2011 HOUSE HUMAN SERVICES

HB 1377

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1377
January 26, 2011
Job #13444

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

To raise the income eligibility of children's health insurance through the state from 150 percent of the federal poverty level to 250 percent.

Minutes: See attached Testimonies #1-9

Chairman Weisz: Opened the hearing on HB 1377.

Rep. Rick Holman: From District 20 sponsored and introduced the bill. (See attached Testimony #1.)

Paul Ronnigan: State Coordinator Children's Defense Fund ND spoke in support. (See Testimony #2.)

Rep. Damschen: Can you tell me what percentage of those who qualify for current programs are utilizing them or enrolled in them?

Ronnigan: I don't know. Maybe the department knows.

Holman: Do you know how many kids this would bring in?

Ronnigan: According to the FN, it was done by the department at 250%. There would be approximately 1,320 additional children that would be brought into this program.

Marlowe Kro: Associate State Director for AARP ND testified in support of the bill. (See Testimony #3.)

Carlotta McCleary: Executive Director of ND Federation of Families for Children's Mental Health testified in support. (See Testimony #4.)

Rep. Damschen: Are the statistics that the reason the children aren't receiving mental health care is because they don't have insurance?

McCleary: There are a combination of reasons. Primarily it is access to care and the stigma that associates around mental illness as well. I'd like to hand out Susan Helgeland's testimony.

Susan Helgeland: Executive Director of Mental Health America of ND. (See attached Testimony #5.)

Veronica Zietz: Executive Director of The Arc of Bismarck testified in support. (See Testimony #6.)

Josh Askvig: Representing the ND Education Association testified in support of the bill. (See Testimony #7.)

Nancy Miller: Executive Director of ND Chapter of National Association of Social Workers testified in support. (See Testimony #8.)

Maggie Anderson: Director of Medical Services for the DHS provided information. (See Testimony #9.) In response to Rep. Damschen's question. We never know that number of how many are out there that are eligible who don't come forward and apply. The last legislative session the outreach program was funded to find those kids. Dakota Medical Foundation is doing a great job. Social marketing is out there and they had an ad. We also use Facebook. In ND we use a joint application and the three programs I talked to you about, Medicaid, CHIP and the Caring Program, we share an application. When one comes to our office or county office, we test that application and that family's income first for Medicaid and if the family does not qualify we then test it for the children's health insurance program. If they don't qualify for CHIP then we send that information to BC/BS and if they are eligible for the Caring Program they are enrolled in the Caring Program.

Rep. Hofstad: When you built your '09-11 budget, did you anticipate the increase from that outreach program?

Anderson: We did in combination with the enrollment we expected because of the increase from 150 to 160. We went from 150 to 160 on July 1, but we had gone from 140 to 150 on October 1, 2008. We built all of the growth from what we were expecting from the 140 to 150 the 150 to the 160 and took into account we knew those children were out there and needed to get the message out to them and bring them in. We are not exceeded our budget in that area.

Rep. Damschen: Does the FN assume 100% participation by new eligible?

Anderson: The way we built the FN for 1113 is when there is a change like this, it gets a lot of attention here and in the media and add additional efforts to our outreach piece. We see large numbers of people typically come on right away and see continued growth throughout the biennium. So, the way we built it is up front large numbers and a certain number each month. We took into account all 1,320 we believe will come on. Those are families that have already applied and were denied coverage so if they hear the income level has increased, then they very likely will apply for coverage again.

Rep. Paur: How many people take advantage of the Caring for Children?

Anderson: I believe that is capped at 150 children. I don't know how many are on today. It is funded with donations and through a foundation and suspect is on what the donations can fund.

Rep. Porter: We had some individuals testifying and estimating somewhere between 13,000 to 14,000 children are still without coverage. When I look at that number and we have the Medicaid program up to 133% of poverty of net income and SCHIP up to 166% of poverty of net income; then we make a move like this to 250% and we only capture another 1300, then where are all of the other uninsured at in the state of ND?

Anderson: The uninsured information is not from our office. Some could go back to be that they are not applying for one reason or another, unaware, or don't see healthcare needs. I wouldn't be able to answer the question.

Rep. Porter: What is in the budget in the next biennium for the outreach program?

Anderson: For the current biennium that contract is $650,000 and we held that even in the budget.

Rep. Porter: We hear a lot about comparisons to ND's program, other states around us and in the nation. I'm interested in how many states are doing net income, just matching minimal coverage inside of their program, vision, dental, and what level of coverage affording inside of their existing programs.

Anderson: Are you asking for all states or surrounding states?

Rep. Porter: No, we are only here for 80 days.

Anderson: Promise?

Rep. Porter: No, no, I do not promise that.

Anderson: We have collected that information from our surrounding states in the past and that would be not fairly easy to get, but I can contact my colleagues and get that information back to you. The last time we collected information was 2008, but since that time CHIP reauthorization happened in 2009. Part of the reauthorization was to add mandatory benefits to the CHIP program, such as dental, orthodontist, and mental health parity. Those services we had already in our program with the exception of orthodontist. Other states did not necessarily do that. I can update the information from the three states and provide it to you. Would that be helpful?

Rep. Porter: It would and along with that the other component that I think is important for us to look at is the allowed deductions in those states and in ND so that we can see specifically what they are.

Anderson: I'll contact ND, oh we are ND. SD, MT and MN.

Rep. Kilichowski: Out of all the applications that you get, how many don't make the Medicaid and CHIP program are referred to the Caring for Children?

Anderson: We can pull that information for you. Would like for the last year, how many each month? Ok, we can do that.

Rep. Holman: What you have in your handout is from the Kaiser Foundation Rep. Porter.

Rep. Schmidt: Standing Rock is in my district and says I don't know, do all your numbers and facts include children on the reservations?

Anderson: Yes they do if they have applied for Medicaid and CHIP and individuals who go to Indian health services can use their Medicaid and CHIP coverage.

Rep. Schmidt: Do you happen to know if their participation rate into these programs are adequate or not adequate?

Anderson: Sometimes because Tribal members can go to Indian health services and receive care, they may not apply for Medicaid or CHIP and may be eligible. But, it is one specific area where targeting some of our outreach efforts is to ensure that American Indian families know that they can apply for these benefits. For example if they apply for Medicaid and still go to Indian health services we are able to capture a 100% federal dollars for those payments. Where if they don't apply for Medicaid they have to use their Indian health services dollars. So we do everything we can to encourage them to apply for the benefits. (Maggie continues to go through her testimony.)

Rep. Porter: What would the process be for ND to move to a gross income on the SCHIP program and put us in line with some of the other states around us that are doing gross income and getting rid of the whole complicated net income that we adopted years ago?

Anderson: I couldn't give you an exact financial analysis or what it would take for the computer system, but in general I can tell you is that the federal healthcare reform legislation requires states to maintain eligibility at the level they were at when the healthcare reform bill was signed into law. Any change we would do between now and 2019 would need to be carefully reviewed with CMS to make sure that any child that currently has eligibility under net would not lose eligibility under gross. When we do implement the changes in healthcare reform, the healthcare reform legislation talks about all states going to modified gross income. We don't have from the federal government yet on what that all means and how we will transition our net income eligibility to modified adjusted gross income. But, we know that is something that will need to happen before what is called for in the law on January 1, 2014. For the CHIP piece we don't know if that will be 2014 or October 1, 2015 which is when the funding currently for CHIP is authorized through. The eligibility system would have significant changes. If we were to do it just for CHIP and not for Medicaid, we would have to pay very close attention to how that would impact various families where Medicaid would still be net and CHIP would be gross and if they were both to go it would be a different consideration. We are looking at these related to what needs to happen for us to get to modified adjusted gross income as well. We

would have to sit down and put together financial and time line estimate of when that could be accomplished.

Rep. Porter: So there isn't any modified guidelines yet on the modified gross income?

Anderson: We are being told as being defined by the internal revenue service what that means in terms of families. No one is supposed to lose coverage because of the provisions of healthcare reform. The floor that will be required for Medicaid is at 133 plus a 5% disregard so let's just say 138. You could have somebody who is above 138 now and that 138 will be modified adjusted gross income, but it is based on net income. All of that guidance of how we are going to transition people from where they are today to the modified adjusted gross, not impacting people's coverage whether they will need to go to the exchange; we just don't have any of that information at this time.

Chairman Weisz: I not sure we wanted to hear that last part.

No Opposition

Chairman Weisz: Closed the hearing on HB 1377.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1377
February 2, 2011
Job #13839

☐ Conference Committee

Committee Clerk Signature Vicky Craktree

Minutes: *See attachments #1-3*

Chairman Weisz: Called meeting to order on HB 1377.

Maggie Anderson: From the DHS passed out three handouts regarding information requested by the committee. (See attachments #1-3)

Rep. Holman: Looking at the Montana one where they made major changes. If we had a similar program here, how many more kids would we have over 1400 or would we have less?

Maggie: Not significantly more. This bill calls for it to go to 250.

Rep. Holman: Last session we played around with 200 and heard that will happen again coming from the Senate side. What would going to 200 do?

Maggie: Going to 200%, we estimated another 937 children would be added to the CHIP program.

Rep. Damschen: There is still the issue of the statistics that we can't gather. Increasing it doesn't raise the participation of the currently eligible individuals and we don't know a 100% of the new eligible will participate either. Is that correct?

Maggie: That is certainly correct. We never know what people will do and choices they will make. Our estimates are based on our experiences with families who have applied for coverage at the current level and have been denied because they are over income.

Rep. Louser: Your outreach budget was $650,000 and why such a high budget if you know who the people are that you would be contacting to get into this program?

Maggie: We know about those families, but there are many that are not aware of the program and have newborns in families and those families never heard of these programs.

Rep. Holman: Did you get the e-mail I sent you? Is it full of holes? If it is close I'd like to hear that.

Maggie: It is close. There were a couple of places where there were numbers that were in accurate. On example 1b the total deductions should be $530, 2b should be 229% of poverty level, 3b should be $550 total income and that would be 300% of the poverty level and the total deductions on that same example should be $2,470.

Chairman Weisz: Welcomed students from Walhalla.

Rep. Holman: If my amendment would not change income it is futile attempt to do it. Last night I visited with Sen. Dever and I believe he has a similar bill coming in from the Senate that goes back to what the Senate passed two years ago at 200%. I'm going to leave it where it is.

Chairman Weisz: That bill is in and it is just a matter if it makes it through the Senate or not or gets amended to a different level also. I think they have had the hearings already.

Rep. Holman: I know they have had the hearings on Sen. Mathern's bill. I don't know about Sen. Dever's bill.

Rep. Porter: I would move a DNP.

Rep. Louser: Second.

Rep. Holman: We have two issues here. One is about money and the other about taking care of kids. How important is it to take care of these 900 or 1400 more kids. Many of them still have healthcare because they get to go to the emergency rooms. That is where the cost issue enters in. So in the long run in many cases, preventive care that is available as a result of these kids getting healthcare may ultimately save money. And I think that is the purpose of having healthcare for children. My purpose for bringing this forward is I had a good idea what was going to happen with the Senate bill. I thought I'd bring it to the House so we could have discussions on it.

Chairman Weisz: Discussions are always worthwhile regardless. Often times we have had discussions and some things have shifted and they did change.

Roll Call Vote: 10 y 3 n DNP Carried

Bill Carrier: Rep. Porter

FISCAL NOTE

Requested by Legislative Council
01/19/2011

Bill/Resolution No.: HB 1377

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.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$3,903,925		$6,934,902
Expenditures			$1,748,203	$3,903,925	$3,147,829	$6,934,902
Appropriations			$1,748,203	$3,903,925	$3,147,829	$6,934,902

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

2009-2011 Biennium			2011-2013 Biennium			2013-2015 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 increases the net income eligibility limit from 160% of the federal poverty level to a net income eligibility limit of 250% of the federal poverty level. It is estimated that this change will make an additional 1,320 kids eligible for CHIP benefits.

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.*

The eligibility increase contained in Section 1 of the Bill would make an additional 1,320 kids eligible for CHIP benefits.

CHIP is subject to an annual federal allotment. Based on the FFY 2011 North Dakota CHIP allotment, the increase to 250% of the federal poverty level would cause ND CHIP expenditures to exceed the annual allotment. However, there are provisions in the Children's Health Insurance Reauthorization Act that allow states to apply for an increased allotment. If the income eligibility level for CHIP is increased, the Department will make application to the Centers for Medicare and Medicaid Services (CMS) for an increased allotment. Until the application is approved by CMS, the Department cannot certify that federal allotment would available for the entire increased expenditure.

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 revenue increase in each biennium is the additional federal funds the state will receive if CMS approves a federal allotment increase due to the eligibility change.

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.*

It is estimated an additional 1,320 children will receive services due to the change in the eligibility limits. The monthly premium is estimated at $274.03 per child for the 2011-13 biennium and is estimated at $312.53 per child for the 2013-15 biennium. This change would result in increased premium costs of $5,461,966 for the 2011-13 biennium and

$9,900,989 for the 2013-15 biennium. The general fund need for each biennium would be $1,689,386 for the 2011-13 biennium and $3,091,089 for the 2013-15 biennium.

In addition, 1.5 FTE would be needed to handle the increased workload. The cost of the FTE would be $190,162 for the 2011-13 and $181,742 for the 2013-15 biennium. The general fund portion of the FTE cost would be $58,817 and $56,740 for the 2011-13 and 2013-15 biennia respectively.

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 Department will need an appropriation increase of $5,652,128 of which $1,748,203 is general fund and $3,903,925 is federal funds for the 2011-13 biennium.

The Department will need an appropriation increase of $10,082,731 of which $3,147,829 is general fund and $6,934,902 is federal funds for the 2013-15 biennium.

Name:	Debra A. McDermott	**Agency:**	Dept. of Human Services
Phone Number:	328-3695	**Date Prepared:**	01/21/2011

Date: 2-2-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1377

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Louser

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN		✓
VICE-CHAIR PIETSCH	✓		REP. HOLMAN		✓
REP. ANDERSON	✓		REP. KILICHOWSKI		✓
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD	✓				
REP. LOUSER	✓				
REP. PAUR	✓				
REP. PORTER	✓				
REP. SCHMIDT	✓				

Total (Yes) 10 No 3

Absent _____

Floor Assignment Rep. Porter

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

DNP

REPORT OF STANDING COMMITTEE

HB 1377: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1377 was placed on the Eleventh order on the calendar.

2011 TESTIMONY

HB 1377

#1

Testimony on House Bill 1377
Expansion of S-CHIP Eligibility
2011 Legislative Session
January 26, 2011
Representative Rick Holman

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Rep. Rick Holman, District 20.

