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2003 HOUSE HUMAN SERVICES

HCR 3066

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2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HCR 3066

House Human Services Committee

☐ Conference Committee

Hearing Date February 26, 2003

Tape Number	Side A	Side B	Meter #
2		X	29.6 - 38.9
Committee Clerk Signature	Sharon Renfrow		

Minutes:

Rep. Sandvig appeared as prime sponsor with written testimony.

Dave Zentner, Director of Medical Services for the Dept. of Human Services appeared neutral on the bill with written testimony.

Rep. Sandvig: When Medicaid covers the premiums, do the people already have the insurance and then Medicaid just picks it up.

Answer: Yes, we just make sure that if its cost effective that they don't drop the insurance, that we pay the premium. If it shows that its not cost effective, then we will not pick it up.

Rep. Sandvig: This wouldn't help somebody that wouldn't have insurance in the first place.

Answer: That's correct, this is for people who already have coverage.

No Opposition.

Rep. Price: Some of the these states that are referenced here as having are definitely backing off on some of their coverage's.

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In fact we've had one state report that they are so short of money overall, particularly in the Medicaid that they are cutting their school year by 20 days.

Rep. Sandvig: I thought this would put some pressure on the Department to check into some of these because I don't think they do everything they could do as far as going for waivers and things like that.

Rep. Pollert: I'm tired of people wanting to come after my income and moves a DO NOT PASS, second by Rep. Porter.

Rep. Sandvig: The idea was to partner with private insurance to get people covered, there is no program out there for those who don't have insurance.

Rep. Devlin noted we just studied this and there is no budget there for this.

Rep. Price: A lot of the States went into this in the just last 2 or 3 yrs and some of them are backing out of it. They are just not being able to fund some of these things.

Rep. Potter: I would be interested in something down the line when finances are better.

Vote: 10 - 3 - 0 Rep. Porter to carry the bill.

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Date: February 26, 2003
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HCR 3066

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DNP on Consent

Motion Made By Rep Pollert Seconded By Rep Porter

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig		✓
Rep. Bill Devlin, Vice-Chair	✓		Rep. Bill Amerman		✓
Rep. Robin Weisz	✓		Rep. Carol Niemeier		✓
Rep. Vonnie Pietsch	✓		Rep. Louise Potter	✓	
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 10 No 3

Absent 0

Floor Assignment Rep Porter

If the vote is on an amendment, briefly indicate intent:

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REPORT OF STANDING COMMITTEE (410)
February 27, 2003 10:19 a.m.

Module No: HR-35-3556
Carrier: Porter
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HCR 3066: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HCR 3066 was placed on the Eleventh order on the calendar.

(2) DESK, (3) COMM

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2003 TESTIMONY

HCR 3066

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HCR 3066

Testimony

Representative Sally Sandvig
District 21, Fargo
Study Resolution

Madam Chairman Price and members of the Human Services Committee:

For the record I am Representative Sally Sandvig from District 21 in Fargo and I'm here as the sponsor of this study resolution.

The purpose of this resolution is to look at the possibility of the Insurance and Medicaid Departments partnering with private insurance agencies and agents to encourage people to buy private health insurance. The state would set the standards, review the products and rates, monitor the program, and educate the public. The insurance companies would collect the premiums and pay the claims. This would allow people to use private insurance before medicaid. Employers could sponsor and pay health insurance for employees that would not have insurance coverage otherwise, and get incentive payments from the state for providing this coverage. They could pay 50% and Medicaid would pay the rest with a federal premium match. The private sector would be subsidized. We could expand or enhance coverage from savings in other programs. We could also use an employer sponsored insurance rebate program

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for providing a Family Health Insurance Assistance Program, or allow tax deductions for partnership policy. The money could come from unspent title 21 dolars, if available.

Another approach would be to reimburse the premiums for people who purchase cost effective insurance coverage. This could be done by using vouchers or subsidies, or allow people to buy into PERS.

States using some of these plans are Mississippi where businesses buy into a program to help employers cover more uninsured employees; Texas, Pennsylvania, and Missouri give small employers incentive payments for providing insurance up to 50% of the cost; Massachusets where the insurance provider must meet certain standards; Iowa's Health Insurance Premium Payments or HIPP, for employer coverage that reimburses premiums for those not eligible for coverage and in which the private sector is subsidized; Oregon's state funded Family Health Assistance Plan, a subsidized program employer plan; also New Jersey and Wisconsin's Badger plan.

