

INCREASING DENALI KIDCARE ELIGIBILITY: THE LIFEBOATS ARE HERE

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ABSTRACT

In this Note, the Author analyzes the current state of Denali KidCare. The Author summarizes the history of state-provided health insurance for children and the particular difficulties associated with providing health care in Alaska. In light of the recent passage of the Children’s Health Insurance Program Reauthorization Act in 2009, the Author then investigates the increased incentives for states to expand health care coverage to more children and describes Alaska’s failure to take advantage of these opportunities. The Article concludes with an argument in favor of specific steps that would allow Alaska to provide health care to as many children as possible at the lowest cost.

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INTRODUCTION

Alaska—The Last Frontier—has been a place where people go to hide, to escape, to live in seclusion and free of intrusion. Such desires are made possible by a land that is one-fifth the size of the United States, and larger than Texas, California, and Montana combined.¹ A land of such tremendous proportions allows for a population density of 1.07 persons per square mile.² Such a vast and unsettled land, however, leads to many costs.

Alaska depends on world demand for its products, including oil, fish, minerals, and timber.³ Dependence on such commodities results in booms and busts, seasonal employment, and general instability.⁴ These factors, together with the state's geography, make providing health care in Alaska particularly difficult and problematic—both in terms of quality and cost.

For example, as of 2007, Alaska's unique situation has resulted in an insurance market where two companies control ninety-five percent of the market.⁵ Such a market leads to a state of affairs where certain low-income residents—too wealthy for Medicaid—could have to pay up to twenty percent of their incomes for health insurance.⁶ It is simple enough to understand that when families have to choose between buying insurance costing twenty percent of their income and having no insurance at all, the result will be many uninsured families and children. In Alaska, around 18,000 children are uninsured.⁷

The federal government has been aware of this problem, which has arisen in many states. In response, it enacted the State Children's Health Insurance Program (S-CHIP)—now called "CHIP"—which the Obama administration reauthorized in the Children's Health Insurance Program Reauthorization Act (CHIPRA).⁸ But Alaska is failing its families and children by not taking full advantage of the benefits provided under CHIPRA to help families too wealthy for Medicaid but

1. ALASKA DEP'T OF HEALTH & SOC. SERVS. STATE CHILD HEALTH PLAN 5, available at <http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/AKCurrentStatePlan.pdf> [hereinafter STATE CHILD HEALTH PLAN].

2. *Id.*

3. *Id.*

4. *Id.*

5. AM. MED. ASS'N, COMPETITION IN HEALTH INSURANCE 7 (2007).

6. See STATE HEALTH ACCESS DATA ASSISTANCE CTR., STATE HEALTH ACCESS PROFILE: ALASKA 1 (2007), available at http://www.shadac.org/files/shadac/states/profiles/alaska_0.pdf.

7. *Id.*

8. See Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8 (codified as amended in scattered sections of 42 U.S.C.).

too poor to afford private coverage.⁹ The federal government is sending Alaska lifeboats to help insure its children, but Alaska has chosen to reject them.

This Note will argue that Alaska needs to change its CHIP laws and policies to better suit low-income children and families. Part I provides the background and origins of S-CHIP. Part II addresses CHIPRA and the changes it established in the system—specifically in terms of finance and outreach. Parts III and IV address Alaska’s background and health care situation. Part V describes Denali KidCare—Alaska’s CHIP. Finally, Part VI provides analysis for what Alaska needs to do to exploit CHIPRA fully and efficiently to provide low-income Alaskan families with maximum benefits.

I. HISTORY OF THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM

In 1977, President Jimmy Carter introduced the Child Health Assessment Program to Congress—a major piece of legislation designed to improve health services for children of low-income families.¹⁰ In the late 1980s, budget legislation phased in Medicaid coverage for children in poverty.¹¹ Additionally, states extended coverage to children and parents at higher income levels through Medicaid options and demonstration waivers.¹² By 1997, around twenty-one million children were enrolled in Medicaid.¹³

In 1997, President Clinton focused his efforts on a disproportionately uninsured group: families too wealthy for Medicaid but too poor to afford private insurance.¹⁴ This group fell between 100% and 200% of the poverty line.¹⁵ What resulted were proposals of different types. For example, Senators Orrin Hatch (R-Utah) and Ted Kennedy (D-Mass.) proposed comprehensive coverage, while other senators proposed expanding Medicaid.¹⁶ The final product was the State Children’s Health Insurance Program (S-CHIP), established by the Balanced Budget Act of 1997 and enacted under Title XXI of the Social Security Act.¹⁷ Professor Lambrew¹⁸ described S-CHIP as “a fine

9. *See infra* Part VI.

10. Health Care Legislation Message to the Congress, 1 PUB. PAPERS 717 (April 25, 1977).

11. JEANNE M. LAMBREW, THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM: PAST, PRESENT, AND FUTURE 1 (2007).

12. *Id.*

13. *Id.*

14. *Id.* at 2.

15. *Id.*

16. *Id.*

17. *See* CONG. BUDGET OFFICE, THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM 1 (2007), available at <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf>.

balance—hard wrought but designed to maintain equilibrium between states and the federal government as well as political conservatives and liberals.”¹⁹

States were charged with administering S-CHIP within broad federal guidelines, and states and the federal government jointly financed it.²⁰ States were given great flexibility in designing their programs.²¹ For example, in 2006, twenty-six states had eligibility thresholds at 200% of the poverty level and nine had thresholds at less than 200%; states went as low as 140% and as high as 350%.²² The poverty guidelines are issued each year by the Department of Health and Human Services.²³ In 2009, the poverty guideline for a family of four in the forty-eight contiguous states and Washington, D.C. was \$22,050.²⁴ For a family of four in Alaska, the poverty guideline for 2009 was \$27,570.²⁵

States were able to administer S-CHIP in three different ways: (1) by expanding Medicaid to cover ineligible children; (2) by creating a separate program under S-CHIP; or (3) through some combination of the first two methods.²⁶ If a state chose to expand Medicaid, it had to provide the same benefits as were already provided under the Medicaid program and had to apply the same rules and regulations.²⁷ If a state chose to create a separate program under S-CHIP, it was subject to minimum standards set by the federal government.²⁸

Federal funding for S-CHIP was allocated based on a formula taking into account the number of children in low-income families, the number of uninsured children, and the wages in health services.²⁹ This method gave the most funding to states with the greatest number of uninsured children, but it caused major distribution imbalances.³⁰ Some states with a high number of uninsured low-income children received too much money—more than they were spending—and some states received too little.³¹

18. Professor Lambrew is an associate professor of Public Affairs and director of the Health and Human Services Office of Health Reform at the University of Texas at Austin.