This bill is about the health of North Dakota Children. There is a gap in coverage between children covered by Medicaid and children whose caregivers can afford health insurance. In the 2009 session, the income eligibility was raised from 150 percent of the Federal poverty rate to 160 percent rightfully adding many more children to the list of those able to access medical care. This bill asks that the level be increased to 250 percent of the poverty level. I've attached a chart, indicating the monthly income for various size family units at several levels of coverage. I've included the 200 percent number because the 2009 legislative session passed it out of the Senate at that level. A conference committee ultimately set the level at 160 percent which was passed by both houses.

Note that Section 2 of the bill limits implementation of the act to an increase in the federal allotment to cover the increase to the net income eligibility.

Also, attached to my testimony is information about what is being done in other states. As is indicated, each state is able to make a choices on how to combine federal and state funds to provide coverage for those children who fall in to the coverage gap.

My personal passion for this comes from the situation of my daughter and my two grandchildren. Divorced with no child support, working full-time at Village Inn as a waitress and attending college, she was not able to afford insurance for her children aged four and eleven. S-Chips provided coverage for her two children for a couple of years until she was employed at the job she has now which provides insurance for her and her family.

I believe that we have a moral responsibility to take care of those who cannot take care of themselves. A policy that limits prevention and care for those who are helpless to take care of themselves is not a good policy. I ask you to seriously consider this expansion of coverage for the children of North Dakota. It's about our future.

I'd be happy to answer any questions.

Information on S-CHIPS
HB 1377

Rep. Rick Holman, ND District 20

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP, formerly SCHIP) was created by the Balanced Budget Act of 1997, enacted Title XXI of the Social Security Act, and has allocated about $20 billion over 10 years to help states insure low-income children who are ineligible for Medicaid but cannot afford private insurance. States receive an enhanced federal match (greater than the state's Medicaid match) to provide for this coverage. Each state is entitled to a specific allotment of federal funds each year. NCSL has tracked and reported on the many changes, expansions and state-based discussions about CHIP programs and has more than 50 online reports, articles, legislative tracking databases on this topic.

2010 Federal Poverty Guidelines

Source: Department of Health and Human Services (HHS), 2010.

Congress took action to keep the 2009 HHS poverty guidelines in effect until May 31, 2010. A notice regarding this extension was published in the January 22, 2010 *Federal Register*. The federal poverty guidelines were updated in August 2010 after legislation to further delay the publication of the 2010 guidelines did not pass. The poverty guidelines for the remainder of 2010 are the same as the guidelines for 2009. For more information, please see the August 2, 2010 *Federal Register.*

Guidelines for the 48 Contiguous States and the District of Columbia

People in Family Unit	Mo 100%	Mo 160%	Mo 200%	Mo 250%	
1	903	1444	1805	2256	
2	1214	1943	2428	3035	
3	1526	2441	3052	3815	
4	1838	2940	3675	4594	
5	2149	3439	4298	5373	
6	2461	3937	4922	6152	
7	2773	4436	5545	6931	
8	3084	4935	6168	7710	
More than 8 add for each	312	499	623	779	

Federal Health Reform and CHIP

President Obama signed the Patient Protection and Affordable Care Act, H.R. 3590, on March 23rd and the Reconciliation Act of 2010, H.R. 4872, on March 30, 2010. (See the combined full text of Public Laws 111-148 and 111-152 here.) Among many provisions, the laws extend the authorization of the federal CHIP program for an additional two years, through September 30, 2015. The laws require states, upon enactment, to maintain current income eligibility levels for CHIP through September 30, 2019. States are prohibited from implementing eligibility standards, methodologies or procedures that are more restrictive than those in place as of March 23, 2010, with the exception of waiting lists for enrolling children in CHIP.

Children's Health Reform: State Laws

More than 9 million children are uninsured in the United States. Six and a half million of these children live in families with household incomes below 200 percent of the federal poverty level and are eligible for Medicaid or CHIP, but are not enrolled. Typically, a child's health care needs center around simple preventative care such as immunizations and regular check-ups to ensure proper growth and development. Research shows early intervention makes a measurable improvement in the future health of these children. On the heels of major reforms like the ones enacted in Maine, Massachusetts and Vermont, states across the nation are considering plans to increase access to health insurance for their citizens. Access to coverage for children is often high on the priority list for states trying to allocate resources and services. For more than a decade, states have provided low-income children with health insurance coverage through Children's Health Insurance Programs (CHIP). CHIP, a state-federal partnership, was created as part of the Balanced Budget Act of 1997 to bridge the safety net gap for low-income children who do not qualify for Medicaid but remain in families that cannot afford insurance. Recently, some states chose to build on established CHIP programs and the corresponding access to federal resources to expand coverage to additional children.

Despite current state budget challenges, ensuring children access to health care remains a priority in a number of states. Due to the vast differences in available state funds, existing programs and uninsured populations, approaches to covering additional children vary. Some states have used state funds without the federal matching dollars to expand CHIP eligibility and other states have focused their funds on outreach to families of children who are eligible for Medicaid and CHIP programs but are not enrolled. The table below provides a snapshot of recent reforms regarding children's health insurance. For a comprehensive list of state CHIP and Medicaid eligibility levels, see the Kaiser Family Foundation's statehealthfacts.org.

Children's Health Reform: A Snapshot of State Action

Please note: The reforms included in the chart below are intended to offer a snapshot of state actions around children's health insurance. This list is not comprehensive and many state programs enacted/implemented before 2005 may not be included. NCSL appreciates additions and corrections.

State	Enacted State Initiatives
Alabama	In 2009, Alabama enacted HB 746, which appropriated funds for the state's Children's Health Insurance Program for the fiscal year ending September 30, 2010. The law increased eligibility guidelines from 200 percent of the federal poverty guidelines to 300 percent of the federal poverty guidelines. This expansion was implemented beginning October 1, 2009. For more information about Alabama's CHIP program: ALL Kids
Alaska	In 2007, SB 27 (Chapter 48) was enacted, which increases Medicaid/CHIP eligibility for children from 150 percent of the federal poverty level to 175 percent of the federal poverty level. For more information about Alaska's CHIP program: Alaska Denali KidCare
Arizona	In 2007, HB 2789 (the fiscal year 2007-2008 state budget) was enacted which removes the rule that prohibited schools from participating in outreach efforts and clarifies that school districts may distribute information about the Arizona Health Care Cost Containment System to potentially eligible students and their families. Pursuant to Ariz. Rev. Stat. § 36-2985(A), the Arizona Health Care Cost Containment System Administration instituted an enrollment cap of the KidsCare program effective January 1, 2010, due to insufficient funding. On March 16, 2010 the Legislature completed its 7th Special Session to address the state's severe budget shortfall for Fiscal Year 2010 and 2011. On March 18, 2010, Governor Jan Brewer signed a budget package (including House Bill 2010/Senate Bill 1010) that eliminated the state's CHIP program, KidsCare, effective June 15, 2010. KidsCare covers children whose families have income between 100 percent and 200 percent of the federal poverty guideline. On March 25, 2010 the Arizona Health Care Cost Containment System released a letter to Governor Brewer regarding the impact of federal health reform on the elimination of KidsCare. The letter recognizes that as a result of the maintenance of effort provision in federal health reform, the state will need to restore, at a minimum, the KidsCare program with a freeze on new enrollment. The letter specifies that the projected general fund cost to restore KidsCare with an enrollment freeze is $38 million from July 1, 2010 through September 30, 2019. In addition, the Centers for Medicare and Medicaid Services (CMS) notified the state that the elimination of the KidsCare program would be in violation of the federal maintenance of effort provisions and would result in the loss of an estimated $7.8 billion in federal Medicaid funds per year. On May 6, 2010, Governor Brewer signed Senate Bill 1043, restoring the KidsCare program. On May 12, 2010, AHCCCS submitted a letter to CMS to withdrawal the March 18th request to terminate KidsCare. CMS also provided clarification to the state that the continuation of the KidsCare enrollment freeze would not trigger a maintenance of effort violation. For more information, see the Arizona Health Care Cost Containment System News and Updates webpage Arizona Drops Children's Health Program, *New York Times*, March 18, 2010 Governor signs Arizona budget-balancing bills, *Business Week*, March 18, 2010 For more information about Arizona's CHIP program: Arizona KidsCare

Arkansas	In March 2009, Chapter 435 (HB 1700) was enacted which increases eligibility for children who are members of a family with a gross family income up to 250 percent of the federal poverty guidelines from 200 percent of the federal poverty guidelines. The expansion will be funded by a tax increase on tobacco, which was enacted by Act 180 (HB 1204) in February 2009. The expansion of the ArKids First program is expected to provide coverage for an additional 8,000 children from low-income families. The law also requests the Department of Human Services to apply to CMS for approval to extend coverage to individuals between 19 and 25 years of age who do not have health care coverage, who are full-time students in an institution of higher education located in the state, who are members of a family with a gross income up to 250 percent of the federal poverty guidelines and who were enrolled in the program before a specified age. The law also requires parity for mental health care services and establishes a copayment for services. For more information about Arkansas' CHIP program: ARKids First
California	In 2001, Chapter 648 (AB 495) was enacted which created the Children's Health Initiative Matching (CHIM) Fund in the State Treasury administered by the Managed Risk Medical Insurance Board. The fund allows for the intergovernmental transfer of local funds used for local County Children's Health Initiatives purposes to draw down federal financial participation matching funds for CHIP eligible children. In June 2004, CMS approved a pilot program to increase eligibility in four California counties through the County Children's Health Insurance Program (C-CHIP). Children, ages 19 and younger, whose family income is up to 300 percent federal poverty level are covered in three counties (Alameda, San Francisco, San Mateo, and Santa Clara) using federal matching dollars. San Mateo covers children from 300 to 400 percent federal poverty level using county funds. In September 2008, California passed its budget 85 days into the fiscal year. Within the 2008 budget bill, limitations were put upon the Medi-cal and Healthy Families programs in order to meet budgetary shortcomings. Families with children insured through Medi-cal are now required to engage in mid-year income status reporting rather than the annual status reporting that was previously required. Healthy Families enrollees with incomes above 150 percent of the federal poverty guidelines will experience an increase in premiums of approximately 2 to 3 dollars per month for each child, with a maximum premium of 51 dollars per month for all enrolled children. In addition, Healthy Families enrollees will have a reduced annual maximum dental benefit of 1,500 dollars per year. In 2009, California's State Budget 2009-10 was enacted, which reduces general fund support for the state's Healthy Families (CHIP) program by $178.6 million. The Managed Risk Medical Insurance Board, which oversees the program, froze new enrollment and established a waiting list effective July 17 because of the budget situation. The Board will disenroll current beneficiaries from the program at their annual eligibility redetermination as necessary. Eligible individuals will subsequently go on the waiting list until they are able to be reinstated as the budget permits. As of July 28, 2009, a total of 33,146 children have been placed on the waiting list. For additional information, see the California Health and Human Service Agency's Budget Facts for 2009-10. To help prevent children from losing coverage, the First 5 California State Commission approved a contribution of up to $81.4 million to the Healthy Families Program. In addition, in September 2009, AB 1422 (Chapter 157) was enacted, which imposes a tax on the total operating revenue of a Medi-Cal managed care plan until January 1, 2011. A percentage of the proceeds of the tax are

	appropriated to the Healthy Families Program. The law also increases premiums and co-payments for families of children enrolled in the Healthy Families program as of November 1, 2009. For more information about California's CHIP program: California Healthy Families
Colorado	In 2007, Colo. Sess. Laws, Chap. 347 (SB 211) was enacted which declares the state's aim to provide coverage to all low-income children by 2010. The law implements presumptive eligibility for children under Medicaid and the state's CHIP program. In 2008, SB 160 was enacted which increases CHIP eligibility from 205 percent of the federal poverty guidelines to 225 percent of the federal poverty guidelines. The law allows that if funding is available, the eligibility level can be raised to 250 percent of the federal poverty guidelines. Colorado delayed implementation of this expansion due to budget shortfalls. In 2009, HB 1293 was enacted which authorizes the state department to charge and collect hospital provider fees. The laws specifies that the hospital provider fees and the available federal matching funds may be used to increases the state's CHIP eligibility level for children and pregnant women, upon federal approval, from 205 to 250 percent of the federal poverty guidelines. The law also provides for 12 month continuous eligibility for children under Medicaid. In addition, the law directs the state department to seek federal authorization to establish a Medicaid buy-in program for disabled adults and disabled children whose families have income up to 450 percent of the federal poverty guideline. The program shall include premium and cost-sharing charges on a sliding scale fee based on the family's income. For more information about Colorado's CHIP program: Colorado Child Health Plan Plus (CHP+)
Connecticut	Conn. Acts, P.A. 185 (2007 SB 1484) increased the HUSKY (CHIP) program eligibility level from 300 percent of the federal poverty guideline to 400 percent of the federal poverty guideline and calls for the automatic enrollment of all eligible newborns into the HUSKY program. The law allowed families with incomes above 400 percent federal poverty level to buy into the HUSKY program at full cost. During the June 2007 Special Session, Public Act 2 was enacted, which repealed section 6 of Public Act 185 and reduced the HUSKY program eligibility level back to 300 percent of the federal poverty guideline. The law also changed the buy-in program eligibility level back to the previous threshold, allowing families with incomes above 300 percent of the federal poverty guideline to buy into the program. For more information about Connecticut's CHIP program: Connecticut HUSKY
Delaware	In June 2008, Chapter 241 (HB 286) was enacted which requires school districts and state agencies to share data for the purpose of enrolling children in free or reduced price health insurance programs. The law requires each school district to provide to the Department of Health and Social Services (DHSS) the contact information for families of children eligible for free and reduced price meals. DHSS will use this information to inform the family, in writing, that its child may be eligible for enrollment in the state's CHIP and Medicaid programs and provide information about how the family may apply for these programs. In 2009, HB 139 was enacted, which extends the CHIP program to eligible children under the age of 19 whose families have incomes above 200 percent of the federal poverty guidelines. The Department of Health and Social Services has the authority to determine co-payments, premiums and deductibles for children enrolled in the buy-in program. The family may purchase the healthcare benefit package if the child is over