These plans provide subsidies for people who cannot afford health care, subsidize worker contributions, offer subsidies to small employers and to individuals and small firms to encourage purchasing of coverage, or provide subsidies or vouchers to use toward employer sponsored

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coverage, or to directly buy insurance.

Idaho offers a state tax deduction for those who buy individual health care coverage,or on all expenditures for health insurance. New York indirectly subsidizes premiums by paying Healthy New York insurers 90% of claims between $30,000.00 and 100,000 dolars per member.

States pick up part of the cost of employer provided health insurance for workers who couldn't otherwise afford it. Some give tax credits if a person pays a large share of the premium and if funds are available up front to buy insurance.

Please give this resolution a due pass recommendation so we can study this issue.

Thank You.

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TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE
REGARDING HOUSE CONCURRENT RESOLUTION 3066
FEBRUARY 26, 2003

Chairman Price, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you today to provide information regarding this resolution. The Department's position is neutral.

When it is cost effective, the federal Medicaid program allows states to pay a portion or the entire monthly private health insurance premium for individuals eligible for Medicaid. The Department has been operating a premium assistance program in the Medicaid program since 1994. While the Department operates a premium assistance program for the Medicaid program, it does not operate one in the SCHIP program.

In order to receive federal approval to operate an employer buy-in program under SCHIP, states must demonstrate that the premium assistance will be directed to employer plans that meet SCHIP requirements, including benefit standards, enrollee cost-sharing limits, and minimum employer premium contribution levels. In addition, states must show that buying the private insurance plan is cost-effective in comparison to the cost of covering the enrollee directly through the state SCHIP program.

The North Dakota Legislative Council staff did prepare information regarding premium assistance programs and actions taken by other states in October 2001, and presented it to the Budget Committee on Health Care (see Attachment A).

I would be happy to respond to any questions you may have.

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39121

Prepared by the North Dakota Legislative Council
staff for the Budget Committee on Health Care
October 2001

PREMIUM ASSISTANCE PROGRAMS - ACTIONS TAKEN BY OTHER STATES

HOUSE BILL NO. 1441

Section 3 of 2001 House Bill No. 1441 directs the Legislative Council to conduct a study of the coordination of the Healthy Steps and Medicaid programs, including the feasibility and desirability of seeking a federal waiver to allow the Healthy Steps program to provide family health insurance coverage through employer-sponsored insurance policies.

ADULT COVERAGE THROUGH THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The state children's health insurance program (CHIP) allows states to design and receive federal funding for programs to provide health insurance coverage for low-income children under age 19 who are not eligible for Medicaid. States have broad flexibility in the design of their CHIP. However, states are generally prohibited from using CHIP funds to cover adults, except for adult coverage provided through a demonstration program implemented pursuant to a Section 1115 demonstration waiver.

FAMILY COVERAGE WAIVERS - SECTION 2105

States may request a family coverage waiver from the Centers for Medicaid and Medicare Services, formerly the Health Care Financing Administration, pursuant to Section 2105(c)(3) of Title XXI of the Social Security Act. Section 2105 provides that federal funds may be paid to a state for the purchase of family coverage under an employer-sponsored group health plan **if the purchase of the family coverage is no more than the cost of enrolling only the children in the CHIP plan.** The North Dakota Department of Human Services has indicated that even though a Section 2105 family coverage waiver allows CHIP funds to be used for adult coverage, in order to implement a demonstration project to provide such coverage, a Section 1115 demonstration waiver must be obtained.

DEMONSTRATION WAIVERS - SECTION 1115

Section 1115 of Title XI of the Social Security Act was enacted by Congress in 1962 to allow the Department of Health and Human Services to waive certain requirements and authorize demonstration projects for Medicaid. More recently, Section 1115 has been used to authorize waivers for CHIP. Section 1115 waivers are used by states to develop research and demonstration projects that provide innovative methods to promote the objectives of a program. The waivers allow states to receive federal matching funds for projects that would not otherwise qualify for federal participation or would qualify at a lower federal matching rate. As of September 25, 2001, five states (Minnesota, New Jersey, New Mexico, Rhode Island, and Wisconsin) have received approval for Section 1115 CHIP demonstration projects; seven states (California, Indiana, Maryland, Minnesota, New Mexico, Ohio, and Oregon) have Section 1115 CHIP demonstration proposals pending approval by the Centers for Medicaid and Medicare Services.