19. LAMBREW, *supra* note 11, at 2.

20. CONG. BUDGET OFFICE, *supra* note 17, at VII.

21. *Id.*

22. *Id.*

23. See Annual Update of the HHS Poverty Guidelines, 74 Fed. Reg. 4199, 4199 (Jan. 23, 2009).

24. *Id.*

25. *Id.*

26. CONG. BUDGET OFFICE, *supra* note 17, at VII.

27. *Id.*

28. *Id.*

29. JENNIFER SULLIVAN, FAMILIES USA, MORE FUNDING FOR CHIP, DIFFERENT RULES: HOW DOES CHIPRA CHANGE CHIP FUNDING? 3 (2009), available at <http://www.familiesusa.org/assets/pdfs/chipra/funding.pdf>.

30. *Id.*

31. *Id.*

States were required to provide matching funds and were given three years to spend their federal allotment; if a state did not spend its federal allotment, the leftover money would be redistributed to a state that had exhausted its allotment.³² To incentivize state participation, the federal government paid a higher share of the spending on S-CHIP than it did in Medicaid.³³ The federal government's matching rate varied between states from sixty-five percent to eighty-three percent, compared to fifty percent to seventy-six percent for Medicaid spending.³⁴ S-CHIP also differed from Medicaid in that it was not an entitlement program without limits on spending; S-CHIP was a grant program with federal spending capped in advance.³⁵

S-CHIP was successful in reducing the number of low-income uninsured children. In the last decade, as a result of Medicaid and S-CHIP—combined with states expanding eligibility and adopting streamlined enrollment procedures—the percentage of low-income uninsured children decreased by one-third.³⁶ In 2007, states were continuing to improve S-CHIP coverage for low-income uninsured children.³⁷ Of the twenty states that expanded S-CHIP eligibility, twelve raised the income eligibility limits to 300% of the poverty guideline.³⁸ S-CHIP reauthorization was not seamless. President George W. Bush vetoed two versions of legislation reauthorizing S-CHIP; in the end, S-CHIP was temporarily extended through March 31, 2009.³⁹

II. CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

S-CHIP expired at the end of fiscal year 2007.⁴⁰ But, on February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) into law—it went into effect April 1, 2009.⁴¹ President Obama called CHIPRA a “down payment on [the] commitment to cover every single American.”⁴² CHIPRA's purpose is to “provide dependable and stable funding for children's

32. CONG. BUDGET OFFICE, *supra* note 17, at VII.

33. *Id.* at VIII.

34. *Id.*

35. *Id.*

36. DONNA COHEN ROSS & CARYN MARKS, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, CHALLENGES OF PROVIDING HEALTH COVERAGE FOR CHILDREN AND PARENTS IN A RECESSION 3 (2009), available at <http://www.kff.org/medicaid/upload/7855.pdf>.

37. *Id.*

38. *Id.*

39. *Id.*

40. CONG. BUDGET OFFICE, *supra* note 17, at 13.

41. Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8 (codified as amended in scattered sections of 42 U.S.C.).

42. Centers for Medicare & Medicaid Services, Overview National CHIP Policy, <http://www.cms.hhs.gov/NationalCHIPPolicy> (last visited Apr. 10, 2010).

health insurance . . . in order to enroll all six million uninsured children who are eligible, but not enrolled”⁴³

A. Financing

CHIPRA extends funding for the Children’s Health Insurance Program (CHIP) through 2013.⁴⁴ The total allotments given to states under CHIPRA are as follows: fiscal year 2009, \$10,562,000,000; fiscal year 2010, \$12,520,000,000; fiscal year 2011, \$13,459,000,000; fiscal year 2012, \$14,982,000,000; and for fiscal year 2013, there will be two semi-annual payments of \$2,850,000,000.⁴⁵ In addition to increasing the total amount of funds available to the states, CHIPRA changed the allotment formula to distribute funds more efficiently.⁴⁶

For fiscal years 2009 and 2010, allotments will not take into account how much the states spent in the past, so all states will receive more money than they have in the past.⁴⁷ But, beginning in 2011, allotments will be based on how much states previously spent. For example, the 2011 allotment will be based on how much states spend in 2010.⁴⁸ This method of allotting funds based on past usage incentivizes states to increase enrollment in the program; if they do not, they will lose funds. For fiscal year 2010, allotments will be calculated based on the amount of the state’s allotment in 2009 plus the amount of funds paid to cure shortfalls, multiplied by the allotment increase factor.⁴⁹ The allotment increase factor will help prevent shortfalls from occurring by taking into account expansion in health care costs and increases in the number of children in each state.

States have two years—instead of the three years given under S-CHIP—to spend their annual allotments.⁵⁰ If a state does not expend its entire allotment, the unused funds will be redistributed to “shortfall states.”⁵¹ Shortfall states are those with approved child health plans and whose projected expenditures under such plan exceed the sum of: the remaining funds from the previous year, the amount of the child enrollment contingency fund payments, and the amount of the state’s allotment for the fiscal year.⁵²

43. Pub. L. No. 111-3 § 2.

44. *Id.* § 101.

45. 42 U.S.C. § 1397dd(a) (2006).

46. SULLIVAN, *supra* note 29, at 4.

47. *Id.*

48. *Id.*

49. 42 U.S.C. § 1397dd(m)(2)(A)(i) (2006). The allotment increase factor, commonly referred to as the “inflation factor,” is calculated with a formula: $((1 + \text{the percentage increase in per capita national health expenditures over the last year}) \times (1 + \text{the percentage increase in the number of children in the state over the last year}))$. 42 U.S.C. § 1397dd(m)(5) (2006).

50. 42 U.S.C. § 1397dd(e)(1) (2006).

51. 42 U.S.C. § 1397dd(f)(1) (2006).

52. 42 U.S.C. § 1397dd(f)(2) (2006).

To prevent against shortfalls, CHIPRA provides for a contingency fund. CHIPRA establishes a fund in the federal Treasury known as the “Child Enrollment Contingency Fund” (the “Fund”).⁵³ The Fund is comprised of money from the Treasury that is not otherwise appropriated; enough will be appropriated to the Fund as is necessary to make payments to eligible shortfall states.⁵⁴ But there is a cap to the contingency fund payments—the total amount available for payment each year cannot exceed twenty percent of the year’s CHIP allotment.⁵⁵

If the total state CHIP shortfalls exceed the amount available for distribution in the Fund, then whatever money is in the Fund will be proportionately distributed among the shortfall states.⁵⁶ If the contingency fund payment cap is not met in any given year, the excess will be made available for performance bonus payments, discussed below, to offset additional Medicaid and CHIP enrollment costs resulting from enrollment and retention efforts.⁵⁷

To receive money from the Fund, a state must demonstrate that its CHIP expenditures are greater than its allotment for the respective year and that it will exceed its CHIP enrollment target.⁵⁸ The target number of children enrolled is determined by increasing the number of children enrolled from the previous year by the population growth factor.⁵⁹ If a state qualifies for contingency payments, the amount of money received is based on the amount by which the enrollees exceed the enrollment target and the per capita cost of CHIP coverage in the state multiplied by the Enhanced Federal Medical Assistance Percentages (FMAPs).⁶⁰

FMAPs are used to determine the amount of funds the federal government will match for state expenditures. The FMAP for any state is 100%, less the percentage that is provided by the state.⁶¹ For example, if a state provides forty-five cents, the federal government will pay fifty-five cents. CHIP’s FMAP—called the “enhanced FMAP” because it is a higher federal contribution percentage than the regular FMAP, which applies to Medicaid—is capped at eighty-five percent.⁶² This means that the maximum the federal government may contribute is eighty-five cents for every fifteen cents a state provides. The enhanced FMAP, however, does not apply to all state CHIP expenditures. If a state

53. 42 U.S.C. § 1397dd(n)(1) (2006).

