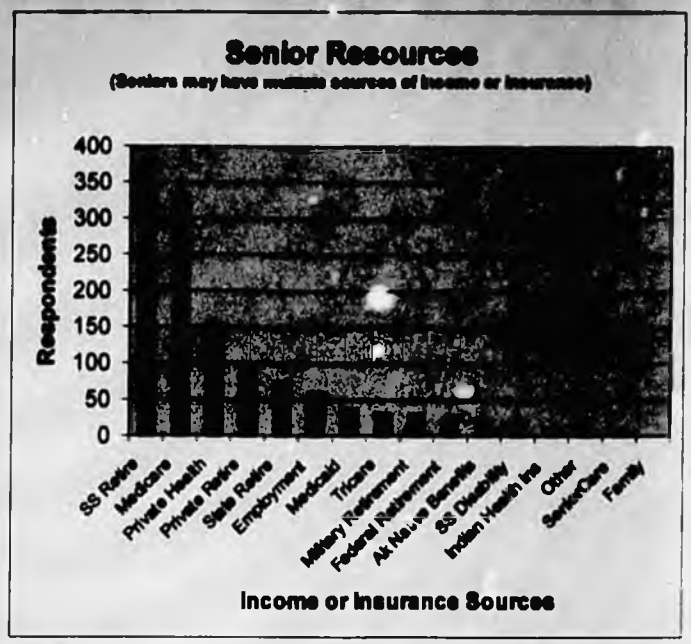
SeniorCare Survey Outcomes:

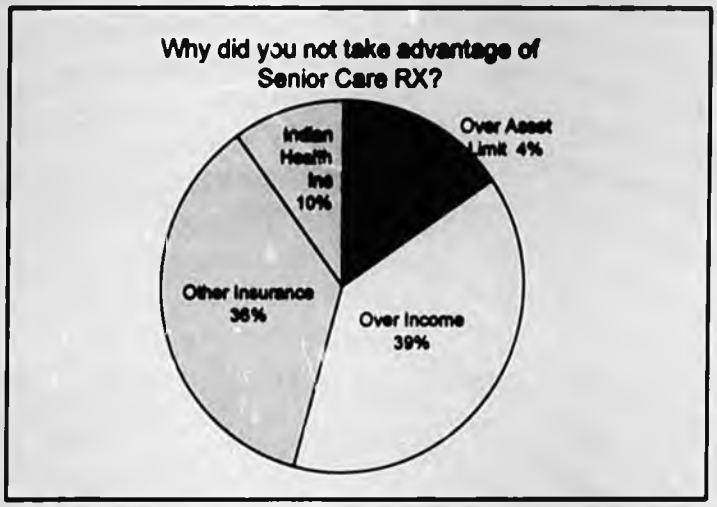
- Surveyors commented that seniors frequently expressed their delight at being asked their opinions and appreciation that the administration valued their input.