Guidelines issued by the Centers for Medicaid and Medicare Services in a July 2000 letter to state health officials provide that in order to qualify for a Section 1115 demonstration project, a state must:

- Operate its CHIP program for at least one year.
- Submit all required enrollment reports and evaluations.
- Offer its program statewide.
- Have open enrollment with no waiting lists.
- Provide coverage for children up to age 19 with family incomes up to at least 200 percent of the federal poverty level.
- Cover lower income individuals in the group targeted by the waiver before covering the higher income individuals in the group. A state may not cover any population group at a higher federal poverty level than the level for targeted low-income children.
- Demonstrate that its application and redetermination process for CHIP and Medicaid promotes enrollment and retention of eligible children.

The July 2000 letter also provides that for demonstration projects that seek to cover populations other than targeted low-income children, the state must show that it has adopted at least three of the following five policies and procedures in its CHIP and Medicaid programs:

- Use a joint, mail-in application and a common application procedure for CHIP and Medicaid (e.g., the same verification and interview requirements).
- Eliminate asset tests for eligibility determination.
- Provide continuous 12-month eligibility.
- Offer presumptive eligibility for children.

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- Have simplified coverage renewal procedures that allow the establishment of continuing eligibility via mail and, if the state operates a separate CHIP program, provide for seamless transitions between Medicaid and CHIP when a child's eligibility status changes.

A Section 1115 demonstration waiver project must contain specific objectives and must include a testing component to determine if the objectives are met. If a state meets the above criteria and receives approval for a Section 1115 demonstration waiver, coverage can be extended to new population groups, such as parents of eligible children or pregnant women. Several states have used Section 1115 demonstration waivers to provide adult and family coverage through a premium assistance program for employer sponsored insurance. Information regarding the plans implemented in four of those states is provided below.

Massachusetts

MassHealth, the Massachusetts combined Medicaid 1115 demonstration and CHIP program, was implemented in 1998 and provides health care coverage either directly or by providing assistance in the purchase of private coverage, such as employer-sponsored health insurance. The goal of the project is to increase health insurance coverage while curbing the growth of disproportionate share hospital and uncompensated care pool expenses.

The MassHealth plan includes various programs to provide coverage options based on the characteristics and income of the recipient, including the MassHealth family assistance program which provides benefits to children and adults. Eligible children are those with gross family income between 150 and 200 percent of the federal poverty level. Eligible children receive premium assistance toward qualifying employer-sponsored health insurance, when available. If the family does not have access to qualifying employer-sponsored health insurance, children receive services through the MassHealth managed care plan. Adults who work for participating employers and have family incomes at or below 200 percent of the federal poverty level qualify for premium assistance payments through the MassHealth family assistance program. The state also provides an insurance partnership payment to the participating employer to assist in the cost of providing health insurance to low-income employees. The employer-sponsored insurance must meet a basic benefit level, and the employer must pay at least 50 percent of the cost of the premium.

New Jersey

New Jersey received approval in January 2001 for an 1115 waiver demonstration project. New Jersey's CHIP demonstration project, called NJ FamilyCare, covers uninsured parents and pregnant women with gross income under 200 percent of the federal poverty level. As part of the demonstration project, premium assistance is provided for parents with incomes between 134 and 200 percent of the federal poverty level, if employer-sponsored insurance is available and cost-effective (i.e., the cost of family coverage is less than the cost of adding the children to CHIP). The NJ FamilyCare premium assistance program has the following requirements and features:

- The employer must contribute at least 50 percent of the premium cost.
- The cost to the state must be no more than the cost of enrolling the children in the CHIP plan.
- There is a required six-month waiting period, during which time the children may not have had employer-sponsored coverage.
- If the employer-sponsored coverage does not meet benchmark coverage standards, the state provides wraparound coverage on a fee-for-service basis.
- Payments for the premium are made directly to the employee.

