2009 HOUSE HUMAN SERVICES

HB 1478

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1478

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 26, 2009

Recorder Job Number: 7761

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz called hearing to order on HB 1478.

Rep. Boucher testified in support of the bill: See Testimony #1.

Tami Wald, Governor John Hoeven's office introduced the bill: Voiced support of bill. Governor Hoeven has (inaudible) to increase the income eligibility levels for the State Children Health Insurance (SCHIP) to 200% net of the poverty level. This will provide more than 1,000 children with timely quality health care.

Maggie Anderson, Director of Medical Services for the DHS: See Testimony #2.

Rep Nathe: What is 200% of poverty level mean?

Maggie Anderson: I don't have the chart with me.

Chairman Weisz: You may want to provide that and also the allowable under the net, the allowable deductions that would increase the income.

Maggie Anderson: I do have it. The April 1, 2008 income guidelines for a family of 4, 200% was $42,396 annually.

Chairman Weisz: And the deductions would add up to what?

Maggie Anderson: There is no easy way to answer that because every family deductions are different.

Chairman Weisz: Maximum allowable.

Maggie Anderson: I don't think they have a maximum allowable.

Chairman Weisz: I thought there was a limit to the child care (inaudible).

Maggie Anderson: There is a limit, after we add them all up, there is not necessarily a maximum. But, we do have a document of all of the disregards and all of the deductions.

Rep. Nathe: Is the net salary or income for that family?

Maggie Anderson: Yes.

Rep. Potter: On page 2 (read part of the testimony) can you explain that to me?

Maggie Anderson: Currently SCHIP applications are processed at the county level and the medical services office at DHS and if it is a SCHIP only case, those cases would be transferred to the department and processed there, if they apply for other programs, then they go to the county level.

Rep. Hofstad: Any economic impact on the counties with their workload? Would there workload increase?

Maggie Anderson: We don't expect significant impact on the county.

Chairman Weisz: Can you provide the information that showed the premium cost and when we started SCHIP in 1999 to present? If we had services covered under like vision and dental, that would be helpful to the committee.

Maggie Anderson: I can do that.

Rep. Nathe: Right now it is 150% net, is that correct.

Maggie Anderson: Yes.

Rep. Nathe: What are the figures now?

Maggie Anderson: $150-31,800 annually.

Rep. Nathe: What would that be gross, do you know?

Maggie Anderson: It's 31 (inaudible) brings your income up 150. If it's gross I would be before deduction and net after deduction. The 31 (inaudible) it won't (inaudible).

Rep. Uglem: Can you give us an average of what the deductions are for a family? The dollar amount.

Maggie Anderson: Might be able to provide an average, but some families may only have one deduction and others may qualify for all of them. We will do our best to provide a range of high and low deductions.

Caitlin McDonald, representing the ND Catholic Conference: See Testimony # 3.

Marlowe Kro Associate State Director Community Outreach AARP: See Testimony #4.

Chairman Weisz: You stated there is only 3 states that have eligibility less than 200% of net.

Marlowe Kro: Yes.

Chairman Weisz: If find that a little hard to believe?

Rep. Porter: What states?

Marlowe Kro: Idaho, Montana and Oregon.

Rep. Porter: But we don't know if it is net or gross.

Marlowe Kro: I can't tell you that right now, but I can sure get that information for you, if you would like.

Rep. Porter: In your second paragraph, you made a statement that SCHIP (inaudible) buffers fewer employers offer coverage that families can afford. Do you have some information regarding that also?

Marlowe Kro: Don't have specific information, but have resources that support the fact that fewer and fewer employers are offering health care coverage for their employees. It's a trend in all industries where that is happening. I can try to track down the specific information for you.

Rep. Porter: I would appreciate that.

Chairman Weisz: You can provide the information to either me or the clerk and we will provide it to the committee.

Josh Askvig with the ND Education Association: Handed out testimony for LeAnn Nelson, Director of Professional Development for the ND Education Association. **See Testimony #5.**

James Moench, Executive Director of ND Disabilities Advocacy Consortium: See Testimony #6.

Carlotta Mc Cleary, Executive Director of ND Federation of Families for Children's Mental Health. See Testimony #7.

Bruce Murry, lawyer for ND Protection and Advocacy Project (P&A): See Testimony #8.

HANDED IN TESTIMONY:

Susan Rae Helgeland, Executive Director Mental Health America of ND: See Testimony #9.

Paul Ronnigen, Executive Director of National Association of Social Workers: See Testimony #10.

Answers to committee questions from Marlowe Kro, AARP: See handout #11.

NO OPPOSITION.

Chairman Weisz closed the hearing.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1478

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 4, 2009

Recorder Job Number: 8714 22min. 23 sec.

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's take up HB 1478.

Rep. Uglem: The 250% is a problem for me. Think it's too high and like to amend bill to 160% and raise the age from 18 to 19.

Rep. Uglem: motioned for 250% to change to 160% and age 18 to change to 19.

Rep. Damschen: Second

Rep. Conrad: I don't think 19 year olds would qualify for CHIPS.

Discussion of over 4,000 children on CHIPS and this would be adding 1100 to 1200 children by going to 160%. Changing age from 18 to 19 would affect about 220 kids.

Rep. Kilichowski: Don't think we should monkey with the age.

Voice vote was taken and so many voices for yea and nay, that Chairman Weisz asked for a Roll Call Vote: 8 yes, 5 no, 0 absent. Motion carried for a DO PASS.

Rep. Hofstad: motion for a DO PASS as amended and rereferred to Appropriations.

Rep. Porter: Second.

Roll Call Vote: 11 yes, 0 no, 0 absent. Motion carried as a DO PASS as amended.

Bill Carrier: Rep. Weisz.

FISCAL NOTE

Requested by Legislative Council

03/23/2009

Amendment to: Reengrossed HB 1478

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$3,071,751		$5,644,694
Expenditures			$1,072,543	$3,071,751	$1,970,922	$5,644,694
Appropriations						

1B. County, city, and school district fiscal effect: *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for a change in the eligibility level for children under the State Children's Health Insurance Program (SCHIP).

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 increases coverage to those currently at 150% (net) of poverty to 200% (net) of poverty. It is estimated that an additional 1,158 children over the course of the biennium will be eligible for coverage at a 2009-2011 projected premium of $228.71 per child per month.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department will be able to access $3,071,751 of federal funding from the Centers of Medicare and Medicaid.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The Medicaid grants line item is estimated to increase by $4,010,430 in total funds of which $1,037,899 is from the general fund and $2,972,531 is federal funds for change in eligibility for 0-18 year olds.
It is estimated that a 1.5 FTE will be needed to process the additional applications. The salary line item is estimated to increase by $133,864 in total funds, of which $34,644 is from the general fund and $99,220 is federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The 2009-2011 Executive Budget for the Department of Human Services (HB 1012) includes the necessary funding for the increase in the eligibility level to 200%.

Name:	Debra A. McDermott	**Agency:**	Human Services

Phone Number:	328-3695	Date Prepared:	03/24/2009

FISCAL NOTE

Requested by Legislative Council
02/17/2009

Amendment to: Engrossed HB 1478

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$1,222,145		$2,247,413
Expenditures			$426,729	$1,222,145	$789,145	$2,247,413
Appropriations			$426,729	$1,222,145	$789,145	$2,247,413

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for a change in the eligibility level for children under the State Children's Health Insurance Program (SCHIP).

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 increases coverage to those currently at 150% (net) of poverty to 160% (net) of poverty. It is estimated that an additional 439 children over the course of the biennium will be eligible for coverage at a 2009-2011 projected premium of $243.93 per child per month.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department will be able to access $1,222,145 of federal funding from the Centers of Medicare and Medicaid.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The Medicaid grants line item is estimated to increase by $1,620,427 in total funds of which $419,367 is from the general fund and $1,201,060 is federal funds for change in eligibility for 0-18 year olds.
It is estimated that a .5 FTE will be needed to process the additional applications. The salary line item is estimated to increase by $28,447 in total funds, of which $7,362 is from the general fund and $21,085 is federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The 2009-2011 Executive Budget for the Department of Human Services (HB 1012) does include the necessary funding for the increase in the eligibility level to 160%.

Name:	Debra A. McDermott	**Agency:**	Human Services

Phone Number:	328-3695	Date Prepared:	01/17/2009

FISCAL NOTE

Requested by Legislative Council
02/11/2009

Amendment to: HB 1478

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$1,222,145		$2,247,413
Expenditures			$426,729	$1,222,145	$789,145	$2,247,413
Appropriations			$426,729	$1,222,145	$789,145	$2,247,413

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for a change in the eligibility level for children under the State Children's Health Insurance Program (SCHIP) and increases the age limit for SCHIP to 19 year olds for which there is no federal match available.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 increases coverage to those currently at 150% (net) of poverty to 160% (net) of poverty. It is estimated that an additional 439 children over the course of the biennium will be eligible for coverage at a 2009-2011 projected premium of $243.93 per child per month.

According to the Center of Medicare and Medicaid, 19 year olds cannot be covered under SCHIP, therefore, coverage for this age group would be all general funds. Information is not currently available to determine the cost per person and the number of 19 year olds who would be eligibile at all general funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department will be able to access $1,222,145 of federal funding from the Centers of Medicare and Medicaid.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The Medicaid grants line item is estimated to increase by $1,620,427 in total funds of which $419,367 is from the general fund and $1,201,060 is federal funds for change in eligibility for 0-18 year olds. No estimate is included for 19 year olds, which would be funded only with general funds.

It is estimated that a .5 FTE will be needed to process the additional applications. The salary line item is estimated to increase by $28,447 in total funds, of which $7,362 is from the general fund and $21,085 is federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The executive budget for the Department of Human Services (HB 1012) does include the necessary funding for the increase in the eligibility level to 160%, however does not include funding for 19 year olds, which would be funded only with general funds.

Name:	Debra A. McDermott	**Agency:**	Human Services
Phone Number:	328-3695	**Date Prepared:**	02/13/2009

FISCAL NOTE

Requested by Legislative Council
01/20/2009

Bill/Resolution No.: HB 1478

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$3,269,565		$6,011,571
Expenditures			$1,141,612	$3,269,565	$2,099,021	$6,011,571
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for a change in the eligibility level for children under the State Children's Health Insurance Program (SCHIP).

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 increases coverage to those currently at 150% net of poverty to 200% net of poverty. It is estimated that an additional 1,158 children over the course of the biennium will be eligible for coverage at a current premium of $243.93 per month.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department will be able to access $3,269,565 of federal funding from the Centers of Medicare and Medicaid.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The Medicaid grants line item is estimated to increase by $4,277,313 in total funds of which $1,106,968 is from the general fund and $3,170,3499 is federal funds.

It is also estimated that 1.5 additional FTE will be needed to process the additional applications. The salary line item is estimated to increase by $133,864 in total funds, of which $34,644 is from the general fund and $99,220 is federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The executive budget for the Department of Human Services (HB 1012) includes the necessary funding for the law change.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	01/23/2009

SCHIP Premiums Template

# of Children:		1,158
Rate:	$	243.93
FMAP:		74.12%

Month	# of Children	Premium	Cost/Month	Increase in # of Children
Jul-09	174	243.93	42,443.82	174
Aug-09	348	243.93	84,887.64	174
Sep-09	385	243.93	93,913.05	37
Oct-09	422	243.93	102,938.46	37
Nov-09	459	243.93	111,963.87	37
Dec-09	496	243.93	120,989.28	37
Jan-10	533	243.93	130,014.69	37
Feb-10	570	243.93	139,040.10	37
Mar-10	607	243.93	148,065.51	37
Apr-10	644	243.93	157,090.92	37
May-10	681	243.93	166,116.33	37
Jun-10	718	243.93	175,141.74	37
Jul-10	755	243.93	184,167.15	37
Aug-10	792	243.93	193,192.56	37
Sep-10	829	243.93	202,217.97	37
Oct-10	866	243.93	211,243.38	37
Nov-10	903	243.93	220,268.79	37
Dec-10	940	243.93	229,294.20	37
Jan-11	977	243.93	238,319.61	37
Feb-11	1,014	243.93	247,345.02	37
Mar-11	1,051	243.93	256,370.43	37
Apr-11	1,088	243.93	265,395.84	37
May-11	1,125	243.93	274,421.25	37
Jun-11	1,158	243.93	282,470.94	33
Total			**4,277,312.55**	1,158

State	**1,106,968.49**
Federal	**3,170,344.06**

Adopted by the Human Services Committee
February 4, 2009

YR
2/5/09

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1478

Page 1, line 13, remove the overstrike over "~~one~~", remove "two", and after "~~fifty~~" insert "sixty"

Page 2, line 1, overstrike "and"

Page 2, line 3, after "eligibility" insert "; and

f. Coverage for children through the age of nineteen"

Renumber accordingly

Date: 2-4-09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Rep. Uglem Seconded By Rep. Damschen

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	✓		REP. TOM CONKLIN		✓
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD		✓
REP. CHUCK DAMSCHEN	✓		REP. RICHARD HOLMAN		✓
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI		✓
REP. CURT HOFSTAD	✓		REP. LOUISE POTTER		✓
REP. MICHAEL R. NATHE	✓				
REP. TODD PORTER	✓				
REP. GERRY UGLEM	✓				

Total (Yes) 8 No 5

Absent 0

Bill Carrier

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

motion for DPO on amend Changes.

Date: 2-4-09

Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Rep. Hofstad Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	✓		REP. TOM CONKLIN	✓	
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD	✓	
REP. CHUCK DAMSCHEN	✓		REP. RICHARD HOLMAN		✓
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI		✓
REP. CURT HOFSTAD	✓		REP. LOUISE POTTER	✓	
REP. MICHAEL R. NATHE	✓				
REP. TODD PORTER	✓				
REP. GERRY UGLEM	✓				

Total (Yes) 11 No 2

Absent 0

Bill Carrier Rep. Weisz

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

pg 2 line 7 overstrike "and" pg 2 line 3 after "eligibility" insert "and" and remove the period. pg after line 3 insert page 19

Re refer to Appropriations

REPORT OF STANDING COMMITTEE

HB 1478: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1478 was placed on the Sixth order on the calendar.

Page 1, line 13, remove the overstrike over "~~one~~", remove "two", and after "~~fifty~~" insert "sixty"

Page 2, line 1, overstrike "and"

Page 2, line 3, after "eligibility" insert "; and

f. Coverage for children through the age of nineteen"

Renumber accordingly

2009 HOUSE APPROPRIATIONS

HB 1478

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1478

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 13, 2009

Recorder Job Number: 9488

Committee Clerk Signature Jeanette Cook

Minutes:

Representative Robin Weisz approached this bill which deals with SCHIP.

Chm. Svedjan: Do you have a fiscal note?

Representative Weisz: The fiscal note is not ready, but I have the numbers. This is a bill that the original appropriation was in the governor's budget. It was taken out of the separate policy bill and was taken to our committee. The original bill would have raised the net income level for SCHIP's from 150% to 200%. The old fiscal note would have added about $1.2 million of general fund spending in the governor's budget. Human services committee adjusted it down to 160% of net. We also changed the age limit from 18 to 19. Currently it is to age 18, and then your CHIP benefits quit. The committee did that because there was discussion in the new authorization that they were going to increase that age to 25. The committee thought it made more sense for those in the lower income bracket to try to get more coverage. Since this bill came out, they did pass reauthorization of SCHIPs. We can go to H-19, but that would require 100% state dollars. We don't have a fiscal note on that yet. The department is trying to figure out what that would be. I think that he committee would have to take a hard look at removing that provision, because that would require 100% of state dollars to go through H-19 at this point.

Rep. Kempenich: Would they have to be at home yet to qualify at 19?

Representative Weisz: Yes, they would have to be part of the family that qualified the income level for CHIP.

Chm. Svedjan: What is the remainder of the fiscal impact for the change you've made, going to 150% net?

Representative Weisz: The state's share going from 150% to 160% is $419,366. So, that is a reduction of not quite $800,000 from the original in the governor's budget. It does increase general fund spending from last biennium of $419,000 and $1.2 million of federal funds. It is anticipated that it would cover 439 additional children.

Chm. Svedjan: What is the current premium?

Representative Weisz: $243.93.

Chm. Svedjan: If it is all state money for those 439, that should give us the fiscal note?

Representative Weisz: The 439 is not based on age 18 to age 19. That is based on the 150 to 160%.

Chm. Svedjan: Any idea how close they are to getting the fiscal note?

Representative Weisz: They are having a hard time identifying that group. The committee passed that part in the amendment on the assumption that we would be able to get the federal cost share, that now has been determined that we can't qualify for. I think that the policy committee would have supported removing that. We didn't have that information when we had to send the bill out to appropriations.

Chm. Svedjan: We could amend that out and be left with a fiscal note that would cost us $419,366 to go to 160% of poverty.

Representative Weisz: Based on a rough draft of kids from 0-18 and possibly 19 and then add 100% cost, it could be another $1.2 million.

Rep. Kempenich: How many are covered under CHIPS right now?

Representative Weisz: We are at 4300 or 4500 kids currently under CHIPS.

Chm. Svedjan: What percentage of the population of kids are we covering right now?

Representative Weisz: I don't have any idea.

Rep. Wald: How much of a co-pay?

Representative Weisz: It's limited by federal, but the max is $5.00.

Rep. Wald: Line 17 has a deductible, how much is the deductible?

Representative Weisz: We don't do a deductible. It is just an option.

Rep. Wald: Who besides BCBS would write this?

Representative Weisz: I have no idea. It is out there for anyone to apply for, but so far nobody but the blues have applied. If you buy the BCBS child package does not have dental and vision.

Rep. Nelson moved to amend line 4, p. 2 Subsection F to remove coverage through age 19.

Rep. Pollert seconded the motion.

Chairman Svedjan: That is the section that would be covered by state only dollars with no federal match.

A voice vote was taken.

The motion carried and the amendment was adopted.

Rep. Pollert: Can you give me the Committee's thought about the 160%?

Representative Weisz: North Dakota is one of the few states that is at net. (? -11m17s) There are 39 deductions that can come off the 160%. There are twenty some disregards of income. At 160 you are well above the medium income in ND. Is this program to help children whose parents can't afford health insurance, or are we supposed to be establishing universal health care for the children? That's why we wanted to extend the age from 18 to 19. If a covered family sends a child off to college, then they are covered.

Rep. Nelson moved a Do Pass as amended.

Rep. Pollert seconded the motion.

Rep. Delzer: In your discussion did you ask anybody by going up at all how many will drop their coverage and go under CHIPS?

Representative Weisz: That discussion did come up, but the department has no way to determine that. Potentially there would be some, and there would be a six month waiting period. At 200% it would have made sense for the state to drop all of its insurance policies. It would save money in the PERS plan.

A roll call vote was taken. **Aye 15 Nay 8 Absent 2**

The motion carried.

Representative Nelson will carry HB 1478.

Prepared by the Legislative Council staff for
House Appropriations
February 13, 2009

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1478

Page 2, line 1, remove the overstrike over "~~and~~"

Page 2, line 3, remove "; and"

Page 2, line 4, remove "f. Coverage of children through the age of nineteen"

Renumber accordingly

Date: 2/13/09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Amend as indicated below.

Motion Made By Delzer Seconded By Pollert

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Rep. Skarphol			Rep. Kroeber		
Rep. Wald			Rep. Onstad		
Rep. Hawken			Rep. Williams		
Rep. Klein					
Rep. Martinson					
Rep. Delzer			Rep. Glassheim		
Rep. Thoreson			Rep. Kaldor		
Rep. Berg			Rep. Meyer		
Rep. Dosch					
Rep. Pollert			Rep. Ekstrom		
Rep. Bellew			Rep. Kerzman		
Rep. Kreidt			Rep. Metcalf		
Rep. Nelson					
Rep. Wieland					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

p. 2, line 4, Auto. – take out 19 provision out.

Voice Vote – Carried

Date: 2/13/09
Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

Full House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass as Amended

Motion Made By Nelson Seconded By Pollert

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan		✓			
Vice Chairman Kempenich	✓				
Rep. Skarphol		✓	Rep. Kroeber	✓	
Rep. Wald		✓	Rep. Onstad	✓	
Rep. Hawken	✓		Rep. Williams	✓	
Rep. Klein	✓				
Rep. Martinson	—				
Rep. Delzer		✓	Rep. Glassheim	✓	
Rep. Thoreson		✓	Rep. Kaldor	✓	
Rep. Berg		✓	Rep. Meyer	✓	
Rep. Dosch		✓			
Rep. Pollert	✓		Rep. Ekstrom	✓	
Rep. Bellew		✓	Rep. Kerzman	—	
Rep. Kreidt	✓		Rep. Metcalf	✓	
Rep. Nelson	✓				
Rep. Wieland	✓				

Total (Yes) 15 No ~~8~~ 8

Absent ~~0~~ 2

Floor Assignment Rep. Nelson

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

REPORT OF STANDING COMMITTEE

HB 1478, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (15 YEAS, 8 NAYS, 2 ABSENT AND NOT VOTING). Engrossed HB 1478 was placed on the Sixth order on the calendar.

Page 2, line 1, remove the overstrike over "~~and~~"

Page 2, line 3, remove "; and"

Page 2, line 4, remove "f. Coverage for children through the age of nineteen"

Renumber accordingly

2009 SENATE HUMAN SERVICES

HB 1478

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 03/02/2009

Recorder Job Number: 9936, 9998

Committee Clerk Signature Mary K Monson

Minutes:

Chairman J. Lee Opened the hearing on HB 1478.

Tammy Wall Governor's Office. Introduced HB 1478. Spoke briefly in support. Explained SCHIP and the changes made by the house to increase eligibility to 160% net instead of 200% net. Introduced Maggie Anderson.

Maggie Anderson Director of the Medical Services Division for the DOHS. Spoke in support of 1478. See attachment #1.

Chairman J. Lee Would you like to comment on the reasons for the movement changing in Medicaid and SCHIP?

Anderson Explained the change using the numbers and graphs on the 3rd page of her testimony. With SCHIP renewals, some children are becoming eligible for the Medicaid program.

Senator Dever Are many eligible children not participating in this program; do you know what the percentage is?

Anderson I don't have the numbers. It is a hard number to discern. We are trying to reach as many children as possible.

Senator Dever Is the increased projection based on current levels of participation?

Anderson The increased projection is based on the data we receive according to how many families are applying for coverage who are over the limit. Spoke about how the DOHS found its most recent data. Also passed out poverty level information, see attachment #2.

Senator Lee Do you have access to poverty levels in other states? I know ND is low but the net might make a difference.

Anderson We can get the numbers but I do not have it on me. Just so you know, 160 is not a natural break in the poverty levels. A family of four at 160 has an income level at $35,280.

Senator Dever Are we seeing an increase in Medicaid applications with the current economic crisis?

Anderson Right now the increases we see in Medicaid are primarily in the children's area.

Representative Merle Boucher District #9. Spoke in support of 1478. See attachment #3.

Caitlin McDonald Health Advocate for the ND Catholic Conference. Spoke in support of 1478. See attachment #4.

Paul Ronningen Executive Director of the National Association of Social Workers ND Chapter. Spoke in support of 1478. See attachment #5.

Chairman J. Lee Do you think that the way the current law is structured does encourage preventative health? Or is there something you would like to see change?

Ronningen I think ND should be proud of its SCHIP program but we do want to extend coverage to new kids.

Chairman J. Lee So you don't think there is some barrier to wellness that leads parents to go to the emergency room instead? It is an enrollment issue rather than the way that the law is structured.

Ronningen I believe that is true, I think Maggie may have a better perspective on that. Spoke about the 12 month eligibility program.

Senator Dever Asked about numbers of eligible kids that are not using the services.

Ronningen I don't know if there are any good answers to that question. We can only use ballpark figures. Clearly there is a need for continued coverage of kids.

Discussion about the Kids Count Sheets

Carlotta McCleary Executive Director of ND Federation of Families for Children's Mental Health. Spoke in support of 1478. See attachment #6.

Chairman J. Lee To Maggie, can you confirm what the mental health coverage is under SCHIP?

Anderson I don't have the numbers but I do know that we cover that.

Sandy Tribke Executive Director of the Children's Caucus. Spoke in support of 1478. See attachment #7.

James M. Moench Executive Director of the ND Disabilities Advocacy Consortium. Spoke in support of 1478. See attachment #8.

Bruce Murry Lawyer with the ND Protection and Advocacy Project. Spoke in support of 1478.

See attachment #9.

Senator Dever If we increase SCHIP to 200% are we making legislation from last session irrelevant?

Murry Having the poverty levels at the same or similar levels does make that question go to the root of the type of coverage. Medicaid is essentially unlimited whereby SCHIP has more limits. I think that is the big difference because it allows more children access to Medicaid.

Chairman J. Lee Just so I understand it, a family at that 200% criterion who had a special needs child would be foolish not to go with a buy in?

Murry In almost every situation, I think they would be better off with a buy in. But, this is very important for children who don't meet that disability standard.

Kayla Pulvermacher ND Farmers Union. Spoke in support of 1478. See attachment #10.

Bob Hanson AARP ND. Spoke in support of 1478. See attachment #11.

Caitlin McDonald I would like to add info about eligible children that are not participating in the program, I do want to point out that if we do leave the eligibility at 160% and there is a child at 165%, we should not penalize them because someone at 150% is not taking advantage of the program. They deserve health care just as much as people who are not taking advantage.

Senator Dever The point of the question was not whether or not we should justify the increase in eligibility but to question whether or not we need to do a better job of marketing.

McDonald I realize that, it just wanted to point that out additionally.

There was no opposition of neutral testimony submitted.

Chairman J. Lee I wanted to mention that BCBS not only administers SCHIP but also administer the caring foundation program. Spoke about the purpose of caring foundation which seeks to take care of children who do not qualify for SCHIP. Also explained how ND is unique for using net figures instead of gross figures.

Senator Dever Asked about the dates on the fiscal notes.

Maggie Anderson This fiscal note was done after the amendments but prior to projections. We have not completed a fiscal note with the new projections. Discussed the policies of surrounding states

Chairman J. Lee Closed the hearing on HB 1478.

See attachment #12 for additional e-mail submitted testimony.

Job #9998

Chairman J. Lee Opened the discussion on HB 1478. Senator Dever's questions about buy in options for families with children with disabilities prompted me to ask Maggie Anderson for more information.

Discussion about differences between Medicaid and SCHIP and how those differences may affect the legislation, also discussed the percentage range 160-200%...The committee felt they needed more information from Maggie Anderson and numbers relating to how many children are eligible for services vs. how many are actually using the services. They also discussed legislation related to HITS and proof of insurance for children. Senator Heckaman was concerned about single parents vs. two parent families. There were some observations made regarding reservation children and their status as insured or uninsured. The committee will reconvene and discuss the bill after they have received more information.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 03/10/2009

Recorder Job Number: 10615

Committee Clerk Signature Mary K Monson

Minutes:

Chairman J. Lee Reopened the discussion on HB 1478.

The info requested in previous discussions from Maggie Anderson in the DOHS was distributed. See attachment #13. The committee discussed poverty levels and how one parent vs. two parent homes affect the income level of particular families

Two potential amendments were distributed as well. Senator Flakoll suggested to Senator Lee that they figure out a way to include signing up for CHIP and other children's health programs at the time a child enrolls in school, that suggested is reflected in the amendment draft. Maggie Anderson is going to visit with DPI and report back to the committee. Senator Heckaman discussed the buy in option for families that she felt would be particularly helpful to rural families, she shared her own personal story—she distributed amendments as well. The committee discussed the information from Maggie Anderson, particularly the yellow sheet discussing plans from different states. There was also discussion about various plan types available to people.

See attachment #14 for proposed amendments 90818.301 and 90818.0302.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 03/11/2009

Recorder Job Number: 10712, 10761

Committee Clerk Signature Mary K Monson

Minutes:

Chairman J. Lee Reopened the discussion on HB 1478

Senator Heckaman Wants the committee to relook at the 200% net income as proposed by the governor's budget. She proposed an amendment in an earlier discussion but forgot to look at the fiscal note before drafting it. She is going to readjust the amendment after speaking with Senator Mathern.

Discussed the buy in statistics—the committee does not have the numbers on bringing the net income up to 200%.

Discussion unrelated to the bill

Chairman J. Lee Is going to pass out revised projection numbers to the committee in the afternoon.

The committee is going to discuss bringing the net income up to 200% in the afternoon.

Senator Dever I am wondering if the committee has any appetite to increase the eligibility for the Medicaid buy in that we passed last time.

Chairman J. Lee That is an interesting question, should I have Maggie Anderson come down?

Senator Dever Yes, I would also be curious about large families and medically fragile children

Brief discussion about buy in options, the committee recessed until the afternoon.

Job #10761

Chairman J. Lee Reopened the discussion on HB 1478. The question was raised that with so few children applying for coverage, perhaps the 200% should be reconsidered. Is there an issue because of a shortage of applications or a qualifying issue as to why this program is underutilized?

Maggie Anderson DHS. It is not an indication of families not qualifying, we have for the most part approved families who have applied for the coverage. Certainly there are those that are over the income guidelines but it is not, for example, that we have had 500 applications and only 10 children have been accepted. It is just a slow/low number of applicants.

Chairman J. Lee Do you see any merit in adjusting the income eligibility level? That might encourage others to sign up since we haven't over taxed the appropriations board in this last biennium.

Anderson Certainly increasing it would lead us to believe that additional children would apply and be eligible since we worked with our own disabilities services and a national company in preparing the estimates for last time. It is hard to know if the estimates from last time were overstated. It is hard to gauge how many children will use the program. We have been reaching out to raise awareness.

Senator Dever I am curious, I see there are two aspects. There is the Medicaid buy in and the medically fragile—up to 15, then 10 and the buy in?

Anderson In the medically fragile waiver for children we have 4 children, that one is limited to 15 slots where as the buy in is a Medicaid program and an entitlement so we can't cap that. We had estimated 400 but we could have 800 in reality. We have four children enrolled in the waiver receiving services and our staff is working with several other families. We were

concerned that we had only fifteen slots and would have to prioritize coming out of the chute but we have not had to do that.