	two years of age and has been uninsured for a continuous period of at least 3 consecutive months, with certain exceptions. For more information about Delaware's CHIP program: Delaware Healthy Children Program
District of Columbia	In January 2007, the DC City Council approved the Fiscal Year 2007 Budget Support Act of 2006 that expands Medicaid/CHIP eligibility to 300 percent federal poverty level. CMS approved the expansion in March and the expansion was implemented starting in June 2007. For more information about the District of Columbia's CHIP program: DC Healthy Families Insurance Program
Florida	In May 2008, Chapter 32 (SB 2534) was enacted which removes the enrollment cap for children in the MediKids and Florida Healthy Kids buy-in programs. Children in families with incomes above 200 percent of the federal poverty guidelines are eligible for enrollment in these buy-in programs. Previously, the enrollment of children in these buy-in programs was limited to ten percent of the total program enrollment. In 2009, SB 918 (Chapter 113; effective July 1, 2009) was enacted, which amends the Florida Kidcare Act. The law reduces the waiting period from 60 to 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of premiums. The law also reduces the waiting period from 6 months to 60 days for a child who is otherwise eligible to enroll in the premium assistance Florida Kidcare program. An eligible child for premium assistance under the Florida Kidcare program may participate if the cost of the family member's health insurance benefit plan is grater than 5 percent of the family's income. In addition, the law specifies that electronic verification of a family's income shall be used to determine financial eligibility for the Florida Kidcare program. For more information about Florida's CHIP program: Florida KidCare
Hawaii	Hawaii Rev. Stat. § 346-59.4 (2007 HB 1008) establishes a three year pilot program, Keiki Care, in which the state pays half the health insurance premiums (a mutual benefit society pays the other half and manages the administration) for children under the age of 19 who are uninsured (for any reason, including immigration status) and are ineligible for public insurance. Keiki Care is expected to cover as many as 3,500 children. The law also expands Hawaii's CHIP program, QUEST, to cover children in families with incomes below 300 percent federal poverty level. Beginning November 1, 2008, the state will no longer provide funding for the Keiki Care program as a result of state budget shortfalls. Hawaii Medical Service Association will provide funding to cover the approximately 2,000 children enrolled in this program though the end of December, 2008. In July 2008, Act 239 (SB 69) was enacted to provide temporary insurance coverage for specified children of former employees of a Hawaii-based corporation. The children will be covered under Hawaii's Keiki Care plan through the end of December 2008 or until the former employee parent of the covered child becomes employed and covered by a prepaid health care plan. The law is expected to extend coverage to as many as 900 children. For more information about Hawaii's CHIP program: Hawaii QUEST; Keiki Care; Covering Kids
Illinois	HB 806 was enacted in 2005 and created the All Kids program. The All Kids program provides children up to the age of 18 with comprehensive health insurance which covers preventative care, dental and vision services, hospital costs, and

	prescription drugs, among other services. The program is available to all Illinois children without private health insurance and has no family income cap. Children do not need to be U.S. citizens for their parents to buy into the program. The children must not be eligible for state programs like Medicaid or Illinois CHIP. Premiums are based on a sliding income scale, starting at $40 per month per child. The All Kids program became effective July 1, 2006. For more information about Illinois' program: Illinois All Kids; More NCSL information
Indiana	In May 2007, HB 1678 was enacted to increase CHIP eligibility for children in families with incomes up to 300 percent federal poverty level. In May 2008, CMS approved the expansion of eligibility to only 250 percent federal poverty level. It is expected that this expansion will allow an additional 5,000 children to enroll in the program in the first year, and up to 10,000 children in subsequent years. The expansion to increase eligibility to 250 percent of the federal poverty level was implemented beginning October 1, 2008. For more information about Indiana's CHIP program: Indiana CHIP; Hoosier Healthwise
Iowa	In 2007, HF 909 was enacted which allocates new state funds to increase outreach to children eligible to be enrolled in CHIP. In 2008, HF 2539 was enacted which provides an additional $25 million over the next three years to extend coverage to more than 50,000 children. The law increases Medicaid and CHIP eligibility for infants whose family income is at or below 300 percent of the federal poverty guidelines from the previous level of 200 percent of the federal poverty guidelines. The law requires that once initial eligibility for Medicaid is determined for a child, the child shall be continuously eligible for a period of up to 12 months. The law also provides provisions to improve outreach to eligible children. Beginning with the 2008 tax return forms, parents can identify any dependent children who do not have health care coverage. If their income on the tax return meets the income eligibility requirements for any medical assistance program, including hawk-i, information about enrollment will be sent to them. (2009 SF 389 requires this procedure beginning with the 2010 tax return forms.) The law also specifies that it is the intent of the general assembly to expand coverage under Hawk-i to children with family incomes at or below 300 percent of the federal poverty guidelines and to establish cost sharing provisions under Hawk-i for children whose family income is between 150 and 200 percent of the federal poverty guidelines if federal reauthorization of CHIP provides sufficient federal allocations to the state. In 2009, SF 389 was enacted which requires the development of a joint program application form and the same application and renewal verification process for both the hawk-i and medical assistance programs. The law increases eligibility for children under Hawk-i to 300 percent of the federal poverty guideline from 200 percent of the federal poverty guideline and establishes cost sharing for children whose family income is between 150 and 300 percent of the federal poverty guidelines. The law directs the Hawk-i board to implement the premium assistance program options described under the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3) for the Hawk-i program. The law specifies that translation and interpreter services as specified pursuant to CHIPRA and dental services shall be added to the benefits included under Hawk-i. Requires presumptive eligibility be provided for eligible children under Hawk-i beginning January 2010. NCSL State Health Notes article: Iowa Takes an Incremental Approach to Universal

	Coverage (May 27, 2008). For more information about Iowa's CHIP program: Iowa hawk-i
Kansas	In 2008, SB 81 was enacted which, subject to appropriations, increases CHIP eligibility from 200 percent of the federal poverty level to 225 percent of the federal poverty guidelines in 2009 and, finally, to 250 percent of the federal poverty guidelines in 2010. The law establishes cost sharing provisions on a sliding scale basis. New participants would not be eligible for coverage for at least eight months if they previously had comprehensive health benefit coverage, with some exceptions. This law also requires participants in CHIP to present documentary evidence of citizenship or of being a lawful alien to be eligible. The law amends the current CHIP program to allow contributions to health insurance premiums in CHIP to be made to a health savings account. In addition, payments for health insurance premiums can be made in conjunction with an employer sponsored health insurance premium assistance plan. For more information about Kansas's CHIP program: Kansas Health Wave
Louisiana	In the 2007 legislative session, Louisiana passed HB 542 (Act 407) which created the Louisiana Children and Youth Health Insurance Program, expanding Louisiana's CHIP program, LaCHIP. Act 407 aims to expand eligibility to children in families with incomes up to 300 percent federal poverty level from the former eligibility threshold of 200 percent federal poverty level. A request for approval of the plan was submitted to CMS in September 2007. In February 2008, CMS approved the expansion of eligibility to only 250 percent federal poverty level. This expansion will extend coverage to approximately 6,500 additional families, adding to the 115,271 children enrolled in LaCHIP. The coverage under this expansion will be provided through the State Group Benefits program, which also provides insurance to state government employees. Families will contribute premiums (approximately $50), co-payments and deductibles. For more information about Louisiana's CHIP program: Louisiana LaCHIP
Maryland	In April 2008, Chapter 251 (HB 115) was enacted, creating an initiative to increase enrollment into Maryland's CHIP program. The law requires a statement including the eligibility requirements of the Maryland Children's Health Program and relevant contact information to be printed on state-issued child support payment check stubs, state-issued tax refund check stubs and state-issued employee paycheck stubs. In May 2008, Chapter 692 (HB 1391) was enacted which encourages eligible parents to enroll their children in the Maryland Children's Health Program (MCHP), Maryland's CHIP program. The Kids First Act requires the comptroller to send a notice this summer (2008) regarding eligibility for MCHP to families with incomes up to 300 percent federal poverty level based on state tax return information. The act also requires parents to report on their next income tax return, the presence or absence of health care coverage for each dependent child. The act leaves open the possibility of a mandate for enrollment if more than 3 percent of children remain uninsured by 2010. At that time the state would decide on whether to withhold the child tax exemption from parents whose children are eligible but not enrolled in MCHP. The act also calls for a study of ways to make health insurance affordable for children whose parents' incomes are higher than the state program's eligibility requirements, but too low to afford private insurance coverage. The following issue brief about this Act was released by the Robert Wood Johnson Foundation in September 2009: *Using Information from Income Tax Forms to Target Medicaid and CHIP Outreach: Preliminary Results of the Maryland Kids First Act*

	In May 2009, Chapter 400 (HB 500) was enacted which requires the Baltimore City Public School System to disclose specified information about each student who is enrolled in the National School Lunch Program to the Department of Health and Mental Hygiene unless a parent elects not to have the information disclosed. The law requires the Department to send eligibility and enrollment information about the Children's Health Program to the parent or guardian of those students. For more information about Maryland's CHIP program: Maryland Children's Health Program (MCHP)
Massachusetts	In April of 2006, Massachusetts passed comprehensive health care reform called the "Act Providing Access to Affordable, Quality, Accountable Health Care." The law does not specifically address children, but it does have components that will increase access for them. The law includes a Medicaid expansion from the previous level of 200 percent of federal poverty guidelines to 300 percent of the federal poverty level. The Commonwealth Insurance Plan will provide low-cost, state subsidized (for specified income levels) insurance that is portable from job to job; presumably, children will gain access to insurance through these programs. The individual mandate that all state residents have health insurance applies only to people over the age of 18. The 2006 HB 4847 was enacted in May 2006 (Chapter 58). For more information about Massachusetts' program: MassHealth
Minnesota	In 2007, Chapter 147 (HF 1078) was enacted which allocates funds to increase outreach to individuals eligible for public health coverage programs. The law calls for implementation of a statewide public awareness and education campaign on the importance and availability of health coverage. The law also includes measures to simplify application and renewal policies. For more information about Minnesota's CHIP program: Minnesota CHIP
Missouri	Senate Bill 577, enacted in May 2007, changed Missouri's Managed Care Plus (MC+) for Kids Program (the state's CHIP program), eligibility requirements. Under the new law children continue to be eligible for the program if they lack access to affordable employer-sponsored health insurance and their family income is between 150 percent and 300 percent of the federal poverty level. This law redefined the definition of "affordable employer-sponsored health insurance" based on the family's gross income, family size, and the monthly premium for coverage as a percentage of a specified percent of the federal poverty level. In addition, plans that do not cover an eligible child's pre-existing condition is not considered "affordable employer-sponsored health care insurance." If a child has exceeded the annual coverage limits for all health care services, the child is not considered insured and does not have access to affordable health insurance. The law also specified that the program will remain in effect only if the federal government appropriates funds. For more information about Missouri's CHIP program: Missouri MC+ for Kids
Montana	In 2007, SB 22 was enacted to increase the CHIP eligibility level for children in families with income up to 175 percent of federal poverty guidelines--from the current level of 150 percent--provided there is funding available. The bill requires the state to leverage any federal dollars available to fund the program, possibly through a Medicaid waiver. In November 2008, Montana voters approved the I-155 ballot initiative, the Healthy Montana Kids Plan Act. This initiative establishes a plan to expand and coordinate coverage for Montana children under the Children's Health Insurance Program (CHIP), the Montana Medicaid Program, and employer-sponsored health insurance. The

	initiative allows the State Health Department to raise income eligibility levels for children under CHIP and Medicaid to 250 percent of the federal poverty guidelines; simplify transitions between CHIP and Medicaid coverage; provide assistance for children in employer-sponsored insurance; and work with health care providers, schools, organizations, and agencies to encourage enrollment of uninsured children. Funding for I-155 will come from a share of the insurance premium tax and federal matching funds. The initiative also requires the establishment of automatic enrollment mechanisms, a board of directors for the premium assistance purchasing pool plan, and an outreach campaign to encourage enrollment. In 2009, the Montana legislature approved the state's budget (HB 2), which appropriated funds to implement the Healthy Montana Kids Plan Act to be effective October 1, 2009. For more information about Montana's CHIP program: Montana CHIP
Nebraska	In 2009, LB 603 was enacted, which increases Medicaid/CHIP eligibility for children from 185 percent of the federal poverty guidelines to 200 percent of the federal poverty guidelines. The expansion was implemented beginning September 1, 2009. For more information: Nebraska Kids Connection
New Hampshire	Chapter 345 (SB 192), enacted in July 2007, creates a public education and outreach program within CHIP. The purpose of the outreach program will be to increase enrollment by informing new parents of the program's availability and assisting families in the completion of the application process as necessary. The law instructs the Department of Health and Human Services to allocate funds for the development of a volunteer program, with tasks including promoting the program to eligible families and identifying families who may require assistance with the application process. Agencies that provide additional follow-up with applicants will be reimbursed with an enhanced application fee for outreach assistance. In 2009, Senate Bill 115 (Chapter 224) was enacted, which establishes the New Hampshire healthy kids corporation to administer the state's CHIP program, Healthy Kids. The law allows uninsured young adults to buy insurance through the Healthy Kids program. Young adults who are 19 to 25 years old, who cannot be included in their family's insurance plan and whose incomes are at or below 400 percent of the federal poverty guidelines are eligible for the buy-in program. In 2009, House Bill 529 (Chapter 317) was enacted, which directs the department of health and human services to seek CMS approval for a limited Medicaid expansion to provide transitional Medicaid eligibility for children whose eligibility for Healthy Kids Gold terminates mid-month and who are eligible for Healthy Kids Silver, but who will not receive coverage until the first of the month following Healthy Kids Gold ineligibility. Coverage of Medicaid services during the transition period shall be funded with CHIP funds. For more information about New Hampshire's CHIP program: New Hampshire Healthy Kids
New Jersey	In 2005, New Jersey enacted SB 2236 creating a new program within CHIP, FamilyCare Advantage, that allows families whose income is above 350 percent of the federal poverty level to buy into CHIP coverage for their uninsured children. Families are responsible for paying the full premiums, but rates are lower than the average private insurance plan ($137/month for one child to $411/month for 3 or more children). This buy-in program does not rely on any federal funding. The state

	reached an agreement with the insurance provider, Horizon Blue Cross Blue Shield of New Jersey, in December 2007 and implementation of the FamilyCare Advantage program began in January 2008. The program expects to extend coverage to 15,000 children. This legislation included other reforms to New Jersey's CHIP program, FamilyCare, such as streamlining the application process and reversing the governor's freeze on covering parents through FamilyCare. In 1999, New Jersey expanded CHIP eligibility from 200 percent of the federal poverty level to 350 percent of the federal poverty level. Currently, children in families with incomes between 150 percent federal poverty level and 350 percent federal poverty level are required to pay monthly premiums and co-payments based on a sliding scale by income. In June 2008, Chapter 38 (SB 1557) was enacted requiring all children 18 years of age and younger to have health insurance coverage. The law appropriates $1 million to create and carry out the NJ FamilyCare initiative to increase outreach, enrollment and retention. The initiative requires the Commissioner of Human Services to establish the Outreach, Enrollment, and Retention Working Group to increase enrollment and retention in public health coverage programs. Additional information is provided in the following NCSL State Health Notes article: The Garden State Plows New Ground (August 4, 2008). For more information: New Jersey FamilyCare
New Mexico	In 2006, SB 267 was enacted to create the Premium Assistance for Kids (PAK) program for uninsured children up to age 11 who are ineligible for Medicaid or CHIP. Through this state-funded program, the state pays up to 50 percent of the premiums for participating plans. In addition, the state expanded Medicaid eligibility for children under six by increasing allowable earning and childcare disregards. In September 2008, Chapter 10 (Special Session SB 22) was enacted which made a $32,500,000 appropriation to the human services department. Portions of this appropriation are designated to provide coverage for individuals enrolled in or eligible for the developmental disabilities Medicaid waiver program, provide coverage for more children under age 18 years through the Medicaid and CHIP, and to provide behavioral health services to individuals through age 18 enrolled in Medicaid or CHIP. This law is effective January 1, 2009. For more information about New Mexico's CHIP program: New Mexico New MexiKids
New York	The state legislature approved the state budget for 2008 (SB 2108; 2007 N.Y. Laws, Chap. 58), which includes an CHIP eligibility level increase from 250 percent of the federal poverty level up to 400 percent of the federal poverty level. Families with incomes above 400 percent may buy-in to the program for their children. Due to the August 17 directive, CMS denied New York's request for this expansion. In April 2008, Chapter 58 (SB 6808), the 2009 budget was enacted and appropriated state funds for the implementation of the expansion of the Child Health Plus program to 400 percent of the federal poverty guidelines. This expansion was implemented beginning September 1, 2008. For more information about New York's CHIP program: New York Child Health Plus
North Carolina	In 2007, North Carolina enacted HB 1473 which created the North Carolina Kids' Care that will increase CHIP eligibility for kids whose family income is between 200 percent federal poverty level and 300 percent federal poverty level. The law states that the expansion will become effective July 1, 2008. Due to the August 2007 CMS directive, North Carolina is exploring funding options for the expansion.