54. 42 U.S.C. § 1397dd(n)(2)(A) (2006).

55. 42 U.S.C. § 1397dd(n)(2)(B) (2006).

56. 42 U.S.C. § 1397dd(n)(2) (2006).

57. 42 U.S.C. § 1397dd(n)(2)(D) (2006).

58. 42 U.S.C. § 1397dd(n)(3) (2006).

59. 42 U.S.C. § 1397dd(n)(3)(B) (2006). The child population growth factor is equal to one plus the percentage increase in child population of the state from July 1 in the previous year to July 1 in the fiscal year involved. 42 U.S.C. § 1397dd(m)(5). The percentage increase is itself determined by starting with the most recent Bureau of the Census estimates before the year involved and then adding one percentage point. *Id.*

60. 42 U.S.C. § 1397dd(n)(3)(A) (2006).

61. 42 U.S.C. § 1396d(b) (2006).

62. 42 U.S.C. § 1397ee(b) (2006).

decides to include children whose families earn more than 300% of the poverty line, the FMAP, rather than the enhanced FMAP, will apply.⁶³ There is one exception: if a state had an approved program before CHIPRA's enactment that included children over the 300% poverty line, then such a state is excluded from the cap.⁶⁴

To incentivize states to enroll as many children as possible, CHIPRA has added a bonus payment system.⁶⁵ The bonus system rewards states that are successful at enrolling low-income children in Medicaid. This incentive exists because states need to be encouraged to enroll the lowest-income children.⁶⁶ Because of the higher federal matching rate for CHIP relative to Medicaid, it costs a state more to cover the lowest-income children under Medicaid.

States qualify for this bonus based on enrollments exceeding target levels. The target level for 2009 is equal to the number of children enrolled in 2007, increased by the population growth for children in the state from 2007 to 2008 plus four percentage points, and further increased by the population growth for children in the state from 2008 to 2009, plus four percentage points.⁶⁷ For 2010–2012, the target levels are based on the number of child enrollees for the state during the previous year, increased by the population growth for children in the state during the year, plus 3.5 percentage points.⁶⁸ The statute also provides guidelines for the targets from 2013–2015, as well as for subsequent years.⁶⁹

In addition to surpassing the target levels, states must meet at least five of eight criteria to qualify for the bonus payments.⁷⁰ These criteria are: (1) continuous eligibility (thirty states comply with this criterion⁷¹)—meaning the state has elected to provide enrolled children continuous eligibility for a full twelve months;⁷² (2) liberalization of asset requirements (thirty-six states)—meaning either the state does not apply any asset or resource test for eligibility, or the state permits a guardian to provide information relating to family assets and the state takes steps to verify the assets other than by requiring documentation from the guardian;⁷³ (3) elimination of an in-person interview requirement (thirty-eight states)—meaning the state does not require the application or renewal to be made in person, nor does the state require a

63. 42 U.S.C. § 1397ee(c)(8)(A) (2006).

64. 42 U.S.C. § 1397ee(c)(8)(B) (2006).

65. 42 U.S.C. § 1397ee(a)(3) (2006).

66. SULLIVAN, *supra* note 29, at 9.

67. 42 U.S.C. § 1397ee(a)(3)(C)(iii)(I) (2006).

68. 42 U.S.C. § 1397ee(a)(3)(C)(iii)(II) (2006).

69. 42 U.S.C. § 1397ee(a)(3)(C)(iii)(III)–(IV) (2006).

70. 42 U.S.C. § 1397ee(a)(4) (2006).

71. All figures for the number of states complying with each criterion come from: JENNIFER SULLIVAN, FAMILIES USA, COVERING MORE CHILDREN, REWARDING SUCCESS: STATE PERFORMANCE BONUSES, 6–7 (2009), available at <http://www.familiesusa.org/assets/pdfs/chipra/state-performance-bonuses.pdf>.

72. 42 U.S.C. § 1397ee(a)(4)(A) (2006).

73. 42 U.S.C. § 1397ee(a)(4)(B) (2006).

face-to-face interview, unless there are discrepancies;⁷⁴ (4) use of a joint application for Medicaid and CHIP (thirty-five states)—meaning only one application is used for Medicaid and CHIP for both establishing and renewing eligibility;⁷⁵ (5) automatic renewal (fourteen states)—meaning the state provides a pre-printed form, completed by the state based on information available to the state, notifying the parent that eligibility of the child will be renewed and continued based on such information, unless the state is provided other information;⁷⁶ (6) presumptive eligibility for children (nine states)—meaning children who appear eligible for Medicaid or CHIP will be presumed eligible at certain qualified locations and can receive up to sixty days of coverage while a formal determination is made;⁷⁷ (7) express lane—meaning the state has exercised its option to use a finding from an “Express Lane” agency⁷⁸ (an agency that the state’s CHIP agency has determined is eligible to make determinations of one or more eligibility requirements);⁷⁹ (8) premium assistance subsidies (fourteen states)—meaning the state has elected to implement the option of providing premium assistance subsidies (a way of putting CHIP or Medicaid dollars toward a family’s employer-provided insurance coverage).⁸⁰

If a state both exceeds its targets and meets at least five of the eight criteria, it qualifies for per-child bonuses for all children enrolled in Medicaid above the Medicaid enrollment target.⁸¹ States exceeding their enrollment target by ten percent or less—referred to in the statute as “first tier”—are awarded a bonus of fifteen percent of the projected per capita state Medicaid expenditures for every child above the target.⁸² For example, if State X has a per capita Medicaid expenditure of \$4000 (including both federal and state contributions), and State X has a fifty percent FMAP, then State X’s share is \$2000; the first-tier-bonus payment would be fifteen percent of the state’s share—\$300 in this example—for every child above the target. Therefore, if State X enrolled 1000 children above the target, it would receive \$300 per child for a total of \$300,000.

States exceeding the target by more than ten percent—second tier—are awarded a bonus of 62.5% of the projected per capita state Medicaid expenditures for every child above the first tier cutoff.⁸³ For example, assume that those 1000 children represent the state exceeding its target

74. 42 U.S.C. § 1397ee(a)(4)(C) (2006).