Senator Dever But if we increase eligibility we might have people move across to that.

Anderson It is possible but they would still have to meet nursing home level care requirements. The eligibility is different for the waiver than from the buy in. We would have to work with each family individually. A child who is on the waiver is also able to receive Medicaid services. Children on Medicaid only receive Medicaid services.

Chairman J. Lee Wouldn't the medically fragile children be pretty easy to find through social services, etc.? It seems to me that there is such great need for those medically fragile children that they are not going to be hard to find.

Anderson I don't think you are wrong, but many of these children want to remain in their own home. It all goes back to each individual family's need. We have had up to ten kids on the waiver but some have gone off as their level of need changes. I do think the staff and the counties who care for the children are aware of the waiver and do provide referrals. If we stay at four forever it might mean that our criterion is too strict and then we would have to look at that.

Chairman J. Lee So if we left in place the way it now, we could expect that you will continue to monitor this thing? Obviously this committee is willing to look at eligibility requirements if they are the right thing to do. We want to make sure that the families are safe. Informally, do you think we are better off with the standards we have now or should we look at changing them? Should we look at them now or might that be something for next session?

Senator Dever If I remember correctly, that bill was introduced at 300% eligibility last session and there was some concern that it was not capped. If I could make a reasonable guess with where we are going, we should start low and increase it later.

Chairman J. Lee Would you like later to be now?

Senator Dever I would like to consider it.

Chairman J. Lee Recognizing our experts here and our noble intentions, what would you like to do? Is it possible that you can give us any ballpark area of what a fiscal note might be if we enhance that number?

Anderson I think we would have to go back and examine the methodology we used three years ago. We estimated 400 children and that was over stated, we would have to go back and determine what was wrong with that methodology and why we thought there were more disabled children in need. We definitely would not want to go back to our old numbers and just increase from there because obviously there was something overstated with the numbers. There have also been some changes in SCHIP and Medicaid that would need to be taken into account.

Carol Olson Director of DHS. I am wondering if we wouldn't all be better off taking the next two years to figure out why it is that we have such a low number enrolled in the program. We would like to get additional information as we only have 6 months worth of data on some of the new programs. I am wondering if it would be better to gather more data and come back in two years. We have been looking at this and wondering why the numbers are so low but I think we need to know why before we increase the eligibility numbers.

Anderson We did use some federal poverty levels to set income eligibility levels but I do think we could work with advocates to help us uncover the reasons why the numbers are the way they are.

Chairman J. Lee Do you have a problem with that Senator Dever?

Senator Dever I have no problem with all of that madam chair. If we have better numbers, it would make it easier to make changes.

Chairman J. Lee Ok, let's focus on the SCHIP program.

Anderson Passed out some additional information. See attachment #15. The green sheet has the most current numbers, there is some disparity between the numbers in her testimony and the green sheet as those numbers were unavailable to her at the time of her testimony. What you have before you is all the scenarios requested over the past few months. Explained the worksheet.

Senator Heckaman In looking at the amendments to increase it 200% and the buy in option suggested by Senator Mathern, did the department costs change any from the original bill?

Anderson The costs would not change.

Senator Erbele Just to clarify, the estimate number of children that you will service in each category are based on the numbers that you have rejected?

Anderson That is correct, we have used the number of people who applied.

Senator Erbele But there could be more out there that have not applied?

Anderson There are potentially more out there but we do also compare all of our numbers to the population data to make sure that things look normal.

Chairman J. Lee I spoke informally with the appropriations committee yesterday and they are just real concerned that we do not undershoot the potential number of children as the economy continues to flatten or dip. Can you remind us again about which month you used to gather these numbers and what sort of assurance we have that these numbers are conservative? I would like to know the maximum amount of children that we might have. That is what concerns some legislators.

Anderson Explained how the numbers were calculated.

Senator Pomeroy Do we have any more information as to why Medicaid went up and SCHIP went down?

Anderson We are continuing to analyze that as it is about a 6 month trend. Around the time the eligibility requirements changed we started to see the trend line start to happen. We do know that some of that has to with the increase in Medicaid and in the continuous fund. Explained at length some hypothetical reasons for the trend.

Chairman J. Lee We had discussed a potential amendment tying eligibility to free and reduced lunches and DPI forms, do you have any updated information on that?

Anderson I visited with my staff member and we would be willing to work with DPI on that and help get information into the packets. We haven't had that meeting with them yet but we have visited about it.

Chairman J. Lee But there was some potential and doing that?

Discussion about forms and making them available, possible ideas were suggested

Bruce Murry ND Protection and Advocacy Project. The only thought I had was that in addition to intent language we should add "may" language so that you had both the intent and the authority to gather information.

Chairman J. Lee I am looking to enable this to happen and we want to make this possible to pursue. So if we leave the school aside, let's talk about poverty levels.

Senator Heckaman I can support 200%

Senator Dever Me too

Senator Erbele I can as well

Senator Heckaman I did some calculations, if we stay at 160% and go to 200%. It will cost about $400 per child per year, $900 per biennium if my figures are correct. I don't think that is a lot of money to add.

Senator Dever Are the premiums per child or per family?

Anderson Per child.

Senator Heckaman I can certainly support that. I presented an amendment on this similar to Senator Mathern's—part is to increase it to 200% and the other part is the buy in. Is that a difficult thing to manage, is that a nightmare? (referencing SB 2362)

Anderson Just so I understand the amendment, the amendment is regarding people over the 300% who would be able to buy into SCHIP at our premium. Between 2-300% we will have to secure federal approval. We do not have all the details from CMS.

Senator Heckaman Before you go any further, so you know, the language is shall provide a buy in option—is that language bad?

Discussion about amendments from this and prior bills—the issue is those eligible between 200-300% and the department needing some time to adjust to the buy in procedure

Senator Heckaman I move the amendment

Senator Marcellais Second

Senator Dever I cannot support the amendment because even though the cost is covered by families, it is still costing federal funds. I feel if we are going to take that responsibility we should take the cost and not pass it on to the federal government.

Senator Heckaman I think this is an opportunity, we might not have many buy ins—we just don't know. I think is an opportunity for those that do not fit under the poverty line but do not have insurance the opportunity to insure their children.

Senator Pomeroy I agree with the merit but I am trying to be practical and I am not sure if we would be able to get that through the house and the senate.

Chairman J. Lee I think it is a noble thing but these amendments were already rejected. I can't support the amendment.

The Clerk called the role on the motion to move the amendment. **Yes: 2, No: 4, Absent: 0.**

Senator Heckaman I move an amendment to raise the SCHIP level up to 200%.

Senator Dever Second

The Clerk called the role on the motion to move the amendment. **Yes: 6, No: 0, Absent: 0.**

Chairman J. Lee Suspended the discussion, the committee will wait for the other amendments before moving further.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 03/16/2009

Recorder Job Number: 11014

Committee Clerk Signature Mary K Monson

Minutes:

Chairman J. Lee Reopened the discussion on HB 1478.

Senator Heckaman How do we re-amend?

Spoke with the intern about the proper process for further amending a bill

Senator Dever I move to further amend HB 1478 to contain legislative intent

Senator Heckaman Second

Chairman J. Lee Explained the amendment and passed out additional information which is included in attachment #15.

Senator Heckaman Likes the part about legislative intent

Senator Dever Observed that section 2 has greater impact on bringing children into the program than Section 1

The Clerk called the role on the motion to move the amendment. **Yes: 6, No: 0, Absent: 0.**

Senator Heckaman I move **Do Pass as Amended and Rerefer to Appropriations**

Senator Dever Second

Discussion on future plans for the bill

The Clerk called the role on the motion to **Do Pass as Amended and Rerefer to Appropriations. Yes: 6, No: 0, Absent: 0. Chairman J. Lee will carry the bill.**

#1A

90818.0301
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
March 2, 2009

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1478

Page 1, line 1, after "to" insert "create and enact a new section to chapter 15.1-06 of the North Dakota Century Code, relating to a requirement for proof of medical insurance before enrollment in school; and"

Page 1, after line 3, insert:

"**SECTION 1.** A new section to chapter 15.1-06 of the North Dakota Century Code is created and enacted as follows:

Proof of medical insurance - Requirement for enrollment. Before a child may be enrolled in any public or nonpublic school, the child's parent shall present to the school proof that the child is covered by medical insurance. Upon the request of a child's parent, each school shall make available to the parent initial contact information regarding medical insurance programs for which the child or the child's family might be eligible."

Renumber accordingly

90818.0302
Title.

Prepared by the Legislative Council staff for
Senator Heckaman
March 3, 2009

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1478

Page 1, line 1, after "to" insert "create and enact two new sections to chapter 50-29 of the North Dakota Century Code, relating to children's health insurance buy-in and premium assistance programs; and to"

Page 1, after line 3, insert:

"**SECTION 1.** A new section to chapter 50-29 of the North Dakota Century Code is created and enacted as follows:

Children's health insurance buy-in program. The department shall establish a buy-in program through which a parent or guardian whose family net income exceeds the income eligibility limit provided for under section 50-29-04 may purchase a plan of coverage for a child who is uninsured. The coverage, copayments, and deductibles for a plan of coverage purchased under this section must be comparable to the coverage, copayments, and deductibles under the children's health insurance program. The premium for coverage may not exceed the amount the children's health insurance program pays per month for a child of comparable age whose family income is within the income eligibility limit provided for under section 50-29-04. The department shall reimburse the county for any costs incurred by the county in the implementation and administration of the buy-in program."

Page 1, line 13, overstrike "one" and insert immediately thereafter "two" and remove "sixty"

Page 2, after line 3, insert:

"7. The department shall seek a federal waiver to increase the net income eligibility level provided under subsection 6 to three hundred percent of the poverty line. Upon approval of the waiver, the income eligibility limit in subsection 6 is increased to the limit approved by the waiver.

SECTION 3. A new section to chapter 50-29 of the North Dakota Century Code is created and enacted as follows:

Premium for coverage. Upon approval of the waiver requested under subsection 7 of section 50-29-04, the department shall charge a monthly premium for coverage for an eligible applicant whose net income exceeds two hundred percent of the poverty line but does not exceed three hundred percent of the poverty line. The monthly premium must be equivalent to the amount expended monthly in state funds for an eligible applicant whose net income is two hundred percent of the poverty line or less."

Renumber accordingly

Date: 3/11/09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0302

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☒ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Heckaman Seconded By Sen. Marcellais

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman		✓	Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair		✓	Senator Richard Marcellais	✓	
Senator Dick Dever		✓	Senator Jim Pomeroy		✓

Total (Yes) 2 No 4

Absent 0

Floor Assignment

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

Motion failed

Date: 3/11/09

Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number move to 20090

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☒ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Heckaman Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

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

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1478

Page 1, line 13, overstrike "one" and insert immediately thereafter "two" and remove "sixty"

Page 2, after line 3, insert:

"**SECTION 2. LEGISLATIVE INTENT.** It is the intent of the Sixty-First Legislative Assembly that public school districts and private schools help ensure that families of enrolled school-aged children are aware of available health care coverage. Health care coverage may be available from individual student policies or from state/federally-funded programs, such as Medicaid or the Children's Health Insurance Program. It is expected that schools will provide information and applications to families as part of annual enrollment efforts. The North Dakota Department of Human Services and the North Dakota Department of Public Instruction may offer assistance to schools with this effort.

Renumber accordingly

Adopted by the Human Services Committee
March 16, 2009

3/16/09

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1478

Page 1, line 2, after "program" insert "; and to provide legislative intent"

Page 1, line 13, overstrike "one" and insert immediately thereafter "two" and remove "sixty"

Page 2, after line 3, insert:

"**SECTION 2. LEGISLATIVE INTENT.** It is the intent of the sixty-first legislative assembly that public school districts and private schools help ensure that families of enrolled school-age children are aware of available health care coverage. Health care coverage may be available from individual student policies or from state or federally funded programs, such as medicaid or the children's health insurance program. It is expected that schools will provide information and applications to families as part of annual enrollment efforts. The department of human services and the superintendent of public instruction may offer assistance to schools with this effort."

Renumber accordingly

Date: 3/16/09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number further amend.

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☒ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

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

Date: 3/16/09

Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1478

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended ☒ Rerefer to Appropriations

☐ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Heckaman Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais	✓	
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator J Lee

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

REPORT OF STANDING COMMITTEE

HB 1478, as reengrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1478 was placed on the Sixth order on the calendar.

Page 1, line 2, after "program" insert "; and to provide legislative intent"

Page 1, line 13, overstrike "one" and insert immediately thereafter "two" and remove "sixty"

Page 2, after line 3, insert:

"**SECTION 2. LEGISLATIVE INTENT.** It is the intent of the sixty-first legislative assembly that public school districts and private schools help ensure that families of enrolled school-age children are aware of available health care coverage. Health care coverage may be available from individual student policies or from state or federally funded programs, such as medicaid or the children's health insurance program. It is expected that schools will provide information and applications to families as part of annual enrollment efforts. The department of human services and the superintendent of public instruction may offer assistance to schools with this effort."

Renumber accordingly

2009 SENATE APPROPRIATIONS

HB 1478

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1478

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: March 25, 2009

Recorder Job Number: 11513

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg called the committee hearing to order on HB 1478 which relates to eligibility under the state children's health insurance program. Roll call was taken. This is one of those bills that is taken out of a budget bill and put into its own policy bill.

Maggie Anderson Department of Human Services. The bill was amended to 160% of poverty net in the House. Senate Human Services amended it back to 200%. Handed out SCHIP scenario—see attachment #1. The green sheet accounts for projections as well as scenarios—compares various percentages and growth expectations. Explained the green sheet.

Senator Krauter The fiscal part.

Anderson It's a $2.2 M general fund savings over what is in HB 1012. The estimate in 1012 was taken before any re-projections or premium changes.

Senator Krauter With the 2.2—is that eligible for the federal match of 300%?

Anderson That is our understanding of the reauthorization

Senator Krauter Would the $2.2 be enough for 300%?

Anderson We don't have that information; that's not how we determine those numbers.

Senator Krater What would it take for 300%?

Anderson I'd have to look that up.

Senator Mathern You're saying this financial scenario and if we added a feature that parents could buy this product by paying the states' portion, we could cover all the children in the state and still be under the governor's budget?

Anderson What this document is saying that at 200% we are saving 2.2M. You're talking about a buy in but I did not bring the numbers for 2362 so I don't know what that would cost. Spoke about 2362. We'd have to request a waiver from CMS to offer a buy in and explain it to them. The way you're describing it, there would be no general funds used.

Paul Ronningen Executive Director, National Association of Social Workers (NASW) and State Coordinator for the Children's Defense Fund, ND. Testified in favor of HB 1478. See attachment # 2. He suggested an on-the-ground intensive research of families in ND to sign up for healthcare coverage.

Fern Pokorny North Dakota Education Association. Testified in favor of HB 1478. No written testimony, but handed out "Ready Child" – see attachment # 3.

Senator Warner The range of people that we're reaching, how would you see us reaching out using the educational system. What part would it play?

Pokorny Since I don't represent the administration, I would venture to guess that we would do what we usually do. We send a flyer home with every student so that parents know they can sign up for this.

Senator Warner Do you see any role for teachers?

Pokorny That would certainly be an option, to have that available.

Bruce Murry North Dakota Protection & Advocacy. Testified in favor of HB 1478. Would offer that we prepare budgets that would help to raise SCHIP to 200% of poverty level.

Senator Christmann When I look at green sheet, the ending case load line, it goes from 5900 down to 4300, I was wondering about that big drop.

Maggie Anderson Explained the green sheet again and the variance due to re-projections. They are expecting fewer children to be on SCHIP when they start the biennium.

Senator Christmann Way up at the top, 200% will add 1100 children, is that from where we are today?

Anderson We picked that number and built from there. Explained what happened in the biennium.

Senator Christmann What happened in that month? The national economy is tanking and the state economy is struggling and yet you reduced the number that was expected to qualify by 20%. What happened?

Anderson In my testimony on 1012 I attached some extra testimony. When we saw decline in SCHIP, we saw rise in Medicaid eligibles. As they are being re-determined, there is continuous eligibility in Medicaid, we are seeing an increase in the number of children eligible for Medicaid. Children that used to be on Medicaid are now getting 12 months of continuous eligibility. We are seeing a decline in SCHIP and an increase in Medicaid.

V. Chair Bowman This is based on net income. Many states have gross income at 200%. How does that quantify 200% of gross or how are things changed if gross instead of net?

Anderson 200% of poverty for a family of four is $42,400 regardless of gross or net. How you get to gross is $42,000 or net is $42,400 with deductions. Gross is very different than net. We do know that at 200% gross we have children currently on the program who would not be eligible and if we went to a gross income test there would be significant computer issues between Medicaid and SCHIP.

V. Chair Bowman We're dealing with different numbers, but 200% of gross is totally different than 200% of net.

Senator Krauter Under this current scenario I've got SCHIP at 4,395. What is average monthly caseload for Medicaid?

Anderson We don't budget that way for children. We don't have an average case load but again on this attachment we were back at about 28,000 in January of 2008 and in 2009 we are at about 34,000 cases—those are eligible, that does not mean that they actually receive services.

Senator Krauter How many uninsured do we have?

Anderson The department doesn't collect information on uninsured.

Senator Krauter When a person goes on Medicare at 65, is there income eligibility?

Anderson There is criteria, but not income criteria.

Senator Mathern What is the federal match rate of Medicaid and SCHIP program?

Anderson For Medicaid we used an average of 63.02 the enhanced is 71.2 for SCHIP.

Senator Mathern Every time we keep a child on SCHIP, it's 10% more compared to Medicaid?

Anderson Correct.

Senator Mathern Do we have a system in place to try to get families onto BC/BS and a system to track that?

Anderson We do not work with that. We do cooperate with the caring for children program. We haven't set up a specific program for premium assistance.

Senator Christmann If people have insurance policy but they qualify for this, who pays the bill?

Anderson If their income changes and they do qualify, there is a crowd out policy. They have a 6 month waiting period after dropping their insurance. There are some exceptions. If they have private insurance they would pay for it, they would not qualify for SCHIP.

Senator Fischer Thought comes to mind about a situation in Pembina, is there a way to get a waiver, when they were let go, they could COBRA?

Anderson We could take a look at it.

Chairman Holmberg closed the hearing on HB 1478.

Senator Mathern had amendments on this bill drawn up.

Chairman Holmberg informed him to keep them and bring them to the subcommittee.

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1478

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: April 2, 2009

Recorder Job Number: 11644

Committee Clerk Signature Rose Laning

Minutes:

Chairman Holmberg opened discussion on HB 1478 concerning S-CHIP.

Senator Fischer moved Do Pass on HB 1478.

Senator Krauter seconded.

Discussion

Senator Mathern moved amendment .0303

Senator Warner seconded.

Senator Mathern: Amendment supports bill and 200% of poverty. Let's permit other families who have need to get insurance up to 300% to pay the state's share of the cost and they then could get their children into this program. Direct department of Human Services to make a waiver to make that possible. Almost every state is over 250%. Paul Ronnigen went to DC and ND is almost at the bottom of eligibility standard. It would not be a new program, it would simply say, families, you pay state portion and if the federal government agrees, you get that same service same as any other family under 200%. It would get us closer to the point of saying that all our kids are covered.

Senator Warner - Having to do with the transition out of poverty, this would expedite that. We want to encourage people to transfer state obligation of paying insurance. They can

participate in private insurance. It has no cost to state except small administration fee. It's a transitional process. As legislators we have a fiduciary responsibility to the citizens of the state and to allow them access to programs. He would give this a do pass.

Senator Kilzer - This would make a huge change. Is there a fiscal note and has there been a hearing.

Senator Mathern -The fiscal note would be about $200,000. We got a fiscal note from Maggie Anderson. There is a cost of hiring staff and administrative procedures to take in the additional applications. There is an assumption that there would be about 1200 more kids. One thing is cost could be taken out of this too and let family pay for it too, but it got real complicated and started looking like a different program.

Senator Kilzer - 1100-1200 kids over and above the 200% of net poverty?

Senator Mathern - Yes. There are a number of restrictions on getting into the program that stay in place and are not changed.

Senator Kilzer - Sounds like there would be an incentive for parents to not carry insurance on their children for 6 months and then let the state cover it.

Senator Mathern - It just families who are unable to cover their children. Discussion on covering children with insurance and eligibility and costs to parents and the state.

Senator Fischer - I'm talking about children already on and their premiums going up.

Senator Krauter - The more individuals on the plan the more you spread out the risk. By adding more people to the pool is the whole concept of insurance.

A Roll Call vote was taken on the Mathern amendment. Yea: 6 Nay: 7 Absent: 1

Amendment failed.

Senator Fischer moved Do Pass on HB 1478.

Senator Krauter seconded.

A Roll Call vote was taken. Yea: 11 Nay: 2 Absent: 1

Senator Judy Lee will carry the bill.

Date:
Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

Senate **Senate Appropriations** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number .0303 Mathern amendment

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Mathern Seconded By Warner

Representatives	Yes	No	Representatives	Yes	No
Senator Fischer		✓	Senator Warner	✓	
Senator Christmann A			Senator Robinson	✓	
Senator Krebsbach		✓	Senator Krauter	✓	
Senator Bowman		✓	Senator Lindaas	✓	
Senator Kilzer		✓	Senator Mathern	✓	
Senator Grindberg		✓	Senator Seymour	✓	
Senator Wardner		✓			
Chairman Holmberg		✓			

Total Yes 6 No 7

Absent 1

Floor Assignment

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

Amendment failed

Date: 4-2-09

Roll Call Vote # 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

Senate **Senate Appropriations** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Fischer Seconded By Krauter

Senators	Yes	No	Senators	Yes	No
Sen. Ray Holmberg, Ch	✓		Sen. Tim Mathern	✓	
Sen. Tony S. Grindberg, VCh	✓		Sen. Aaron Krauter	✓	
Sen. Bill Bowman, VCh		✓	Sen. Larry J. Robinson	✓	
Sen. Randel Christmann A			Sen. John Warner	✓	
Sen. Rich Wardner	✓		Sen. Elroy N. Lindaas	✓	
Sen. Ralph L. Kilzer		✓	Sen. Tom Seymour	✓	
Sen. Tom Fischer	✓				
Sen. Karen K. Krebsbach	✓				

Total Yes 11 No 2

Absent 1

Floor Assignment back to Human Services Judy Lee

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

REPORT OF STANDING COMMITTEE

HB 1478, as reengrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (11 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). Reengrossed HB 1478, as amended, was placed on the Fourteenth order on the calendar.

2009 HOUSE HUMAN SERVICES

CONFERENCE COMMITTEE

HB 1478

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1478

House Human Services Committee

☒ Check here for Conference Committee

Hearing Date: April 22, 2009

Recorder Job Number: 12090

Committee Clerk Signature Vicky Grabinger

Minutes:

Chairman Porter called the conference committee meeting to order on HB 1478.

Chairman Porter: I'll turn it over to Sen. Lee to explain the Senate's amendments.

Sen. J. Lee: I will defer that to Sen. Fischer since he tidied up the details in Appropriations after we established the policy in our committee.

Sen. Fischer: What we in the appropriations discovered was we could actually fund 200% of poverty with the same dollars or less than what came out of the House with the re-projections of the number of people that would be on the program, as well as the reduced premium. You will see on the green sheet **(See attachment #1)** on the bottom, from $243.93 which is a preliminary premium down to $228.71 which is the final premium that was negotiated between DHS and BCBS. (Called Maggie Anderson from the DHS to the podium.)

Maggie Anderson from the DHS: When the bill left the House at 160, the dollars that were in the department's budget were the $32.6 million, in the left hand column. In the middle column is that re-projected number and that is a combination of the reduced premium, the final premium that we received from BCBS during crossover. Tied to that is re-projection is the other sheet that was passed around. **(See attachment #2)** Because the number of SCHIP children was declining, we re-projected the starting point of where we would begin the

biennium. We did not remove any (inaudible) we still believe (inaudible) 1,158 children if we increase to 200%. We only re-projected the starting point, left the growth in for 200 and we left the continued growth (inaudible) 1-150 because we had budgeted that growth for 150 over a one year period and that one year period won't kick in until October 2009. They're projecting that we will need $24.1 million to go to 200% of poverty and (inaudible) the difference that in the $8.5 million. The total being $2.2 million in general funds. The Senate amendment reflected using that re-projected number and the Senate amended the bill to 200%.

Sen. Fischer: This is also in HB 1012 and they have also asked for these re-projections. You will see it is $281,733 in savings.

Sen. J. Lee: I'd like to bring to your attention in the amendment the legislative intent. Sen. Flakoll discussed how we could have a better outreach (inaudible) enrollment. We would like to encouraged collaborative efforts between the school systems and the department with enrolling. We wanted it in writing.

Chairman Porter: (Asks M. Anderson) The Healthy Steps enrollment and the Medicaid enrollment, they are kind of crossing back in June of 08. Can you explain to us the trends of what is going on between the two programs?

Maggie Anderson: The reason for the increase because of continued eligibility for 12 months. The downward in SCHIP is because ten families a year are going to Medicaid.

Chairman Porter: Are we still seeing the same trend of the 10 families going to Medicaid.

Maggie Anderson: Yes, through January. We don't have data yet for February and March.

Sen. Fischer: When you do the calculations on Medicaid, those are just people who enrolled in it and not necessarily using it?

Maggie Anderson: Our figures were based on what the average cost per person who is involved with that (inaudible) .

Chairman Porter: Unlike the Medicaid program the SCHIP is an actual dollar premium paid just like any other insurance product so if we had 3,399 in January we paid for 3,399 whether we use it or not.

Maggie Anderson: Absolutely.

Sen. J. Lee: That CHIP is really a fee for services where Medicaid is a reimbursement (inaudible).

Maggie Anderson: We pay the premiums to BCBS (inaudible) then Medicaid providers.

Chairman Porter: On the House version it left at 160% of poverty so the lower right column is representative of how the bill left in the House. Is that correct?

Maggie Anderson: If you look at the far left column that is your $32.6 million that matches way up in the upper left. The next column is the re-projected and there is a typo there. It really is the 160 number instead of 185. If the bill was to remain at the 160 level, it would $10.9 million estimated figure.

Chairman Porter: In that column then the next one up would be 165 and the next one up 170 and the other side is correct?

(Everyone talking at once, inaudible.)

Chairman Porter: We all have the copy of the poverty guidelines. **(See attachment #3)** The one we tend to use the most in our discussions is the annual guidelines of a family of 4 and you can see that is $44,100 net at 200% of poverty. SCHIP is a continuous eligibility on an annual basis.

Maggie Anderson: Both Medicaid and SCHIPS are annual, but we look at the income based on the family situation for a wage earner. If self-employed or a farmer you would look at more of his annual income. We look at both guidelines.

Sen. J. Lee: We had a discussion about the family of 4. It is quite likely there will be one parent with one or two children. What percentage of our users might be a family of four?

Maggie Anderson: When that question came up in appropriations (inaudible).

Sen. J. Lee: We need to look at that too.

Sen. Heckaman: Was going to say same as Sen. Lee.

Chairman Porter: One question that has come up in the discussions in the House since the bill has left, is the process of the family or children coming into the program, if they have coverage and lose because of change of employment or choose to drop the coverage, the waiting periods and length of time before they become eligible to participate in the program.

Maggie Anderson: The SCHIP program prohibits families from coming onto the SCHIP program is they voluntarily gave up their insurance coverage. If they lose employment or their coverage is removed involuntarily from the family then that cutoff period is waived.

Chairman Porter: What is the waiting period on the voluntary provision?

Maggie Anderson: Six months.

Chairman Porter: We are adjourned and will come back as we are waiting to see what happens to HB 1012.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1478

House Human Services Committee

☒ Check here for Conference Committee

Hearing Date: April 23, 2009

Recorder Job Number: 12166

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Porter called to order the conference committee meeting on HB 1478.

Chairman Porter: It is incumbent on me to relay the House's position, and have that discussion. I don't think there is any problem with Section 2 of this piece of legislation. I understand that this bill has no money it and does exist inside of the DHS budget. However, there is concern over the percentage of net income. The position I will relay is somewhere between the bill that was passed out of the House and what was passed out of the Senate has an area of compromise.

Sen. J. Lee: The Senate thought it was an excellent idea to follow the recommendation in the Governor's budget at 200% considering it was going to cost (inaudible). When the bill came to us from the House in at 160%. We being financially and fiscally responsible at looking at a project that was going to be about the same as (inaudible) that we would be able to enroll additional children. Because we have reduced projection of numbers and we do premium dollar requirements at this point to use those dollars which were originally approved by the House to cover additional children seemed like the right thing to do.

Sen. Heckaman: Looking at the cost savings between many of these others, if you go down to 175% from 200% and look at the number of children that would be served with the difference

of the funding of under $300,000 to serve 300 children. We looked at the number of children in each of the (drops sentence). There are a lot more children that can be served at 200% with not much more money.

Chairman Porter: We have all looked at the numbers and the different percentages and what they do ever since the program started at 140%, but the movement last session to 150% which Sen. Lee and myself were both sponsors of. It was money well spent. I don't think it comes back in the House's position as being a money issue. It comes back as a perception and (inaudible) issue. It would have been a lot easier debate and discussion if we had been working with gross income rather than net income. Because of the moving target of what net income really is it makes it a harder sell to be on level where the meat actually is.

Sen. J. Lee: (Read from an information sheet she had.) Montana is at a 175% and Idaho at 185% and no one else is under 200%. We are significantly lower than other states.

Chairman Porter: Is there any interest from the Senate in changing that top number?

Sen. Heckaman: On behalf of my caucus we are not interested in changing the number 200%. Our caucus would prefer additional children added to this through buy in. We are supporting the 200%.

Rep. Pietsch: I'm not 100% behind this I **Motion to Accede to the Senate Amendments.**

Sen. Heckaman: Second.