	For more information about North Carolina's CHIP program: North Carolina Health Choice for Children
North Dakota	In 2007, HB 1463 was enacted which increased CHIP eligibility levels from the current level of 140 percent of federal poverty guidelines to 150 percent for children up to age 19; CMS approved this expansion on June 5, 2008. In 2009, HB 1012 (Chapter 12) was enacted, which increased the net income eligibility limit from 150 percent to 160 percent of the federal poverty guidelines for the state's children's health insurance program. The law also requires the department of human services to award a contract for outreach services for the state children's health insurance program to an entity other than an insurance company, for the biennium beginning July 1, 2009 and ending June 30, 2011. For more information about North Dakota's CHIP program: North Dakota CHIP
Ohio	In June 2007, the 2008-09 state budget (HB 119), was signed into law, which includes an expansion of CHIP eligibility for children with family incomes up to 300 percent of the federal poverty level from the previous level of 200 percent of the federal poverty guidelines. This bill also allows children under 19 years of age with family incomes above 300 percent of the federal poverty guidelines to buy-in to the program if the individual has not had creditable coverage for at least six months and is unable to obtain coverage due to a pre-existing condition, lost coverage because the individual has exhausted a lifetime benefit limitation, the premium for the only coverage available is greater than 200 percent of the premium under the buy-in program, or the individual participates in the program for medically handicapped children. In response to the August 2007 CMS directive, Ohio explored additional funding options. In April 2008, an executive order was signed by the governor establishing the Children's Buy-In program, which enables families with incomes above 300 percent federal poverty level to purchase public coverage for their children. The program intends to target children from middle-class families with serious health conditions that make private coverage unaffordable or unavailable. The program accepted applications starting April 1, 2008 and began enrollment June 1, 2008. Additional information is provided in the following NCSL State Health Notes article: Ohio to Cover Children with Serious Health Conditions (April 28, 2008). In June 2008, House Bill 562 was enacted which changes the minimum income eligibility requirement for the Children's Buy-In program to be income above 250 percent of the federal poverty guidelines. An individual's countable family income, rather than just the individual's income shall be used to determine whether the individual meets the income eligibility requirements. An individual may be granted an exception to the requirement that the individual not have had credible coverage for at least six months before enrolling in the program if the individual exhausted a lifetime benefit limitation. The act requires specified cost sharing provisions, including monthly premiums and co-payments. For more information about Ohio's CHIP program: Ohio Healthy Start
Oklahoma	SB 424, the All Kids Act, was enacted in 2007 which creates a premium assistance program within Medicaid for children under age 18 whose family income is between 185 percent and 300 percent of the federal poverty level. The program is expected to assist as many as 42,000 additional children in obtaining health care coverage. As a result of the August 2007 CMS directive, Oklahoma will only provide this premium assistance program to children whose family income is up to 250 percent of the federal poverty level.

	For more information about Oklahoma's CHIP program: Oklahoma SOONERCARE
Oregon	In 2009, HB 2116 was enacted, which directs the Office of Private Health Partnerships to administer a private health option to expand access to health insurance for Oregon's children. The premium assistance shall be equal to the full cost of the premium for children whose family income is at or below 200 percent of the federal poverty guidelines and who have access to employer sponsored health insurance. The premium assistance shall be based on a sliding scale for children whose family income is above 200 percent but at or below 300 percent of the federal poverty guidelines, regardless of whether the child has access to coverage under an employer sponsored health benefit plan. A child whose family income is more than 300 percent of the federal poverty guidelines shall be offered the option of purchasing a health benefit plan through the private health option at full cost. A press release from the Oregon House of Representatives, Office of the Speaker on June 8, 2009 estimates that the legislation will cover 80,000 Oregon children. For more information about Oregon's CHIP program: Oregon Health Plan
Pennsylvania	In 2006, Act 136 (HB 2699) was enacted to create the Cover All Kids program, which expands eligibility for the CHIP program. Prior to the expansion, Pennsylvania covered children in families with income up to 200 percent of federal poverty guidelines through CHIP. The state will continue that coverage and open the program to children in families with income up to 300 percent of federal poverty guidelines with premiums based on a sliding income scale, ranging from $36 to $57 per child per month. Families with incomes above this threshold may buy into the CHIP program if coverage has been denied due to a preexisting condition, private insurance premiums are 150 percent higher than the state's monthly premium, or the cost of insurance exceeds 10 percent of annual family income. For parents at this income level who can access private insurance but cannot afford the premiums, the state will subsidize the cost. The expansion was approved by CMS in February and the program began implementation in March 2007. For more information about Pennsylvania's CHIP program: Pennsylvania CHIP
Rhode Island	In May 2008, Chapter 9 (HB 7204), removed coverage for noncitizen children lawfully residing in the United States under the RIte Care, Rhode Island's CHIP program. The RIte Care program currently covers children up to age 19 in families with income up to 250 percent of the federal poverty guidelines and continues to cover legal immigrant children after five years of residency as provided under federal law. For more information about Rhode Island's CHIP program: RIte Care
South Carolina	A provision in the 2007-2008 budget (2007 HB 3620) passed the state legislature in June 2007 and creates a separate Children's Health Insurance Program, Healthy Connections Kids, that expands eligibility to children with family incomes up to 200 percent of the federal poverty level. This provision was vetoed by the Governor, but the legislature overrode the veto. For more information about South Carolina's CHIP program: South Carolina Partners for Healthy Children; Healthy Connections Kids
Tennessee	Cover Kids (2006 Tenn. Pub. Acts, Chap. 867) was enacted in 2006. The state received federal approval in January 2007 and the program began implementation in April 2007. The Cover Kids plan expands health insurance to uninsured children under age 19 who are not eligible for Medicaid and who have been uninsured for at least three months. Cost-sharing for more services is required for all participants. Eligible

	enrollees with income less than 250 percent of federal poverty guidelines do not pay premiums. Families whose income is above 250 percent federal poverty level can buy-in to the program by paying monthly premiums (approximately $225 per month per child for the year 2008). The benefits of the plan are based on the state employees' health insurance plan and focus on preventative and well-child care. For more information about Tennessee's CHIP program: Tennessee CoverKids
Texas	In June 2007, HB 109 was enacted which created a community outreach campaign for CHIP and extended continuous coverage for children from 6 to 12 months and eliminated a 90-day waiting period, except for certain applicants. In May 2009, Senate Bill 187 (Chapter 34) was enacted, which directs the executive commissioner of the health and human services commission to develop and implement, not later than December 1, 2009, a Medicaid buy-in program for children with disabilities whose family incomes do not exceed 300 percent of the federal poverty guidelines. Monthly premiums according to a sliding scale based on family income shall be required. For more information about Texas's CHIP program: Texas CHIP
Utah	The Governor pledged $4 million to lift the enrollment cap on the state's CHIP program to enroll 14,000 additional children in his 2007 State of the State address. Funding was approved in the 2007 state budget, and enrollment was re-opened in July 2007. In March 2008, Chapter 386 (HB 326) was enacted which requires the Department of Health to keep enrollment in Utah's CHIP open so that all eligible children who apply for coverage under CHIP can enroll in the program and designates appropriations. Also in March 2008, Chapter 383 (HB133) was enacted which specifies that adults who enroll in Utah's Premium Partnership for Health Insurance (UPP), must also enroll their children in the program, who would then be ineligible to enroll in Utah's CHIP program. UPP is a premium assistance program that helps adults and families pay for monthly premiums when they enroll in their employer's health insurance plan. In addition, the bill allows approval for UPP to be considered a qualifying event for applicants to enroll in their employer-sponsored health insurance plan at any time. For more information about Utah's CHIP program: Utah CHIP For more information about the UPP program: Utah's Premium Partnership for Health Insurance
Vermont	Enacted in 2006, HB 861 (Act 191) aimed to achieve near-universal coverage for state residents. Before this legislation, eligibility levels for children for Medicaid/CHIP programs were already at 300 percent of federal poverty guidelines. However, the reforms reduce premiums for children in the Dr. Dynasaur, Vermont's CHIP program, by half. A private insurance plan that is subsidized by the state (for individuals or families with income below 300 percent of federal poverty guidelines) will be available for children and families who are not eligible for other public insurance. Individuals and families with income above 300 percent of federal poverty guidelines may buy-in to the program. In addition, the reforms provided funding for outreach efforts. In June 2008, Chapter 192 (HB 891) was enacted which increases the premiums for Dr. Dynasaur, Vermont's CHIP program, from $40.00 to $60.00 for children in households whose income is greater than 225 percent and less than or equal to 300 percent of the federal poverty level. For more information about Vermont's CHIP program: Vermont Dr. Dynasaur For more information about Vermont's Catamount Health program: Catamount Health

	2006 Legislation; Vermont's 2006 Health Reform Initiatives
Washington	SB 5093, enacted in 2007 (Chapter 5), expands Washington's CHIP eligibility level to children, regardless of their citizenship status, in families with incomes at or below 250 percent of federal poverty guidelines. Cost sharing on a sliding scale is required for families with incomes between 200 and 250 percent of federal poverty guidelines. The law includes outreach and administrative measures, including consolidating applications for three state-sponsored insurance programs into one application. The law also states that effective January 1, 2009, upon appropriation of funds, eligibility shall be increased to 300 percent of the federal poverty level and that families above 300 percent of the federal poverty level shall be able to buy-in to the program. For more information about Washington's CHIP program: Washington SCHIP
West Virginia	In 2006, HB 4021 (Chapter 106) was enacted which expanded CHIP eligibility up to 300 percent of the federal poverty level. The government requested that the expansion be delayed until Congress reauthorized the SCHIP program; the state then decided to implement the expansion incrementally. As of January 1, 2007, the state began enrolling children with incomes up to 220 percent of the federal poverty level. As of January 1, 2009, eligibility of the CHIP program was expanded to 250 percent of the federal poverty guidelines. Families with income between 200 and 250 percent of the federal poverty guidelines are required to pay premiums and co-payments. For more information about West Virginia's CHIP program: West Virginia WVSCHIP
Wisconsin	In 2007, SB 40 (Act 20) was enacted to expand CHIP eligibility to families with incomes up to 300 percent of the federal poverty level. Due to the August 2007 CMS directive, state-only funds will be used to finance coverage for children with family incomes between 250 and 300 percent of the federal poverty level. Under the BadgerCare Plus program, Wisconsin's SCHIP program, families with annual incomes between 200 percent and 300 percent of the federal poverty level are eligible for health coverage for their children and will be required to pay premiums (approximately $10 to $90.74 per month). Families with annual incomes more than 300 percent of the poverty level may buy-in to the program and must contribute the full cost of coverage, about $1,089 per child per year. The program does not cover undocumented immigrant children or parents whose employers cover 80% of the cost of family coverage. For more information about Wisconsin's CHIP program: Wisconsin BadgerCare Plus; BadgerCare Eligibility Handbook

Source: National Conference of State Legislatures, Kaiser Family Foundation: State Coverage Initiatives for Children

Note: *List may not be comprehensive, but is representative of state plans and proposals. NCSL appreciates additions and corrections. To submit additions or corrections, please email us at* health-info@ncsl.org

Vicki

Children's Health Insurance Program
Income Examples at 250% and 160% Federal Poverty Level (FPL) (net)
January 2011

Proposed: Example 1a: 250 Family of 3 (Mother and 2 children)

Mother works and earns: $4,500 per month (gross income is at 295% of FPL)
Deductions:

- Mother receives $30 work/training allowance
- Mother has withholding for taxes of $675

Total Deductions $705
NET INCOME: $3,795 PER MONTH ($45,540/YR)– PASSES NET INCOME TEST AT 250% ($3,815)

Existing Law: Example 1b: 160 Family of 3 (Mother and 2 children)

Mother works and earns: $3000 per month (gross income is at 164% of FPL)
Deductions:

- Mother receives $30 work/training allowance
- Mother has withholding for taxes of $500

Total Deductions $430
NET INCOME: $2470 PER MONTH – ($29,640/YR) - (161.8%) 160 %=($2441)

Present: $2470/month exceeds allowed net income.

Proposed: Example 2a: 250 Family of 4 (Father, Mother and 2 children)

Father works and earns $3,500 per month (gross income)
Mother works and earns $2,500 per month (gross income)
$6,000 total (gross income is at 327% of FPL)
Deductions:

- Mother and father each receive $30 work/training allowance per month (total $60)
- Father's withholding for taxes is $525 and Mother's withholding for taxes is $375 (total $900)
- Child care expenses of $500 per month

Total Deductions $1,460
NET INCOME $4,540 PER MONTH ($54,480/YR)– PASSES NET INCOME TEST AT 250% ($4,595)

Existing Law: Example 2b: 160 Family of 4 (Father, Mother and 2 children)

Father works and earns $2,600 per month (gross income)
Mother works and earns $1600 per month (gross income)
$4,200 total (gross income is at 218% of FPL)
Deductions:

- Mother and father each receive $30 work/training allowance per month (total $60)
- Father's withholding for taxes is $400 and Mother's withholding for taxes is $250 (total $650)
- Child care expenses of $500 per month

Total Deductions $1,210
NET INCOME $2990 PER MONTH ($ 35,880/YR) = 162.9%
NET INCOME TEST AT 160% = ($2940)

Present: $2990/month exceeds allowed net income.