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

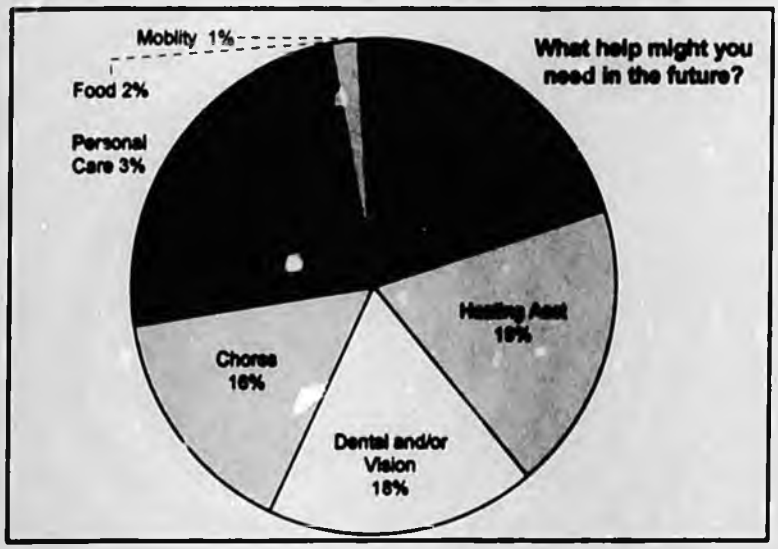
-- More --

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





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



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

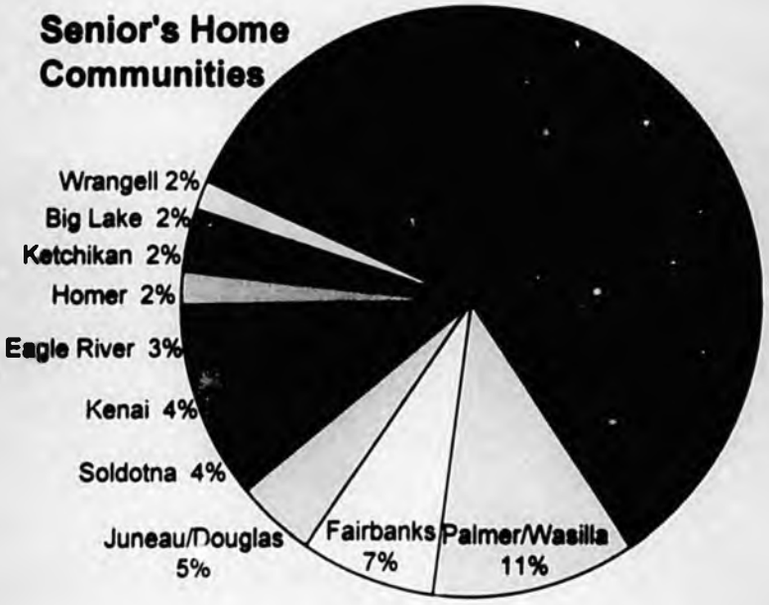
- The survey indicates that Alaska's seniors continue to strive to remain independent and would like more services oriented toward continued independence.

-- More --

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

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

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



Other Communities	
Dillingham	Talkeetna
North Pole	Alakanuk
Valdez	Anchor Point
Chugiak	Covington Cove
Petersburg	False Pass
Seward	Girdwood
Cordova	Glennallen
Goodnews Bay	Holy Cross
Hoonah	Hope
Kiana	Indian
Kodiak	Kasilof
Kotzebue	Kwethluk
McGrath	Nikiski
Nenana	Nome
Savoonga	Ouzinkie
Scammon Bay	Pedro Bay
Sitka	Pilot Station
Skagway	Sterling
Willow	

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

-30-

-- More --

SB

98

Alaska State Legislature

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

Senator Bettye Davis

SB 98 **"An Act relating to dental hygienists"**

SPONSOR STATEMENT

SB 98 will greatly improve the oral health care, overall health, wellbeing, individual appearance, and comfort of Alaskans across the state.

SB 98 allows Alaskans better access to professional training, skills, and technology available to meet their oral health care needs with expanded services provided by dental hygienists licensed under AS 08.32. Many Alaskans either cannot afford regular oral health care, do not understand the need for it, or live in areas or facilities not served by oral health care professionals. SB 98 also will help stem what the Surgeon General reported as a "*silent epidemic of oral diseases. . . affecting our most vulnerable citizens. . . . No one should suffer from oral diseases or conditions that can be effectively prevented and treated.*"

Dental hygienists licensed under this statute are well prepared to deliver the oral health care services specifically defined and authorized in SB 98 under the direct supervision of or in collaboration with licensed dentists with board approval. Similar services are performed by dental hygienists in other states. Dental hygienists are licensed by the state only after successfully graduating from American Dental Association accredited dental hygiene programs or other programs accredited by the board and passing a national examining board's restorative examination and state clinical examination.

In addition to the usual services allowed under AS 08.32, SB 98 permits a licensed dental hygienist to:

1) place restorations into a cavity prepared by a licensed dentist and thereafter carve, contour, and adjust contacts and occlusion of the restoration.
2) administer local anesthetic agents if certified by the board and performed under direct, indirect, or general supervision of a dentist;
3) enter into a collaborative agreement with a licensed dentist with approval by the board authorizing the dental hygienist to perform defined procedures or services without the presence of the licensed dentist.

Services provided by dental hygienists under collaborative agreements require prior board approval and a minimum of 4,000 hours clinical experience within the prior five years. Dentists licensed under Alaska statute will diagnose, review, and/or complete all work performed by dental hygienists under collaborative agreements proposed by this bill.