75. 42 U.S.C. § 1397ee(a)(4)(D) (2006).

76. 42 U.S.C. § 1397ee(a)(4)(E) (2006).

77. 42 U.S.C. § 1397ee(a)(4)(F) (2006); *see also* SULLIVAN, *supra* note 71, at 7 tbl.2 (citing ROSS & MARKS, *supra* note 36).

78. 42 U.S.C. § 1396a(e)(13)(F) (2006). This was a new provision as of 2009, so no state had yet implemented the “express lane” option. *See* SULLIVAN, *supra* note 71, at 7 tbl.2.

79. 42 U.S.C. § 1397ee(a)(4)(G) (2006).

80. 42 U.S.C. § 1397ee(a)(4)(H) (2006).

81. SULLIVAN, *supra* note 29, at 10.

82. 42 U.S.C. § 1397ee(a)(3)(B)(i) (2006).

83. 42 U.S.C. § 1397ee(a)(3)(B)(ii) (2006).

by exactly ten percent. If State X had actually exceeded its enrollment target by 1250 children—that is, by 12.5%—then State X would receive the first tier bonus for the first 1000 children and would receive 62.5% of the state expenditures for the 250 children by which the state enrollment exceeded the first tier cutoff. In this scenario, State X would receive the first tier bonus of \$300,000, plus \$312,500 (\$1250 (62.5% of \$2000) multiplied by 250 (number of children above ten percent of the target)) for a grand total of \$612,500.

B. Outreach and Enrollment

In its efforts to expand health coverage for low-income children who are eligible but not enrolled, CHIPRA created a \$100 million outreach fund.⁸⁴ Grants will be awarded through 2013.⁸⁵ Of the \$100 million, \$10 million is to be used to carry out a national enrollment campaign,⁸⁶ \$10 million is to be used to award grants to Indian Health Service providers and urban Indian organizations,⁸⁷ and \$80 million is granted to other eligible entities, which may include: state, county, and local governments; community-based or faith-based organizations; schools; and federal safety net providers.⁸⁸ The Centers for Medicaid and Medicare Services (CMS) administer the grants.⁸⁹ CHIPRA provides that priority is given to entities proposing to target geographic areas: (1) with high rates of eligible but un-enrolled children residing in rural areas, (2) with racial and ethnic minorities and health disparity populations, and (3) that submit the most demonstrable evidence required.⁹⁰

To apply for these grants, eligible entities must: (1) demonstrate that they include members who have access to and credibility with ethnic or low-income populations in the communities; (2) provide evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns, or punitive fears associated with receipt of benefits; (3) give specific quality or outcome performance measures to evaluate the effectiveness of activities funded by a grant; and (4) provide assurances that the eligible entity will assess the effectiveness of the activities, cooperate with the collection and reporting of enrollment data, and, in the case of

84. 42 U.S.C. § 1397mm(g) (2006).

85. 42 U.S.C. § 1397mm(a) (2006).

86. 42 U.S.C. § 1397mm(a)(2) (2006).

87. 42 U.S.C. § 1397mm(b)(2) (2006).

88. 42 U.S.C. § 1397mm(f) (2006).

89. CENTER FOR CHILDREN & FAMILIES, GEORGETOWN UNIV. HEALTH POLICY INST., AN OVERVIEW OF THE CHIPRA OUTREACH AND ENROLLMENT GRANTS 1 (2009), available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20S-CHIP%20policy/outreach%20grants%20final.pdf> [hereinafter OVERVIEW OF GRANTS].

90. 42 U.S.C. § 1397mm(b)(1) (2006).

an eligible entity that is not the state, provide the state with enrollment data.⁹¹

In announcing the grants, CMS provided that the purpose of the grants is not only to enroll un-enrolled eligible children but also to retain coverage as well.⁹² CMS has announced that it will award the grant funds in different rounds.⁹³ The first round will provide up to \$40 million in two-year projects costing up to \$1 million—CMS anticipates awarding around two hundred grants in this first round.⁹⁴

III. HEALTH CARE IN ALASKA: BACKGROUND

Many of Alaska's health care problems result from its geographic location, its size, its scattered population, and its seasonal employment pattern. Relative to other states in the United States, Alaska has a very young population, proportionately fewer females, proportionately more Native people, and proportionately fewer African Americans.⁹⁵ Alaska is very large—one-fifth the size of the rest of the United States—and is sparsely populated, with a population density of 1.07 persons per square mile.⁹⁶ Because Alaska lacks a complete road system, air or sea travel is the primary way to reach most of the state.⁹⁷

Alaska relies on seasonal employment for much of its industry, including oil, timber, mining, fishing, and tourism.⁹⁸ A higher percentage of Alaskans are seasonally employed than in other states.⁹⁹ As a result of the seasonal employment and the transitions in military personnel, large numbers of people are often in search of employment.¹⁰⁰

Because a majority of Alaska's population resides in Anchorage, it is the only city in Alaska where specialized consultative services are available.¹⁰¹ Alaska has two military hospitals: one in Anchorage and one in Fairbanks.¹⁰² Smaller urban communities have access to community hospitals.¹⁰³

For rural Alaska, tribal health care is essentially the sole provider of health care services.¹⁰⁴ There are five hospitals in hub communities for different regions.¹⁰⁵ These hospitals send Alaska Native patients to

91. 42 U.S.C. § 1397mm(c)(1)-(4) (2006).

92. OVERVIEW OF GRANTS, *supra* note 89, at 2.

93. *Id.*

94. *Id.*

95. STATE CHILD HEALTH PLAN, *supra* note 1, at 5.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *See id.*

101. *Id.* at 6.

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

the Native hospital located in Anchorage.¹⁰⁶ Funded by the Indian Health Service, twelve Native Health corporations manage the services provided in more than two hundred villages in Alaska.¹⁰⁷ With the help of a physician over the phone, community health aides—trained residents of a village—provide primary care and emergency services in their communities.¹⁰⁸ The state provides maternal and child health to medically underserved areas through Public Health Nurses.¹⁰⁹ Though there are some preferred provider arrangements, managed care is not thriving in Alaska;¹¹⁰ there are no health maintenance organizations (HMOs) in the state.¹¹¹

Approximately 18,000 children in Alaska (nineteen percent of Alaska's residents who are age eighteen or younger) are uninsured.¹¹² Private health care coverage for children has declined over thirty percent in the last ten years.¹¹³ Uninsured children with medical needs are five times more likely to not have a regular doctor than are insured children and are four times as likely to use emergency rooms, which are considerably more expensive than a regular visit to the doctor.¹¹⁴

One major issue is that health insurance choices in Alaska are very limited—Premera Blue Cross alone constitutes sixty percent of the health insurance market share.¹¹⁵ The top two insurance providers in Alaska account for ninety-five percent of the total market share.¹¹⁶ This leads to expensive insurance policies.