Roll Call Vote: 6 yes, 0 no, 0 absent.

MOTION CARRIED.

BILL CARRIER: Rep. Porter.

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1478 (, as (re)engrossed): Date: 4-22-09

Your Conference Committee Human Services

For the Senate:	YES / NO		For the House:	YES / NO		Attend.
✓ Sen. J. Lee			Rep. PORTER			✓
✓ Sen. Fischer			Rep. Pietsch			✓
✓ Sen. Heckaman			Rep. Potter			✓

Attend.

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____
CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ **YES** ___ **NO** ___ **ABSENT**

Revised 4/1/05

/

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1478 (, as (re)engrossed): Date: 4-23-09

Your Conference Committee Human Services

For the Senate:		YES	NO	For the House:	YES	NO	
✓	Sen. J. Lee	✓		Rep. Porter	✓		✓ attend
✓	Sen. Tyacker	✓		Rep. Pietsch	✓		✓
✓	Sen. Heckaman	✓		Rep. Potter	✓		✓

attend.

recommends that the (SENATE/~~HOUSE~~) (ACCEDE to) (RECEDE from)

the (~~Senate~~/House) amendments on (SJ/HJ) page(s) 1325 - _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: _____

CARRIER: _____

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: Rep. Pietsch

SECONDED BY: Sen. Heckaman

VOTE COUNT 6 YES 0 NO 0 ABSENT

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE

HB 1478, as reengrossed: Your conference committee (Sens. J. Lee, Fischer, Heckaman and Reps. Porter, Pietsch, Potter) recommends that the **HOUSE ACCEDE** to the Senate amendments on HJ page 1325 and place HB 1478 on the Seventh order.

Reengrossed HB 1478 was placed on the Seventh order of business on the calendar.

2009 TESTIMONY

HB 1478

#1

HOUSE HUMAN SERVICES COMMITTEE

HB1478

REPRESENTATIVE MERLE BOUCHER

CHAIRMAN WEISZ AND MEMBERS OF THE HOUSE HUMAN SERVICES COMMITTEE. FOR THE RECORD I AM REPRESENTATIVE MERLE BOUCHER, REPRESENTING DISTRICT NINE (9).

I AM APPEARING BEFORE THE HOUSE HUMAN SERVICES COMMITTEE TODAY SUPPORTING THE GOVERNOR'S RECOMMENDATION TO RAISE THE ELIGIBILITY LIMIT FOR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) TO 200% OF THE POVERTY LEVEL.

THE CURRENT ELIGIBILITY THRESHOLD WOULD INCREASE FROM 150% OF POVERTY TO 200%. THIS WOULD B E A GOOD INVESTMENT IN OUR CHILDREN, OUR FAMILIES AND OUR STATE'S FUTURE.

EXTENDING COVERAGE TO CHILDREN IS A GOOD FISCAL INVESTMENT FOR STATE GOVERNMENT. PROVIDING THIS EXPANDED COVERAGE SHOULD REALISTICALLY CREATE MORE PREVENTATIVE CARE. IT IS A COMMONLY UNDERSTOOD FACT, THAT PREVENTATIVE CARE CAN LOWER FUTURE HEALTH CARE COSTS SIGNIFICANTLY.

THE RECOMMENDATION IS THE RIGHT THING TO DO FOR PEOPLE AND RESPONSIBLE FISCAL POLICY.

I URGE THIS COMMITTEE TO SUPPORT HB1478 WITH A DO PASS RECOMMENDATION.

THANK YOU.

MB

#2

Testimony
House Bill 1478 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 26, 2009

Chairman Weisz, members of the Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here in support of House Bill 1478.

House Bill 1478 would increase the income eligibility level for the State Children's Health Insurance Program (SCHIP) to 200 percent (net) of the poverty level. During the current biennium (effective October 1, 2008), the income level for SCHIP was increased to 150 percent (net). For the 2009-2011 Executive Budget, SCHIP was built on an average monthly caseload of 6,021 children, which includes the growth expected as a result of increasing the income level to 200 percent (net). The estimated growth in SCHIP as a result of increasing the income level to 200 percent (net) is 1,158 children.

Attachment A shows the number of children enrolled each month in Healthy Steps since the beginning of the current biennium, and also provides the number of children enrolled in Medicaid for the same time period. Clearly, we are experiencing an enrollment trend change, which appears to be directly related to the implementation of 12-month continuous eligibility for Medicaid children. You can see from the chart that the SCHIP enrollment declined a bit between June and July. This decline has increased at a higher rate in the past two months. The chart also shows that enrollment of children in Medicaid, starting in June 2008, has significantly increased. The Department continues to explore the

details of this trend change to ensure we can appropriately project expenditures for the current biennium and for 2009-2011.

The fiscal note for House Bill 1478 contains $4,277,313 of which $1,106,968 are general funds to increase the income eligibility level to 200 percent (net). As noted earlier, it is expected this increase will expand coverage to enroll an average of 6,021 children per month, at an average premium of $243.93 per child.

The fiscal note also contains $133,864 of which $34,644 are general funds, for salary and other expenses of the additional 1.5 FTE funded in the Executive Budget related to increasing SCHIP to 200 percent (net) of the federal poverty level. Currently 33 percent of SCHIP applications are processed by the SCHIP eligibility staff in the Medical Services Division. If the income level for SCHIP is increased to 200 percent (net), we would expect a greater percentage of the applications to be processed in Medical Services. This is because, as the income threshold is increased, a lower number of applicants will also qualify for other economic assistance programs. The Medical Services Division will monitor the need to fill these positions, as we track SCHIP enrollment and program operations.

The Healthy Steps increase to 200 percent (net) is also contingent upon Congressional action regarding the reauthorization of, and increased appropriations for, the State Children's Health Insurance Program. In addition, any increase to the income level will require federal (Centers for Medicare and Medicaid) approval.

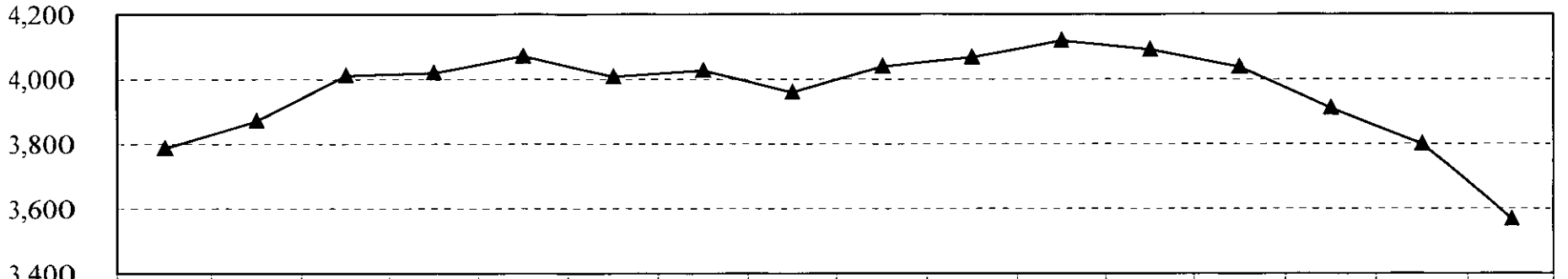
I would be happy to respond to any questions you may have.

North Dakota Department of Human Services

Attachment A

Healthy Steps Enrollment by Month

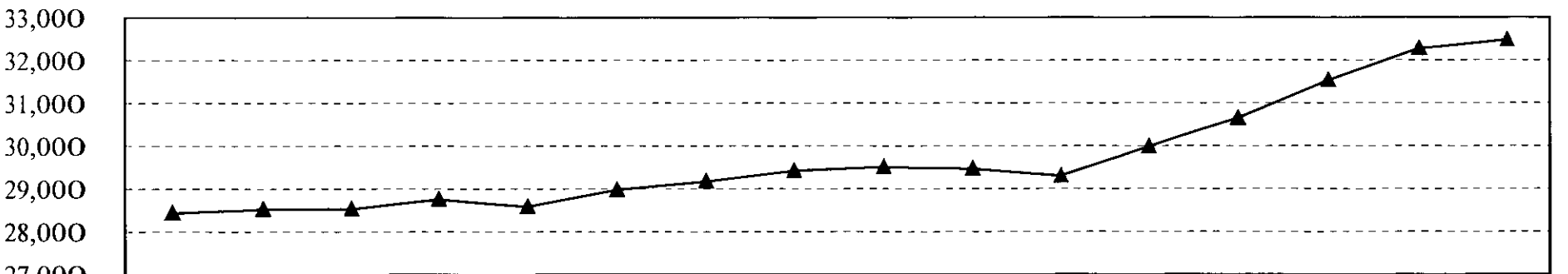
August 2007 - November 2008



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08
3,787	3,871	4,011	4,019	4,071	4,008	4,027	3,959	4,039	4,067	4,119	4,091	4,038	3,911	3,800	3,568

Children Enrolled in Medicaid by Month

August 2007 - November 2008



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08
28,435	28,522	28,531	28,758	28,590	28,977	29,173	29,420	29,508	29,462	29,306	29,984	30,652	31,532	32,274	32,479

January 26, 2009

House Human Services Committee

HB 1478

Chairman Weisz and Members of the Committee:

Good morning, my name is Caitlin McDonald, and I am here on behalf of the North Dakota Catholic Conference. We support HB 1478 and urge a do pass.

This bill aims to increase the eligibility level for the State's Children Health Insurance Program, or Healthy Steps, from the current rate of 150% of the poverty level to 200% of the poverty level. The proposed increase would allow the program to include 1,158 children that do not qualify for Medicaid and do not have other means of health insurance.

The North Dakota Catholic Conference believes that increasing the eligibility level of SCHIP is an action that furthers the common good and helps protect the inherent dignity of all persons. Affordable healthcare is a basic right that must not be denied to the young and vulnerable, and we feel improving coverage for children is a moral priority and an investment in the future.

Expanding the current SCHIP program is a good step forward for North Dakota. Please consider a Do Pass on HB 1478. I thank you for your time and consideration.

#4

Testimony on House Bill 1478
House Human Services Committee
January 26, 2009

Presented by Marlowe Kro
Associate State Director, Community Outreach, AARP North Dakota

Chairman Weisz, members of the House Human Services Committee, I am Marlowe Kro, the associate state director for community outreach for AARP North Dakota. I am here today on behalf of AARP's 88,000 North Dakota members to speak in support of House Bill 1478.

The State Children's Health Insurance Program, known as Healthy Steps in North Dakota, covers children in working families who cannot afford health insurance but do not have incomes low enough to qualify for Medicaid. AARP believes expanding and strengthening the program is important as families struggle with the escalating cost of health care. Thousands of children in North Dakota who otherwise would be uninsured are receiving needed health care because of SCHIP. Along with Medicaid, SCHIP has been an essential buffer as fewer employers offer coverage that families can afford.

The Kaiser Family Foundation estimates that more than 14,000 North Dakota children (9 percent) are still without health coverage. We should not allow so many children to go without access to basic, necessary health care. Failure to

address children's health needs creates a legacy of increasing health care costs for society and future generations of less healthy older Americans.

AARP supports continuing efforts to increase eligibility for SCHIP. This proposal to provide coverage to children in families with income levels at or below 200 percent of the poverty level is an important step toward the goal of ensuring health care for every child. It is expected that enrollment in the program would increase by about 1,400 children to just over 6,000.

In 2007, the North Dakota legislature voted to expand SCHIP income eligibility from 140% to 150% of the poverty level. This change took effect in October 2008. Even with the expansion to 150%, our state still has the most restrictive SCHIP eligibility level in the nation. And only three other states are below the 200% level according to the Kaiser Family Foundation.

Members of the committee, AARP asks for your support of this bill. Thank you for your time and attention.

#5

LeAnn Nelson
North Dakota Education Association
Testimony on HB 1478

Good Afternoon Chairman Weisz and Members of the Human Services Committee. Thank you for the opportunity to speak to you today regarding HB 1478. For the record, my name is LeAnn Nelson, Director of Professional Development for the North Dakota Education Association. I am here to voice NDEA's support for HB 1478.

According to Maslow's Hierarchy of Needs, for children to learn to their fullest capacity basic needs need to be met: safety, food & water, health, etc. and on up the hierarchy. If any of these needs are not being met, the body will focus on meeting these needs. If the body is focused on meeting any of these needs a student cannot learn to his/her fullest capacity. It is for this reason that we support HB 1478. The healthier the child the more they are ready to learn.

Chairman Weisz and Members of the Human Services Committee, thank you for the opportunity to speak to you this afternoon on HB 1478. We hope you give HB 1478 a 'Do Pass."

#6

Testimony
North Dakota Disabilities Advocacy Consortium
HB 1478
House Human Services Committee
Chairman Representative Robin Weisz

Chairman Weisz and members of the House Human Services Committee, my name is James M. Moench, Executive Director of the North Dakota Disabilities Advocacy Consortium (NDDAC). The Consortium is made up of 23 member organizations concerned with addressing the issues that affect people with disabilities.

NDDAC supports the proposal to change the net income eligibility limit to qualify a child for the State Children's Health Insurance Program (SCHIP) from 150% of poverty to 200 % of poverty as found in House Bill 1478.

NDDAC believes North Dakota can have no higher goal than insuring health care coverage to all the children in the state. This change will move us closer to that goal.

We urge your support of HB 1478.

Thank you.

#7

Testimony
House Bill 1478
House Human Services Committee
Representative Robin Weisz, Chairman
January 26, 2009

Chairman Weisz and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

NDFFCMH supports HB 1478. Expanding the net income eligibility allows more children to access mental health care. For many children, mental health care is a key component of the array of services needed for healthy childhood development.

Mental disorders affect about one in five American children and one in ten experience serious emotional disturbances that severely impair their functioning, according to the Surgeon General's comprehensive report on mental health. **Moreover, low-income children enrolled in Medicaid and SCHIP have the highest rates of mental health problems.**

Sadly, over two-thirds of children struggling with mental health disorders do not receive mental health care. The President's New Freedom Commission on Mental Health found that without early and effective identification and interventions, childhood mental disorders can lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are at a much higher risk for suicide.

Please support children's access to mental health care. Thank you for your time.

Carlotta McCleary, Executive Director
ND Federation of Families for Children's Mental Health
PO Box 3061
Bismarck, ND 58502

Phone/fax: (701) 222-3310
Email: carlottamccleary@bis.midco.net

#8

TESTIMONY – PROTECTION AND ADVOCACY PROJECT

HOUSE BILL 1478 (2009)

HOUSE HUMAN SERVICES COMMITTEE

Honorable Robin Weisz, Chairman

January 26, 2009

Chairman Weisz, and members of the House Human Services Committee, I am Bruce Murry, a lawyer with the North Dakota Protection and Advocacy Project (P&A). Please favorably consider House Bill 1478 to increase the income limit to North Dakota's State Children's Health Insurance Program.

This program offers access to quality health care coverage for children. The program discourages inappropriately dropping existing coverage. The program leaves adults responsible to obtain health insurance to meet their own needs. Adults are better able prioritize their own needs, or to bear the burden of mistaken priorities.

P&A believes health care for children is important enough to justify helping parents meet this responsibility. Especially, P&A wants to see children get the services they need to minimize or avoid the impact of disabilities in the future.

Consider the incomes provided as 200% of poverty level. Then factor in the cash share of health insurance for a typical working North Dakotan. Consider the additional payments for full family health insurance. Many parents earning 200% of poverty level could not afford a safe, modest standard of living with family health insurance. Even in situations where we might question the priorities of a parent, P&A suggests it is better for all that our youth join the workforce and community in good relative health.

#9

TESTIMONY
Mental Health America of North Dakota

House Bill 1478
House Human Services Committee

Representative Weisz, Chairman
January 26, 2009

Chairman Weisz and members of the House Human Services Committee, my name is Susan Rae Helgeland. I am the Executive Director of Mental Health America of North Dakota (MHAND). I am writing this testimony in support of House Bill 1478.

MHAND is a nonprofit organization whose mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

I met with my Board of Directors last Thursday, January 22; 2009 and they voted to support increase from 150% of poverty to 200% for the ND Children's Health Insurance Program. The MHAND mission speaks to providing access to quality care for North Dakota's Children and we urge you to support HB 1478.

#10

HB 1478

House Human Services Committee

January 26, 2009

Chairman Weisz and members of the House Human Services Committee, I am Paul Ronningen, Executive Director of the National Association of Social Workers (NASW) North Dakota Chapter and also the State Coordinator for the Children's Defense Fund (CDF). Thank you for the opportunity to provide testimony **in support of HB 1478** for both NASW and the Children's Defense Fund.

First of all, NASW and CDF want to commend the Governor and the Department of Human Services for this step forward in addressing the health insurance needs of North Dakota's children. Moving to 200% of the poverty level for the state children's health insurance program is **good public policy**!

The Department estimates that **an additional 1,158 children** will be provided health insurance coverage through this bill. While more children are benefiting from SCHIP this biennium, about 9% of all children (14,305 children ages 0-18) remain uninsured in North Dakota.*

In order to increase access to this program and others, Children's Defense Fund will be launching a web-based screening tool, Bridges to Benefits this spring. It that will quickly help low income working families determine if they may be eligible for assistance and will direct them to resources where they may access help. **Bridges to Benefits** will look at eligibility guidelines for programs such as Child Care Assistance, Medicaid, Healthy Steps, School Meal Programs, Energy Assistance and Earned Income Tax Credit. In addition, training will be provided to other non-profit agencies in North Dakota to help screen eligible families and refer them on to county social services or to the provider of the service. It is critically important for struggling families to be aware of and have access to these programs.

Therefore, the Children's Defense Fund and NASW fully support implementation of HB 1478. Thank you.

*North Dakota Kids Count

#11

January 27, 2009

Representative Robin Weisz, Chairman
House Human Services Committee
State Capitol
Bismarck ND 58505

RE: HB 1478 – SCHIP eligibility

Dear Chairman Weisz and members of the House Human Services Committee:

I am responding to questions the committee asked regarding information in my testimony on HB 1478 given January 26, 2009.

Question #1:
"Is the income eligibility level for SCHIP in other states based on net income or gross income?"

Response:
- "*The income eligibility levels noted may refer to gross or net income depending on the state.*" Each states sets policy to use gross or net income to determining SCHIP eligibility.
  - Source: Attachment – "*Kaiser Family State Health Facts*," page 2, second sentence under 'Notes.'

Question #2:
Please provide documentation supporting that: "*fewer employers offer coverage that families can afford.*"

Response:
- Sources – Attached:
  - The National Coalition on Health Care, "Health Insurance Coverage."
  - Robert Wood Johnson Foundation, "Fewer Employers Offer Lower Income Parents Health Coverage."
  - Economic Policy Institute, "Health insurance eroding for working families: Employer-provided coverage declines for fifth consecutive year."

If you or any committee members have additional questions on this matter, please contact me and I will be happy to provide additional information.

Sincerely,

Marlowe D. Kro

Marlowe D. Kro, Associate State Director – Community Outreach
AARP North Dakota
mkro@aarp.org
701-355-3643

Enclosures

statehealthfacts.org
Your source for state health data

< Back to previous page

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical) View by: % | $

Rank Order: ▲▼

	Income Eligibility --Separate SCHIP Prog
	Income Eligibility --Separate SCHIP Prog
United States	NA [1]
Alabama	200%
Alaska	NA
Arizona	200%
Arkansas	NA
California	250%
Colorado	205%
Connecticut	300%
Delaware	200%
District of Columbia	NA
Florida	200% [2]
Georgia	235%
Hawaii	NA
Idaho	185%
Illinois	200% [3]
Indiana	250%
Iowa	200%
Kansas	200%
Kentucky	200%
Louisiana	250% [4]
Maine	200%
Maryland	NA
Massachusetts	300% [3]
Michigan	200%
Minnesota	NA
Mississippi	200%
Missouri	300%
Montana	175%
Nebraska	NA
Nevada	200%
New Hampshire	300%
New Jersey	350%
New Mexico	NA
New York	250% [3]

North Carolina	200%
North Dakota	150%
Ohio	NA
Oklahoma	NA
Oregon	185%
Pennsylvania	300%
Rhode Island	NA
South Carolina	200% [5]
South Dakota	200%
Tennessee	250% [6]
Texas	200%
Utah	200%
Vermont	300% [7]
Virginia	200%
Washington	250%
West Virginia	220%
Wisconsin	NA [8]
Wyoming	200%

Notes: Data as of January 2009.
The income eligibility levels noted may refer to gross or net income depending on the state. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.
Eligibility levels shown as percent of the FPL. Currency figures based on FPL for a family of three in 2008: $17,600 for 48 contiguous states and District of Columbia, $22,000 for Alaska, $20,240 for Hawaii.

Sources: Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enr[illegible] and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009. Data based on a national survey condu[illegible] by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2009. Available at http://www.kff.org/medicaid/7855.cfm.

Definitions: **SCHIP:** State Children"s Health Insurance Program.
The Federal Poverty Level (FPL) was established to help government agencies determine eligibility levels for public assistance programs such as Medicaid. FPL is represented in this resource as poverty guidelines as opposed to the slightly different poverty thresholds.
NA: Not applicable because state does not have separate SCHIP program.

Footnotes:

1. Not applicable because there are no national eligibility levels.

2. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children ages five through nineteen, as well as younger siblings in some locations. Medi-Kids covers children ages one through four.

3. Illinois, Massachusetts, and New York provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is unlimited in Illinois and is 400% in Massachusetts and New York.

4. Louisiana created a separate SCHIP program in 2008.

5. South Carolina implemented a separate SCHIP program for children with income between 150 and 200 percent of the federal poverty line in April 2008.

6. In 2007 the state created a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line. Children not [illegible]gible for regular Medicaid and children closed out of TennCare Standard who meet the SCHIP income guidelines can enroll in the separate [illegible]P [illegible]rogram.

7. In Vermont, Medicaid covers uninsured children in families with income at or below 225 percent of the federal poverty line; uninsured children in families with income between 226 and 300 percent of the federal poverty line are covered under a separate SCHIP program. Underinsured children are covered under Medicaid up to 300 percent of the federal poverty line. This expansion of coverage for underinsured children was achieved through an amendment to the states Medicaid Section 1115 waiver.

8. Wisconsin implemented BadgerCare Plus in February 2008. Badgercare Plus has no income limit for children. The state will receive Medicaid reimbursement for children up to 250 percent of the federal poverty line and children with incomes between 251 percent and 300 percent of the federal poverty line are covered with state funds.

National Coalition on Health Care

Health Insurance Coverage

This document is also available as a printable .pdf file.
Health Insurance Coverage

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Facts on Health Insurance Coverage

Introduction

Most Americans have health insurance through their employers. But, employment is no longer a guarantee of health insurance coverage.

As America continues to move from a manufacturing-based economy to a service economy, and employee working patterns continue to evolve, health insurance coverage has become less stable. The service sector offers less access to health insurance than its manufacturing counterparts. Further, an increasing reliance on part-time and contract workers who are not eligible for coverage means fewer workers have access to employer-sponsored health insurance.

Due to rising health insurance premiums, many small employers cannot afford to offer health benefits. Companies that do offer health insurance, often require employees to contribute a larger share toward their coverage. As a result, an increasing number of Americans have opted not to take advantage of job-based health insurance because they cannot afford it.

Who are Who are the uninsured?

- Nearly 46 million Americans, or 18 percent of the population under the age of 65, were without health insurance in 2007, the latest government data available.[1]
- The number of uninsured rose 2.2 million between 2005 and 2006 and has increased by almost 8 million people since 2000.[1]
- The large majority of the uninsured (80 percent) are native or naturalized citizens.[2]
- The increase in the number of uninsured in 2006 was focused among working age adults. The percentage of working adults (18 to 64) who had no health coverage climbed from 19.7 percent in 2005 to 20.2 percent in 2006.[1] Nearly 1.3 million full-time workers lost their health insurance in 2006.
- Nearly 90 million people – about one-third of the population below the age of 65 spent a portion of either 2006 or 2007 without health coverage.[3]
- Over 8 in 10 uninsured people come from working families – almost 70 percent from families with one or more full-time workers and 11 percent from families with part-time workers.[2]
- The percentage of people (workers and dependents) with employment-based health insurance has dropped from 70 percent in 1987 to 62 percent in 2007. This is the lowest level of employment-based insurance coverage in more than a decade.[4, 5]
- In 2005, nearly 15 percent of employees had no employer-sponsored health coverage available to them, either through their own job or through a family member.[6]
- In 2007, 37 million workers were uninsured because not all businesses offer health benefits, not all workers qualify for coverage and many employees cannot afford their share of the health insurance premium even when coverage is at their fingertips.[1]
- The number of uninsured children in 2007 was 8.1 million – or 10.7 percent of all children in the U.S.[1]
- Young adults (18-to-24 years old) remained the least likely of any age group to have health insurance in 2007 – 28.1 percent of this group did not have health insurance.[1]

- The percentage and the number of uninsured Hispanics increased to 32.1 percent and 15 million in 2007.[1]
- Nearly 40 percent of the uninsured population reside in households that earn $50,000 or more.[1] A growing number of middle-income families cannot afford health insurance payments even when coverage is offered by their employers.

Why is the number of uninsured people increasing?

- Millions of workers don't have the opportunity to get health coverage. A third of firms in the U.S. did not offer coverage in 2007.[4]
- Nearly two-fifths (38 percent) of all workers are employed in smaller businesses, where less than two-thirds of firms now offer health benefits to their employees.[7] It is estimated that 266,000 companies dropped their health coverage between 2000-2005 and 90 percent of those firms have less than 25 employees.
- Rapidly rising health insurance premiums are the main reason cited by all small firms for not offering coverage. Health insurance premiums are rising at extraordinary rates. The average annual increase in inflation has been 2.5 percent while health insurance premiums for small firms have escalated an average of 12 percent annually.[4]
- Even if employees are offered coverage on the job, they can't always afford their portion of the premium. Employee spending for health insurance coverage (employee's share of family coverage) has increased 120 percent between 2000 and 2006.[8]
- Losing a job, or quitting voluntarily, can mean losing affordable coverage – not only for the worker but also for their entire family. Only seven (7) percent of the unemployed can afford to pay for COBRA health insurance – the continuation of group coverage offered by their former employers. Premiums for this coverage average almost $700 a month for family coverage and $250 for individual coverage, a very high price given the average $1,100 monthly unemployment check.[9]
- Coverage is unstable during life's transitions. A person's link to employer-sponsored coverage can also be cut by a change from full-time to part-time work, or self-employment, retirement or divorce.[10]

How does being uninsured harm individuals and families?

- Lack of insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than insured individuals.[11]
- Regardless of age, race, ethnicity, income or health status, uninsured children were much less likely to have received a well-child checkup within the past year. One study shows that nearly 50 percent of uninsured children did not receive a checkup in 2003, almost twice the rate (26 percent) for insured children.[12]
- The uninsured are increasingly paying "up front" -- before services will be rendered. When they are unable to pay the full medical bill in cash at the time of service, they can be turned away except in life-threatening circumstances.[7]
- About 20 percent of the uninsured (vs. three percent of those with coverage) say their usual source of care is the emergency room.[2]
- Studies estimate that the number of excess deaths among uninsured adults age 25-64 is in the range of 18,000 a year. This mortality figure is more than the number of deaths from diabetes (17,500) within the same age group.[10]
- According to one study, over a third of the uninsured have problems paying medical bills. The unpaid bills were substantial enough that many had been turned over to collection agencies – and nearly a quarter of the uninsured adults said they had changed their way of life significantly to pay medical bills.[13]

What additional costs are created by the uninsured population?

- The United States spends nearly $100 billion per year to provide uninsured residents with health services, often for preventable diseases or diseases that physicians could treat more efficiently with earlier diagnosis.[14]
- Hospitals provide about $34 billion worth of uncompensated care a year.[14]
- Another $37 billion is paid by private and public payers for health services for the

uninsured and $26 billion is paid out-of-pocket by those who lack coverage.[14]

- The uninsured are 30 to 50 percent more likely to be hospitalized for an avoidable condition, with the average cost of an avoidable hospital stayed estimated to be about $3,300.[14]
- The increasing reliance of the uninsured on the emergency department has serious economic implications, since the cost of treating patients is higher in the emergency department than in other outpatient clinics and medical practices.[11]
- A study found that 29 percent of people who had health insurance were "underinsured" with coverage so meager they often postponed medical care because of costs.[15] Nearly 50 percent overall, and 43 percent of people with health coverage, said they were "somewhat" to "completely" unprepared to cope with a costly medical emergency over the coming year.[15]

Getting Everyone Covered Will Save Lives and Money

The impacts of going uninsured are clear and severe. Many uninsured individuals postpone needed medical care which results in increased mortality and billions of dollars lost in productivity and increased expenses to the health care system. There also exists a significant sense of vulnerability to the potential loss of health insurance which is shared by tens of millions of other Americans who have managed to retain coverage.

Every American should have health care coverage, participation should be mandatory, and everyone should have basic benefits.

Notes

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14. Institute of Medicine. Hidden Costs, Values Lost: Uninsurance in America. The National Academies Press. 17 June 2003 **http://www.iom.edu/Report.asp?id=12313**.
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Robert Wood Johnson Foundation

Fewer Employers Offer Lower Income Parents Health Coverage

Nearly 70 percent of low-income kids are uninsured; Mississippi, Arizona, Oregon top list.

As President Bush, governors and members of Congress debate how much federal funding to devote to the State Children's Health Insurance Program (SCHIP), a new analysis provides a clearer look at uninsured children in every state. The analysis, released today by the Robert Wood Johnson Foundation, shows that since 1997, employer offers of health insurance to parents with lower incomes have fallen three times as fast as offers to parents who earn more money.

The figures underscore that working parents who earn modest incomes are experiencing dramatic erosion in employee benefits. Nationally, fewer than half (47 percent) of parents in families earning less than $40,000 a year* are offered health insurance through their employer—a 9 percent drop since 1997. Meanwhile, offers of health insurance to parents in families earning $80,000** or more have held steady at about 78 percent.