ALASKA STATE LEGISLATURE

Vice Chair:
House Finance Committee

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

Session:
Alaska State Capitol, Rm 501
Juneau, AK 99801-1182
Phone: (907) 465-4958
Fax: (907) 465-4928

District:
600 E. Railroad Ave.
Wasilla, AK 99654

BILL STOLTZE
STATE REPRESENTATIVE
Representative_Bill_Stoltze@legis.state.ak.us

House Bill 136 (Version M)
Sectional Analysis

Section 1 authorizes the Board of Dental Examiners to issue a restorative function endorsement to a licensed dental hygienist if the hygienist has successfully completed an accredited program and has passed the required restorative function examination(s).

A restorative function endorsement will allow a licensed dental hygienist to place restorations, i.e. fillings, into a cavity prepared by a licensed dentist and thereafter carve, contour and adjust contacts and occlusion of the restoration under the direct supervision of a licensed dentist.

Section 2 authorizes a licensed dental hygienist to administer local anesthetic agents under the general supervision of a licensed dentist.

Local anesthesia renders a small part of the body, such as a tooth, insensitive to pain without affecting consciousness. Licensed dental hygienists in the state who are certified by the Board have been administering local anesthesia under "direct" or "indirect" supervision of a licensed dentist since 1981. Adding "general" supervision would allow a licensed, Board-certified dental hygienist to administer local anesthetic agents without the requirement for a licensed dentist being present in the dental facility.

Section 3 includes under dental hygienists' scope of practice the ability to place restorations (section 1) and perform the activities authorized under a collaborative agreement with a licensed dentist (section 4).

Section 4 authorizes the Board to approve a collaborative agreement between a licensed dentist and a licensed dental hygienist and specifies the services and procedures allowed under a collaborative agreement.

Working under a collaborative agreement with a licensed dentist, a dental hygienist would be able to initiate treatment within their scope of practice based on his or her assessment of a patient's needs without the specific authorization of a dentist.

Section 5 applies supervision requirements to a dental hygienist operating in conjunction with a licensed dentist under a collaborative agreement.

HB 136 (Shortened version)

Sec. 1. AS 08.32 is amended by adding a new section to read:

Sec. 08.32.085 Restorative function license endorsement (a) The board shall issue a restorative function endorsement to a dental hygienist who is licensed under this chapter if the licensee furnishes evidence satisfactory to the board that the licensee has

1) successfully completed a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the board; and

2) passed the Western Regional Examining Board's restorative examination or other equivalent examination approved by the board within the five years preceding the licensee's endorsement application, ~~or the licensee has legal authorization from another state or jurisdiction~~ or is licensed in another US state or territory to perform restorative functions.

(b) An endorsement issued under this section authorizes a ~~licensed~~ dental hygienist under direct supervision of a licensed dentist to place restorations into a cavity prepared by the licensed dentist and thereafter carve, contour, and adjust contacts and occlusion of the restoration.

(c) The board may by regulation establish renewal and continuing education requirements for an endorsement under this section.

Sec. 3. AS 08.32.110(a) is amended to read:

(6) if certified by the board and under the direct, [OR] indirect, **or general** supervision of a licensed dentist, administer local anesthetic agents.

Sec. 4. AS 08.32.110 is amended by adding a new subsection to read:

(c) this section does not prohibit a dental hygienist

(1) with an endorsement issued under AS 08.32.085 from performing the activities authorized under AS 08.32.085; or

(2) who has entered into a collaborative agreement approved by the board under AS 08.32.115 from performing the activities authorized under the collaborative agreement.

Sec. 5. AS 08.32 is amended by adding a new section to read:

Sec. 08.32.115. Collaborative agreements. (a) A dentist may not enter into a collaborative agreement with more than five dental hygienists. If the collaborative agreement is approved by the board under (c) of this section, a dental hygienist with a minimum of 4,000 documented hours of clinical experience within the last five years preceding application for the board's approval may enter into a collaborative agreement with an Alaskan licensed dentist in which the licensed dentist authorizes the licensed dental hygienist to perform one or more of the following:

(1) oral health promotion and disease prevention education;

(2) the removal of calcareous deposits, accretions, and stains from the surfaces of the teeth

(3) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(4) polishing and smoothing restorations;

(5) removal of marginal overhangs;

(6) preliminary charting and triage;

(7) radiographs;

(8) use of ~~chemotherapeutic~~ local periodontal therapeutic agents; and

(9) performance of non-surgical periodontal therapy with or without the administration of local anesthesia, subsequent to a licensed dentist's authorization or diagnosis as specified in the licensed dental hygienist's collaborative agreement.