The Child and Adolescent Health Measurement Initiative ranked Alaska in the lowest group for percentage of children uninsured.¹¹⁷ The same study shows that in 2007, 18.5% of children lacked consistent insurance coverage in the previous year.¹¹⁸

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Medical Assistance Eligibility: Hearing on S.B. 13 Before the S. Comm. on Health & Soc. Servs.*, 26th Leg., 1st Sess., 5 (Alaska 2009), available at <http://www.legis.state.ak.us/pdf/26/M/SHSS2009-02-091334.pdf> [hereinafter *Hearing before S. Comm. on Health & Soc. Servs.*].

113. *Medical Assistance Eligibility: Hearing on S.B. 13 Before the S. Fin. Comm.*, 26th Leg., 1st Sess., 9 (Alaska 2009), available at <http://www.legis.state.ak.us/pdf/26/M/SFIN2009-02-250903.pdf> [hereinafter *Hearing before S. Fin. Comm.*].

114. *Id.*

115. See AM. MED. ASS'N, *supra* note 5, at 7.

116. *Id.*

117. CHILD & ADOLESCENT HEALTH MEASUREMENT INITIATIVE, 2007 NATIONAL SURVEY OF CHILDREN'S HEALTH, http://nschdata.org/Rankings/RankingMap.aspx?item=07_ind3_1chbk (last visited Apr. 10, 2010).

118. CHILD & ADOLESCENT HEALTH MEASUREMENT INITIATIVE, 2007 NATIONAL SURVEY OF CHILDREN'S HEALTH, http://www.nschdata.org/StateProfiles/CustomProfile_07.aspx?rid=5&geo2=Nationwide&geo=Alaska (last visited Apr. 10, 2010).

IV. DENALI KIDCARE

When establishing its CHIP, Alaska had the option to create a separate children's health insurance plan, expand benefits under its Medicaid plan, or enact some combination of both.¹¹⁹ Alaska chose to expand benefits under its Medicaid plan and called the plan Denali KidCare.¹²⁰

A. Background

Initially, Alaska expanded Medicaid eligibility to children up to age nineteen with families earning 200% of the Alaska Federal Poverty Guidelines (FPG) or less.¹²¹ But in 2003, Alaska reduced the eligibility to children with families earning 175% or less of the Alaska FPG.¹²² This meant that a family of four was ineligible if it earned more than \$3555 per month.¹²³ By 2007, the eligibility level from 2003—175% of Alaska's 2003 FPG—had become the equivalent of 154% of the 2007 Alaska FPG.¹²⁴ On July 12, 2007, Governor Sarah Palin signed legislation increasing the eligibility to 175% of the 2007 Alaska FPG.¹²⁵ To prevent the eligibility level from falling in real terms, similar revisions occur annually.¹²⁶

To increase enrollment, the State, through the Department of Health and Social Services, attempted to separate the Medicaid eligibility determination from public assistance programs, and it engaged in expanded outreach efforts.¹²⁷ These efforts were made to remove any negative stigmatization from the Medicaid program so it would not be considered a "welfare" program.¹²⁸ There are now separate Medicaid administrative units making eligibility determinations.¹²⁹

Additional efforts were made to simplify the application process. For example, any necessary follow-up is now done by phone.¹³⁰ Furthermore, the asset test was eliminated, and continuous eligibility was simplified to ensure that children would remain insured.¹³¹

119. See STATE CHILD HEALTH PLAN, *supra* note 1, at 3.

120. See *id.* at 9-10.

121. *Id.* at 9.

122. *Id.*

123. *Id.*

124. STATE COVERAGE INITIATIVES FOR CHILDREN, KAISER FAMILY FOUNDATION 4 (July, 2009), available at <http://www.kff.org/uninsured/upload/stateinitiativesforchildren1.pdf>.

125. *Id.*

126. See STATE CHILD HEALTH PLAN, *supra* note 1, at 9.

127. *Id.* at 10.

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

Continuity of care is very important in Alaska because of the high percentage of the population that is seasonally employed.¹³²

Denali KidCare applications are widely available, especially in locations commonly visited by children and families.¹³³ Additionally, relationships have been formed with state and local governments, schools, health care providers, tribes, and nonprofit organizations to further promote Denali KidCare and support for eligible families in the application process.¹³⁴ Advertising has also been used to increase awareness of the program.¹³⁵ Grants have greatly empowered outreach efforts, especially to Alaska Native communities, where Alaska Natives make up a disproportionate percentage of the un-enrolled Medicaid-eligible population.¹³⁶

When Denali KidCare was first implemented, children enrolled in the program were given only six months of continuous eligibility.¹³⁷ This made it more difficult to ensure continuity of care and was cumbersome for families. But in April 2009, the continuous eligibility was raised from six months to twelve months,¹³⁸ meaning as soon as a child is enrolled in Denali KidCare, he or she is guaranteed twelve months of coverage, regardless of changes in income, resources, family status, or household composition.¹³⁹ The extension of continuous eligibility allows Alaska to meet one more of the eight criteria necessary to qualify for the performance bonus payments provided under CHIPRA.¹⁴⁰ This change also allows increased efficiency and decreased administrative costs.¹⁴¹

To further facilitate continuity and ease of application, Denali KidCare provides a preprinted renewal form, sent prior to eligibility expiring.¹⁴² Currently, the forms are sent to families with their information pre-completed and confirmation requested.¹⁴³ An alternative renewal option, encouraged by CHIPRA, is to require a response to the pre-completed form only when income or other circumstances have changed.¹⁴⁴ The latter may be the better option for

132. *Id.*

133. *Id.* at 15.

134. *Id.*

135. *Id.*

136. *See id.*

137. *See* ALASKA TITLE XXI PROGRAM FACT SHEET 2, available at <http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/AKCurrentFactsheet.pdf> [hereinafter FACT SHEET].

138. *Id.*

139. *See* STATE CHILD HEALTH PLAN, *supra* note 1, at 10.

140. *See* 42 U.S.C. § 1397ee(a)(4)(A) (2006).

141. SULLIVAN, *supra* note 71, at 8.

142. ALASKA DEP'T OF HEALTH & SOC. SERVS. ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT 7, available at http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/AK_FY2008CHIPAnnualReport.pdf [hereinafter ANNUAL REPORT].

143. *Id.*

144. *See* SULLIVAN, *supra* note 71, at 7-8.