"In reauthorizing SCHIP, Congress must provide the funds needed to maintain coverage for all currently enrolled kids and the millions more who are eligible, but remain unenrolled. We must ensure that children whose parents work hard, but cannot afford health insurance for their kids can get the health care they need to thrive," said Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of the Robert Wood Johnson Foundation. "For the last decade, SCHIP has provided a much-needed safety net for our nation's kids, especially as there has been a decline in the number of children in low-income families covered by employer-sponsored health insurance. Parents realize that providing health insurance for their children is becoming more costly and those who earn modest wages are doubly squeezed. They are less likely to be offered insurance on the job, and less able to afford to purchase it on their own."

Many uninsured children would likely be eligible for free or low-cost insurance coverage through SCHIP, which Congress is set to reauthorize this year. Signed into law in 1997, SCHIP provides each state with federal funds to design a health insurance program for vulnerable children. The states each determine eligibility rules, benefit packages and payment levels.

Other information contained in the analysis includes:

- Most uninsured children—including children in low-income homes—have parents who work. Across the nation, 75 percent of uninsured children live with someone who works full-time.
- Nearly 9 million children in the United States are uninsured - that's an average of 11.5 percent, or about one in every eight kids.
- States with the highest percentage of uninsured children include Texas (20.3 percent), Florida (16.9 percent), New Mexico (16.6 percent), Nevada (16.4 percent) and Montana (16.2 percent).
- States with the lowest percentage of uninsured children are Vermont (5.6 percent), New Hampshire (6.0 percent), Michigan (6.1 percent), Hawaii (6.2 percent), Minnesota (6.5 percent) and Nebraska (6.5 percent).

- For uninsured children in families that earn modest incomes, the situation is even more dire. The analysis shows nearly two out of three uninsured kids in the United States (64 percent) live with adults who earn modest incomes, calculated at roughly $40,000 or less for a family of four.
  States with the highest percentage of uninsured children who are in families with modest incomes are: the District of Columbia (73.9 percent), Mississippi (73.7 percent), Kentucky (73.4 percent), Arizona (72.3 percent) and North Dakota (71.5 percent).
- States with the lowest percentage of uninsured children who are in families with modest incomes are: Vermont (36.2 percent), New Hampshire (41.3 percent), Hawaii (42.5 percent), Wyoming (46.2 percent) and Massachusetts (48.0 percent).
- Last fiscal year, more than 6 million children in the United States were enrolled in SCHIP.

"Because of SCHIP, millions of children can see doctors when they are sick and get the check-ups and prescription medicines they need. That's an important investment in our nation's future," said Lavizzo-Mourey. "Many parents who work but cannot afford health insurance, or are not offered coverage through their jobs, can make sure their children get the health care they need because of these programs. Healthy children are better prepared to learn in school and succeed in life."

Today's report was prepared by analysts at the State Health Access Data Assistance Center (SHADAC), located at the University of Minnesota. The report analyzes data from the U.S. Census Bureau (1998-2006 Current Population Surveys), U.S. Centers for Medicare & Medicaid Services (2002-2005) and the U.S. Centers for Disease Control and Prevention's National Health Interview Survey (1997 and 2005).

The report and other information on the uninsured are available at *www.CoverTheUninsured.org*.

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00 percent of the federal poverty level is equal to approximately $40,000 for a family of four in 2005, the year with the most ent data.
** 400 percent of the federal poverty level is equal to approximately $80,000 for a family of four in 2005, the year with the most recent data.

The U.S. Census Bureau has revised the number of uninsured in 2005 from 46.6 million to 44.8 million. The change is the result of a correction to a data processing error in the health insurance data that has been in place since the U.S. Census Bureau converted the Current Population Survey to a computerized instrument in 1995.

As a result, the Robert Wood Johnson Foundation (RWJF) has adjusted the number of uninsured accordingly and will make other corrections as additional data become available from the U.S. Census Bureau. RWJF will not change data in previously published research reports, papers, and publications.

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The Robert Wood Johnson Foundation, based in Princeton, N.J., is the nation's largest philanthropy devoted exclusively to health and health care.

Health insurance eroding for working families: Employer-provided coverage declines for fifth consecutive year

by Elise Gould

September 28, 2006 | EPI Briefing Paper #175

Health insurance eroding for working families
Employer-provided coverage declines for fifth consecutive year

by Elise Gould

More Americans are uninsured because of the continued erosion in employer-provided health insurance, the most prominent form of U.S. health insurance. The number of people without health insurance grew significantly for the fifth year in a row. Nearly 46.6 million Americans were uninsured in 2005—up almost 7 million since 2000. The rate of those without insurance has grown 1.7 percentage points during this period, from 14.2% in 2000 to 15.9% in 2005.

The percent of people with employer-provided health insurance also fell for the fifth year in a row, 4.1 percentage points in total. Over 3 million fewer people of all ages had employer-provided insurance in 2005 than in 2000 as a result of rising health costs coupled with weak labor demand. However, this decline does not take into account population growth. As many as 9 million more people would have had employer-provided health insurance in 2005 if the coverage rate had remained at the 2000 level.

Because of these large declines in employer-provided health insurance, workers and their families have been falling into the ranks of the insured at alarming rates. There were almost 4 million more uninsured workers in 2005 than in 2000. While uninsured workers are disproportionately young, non-white, less educated, and low-wage, workers across the socio-economic spectrum have experienced losses in coverage. Men lost coverage at nearly twice the rate of women, as did non-Hispanic whites over blacks. Even the most highly educated and highest wage workers had lower rates of insurance coverage in 2005 than in 2000.

As with workers, the downward trend in employer-provided coverage for children continued into 2005. In the previous four years, children were less likely to become uninsured as public-sector health coverage expanded. This year that trend reversed and the number of uninsured children rose 361,000 to 8.3 million in 2005. This is the first time in seven years that the rate of uninsured children has increased.

The safety net health programs—Medicaid and the State Children's Health Insurance Program (SCHIP)—have kept millions of families insured when their employment-based benefits were lost. Unfortunately, medical inflation and state budget constraints have weakened this safety net.

While Medicaid and SCHIP still work for many, it is clear that the government has not picked up coverage for everybody who lost insurance. The weakening of this system—notably for children—is particularly difficult for workers and their families in a time when they are facing the challenges of stagnant incomes. Furthermore, these programs are simply not designed to assist low income adults or middle or high income families from becoming uninsured. Even for middle or high income families, serious unexpected illness can lead to grave financial difficulty or bankruptcy.

The employer market has been the primary method of obtaining health insurance in this country. Its strength lies in the effective sharing of risk among individuals. Unfortunately, labor market pressures and rising medical care inflation are weakening this system. In a weak labor market, workers may lose their jobs or be forced to take jobs without benefits and lose their already tenuous connection to the employer-provided health insurance system. During periods of weak labor demand, workers do not have the bargaining power to bid up their wages or benefits. During a period of simultaneous weak bargaining power and rising health costs, employers demand that workers pay for higher premiums or pay more out-of-pocket for their care. This shift is occurring in a period when capital's share of corporate income was the highest in nearly 40 years. Furthermore, by pushing workers out of the employer system and into the public one, employers are shifting the cost of insuring their workers onto taxpayers.

The government at both the federal and state level have responded to medical inflation with policy changes that reduce public insurance eligibility or with proposals to reduce government costs. Budget crises at the state level are putting Medicaid and SCHIP funding at risk. Simultaneously, policy proposals at the federal level either to lessen the tax advantage of workplace insurance or to encourage a private purchase system could further destabilize an already weakening employer-provided health insurance system.

Given the erosion of employer-provided health insurance and rising costs of medical care, now is a critical time to consider health insurance reform. There are several promising solutions that would increase access to affordable health care. The key to all of the policies is creating large, varied, and stable risk pools.

This report's central findings regarding health insurance coverage include:

- The number of uninsured Americans rose by nearly 7 million, from 39.8 million in 2000 to 46.6 million in 2005. This increase was due primarily to the precipitous decline in employer-provided health coverage for workers and their families.
- Nearly 4.5 million fewer Americans under 65 had employer-provided coverage in 2005 than in 2000. As many as 8.2 million more people under 65 would have had employer-provided health insurance in 2005 if the coverage rate had remained at the 2000 level.
- The downward trend in the rate of employer-provided health insurance continued from 2004 to 2005, during a period in which the economy created over 2 million jobs.
- Individuals among the bottom 20% of household income were the least likely to have employer coverage; 21.9% of the bottom income quintile were covered compared to 86.4% for workers in the highest income quintile.
- Householders experienced a significant decline in health insurance coverage from 2000 to 2005. In 2000 74.2% of workers had employer-provided coverage, whereas 70.5% of workers had coverage in 2005.
- No category of workers was insulated from loss of coverage. Even full-time workers, workers with a college degree, and workers in the highest wage quintile experienced declines in coverage between 2000 and 2005.
- Children experienced declines in employer-provided health insurance coverage in each of the last five years. In 2000, 65.6% of children had employer-provided coverage, whereas in 2005 only 60.5% did, a fall of over 5 percentage points. Fewer children had Medicaid or SCHIP in 2005 than in 2004. For the first time since 1998, the rate of uninsured children has increased.
- There is a market increase in health insurance inequality as the drop in employer-provided coverage for children in the lowest household income quintile was 6.6 percentage points while the drop for those in the highest quintile was only 0.1 percentage points between 2000 and 2005.
- The decline in employer coverage was pervasive and felt throughout the country. When comparing the 1999-2000 and 2004-05 periods, 34 states experienced significant losses in coverage with Indiana, Utah, Maryland, and Missouri experiencing losses in excess of 8 percentage points. No state experienced a significant increase in their employer-provided coverage rate.

Declines in overall employer-provided coverage

About 4.4 million fewer people under the age of 65—including workers, their spouses, and their children—had employer-provided health insurance in 2005 than in 2000. The percent with employer-provided health insurance fell from 67.7% in 2000 to 62.8% in 2005, a decline of 5.0 percentage points.

As shown in **Table 1**, these declines in coverage occurred across all lines: by age, sex, race, education, and household income level. Some

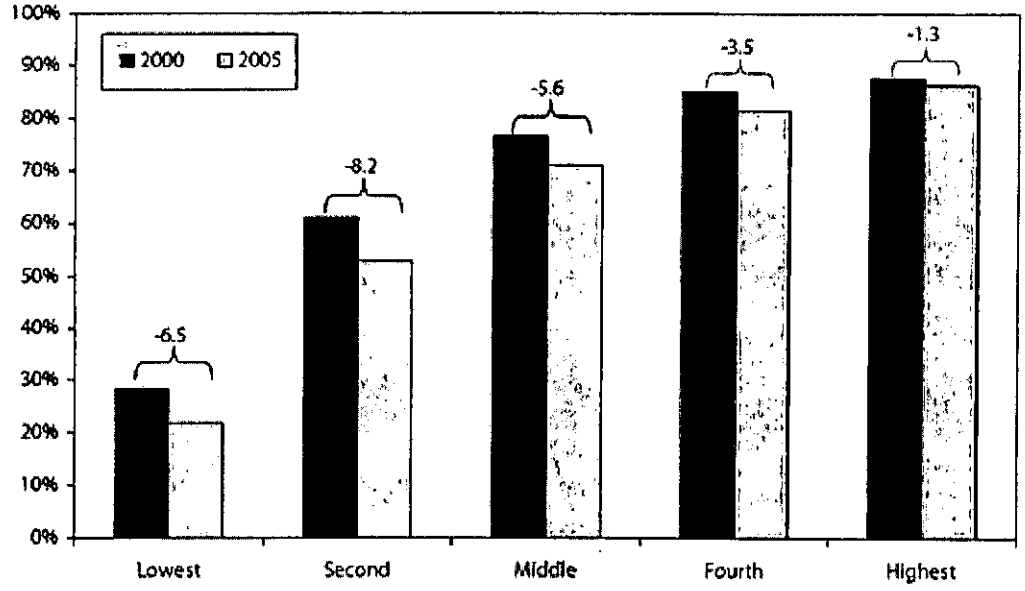
people, however, were more hurt than others by the declines. Those with only a high school education and those in the second-to-lowest household income quintile were the hardest hit in the last five years. High school graduates were not only less likely than college graduates to have employer-provided insurance (57.7% vs. 79.4%), but they experienced declines in coverage twice as large (7.3 vs. 3.6 percentage-point drops).1

Health insurance coverage rates were also dramatically different by age, race, and ethnicity. Children under 18, adults 18-24 years old, and adults 25-54 years old experienced significant declines in employer-provided health coverage of 5.1, 5.6, and 5.8 percentage points, respectively. The lack of losses in employer-provided coverage for older Americans may be attributed to their increased employment-to-population ratios during this period. In 2005, 70.4% of whites had employer-provided coverage as compared to 50.8% of blacks and 41.6% of Hispanics. Nearly a million fewer black Americans had employer coverage in 2005 than in 2000. Blacks and Hispanics also experienced larger declines in coverage over the past year.

The lowest rates of employer-provided coverage occurred within households with the lowest incomes. Only about one in five individuals in household in the bottom 20% of the income scale had employer-provided health insurance, whereas more than four in five individuals in households at the highest 20% of earners had such coverage (**Figure A**). Individuals in households in the second quintile saw the largest declines in coverage. Their coverage rates fell 8.2 percentage points, from 61.2% in 2000 to 53.0% in 2005, which translates into 3 million fewer Americans in the second quintile with employer-provided coverage. It was individuals in the middle fifth of household income, however, who experienced the largest declines in coverage over the last year, a drop of 1.6 percentage points.

FIGURE A

Employer-provided health insurance for individuals under 65 by household income quintile, 2000-05



SOURCE: Author's analysis of the March Current Population Survey, 2001-06

Declining coverage for workers

Employer-provided health insurance

The percent of workers with employer-provided health insurance coverage fell from 2004 to 2005, continuing the uninterrupted decline that it began in 2000. As shown in **Table 2**, 70.5% of workers in 2005 had employer-provided health insurance either from their own or their spouse's job, down from 70.9% the year before and down a total of 3.7 percentage points since 2000. Nearly 2.8 million fewer workers had employer-provided health insurance in 2005 than in 2000.

Table 2
Share of workers (18-64 years old) receiving employer-provided health insurance, 2000-05

	Health Insurance coverage						Percentage-point change
	2000	2001	2002	2003	2004	2005	2000-05
All workers	74.2%	73.5%	72.2%	71.4%	70.9%	70.5%	-3.7
Gender							
Male	73.5%	72.6%	71.1%	70.4%	69.4%	69.0%	-4.4
Female	75.0	74.5	73.5	72.6	72.5	72.2	-2.8
Race							
White, non-Hisp.	79.0%	78.4%	77.1%	76.3%	75.7%	75.5%	-3.5
Black	68.0	68.1	66.0	66.5	66.0	65.1	-2.8
Hispanic	53.1	52.0	52.8	50.6	50.6	49.9	-3.2
Other	70.0	67.9	67.4	68.2	68.6	68.7	-1.4
Education							
High school	71.2%	70.2%	68.3%	67.0%	66.4%	65.6%	-5.6
College	84.7	84.2	83.0	81.9	82.2	81.6	-3.0
Wage quintiles							
Lowest	48.8%	48.1%	46.6%	45.1%	44.5%	44.1%	-4.7
Second	68.2	67.4	65.1	64.0	62.6	62.5	-5.7
Middle	80.1	79.9	79.2	77.9	77.2	76.8	-3.3
Fourth	86.5	86.9	85.8	84.9	84.5	84.2	-2.3
Highest	88.1	87.1	85.8	86.3	86.5	86.1	-2.1
Work time							
Full time	77.1%	76.5%	75.5%	74.7%	74.2%	73.7%	-3.4
Part time	59.4	58.3	56.6	56.1	54.8	55.0	-4.4

SOURCE: Author's analysis of the March Current Population Survey, 2001-06

The loss of coverage was greater for men than women, as the coverage rate for working men with employer-provided insurance fell 4.4 percentage points compared to 2.8 points for women workers. About two-thirds of workers with a high school education were covered in 2005, whereas 81.6% of college-educated workers had employer-provided health coverage. This disparity reflects the fact that higher-skilled workers are likely to have higher-quality jobs that offer health benefits. That said, even college graduates have not been insulated from the decline in employer-provided health insurance. Nonetheless, workers with only a high school education still fared worse than those with a college degree (a decline of 5.6 vs. 3.0 percentage points).

Workers earning lower hourly wages are significantly less likely to have employer-provided health coverage than those earning higher wages; however, even those in the highest wage quintile were subjected to losses in coverage. Full-time workers are more likely to have employer-provided health insurance than part-time workers (73.7% vs. 55.0%). At the same time, over one-fourth of full-time workers, or nearly 32 million full-time workers, are not receiving employer-provided health insurance. These numbers have also been increasing consistently over the last five years.

An important group of workers to examine more closely are workers who are significantly attached to the private sector labor force, defined as those who work in the private sector at least 20 hours per week and 26 weeks per year. The coverage trends for these workers have also fallen over the last year, continuing a steady climb downwards (**Table 3**). Less than 55% of these steady workers receive health insurance from their own employer, down almost 4 percentage points since 2000.

Table 3
Share of private-sector workers* insured by own employer, by occupation, firm size, and industry, 2000-05**

	Health insurance coverage (%)						Percentage-point change
	2000	2001	2002	2003	2004	2005	2000-05
All workers*	58.9%	58.2%	57.3%	56.4%	55.9%	54.9%	-3.9
Occupations							
White collar	65.0%	64.5%	63.1%	62.4%	62.4%	61.2%	-3.8
Blue collar	59.0	58.1	57.1	56.4	54.8	53.9	-5.1
Service	33.9	33.3	31.6	28.7	29.4	28.7	-5.3
Firm size (no. of employees)							
Less than 100	43.9%	43.4%	42.6%	42.0%	41.0%	40.4%	-3.5
100 - 499	65.9	64.8	64.8	63.7	63.2	61.7	-4.2
500 or more	69.6	69.3	68.6	67.9	67.6	66.6	-2.9

	2002	2003	2004	2005	2002-05
Industry***					
Agriculture, forestry, fishing, and hunting	37.1%	29.1%	25.8%	26.1%	-11.0
Arts, entertainment, recreation, accommodation, and food services	32.5%	30.4%	30.5%	30.6%	-1.9
Construction	47.5	44.8	42.4	42.4	-5.1
Educational, health, and social services	59.4	59.4	60.2	57.5	-1.9
Financial, insurance, real estate, and rental and leasing	65.8	65.5	65.2	64.4	-1.4
Information	73.0	71.3	70.1	72.3	-0.7
Manufacturing	72.7	73.0	71.8	71.2	-1.5
Mining	78.4	76.8	79.1	73.4	-5.0
Other services (except public administration)	40.1	38.9	39.2	39.5	-0.6
Professional, scientific, management, admin., and waste man. service	57.4%	55.1%	55.8%	54.7%	-2.7
Transportation and utilities	66.9	65.7	66.8	63.6	-3.3
Wholesale and retail trade	53.9	52.9	52.7	51.9	-2.0

* Private-sector, wage and salary workers, age 18-64, who worked at least 20 hours per week and 26 weeks per year.
** Workers received employer-provided health insurance through their own job and employer had to pay at least part of their insurance premiums to qualify as employer-provided insurance coverage.
*** Industry classifications changes make it impossible to compare 2005 with years earlier than 2002.

SOURCE: Author's analysis of the March Current Population Survey, 2001-06.

White collar, blue collar, and service sector workers experienced declines in coverage, but service workers are insured at the lowest rates (28.7%) and experienced the greatest drop (5.3 percentage points). Blue collar workers experienced the largest decline over the last year, a drop of 3.2 percentage points. Workers in larger firms are more likely to have employer-provided health insurance from their employer than workers in smaller firms. Only 40.4% of workers in small firms (firms of less than 100 employees, which represent about 42% of the workforce) had employer-provided health insurance compared with over 60% in firms greater than 100 employees. Workers in firms of all sizes lost coverage, but those in firms with more than 100 but less than 500 employees had the greatest declines over the last year and since 2000.

Coverage rates in 2005 differ dramatically by the worker's major industrial sector. Workers in the largest sectors—wholesale and retail trade and education, health, and social services (18%, and 16%, respectively, of the total private workforce in 2005)—have coverage rates between 52% and 58%. Workers in these sectors experienced declines in coverage of about 2 percentage points since 2002. Manufacturing, another large sector, had a coverage rate of 71.2% in 2005, a decline of 1.5 percentage points from 2002. Manufacturing jobs have been falling as a share of total private sector jobs, as total employment in this sector declined 7% over this period. These high quality jobs, as defined by a [redacted]ter likelihood of providing health benefits, are declining both because less workers in the industry are getting benefits and because there [redacted]fewer workers in the industry than in previous years.

Uninsured workers

While the predominant form of health insurance for workers is through the workplace, some are eligible for Medicaid or Medicare and

others may choose to purchase in the private market. To best understand the growing insecurity of many working families, it's important to examine the growth in the uninsured workforce. In 2005, 18.7% workers 18-64 years old were uninsured (**Table 4**). These 27.3 million uninsured workers make up about 60% of the total uninsured population. Since 2000, the number of uninsured workers has grown an additional 2.2 percentage points (3.8 million workers).

Table 4
Workers without any health insurance coverage, 2000-05

	Uninsured						Percentage-point change
	2000	2001	2002	2003	2004	2005	2000-05
All workers	16.5%	17.0%	18.0%	18.6%	18.5%	18.7%	2.2
Age							
18-24 years	26.1%	26.7%	28.7%	29.4%	29.8%	29.4%	3.3
25-34 years	20.1	21.5	22.6	24.1	23.3	24.2	4.1
35-44 years	14.4	14.7	16.2	16.7	16.8	17.0	2.7
45-54 years	11.3	11.8	12.5	13.1	13.0	13.3	2.0
55-64 years	12.0	11.6	11.5	11.3	11.2	11.9	-0.1
Gender							
Male	18.2%	18.9%	20.3%	20.7%	20.8%	21.0%	2.9
Female	14.7	14.9	15.4	16.3	15.8	16.1	1.5
Race							
White, non-Hispanic	11.8%	12.2%	13.2%	13.9%	13.8%	14.0%	2.1
Black	21.6	21.8	23.6	22.8	22.2	22.6	1.0
Hispanic	38.1	39.1	38.5	40.0	39.4	39.4	1.3
Other	20.5	21.6	21.2	21.0	19.3	19.9	-0.5
Education							
Less than high school	39.5%	40.9%	41.4%	43.2%	42.4%	42.7%	3.2
High school	19.6	20.1	21.9	22.9	22.6	23.7	4.1
Some college	13.4	13.8	14.7	15.4	15.6	15.8	2.4
College	8.0	8.6	9.3	9.9	9.8	9.5	1.5
Post-college	4.3	4.7	5.5	5.7	5.0	5.1	0.8
Wage quintiles							
Lowest (1-20)	36.5%	38.0%	39.6	41.9%	40.9%	40.4%	3.9
Second (21-40)	19.7	19.3	21.0	21.7	21.9	22.1	2.4
Middle (41-60)	12.0	12.0	13.0	13.2	13.9	14.2	2.2
Fourth (61-80)	7.8	8.8	8.5	8.9	8.7	9.7	1.9
Highest (81-100)	6.4	6.8	7.7	7.4	6.9	7.1	0.6
Work time							
Full time	15.7%	16.0%	16.8%	17.5%	17.3%	17.7%	2.0
Part time	20.6	22.0	23.5	23.8	24.2	23.5	2.9

SOURCE: Author's analysis of the March Current Population Survey, 2001-06

Uninsured workers tend to be younger. Nearly 30% of young workers (18-24 years old) are uninsured as compared to about 12% of workers age 55-64. The groups of young and older workers represent about 14% of the workforce each, but 22% and 9% of the uninsured workforce, respectively (**Table 5**).

Table 5
Profile of workers without any health insurance coverage as compared to all workers, 2005

	All workers	Uninsured workers
Age		
18-24 years	13.9%	21.9%
25-34 years	22.6%	29.2%
35-44 years	24.9%	22.6%
45-54 years	24.3%	17.2%
55-64 years	14.3%	9.1%
Gender		
Male	53.3%	59.7%
Female	46.7%	40.3%
Race		
White, non-Hispanic	69.3%	51.8%
Black	10.9%	13.2%
Hispanic	13.5%	28.3%
Other	6.3%	6.7%
Education		
Less than high school	10.6%	24.2%
High school	29.8%	37.7%
Some college	30.2%	25.5%
College	19.7%	9.9%
Post-college	9.7%	2.7%
Wage quintiles		
Lowest	20.0%	39.1%
Second	20.0%	27.8%
Middle	20.0%	15.7%
Fourth	20.0%	9.9%
Highest	20.0%	7.5%
Work time		
Full-time	82.9%	78.5%
Part-time	17.1%	21.5%

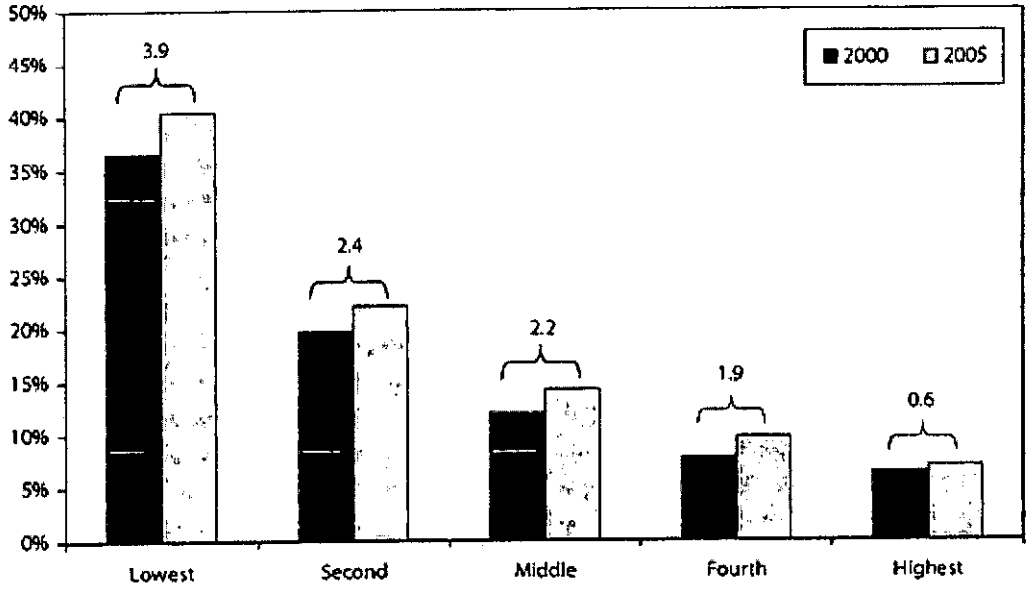
SOURCE: Author's analysis of the March Current Population Survey, 2001-06

Male workers are more likely to be uninsured and experienced a larger increase in their uninsured rate since 2000 than female workers. Hispanic workers have the highest uninsured rate of any other race/ethnicity, in fact, nearly twice as high. Almost 40% of Hispanic workers uninsured. Uninsurance among workers falls consistently with education from 42.7% for those with less than a high school degree to % for those with graduate education.

Uninsurance declines as wages rise (**Figure B**). While 40.4% of workers in the lowest wage quintile are uninsured, only 7.1% of workers in the highest quintile are. Nearly 40% of uninsured workers fall in the lowest wage quintile, while a disproportionately small number of uninsured workers are middle or high income. Workers' rates of uninsurance from 2000 to 2005 also decline with income. Workers in the lowest wage quintile experience an increase over six times the amount experienced by those in the highest wage quintile (3.9 vs. 0.6). Full-time workers have lower rates of uninsurance than part-timers, however, both declined significant amounts in the last five years.

FIGURE B

Share of workers (18-64) who are uninsured, by wage quintile, 2000-05



SOURCE: Author's analysis of the March Current Population Survey, 2001-06.

Declining coverage for children

Most children receive health insurance through their parent's job. The rate of employer-provided health insurance for children fell 5.1 percentage points between 2000 and 2005, a decline from 65.6% to 60.5%. This drop occurred across all socio-economics group, as shown in **Table 6**.