Proposed: Example 3a: 250 Family of 4 (Father, Mother and 2 children)

Father works and earns $3,500 per month (gross income)
Mother works and earns $3,800 per month (gross income)
$7,300 total (gross income is at 397% of FPL)
Deductions:

- Mother and father each receive $30 work/training allowance (total $60)
- Father 's withholding for taxes is $540 and Mother's withholding for taxes is $600 (total $1,140)
- Father pays $400 child support
- Child care expenses of $800
- Mother and Father each pay $180 per month for a 'single' health insurance plan through their employer (total $360)

Total Deductions $2,760
NET INCOME $4,540 PER MONTH ($ 54,480/YR) – PASSES NET INCOME TEST AT 250% ($4,595)

Existing Law: Example 3b: 160 Family of 4 (Father, Mother and 2 children)

Father works and earns $2,600 per month (gross income)
Mother works and earns $2,900 per month (gross income)
$5,700 total (gross income is at 288% of FPL)
Deductions:

- Mother and father each receive $30 work/training allowance (total $60)
- Father's withholding for taxes is $450 and Mother's withholding for taxes is $500 (total $950)
- Father pays $400 child support
- Child care expenses of $700
- Mother and Father each pay $180 per month for a 'single' health insurance plan through their employer (total $360)

Total Deductions $2,570
NET INCOME $3030 PER MONTH ($ 36,360/YR) - (164.8%) 160 %=($2940)

Present: $3030/month exceeds allowed net income.

HB 1377
Senate Human Services Committee
January 26, 2011

Chairman Weisz and members of the House Human Services Committee, I am Paul Ronningen, State Coordinator for the Children's Defense Fund – North Dakota. I am also representing the North Dakota Economic Security and *Prosperity Alliance (NDESPA) and the North Dakota Conference of Social* Welfare.

These organizations, are concerned about health care coverage for children from low-income ***working*** families through the Children's Health Insurance Program. **North Dakota is now recognized as having the lowest coverage for children from low income working families in the United States at 160% of the federal poverty level.**

North Dakota is in an era of unprecedented fiscal health. We believe our current situation is an opportunity to expand healthcare coverage to children of **working families** equal to that of Montana. In Montana, the coverage was extended to 250% after a successful initiative measure was filed. The general population of *Montanan passed this measure by approximately 69% of the state-wide vote.*

The range in coverage is North Dakota (lowest) at 160% of poverty while New York covers children from low-income families up to 400% of the federal poverty level. CHIP eligibility in surrounding states include:

- Iowa 300% of poverty
- Minnesota 275% of poverty
- Montana 250 % of poverty
- South Dakota 200% of poverty
- Wyoming 200% of poverty

11 states cover families at 300 % of poverty or higher. **The average level of eligibility is 245% of the federal poverty level**.

I have also attached a study by NDSU, Making Ends Meet in North Dakota, May 2010 (Attachment A), which indicates that a single **working mother** of two children, ages 4 and 6, must earn $20.95/hour to stay off of public assistance and pay her bills. To pay her taxes her hourly income needs to be $25.75/hour...or an annual salary of $53,570. However, single mothers in North Dakota have a median income of $21,524. In fact, all North Dakota women who work full-time, year round, earn a median $28,789. Both are well below the amount NDSU researchers found to be needed.

This bill, however, would support this **working mother** by providing health insurance for her children up to an annual salary of $47,775 (250% of poverty

level for a family of three). Support of this family with a CHIP Bill at 250% of poverty thus reduces the likelihood that this mother will slip into the Medicaid program, costing the tax payers of North Dakota additional money while providing her children health care and many additional supports beyond what a CHIP Program at 250% is requiring.

You may hear some Legislators talk about North Dakota's disregards as an explanation for keeping our income eligibility so low. But, many states have disregards. However, our level of disregards in no way compensates for North Dakota's extremely low eligibility level. The fact is, that at 160%, North Dakota has the lowest eligibility in the nation.

Why expand health care coverage to more children?

Compared to their insured peers, uninsured children are:

- Almost ten times as likely to have an unmet medical need
- More than eight times as likely to have delayed medical care due to cost;
- More than five times as likely to have an unmet dental need
- More than four times as likely to have gone more that two years without seeing a doctor
- Twice as likely to have gone more than two years without a dental visit
- Children without insurance are 60% more likely to die than their insured counterparts when needing hospitalization.

Investing in children's health is an investment in the future:

- Studies show that increased life expectancy and improved health status results from covering children – in addition to productivity gains for future workers will yield cost-savings for society.
- Lack of health insurance has been shown to impact educational attainment, which in turn impacts income.

It costs less to cover children than any other group of people:

- A year's coverage for a **single working adult** cost about three times what it costs to cover a child for the same length of time.
- Prevention and early care are cost-effective.
- Primary care doctor visits cost less than emergency rooms.
- Studies show children enrolled in CHIP miss fewer classes and demonstrate better school performance than when they were uninsured.

The federal government matches our state investment in the Children's Health Insurance Program.

Under the new federal healthcare reform law, states are prohibited from falling below Medicaid and CHIP coverage levels that were in place when Federal Healthcare went into effect. However, that does NOT mean states are prohibited from *increasing* eligibility.

It is also important to point out that under healthcare reform, Medicaid is expanded from 100% to 133% for children between the ages of 6-19, effectively moving some children currently covered by CHIP to Medicaid.

In summary, providing health care coverage to children from low-income families does several things. First of all, health care coverage is a tool for **working families** to assist them in raising children who can become productive citizens of our state. It makes economic sense; it is cheaper to provide preventative care than incur the costs of unattended health issues.

North Dakota is in a period of economic prosperity where we can easily extend this coverage to our children. We understand the importance of being careful with the state's financial resources and no one wants to see North Dakota suffer the economic woes of other states. And we appreciate the care that is used in determining when increasing spending is justified.

However, we also understand that we have an opportunity before us. We can leverage federal dollars available to us and for a relatively nominal amount, cover more children, thus, reaping the reward of healthier and better educated children and, ultimately, a stronger adult workforce.

Now let me introduce you to the Anderson family and their attempt to get Children's Health insurance in North Dakota and the surrounding states (Attachment B)

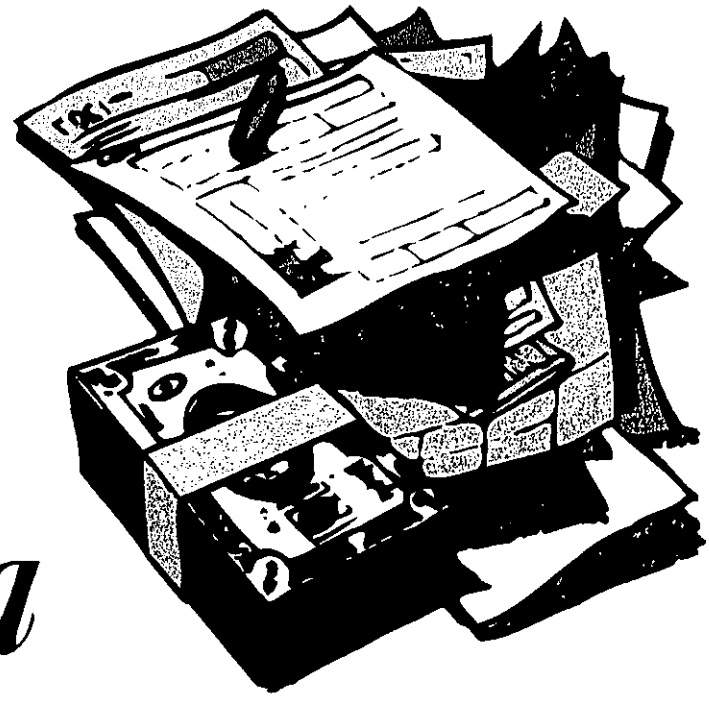
We need to make sure we take advantage of every opportunity presented by current fiscal situation so that we can maintain the strength and well being of **working** North Dakotans.

Thank you.

A

FE-577 (Revised)

Making Ends Meet in North Dakota



Debra Pankow, family economics specialist • **Marina Serdiouk**, graduate student

What would an employed mother with two children need to earn to meet her monthly bills in North Dakota without relying on government assistance?

Welfare reform has mandated the dual challenges of moving recipients off public assistance into employment and limiting access to public assistance for a lifetime total of only 60 months. However, these changes in the social safety net assume not only that enough jobs will be available, but they will pay sufficiently to end any further need for assistance.

So two questions need to be answered: What is the amount of monthly income necessary to support a family without having to fall back onto public assistance? And, is North Dakota's economy producing the kinds of full-time employment opportunities that will eliminate the need for assistance?

NDSU Extension Service
North Dakota State University
Fargo, North Dakota 58108

May 2010

Calculating a Cost-of-living Budget

Since the beginning of this century, researchers have made efforts to determine the minimum costs of meeting a family's monthly needs. Typically, these efforts were based on actual household spending (frequently urban households) as reported in surveys or diaries.

Today, the discussion of a living wage arises in part from the inability of the current minimum wage to provide an income adequate for a family to live above the poverty line. These debates are about whether businesses applying for government grants or subsidies should be paying a wage sufficient to keep their workers above the poverty line, eliminating the need for their employees to seek further government assistance.

A living wage is the amount of earnings necessary for a family to meet minimum monthly costs. Typically included in this are the costs for housing and utilities, food, child care, transportation, and basic household and personal care items. Not typically included are costs for items such as entertainment, birthday or other gifts, toys, tobacco products or alcohol.

Existing models figure these costs to calculate what a family must earn to meet a minimum monthly budget.

Typically, advocacy groups calculate these for urban areas, especially those with upcoming or pending living-wage legislation. However, because costs are not the same in rural and urban areas, the results cannot be generalized across the geographic spectrum.

Differences in the local cost of living vary not only by region but also by rural and urban residence. In urban areas, public transportation is available not only for getting to and from work, but also for grocery shopping, visiting a doctor or many other purposes. But in rural areas, public transportation is rare. The only way for an individual to get around in most rural communities is by personal transportation, whether that's owning one's own vehicle or sharing a ride with someone who does.

Further evidence of this disparity can be found in the 2008 Consumer Expenditure Survey. Transportation costs were 16.7 percent of urban but 21.2 percent of rural monthly household expenditures. Utilities are 7.1 percent of urban but 8.6 percent of rural household costs. Health-care costs consume just more than 5.7 percent of the average urban household's expenditures, but nearly 8 percent of rural households' expenditures.

What, then, would an employed mother (age 24) with two children (age 4 and 6) need to earn to meet her monthly bills in North Dakota without relying on government assistance?

The information designated * are costs associated with essential living items that were collected through research in the Fargo-Moorhead area. In instances where local data were not available, reasonable estimates were derived from the 2006 Consumer Expenditure Survey for the Midwest region. Food costs were taken from the Official USDA Food Plans: Cost of Food at Home at Four Levels, U.S. Average, Thrifty Food Plan, August 2008, for a female age 19 to 50 and two children, age 4 and 6.

The estimated cost of living for an employed single mother with two children in North Dakota is $838 a week, $3,633 a month or $43,596 a year. To meet her monthly cost of living, a single mother must earn a take-home wage of $20.95 an hour.

Adding OASDI (Old Age, Survivors and Disability Insurance) and Medicare taxes (6.2 percent and 1.45 percent), as well as income taxes (15 percent),

Item	Monthly Cost
* Housing (rent, insurance, utilities)	830
* Phone	35
Food	401
* Child care	993
Household, personal care items and clothing	328
Transportation (car payments, gas, repairs, insurance, etc.)	811
Health care (insurance, prescriptions, etc.)	235
Total per month	3,633
Total per year	43,596

* Based on local information

the necessary minimum monthly income needed to generate the net income to make ends meet would rise to approximately $4,464, or $53,570 per year. This would require an hourly wage of $25.75 per hour for full-time work for a year to both meet a minimum monthly budget and pay these taxes.

Opportunities in North Dakota's Economy

In the last decade, North Dakota's economic news has been mixed. Unemployment rates have dropped from 4.3 percent in 1989 to 3.6 percent in August 2008, placing North Dakota's unemployment rate considerably below the 6.1 percent national rate. The state has had an increase in the availability of jobs, yet the per-capita income for North Dakotans in 2007 was $34,846, compared with the national per-capita income of $ 38,611. Given this, what are the prospects of low-income North Dakotans enrolled in Temporary Assistance to Needy Families (TANF) achieving economic self-sufficiency, the stated goal of the program?

According to the U.S. Bureau of Labor Statistics, the median weekly income for females employed full time in 2007 was $614, or $15.35 per hour. The median weekly income is the point where half of all weekly incomes are more and half less than the median figure. Median income for men was $766 a week, or $19.15 per hour.

Relying on an average wage masks the earning differences for men and women by educational level and employment sector. In 1990, the median hourly wage of all North Dakota women employed full time

was $8.70 an hour, compared with $12.13 for men. These figures rose to $10.15 for women and $13.45 for men in 1995. In 2000, the median wage for a woman in North Dakota was $10 an hour, while for men it was $13.90. In 2004, median weekly earnings for men in North Dakota rose to $622, or $15.55 an hour, while median weekly earnings for women were $467, or $11.67 an hour. In 2007, median weekly earnings for men in North Dakota rose to $ 589.2, or $ 14.73 an hour, while median weekly earnings for women in North Dakota rose to 373.3, or $9.3 an hour.

The 2007 American Community Survey shows the four largest types of employers in North Dakota are services, retail trade, agricultural and manufacturing. Women are more likely than men to be employed in services and retail trade than in agriculture and manufacturing. In 2006, the national median weekly earnings for the accommodation and food service industries was $371:$355 for females ($ 8.88 per hour) and $389 for males ($ 9.73 per hour). It was $538 ($13.45 per hour) for females and $ 696 for males ($17.40 per hour) employed in sales (Highlights of Women's Earnings in 2006, U.S. Bureau of Labor Statistics September 2007).

The federal minimum wage is set at $6.55 an hour. If a single mother worked 2,080 hours a year at the current minimum wage, she would earn only $13,624 a year before taxes. If this single mother had two dependent children, these wages would not bring her and her children above $17,600 a year, the current poverty threshold for a family of three. This means that to meet the basic cost of living in North Dakota for a family of three, a single working mother would need to earn an additional $19.20 an hour ($3,328 a month or $39,936 a year) on top of minimum wage. At the current minimum wage, our single mother does not have enough extra hours to work every week just to meet the most basic monthly cost-of-living budget without further assistance.

If the employer offered health insurance or other benefits, the monthly cost of living for this family would decrease significantly – more than $200 a month if health insurance were provided. And arrangements may be available for child care that cost much less than the average of $993 a month for two children. Food stamps are another resource that can extend the earnings of limited-resource individuals and families. In addition, housing costs may be much lower in rural areas, but food and transportation may be higher. For this analysis, we have chosen to highlight the Fargo-Moorhead area because it is the largest community in the state where jobs are available.

Conclusions

How much does an employed single mother with two dependent children living in North Dakota need to earn to meet her family's monthly needs? And how likely is this mother to find employment that meets this monthly budget without also needing government assistance? This analysis demonstrates that even presuming employment opportunities in North Dakota, a significant gap is likely between earnings and the actual cost of meeting a monthly household budget for the typical family receiving public assistance (for example, a single mother with two dependent children not receiving child support).