(b) These services described in (a) of this section may be performed under a collaborative agreement approved by the board

1) without the presence of the dentist;

2) in a setting other than the usual place of practice of the licensed dentist; and

3) ~~without~~ prior to the dentist's diagnosis and with completion of a treatment plan within one year unless otherwise specified in the collaborative agreement or in (a) of this section.

(c) The board shall adopt regulations regarding approval of collaborative agreements between licensed dental hygienists and licensed dentists.

Sec. 6. AS 08.32.140 is amended to read:

Sec. 08.32.140 Supervision required. A dental hygienist, other than a dental hygienist practicing according to a collaborative agreement approved under AS 08.32.115, may not practice except under the general supervision of a licensed dentist or, if required by regulations adopted under AS 08.32.110 (b), the direct or indirect supervision of a licensed dentist.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB136-COM-OL-03-05-07
Bill Version: HB 136
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Dental Hygienists
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Stoltze
Requester: House HES
Component No.: 2360

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						
1156 Receipt Supported Services	•	•	•	•	•	•
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)*

This legislation amends AS 08.32 relating to Dental Hygienists to provide for a restorative function license endorsement, to amend supervision requirements, and to provide for collaborative agreements for certain dental hygienists to provide certain services.

Typically license endorsement fees are $50 and do not included the costs of additional accredited programs requested or approved by the Alaska State Dental Board. There are over 500 licensed Dental Hygienist in the State. At this time the Division of Corporations, Business, and Professional Licensing does not know how many licensees will request a restorative function endorsement and therefore, is unable to estimate costs and revenue.

All Occupational Licensing programs are required to cover costs with licensing fees under AS 08.01.065. Licensees requesting the endorsement will cover the additional fees.

Prepared by: Chris Wyatt, Administrative Manager — Phone (907) 465-2572
Division: Corporations, Business, and Professional Licensing — Date/Time 3/5/07 2:00 PM
Approved by: Emil Notti, Commissioner — Date 3/5/2007
Agency: Commerce, Community, and Economic Development

Number of Denists and Dental Hygienists by Region

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

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

Source: State population data from ADOL&WD, 2005

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

SB 98 – "An act relating to Dental Hygienists"

Fact Sheet: Local Anesthesia

What is Local Anesthesia?	• Local Anesthesia renders a small part of the body, such as a tooth, insensitive to pain without affecting consciousness. It reduces stress and allows a client to be comfortable while being treated by a hygienist for moderate to advanced gum disease.
Statute Change	• AS 08.32.110(a) is amended to read: *** (6) if certified by the board and under the direct, [OR] indirect, **or general** supervision of a licensed dentist, administer local anesthetic agents.
Definitions	• **"Direct supervision"** means the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before dismissal of the patient evaluates the performance of the dental hygienist. • **"Indirect supervision"** means a licensed dentist is in the dental facility, authorizes the procedures, and remains in the dental facility while the procedures are being performed by the dental hygienist. • **"General supervision"** means the dentist has authorized the procedures and they are being carried out in accordance with the dentist's diagnosis and treatment plan.
Dental Hygienists Can Help	• **Education** – The dental hygiene curriculum is established and competency requirements are enforced by the American Dental Association. Numerous hours of didactic and clinical experience, as well as written and clinical testing are required before a dental hygienist is licensed to administer local anesthetic agents. Additionally, in Alaska, a separate written and clinical exam administered by WREB, a National Dental and Dental Hygiene testing agency, is required prior to obtaining a license for administering local anesthesia. • **25 years of experience** – Dental hygienists in Alaska have been delivering local anesthesia under direct or indirect supervision since July 20, 1981. • **Record of safety** – An Alaskan dental hygienist has never had disciplinary action taken against his/her license due to the administration of local anesthesia under the current statutes. • **Liability insurance** – A dental hygienist's liability insurance cost is the same whether they have a license to deliver local anesthesia or not. Therefore, it can be assumed that insurance companies do not see local anesthesia as an increased risk. • **Emergency training** – Dental hygienists are required to maintain current CPR certification and are capable of responding appropriately in emergency situations. • **Dentist discretion** – The administration of local anesthesia under general supervision remains at the discretion of the supervising dentist (i.e. a dentist's authorization would still be required) • **Other states** – The states of *Idaho* and *Oregon* allow local anesthesia under General Supervision. There have been no disciplinary cases against a dental hygienist as related to the administration of local anesthesia.