Alaska because it will allow Alaska to receive performance bonus payments.¹⁴⁵

Because Denali KidCare is an entitlement program as a result of being an expansion of Medicaid, there is no incentive to fill out the forms on time.¹⁴⁶ Limitations or restrictions on Denali KidCare cannot be imposed as a result of tardy renewal.¹⁴⁷ Since a recipient under Medicaid can simply fill out an application whenever services are desired, there is no incentive to apply on time. Fear of delayed processing, however, may incentivize punctual application.¹⁴⁸

In order to increase enrollments in rural areas—areas without eligibility offices—the state is using a system of “Fee Agents.”¹⁴⁹ Fee Agents are community members trained in eligibility issues and paid on a per-application basis, who assist people in the application process.¹⁵⁰

Denali KidCare does not provide presumptive eligibility for children.¹⁵¹ Retroactive eligibility is available—up to three months for qualifying families.¹⁵² Denali KidCare has a mail-in application, provides an application on its website, does not allow applications over the phone, and does not allow applications online.¹⁵³ It does not require a face-to-face interview, but it requires children to be uninsured for a minimum amount of time prior to enrollment.¹⁵⁴

Denali KidCare serves an estimated 7900 Alaskan children¹⁵⁵ and is one of the cheapest medical assistance programs in Alaska, costing approximately \$1700 per child.¹⁵⁶ It costs about twenty percent of what adult senior coverage costs.¹⁵⁷

B. Qualifying Income Eligibility Standard

Alaska is one of only five states that funds its CHIP below 200% of the FPG.¹⁵⁸ Forty-four states and Washington, D.C. cover children and families with incomes of 200% or higher of the FPG; thirty-three states cover children and families with incomes between 200% and 250% of the FPG; nineteen states and Washington, D.C. cover children and families with income of 250% or higher of the FPG, and ten of those states cover families with incomes of equal to or greater than 300% of the FPG.¹⁵⁹

145. For a discussion of alternative options, see *infra* Part VI.

146. ANNUAL REPORT, *supra* note 142, at 70.

147. *Id.*

148. *Id.*

149. STATE CHILD HEALTH PLAN, *supra* note 1, at 10.

150. *Id.*

151. ANNUAL REPORT, *supra* note 142, at 3.

152. *Id.* at 4.

153. *Id.*

154. *Id.* at 5.

155. *Hearing before S. Fin. Comm., supra* note 113, at 9.

156. *Hearing before S. Comm. on Health & Soc. Servs, supra* note 112, at 4.

157. *Id.*

158. *Id.*

159. *Id.*

C. Raising the Eligibility Level

For a family of four in Alaska, the poverty guideline for 2009 is \$27,570.¹⁶⁰ For a family to qualify for Denali KidCare, it must earn less than 175% of \$27,570—that is, less than \$48,247. The problem arises from the fact that of thirteen policies available to a family of four, the average price is \$671.46 per month, or \$8,057.52 per year.¹⁶¹ This means a family of four would be spending an average of seventeen percent of its income on health insurance. Even more problematic, a family of four earning 151% of the Alaska FPG—that is, \$41,355 per year—is too wealthy to qualify for Medicaid and thus would be spending as much as twenty percent of its yearly income on health insurance. Because of this problem, efforts are underway to raise the eligibility level.

In January of 2009, Alaska State Senator Bettye Davis proposed Senate Bill No. 13 (S.B. 13).¹⁶² The purpose of S.B. 13 was to increase and restore the qualifying income eligibility standard for Denali KidCare to the original 200% level of the FPG, making health insurance accessible to an estimated 1300 more uninsured children and 225 pregnant women in Alaska.¹⁶³

Representatives Sharon Cissna and Max Gruenberg introduced House Bill No. 61 (H.B. 61) in January of 2009.¹⁶⁴ This bill, like S.B. 13, sought to raise the eligibility to 200% of the FPG for uninsured children and pregnant women.¹⁶⁵ However, H.B. 61 never made it out of the Health & Social Services and Finance Committees.¹⁶⁶ During the same session, two additional House Bills introduced to increase the Denali KidCare eligibility level to 200% also failed to leave the Health & Social Services and Finance Committees.¹⁶⁷

Though Democrats introduced most of the bills, support for raising the eligibility level to at least 200% has support from both sides of the aisle. For example, former Governor Palin supported increasing the Denali KidCare eligibility to 200%.¹⁶⁸ United States Senator Mark Begich (D-Alaska)—previously mayor of Anchorage—also believes that the

160. Annual Update of the HHS Poverty Guidelines, 74 Fed. Reg. 4199, 4200 (Jan. 23, 2009).

161. See Blue Cross Blue Shield, Individual & Family Health Plans, <https://pbcbsak.inshealth.com/ehi/Alliance?allid=Pre25315> (last visited Apr. 10, 2010). This monthly cost was obtained from the Premera Blue Cross website, using a family of four with two adults (both aged thirty-three), and two children (ages four and five), on February 28, 2010.

162. S.B. 13, 26th Leg., 1st Sess. (Alaska 2009).

163. *Hearing before S. Comm. on Health & Soc. Servs.*, *supra* note 112, at 8.

164. H.B. 61, 26th Leg., 1st Sess. (Alaska 2009).

165. *Id.* at 4.

166. Legis. History for H.B. 26, available at http://www.legis.state.ak.us/basis/get_complete_bill.asp?session=26&bill=HB61.

167. H.B. 62, 26th Leg., 1st Sess. (Alaska 2009); H.B. 118, 26th Leg., 1st Sess. (Alaska 2009).

168. Press Release, Office of Alaska Governor (Dec. 4, 2008), available at http://www.hss.state.ak.us/press/2008/Health_Priorities_120408.pdf.

eligibility level should be increased, but he believes it should be increased even higher than 200%.¹⁶⁹

The Alaska Commission on Aging (ACoA) also supported S.B. 13.¹⁷⁰ The ACoA believed that S.B. 13 would help the growing number of older Alaskans who take care of their grandchildren while living on fixed incomes.¹⁷¹ The ACoA cites a study showing that one in five senior households with a grandchild present is at risk of hunger, compared to one in twenty households without a grandchild present being at risk.¹⁷² In supporting S.B. 13, the ACoA was trying to protect grandparent-headed families that earned too much to qualify for Medicaid but not enough to pay the rising costs of insurance.¹⁷³

Additional support for raising the eligibility level came from the Governor's Health Care Strategies Council, which recommended increasing the eligibility to 200% of the Alaska FPG.¹⁷⁴ The Alaska Health Care Strategies Planning Council also recommended raising the eligibility standard from 175% to 200% of the FPG.¹⁷⁵

Though increasing the eligibility to 200% has a great deal of bipartisan support, some politicians believe it would be a bad policy choice.¹⁷⁶ Some Alaskan state senators have expressed concern over an increase in costs and expenditures that would result from increasing the income eligibility. For example, Senator Con Bunde—who voted against S.B. 13—expressed his belief that “the state should work harder to REDUCE, rather than expand state subsidies, not just to DKid Care, but across the board.”¹⁷⁷ He explained that Alaska has spent over \$1 billion more than it has received, and that at such a rate, Alaska's reserves would be depleted in three years.¹⁷⁸

Senator Fred Dyson's chief of staff described some of the reasons why the senator had voted against S.B. 13. He explained that Senator Dyson was concerned about “committing the state to increased future outlays at a time when the state is facing deficit budgets for the next several years.”¹⁷⁹ He did not want to “increase benefits to Alaskans one

169. Letter from Mark Begich, U.S. Senator, to Gary Stevens, Bert Stedman & Lyman Hoffman, Alaska Senators (Feb. 25, 2009), *available at* http://www.legis.state.ak.us/basis/get_documents.asp?session=26&docid=1294.