Table 6
Employer-provided health insurance, children age 17 and under, 2000-05

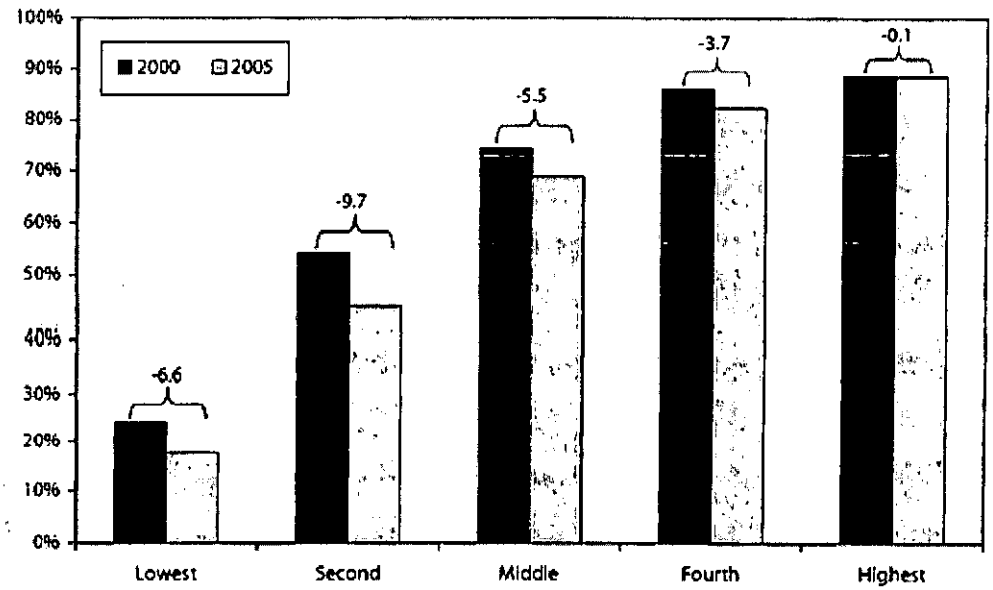
	Health insurance coverage (%)						Percentage-point change
	2000	2001	2002	2003	2004	2005	2000-05
All under 18	65.6%	63.9%	63.0%	61.2%	61.0%	60.5%	-5.1
Race							
White, non-Hisp.	76.0%	74.5%	73.8%	72.3%	71.7%	71.6%	-4.4
Black	50.8	50.6	48.4	45.3	46.1	45.0	-5.8
Hispanic	42.4	41.0	40.2	39.6	40.1	39.0	-3.4
Other	64.2	58.6	60.8	59.1	61.7	62.4	-1.8
Education of family head							
Less than high school	34.0%	30.8%	29.8%	28.2%	27.7%	26.8%	-7.2
High school	63.3	60.2	58.4	56.2	56.7	55.0	-8.3
Some college	73.5	71.5	69.9	67.8	67.1	66.0	-7.4
College	85.8	85.7	85.1	83.2	83.4	83.1	-2.7
Post-college	87.6	88.1	87.3	87.1	86.7	86.7	-0.9
Household income fifth							
Lowest	24.3%	22.0%	20.7%	18.6%	18.4%	17.7%	-6.6
Second	54.3	51.0	49.2	45.7	45.9	44.6	-9.7
Middle	74.5	74.0	72.7	71.4	70.6	69.0	-5.5
Fourth	86.1	84.3	84.5	83.2	82.7	82.4	-3.7
Highest	88.8	88.3	88.1	87.0	87.5	88.7	-0.1

SOURCE: Author's analysis of the March Current Population Survey, 2001-06

Ranking children by their household's income is particularly revealing of the unequal distribution of employer-provided health care (**Figure C**). Only 17.7% of children in the lowest income quintile were found to have employer-provided health insurance, compared with 8.7% of the children in the highest income quintile. In other words, children whose household incomes were in the top 20% were nearly [redacted] times more likely to have employer-provided health insurance than children in the lowest 20% of household income. This disparity has [redacted]ly been exacerbated over the past five years: the drop in coverage for those in the lowest income quintile was 6.6 percentage points, while the drop for those in the highest quintile was only 0.1 percentage points. The group hurt the worst, however, was children in the second lowest quintile; their coverage rates declined by 9.7 percentage points, from 54.3% to 44.6%.

FIGURE C

Employer-provided health coverage for children, by household income quintile, 2000-05

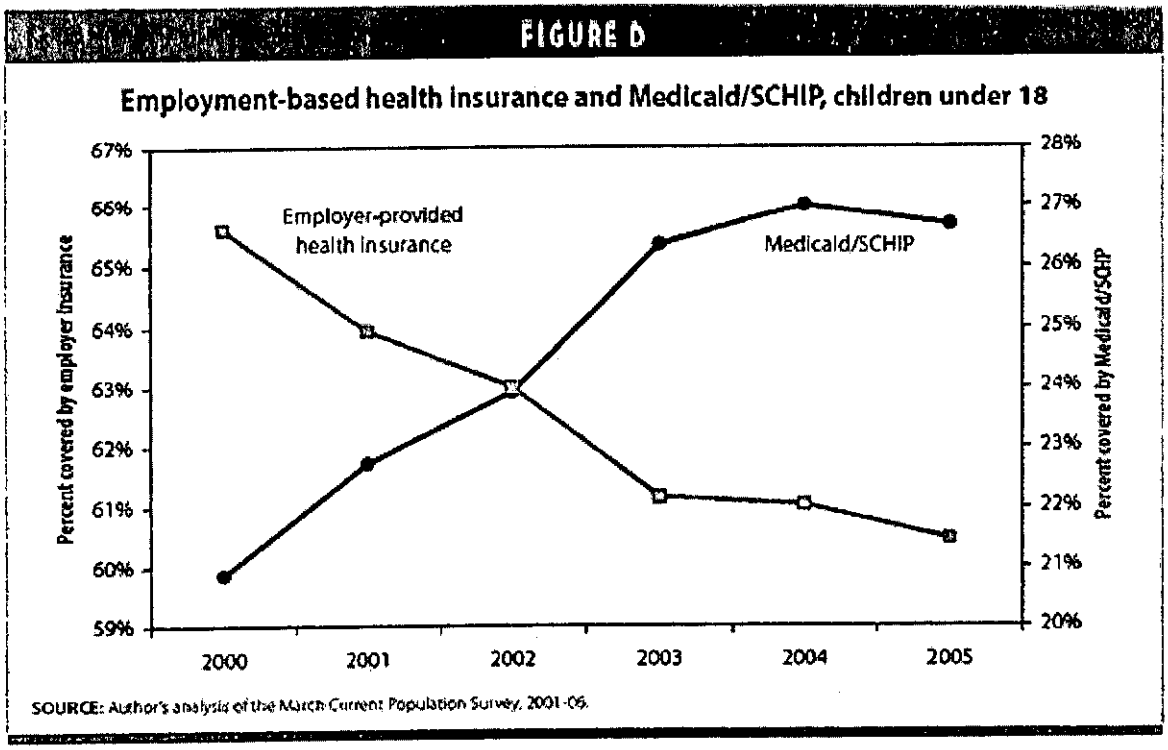


SOURCE: Author's analysis of the March Current Population Survey, 2001-06

The second set of numbers in Table 6 assign each child the education level of their family head. Children with parents of lower education attainment fare much worse than those with college or advanced degrees. Only about 55.0% of children with high-school-educated parents have employer-provided health insurance as compared to 83.1% of children with college-educated parents. The declines in coverage from 2000 to 2005 were more than three times greater for the former group as well.

The number of uninsured children rose 361,000 from 2004 to 2005 to a total of 8.3 million uninsured children. The percent of uninsured children rose from 10.8% to 11.2%, a statistically significant increase. This is the first time the uninsured rate has increased since 1998. This unfortunate turnaround in the number and percent of uninsured children was caused by the confluence of two events. First, there has been a significant drop in the number of children covered by employer-provided health insurance. In the last year alone, nearly 300,000 fewer children had employer-provided health insurance. Second, there has been a significant reversal in trend in the number of children insured by Medicaid or SCHIP in the last year. Nearly 1%, or 184,000, fewer children had Medicaid or SCHIP in 2005 than in 2004. In previous years, the strength of government programs aimed at children kept many from falling into the ranks of the uninsured, keeping them better insulated from the losses in employer-provided coverage. This phenomenon and the recent reversal in trend is illustrated in **Figure D**. The safety net does not appear to be catching as many children as in the past.

FIGURE D



Coverage by state

While the majority of states experienced significant declines in employer-provided coverage for the under-65 population between the 1999-2000 and 2004-05 periods, the level and extent of coverage loss varied by state, as shown in **Table 7**. The states with the highest employer-provided coverage rates in the merged 2004-05 years were New Hampshire (76.7%), Minnesota (73.0%), and New Jersey (72.4%). The lowest coverage rates were found in New Mexico (52.9%), Montana (54.6%), and Texas (55.1%). Thirty-four states experienced significant losses in coverage with Indiana, Utah, Maryland, and Missouri experiencing losses in excess of 8 percentage points. No state experienced significant increase in their coverage rate.

Table 7
Employer-provided health insurance coverage, by state, population under 65 years old, 1999-2000 to 2004-05

	Health insurance coverage (%)			*Health insurance coverage (persons)*		
State	1999-2000	2004-05	Percentage-point change	1999-2000	2004-05	Change
Nationwide	67.6%	63.0%	**-4.6**	164,690,091	161,975,552	**-2,714,539**
Alaska	61.6	58.3	-3.3	363,920	357,747	-6,174
Alabama	67.2	62.6	**-4.6**	2,604,963	2,490,624	**-114,339**
Arkansas	62.6	56.7	**-5.9**	1,396,066	1,347,867	**-50,199**
Arizona	61.2	55.6	**-5.6**	2,732,338	2,864,256	131,918
California	60.1	55.4	**-4.6**	18,366,168	17,742,883	**-623,285**
Colorado	69.3	64.8	**-4.5**	2,698,472	2,703,859	5,387
Connecticut	77.6	71.3	**-6.3**	2,224,218	2,164,888	**-59,330**
District of Columbia	61.8	58.0	-3.8	287,361	278,858	-8,503
Delaware	74.1	69.1	**-4.9**	504,688	502,575	-2,113
Florida	61.8	57.2	**-4.6**	7,983,823	8,486,295	**502,472**
Georgia	67.0	59.9	**-7.0**	4,810,056	4,845,872	**35,816**
Hawaii	72.4	71.3	-1.0	768,558	772,048	3,490
Iowa	76.3	71.1	**-5.3**	1,865,700	1,796,449	**-69,251**
Idaho	66.1	62.4	**-3.7**	744,187	792,338	**48,151**
Illinois	71.9	68.2	**-3.7**	7,845,350	7,562,796	**-282,554**
Indiana	76.1	66.8	**-9.4**	3,966,921	3,674,600	**-292,322**
Kansas	70.1	69.0	**-1.2**	1,599,438	1,616,042	**16,605**
Kentucky	67.5	63.6	**-3.9**	2,364,997	2,272,539	**-92,458**
Louisiana	59.0	57.7	**-1.3**	2,277,998	2,134,119	**-143,879**
Massachusetts	72.2	69.6	**-2.6**	3,936,765	3,908,400	-28,365
Maryland	77.9	69.3	**-8.6**	3,488,610	3,407,834	**-80,777**
Maine	69.1	62.9	**-6.2**	763,011	711,003	**-52,008**
Michigan	74.9	69.9	**-5.0**	6,629,836	6,146,353	**-483,483**
Minnesota	76.9	73.0	**-3.8**	3,343,628	3,303,892	-39,736
Missouri	74.0	65.7	**-8.2**	3,612,328	3,252,189	**-360,139**
Mississippi	63.1	55.7	**-7.4**	1,531,715	1,395,216	**-136,499**
Montana	58.7	54.6	**-4.1**	459,662	431,902	**-27,760**
North Carolina	68.0	61.4	**-6.6**	4,642,996	4,614,681	-28,315
North Dakota	66.0	66.0	0.0	349,087	358,463	9,377
Nebraska	68.4	68.0	-0.4	1,007,220	1,039,770	32,551
New Hampshire	77.7	76.7	-1.0	851,812	871,941	20,130
New Jersey	75.6	72.4	**-3.2**	5,407,423	5,523,454	116,032
New Mexico	53.7	52.9	-0.8	845,825	886,539	40,714
Nevada	67.9	66.3	-1.6	1,204,995	1,410,974	**205,979**
New York	63.4	63.6	0.2	10,316,890	10,521,159	**204,269**
Ohio	74.5	69.8	**-4.7**	7,311,591	6,914,623	**-396,969**
Oklahoma	60.3	57.9	**-2.5**	1,721,269	1,731,099	**9,830**
Oregon	67.6	62.4	**-5.2**	2,036,343	1,955,020	**-81,324**
Pennsylvania	75.1	70.0	**-5.1**	7,680,327	7,323,044	**-357,283**
Rhode Island	74.8	67.5	**-7.3**	640,473	626,825	-13,649
South Carolina	68.3	60.4	**-7.8**	2,320,504	2,187,949	**-132,555**
South Dakota	66.7	61.6	**-5.1**	412,493	404,853	-7,640
Tennessee	65.5	59.1	**-6.4**	3,262,868	3,007,922	**-254,947**
Texas	60.4	55.1	**-5.3**	11,061,785	11,164,201	**102,416**
Utah	74.6	65.6	**-9.0**	1,513,068	1,490,325	**-22,743**
Virginia	70.8	68.8	**-2.0**	4,321,818	4,547,248	**225,430**
Vermont	67.1	64.0	**-3.1**	359,246	345,023	**-14,224**
Washington	66.1	64.9	**-1.2**	3,409,654	3,558,722	**149,068**
Wisconsin	76.6	70.0	**-6.5**	3,613,230	3,329,852	**-283,378**
West Virginia	63.5	60.6	**-2.9**	946,555	924,135	**-22,420**
Wyoming	65.1	62.1	**-3.0**	279,854	274,297	**-5,557**

Note: Bolded numbers are statistically significant at the 5% level.

SOURCE: Author's analysis of the March Current Population Survey, 2000-06

Table 8 displays the coverage levels and rates for workers who are significantly attached to the private sector labor force and receive employer-provided coverage from their own job. The state with the highest rate of employer-provided coverage among workers was Hawaii, with a coverage rate in 2004-05 of 69.9%. This is likely due to the fact that Hawaii has a government mandate requiring employers to provide health insurance to their workers who work at least 20 hours per week. The largest declines in coverage for workers between 1999-2000 and 2004-05 were in Arkansas and New Jersey, with declines over 7 percentage points. As with the under-65 population, there is no [redacted] with a statistically significant increase in its coverage rate for workers.

Table 8
Employer-provided health insurance coverage, by state, 1999-2000 to 2004-05, percent of workers* insured by own employer**

	Health insurance coverage (%)			*Health insurance coverage (persons)*		
State	1999-2000	2004-05	Percentage-point change	1999-2000	2004-05	Change
Nationwide	58.9%	55.4%	-3.5	55,724,411	53,549,335	-2,175,077
Alaska	54.1	51.5	-2.6	92,149	93,301	1,152
Alabama	59.9	56.0	-3.9	893,259	816,021	-77,239
Arkansas	56.9	49.3	-7.6	456,602	431,154	-25,448
Arizona	53.3	52.3	-1.0	883,760	985,057	101,297
California	55.8	52.4	-3.4	6,315,126	5,957,676	-357,450
Colorado	59.0	55.9	-3.1	914,776	901,970	-12,806
Connecticut	64.3	60.1	-4.2	739,028	720,723	-18,305
District of Columbia	62.7	60.3	-2.3	108,587	104,038	-4,549
Delaware	63.9	59.2	-4.7	179,975	179,010	-965
Florida	52.8	50.6	-2.2	2,776,328	2,933,989	157,661
Georgia	58.8	54.3	-4.6	1,679,902	1,649,683	-30,219
Hawaii	70.5	69.9	-0.6	270,692	273,726	3,034
Iowa	61.2	57.5	-3.6	625,227	591,754	-33,473
Idaho	54.3	54.8	0.4	220,904	244,962	24,058
Illinois	61.0	59.5	-1.5	2,783,702	2,557,947	-225,755
Indiana	64.1	57.1	-6.9	1,370,193	1,243,671	-126,523
Kansas	60.9	60.7	-0.2	542,715	527,064	-15,651
Kentucky	57.8	59.1	1.3	783,531	763,533	-19,998
Louisiana	51.2	53.0	1.8	661,337	651,259	-10,078
Massachusetts	62.5	56.3	-6.2	1,439,406	1,266,191	-173,215
Maryland	62.3	55.6	-6.8	1,023,502	996,396	-27,106
Maine	60.0	56.7	-3.3	254,870	250,787	-4,084
Michigan	63.4	58.3	-5.1	2,235,350	1,922,316	-313,034
Minnesota	63.2	61.1	-2.1	1,182,181	1,180,116	-2,065
Missouri	65.5	59.2	-6.3	1,361,994	1,161,937	-200,057
Mississippi	54.8	50.8	-4.0	462,323	415,661	-46,663
Montana	49.9	46.9	-3.0	128,400	124,178	-4,223
North Carolina	59.7	54.4	-5.3	1,655,292	1,479,653	-175,639
North Dakota	55.0	54.3	-0.7	107,816	113,126	5,310
Nebraska	57.3	57.7	0.4	341,424	347,910	6,486
New Hampshire	60.8	60.5	-0.3	277,104	296,191	19,088
New Jersey	63.1	55.9	-7.2	1,856,666	1,653,151	-203,515
New Mexico	48.7	43.0	-5.7	239,939	229,501	-10,439
Nevada	62.6	60.4	-2.2	457,349	533,705	76,357
New York	55.3	53.9	-1.4	3,236,245	3,227,961	-8,284
Ohio	63.2	58.3	-4.9	2,491,640	2,336,752	-154,888
Oklahoma	53.3	53.8	0.6	528,119	569,633	41,514
Oregon	62.2	57.1	-5.1	743,421	652,356	-91,065
Pennsylvania	64.8	61.5	-3.3	2,685,786	2,595,750	-90,036
Rhode Island	59.9	55.7	-4.2	212,513	210,817	-1,696
South Carolina	57.5	53.7	-3.8	734,344	699,994	-34,350
South Dakota	54.9	51.9	-3.1	130,186	135,240	5,054
Tennessee	56.1	55.6	-0.8	1,110,269	1,052,378	-57,891
Texas	55.0	51.2	-3.8	3,756,449	3,717,309	-39,140
Utah	55.3	49.4	-5.8	380,522	397,726	17,204
Virginia	62.5	57.1	-5.3	1,457,401	1,458,414	1,014
Vermont	55.8	54.0	-1.8	119,021	114,818	-4,203
Washington	61.4	62.1	0.7	1,255,100	1,304,811	49,711
Wisconsin	59.9	58.2	-1.7	1,183,934	1,129,815	-54,119
West Virginia	54.2	51.3	-3.0	297,794	269,042	-28,753
Wyoming	54.3	51.7	-2.6	80,272	79,175	-1,097

Note: Bolded numbers are statistically significant at the 5% level.
* Private-sector, wage and salary workers, age 18-64, who worked at least 20 hours per week and 26 weeks per year.
** Worker received employer-provided health insurance through their own job and employer had to pay at least part of their insurance premiums to qualify as employer-provided insurance coverage.

SOURCE: Author's analysis of the March Current Population Survey, 2000-05.

State-by-state employer-provided coverage levels and rates for children are displayed in **Table 9.** The highest rates of employer-provided coverage for children were in New Hampshire (78.2%), Minnesota (74.0%), and New Jersey (73.0%). New Mexico, Mississippi, and the District of Columbia cover less than half their children with employer-provided health insurance. Indiana and Mississippi experienced significant declines in coverage rates in excess of 11 percentage points. Massachusetts was the only state that significantly increased its coverage rate from 1999-2000 to 2004-05.

Table 9
Employer-provided health insurance coverage, by state, children under 18 years old
1999-2000 to 2004-05

	Health insurance coverage (%)			*Health insurance coverage (persons)*		
State	1999-2000	2004-05	Percentage-point change	1999-2000	2004-05	Change
Nationwide	65.4%	60.8%	**-4.6**	47,279,110	44,891,380	**-2,387,731**
Alaska	59.1	57.1	**-2.0**	116,507	106,296	**-10,212**
Alabama	63.7	60.9	-2.7	723,709	663,715	-59,995
Arkansas	61.4	55.0	**-6.5**	424,218	374,916	-49,302
Arizona	58.5	52.4	**-6.1**	828,421	837,139	8,719
California	57.2	52.4	**-4.8**	5,422,506	5,063,407	**-359,099**
Colorado	66.5	64.9	-1.7	763,430	764,121	691
Connecticut	77.6	71.4	**-6.3**	677,678	596,594	**-81,084**
District of Columbia	50.5	47.3	-3.2	56,318	53,303	-3,015
Delaware	70.0	67.3	-2.8	141,009	131,671	-9,338
Florida	59.4	55.6	**-3.9**	2,163,937	2,249,647	85,711
Georgia	64.0	55.2	**-8.9**	1,382,979	1,299,253	**-83,726**
Hawaii	67.4	69.1	1.7	210,595	204,590	-6,005
Iowa	78.1	70.1	**-8.0**	571,971	478,683	**-93,288**
Idaho	64.3	58.5	**-5.8**	234,443	227,888	-6,555
Illinois	70.3	66.0	**-4.2**	2,277,293	2,152,153	**-125,140**
Indiana	75.5	64.0	**-11.4**	1,138,676	1,030,964	**-107,712**
Kansas	68.8	66.5	**-2.3**	464,111	458,094	-6,017
Kentucky	65.3	60.6	**-4.8**	630,729	597,404	-33,325
Louisiana	55.7	55.6	-0.1	662,670	614,475	**-48,195**
Massachusetts	68.0	72.4	**4.4**	1,008,322	1,081,558	73,236
Maryland	77.8	67.4	**-10.3**	1,008,151	934,884	**-73,268**
Maine	68.4	60.4	**-8.0**	205,169	170,695	**-34,474**
Michigan	73.8	70.5	**-3.3**	1,989,809	1,798,064	**-191,745**
Minnesota	78.2	74.0	**-4.2**	1,008,804	917,448	-91,356
Missouri	71.2	61.8	**-9.4**	1,016,045	863,561	**-152,484**
Mississippi	58.9	47.8	**-11.1**	451,048	363,569	**-87,479**
Montana	57.2	54.9	**-2.3**	133,221	118,121	**-15,103**
North Carolina	64.5	58.5	**-6.0**	1,258,503	1,271,825	13,322
North Dakota	63.1	65.6	**2.4**	93,992	93,864	-128
Nebraska	68.2	67.9	-0.4	305,912	298,171	-7,742
New Hampshire	78.9	78.2	-0.7	257,719	236,005	**-21,714**
New Jersey	76.5	73.0	**-3.5**	1,523,879	1,598,014	74,136
New Mexico	49.4	48.1	**-1.3**	258,792	237,715	**-21,078**
Nevada	67.7	68.3	0.6	388,199	433,291	45,093
New York	60.4	61.8	**1.4**	2,836,710	2,821,586	-15,124
Ohio	73.6	68.2	**-5.4**	2,123,524	1,886,403	**-237,121**
Oklahoma	55.4	52.6	**-2.8**	463,297	452,439	-10,858
Oregon	66.8	61.2	**-5.5**	575,887	532,475	-43,412
Pennsylvania	74.7	66.7	**-8.0**	2,126,725	1,893,583	**-233,142**
Rhode Island	74.2	63.6	**-10.6**	188,355	159,617	**-28,738**
South Carolina	66.0	58.1	**-7.9**	634,713	594,829	**-39,884**
South Dakota	69.2	58.5	**-10.7**	128,463	110,159	-18,304
Tennessee	62.8	60.5	**-3.3**	890,152	851,310	**-38,843**
Texas	56.9	50.9	**-6.0**	3,306,916	3,252,010	-54,906
Utah	76.9	66.1	**-10.8**	556,773	507,102	**-49,671**
Virginia	68.6	69.1	0.5	1,202,873	1,266,820	63,947
Vermont	65.6	60.6	**-5.0**	96,253	80,784	**-15,470**
Washington	63.7	62.2	-1.4	939,707	944,967	5,261
Wisconsin	76.9	69.8	**-7.1**	1,108,050	910,624	**-197,427**
West Virginia	58.0	60.2	**2.1**	219,108	233,373	**14,266**
Wyoming	64.4	61.4	**-3.0**	82,851	72,211	**-10,640**

Note: Bolded numbers are statistically significant at the 5% level.

SOURCE: Author's analysis of the March Current Population Survey, 2000-06.

Conclusion

Social insurance is intended to insulate people from negative shocks such as job loss, illness, or natural disaster. Public insurance is intended to provide a safety net to people who have limited access to private insurance markets. Clearly, there are many Americans who fall through the growing gulf between employer-provided coverage and government health programs. A universal system, one that provides a minimum standard of care to everyone, would provide Americans with access to the type of health care appropriate for the most prosperous nation in the world. Taking insurance out of the job market and into the public sector has the potential to provide a stronger safety net, particularly during times of weak labor growth. This can lead more Americans to have steadier insurance access and increase their ability to secure regular medical care.

From 2000 to 2005, this country saw a substantial rise in the number of uninsured. A continued decline in those with employer-provided

health insurance along with a weakening of the health insurance safety net will undoubtedly cause more and more Americans to lose coverage and therefore access to adequate health care.

The author thanks Jin Dai and Rob Gray for their research assistance on this Briefing Paper. EPI thanks the Ford Foundation, the Rockefeller Foundation, the Charles Stewart Mott Foundation, the Annie E. Casey Foundation, the Joyce Foundation, the Charle & Catherine T. MacArthur Foundation, and the Open Society Institute for their support of this research.

Endnotes

1. In this analysis, children under 18 are assigned the education level of their family head.

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#1

Testimony
House Bill 1478 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
March 2, 2009

Chairman Lee, members of the Senate Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here in support of House Bill 1478.

As introduced House Bill 1478 would increase the income eligibility level for the State Children's Health Insurance Program (SCHIP) to 200 percent (net) of the poverty level. During the current biennium (effective October 1, 2008), the income level for SCHIP was increased to 150 percent (net). For the 2009-2011 Executive Budget, SCHIP was expected to have an average monthly caseload of 6,021 children, which includes the growth expected as a result of increasing the income level to 200 percent (net). The estimated growth in SCHIP as a result of increasing the income level to 200 percent (net) is 1,158 children.

House Bill 1478 was amended in the House to increase the eligibility level to 160 percent (net), rather than 200 percent (net).

Attachment A shows the number of children enrolled each month in Healthy Steps since the beginning of the current biennium, and also provides the number of children enrolled in Medicaid for the same time period. Clearly, we are experiencing an enrollment trend change for both Medicaid and Healthy Steps, which appears to be related to the implementation of 12-month continuous eligibility for Medicaid children. The Department continues to explore the details of this trend change to ensure we can appropriately project expenditures for the current biennium and for 2009-2011.

The fiscal note for the amended version of House Bill 1478 contains $1.6 million of which $.4 million are general funds to increase the income eligibility level to 160 percent (net). It is expected this increase will expand coverage to cover 439 children, at an average premium of $243.93 per child, per month. The Healthy Steps increase to 160 percent (net) is also contingent upon federal approval from the Centers for Medicare and Medicaid Services.

The Department continues to support the Executive Budget request to increase the income level to 200% of the poverty level. As part of the Department's monitoring of the trend change noted earlier in my testimony, we have reprojected the SCHIP enrollment expectations for 2009-2011. Because of the decline in SCHIP enrollment that we are experiencing, our estimates now indicate:

Executive Budget (with SCHIP at 200%)	$35.2 million
Reprojected Cost to increase SCHIP to 200%	$25.7 million
Funds currently in HB 1012 to increase to 160%	$32.6 million

Summary: Increasing SCHIP to 200%, based on the reprojected enrollment, compared to the current funding in HB 1012 to increase SCHIP to 160% will be a decrease of $6.9 million, of which $1.7 million are general funds.

The Department respectively requests that the 200% income threshold requested in the Executive Budget be restored at the reprojected amounts.

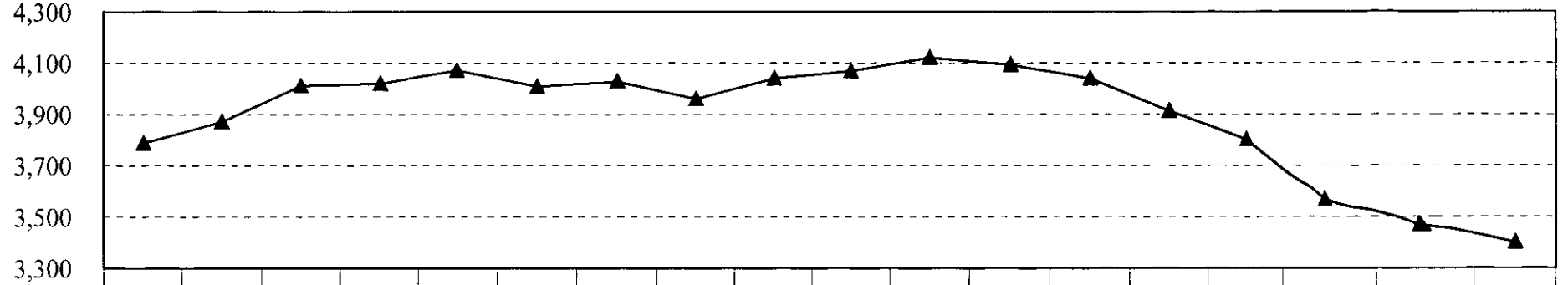
I would be happy to respond to any questions you may have.