North Dakota's labor market is heavily weighted toward the services sector, which has a high proportion of minimum- to low-wage jobs. These are jobs unlikely to provide wages at the $25.75 an hour before taxes necessary for a single mother with two dependent children to live without additional assistance. Yet the opportunity for welfare recipients to move into jobs with adequate pay is the key assumption upon which the success of welfare reform depends.

North Dakota adults receiving public assistance who are required to move into the labor force as quickly as possible face a labor market where jobs, when they can be found, likely will be at or just above minimum wage. Yet, because the majority of TANF cases are single-parent families – typically single mothers – they will need to find employment that pays enough wages to meet their monthly costs of living.

This analysis indicates that with welfare reform, North Dakota's employed single mothers living in rural areas are facing even greater challenges in meeting their families' minimum needs. The analysis also highlights an unanswered question: If individuals are employed full time but still do not earn enough to meet their families' monthly costs of living, how do they close the gap between earnings and monthly costs, especially after exhausting their 60-month lifetime limit of assistance?

2008 HHS Poverty Guidelines

People in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,400	$13,000	$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: Federal Register, Vol. 73, No. 15, Jan. 23, 2008, pp. 3971–3972

Sampling of programs in which eligibility is partially based on federal poverty guidelines:

- Head Start ..... 100 percent of poverty or below
- Food stamps ..... Gross income less than 130 percent of poverty
- Free school breakfast and/or lunch ..... 130 percent of poverty or below
- Reduced-price school breakfast and/or lunch ..... 130 to 185 percent of poverty
- Medical Assistance ..... 133 percent of poverty or below*
- WIC (Women, Infants and Children) ..... 185 percent of poverty or below
- Healthy Steps (children's health insurance program) ..... 140 percent of poverty or below*

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1) Regional and State Employment and Unemployment Summary: August 2008. Bureau of Labor and Statistics. Link: *www.bls.gov/news.release/laus.nr0.htm*

2) Household Data Annual Averages Link: *ftp://ftp.bls.gov/pub/special.requests/lf/aat39.txt*

3) Employment situation summary. Bureau of Labor and Statistics. Link: *www.bls.gov/news.release/empsit.nr0.htm*

4) Regional and State Employment and Unemployment Summary. Link: *www.bls.gov/news.release/laus.nr0.htm*

5) Highlights of Women's Earnings in 2006. U.S. Department of Labor Sept 2007 Link: *www.bls.gov/cps/cpswom2006.pdf*

6) Per Capita Personal Income by State. Link: *www.unm.edu/~bber/econ/us-pci.htm*

7) Official USDA Food Plans: Cost of Food at Home at Four Levels, U.S. Average, August 2008. U.S. Department of Agriculture. Link: *www.cnpp.usda.gov./USDAFoodCost-Home.htm*

8) Consumer Expenditure Survey 2006

9) Median earnings in the past 12 months by sex. 2007 Community Survey. Link: *http://factfinder.census.gov/*

10) Population and Housing Narrative Profile: 2007. American Community Survey 1-year Estimates. Link: *http://factfinder.census.gov/*

For more information on this and other topics, see: www.ag.ndsu.edu

County Commissions, NDSU and U.S. Department of Agriculture Cooperating.
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3M-3-02; Web-10-06; 2M-5-10

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January 2011

Putting North Dakota's Children's Health Insurance Program (CHIP) in Perspective

A report from North Dakota KIDS COUNT

North Dakota's Children's Health Insurance Program is called "Healthy Steps."

Three programs help children obtain health care in our state.

Health insurance program name	What is this program?	What are the income requirements for eligibility?
Medicaid	A health insurance program for North Dakotans with incomes usually below the poverty level. It is mainly a free program, although there may be some small costs (co-pays).	Children ages 6-19 in families with net incomes at or below the poverty level and children ages 0-5 in families with net incomes at or below 133% of the poverty level are eligible for Medicaid.
Healthy Steps (CHIP)	Healthy Steps is North Dakota's CHIP - our Children's Health Insurance Program. Since 1997, all states have created health insurance programs to cover children who do not have health insurance, are 18 years of age or younger, do not qualify or are not fully covered by Medicaid, and live in lower-income families.	Children ages 0-18 in families with net incomes at or below 160% of the poverty level are eligible.
Caring for Children	Caring for Children is funded by the North Dakota Caring Foundation, a not-for-profit organization that was begun by Blue Cross Blue Shield of North Dakota in 1989. It is for children who do not have health insurance coverage and do not qualify for Medicaid or Healthy Steps.	Children ages 0-18 in families with net incomes from 161% to 200% of the poverty level are eligible. A limit of 750 children can be covered by this program.

2010-11 Poverty Guidelines

Eligibility for CHIP is based on children's age and their families' income with respect to the poverty level. The poverty level is influenced by family size.

Size of Family	100% of Poverty	160% of Poverty	200% of poverty	300% of poverty
2	$14,570	$23,312	$29,140	$43,710
3	$18,310	$29,296	$36,620	$54,930
4	$22,050	$35,280	$44,100	$66,150
5	$25,790	$41,264	$51,580	$77,370
6	$29,530	$47,248	$59,060	$88,590

Putting North Dakota's Children's Health Insurance Program (CHIP) in Perspective...

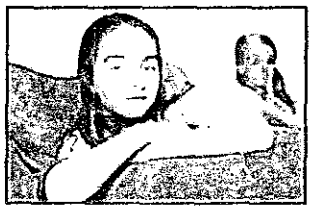
How does North Dakota compare?

North Dakota uses "net income" to determine CHIP eligibility. Net income results when you subtract allowable deductions from a family's gross (or total) income.

Most states say they use gross (or total) income to determine eligibility, yet many of these states also allow deductions.

State	Family Income Eligibility Level for CHIP	Common Monthly Deductions (amounts families can subtract from their gross income when calculating their CHIP income eligibility level)				
		Earnings ($$ per worker, per month)	Child Care Expenses	Child Support Received	Child Support Paid	Medical Premiums and Medical Expenses for Other Family Members
Iowa	300% of poverty	0	0	$50	0	0
Minnesota	275% of poverty	0	0	0	0	0
Montana	250% of poverty	$120	up to $200	0	0	0
South Dakota	200% of poverty	0	up to $500	$50	full amount	0
Wyoming	200% of poverty	0	0	0	0	0
North Dakota	**160% of poverty**	**$90***	**full amount**	**$50**	**full amount**	**full amount**

*Or the sum of state income tax, federal income tax, FICA, and any union dues, whichever is greater. In addition to these common deductions, see a complete list of deductions at www.state.nd.us/humanservices/policymanuals/healthysteps-508/healthy_steps.htm.



Meet the Anderson Family...

The Andersons have two children (ages 12 and 14). Their combined annual employment income is $44,100. Neither parent has health care coverage at work. They do not have child care costs. Would the Anderson children be eligible for children's health insurance coverage in North Dakota or in nearby states?

While North Dakota allows many deductions, the Andersons do not have enough deductions to enable their children to benefit from CHIP.

State	Anderson Family annual income (two workers)	Amount of annual deductions allowed the Anderson Family by CHIP	Anderson Family annual income after deductions	CHIP Family Income Eligibility Level in 2010 (for family of four)	Are the Anderson children eligible for CHIP?
Iowa	$44,100	0	$44,100	$66,150	Yes
Minnesota	$44,100	0	$44,100	$60,638	Yes
Montana	$44,100	$2,880	$41,220	$55,125	Yes
South Dakota	$44,100	0	$44,100	$44,100	Yes
Wyoming	$44,100	0	$44,100	$44,100	Yes
North Dakota	**$44,100**	**$4,887***	**$39,213**	**$35,280**	**No**

*Deductions for state taxes, federal taxes, and FICA assuming the Andersons take 4 exemptions on their W-4.

#3

Testimony on House Bill 1377
House Human Services Committee
January 26, 2011

Presented by Marlowe Kro
Associate State Director, AARP North Dakota

Chair Wiesz, members of the House Human Services Committee, I am Marlowe Kro, Associate State Director for AARP North Dakota. I am here today on behalf of AARP's 83,000 North Dakota members to speak in support of House Bill 1377.

The State Children's Health Insurance Program (SCHIP) covers children in working families who cannot afford health insurance but do not have income 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 the SCHIP. Along with Medicaid, SCHIP has been an essential buffer for families to access health care for their children.

The Kaiser Family Foundation (www.kff.org) 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 adults.

AARP supports continuing efforts to increase eligibility for SCHIP. This proposal to provide coverage to children in families with income levels at or below 250 percent of the poverty level is an important step toward the goal of ensuring health care for every child.

In 2009, the North Dakota legislature voted to expand SCHIP income eligibility from 150% to 160% of the poverty level. Even with the expansion to 160%, our state still has the most restrictive SCHIP eligibility level in the nation.

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

#4

Testimony
House Bill 1377
House Human Services Committee
Representative Robin Weisz, Chairman
January 26, 2011

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 increasing the net income eligibility from 160% to 250% of the poverty line for the state children's health insurance program. 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 intervention, 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.

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

#5

TESTIMONY
HB 1377
House Human Services Committee
Representative Robin Weisz - Chairman
January 26, 2011

Chairman Weisz and members of the Senate Human Services Committee, my name is Susan Rae Helgeland, Executive Director of Mental Health America of North Dakota. The mission of our organization is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

Mental Health America of North Dakota supports **HB 1377** to increase the eligibility for Children's Health Insurance Program (CHIP) from 160% to 250% of poverty. As our mission states, we advocate for increased access to mental health care and we feel, at 250% of poverty, more North Dakota families will have access to mental health care for their children.

In this time of economic challenge and the high cost of health insurance, it is more and more difficult for families to have sufficient health care coverage. Investing in the health of North Dakota's children is not only the right thing to do; it is a sound investment in the future of our state.

P.O. Box 2081
Bismarck, ND 58502-2081
701.222.1854
veronica.zietz@thearcofbismarck.org
www.thearcofbismarck.org

#6

Testimony of Support House Bill 1377
Human Services Committee
January 26, 2011

Good morning Chairmen Weisz and members of Human Services Committee. My name is Veronica Zietz (#99); I am the Executive Director at The Arc of Bismarck and I'm here today representing both The Arc of Bismarck and The Arc of Cass County. The Arc is an organization that provides education and advocacy to people with disabilities to foster empowerment and full inclusion in the community.

The Arc strongly supports House Bill 1377, which would increase the net income eligibility limit to 250% of poverty level for the Children's Health Insurance Program (CHIP). It is necessary to increase this limit, in order to extend insurance to the children that fall between the gaps in coverage offered by public programs and that is available through private means. All children, especially those with a disability can benefit from the increased access to health care that is associated with insurance coverage. An enhancement to CHIP would allow children in ND to access the health care they need more easily; essentially this would allow for regular check-ups and preventative care that could thwart bigger problems that cost more money in the long term.

Additionally, CHIP would be very valuable for children with disabilities that frequently utilize more specialized services as well as an increased variety and volume of health care services. Parents of children with disabilities often have limited affordability for the increased services that their children require. An increase of the net income eligibility limit could help kids with disabilities amongst others get the services they need.

It is time for North Dakota to extend CHIP to more low income families. This gap in services is a disincentive to hardworking parents whose children would be eligible for CHIP in surrounding states. I urge the committee to support House Bill 1377. Thank you for your time and consideration.

#7

House Human Services Committee
TESTIMONY IN SUPPORT OF HB1377
January 26, 2011

Josh Askvig – 701-223-0450 – josh.askvig@ndea.org

Chairman Weisz, members of the House Human Services Committee, for the record my name is Josh Askvig and I represent the North Dakota Education Association. We rise today in support of HB1377, which would raise the income eligibility level for access to the Children's Health Insurance Program.

The NDEA strongly supports efforts to ensure that Children are "ready to learn" and "ready for life," through our Ready Child Initiative. The vision of the NDEA Ready Child Initiative is to unite North Dakota's adults in doing what's best for kids. Our mission is to help every North Dakota child be ready for learning and ready for life through our promotion of the Ready Nine:

1. Caring adults
2. Early literacy
3. Safe environments
4. Good health
5. Self-discipline
6. Resilience
7. Marketable skills
8. Opportunities to give
9. Hope

As you can see, number four on this list is good health. The NDEA Ready Child initiative supports efforts to ensure that children are healthy and ready for school. Ensuring children have access to quality health care is vital and providing good health insurance coverage is an important step in ensuring access, especially for low and moderate income families. HB1377 moves ND forward in achieving that goal and we support HB1377.

I appreciate your time today and we urge you to support HB1377!

#8

Senate Human Services Committee
January 26, 2011
HB 1377

Good morning, Chairman Weisz and members of the House Human Services Committee.

My name is Nancy Miller and I am the Executive Director of the North Dakota Chapter of the National Association of Social Workers (NASW). NASW is the largest membership organization of professional social workers in the world, with 145,000 members. **In our effort to advance sound social policies, we offer support of HB1377, which will help to increase health care coverage to uninsured children.**

Many of the great things occurring in North Dakota as of late have caught the attention of those outside our borders. Our reputation of being a great place to live, work, and play, coupled with our economic prosperity (despite national trends), continues to make headlines. We are very fortunate to have a strong, responsible government which has helped to foster such a great financial surplus. Families are leaving other states and venturing to ours, with the hopes of a brighter future. And, the most recent census estimate show that North Dakota has had near record population *growth*. These are indeed good times.

Yet, all is not bright. There are an estimated 13,000 uninsured children in North Dakota[1]. Over the years, efforts have been made to reduce that number, especially with programs such as the Children's Health Insurance Program (CHIP). However, there is still more that can be done. The just released *Tenth Annual Kaiser Commission on Medicaid and Uninsured State Survey of Medicaid and CHIP Eligibility Rules*, shows that only 4 states (AK - 175%, ID - 185%, ND - 160%, and OK - 185%) now have eligibility levels of less than 200 percent of the federal poverty level[2]. **And, not only is North Dakota in that mix, but our 160% level puts as the lowest in the nation.**

Across the nation, even despite tight budgets, nearly all states maintained or made targeted expansions or improvements in their Medicaid and CHIP eligibility and enrollment rules in 2010, preserving the programs' important role of providing coverage to millions of low-income Americans who otherwise lack affordable options. And, all for good reason: the need for strong CHIP programs is greater now than ever:

- Rising premiums are becoming increasingly out of reach for low and moderate income families.
- As an increasing number of families are unable to afford health care coverage, it's our children who are most vulnerable.
- Children without health care coverage are less likely to have a usual source of health care and access preventive and other needed health services.
- A child who does not have access to preventative care now will be more at-risk for health problems later in life.
- Children are constantly in contact with large groups of other children, whether in school settings, athletics or other extracurricular activities. Given recent concerns over communicable diseases such as H1N1, as a matter of public health it benefits North Dakota to ensure children who are sick have access to health care coverage.
- Without access to health care, children's education and their social and emotional development suffer.