170. Letter from Denise Daniello, Executive Dir., Alaska Commission on Aging, to Members of the Alaska Senate (Apr. 3, 2009), *available at* <http://www.hss.state.ak.us/acoa/legislative/S.B.13.pdf>.

171. *Id.*

172. *Id.*

173. *Id.*

174. ANNUAL REPORT, *supra* note 142, at 81.

175. ALASKA HEALTH CARE STRATEGIES PLANNING COUNCIL, FINAL REPORT 3 (2007), *available at* http://www.hss.state.ak.us/commissioner/legislature/pdf/HCSFPC_report.pdf.

176. *See* ANNUAL REPORT, *supra* note 142, at 81.

177. E-mail from Con Bunde, Senator, Alaska State Senate, to Author (July 16, 2009) (on file with author).

178. *Id.*

179. E-mail from Lucky Shultz, Chief of Staff for Fred Dyson, Senator, Alaska State Senate, to Author (July 13, 2009) (on file with author).

year . . . then reduce the benefit through budget cutting at a later date.”¹⁸⁰ The state is having difficulties meeting its current obligations due to: (1) fears of increased funding necessary for higher and lengthier unemployment rates, (2) high costs of fuel in remote villages, and (3) the quickly growing group of seniors in Alaska.¹⁸¹ Ultimately, Senator Dyson claimed that it is “unconscionable” to “increase funding of one group of people who are already receiving funding, while . . . denying funds to Alaskans unable to meet immediate day-to-day costs to heat their home during an Alaskan winter, or to put food on the table to feed those same children, or to buy medicine for immediate needs”¹⁸²

Staff to Senator Therriault commented that the vote against S.B. 13 came because of the concern that the legislation “will impose an unsustainable financial obligation on Alaska’s treasury and be politically difficult to take back if required to do so at a future date due to declined oil revenue.”¹⁸³ The fear of declining oil prices is also causing apprehension toward expanding eligibility: oil prices need to average at least \$57/bbl in order to break even with the fiscal year 2010 budget. Currently, Alaska North Slope oil is trading around \$60/bbl.¹⁸⁴

V. TAKING FULL ADVANTAGE OF CHIPRA

As expressed by the Alaska senators who voted against S.B. 13, costs and expenses associated with increasing the eligibility standard are the primary obstacles. These concerns are valid and legitimate because of the way Denali KidCare is currently set up. CHIPRA has provided mechanisms for states to be financially able to increase eligibility standards, but Alaska has not taken advantage of these mechanisms. Two such mechanisms are the performance bonus payments and outreach grants set up under CHIPRA.

A. Performance Bonus Payments

If Alaska’s enrollment in Medicaid exceeds the target and Alaska meets five of the eight criteria mentioned above, then Alaska will qualify for bonus payments. Alaska, however, only meets four of the eight criteria, disqualifying it from receiving the performance bonus payments.

One criterion that Alaska could easily meet is the automatic renewal criterion.¹⁸⁵ Alaska is not saving money by requiring responses to the renewal reminder. Of the cases that “auto-close”—meaning people fail to respond to the renewal reminder—renewal was around

180. *Id.*

181. *Id.*

182. *Id.*

183. E-mail from Ernest Prax, Staff of Gene Therriault, Senator, Alaska State Senate, to Author (July 10, 2009) (on file with author).

184. *Id.*

185. 42 U.S.C. § 1397ee(a)(4)(E) (2006).

thirty percent within thirty days of expiration.¹⁸⁶ An even greater percentage renews their coverage after expiration within a six-month period.¹⁸⁷ Presumably, even more will renew when care is necessary, so as to not have to pay out-of-pocket for their immediate medical expenses.

Allowing automatic renewal—subject to notice that a family’s circumstances have changed—would not burden the State because so many families renew anyway. But the benefits to Alaska could be substantial if automatic renewal is provided. Automatic renewal is one of the eight criteria that qualify states for performance bonuses under CHIPRA; if Alaska were to adopt automatic renewal, it would meet five of the necessary criteria to qualify for the performance bonuses. Thus, the benefit of providing automatic renewal far outweighs any nominal costs associated with it.

B. Outreach Grants

Alaska could be a strong contender for receiving outreach grants established under CHIPRA. The priority regions for the outreach grants are those with high rates of children in rural areas who are unenrolled but eligible, as well as those regions with high percentages of racial and ethnic minorities.¹⁸⁸ Approximately fifteen percent of the Alaskan population is Alaska Native or American Indian.¹⁸⁹ According to Alaska Native Tribal Health Consortium research, this minority group could also be considered a “health disparity population” under CHIPRA.¹⁹⁰ The State of Alaska can demonstrate all of the necessary requirements to qualify for these grants:¹⁹¹ it has a history and has established relationships with the Alaska Native population; it has the ability to address barriers to enrollment (for example, the Alaska Native Tribal Health Consortium has made concerted education efforts); and the State has the capital and resources to measure quality and results.

Presumably, a state would take advantage of essentially free federal money, especially when it has a CHIP fully in place. But the State of Alaska has decided not to apply for these outreach grants. The exact reasoning for not applying for these grants is unclear. The forgone benefits are, however, clear—by not applying, the State gives up the opportunity to receive a grant of \$1 million, which could pay for half the

186. ANNUAL REPORT, *supra* note 142, at 70.

187. *Id.*

188. 42 U.S.C. § 1397mm(b)(1) (2006).

189. UNITED STATES CENSUS BUREAU, ALASKA QUICK FACTS (2009), <http://quickfacts.census.gov/qfd/states/02000.html> (last visited Apr. 10, 2010).

190. *Alaska Native Health Status Report*, Alaska Native Tribal Health Consortium, available at <http://www.anthc.org/chs/epicenter/upload/ANHSR.pdf>.

191. 42 U.S.C. § 1397mm(c)(1)–(4) (2006).

total cost of increasing the Denali KidCare eligibility level from 175% to 200%.¹⁹²

In response to an inquiry as to why the State decided not to apply for the outreach grants, the commissioner of the Department of Health and Social Services wrote, “[W]e have chosen to support our community partners in their efforts. We will continue to work with them to identify and support their outreach strategies, particularly those that ensure that those kids and families most in need are enrolled in the program.”¹⁹³ Admittedly, the State’s application would discourage other organizations from applying for the grants. However, the breadth of the state government and its available capital make it the best user of these grants—especially when the grants could help the State afford to cover more children under Denali KidCare.