The objectives of the 1115 demonstration project are to demonstrate that:

- Providing family coverage will facilitate the enrollment of uninsured children, will improve the health status of covered children and their families, and will complement welfare reform activities.
- Providing coverage to pregnant women with family incomes up to 200 percent of the federal poverty level will protect the health status of the fetus.

Rhode Island

Rhode Island received approval in January 2001 for an 1115 demonstration waiver project. The demonstration project includes establishment of the Rite Share program, which subsidizes the costs of enrolling Medicaid-eligible families, pregnant women, and children under the age of 19 in employer-sponsored health insurance. Enrollment began on a pilot basis in February 2001, and full implementation began in April 2001.

The goals of the Rite Share premium assistance program are to:

- Improve the health status of Rhode Islanders by improving access to and the quality of health care.
- Reduce the rate of uninsurance in Rhode Island by maximizing access to affordable health

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insurance through the use of both private and public funds.
- Serve as a pilot project for developing a combined Medicaid and CHIP premium assistance program.

Rite Share participants receive health care services through the provisions of their employer-sponsored health plans. Benefits must be substantially similar to those provided by Rite Care, the state's Medicaid managed care demonstration project. The state pays the employee's share of the insurance premium directly to the employer. The state also pays the deductibles, copayments, and other cost-sharing obligations for Medicaid-covered services. Services not provided through the employer-sponsored insurance are covered under Medicaid on a fee-for-service basis. The state's Rite Care and Rite Share plans cover the following groups:
- Uninsured pregnant women under 250 percent of the federal poverty level.
- Children up to age 19 below 250 percent of the federal poverty level.
- Uninsured parents of enrolled children under age 19 with incomes up to 185 percent of the federal poverty level.

Wisconsin

Wisconsin received approval in January 2001 for an 1115 demonstration waiver project. The Wisconsin combined CHIP and Medicaid demonstration project, known as Badger Care, provides coverage for parents and children with family incomes up to 185 percent of the federal poverty level. Parents can qualify for subsidies to enroll in employer-sponsored insurance, even if the cost-effectiveness test is not met. The state will receive the CHIP enhanced federal matching rate for the costs of enrolling both the parents and the children if the cost-effectiveness test is met. If the cost-effectiveness test is not met, the state will receive the regular Medicaid matching rate and the family will be covered through the state's Medicaid buy in program. Once a family is enrolled, eligibility is retained until the family income reaches 200 percent of the federal poverty level.

Families enrolled in employer-sponsored insurance receive Medicaid wraparound coverage for services not included in the employer's plan. Families with income above 150 percent of the federal poverty level pay a premium equal to 3 percent of family income. The employer must pay at least 60 percent of the premium amount. Applicants who have had access to employer-sponsored insurance during the past 18 months and work for an employer that pays 80 percent or more of the premium are not eligible to participate.

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY INITIATIVE

In August 2001, the Centers for Medicaid and Medicare Services released guidelines relating to the Health Insurance Flexibility and Accountability (HIFA) initiative. This initiative encourages state Section 1115 waiver demonstration projects to increase the number of individuals with health insurance. The initiative encourages statewide projects that coordinate private and public health insurance coverage and target Medicaid and CHIP resources to populations below 200 percent of the federal poverty level. The goals of the HIFA initiative are listed by the Centers for Medicaid and Medicare Services as follows:
- To encourage innovation in the use of Medicaid and CHIP funds to increase health insurance coverage for low-income individuals.
- To give states the programmatic flexibility required to increase private health insurance coverage options.
- To simplify the 1115 waiver application process by providing clear guidance and data templates.
- To increase accountability in the state and federal partnership by ensuring that Medicaid and CHIP funds are effectively being used to increase health insurance coverage, including private health insurance coverage options.
- To give priority review to state proposals that meet the general guidelines of the HIFA initiative.

The Centers for Medicaid and Medicare Services has provided a template for state proposals; proposals submitted based on the template model are to receive priority review. The initiative allows expansion of a state's Medicaid or CHIP. Medicaid proposals must be budget-neutral, meaning they cannot increase federal costs. Children's health insurance program proposals must be allocation-neutral, meaning they can increase a state's use of current CHIP allocations but cannot result in the receipt of additional redistributed amounts. Initial waivers will be granted for a five-year period, with three-year extensions available. The HIFA initiative offers states the increased programmatic flexibility of a Section 1115 waiver through a simplified application and approval process.

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