We respect the care that must be taken when weighing requests for additional funding during this legislative session. However, through testimony given today, you have heard many reasons why the action taken with HB1377 is justified. And, you have seen how North Dakota's existing level stacks up against our neighboring states. **If you use the fiscal note numbers presented, this change will make it possible for an additional 1,320 North Dakota children eligible to receive insurance.**

Providing health insurance for children is a moral obligation. As a society, we should be working to ensure that all of our children have the health care they need to both grow and learn. This generation of children can be the smartest, healthiest, and strongest generation yet, but, to get there, we must invest in health care for all children. This is just one way in which we can do so.

Again, we support HB1377. Thank you.

NOTES

[1]U.S. Department of Commerce, Bureau of the Census, Current Population Survey, 2007, 2008, and 2009 Annual Social and Economic Supplement (ASEC); and U.S. Department of Commerce, Bureau of the Census, "State Single Year of Age and Sex Population Estimates: April 1, 2000 to July 1, 2008 - RESIDENT," which can be found at: http://www.census.gov/popest/states/asrh/files/SC-EST2008-AGESEX-RES.csv. Calculations by Children's Defense Fund, Oct. 2009.

[2]*Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-11* (Georgetown University Center for Children and Families, and Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation, Jan. 2011). Full report and additional information can be found at: http://www.kff.org/medicaid/Medicaid-CHIP-Coverage-Recession-Health-Reform.cfm

#9

Testimony
House Bill 1377– Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 26, 2011

Chairman Weisz, members of the House Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here to provide information regarding House Bill 1377.

House Bill 1377 would increase the income eligibility level for the Children's Health Insurance Program (CHIP) to 250 percent (net) of the poverty level. During the current biennium (effective July 1, 2009), the income level for CHIP was increased to 160 percent (net). For the 2011-2013 Executive Budget, CHIP was built on an average monthly caseload of 4,256 children, with an estimated premium of $274.03 per child per month.

The federal poverty level (FPL) at 250 percent is $55,125 for a family of four; and eligibility is based on net income. Attachment A provides examples of various earning and deduction scenarios showing how this would be calculated.

Attachment B shows the number of children enrolled each month in CHIP since December 2008, and also provides the number of children enrolled in Medicaid for the same time period. We continue to experience an enrollment increase for both Medicaid and CHIP. During the current biennium, the Department contracted with Dakota Medical Foundation to conduct outreach for children's healthcare coverage. Since the contract work began in August 2009 through November 2010, an additional 2,888 children have been enrolled for Medicaid and CHIP coverage.

The estimated growth in CHIP as a result of increasing the income level to 250 percent (net) is 1,320 children. The fiscal note for House Bill 1377 contains $5,652,128 of which $1,748,203 are general funds. The costs are detailed in the following table:

	Total	General	Federal
Premium Cost From 160% (Net) to 250% (Net) of FPL :	5,461,966	1,689,386	3,772,580
1.5 FTE to Increase to 250% of FPL:	190,162	58,817	131,345
Total Cost From 160% (Net) to 250% (Net) of FPL:	5,652,128	1,748,203	3,903,925

Unlike Medicaid, CHIP is not an entitlement. Rather, each state receives an annual allotment of federal funds. In section B of the fiscal note, the Department states, "CHIP is subject to an annual federal allotment. Based on the FFY 2011 North Dakota CHIP allotment, the increase to 250% of the federal poverty level would cause ND CHIP expenditures to exceed the annual allotment. However, there are provisions in the Children's Health Insurance Reauthorization Act that allow states to apply for an increased allotment. If the income eligibility level for CHIP is increased, the Department will make application to the Centers for Medicare and Medicaid Services (CMS) for an increased allotment. Until the application is approved by CMS, the Department cannot certify that federal allotment would be available for the entire increased expenditure."

Section 2 of House Bill 1377 contains language that ensures that the Department would receive approval for the increased CHIP allotment prior to implementing the expansion contained in the bill.

The fiscal note contains $190,162 of which $58,817 are general funds, for salary and other expenses of the additional 1.5 FTE expected to be needed if the CHIP income level is increased to 250 percent (net) of the federal poverty level. Currently, 34 percent of CHIP applications are processed by the CHIP eligibility staff in the Medical Services Division. If the income level for CHIP is increased to 250 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.

In addition to the approval needed for the increased allotment, any increase in the CHIP income level will require federal (Centers for Medicare and Medicaid) approval of a CHIP State Plan Amendment.

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

Attachment A

North Dakota Department of Human Services
Children's Health Insurance Program
Income Examples at 250% Federal Poverty Level (FPL) (net)
January 2011

Example 1: Family of 3 (Mother and 2 children)

Mother works and earns: $4,500 per month (gross income is at 295% of FPL)

Deductions:

- Mother receives $30 work/training allowance
- Mother has withholding for taxes of $675

Total Deductions $705

Net Income: $3,795 per month – passes net income test at 250% ($3,815)

Example 2: Family of 4 (Father, Mother and 2 children)

Father works and earns	$3,500 per month (gross income)	
Mother works and earns	$2,500 per month (gross income)	
	$6,000 total	(gross income is at 327% of FPL)

Deductions:

- Mother and father each receive $30 work/training allowance per month (total $60)
- Father's withholding for taxes is $525 and Mother's withholding for taxes is $375 (total $900)
- Child care expenses of $500 per month

Total Deductions $1,460

Net Income $4,540 per month – passes net income test at 250% ($4,595)

Example 3: Family of 4 (Father, Mother and 2 children)

Father works and earns	$3,500 per month (gross income)	
Mother works and earns	$3,800 per month (gross income)	
	$7,300 total	(gross income is at 397% of FPL)

Deductions:

- Mother and father each receive $30 work/training allowance (total $60)
- Father 's withholding for taxes is $540 and Mother's withholding for taxes is $600 (total $1,140)
- Father pays $400 child support
- Child care expenses of $800
- Mother and Father each pay $180 per month for a 'single' health insurance plan through their employer (total $360)

Total Deductions $2,760

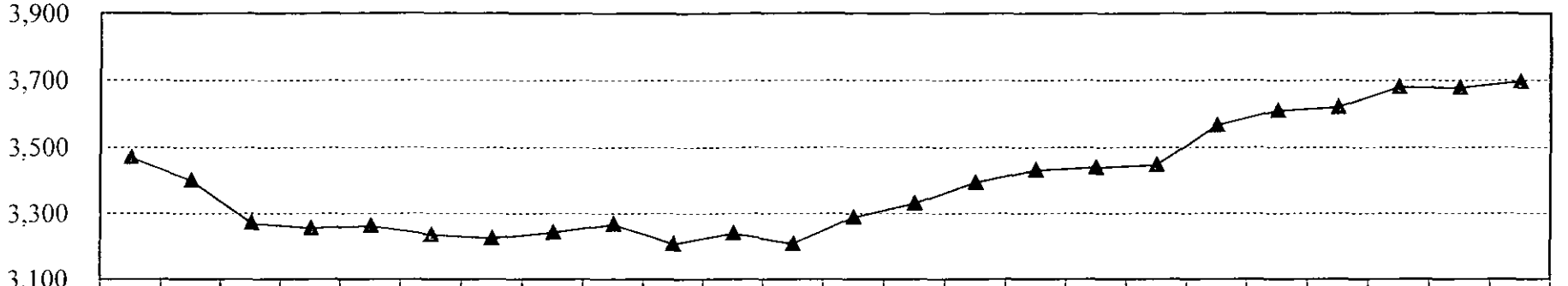
Net Income $4,540 per month – passes net income test at 250% ($4,595)

North Dakota Department of Human Services

Attachment B

Healthy Steps Premiums Paid by Month

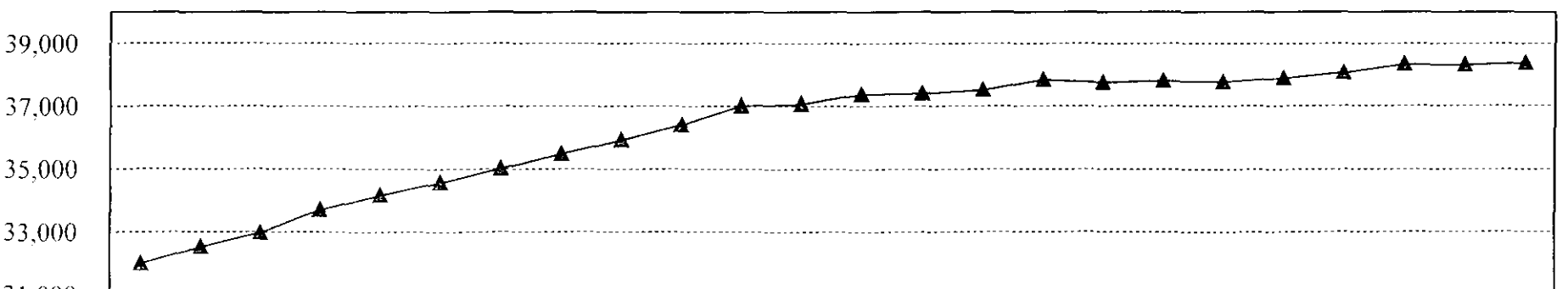
December 2008 - November 2010



Dec '08	Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10
3,468	3,399	3,270	3,255	3,262	3,235	3,224	3,242	3,267	3,207	3,239	3,207	3,288	3,330	3,393	3,431	3,439	3,446	3,565	3,609	3,620	3,680	3,678	3,696

Children Enrolled in Medicaid by Month

December 2008 - November 2010



Dec '08	Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10
31,986	32,504	32,964	33,694	34,168	34,577	35,012	35,480	35,916	36,399	37,002	37,058	37,358	37,385	37,499	37,824	37,739	37,797	37,761	37,876	38,056	38,337	38,313	38,375

1/7/11-cj-1113legis\hs enroll & elig

north dakota department of human services

Fact Sheet

October 2010

600 E Boulevard Avenue, Bismarck, ND 58505-0250 www.nd.gov/dhs

Medicaid and Healthy Steps Information

Medicaid Covers:

- Children up to age 21
- Caretakers of deprived children
- Workers with Disabilities (age 16 – 65)
- Low-income Medicare beneficiaries (Medicare Savings Programs)
- Pregnant Women
- Persons over age 65
- Children with Disabilities (birth to 19)
- Other blind and disabled people of all ages

- Some people can qualify for full Medicaid benefits, while others have to pay for part of their care. People who qualify under the Medicare Savings Programs are only allowed specific benefits. Many have to pay co-payments for doctor, hospital, dental, chiropractic, and prescription benefits.
- Most children under the age 19 can qualify for up to 12 months of ongoing Medicaid coverage. That is, once they qualify, they will stay covered for up to 12 months even if their income or circumstances change.
- Some people can qualify for more than one type of coverage at the same time (Medicare Savings Programs and other Medicaid coverages).
- Medicaid applies an asset test to most people over the age of 65, or blind, or disabled persons.* There is no asset test for Children with Disabilities coverage, other children and family coverage options, or for Healthy Steps.
- Medicaid allows coverage to begin up to 3 calendar months prior to the month of application.

* To be considered blind or disabled, Medicaid follows the Social Security Administration decisions.

Medicaid Asset Levels for People over 65, Blind, or Disabled Coverage

There is one asset level that applies to most people on Medicaid.

- $3000 for a one person household
- $6000 for a two person household
- Plus $25 for each additional household member

People who qualify for the Workers with Disabilities coverage are allowed an additional $10,000 in assets.

Income Levels

There are different income levels at which a person or a family may qualify.

- Most people who are covered by Medicaid qualify for full medical coverage.
  - People with excess income may still be eligible for Medically Needy Coverage.
  - People with income in excess of the Medically Needy level are responsible to pay the difference towards their medical bills. This is called Recipient Liability.
- The income level for nursing care is $50.

Medicare Savings Programs

There is one asset level that applies to the Medicare Savings programs and it changes every January.

People who qualify for the Medicare Savings Programs, (which includes Qualified Medicare Beneficiaries (QMB's), Special Low-Income Medicare Beneficiaries (SLMBs), and other Qualifying Individuals (QI's)), are entitled to coverage of their Medicare cost sharing. These benefits range from:

- Full coverage of all Medicare premiums, deductibles, and co-insurance for QMBs
- Coverage of the Medicare Part B premium for SLMBs and other Qualifying Individuals

Spousal Impoverishment Coverage

- This coverage is for married couples where one spouse needs nursing care services (in a facility or at home).
- The spouse who remains in the community is allowed to keep half of the couple's countable assets (as of the date of entry into nursing care). There is a maximum amount of assets the Community Spouse can keep to qualify. There is also a minimum amount, which may allow the Community Spouse to keep more than half of the couple's assets. These amounts change every January.
- The community spouse income level is $2,267.

Healthy Steps (SCHIP) Covers

- Children up to age 19 who do not qualify for Medicaid due to income.
- Children who qualify may have co-payments for some services they receive.
- Healthy Steps coverage begins the month following the month the child is determined to qualify for coverage.

Income Levels

- Families with net countable income that does not exceed 160% of the Federal Poverty Level qualify for Healthy Steps Coverage.

Eligibility Determinations

- Eligibility for Medicaid is determined at 51 county social service offices.
- Eligibility for Healthy Steps is determined at the county social service offices or the state Medical Services office.
- Applicants have a choice of different ways to apply for assistance.
    - A short application is available for children and families who want to apply for healthcare coverage.
    - A short application is available for people who are elderly or disabled and want to apply for healthcare coverage.
    - A combined application is available for people who also want to apply for other economic assistance programs such as Temporary Assistance for Needy Children (TANF), the Supplemental Nutrition Assistance Program (SNAP), Child Care Assistance Program (CCAP) and so on.
    - Online application and electronic forms can be found at http://www.nd.gov/dhs/info/pubs/medical.html
    - Forms are also available at county social services offices in North Dakota. www.nd.gov/dhs/locations/countysocialserv/index.html

1-877 KIDS-NOW

(1-877-543-7669)

This toll-free resource line helps uninsured families learn about low-cost and free health care coverage programs offered in North Dakota.

Call today to receive more information or to request an application for these health care coverage programs.

- Medicaid
- Healthy Steps
- Caring for Children

To determine if your child may qualify for these programs, please refer to the chart below.

Family Size	*Monthly Net Income	*Yearly Net Income
2	$2,429 or less	$29,148 or less
3	$3,052 or less	$36,624 or less
4	$3,675 or less	$44,100 or less
5	$4,299 or less	$51,588 or less

Program Eligibility Guidelines are based on family size, age of family members and household income after taxes and allowable deductions.