C. Providing Insurance Can Save Money

In the context of Denali KidCare, it is possible that providing low-income children with health insurance will save Alaska money in the long run. Uninsured children with a medical need are five times more likely not to have a regular doctor, and four times as likely to use emergency rooms—which are considerably more expensive than a routine visit to the doctor.¹⁹⁴

It is argued that insured children are less expensive to the State than uninsured children. Politicians of all ranks and affiliations posit that preventive care saves money in the long run. Former Senator John Edwards (D-N.C.) stated, “Study after study shows that primary and preventive care greatly reduces future health care costs, as well as increasing patients’ health.”¹⁹⁵ Former Governor Mike Huckabee (R-Ark.) has said that preventive care “would save countless lives, pain and suffering . . . and billions of dollars.”¹⁹⁶ But it may not be so simple.

In order to determine whether preventive care will save money, cost-benefit analyses must be done for each type of treatment to determine which methods of preventive care will result in cost savings.¹⁹⁷ Denali KidCare could greatly benefit from research detailing whether the treatments received by low-income children in the program result in cost savings. Other states have done similar research for their respective CHIPs and have made optimistic projections for their programs’ cost savings.

192. OVERVIEW OF GRANTS, *supra* note 89, at 2.

193. E-mail from William Hogan, Commissioner, Alaska Department of Health and Social Services, to author (July 20, 2009) (on file with author).

194. *Hearing before S. Fin. Comm.*, *supra* note 113, at 9.

195. Joshua T. Cohen, Peter J. Neumann & Milton C. Weinstein, *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 661 (2008).

196. *Id.*

197. *See generally id.*

Texas, for example, investigated increasing costs for its CHIP in 2001. The Texas Legislative Budget Board—charged with writing the official cost estimates for legislation—estimated that Texas would save \$4.6 billion over the course of ten years, and \$10 billion over the course of twenty years from “reduced emergency room use, reduced hospital days, increased immunizations, and reduced charity care.”¹⁹⁸ Assuming its situation is similar to Texas’, Alaska could experience great savings by increasing eligibility to 200%.

D. Costs Are Low

Relative to Alaska’s 2009 budget—\$10.1 billion¹⁹⁹—increasing Denali KidCare’s eligibility level to 200% would not have a drastic effect on the budget. The total cost of increasing the eligibility level to 200% would be around \$2.7 million, which is approximately 0.03% of the fiscal year 2010 budget.²⁰⁰ Additionally, the State of Alaska would not be paying the entirety of those costs, as the federal government matches the costs with the allotted funds at the enhanced FMAP rate.

With the enhanced FMAP, CHIP is a much cheaper way to fund health insurance programs for children. United States Senator Mark Begich called Denali KidCare “frankly a very good deal.”²⁰¹ Senator Begich was referring to the enhanced FMAP, which for Alaska is at sixty-six percent—compared to the FMAP for Medicaid, which is at fifty-one percent.²⁰² This means that of the \$2.7 million in additional costs incurred by increasing the eligibility level, the State of Alaska would only be paying thirty-three percent of the total cost, or a mere \$900,000. This \$900,000 amounts to 0.0089% of the annual budget. Alaska would be insuring 1300 additional children for only \$692 per child, per year; or \$58 per child, per month.

Before CHIPRA, the federal government would have allocated Alaska \$10.4 million to fund Denali KidCare for fiscal year 2009.²⁰³ CHIPRA increased this allocation by over 200% with around \$24 million

198. ANNE DUNKELBERG, CENTER FOR PUBLIC POLICY PRIORITIES, STATUS REPORT: CHILDREN’S MEDICAID ELIGIBILITY SIMPLIFICATION, 2 (2001), available at <http://www.cppp.org/files/3/pp125.pdf>.

199. OFFICE OF MANAGEMENT AND BUDGET, STATE OF ALASKA, FISCAL 2010 ENACTED FISCAL SUMMARY (2009), available at http://www.gov.state.ak.us/omb/10_omb/budget/10%20PDFs/FY2010_Fiscal_Summary_5-20-09.pdf.

200. See *Hearing before S. Comm. on Health & Soc. Servs*, supra note 112.

201. See Letter from Mark Begich, supra note 169, at 2.

202. CTR. FOR CHILDREN & FAMILIES, GEORGETOWN UNIV. HEALTH POLICY INST., FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES FY 2009–FY 2011 (2009), available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/financing/fmap.pdf>.

203. CTR. FOR CHILDREN & FAMILIES, GEORGETOWN UNIV. HEALTH POLICY INST., ESTIMATED ALLOTMENTS UNDER CHIPRA 2009 (2009), available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=policy/2009S-CHIPreauth/estimated_allotments.pdf.

allotted from the federal government.²⁰⁴ Before the increase in CHIPRA allotments, Denali KidCare served around 7900 children.²⁰⁵ With an increase from the 175% eligibility to 200% eligibility, it is estimated that an additional 1300 children will be covered;²⁰⁶ this would be an increase of approximately sixteen percent. The increased allocation under CHIPRA of over 200% to \$24 million more than covers the cost of enrolling an additional sixteen percent of children in Denali KidCare if the eligibility is increased. Therefore, budgetary pressures are not a compelling reason for not supporting an increase in the eligibility.

CONCLUSION

A man is drowning in the ocean. He prays for God to help him. God does not respond. A small fishing boat approaches the man, and offers to save him. The man says no, for he is a man of faith, and God will save him. He continues to pray, and still no response from God. A second vessel—a ship with a life raft—approaches the man, and tries to save him. Yet the man denies rescue again: he is a man of faith, and God will save him. The man is near death when the Coast Guard finally arrives with a helicopter to save him. With the little life he has left, he avoids and denies the rescue: for he is a man of faith, and God will save him. The man died. In the next life, he found himself conversing with God; and out of curiosity, he asked God why God did not decide to save such a staunch believer. God responded: “I tried to save you three times; I sent you a boat, a ship, and a helicopter, yet you denied them all.”

Alaska is being sent a boat, a ship, and a helicopter. For some reason, though, it continues to deny rescue. Alaska is rejecting the opportunity to insure an additional 1300 children for the mere price of \$58 per child, per month. It is rejecting the opportunity to insure an additional 1300 children for the price of 0.0089% of its annual budget. The federal government is providing lifeboats in the form of performance bonus payments and outreach grants, yet Alaska is rejecting those too.

Alaska is known for many great and distinct attributes, but the Alaska Legislature should no longer allow the state to be known for being one of five states limiting CHIP eligibility to less than 200%.

204. CTR. FOR CHILDREN & FAMILIES, GEORGETOWN UNIV. HEALTH POLICY INST., FY 2009 CHIPRA ALLOTMENTS (2009), available at <http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/fy%202009%20allotments.pdf>.

205. *Hearing before S. Fin. Comm.*, *supra* note 113, at 9.

206. *Hearing before S. Comm. On Health & Soc. Servs.*, *supra* note 112, at 8.