North Dakota Department of Human Services

Attachment A

Healthy Steps Enrollment by Month

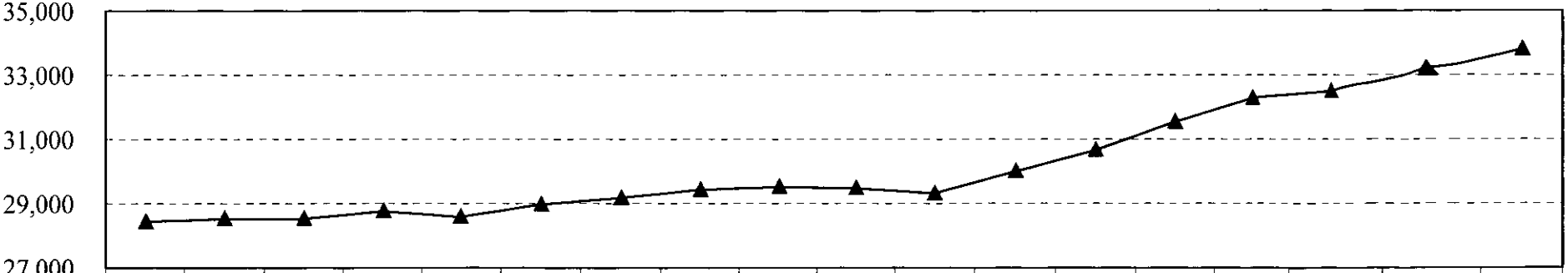
August 2007 - January 2009



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09
3,787	3,871	4,011	4,019	4,071	4,008	4,027	3,959	4,039	4,067	4,119	4,091	4,038	3,911	3,800	3,568	3,468	3,399

Children Enrolled in Medicaid by Month

August 2007 - January 2009



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09
28,435	28,522	28,531	28,758	28,590	28,977	29,173	29,420	29,508	29,462	29,306	29,984	30,652	31,532	32,274	32,479	33,184	33,795

2/19/09-cj-hgw\0911 legis\hs enroll & elig

effective through 3/31/09

2008 POVERTY LEVEL GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

Income Guidelines as Published in the Federal Register on January 23, 2008

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	10,400.00	12,480.00	13,832.00	14,040.00	15,600.00	18,200.00	19,240.00	20,800.00	26,000.00
2	14,000.00	16,800.00	18,620.00	18,900.00	21,000.00	24,500.00	25,900.00	28,000.00	35,000.00
3	17,600.00	21,120.00	23,408.00	23,760.00	26,400.00	30,800.00	32,560.00	35,200.00	44,000.00
4	21,200.00	25,440.00	28,196.00	28,620.00	31,800.00	37,100.00	39,220.00	42,400.00	53,000.00
5	24,800.00	29,760.00	32,984.00	33,480.00	37,200.00	43,400.00	45,880.00	49,600.00	62,000.00
6	28,400.00	34,080.00	37,772.00	38,340.00	42,600.00	49,700.00	52,540.00	56,800.00	71,000.00
7	32,000.00	38,400.00	42,560.00	43,200.00	48,000.00	56,000.00	59,200.00	64,000.00	80,000.00
8	35,600.00	42,720.00	47,348.00	48,060.00	53,400.00	62,300.00	65,860.00	71,200.00	89,000.00

For family units of more than 8 members, add $3,600 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	866.67	1,040.00	1,152.67	1,170.00	1,300.00	1,516.67	1,603.33	1,733.33	2,166.67
2	1,166.67	1,400.00	1,551.67	1,575.00	1,750.00	2,041.67	2,158.33	2,333.33	2,916.67
3	1,466.67	1,760.00	1,950.67	1,980.00	2,200.00	2,566.67	2,713.33	2,933.33	3,666.67
4	1,766.67	2,120.00	2,349.67	2,385.00	2,650.00	3,091.67	3,268.33	3,533.33	4,416.67
5	2,066.67	2,480.00	2,748.67	2,790.00	3,100.00	3,616.67	3,823.33	4,133.33	5,166.67
6	2,366.67	2,840.00	3,147.67	3,195.00	3,550.00	4,141.67	4,378.33	4,733.33	5,916.67
7	2,666.67	3,200.00	3,546.67	3,600.00	4,000.00	4,666.67	4,933.33	5,333.33	6,666.67
8	2,966.67	3,560.00	3,945.67	4,005.00	4,450.00	5,191.67	5,488.33	5,933.33	7,416.67

RE: SB 2362 - The income level @ 350% for a family of four is $74,208.

1/28

2

#3

SENATE HUMAN SERVICES COMMITTEE

HB1478

REPRESENTATIVE MERLE BOUCHER

CHAIRMAN LEE AND MEMBERS OF THE SENATE HUMAN SERVICES COMMITTEE. FOR THE RECORD I AM REPRESENTATIVE MERLE BOUCHER, REPRESENTING DISTRICT NINE (9).

I AM APPEARING BEFORE THE SENATE HUMAN SERVICES COMMITTEE TODAY SUPPORTING THE GOVERNOR'S RECOMMENDATION TO RAISE THE ELIGIBILITY LIMIT FOR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) TO 200% OF THE POVERTY LEVEL.

THE CURRENT ELIGIBILITY THRESHOLD WOULD INCREASE FROM 150% OF POVERTY TO 200%. THIS WOULD B E A GOOD INVESTMENT IN OUR CHILDREN, OUR FAMILIES AND OUR STATE'S FUTURE.

EXTENDING COVERAGE TO CHILDREN IS A GOOD FISCAL INVESTMENT FOR STATE GOVERNMENT. PROVIDING THIS EXPANDED COVERAGE SHOULD REALISTICALLY CREATE MORE PREVENTATIVE CARE. IT IS A COMMONLY UNDERSTOOD FACT, THAT PREVENTATIVE CARE CAN LOWER FUTURE HEALTH CARE COSTS SIGNIFICANTLY.

THE RECOMMENDATION IS THE RIGHT THING TO DO FOR PEOPLE AND RESPONSIBLE FISCAL POLICY.

I URGE THIS COMMITTEE TO SUPPORT HB1478 WITH A DO PASS RECOMMENDATION.

THANK YOU.

#4

North Dakota Catholic Conference

Representing the Diocese of Fargo and the Diocese of Bismarck

Christopher T. Dodson
Executive Director and
General Counsel

March 2, 2009
Senate Human Services Committee
HB 1478

Madame Chair Lee and Members of the Committee:

Good morning, my name is Caitlin McDonald, and I am the Healthcare Advocate for the North Dakota Catholic Conference. We support HB 1478 and request a do pass recommendation.

This bill as passed by the House aims to increase the eligibility level for the State's Children Health Insurance Program, or Healthy Steps, from the current rate of 150% of the poverty level to 160% of the poverty level. The North Dakota Catholic Conference believes that increasing the eligibility level of SCHIP is an action that furthers the common good and helps protect the inherent dignity of all persons. While we feel the 200% is a more comprehensive attempt at covering children, the 160% is a step in the right direction.

All children deserve affordable healthcare, and there are currently 14,000 children in North Dakota that are uninsured. Expanding the current SCHIP program is a good step forward for North Dakota. Please consider a Do Pass on HB 1478. I thank you for your time and consideration.

103 S. 3rd St., Suite 10 • Bismarck, ND 58501
(701) 223-2519 • 1-888-419-1237 • FAX # (701) 223-6075
http://ndcatholic.org • ndcatholic@btinet.net

#5

H. B. 1478

Senate Human Services Committee

March 2, 2009

Chairman Lee and members of the Senate Human Services Committee, I am Paul Ronningen, Executive Director of the National Association of Social Workers (NASW) North Dakota Chapter and also the State Coordinator for the Children's Defense Fund. Thank you for the opportunity to provide testimony in support of HB 1478 for both NASW and the Children's Defense Fund.

First of all, NASW and the Children's Defense Fund want to commend the Governor and the Department of Human Services for increasing children's health insurance from 150% of poverty to 200% of poverty in the Governor's budget. This proposal would have provided coverage to an additional 1,158 children. This was a great step forward in public policy. Currently, there are over **14,000 children without coverage in North Dakota**. This represents cities the approximate size of a Jamestown, or Williston or Mandan!

HB 1478 children's health insurance coverage was reduced to 160% of poverty in the House and will cover only 439 children of the 14,000 uninsured children in the State.

Health Insurance for children is critical. Children who are healthy **do better in school**, have **better outcomes** with law enforcement and **better long term health.**

It should be noted that for every state general fund dollar for this important coverage, **the federal government will match with three dollars**. This 1 to 3 match is a great investment, especially in today's world.

In conclusion, all children need and deserve health care coverage. North Dakota is positioned to move from the back of the pack in children's health coverage. Please consider moving children's health care coverage from the emergency room to the clinic, from a reactionary response to a health crisis to a planned and thoughtful opportunity for working poor parents to access health care for their children.

Thank you.

#6

Testimony
House Bill 1478
Senate Human Services Committee
Senator Judy Lee, Chairman
March 2, 2009

Chairman Lee and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

NDFFCMH supports HB 1478 in its original form. Expanding the net income eligibility to 200% allows more children to access mental health care. For many children, mental health care is a key component of the array of services needed for healthy childhood development.

Mental disorders affect about one in five American children and one in ten experience serious emotional disturbances that severely impair their functioning, according to the Surgeon General's comprehensive report on mental health. **Moreover, low-income children enrolled in Medicaid and SCHIP have the highest rates of mental health problems.**

Sadly, over two-thirds of children struggling with mental health disorders do not receive mental health care. The President's New Freedom Commission on Mental Health found that without early and effective identification and interventions, childhood mental disorders can lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are at a much higher risk for suicide.

Please support children's access to mental health care. Thank you for your time.

Carlotta McCleary, Executive Director
ND Federation of Families for Children's Mental Health
PO Box 3061
Bismarck, ND 58502

Phone/fax: (701) 222-3310
Email: carlottamccleary@bis.midco.net

#7

H.B. 1478
Senate Human Services Committee
March 2, 2009

Chairman Lee and members of the Senate Human Services Committee, I am Sandy Tibke, Executive Director of the Children's Caucus. Thank you for the opportunity to provide testimony in support of HB 1478 on behalf of the Children's Caucus.

The Children's Caucus is in support of Governor Hoeven's budget increasing children's health insurance from 150% of poverty to 200% poverty. This will increase children's health care coverage for 1,158 children in the state of North Dakota.

Access to health care is critical for children. Currently, 14,000 North Dakota children are without health care coverage. That number is just a few thousand less than my home community of Mandan. Health Care coverage is a key indicator of child well-being. Children with coverage see doctors more often for wellness checks and immunizations and early signs of illness, miss fewer days of school and perform better in school. Investment in health care coverage for every child saves the state, over time, on remedial education services, juvenile justice services, emergency room services and other health care costs, and builds a strong future work force.

In the State of North Dakota we value family, our children and being fiscally responsible. As policy makers you are in a unique position to incorporate core values with sound policy to provide health care for all children in North Dakota. There are financial impacts to uninsured and uncompensated health care.

The uninsured are more likely to obtain emergent care than the insured. They tend to use emergency rooms as their primary care facility. In North Dakota of the 58,660 emergency room visits 9,500 were categorized non-emergencies (16%). Another 16% were emergent but could have been treated earlier with primary care. 30% (16,718) of these emergency room visits were self-pay.

In 2003-2004 the North Dakota Health Care Association Finance Council, issued a report that North Dakota healthcare facilities acquired total bad debts of about $40 million and approximately $12 million in charity care. Where do these bad debts go? They go to shifting charges to private insurers (cost shifting), using government subsidies, taking advantage of other government payment programs and generating revenue from non-patient sources (fundraising).

From this report you can see that it would save money to insure children in the state of North Dakota. It is the right thing to do and as our policy makers you are being fiscally responsible by increasing children's health insurance poverty rate from 150% to 200%.

#8

Testimony
North Dakota Disabilities Advocacy Consortium
HB 1478
Senate Human Services Committee
Chairman Senator Judy Lee

Chairman Lee and members of the Senate Human Services Committee, my name is James M. Moench, Executive Director of the North Dakota Disabilities Advocacy Consortium (NDDAC). The Consortium is made up of 24 member organizations concerned with addressing the issues that affect people with disabilities.

NDDAC supports the proposal to change the net income eligibility limit to qualify a child for the State Children's Health Insurance Program (SCHIP) from 150% of poverty to 200 % of poverty as envisioned in the original House Bill 1478. We would support an amendment that moved the Bill's current level of 160% to 200%.

NDDAC believes North Dakota can have no higher goal than insuring health care coverage to all the children in the state. This initiative will move us closer to that goal.

We urge your support of HB 1478.

Thank you.

NORTH DAKOTA DISABILITIES ADVOCACY CONSORTIUM

2008-09 Membership

1. AARP
2. American People Self Advocacy Association
3. Autism Society of North Dakota
4. Experience Works, Inc.
5. Fair Housing of the Dakotas
6. Family Voices of North Dakota
7. Independence, Inc.
8. Mental Health America of North Dakota
9. Metro Area Transit – Fargo, ND
10. ND APSE: The Network on Employment
11. ND Association for the Disabled
12. ND Association of Community Facilities
13. ND Association of the Blind
14. ND Association of the Deaf
15. ND Center for Persons with Disabilities
16. ND Children's Caucus
17. ND Consumer & Family Network
18. ND Federation of Families for Children's Mental Health
19. ND IPAT Consumer Advisory Committee
20. Protection & Advocacy Project
21. Senior Health Insurance Counseling/Prescription Connection
22. The Arc of Bismarck
23. The Arc of Cass County
24. The Arc of North Dakota

#9

TESTIMONY – PROTECTION AND ADVOCACY PROJECT
HOUSE BILL 1478 (2009)
SENATE HUMAN SERVICES COMMITTEE
Honorable Judy Lee, Chairman
March 2, 2009

Chairman Lee, and members of the Senate Human Services Committee, I am Bruce Murry, a lawyer with the North Dakota Protection and Advocacy Project (P&A). Please favorably consider House Bill 1478 to increase the income limit to North Dakota's Children's Health Insurance Program (CHIP).

This program offers access to quality health care coverage for children. The program discourages inappropriately dropping existing coverage. The program leaves adults responsible to obtain health insurance to meet their own needs. Adults are better able to prioritize their own needs, or to bear the burden of mistaken priorities. P&A believes health care for children is important enough to justify helping parents meet this responsibility. Especially, P&A wants to see children get the services they need to minimize or avoid the impact of disabilities in the future.

Consider North Dakota families earning between 150% and 200% of poverty level. Factor in the costs of modest but decent housing and groceries. Consider transportation and heating costs. Even parents earning 200% of poverty level might be unable to afford a safe, modest standard of living with family health insurance. We might question the priorities of this hypothetical parent. P&A suggests it is nevertheless better for all that our youth join the workforce and community in good relative health.

Thank you for your consideration.

#10

NORTH DAKOTA
Farmers Union

PO Box 2136 • 1415 12th Ave SE
Jamestown ND 58401
800-366-8331 • 701-252-2341
www.ndfu.org

March 1, 2009

HB 1478
Senate Health and Human Services Committee
Senator Judy Lee, Chairman

Chairman Lee and members of the Senate Health and Human Services Committee,

My name is Kayla Pulvermacher; I am here representing the members of North Dakota Farmers Union. I am testifying in support of House Bill 1478.

North Dakota Farmers Union believes that affordable, comprehensive health plans should be developed to enable all citizens' access to health insurance.

NDFU long standing policy urges the state to increase funding of the state children's health insurance to 200% of poverty level.

With passage of the bill proposed, we will begin to close the gap of uninsured and cover more of North Dakota's children, which is the ultimate goal.

We respectfully urge a "do pass" recommendation for HB 1478.

Thank you Chairman Lee and members of the committee. I will answer any questions that you may have.

#1

HB 1478
Senate Human Services
March 2, 2009

Chairman Lee and members of the Senate Human Services Committee. My name is Bob Hanson and I am an advocacy volunteer for AARP North Dakota. Today I represent over 88,000 North Dakota members.

I stand before you today to speak in favor of House Bill 1478.

In 2002, the Institute of Medicine reported that the uninsured not only receive too little care too late, and worse care than insured people, but also are sicker and die younger.

For nearly two decades, America has been looking for ways to reduce the number of uninsured. We have HIPAA (Health Insurance Portability and Accountability Act), tax deductions, grants to start state-funded high risk pools...and the most effective reform in that regard has been the Children's Health Insurance Program.

Failure to address children's health needs creates a legacy of increasing health care costs for all of us. A defining objective of health care policy must be to create more secure and effective access to health care for everyone. Let's begin by pursuing health care for every child in North Dakota.

We are aware of the House action which moved the net income eligibility in this legislation from 200% of poverty to 160%. We urge the committee to reconsider that benchmark, and move the eligibility back to 200% of poverty, as it was in the executive budget.

AARP supports continuing efforts to increase eligibility to the State Children's Health Insurance Program. We urge your favorable action on HB 1478.

#2

NDLA, S HMS

From: Lee, Judy E.
Sent: Monday, March 02, 2009 1:42 PM
To: NDLA, S HMS
Subject: FW: House Bill 1478

Mary – Please make copies for each of us.

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: josh.askvig@ndea.org [mailto:josh.askvig@ndea.org]
Sent: Sunday, March 01, 2009 8:54 PM
To: Lee, Judy E.; Erbele, Robert S.; Dever, Dick D.; Heckaman, Joan M.; Marcellais, Richard; Pomeroy, Jim R.
Cc: fern.pokorny@ndea.org; greg.burns@ndea.org; leann.nelson@ndea.org; dakota.draper@ndea.org
Subject: House Bill 1478

Chairwoman Lee and members of the Senate Human Services Committee,

On behalf of the North Dakota Education Association, I am emailing you all in support of HB1478. We will try to get someone at the hearing tomorrow morning but in case we cannot we wanted to go on record in support of HB1478. The NDEA supports this legislation because we have started an initiative called "Ready Child." The mission of Ready Child is to help every North Dakota child be ready for learning and ready for life. You can find more about the Ready Child Initiative here (http://www.readychild.org/). Research and experience has shown that children who are healthy and without medical, dental, or vision difficulties are more likely to succeed in school. One of the most important factors in ensuring children are healthy is access to medical services when needed. Parents that have health insurance for their children are much more likely to get their child medical services more often. Children who get their sickness and illnesses taken care of will allow them to be "ready to learn and ready for life."

As you may know, when the Governor originally put forward his budget, he increased the eligibility level from the current rate of 150% of poverty up to 200%. The House of Representatives amended this bill to move the rate from 150% only to 160%. We certainly support any improvement but believe that the Governor's proposal was correct and would ask you to restore the bill to allow up to 200% of the poverty level.

Again, thank you for your time and we appreciate your consideration. We will be around the capitol if you have any questions in regards to our position. Please restore the Governor's proposal and then give this bill a Do Pass Recommendation.

Josh

Josh Askvig
Northwest UniServ Director
North Dakota Education Association
410 East Thayer Ave

Bismarck, ND 58501
josh.askvig@ndea.org
Phone: 701-223-0450 or 1-800-369-6332
Fax: 701-224-8535

NDLA, S HMS

From: Lee, Judy E.
Sent: Monday, March 02, 2009 1:29 PM
To: NDLA, S HMS
Subject: FW: HB1478

Importance: High

Mary –
Would you please make a copy of this testimony for each of us?

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: Donene Feist [mailto:feist@drtel.net]
Sent: Monday, March 02, 2009 9:06 AM
To: Lee, Judy E.; Erbele, Robert S.; Dever, Dick D.; Heckaman, Joan M.; Marcellais, Richard; Pomeroy, Jim R.
Subject: HB1478
Importance: High

Senators,
I'm writing to you today to ask you to consider raising the eligibility for the SCHIP program above the 160% level as passed in the House. Please consider the 200% that was approved by the Governor.

As you know I advocate for services for children with special health care needs. There are 14,000 children in ND who have no insurance. Over 1000 of those families are children with special health care needs.

I realize that last session we passed the Medicaid Buy In. However, I want to point out a couple of issues with that for children with special health care needs.

1) In order to buy into Medicaid the child must be SSI medically eligible. Not all children will be SSI medically eligible. There could be a couple reasons for this. SSI you must have at least 3 of 5 criteria that the child is delayed. For children who have a chronic health condition such as heart defects, kidney disorders, health conditions that will last longer than a year but none the less are chronic may not meet the SSI eligibility. These families concern me as their medical bills are through the roof, may not have the means to sustain them, may not qualify under the family health plan, or any comprehensive coverage due to the pre existing condition etc.
SCHIP is critical for these families.

2) While I understand we are using net income. We must not forget it doesn't take long and the disregards will no longer apply. Example: child care credits, etc. Once a child is school age and beyond many of these credits that assist younger families DO NOT help families of school age children. While they are in the 0-3 age, there are other programs that may assist them. Beyond that is where we see the problems begin.

3) While I know that Congress passed SCHIP at 300% of the FPL, I understand why you would not want to go that high. But I don't want you to think we completely fixed the problem for children with special health care needs with the Waiver and Buy In. It was a nice start but not the end all. At 200% of the FPL, even a family at this level adds many constraints. If the family were to pay for family coverage that is $1000 off the top of their income immediately. Many

families cannot afford this. Even higher if a child has a pre existing condition. Or they insurance may not take them at all. Insurance companies are leaving more and more of our families in the dark.

[redacted] data also shows that ND families have one of the highest out of pocket expenses occurred in the country. For a family [redacted]o has a child with a chronic condition this is a travesty.

A family contacted us just last week with a child with leukemia. They were over the eligibility criteria, and in essence in 24 months they were in debt $60,000....
This family had some medical insurance but it did not cover many of her needed services. Now they have also had to change jobs in which the family will not be able to insure the daughter as this is now considered preexisting. COBRA or any other coverage will be beyond their reach. They have now also had 12 shut off and disconnect notices, 2 eviction notices and are now getting food at the food pantries where they live. This family lives in Grand Forks. At 160% they would not qualify, at 200% they could.

Please let us be mindful of these families who have children with chronic health conditions. We cannot leave them in the dark. Each and every day we receive calls with another story similar to the above. My biggest heart ache is when I have to tell them there is nothing for them out there. We can do better.

Thank you
Donene Feist
PO Box 163
Edgeley, ND 58433
701-493-2333

3.4.09 Maggie Anderson #13

North Dakota Department of Human Services

Healthy Steps Mental Health Benefits

Requested by Senate Human Services – Regarding HB1478

March 2009

- Inpatient services are covered at 100% of allowed charge, after payment of the $50 copayment amount per admission. Maximum benefit allowance of 45 days per member per benefit period, (Preauthorization is required).
- Partial hospitalization services are covered at 100% of allowed charge subject to an aggregate maximum benefit allowance of 120 days per benefit period, (Preauthorization is required).
- Psychiatric Residential Treatment Services are covered at 100% of allowed charge, after payment of the $50 copayment amount per admission. Subject to a maximum benefit allowance of 120 days per benefit period, (Preauthorization is required).
- Outpatient Psychiatric services are covered at 100% of allowed charge for up to 30 hours per benefit period.

Benefit Period

A claim for benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a calendar year (January 1 through December 31) Benefit Period.

north dakota
department of
human services

Medical Services
(701) 328-2321
Toll Free 1-800-755-2604
Fax (701) 328-1544
ND Relay TTY 1-800-366-6888
Provider Relations (701) 328-4030

John Hoeven, Governor
Carol K. Olson, Executive Director

March 4, 2009

To: Senator Judy Lee and Senate Human Services Committee

From: Maggie Anderson, Medical Services Division

RE: Effective Dates for HB 1477 and HB 1478

During the final preparations for our testimony in front of Senate Appropriations, we became aware that House Bill 1477 (Funeral Set Aside) and House Bill 1478 (SCHIP) do not contain effective date clauses; therefore, these bills would become effective August 1, 2009, rather than July 1, 2009.

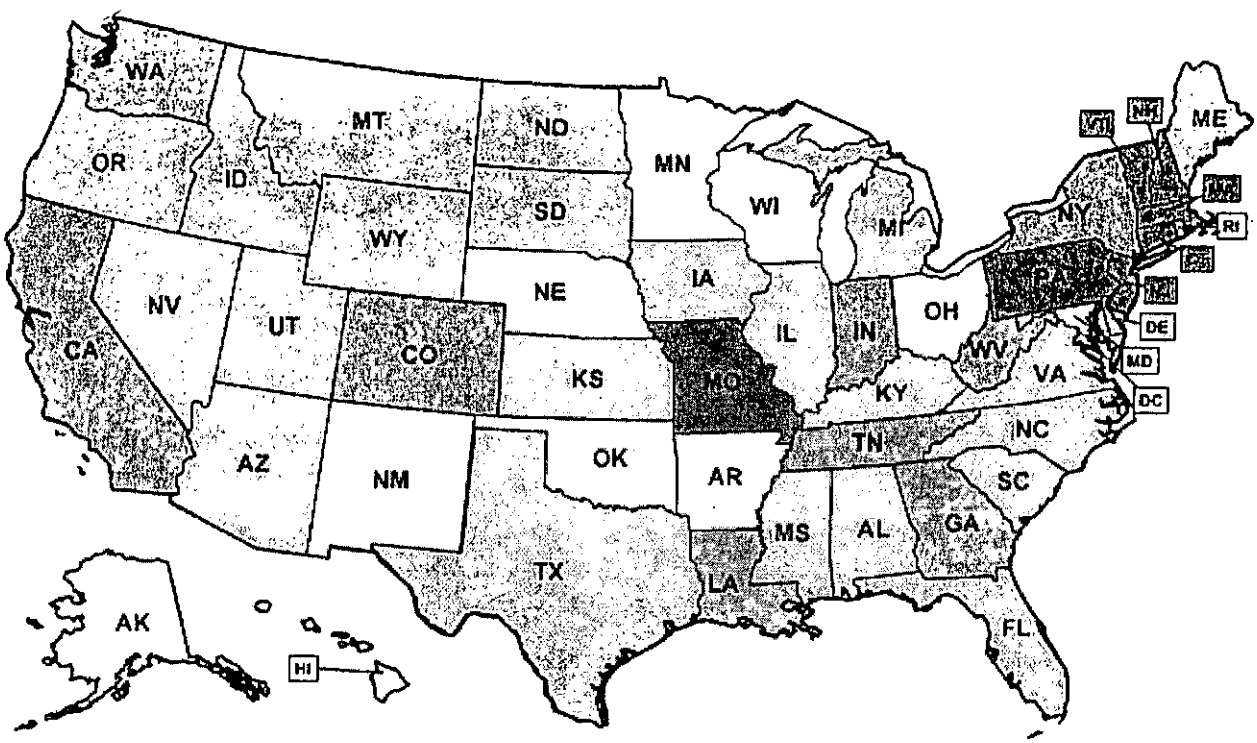
We wanted to draw this to your attention in case you wanted to add an amendment to approve the effective date of July 1, 2009.

Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009

Bar Graph | Table | Map | Map & Table

Rank by: State name (alphabetical) View by: % | $

Rank Order: Δ▼



☐ 150% - 200% ▨ 205% - 250%

▩ 300% - 350%

	Income Eligibility --Separate SCHIP Prog
United States	NA [1]
Alabama	200%
Alaska	NA
Arizona	200%
Arkansas	NA
California	250%
Colorado	205%
Connecticut	300%
Delaware	200%
District of Columbia	NA
Florida	200% [2]

Georgia	235%
Hawaii	NA
Idaho	185%
Illinois	200% [3]
Indiana	250%
[redacted]	200%
[redacted]nsas	200%
Kentucky	200%
Louisiana	250% [4]
Maine	200%
Maryland	NA
Massachusetts	300% [3]
Michigan	200%
Minnesota	NA
Mississippi	200%
Missouri	300%
Montana	175%
Nebraska	NA
Nevada	200%
New Hampshire	300%
New Jersey	350%
New Mexico	NA
New York	250% [3]
North Carolina	200%
North Dakota	150%
[redacted]	NA
[redacted]homa	NA
Oregon	185%
Pennsylvania	300%
Rhode Island	NA
South Carolina	200% [5]
South Dakota	200%
Tennessee	250% [6]
Texas	200%
Utah	200%
Vermont	300% [7]
Virginia	200%
Washington	250%
West Virginia	220%
Wisconsin	NA [8]
Wyoming	200%

Notes: Data as of January 2009.

The income eligibility levels noted may refer to gross or net income depending on the state. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

[redacted]

Eligibility levels shown as percent of the FPL. Currency figures based on FPL for a family of three in 2008: $17,600 for 48 contiguous states and District of Columbia, $22,000 for Alaska, $20,240 for Hawaii.

Sources: Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009. Data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, January 2009. Available at http://www.kff.org/medicaid/7855.cfm.

Definitions: **SCHIP**: State Children"s Health Insurance Program.
The Federal Poverty Level (FPL) was established to help government agencies determine eligibility levels for public assistance programs such as Medicaid. FPL is represented in this resource as poverty guidelines as opposed to the slightly different poverty thresholds.
NA: Not applicable because state does not have separate SCHIP program.

Notes:

1. Not applicable because there are no national eligibility levels.

2. Florida operates two SCHIP-funded separate programs. Healthy Kids covers children ages five through nineteen, as well as younger siblings in some locations. Medi-Kids covers children ages one through four.

3. Illinois, Massachusetts, and New York provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is unlimited in Illinois and is 400% in Massachusetts and New York.

4. Louisiana created a separate SCHIP program in 2008.

5. South Carolina implemented a separate SCHIP program for children with income between 150 and 200 percent of the federal poverty line in April 2008.

6. In 2007 the state created a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line. Children not eligible for regular Medicaid and children closed out of TennCare Standard who meet the SCHIP income guidelines can enroll in the separate SCHIP program.

7. In Vermont, Medicaid covers uninsured children in families with income at or below 225 percent of the federal poverty line; uninsured children in families with income between 226 and 300 percent of the federal poverty line are covered under a separate SCHIP program. Underinsured children are covered under Medicaid up to 300 percent of the federal poverty line. This expansion of coverage for underinsured children was achieved through an amendment to the states Medicaid Section 1115 waiver.

8. Wisconsin implemented BadgerCare Plus in February 2008. Badgercare Plus has no income limit for children. The state will receive Medicaid reimbursement for children up to 250 percent of the federal poverty line and children with incomes between 251 percent and 300 percent of the federal poverty line are covered with state funds.

2008/2009 HHS Poverty Guidelines

For all states (except Alaska and Hawaii) and for the District of Columbia

Size of family unit	100 Percent of Poverty	150 Percent of Poverty	160 Percent of Poverty
1	$10,400	$15,600	$16,640
2	$14,000	$21,000	$22,400
3	$17,600	$26,400	$28,160
4	$21,200	$31,800	$33,920
5	$24,800	$37,200	$39,680
6	$28,400	$42,600	$45,440
7	$32,000	$48,000	$51,200
8	$35,600	$53,400	$56,960

For family units with more than 8 members, add $5,760 for each additional person at 160 percent of poverty.

Note: For optional use in FFY 2008 and mandatory use in FFY 2009

Page Last Updated: June 4, 2008

north dakota
department of
human services

ND Department of Human Services
Medical Services Division
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250
(701) 328-2321 • Fax (701) 328-1544
800-755-2604

#15

TO: Senator Lee (Judy Lee)

FROM: Maggie D. Anderson, Director, Division of Medical Services

DATE: 3-12-09

SUBJECT: Free and Reduced-Price Meal Application

Here is the current application.