*These guidelines are effective through March 2011.

www.ndcaring.org

North Dakota Resources

Health Coverage Programs

Three programs, one toll-free helpline
Call 1-877 KIDS NOW (1-877-543-7669)

- Medicaid
- Healthy Steps
- Caring for Children

Dental Programs

Dental Access Programs	1-701-364-5364

Prescription Programs

Prescription Connection	1-888-575-6611
Familywize	1-800-222-2818

Vision Programs

Vision USA- ND Project	1-701-258-6766
VSP Sight for Students	1-888-290-4964

Mental Health Programs

Mental Health Helpline	1-800-472-2911

Children with Special Needs

Children's Special Health Services	1-800-755-2714
Family Voices	1-888-522-9654

Women's Preventive Care

Women's Way	1-800-44WOMEN (1-800-449-6636)

Children's Defense Fund

Bridge to Benefits	bridgetobenefits.org

BlueCross BlueShield of North Dakota
An independent licensee of the Blue Cross & Blue Shield Association

DMF DAKOTA MEDICAL FOUNDATION

United Way

Noridian Mutual Insurance Company (0641) 6-10

Do you know an *uninsured* child?

Free and Low-Cost Health Care

Children

without health care coverage don't always get the medical care they need. Is your child, grandchild, neighbor or student [illegible] thousands of North Dakota's uninsured?
If so, they may be eli[illegible] for a health care coverage program offered at no or low-cost.

Medicaid

Medicaid provides comprehensive medical, dental and vision coverage for North Dakota children and adults, and it encourages members to have a primary care provider. Medicaid is administered by your local county social service agency.

You may be eligible if you qualify for other federal assistance programs.

Comprehensive coverage includes:

- Routine and primary medical care
- Inpatient (hospital) care
- Immunizations
- Mental health and substance abuse
- Prescriptions
- Vision care
- Primary and preventive dental care

North Dakota MEDICAID

Healthy Steps (CHIP)

Healthy Steps is a benefit plan for eligible North Dakota children up to 19 years old who do not qualify for Medicaid. The program offers comprehensive medical, dental and vision coverage, and it is administered by the state of North Dakota.

Children with Indian Health Services may participate in Healthy Steps.

Comprehensive coverage includes:

- Routine and primary medical care
- Inpatient (hospital) care
- Immunizations
- Mental health and substance abuse
- Prescriptions
- Vision care
- Primary and preventive dental care

Healthy Steps
North Dakota's Children's Health Insurance Plan

Caring for Children

Caring for Children is a benefit plan for eligible North Dakota children up to age 19 who do not qualify for Medicaid or Healthy Steps and have no other insurance. Benefits include primary and preventive medical and dental care. Caring for Children is a program of the North Dakota Caring Foundation, a non-profit 501(c)(3) foundation established by Blue Cross Blue Shield of North Dakota (BCBSND) in 1989. BCBSND provides Caring for Children administrative services as an in-kind donation.

Primary and preventive care includes:

- Routine and primary medical care
- Limited inpatient (hospital) care
- Immunizations
- Mental health and substance abuse
- Primary and preventive dental care

Established 1989
Caring for Children
A program of the North Dakota Caring Foundation, Inc.

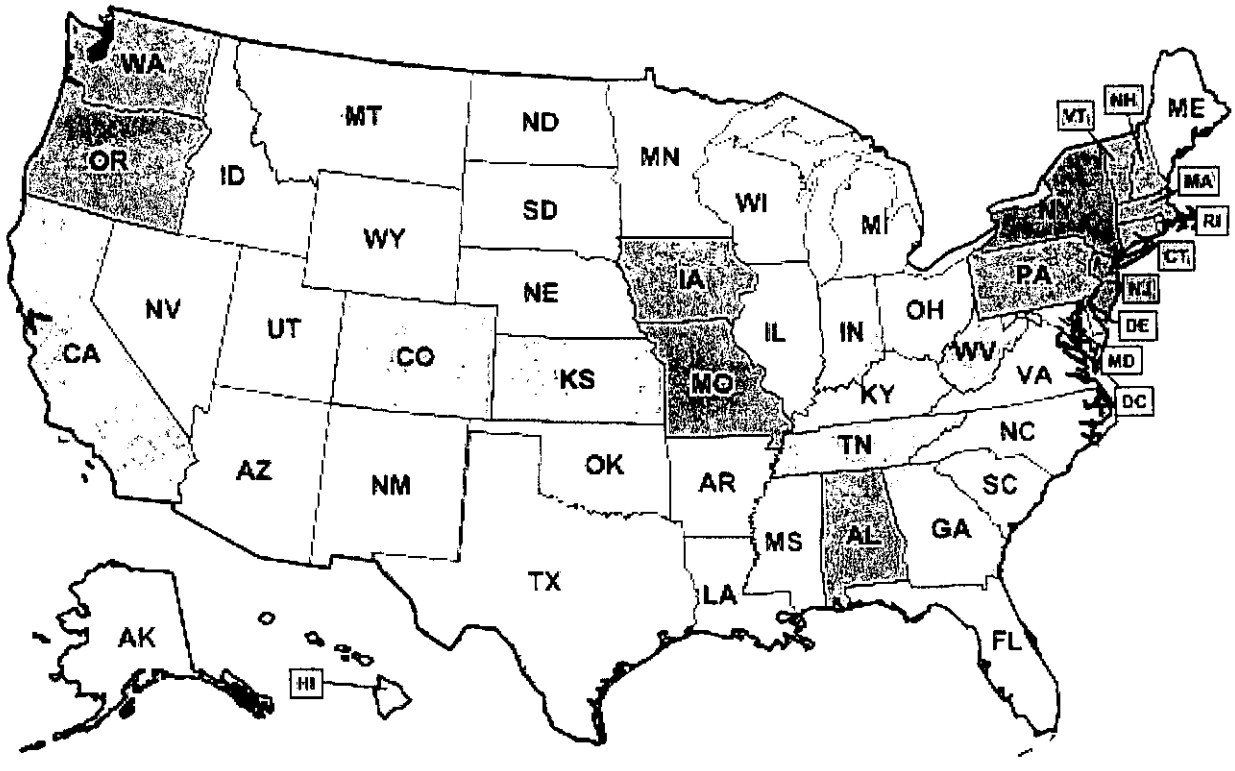
Have questions?
Want to apply?

Three programs
One toll-free helpline

1-877-KIDS-NOW
(1-877-543-7669)

INCOME ELIGIBILITY LIMITS FOR CHILDREN'S SEPARATE CHIP PROGRAMS BY ANNUAL INCOMES AND AS A PERCENT OF FEDERAL POVERTY LEVEL

JANUARY 2011



☐ 0% - 200%

☐ 235% - 250%

☐ 300%

■ 350% - 400%

Income Eligibility Limits for Children's Separate CHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, January 2011

statehealthfacts.org
Your source for state health data

Rank (1=low | 51=high)	Income Eligibility -- Separate CHIP Prog
United States	NA[1]
1. Alaska	NA
1. Arkansas	NA
1. District of Columbia	NA
1. Hawaii	NA
1. Maryland	NA
1. Minnesota	NA[5]
1. Nebraska	NA
1. New Mexico	NA
1. Ohio	NA[5]
1. Oklahoma	NA
1. Rhode Island	NA
1. South Carolina	NA[11]
1. Wisconsin	NA[5]
14. North Dakota	160%
15. Idaho	185%
16. Arizona	200% (closed)[2]
17. Delaware	200%
17. Florida	200%[5,6]
17. Kentucky	200%
17. Maine	200%[5]
17. Michigan	200%
17. Mississippi	200%
17. Nevada	200%
17. North Carolina	200%[5]
17. South Dakota	200%
17. Texas	200%
17. Utah	200%
17. Virginia	200%
17. Wyoming	200%
30. Georgia	235%
31. Kansas	241%[8]
32. California	250%[3]
32. Colorado	250%[4]
32. Indiana	250%
32. Louisiana	250%
32. Montana	250%
32. Tennessee	250%[5,12]
32. West Virginia	250%
39. Alabama	300%
39. Connecticut	300%[5]
39. Iowa	300%
39. Massachusetts	300%[9]
39. Missouri	300%
39. New Hampshire	300%[5]
39. Oregon	300%[5,10]
39. Pennsylvania	300%[5]
39. Vermont	300%[13]
39. Washington	300%
49. New Jersey	350%[5]
50. New York	400%[5]
51. Illinois	200% (300%)[5,7]

Notes: Data as of January 1, 2011, unless noted otherwise.
The income eligibility levels noted may refer to gross or net income depending on the state. Income eligibility levels listed are either for "regular" Medicaid (Title XIX) where states receive "regular" Medicaid matching payments or show eligibility levels for the state's CHIP-funded Medicaid expansion program (Title XXI) where the state receives the enhanced CHIP matching payments for these children.
The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children. These programs typically provide coverage through the child's 19th birthday.
Eligibility levels shown as percent of the FPL. Currency figures based on FPL for a family of three in 2010: $18,310 for 48 contiguous states and District of Columbia, $22,890 for Alaska, $21,060 for Hawaii.

Sources: Holding Steady, Looking Ahead: Annual Findings of a 50-state Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011. Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011. Available at: http://www.kff.org/medicaid/8130.cfm.

2010 HHS Poverty Guidelines: http://aspe.hhs.gov/poverty/10poverty.shtml.

Definitions: **CHIP**: 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 CHIP program.

Footnotes:

1. Not applicable because there are no national eligibility levels.
2. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009. The program remains closed to new applicants.
3. Infants born to mothers in California's Access for Infants and Mothers (AIM) program are automatically enrolled in CHIP. The income guideline for these infants, through their second birthday, is 300% of the FPL.
4. Colorado increased eligibility from 205% to 250% of the FPL on May 1, 2010. The state has also passed legislation authorizing coverage of lawfully residing immigrant children, but has not provided funding for the expansion.
5. Connecticut, Florida, Illinois, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Wisconsin allow families with incomes above the levels shown buy into Medicaid/CHIP.
6. Florida operates three CHIP-funded separate programs. Healthy Kids covers children ages 5 through 19, as well as younger siblings in some locations. MediKids covers children ages 1 through 4. The Children's Medical Service Network serves children with special health care needs from birth through age 18.
7. Illinois provides state-financed coverage to children with incomes above CHIP levels. Eligibility is shown in parentheses.N
8. Kansas increased eligibility from 200% to 250% of the 2008 FPL (approximately 241% of the 2009 FPL) on January 1, 2010.
9. In Massachusetts, children at any income are eligible for more limited state-subsidized coverage under the state's Children's Medical Security Plan; premiums are charged on a sliding scale based on income.
10. Oregon increased eligibility from 200% to 300% of the FPL on February 1, 2010.
11. South Carolina converted its separate CHIP program to a Medicaid expansion in October 2010.
12. Tennessee reopened its separate CHIP program (CoverKids) to new applicants on March 1, 2010.
13. In Vermont, Title XIX funding covers uninsured children in families with income at or below 225% of the FPL; uninsured children in families with income between 226% and 300% of the FPL are covered via Title XXI funding under a separate CHIP program. Underinsured children are covered in Medicaid through Title XIX funding up to 300% of the FPL.

North Dakota Department of Human Services
Medical Services Division
Children's Health Insurance Program (CHIP)
Surrounding State Comparison Information
January 2011

South Dakota

Information provided by Larry Iverson, South Dakota Department of Social Services.

South Dakota looks at gross income, but has the following allowable deductions:

1. Less than 140% - there is a 20% earning disregard or $90, whichever is higher.
2. Childcare expenses
3. First $50 in child support payment received
4. Child support payments made

SD has two CHIP programs. One is the Medicaid "look-alike" that goes to 140% FPL. The other is an expansion from 141% to 200%. All CHIP kids receive all of the services the Medicaid kids do, including dental and vision services.

Minnesota

Information provided by Patricia Callaghan, Minnesota Department of Human Services.

Minnesota CHIP covers the noncitizen pregnant women (through the unborn child group) up to 275% FPL. Effective July 1, 2010, Minnesota adopted Medicaid coverage for noncitizen pregnant women and children lawfully residing in the U.S. This meant that coverage for some lawfully residing pregnant women shifted from the CHIP unborn group into Medicaid pregnant woman coverage (e.g. pregnant women within the 5-year bar period).

Effective January 31, 2009, Minnesota terminated (as required by CMS) its CHIP section 1115 waiver for parents with income between 100 and 200% FPL. The coverage for this population has been switched to the MinnesotaCare program.

Minnesota CHIP continues to cover a Medicaid expansion group of infants under age 2 with income between 275 and 280% FPL.

Minnesota's regular Medicaid program (State Plan) covers children between ages 2 and 19 with net income up to 150% FPL. Under a Medicaid section 1115 waiver program known as MinnesotaCare, the state covers families and children under age 21 up to 275% FPL based on family gross income and household size.

Note: Parents and children whose income levels overlap with MinnesotaCare are permitted to choose between the two programs, in other words they may choose to pay a premium under the MinnesotaCare program.

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Montana

Information provided by Katherine Buckley-Patton from the Montana Health Kids Program

July 2007 MT CHIP eligibility level went to 175%. (Was previously 150%)
Effective October 1, 2009, the income eligibility level was raised to 250% FPL
Effective Oct 1, 2009, Montana CHIP became part of the Healthy Montana Kids (HMK) Program, the result of a ballot initiative passed in November 2008. The HMK Program combines under one 'umbrella' the Healthy Montana Kids *Plus* coverage group (formerly children's Medicaid) and the Healthy Montana Kids coverage group (formerly CHIP).

Montana allows these deductions in the HMK coverage group:

1. $1,440 per year for each family member with earned income.
2. $2,400 per year for dependent care expenses for each individual who has dependent care expenses. (Parents have to be working or going to school.)

Montana CHIP covers dental and vision. Dental services are limited to $350 per child per year. Effective 10/1/2010 (and in compliance with CHIPRA) MT's "Basic Dental Benefit" available to all enrolled members is $1200 in reimbursable services with a benefit year (Oct 1-Sept 30). MT's basic dental is now benchmarked on the state employee benefit plan. The Extended Dental Plan is in addition to the Basic Dental Plan and dentists can apply for additional funding (up to $1000 per child) for children with extensive needs.

As requested during the Hearings on Senate Bill 2264 and House Bill 1377

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North Dakota Department of Human Services

Medical Services Division

HB 1377

Information Requested on Referrals to the Caring for Children Program

Number of Children referred by the Department of Human Services to the Caring for Children Program in Calendar Year 2010:

Jan. 2010—58	July 2010—101
Feb. 2010—63	August 2010—78
March 2010—84	Sept. 2010—100
April 2010—101	Oct. 2010—99
May 2010—105	Nov. 2010—105
June 2010—105	Dec. 2010--115

Number of Children enrolled in the Caring for Children Program in Calendar Year 2010:

Jan. 2010—503	July 2010—499
Feb. 2010—469	August 2010—508
March 2010—476	Sept. 2010—498
April 2010—464	Oct. 2010—495
May 2010—480	Nov. 2010—479
June 2010—482	Dec. 2010--480

Requested during 1-26-2011 Hearing on HB 1377