Maggie

APPLICATION FOR FREE AND REDUCED-PRICE MEALS

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
CHILD NUTRITION AND FOOD DISTRIBUTION PROGRAMS
(Rev. 6/04) G/Tools/SNP/Application for Free and Reduced-Price Meals

1. **Households** not receiving Food Stamps, TANF, or Commodity assistance, complete **only section 1**, sign below and return.
2. **Food Stamp Households, TANF, or Commodity Recipients:** If this application is for a child(ren) receiving any of these benefits, complete **only section 2**, sign below and return.
3. **Foster Child:** If this application is for a foster child, complete **only section 3**, sign below and return.

1. **Households:** (a) List the names of EVERYONE living in your household. If you need more space, attach a separate sheet of paper. (b) List all income on the same line with the person who received it. Record income under the correct pay period category. See the back of this application for additional assistance with income. (c) Print the Social Security Number of the household member who signs the form. If this household member does not have a Social Security Number, write "none". If all children receive Food Stamps, TANF or Commodity Assistance, DO NOT complete section 1.

HOUSEHOLD MEMBERS: List the names of all household members	SCHOOL (if applicable)	Grade	Earnings from work before deductions. Enter **gross** income under the appropriate pay period. Record each income only **once**.				Other Income		
			Weekly	Every Two Weeks	Twice a Month	Monthly	Farm/Self Employment **(Annual)** (see back)	Child Support/ Spousal Support (indicate how often)	All Other Income (interest, unemploy., Soc. Security) (indicate how often)
1.									
2.									
3.									
4.									
5.									
6.									

Name of the Household Member who Signs this Form: | Social Security Number:

2. **Food Stamp Households, TANF, or Commodity Recipients:** If you are NOW receiving Food Stamps or TANF for your child(ren), enter the Food Stamp or TANF case number(s) in the space provided at the left. If you are now receiving Commodity assistance through the Food Distribution Program on Indian Reservations (FDPIR) for your child(ren), indicate "yes" in the space beside the notation. "FDPIR Commodity Assistance." Sign the application and return it to the school. If there is any child for whom you do not receive Food Stamps, TANF, or Commodity assistance, complete Section 1 for that child. If you receive a Meal Benefit Notice from the Department of Public Instruction, you may sign that notice and submit it to the school instead of this application.

Case Number	Child's Name	School	Grade	Child's Name	School	Grade
TANF #						
F.S. #						
FDPIR Commodity Assistance						

3. **Foster Child:** In certain cases a foster child is eligible for free or reduced-price meals regardless of your household income. If you have a foster child living with you who meets the definition of a foster child as defined on the back of this application, complete this section only, sign the application and return it to the school office. **You must complete a separate application for each foster child.**

Foster Child's Name	School	Grade	**MONTHLY INCOME**: (monies received for child's personal use only, even if $.00)
			$

OTHER BENEFITS: If your children are not currently covered by health insurance, they may be eligible for one of the children's health insurance programs. Call 1-877-KIDS NOW (1-877-543-7669) for information and application assistance.

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that school officials may verify the information on the application, and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of Adult Household Member	Date	Home Phone	Work Phone

Print Name (last, first)	Street Address	City	State	Zip

3/18/09

Foster Children

DEFINITION — A foster child is a child who is living with a household, but who remains the legal responsibility of the welfare agency or court. Such a child is considered a household of one.

INCOME FOR FOSTER CHILDREN — In determining income for the foster child, only the following should be considered.

1. Funds provided by the welfare agency that are specifically identified by category for personal use of the child, such as for clothing, school fees, and allowances. Welfare funds identified by category for shelter and care, and those identified as special needs funds, such as those for medical and therapeutic needs are not considered as income. Where welfare funds cannot be identified by category, no portion of the provided funds is considered as income.

2. Other funds received by the child. This includes but is not limited to, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time jobs.

Privacy Act Statement: This explains how we will use the information you give us.

The National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your children for free or reduced price meals. The Social Security Number of the adult household member who signs the application is required unless you list Food Stamp or TANF case numbers or indicate that you are receiving FDPIR commodity assistance for all children you are applying for, OR if you are applying for a foster child. If the adult household member signing the application does not have a Social Security Number, write the word "none" on the line. We WILL use your information to see if your children are eligible for free or reduced price meals, to run the program, and to enforce the rules of the program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into misuse of program rules.

FOR SCHOOL USE ONLY

Date Received	Date of Approval & Notification to Family

Determination:
☐ Approved Free ☐ Reduced-Price ☐ Denied

Reason For Denial:

Signature of Determining Official

Calculating Income

To determine yearly income:
If paid every week, multiply the weekly gross income by 52.
If paid every two weeks, multiply the gross income by 26.
If paid twice a month, multiply the gross income by 24.
If paid once a month, multiply the gross income by 12.

Calculating Farm or Self-Employment Income

Persons engaging in farming or who operate other types of private business where cash flow varies throughout the year, making it impossible to predict income with any accuracy, may use their income tax records for the preceding calendar year and adjust for the current year. Any adjustments made for the current year must be substantiated with documents for verification purposes. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income.

ALSO, IF YOU HAVE ADDITIONAL INCOME FROM OTHER SOURCES, THIS INCOME MUST BE TREATED AS SEPARATE AND APART FROM THE INCOME GENERATED FROM YOUR BUSINESS OR FARM VENTURE.

The information for arriving at allowable income from a private business operation may be taken from the Income Tax Return – 1040 form.

*FARMING INCOME: Add together the amounts reported on the following lines of your 1040 Form, if the amounts relate to farm income.
Line 13 $_____ (capital gain or loss)
Line 14 $_____ (other gains or losses)
Line 17 $_____ (rent, royalties, etc.)
Line 18 $_____ (farm income or loss) Total $_____

(Transfer this total to the front of the application under Farm/Self Employment Income. If the total is negative, it must be transferred to the front of this application as $0. A NEGATIVE CANNOT BE USED TO OFFSET ANY OTHER INCOME)

*SELF-EMPLOYED OR BUSINESS INCOME: Add together the amounts reported on the following lines of your 1040 Form, if related to business income.
Line 12 $_____ (business income or loss)
Line 13 $_____ (capital gain or loss)
Line 14 $_____ (other gains or losses.)
Line 17 $_____ (rent, royalties, etc.) Total $_____

(Transfer this total to the front of the application under Farm/Self Employment Income. If the total is negative, it must be transferred to the front of this application as $0). A NEGATIVE CANNOT BE USED TO OFFSET ANY OTHER INCOME.

NOTE: THIS IS FOR THE CALCULATION OF FARM AND BUSINESS INCOME ONLY. ALL OTHER INCOME RECEIVED BY THE FAMILY MUST BE LISTED ON THE FRONT OF THIS FORM.

Date of Verification	Did Verification Change the Determination? ☐ Yes ☐ No

If yes, explain:

3/11/09

Department of Human Services
S-CHIP Scenarios
Reprojections and Updated BCBS Premiums

S-CHIP Budget @ 160% Compared to Reprojection @ 200%
It is estimated 200% will add 1,158 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 200% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload & Cost
Monthly Average Caseload	5,567	4,395	(1,172)
Ending Caseload	5,907	5,000	(907)
General	8,431,055	6,243,672	(2,187,383)
Federal	24,143,800	17,879,974	(6,263,826)
Total	32,574,855	24,123,646	(8,451,209)

S-CHIP Budget @ 160% Compared to Reprojection @ 160%
It is estimated 160% will add 439 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 160% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	3,941	(1,626)
Ending Caseload	5,907	4,281	(1,626)
General	8,431,055	5,598,799	(2,832,256)
Federal	24,143,800	16,033,737	(8,110,063)
Total	32,574,855	21,632,536	(10,942,319)

S-CHIP Budget @ 160% Compared to Reprojection @ 175%
It is estimated 175% will add 829 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 175% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,191	(1,376)
Ending Caseload	5,907	4,671	(1,236)
General	8,431,055	5,954,214	(2,476,841)
Federal	24,143,800	17,051,266	(7,092,534)
Total	32,574,855	23,005,480	(9,569,375)

S-CHIP Budget @ 160% Compared to Reprojection @ 185%
It is estimated 185% will add 980 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 185% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,279	(1,288)
Ending Caseload	5,907	4,822	(1,085)
General	8,431,055	6,079,139	(2,351,916)
Federal	24,143,800	17,408,925	(6,734,875)
Total	32,574,855	23,488,064	(9,086,791)

Note:
The Executive Budget was based upon a preliminary premium from BCBS of $243.93.
The Department has just received the final 09-11 premium of $228.71 from BCBS.

north dakota department of human services

Application For Health Care Coverage

for Children, Families, and Pregnant Women

State of North Dakota, Department of Human Services

Questions and Answers

What programs am I applying for?

By sending in this application, we will determine if family members are eligible for health care coverage from either the Medicaid or Healthy Steps (State Children's Health Insurance Program). If someone does not meet our eligibility guidelines, with your permission we will forward information from this application to the Caring for Children Program as they may help provide assistance with health care coverage for the children.

What health care services are covered?

Covered services include doctor visits, inpatient and outpatient hospitalizations, mental health and substance abuse services, prescribed medicines, dental and vision services, routine preventive services such as check-ups and immunizations, medical equipment, family planning, chiropractic services, and other services. Limits may apply.

How can I tell who is eligible?

Because eligibility is based on a number of different things, you will have to apply to know for sure who is eligible. Items used in determining if someone is eligible include: the number people in your family, age of family members, residency, monthly income and expenses. (You must be a North Dakota resident to be eligible.)

Can I use this application to apply for other programs?

No, this application is only for health care coverage. If you want to apply for health care coverage and other programs such as Food Stamps, Temporary Assistance for Needy Families (TANF), or Child Care Assistance, this application should not be used. Contact your local county social service office for the proper application.

Other Information

- If more than one family lives in your home, please fill out a separate application for each family seeking health care coverage.
- The application can be mailed and does not require a face-to-face interview. You may be contacted to clarify information.
- Your application will be reviewed as soon as possible. You should receive a decision in 45 days or less.
- If someone is eligible, a letter will be sent to you that explains when health care coverage begins.

Contact Information

For questions, please contact your local county social service office or the North Dakota Department of Human Services in Bismarck, ND at:

(Toll-Free) 1-877-KIDS NOW (1-877-543-7669) or (TTY) 1-701-328-3480

Or visit our website: www.state.nd.gov/humanservices/services/medicalserv/

6/11/09

Checklist Of Needed Information

- ☐ I have completed the application. (If you need additional space, attach a separate sheet of paper.)
- ☐ **US Citizens** - I have provided proof of US citizenship status for each individual who is requesting assistance. Examples: US Passport or a certified embossed birth certificate.
- ☐ **Non US Citizens** - I have provided proof of citizenship status for each individual who is requesting assistance. Examples: Resident Alien Card (Form I-551); Employment Authorization Card (Form I-688A); Temporary Resident Card (Form I-688); or Arrival-Departure Record (Form I-94).
- ☐ I have provided proof of identity for each individual who is requesting assistance. Examples: Driver's License, Picture ID Card issued by the federal, state, or local government; US Military ID Card, Military dependent's ID card, school picture ID, or for children under age 16, a signed affidavit which you can get from your local social services office.
- ☐ I have included a copy of the most recent federal income tax return if someone in the household is self-employed. If the business is new, copies of my income and expense ledgers are attached. (If someone is self-employed, you may want to send in copies of the last three years federal income tax returns as we may use an average of the last three years of self-employment income if you do not qualify for coverage using the most recent income tax return.) (Page 2, Section 6)
- ☐ I have included copies of last month's and this month's pay stubs for each household member who has a job. (Page 3, Section 7)
- ☐ I have included proof of amounts received for child support, spousal support, social security benefits, unemployment compensation benefits, Individual Indian Monies, rental income, money from friends/relatives, workers' compensation, or veteran's benefits. (Page 3, Section 8)
- ☐ I have included proof of amounts paid for court-ordered child support, spousal support or medical support. (Page 3, Section 9)
- ☐ I have included proof of amounts paid for child care. (Page 3, Section 10)
- ☐ I have included proof of amount paid for health insurance premiums.
- ☐ I have included proof of income and child care expenses for each of the last 3 months for which I would like assistance with medical bills. (Page 4, Section 13)
- ☐ I have read the "Rights and Responsibilities" section and signed the application. (Page 6, Section 18)

Include the required verifications with this form and Fax, mail or deliver them to the address below.

ND Department of Human Services
600 East Boulevard Ave Dept. 325
Bismarck, ND 58505-0250
FAX: (701) 328-2085

or to

County Address:

Insuring North Dakota's Children And Our Future

north dakota
department of human services

APPLICATION FOR HEALTH CARE CO[redacted]AGE FOR CHILDREN, FAMILIES, AND PREG[redacted]NT WOMEN

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 502 (5-2008)

AGENC[redacted]ONLY
Date Received:
Case Number:

1 Tell Us About You - This person is the person filling out this form.

First Name	Middle Initial	Last Name	Home Telephone Number	Work/Cell or Message Telephone Number

Address Where You Live	Mailing Address (If Different)

City	State	Zip Code	County	City	State	Zip Code

2 Tell Us About The People In Your Home - List yourself first, then your spouse, your children (including unborn children), other adults and children living in your home.

* You do not need to provide the social security numbers or citizenship status for people age 21 or older who do not want coverage or for children under age 21 who you do not want to include in the family size when determining eligibility.
** Disclosure of Race and Ethnicity information is voluntary and will not effect eligibility.

Marital Status: MA - Married, NM - Never Married, DI - Divorced, SE - Separated, WI - Widowed

Race / Ethnicity (**Optional) Check all that apply: AI - American Indian/Alaska Native, P - Native Hawaiian/Pacific Islander, B - Black/African American, W - White/Caucasian, A - Asian

Household Members (Enter Legal Name) First / Middle Initial / Last	Relationship to Person Completing Application	Social Security Number *	Date Of Birth	Sex (Male or Female)	Marital Status	Race	Hispanic Or Latino	US CITIZEN
	SELF			☐M ☐F	☐MA ☐DI ☐WI ☐NM ☐SE	☐AI ☐B ☐A ☐P ☐W	☐Y ☐N	☐Y ☐N
				☐M ☐F	☐MA ☐DI ☐WI ☐NM ☐SE	☐AI ☐B ☐A ☐P ☐W	☐Y ☐N	☐Y ☐N
				☐M ☐F	☐MA ☐DI ☐WI ☐NM ☐SE	☐AI ☐B ☐A ☐P ☐W	☐Y ☐N	☐Y ☐N
				☐M ☐F	☐MA ☐DI ☐WI ☐NM ☐SE	☐AI ☐B ☐A ☐P ☐W	☐Y ☐N	☐Y ☐N
				☐M ☐F	☐MA ☐DI ☐WI ☐NM ☐SE	☐AI ☐B ☐A ☐P ☐W	☐Y ☐N	☐Y ☐N
				☐M ☐F	☐MA ☐DI ☐WI ☐NM ☐SE	☐AI ☐B ☐A ☐P ☐W	☐Y ☐N	☐Y ☐N
				☐M ☐F	☐MA ☐DI ☐WI ☐NM ☐SE	☐AI ☐B ☐A ☐P ☐W	☐Y ☐N	☐Y ☐N

List anyone named above who is disabled (including children)	List any children named above whose father's name is not listed on the birth certificate.
I / We have lived in North Dakota since: (Month, Year)	Do you intend to remain in North Dakota? ☐Yes ☐No

Is anyone temporarily out of the home? ☐Yes ☐No If yes, please provide the information requested below for each person who is temporarily out of the home:

Name (First, Middle Initial, Last)	Why is this person absent?	When do you expect this person to return?

3 Tell Us If Anyone Living In The Home Is Pregnant - List anyone in the household who is pregnant.

Pregnant Mother's Name (First and Last)	How Many Babies Are Due?	Expected Due Date	Father's Name (First and Last)

How Was Pregnancy Determined? ☐ Physician ☐ Home Pregnancy Test ☐ Public Health Agency ☐ Other (Specify): ____________________

4 Tell Us About Students In Your Home - List any household member age 14 or older who is a student or planning to attend school.

Student Name	Where Attending School	Last Grade Completed	Student Status	Start Date
			☐ Full Time ☐ Part Time	
			☐ Full Time ☐ Part Time	
			☐ Full Time ☐ Part Time	

5 Tell Us About Parents Who Are Not Living In The Home - List any parents who are not living in the home, otherwise go to Section 6.

List individuals under age 21 whose parent(s) do not live in the home:

Reason Parent(s) Are Not Living In The Home:
AN - Annulled; AB - Abandoned; AS - Attending School; DE - Deceased; DI - Divorced; JP - Jail/Imprisonment; LW - Looking for Work; MC - Medical Care; MS - Military Service; NM - Never Married; PR - Parental Right Terminated; SE - Separated; WO - Working Out of Town/State

Name of Children Whose Parent(s) Do Not Live in the Home	Name Of Parent(s) Not Living In The Home	Complete to the best of your ability: Parent's Birth Date	Parent's Social Security Number	Reason Parent(s) Are Not Living In The Home
	Mother			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Father			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Mother			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Father			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Mother			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Father			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE

6 Tell Us About Any Household Members That Are Self-Employed - Complete this section if someone is self employed. Attach a copy of the most recent Federal Income Tax return. If the business is new, send copies of income and expense ledgers. (You may want to send in copies of the last three year's federal income tax returns as we may be able to use an average of the last three years if you do not qualify for coverage using the most recent income tax return).

Name Of Business	Type Of Business	Date Business Started (Month & Year)	Name Of Household Member(s) Who Owns The Business

7 Tell Us [redacted]t Any Household Members That Are Working - List information [redacted]out full-time, part-time, seasonal, or temporary employment of all adults and children. If space is needed to list more jobs, use a separate sheet of paper. (Attach a copy of last month's and this month's pay stubs.)

First and Last Name Of Person Working Or Receiving Income	Employer	Date Paid	Amount Before Taxes This Month	How Often Paid?	Amount Of Tips, Or Other Compensation	Do You Expect Income To Change Next Month
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No

If both parents live in the home, list the parent who had the most income from self-employment or employment in the past 24 months.

If you indicated you expect income to change next month, please explain:

Has any household member received commissions, bonuses, or incentives other than those included above within the last year? ☐ Yes ☐ No If Yes, answer below:

Name of Household Member	Date Received	Amount

8 Tell Us About All Unearned Income Received By Household Members - Unearned income is any money not received from a job. (Example: child support, spousal support, social security, unemployment compensation, Individual Indian Monies, rental income, money from friends/relatives, workers' compensation, veterans benefits). Send in proof of all unearned income.

Type Of Income	Who Receives The Income	How Often Is The Income Received	Amount This Month	Amount Expected Next Month

9 Tell Us About Court-Ordered Support Payments Made - Complete this section if any household member pays child support, provides health insurance, or makes any other support payments resulting from a court order. This information may help household members become eligible. Attach proof of amounts paid.

Household Member Making Support Payments	Type Of Support	Court Ordered Amount	Amount Paid

10 Tell Us About Child Care Payments Made - Complete this section if someone in the home pays child care so they can work or go to school. Do not include amounts paid by Child Care Assistance Programs. This information may help household members become eligible. Attach proof of amounts paid.

Names Of Children Being Cared For	Name Of Person Paying Expenses	Amount Paid This Month	Amount You Expect To Pay Next Month

11 Tell Us About Any Health Insurance Coverage - Tell us if any household members currently have health insurance (Indian Health Services is not considered health insurance) Attach Proof of amounts paid.

Policy Holder's Name And Address	Person(s) Covered	Effective Date	Health Insurance Name And Address	Monthly Premium (Send Proof)	Group Number	Policy Number	Coverage Type
							☐ Hospital ☐ Champus/Tri Care ☐ HMO Insur ☐ Doctor ☐ Medicare Supplement/Advantage ☐ Court Orde ☐ Dental ☐ Prescription Medication ☐ Medicare Part A ☐ Vision ☐ Veterans ☐ Medicare Part B ☐ Nursing Home ☐ Accident/Workers Comp ☐ Medicare Part D ☐ Cancer ☐ Major Medical/Lab/X-ray
							☐ Hospital ☐ Champus/Tri Care ☐ HMO Insurance ☐ Doctor ☐ Medicare Supplement/Advantage ☐ Court Ordered ☐ Dental ☐ Prescription Medication ☐ Medicare Part A ☐ Vision ☐ Veterans ☐ Medicare Part B ☐ Nursing Home ☐ Accident/Workers Comp ☐ Medicare Part D ☐ Cancer ☐ Major Medical/Lab/X-ray

Does anyone outside the household pay the premium? ☐ Yes ☐ No If yes, who pays premium?

Does anyone expect a change in health insurance coverage? ☐ Yes ☐ No If yes, why?

Did anyone in your household have health insurance cancelled or stopped within the last six months? ☐ Yes ☐ No If yes, who: Date: Reason:

Does any household member's employer offer health insurance? ☐ Yes ☐ No If yes, does the employer pay 50% or more of the premium? ☐ Yes ☐ No If yes, name of insurance:

12 Tell Us About Your Primary Care Provider (PCP) - List the Primary Care Provider (doctor, clinic or HMO) for each person in the household. (Not needed for refugees, disabled persons, or anyone age 65 or older)

If someone is determined eligible for health care coverage through the Medicaid program, he or she will have to choose a Primary Care Provider before benefits will be paid to the doctor, clinic, or HMO.

Household Member(s)	Name Of Provider	Household Member(s)	Name Of Provider

13 Tell Us [redacted]ut Your Medical Bills

Does any household member have unpaid medical bills for any of the past 3 months for which you would like assistance? ☐ Yes ☐ No If yes, which months: _____
(If you would like assistance with these bills, you must attach proof of income and child care expenses for each month with unpaid medical bills.)

Does any household member have unpaid medical bills older than three months? ☐ Yes ☐ No If yes, provide proof of unpaid amounts owed, the date of service, the type of service, and the provider of the service. Providing this information may help reduce the amount you have to pay out of your pocket for future medical bills.

Has any household member turned down or dropped medical coverage from a current employer because of the cost? ☐ Yes ☐ No Medicaid may be able to help pay the cost of this insurance.

Does any household member have medical problems due to an accident? ☐ Yes ☐ No

Has anyone living in your household received help with health care coverage from another state during the past three months? ☐ Yes ☐ No If yes, which state?

Tell Us About Your Household Assets - Answering this question may help North Dakota get additional funding for health care programs. (Your answer will not affect eligibility or amount of benefits you may receive.)

Are your household assets (do not count one vehicle, your home, clothing, household goods, or property used as part of a business) higher than $6,000? ($3,000 if you are the only person in your household) ☐ Yes ☐ No

15 Other Services

CARING FOR CHILDREN PROGRAM

If children listed on this application are not eligible for health care coverage through either the Medicaid or Healthy Steps program, they may be eligible for the Caring for Children program. This program is offered by a private nonprofit organization called the North Dakota Caring Foundation.

If you have children who are not eligible for health care coverage through either the Medicaid or Healthy Steps program, information from this application may be forwarded to the Caring for Children program so they can determine if your children are eligible for their program. If you **DO NOT** want us to forward information to the Caring for Children program, please check the box below.

☐ Check this box if you **DO NOT** want us to forward information to the Caring for Children program.

Please note that the North Dakota Department of Human Services and county social service offices do not determine eligibility for the Caring for Children program and any appeal of their decision regarding program must be made to the North Dakota Caring Foundation.

MEDICAL COVERAGE

The Child Support Enforcement Division (CSED) may help children get medical coverage from parents who do not live in the home and who are or can be court ordered to provide medical coverage. If a child is eligible for Medicaid and a parent is absent from the home, a referral to CSED may be made. A referral will not be made for children who are eligible for the Healthy Steps (State Children's Health Insurance Program). If you have a child eligible for the Healthy Steps (State Children's Health Insurance Program) and would like assistance from the CSED, please contact them at 1-800-231-4255.

If you are interested in Medicaid coverage for yourself or your children and do not want assistance from CSED because your cooperation might not be in the best interest of your child (example: domestic violence situation), you may claim "good cause." If you claim "good cause," you will be asked to provide additional information so "good cause" can be established.

Are you interested in claiming "good cause"? ☐ Yes ☐ No Claiming "good cause" or failure to cooperate with CSED will not affect your child's eligibility.

If you choose not to cooperate with CSED efforts and you have not claimed 'good cause' or your claim of 'good cause' has been denied, you will not be eligible for Medicaid coverage. However, your children will continue to be eligible for Medicaid or Healthy Steps coverage, provided they meet all other program requirements.

16 Tell U[redacted] Or Where You Found Out About Health Care Coverage (C[redacted] One)

☐ Business/Service Club	☐ Faith-Based Organization	☐ Head Start	☐ WIC	☐ Public Health Agency	☐ Newspaper/Magazine/Newsletter	☐ Other
☐ Caring For Children Program	☐ Food Pantry	☐ Insurance Agent	☐ Medical Provider	☐ Radio	☐ Social Service Agency	
☐ Daycare	☐ Friend/Relative	☐ Internet	☐ Pharmacy	☐ Television	☐ Capitol in Bismarck	

17 Tell Us Where You Got This Application (Check One)

☐ 1-877-KIDS-NOW	☐ Daycare	☐ Friend/Relative	☐ Internet	☐ School	☐ WIC
☐ Caring For Children Program	☐ Faith-Based Organization	☐ Head Start	☐ Medical Provider	☐ Public Health Agency	☐ Capitol in Bismarck
☐ Community Resource Coordinator	☐ Food Pantry	☐ Insurance Agent	☐ Pharmacy	☐ Social Service Agency	☐ Other

18 Read The Following:

I certify that all the information I have provided on this application is true and correct to the best of my knowledge. I understand that if I give incorrect or false information or if I fail to report changes within 10 days, I may be required to repay any benefits I receive. I understand that state and federal laws provide for fine, imprisonment, or both for any person convicted of withholding or providing false information to obtain Medicaid or Healthy Steps benefits to which he or she is not entitled. I know that the information I have given may be reviewed and verified by the North Dakota Department of Human Services or county social services staff. If my case is reviewed, I understand that I must cooperate fully.

I understand that the information I have provided will be kept confidential and is only used to determine eligibility or provide services.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, political belief, or national origin.

I understand social security numbers may be used to check the identity of household members, to prevent duplicate participation, to monitor compliance with program regulations, for official examinations by Federal or State agencies, and to make mass changes. The social security number is also used to check information in our records against other Federal, State or local government computer matching systems which may affect eligibility and benefits, including but not limited to the IRS, SSA, and Department of Labor.

I understand that I may request a fair hearing if I disagree with any decision to deny, reduce or end Medicaid or Healthy Steps benefits. Hearings must be requested within 30 days of a decision.

I understand that when a person receives Medicaid, that person gives the state the right to payments from a third party for medical services received and must report within 10 days of receiving payment, any third party payments (example: accident settlement) received for medical care.

I understand that if a parent wants Medicaid coverage and is not pregnant or does not have "good cause," the parent must cooperate with child support enforcement when the other parent does not live in the home. Claiming "good cause" or failure to cooperate with Child Support Enforcement will not affect a child's eligibility.

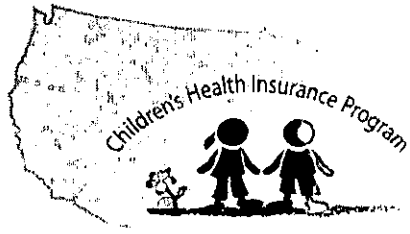
I understand that unless I have indicated otherwise by checking the box in Section 15 on page 5 of this application, information may be forwarded to the Caring for Children program so they can determine if any of the children listed on this application are eligible for their program.

AUTHORIZATION TO RELEASE INFORMATION

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I also authorize the North Dakota Department of Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits provided under the Healthy Steps (State Children's Health Insurance Program). This authorization will remain valid until revoked in writing or until coverage ends. A copy of this authorization is as valid as the original.

Signature of Applicant:	Date:

1478



CHIPRA 101: Overview of the CHIP Reauthorization Legislation

The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health coverage to low-income children in working families who make too much money to be eligible for Medicaid but not enough to afford private coverage. The program currently covers more than 7 million children. In February 2009, after a protracted political fight, Congress enacted, and President Obama signed, legislation that renewed CHIP through the end of 2013 and expanded its scope. This series of issue briefs examines the new provisions that were included in the reauthorization and how they will affect implementation in the coming months.

When CHIP was created, it represented a new federal commitment to ensuring that children in working families would have access to high-quality, affordable health coverage. CHIP enjoyed broad, bipartisan support, and it played an integral role in reducing the percentage of children who are uninsured by nearly a third, even as the percentage of adults who were uninsured increased markedly. The new legislation (H.R. 2; the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA) signals that the federal government intends to stand behind and build upon its commitment to improve access to health care for children in working families.

Eleven years of experience with CHIP have provided Congress with a wealth of information about how to improve upon an already successful program. As a result, the CHIPRA legislation includes significant changes to the existing CHIP program that are designed to increase participation among eligible uninsured children. In particular, the legislation provides states with additional funding, new tools and incentives to make it easier to enroll eligible children, and a better benefits package to ensure that children who are enrolled get access to the full range of health care services that they need.

The Basics

CHIP was originally authorized for 10 years, from 1997-2007. In order for the program to continue beyond its original authorization, federal action had to be taken before the end of September 2007. On two occasions in 2007, Congress passed legislation to reauthorize CHIP, but President Bush vetoed that legislation each time it was placed on his desk. In response, Congress passed stopgap legislation to continue the program for 18 months, extending it through the end of March 2009.

In early January 2009, the 111th Congress passed legislation (CHIPRA) that formally reauthorized the program. President Obama, who has been a longtime supporter of the program, signed CHIPRA into law on February 4, 2009, and it will take effect on April 1, 2009. This reauthorization lasts through the end of September 2013 (when CHIP will need to be reauthorized again). The Congressional Budget Office anticipates that CHIPRA will allow states to continue covering all of the children who are currently enrolled and to enroll an additional 4.1 million uninsured children in CHIP and Medicaid by the end of September 2013.[1]

The overall goal of CHIPRA is to induce states to enroll more uninsured children. To achieve that end, it not only increases the amount of money that is available to states for children's health coverage, it also makes significant changes to how money flows through CHIP. These changes reward states for enrolling more children and for making it easier for families to learn about CHIP and Medicaid, to enroll in these programs, and to keep their coverage for as long as they are eligible. The law also makes a landmark policy change by allowing states to provide coverage to legal immigrant children and pregnant women who have been in the country for fewer than five years.

While CHIPRA will make it easier for states to cover more children, it also includes provisions that may reduce the likelihood that states will expand coverage to children in families with incomes above 300 percent of the federal poverty level ($54,930 for a family of three in 2009). It also phases out CHIP-funded coverage for adults. We discuss these and other changes in more detail below.

Significant New Funding

One of the issues that was of paramount importance in the CHIP reauthorization process was ensuring that the program was granted sufficient funding to both maintain coverage for current enrollees and to make significant progress in covering more of the 8.6 million remaining uninsured children.[2] The law achieves this by adding $44 billion in new federal funding between 2009 and 2013 on top of the so-called "baseline" of $5 billion per year, bringing the total amount available for CHIP to $69 billion.[3] This increase was largely funded by raising the federal tobacco tax by 62 cents. (Note: Although in the legislative fight to pass CHIPRA, the amount of funding that Congress had to "pay for" for budgetary purposes was $32.8 billion, this amount does not correspond directly to the total amount that will be available for CHIP allotments.)

The total amount of funding that will be available for state CHIP allotments in fiscal year (FY) 2009 under CHIPRA is nearly twice as much as the amount that was available in FY 2008 ($10.6 billion in FY 2009, compared to $6.2 billion in FY 2008). And according to the Congressional Research Service, which has estimated each state's CHIP allotment for FY 2009 under the new law, on average, state allotments will be 96 percent higher under the new law than they would have been under the old law.[4]

With one exception that is described below (see "Interpretation and Translation Services" on page 7), the law does not change the state-federal match structure of CHIP funding: Each state will continue to pay a share of all of its CHIP expenditures, and that state funding will be matched by federal CHIP dollars. States will continue to receive an "enhanced" federal matching rate that is higher than the matching rate for their Medicaid program. The average CHIP matching rate for FY 2009 is 72 percent, which means that, on average, for every $1.00 a state spends on CHIP, the federal government contributes a matching amount of $2.57.

Funding: Use It or lose It

In addition to increasing the amount of money that is available for children's health coverage, CHIPRA also establishes a new way to better target the money to those states that are covering more children. Under the old law, each state had three years to spend its annual CHIP allotment. Under CHIPRA, states will instead have only two years to spend the money. Any amounts that are not used by the end of the second year will revert back to the "pot" and will be redistributed to other states that demonstrate a need for more CHIP funds.

Just as before, a specific amount of federal CHIP funding will be available for each state for each fiscal year. However, these annual allotments will be distributed to states according to a new formula that takes into account how much each state actually spends on CHIP, as follows:

- Each state's FY 2009 CHIP allotment will be based on the highest of the following: its FY 2008 CHIP spending (plus an inflation factor), its FY 2008 allotment (plus an inflation factor), or its projected CHIP spending in FY 2009. As noted above, each state's FY 2009 allotment will be significantly higher than it has ever been.
- In FY 2010 and FY 2012, each state's allotment will automatically be increased over the previous year's allotment according to an inflation factor (to account for medical inflation and for the growth in the number of children in the state).
- In FY 2011 and FY 2013, allotments will be "rebased" (basically, recalibrated) according to how much each state actually *spent* the previous year (rather than how much it *received* in its allotment), as well as increased to account for medical inflation and the growth in the number of children in the state. This rebasing process will ensure that states that are not spending their allotments cannot withhold that unused funding from the states that *are*.
- States that want to expand CHIP and that therefore need more funding than their "rebased" allotments for FY 2011 or FY 2013 can request additional funding from CMS.

Preventing Shortfalls

Historically, some states have experienced CHIP funding shortfalls. The new distribution formula will help prevent this from happening in the future, but CHIPRA also creates a Contingency Fund of readily available federal dollars to help fill any shortfalls that states may encounter. States that have a funding shortfall *and* that are exceeding their CHIP enrollment targets (as defined in the statute) will automatically be eligible to receive assistance from the Contingency Fund.

Rewarding Success

Another new feature that CHIPRA creates is a system of annual performance bonuses that are designed to reward states that are effectively covering the lowest-income children in their state—those children who are eligible for Medicaid. The bonuses will be awarded on a per-child basis to states that exceed their enrollment targets for children in Medicaid.[5] States must do two things to qualify for these bonuses: (1) exceed their enrollment target for children in Medicaid; and (2) implement at least five of the following eight outreach/enrollment/retention best practices:

- 12-month continuous eligibility,
- elimination of asset tests/administrative verification of assets,
- elimination of a face-to-face interview requirement,
- joint Medicaid/CHIP application,
- automatic/administrative renewal,
- presumptive eligibility,
- express lane eligibility, or
- premium assistance.

Who Is Eligible for CHIP?

CHIPRA makes some changes and clarifications about who is eligible for CHIP-funded health coverage.

Children

States will no longer be permitted to receive the full CHIP matching rate for covering children in families with incomes greater than three times the federal poverty level ($54,930 for a family of three in 2009). They will still be allowed to cover these children (as long as they have received federal approval to do so), but they will receive the lower Medicaid matching rate instead. New York and New Jersey, which already had federal approval or had enacted legislation to expand CHIP eligibility to these children before CHIPRA was signed into law, are exempt from this restriction.

Beginning in October 2009, states will need to apply the Medicaid citizenship documentation requirement to children who apply for CHIP coverage as well. (To learn more, see one of Families USA's many publications on the citizenship documentation requirement online at http://www.familiesusa.org/issues/medicaid/citizenship-documentation.) However, the new law eases this burden on families by allowing states to verify citizenship status using Social Security Administration databases when possible, rather than requiring families to comply with cumbersome documentation requirements.

CHIPRA also makes changes to existing law with respect to CHIP and premium assistance. States will now have the option to use CHIP funding to subsidize qualified job-based coverage for children who are eligible for CHIP. Families that have an offer of job-based coverage must be given a choice between the state's CHIP plan and premium assistance; they cannot be forced to participate in premium assistance if they would prefer to enroll in CHIP instead. For families that do enroll their children in CHIP-funded premium assistance, states must provide any benefits that are included in the CHIP plan that the job-based plan does not cover (known as wrap-around coverage), and states must provide the same cost-sharing protections that apply to children who are enrolled in the CHIP plan.

Pregnant Women

States are already permitted to use CHIP funds to cover pregnant women using waivers. Under the new CHIP law, they will be able to do so through state plan amendments, which are less onerous administratively and which do not require periodic renewal as waivers do. As of 2007, six states had waivers to cover pregnant women using CHIP funding: Colorado, Idaho, Nevada, New Jersey, Rhode Island, and Virginia.[6]

Legal Immigrant Children and Pregnant Women

CHIPRA eliminates the five-year waiting period for legal immigrant children and pregnant women who are eligible for Medicaid or CHIP. Nineteen states currently offer state-funded coverage for these individuals and will now be able to cover them using federal funding.[7] Other states are now allowed to expand federally funded coverage to this group of legal immigrants as well. Legal immigrant children and pregnant women will be required to verify their citizenship status every time they renew their coverage. The law reiterates the existing bar on federally funded coverage for illegal immigrants.

Parents and Other Adults

Although in the past states have been granted waivers to offer CHIP-funded coverage to parents and other adults without dependent children, the new CHIP law will gradually shift these individuals out of CHIP. It also prohibits any new CHIP waivers for adult coverage. Currently, 11 states provide CHIP coverage to parents and/or adults without dependent children: Arizona, Arkansas, Idaho, Illinois, Michigan, Minnesota, Nevada, New Mexico, Oregon, Rhode Island, and Wisconsin.

States that use CHIP funds to cover parents can continue doing so and continue receiving the CHIP matching rate through the end of FY 2011. Beginning in FY 2012, states that still cover parents with CHIP funding and that elect to continue doing so will need to cover these parents through a separate block grant that will be deducted from their CHIP allotment. They will also need to meet child enrollment targets (as defined in the statute) in order to continue getting the CHIP matching rate for these adults. Otherwise, the state will get only the Medicaid match for them. In FY 2013, states that are meeting their child enrollment targets will get a matching rate that is lower than the CHIP matching rate but still higher than the Medicaid matching rate (the "reduced enhanced medical assistance percentage" or REMAP); otherwise, they will get the Medicaid matching rate for parent coverage.

States that use CHIP funds to cover adults without dependent children can continue to cover these individuals and receive the enhanced CHIP matching rate through the end of December 2009. These states can apply for a Medicaid waiver to transition these individuals to Medicaid coverage, but they will not be allowed to cover them using CHIP funds after December 31, 2009.

Getting More Children Enrolled

Congress intended to cover more than 4 million uninsured children through the new CHIP law. An estimated two-thirds of these uninsured children are eligible for CHIP, and the remaining third are eligible for Medicaid.[8] In order to help states reach out to these uninsured, eligible children, CHIPRA gives states a variety of incentives and tools to make outreach and enrollment in both CHIP and Medicaid easier and more effective. As described above, performance bonuses will provide states with a direct financial incentive to find and enroll the lowest-income uninsured children in Medicaid. States will have to implement outreach, enrollment, and retention best practices in order to receive this bonus. Research and state experience have shown that these practices are the most effective ways to increase enrollment of uninsured children; without these practices in place, a state would be unlikely to exceed its Medicaid enrollment target.

Express Lane Eligibility/Auto-Enrollment

States were given a new option to find and enroll children who are already participating in other means-tested programs, such as the free and reduced-price school lunch program and food stamps. This new option is called "Express Lane Eligibility." Express Lane Eligibility allows state CHIP and Medicaid agencies to accept income determinations from state agencies that administer other means-tested programs instead of requiring families to prove their income separately for CHIP or Medicaid eligibility or renewal.

CHIPRA also allows states to use this information to "auto-enroll" children into CHIP and Medicaid. Under this option, a family that is applying for a means-tested program other than CHIP or Medicaid can consent to have their child auto-enrolled in CHIP or Medicaid if he or she is determined to be eligible. If the child meets the income requirements for either

program, he or she can be automatically enrolled in the program without the parents having to complete a separate application. This will allow states to enroll uninsured children who are eligible for coverage but whose parents might not otherwise have known about CHIP or Medicaid, or whose parents would have had to complete a separate application process to get their child enrolled.

Outreach Grants

The new CHIP law includes $100 million in funding that is to be used specifically for grants to organizations that promote CHIP and Medicaid outreach and enrollment. Of this, $10 million will be used for a nationwide outreach campaign, $10 million will be for grants specifically to reach out to Native American children, and the remaining $80 million will be for grants to state and local organizations (including government agencies). The Secretary of Health and Human Services (HHS) will award these grants, with a preference given to organizations that serve areas with a high percentage of uninsured children and to organizations that specifically serve racial and ethnic minorities.

Interpretation and Translation Services

CHIPRA allows states to receive a significantly higher matching rate (at least 75 percent, higher depending on the state) for providing translation and interpretation services in their CHIP and Medicaid programs. This will be an incentive for states to provide better, more culturally appropriate outreach to children in racial and ethnic minority groups who may benefit from translation of outreach and enrollment documents, or from a translator to facilitate the enrollment process. It will also allow these children to receive more appropriate health care services once they are enrolled, since the higher matching rate is also available for translation and interpretation services in health care delivery settings.

Improving Children's Health

Finally, there are several significant changes in the new law that are designed to improve the health care that children receive in CHIP and Medicaid.

Dental Benefits

There are two provisions in the legislation that are designed to improve access to dental care for children. First, CHIPRA requires states to include dental coverage in their CHIP benefit packages. Although most states currently provide dental coverage through CHIP, they are not required to do so, and in the past, states could cut these services if they chose to. Now, states must offer a dental benefit that is equivalent to one of the following: the children's coverage that is provided in the Federal Employees Health Benefits Program (FEHBP), state employee dependent dental coverage, or dental coverage that is offered through the commercial dental plan in the state with the highest non-Medicaid enrollment. Dental care is an essential health care benefit, especially for children, and now, children enrolled in CHIP will be assured of having adequate dental coverage.

Second, it allows states for the first time to offer dental coverage to children who are enrolled in private or job-based plans that do not include dental coverage. As long as these children are otherwise eligible for CHIP, states can enroll them in CHIP exclusively for dental coverage. This new provision is a significant change in the program, because previously, children could get coverage in CHIP only if they were uninsured. This provision for the first time allows children who have other health coverage to benefit from CHIP. It is an especially important provision because dental coverage is frequently sold separately from other health coverage, and many children who are otherwise insured lack access to dental care.

Mental Health Parity

The new CHIP law also guarantees mental health parity in CHIP. This means that, as with job-based coverage, states must provide the same level of services for mental health benefits in CHIP as they provide for physical health benefits. States that operate CHIP as a Medicaid expansion and hence offer early and periodic screening, diagnosis and treatment (EPSDT, which essentially guarantees all medically necessary health services for children) are considered to be in compliance with the mental health parity requirement. In the past, states could charge different cost-sharing amounts or impose separate spending caps on mental health services than they did for other health benefits. They could also meet the CHIP benefit requirements by providing only 75 percent of the actuarial value of mental health benefits in one of the benchmark benefit plans. Now, states must offer the full actuarial equivalent for mental health services.

Quality Improvements

CHIPRA includes several measures that are designed to improve other aspects of medical care that is provided to children through CHIP and Medicaid, including the following:

- the creation of new quality measures for children's coverage,
- a $20 million demonstration project to study quality measures and health information technology (HIT) for children,
- a $25 million demonstration project to prevent child obesity,
- $5 million for the development of children's electronic medical records, and
- development of a Medicaid and CHIP Payment Advisory Committee (MACPAC, similar to Medicare's "MEDPAC") to review and make recommendations about payment rates for children's coverage in Medicaid and CHIP.

Conclusion

Together, the increased funding that is available for children's coverage, the new tools that are designed to enhance outreach and enrollment, and the significant improvements to CHIP benefits and children's health care delivery will make it possible for states to make great progress in covering many of the approximately 8.6 million uninsured children in the country. However, states will be successful in reaching these children only if they take advantage of the many new opportunities—progress is possible only if states take action.

Subsequent briefs in this series will examine in much greater depth specific aspects of CHIPRA and how states can implement them effectively.

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[1] Congressional Budget Office, *H.R. 2 Children's Health Insurance Program Reauthorization Act of 2009* (Washington: Congressional Budget Office, February 11, 2009), available online at: http://www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf.

[2] Jennifer Sullivan and Rachel Klein, *Left Behind: America's Uninsured Children* (Washington: Families USA, November 2008).

[3] CHIP has been operating under a temporary extension since October 2007, when its original 10-year authorization period expired. Because President Bush vetoed the reauthorization legislation that Congress presented to him on two occasions, the program was temporarily extended through the end of March 2009.

[4] Families USA calculations based on Chris L. Peterson, *Projections of FY2009 Federal SCHIP Allotments under CHIPRA 2009* (Washington: Congressional Research Service, January 22, 2009).

[5] This Medicaid enrollment baseline is initially calculated based on the number of children who are enrolled in Medicaid in FY 2007, increased by the growth rate in the state's child population plus 4 percentage points, for both FY 2008 and FY 2009. For FY 2010-2012, the baseline is the previous year's baseline increased by the growth rate in the state's child population plus 3.5 percentage points. For FY 2013-2015, the baseline is the previous year's baseline increased by the growth rate in the state's child population plus 3 percentage points.

[6] Kathryn Allen, Testimony before the U.S. Senate Committee on Finance, *State Experiences in Implementing SCHIP and Considerations for Reauthorization* (Washington: Government Accountability Office, February 1, 2007).

[7] National Immigration Law Center, *Talking Points: SCHIP Reauthorization Legislation Can Help Ensure that Children Receive Timely Health Care Coverage* (Washington: National Immigration Law Center, January 13, 2009), available online at http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA_Talking_Points_Final_1-8-09.pdf.

[8] Congressional Budget Office, op. cit.

Acknowledgments

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Department of [illegible]an Services
S-CHI[illegible]narios
Reprojections and Updated BCBS Premiums

S-CHIP Budget @ 160% Compared to Reprojection @ 200%
It is estimated 200% will add 1,158 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 200% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload & Cost
Monthly Average Caseload	5,567	4,395	(1,172)
Ending Caseload	5,907	5,000	(907)
General	8,431,055	6,243,672	(2,187,383)
Federal	24,143,800	17,879,974	(6,263,826)
Total	32,574,855	24,123,646	(8,451,209)

S-CHIP Budget @ 160% Compared to Reprojection @ 170%
It is estimated 170% will add 722 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 185% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,118	(1,449)
Ending Caseload	5,907	4,564	(1,343)
General	8,431,055	5,850,541	(2,580,514)
Federal	24,143,800	16,754,470	(7,389,330)
Total	32,574,855	22,605,011	(9,969,844)

S-CHIP Budget @ 160% Compared to Reprojection @ 185%
It is estimated 185% will add 980 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 160% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,279	(1,288)
Ending Caseload	5,907	4,822	(1,085)
General	8,431,055	6,079,139	(2,351,916)
Federal	24,143,800	17,408,925	(6,734,875)
Total	32,574,855	23,488,064	(9,086,791)

S-CHIP Budget @ 160% Compared to Reprojection @ 165%
It is estimated 165% will add 608 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 185% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,043	(1,524)
Ending Caseload	5,907	4,450	(1,457)
General	8,431,055	5,743,795	(2,687,260)
Federal	24,143,800	16,448,854	(7,694,946)
Total	32,574,855	22,192,649	(10,382,206)

S-CHIP Budget @ 160% Compared to Reprojection @ 175%
It is estimated 175% will add 829 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 175% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,191	(1,376)
Ending Caseload	5,907	4,671	(1,236)
General	8,431,055	5,954,214	(2,476,841)
Federal	24,143,800	17,051,266	(7,092,534)
Total	32,574,855	23,005,480	(9,569,375)

S-CHIP Budget @ 160% Compared to Reprojection @ 160%
It is estimated 160% will add 439 children

	Current SCHIP Budget @ 160%	SCHIP Budget @ 185% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	3,941	(1,626)
Ending Caseload	5,907	4,281	(1,626)
General	8,431,055	5,598,799	(2,832,256)
Federal	24,143,800	16,033,737	(8,110,063)
Total	32,574,855	21,632,536	(10,942,319)

Note:
The Executive Budget was based upon a preliminary premium from BCBS of $243.93.
The Department has just received the final 09-11 premium of $228.71 from BCBS.

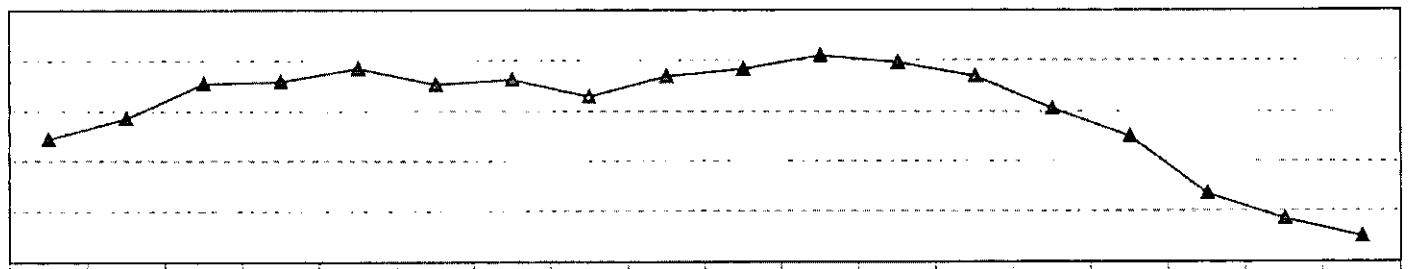
ATTACHMENT #2

North Dakota Department of Human Services

Attachment D

Healthy Steps Enrollment by Month

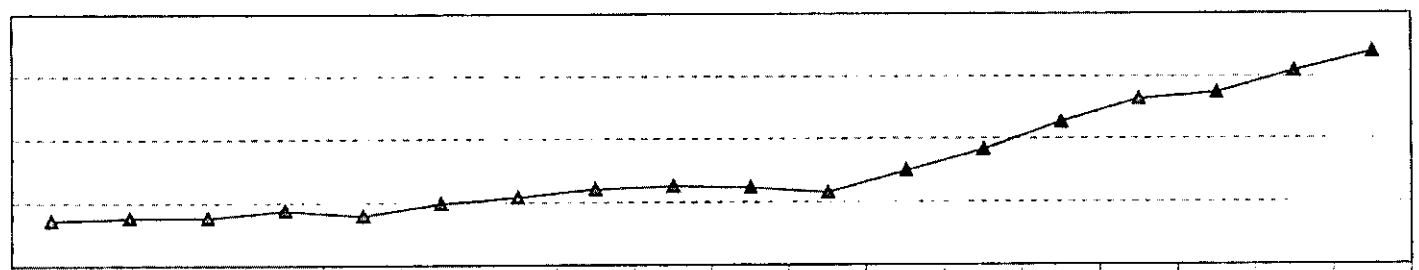
August 2007 - January 2009



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09
3,787	3,871	4,011	4,019	4,071	4,008	4,027	3,959	4,039	4,067	4,119	4,091	4,038	3,911	3,800	3,568	3,468	3,399

Children Enrolled in Medicaid by Month

August 2007 - January 2009



Aug 07	Sep '07	Oct '07	Nov '07	Dec '07	Jan '08	Feb '08	Mar '08	Apr '08	May '08	Jun '08	Jul '08	Aug '08	Sep '08	Oct '08	Nov '08	Dec '08	Jan '09
28,435	28,522	28,531	28,758	28,590	28,977	29,173	29,420	29,508	29,462	29,306	29,984	30,652	31,532	32,274	32,479	33,184	33,795

2/19/09-cj-hgw\0911 legis\hs enroll & elig

2009 POVERTY GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

ANNUAL GUIDELINES

	PERCENT OF POVERTY GUIDELINES										
FAMILY SIZE	100%	120%	133%	135%	150%	175%	185%	200%	250%	160%	170%
1	10,830	12,996	14,404	14,621	16,245	18,953	20,036	21,660	27,075	17,328	18,411
2	14,570	17,484	19,378	19,670	21,855	25,498	26,955	29,140	36,425	23,312	24,769
3	18,310	21,972	24,352	24,719	27,465	32,043	33,874	36,620	45,775	29,296	31,127
4	22,050	26,460	29,327	29,768	33,075	38,588	40,793	44,100	55,125	35,280	37,485
5	25,790	30,948	34,301	34,817	38,685	45,133	47,712	51,580	64,475	41,264	43,843
6	29,530	35,436	39,275	39,866	44,295	51,678	54,631	59,060	73,825	47,248	50,201
7	33,270	39,924	44,249	44,915	49,905	58,223	61,550	66,540	83,175	53,232	56,559
8	37,010	44,412	49,223	49,964	55,515	64,768	68,469	74,020	92,525	59,216	62,917

MONTHLY GUIDELINES

	PERCENT OF POVERTY GUIDELINES										
FAMILY SIZE	100%	120%	133%	135%	150%	175%	185%	200%	250%	160%	170%
1	903	1,083	1,200	1,218	1,354	1,579	1,670	1,805	2,256	1,444	1,534
2	1,214	1,457	1,615	1,639	1,821	2,125	2,246	2,428	3,035	1,943	2,064
3	1,526	1,831	2,029	2,060	2,289	2,670	2,823	3,052	3,815	2,441	2,594
4	1,838	2,205	2,444	2,481	2,756	3,216	3,399	3,675	4,594	2,940	3,124
5	2,149	2,579	2,858	2,901	3,224	3,761	3,976	4,298	5,373	3,439	3,654
6	2,461	2,953	3,273	3,322	3,691	4,306	4,553	4,922	6,152	3,937	4,183
7	2,773	3,327	3,687	3,743	4,159	4,852	5,129	5,545	6,931	4,436	4,713
8	3,084	3,701	4,102	4,164	4,626	5,397	5,706	6,168	7,710	4,935	5,243

Produced by: CMSO/DEHPG/DEEO

Derived from poverty guidelines as published in the Federal Register on January 23, 2009

ATTACHMENT #2

Department of Human Services
S-CHIP Scenarios
Reprojections and Updated BCBS Premiums

S-CHIP Budget @ 160% Compared to Reprojection @ 200% It is estimated 200% will add 1,158 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 200% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload & Cost
Monthly Average Caseload	5,567	4,395	(1,172)
Ending Caseload	5,907	5,000	(907)
General	8,431,055	6,243,672	(2,187,383)
Federal	24,143,800	17,879,974	(6,263,826)
Total	32,574,855	24,123,646	(8,451,209)

S-CHIP Budget @ 160% Compared to Reprojection @ 160% It is estimated 160% will add 439 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 160% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	3,941	(1,626)
Ending Caseload	5,907	4,281	(1,626)
General	8,431,055	5,598,799	(2,832,256)
Federal	24,143,800	16,033,737	(8,110,063)
Total	32,574,855	21,632,536	(10,942,319)

S-CHIP Budget @ 160% Compared to Reprojection @ 175% It is estimated 175% will add 829 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 175% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,191	(1,376)
Ending Caseload	5,907	4,671	(1,236)
General	8,431,055	5,954,214	(2,476,841)
Federal	24,143,800	17,051,266	(7,092,534)
Total	32,574,855	23,005,480	(9,569,375)

S-CHIP Budget @ 160% Compared to Reprojection @ 185% It is estimated 185% will add 980 children			
	Current SCHIP Budget @ 160%	SCHIP Budget @ 185% with Current Reprojection & Updated BCBS Premiums	Decrease in Caseload and Cost
Monthly Average Caseload	5,567	4,279	(1,288)
Ending Caseload	5,907	4,822	(1,085)
General	8,431,055	6,079,139	(2,351,916)
Federal	24,143,800	17,408,925	(6,734,875)
Total	32,574,855	23,488,064	(9,086,791)

Note:
The Executive Budget was based upon a preliminary premium from BCBS of $243.93.
The Department has just received the final 09-11 premium of $228.71 from BCBS.

H. B. 1478

Senate Appropriations Committee

March 25, 2009

Chairman Holmberg and members of the Senate Appropriations Committee, I am Paul Ronningen, Executive Director of the National Association of Social Workers (NASW) North Dakota Chapter and also the State Coordinator for the Children's Defense Fund. Thank you for the opportunity to provide testimony in support of HB 1478 for both NASW and the Children's Defense Fund.

First of all, NASW and the Children's Defense Fund want to commend the Governor and the Department of Human Services for increasing children's health insurance from 150% of poverty to 200% of poverty in the Governor's budget. This proposal would have provided coverage to an additional 1,158 children. This was a good step forward in public policy which has now been adopted by the Senate Human Services Committee. Currently, there are approximately **14,000 children without coverage in North Dakota**. This represents cities the approximate size of a Jamestown, or Williston or Mandan!

HB 1478 was reduced to 160% of poverty in the House and would cover only 439 children of the 14,000 uninsured children in the State.

Health Insurance for children is critical. Children who are healthy **do better in school**, have **better outcomes** with law enforcement and **better long term health.**

It should be noted that for every state general fund dollar for this important coverage, **the federal government will match with three dollars**. This 1 to 3 match is a great investment, especially in today's world. In addition, the Federal Reserve Bank in Minneapolis found that the best investment of government can make is to put money into the well-being of young children. They found that every dollar invested in a child **comes back up to 12 times** over the life of that child.

All children need and deserve health care coverage. North Dakota is positioned to move from the back of the pack in children's health coverage. Please consider moving children's health care

coverage from the emergency room to the clinic, from a reactionary response to a health crisis to a planned and thoughtful opportunity for working low income parents to access health care for their children.

In conclusion, I would like to quote the Fargo Forum: "North Dakotan's know instinctively that strong families are vital to maintaining the strength of the state's social and economic fabric."

Health insurance for all children reflects this common sense, family-friendly culture of the state. Indeed, it's a bit of a surprise that such a sensible, cost-effective approach has not been part of social services before now. It literally helps stabilize families in multiple ways.

In summary:

-14,000 children from working poor families are currently uninsured.

-One dollar of state money for coverage is matched with 3 dollars of federal money.

-The Federal Reserve Bank of Minneapolis estimates that the return on every dollar invested in children has a return of up to $12.

-Healthy children have better outcomes in school, with law enforcement and with long term health.

-50% of bankruptcies tie back to a health crisis.

-Outreach services should be strengthened with "on the ground" advocacy added to the mix.

Thank you.

ReadyChild
AN NDEA INITIATIVE

Attention Macintosh users

We deeply regret that you are unable to navigate the toolbars in this website. We hope to have a more user-friendly site developed later this year. Please consider accessing our site from a PC if you get the chance.

Ready Child

- Home
- The Ready Nine
- Just for Parents
- Just for Teachers
- Just for ESP's
- Just for Kids
- Just for Teens
- Quotes and Statistics
- Recommended Reading
- Links
- Donate to Ready Child
- Comments

- Ready Child is an initiative of the North Dakota Education Association (NDEA).
- The mission of Ready Child is to help every North Dakota child be ready for learning and ready for life.
- We believe that North Dakota's adults must work together to meet the needs of North Dakota's children. By meeting those needs, The Ready Nine, we believe our children will succeed!

The Ready Nine

1. *Caring adults*
2. *Early literacy*
3. *Safe environments*
4. *Good health*
5. *Resilience*
6. *Self-discipline*
7. *Opportunities to give*
8. *Marketable skills*
9. *Hope*

An organization of 8,000 school employees working to ensure Great Public Schools—A Basic Right!

NDEA is an affiliate of the National Education Association.

Hot Spot!

Ready Child and NDEA to convene Dropout Prevention Summit June 8-9, 2009

To contact us:

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