2011 SENATE HUMAN SERVICES

SB 2135

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2135
1-12-2011
Job Number 12819

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to the income eligibility limit for the children's health insurance program.

Minutes: Attachments included.

Senator Judy Lee opened the hearing on SB 2135.

Senator Tim Mathern, prime sponsor, introduced SB 2135. He believes it is morally correct to assure all children have health care coverage, fiscally prudent to use the healthy steps program to accomplish that, and coverage of health care for all children is cost effective. Keeping children healthy not only saves lives but also leads to a reduction in future health care costs for society in general.
This bill just changes the eligibility guidelines from 160% to 250% of poverty.
He handed out copies of testimony from **Donene Feist**, state director for Family voices of ND. Attachment #1
The fiscal note was discussed. The next biennium the numbers would be higher than this biennium for several reasons such as implementing, people becoming aware, taking the program to other levels etc.

Senator Ryan Taylor, District 7 and co-sponsor, gave his support for SB 2135. There are families that fall through the crack. Some families are not able to afford health insurance and yet they don't qualify for Medicaid at the 160% level.

Maggie Anderson, Dept. of Human Services, provided neutral information and a pamphlet with background information. Attachment #2
Other information provided by Ms. Anderson - Attachment #3

Senator Dick Dever asked if the need for 1 ½ FTE's should be in this bill.

Ms. Anderson replied that it should be encompassed in the overall appropriation that would be needed for the increase.

Senator Spencer Berry asked whether the allotment would be a guaranteed reimbursement from the federal government and if the allotment is the same for each state.

Ms. Anderson said they would have to make application to the centers for Medicare and Medicaid services. It is not a guaranteed increase.

Senator Spencer Berry asked where the funds would come from if they weren't allotted the additional funds.

Ms. Anderson replied they would need direction from the legislature.
Every states allotment is different.

Senator Judy Lee pointed out that the committee could say that the increase would not go into place unless the allotment increase was approved by the feds. The Dept. would not be able to go forward unless the additional money was available.

Paul Ronningen, State Coordinator for the Children's Defense Fund – ND. He also represents NDESPA. They are concerned about health care coverage for children from low-income families through CHIP. Attachment #4

Dr. Joan Connell, NDAAP, spoke in support of SB 2135. Attachment #5

Dr. Emmet Kenney, North Dakota Hospital Association, spoke in support. Attachment #6

Josh Askvig, NDEA, provided supporting testimony. Attachment #7

JoAnn Brager, ND Association for the Education of Young Children, supports SB 2135. Attachment #8

Marlowe Kro, AARP of North Dakota, was in support of SB 2135. Attachment #9

There was discussion that there is no asset or income test for people on Medicare. Medicare, in essence, is a guarantee of health insurance for those 65 and over. There are certain categories of persons under 65 with certain disabilities that would also be eligible for Medicare. It was pointed out that throughout our working lives we prepay those premiums for Medicare.

Carlotta McCleary, Mental Health America, spoke in support of increasing the net income eligibility. Attachment #10 She also provided testimony from **Susan Rae Helgeland** – Attachment #11.

Renae Stromme, ND Women's Network, presented supporting testimony. Attachment #12

Bryan Quigley, ND Social Services, testified in support.

Rep. Richard Holman, District 20, spoke in support. He told about a family member who was a recently divorced single mom with no child support and her experience with this. This program served as a two year gap filler for her until she was able to further her education and get a job with benefits. The other side worth mentioning is that those without insurance often times delay care for a child until it reaches a point where an

emergency room run is needed. Emergency room care costs more than preventive care or just regular care.

Al Nygard, Empowerment First, spoke on behalf of the native community of ND about two issues he felt important to the future of native people. 1. The graduation rate of native children in ND is only 55%. Allowing the children to have the security of better health care allows parents to eliminate the burden of how they are going to get their kids to school and keep them in school. 2. He said that native kids, particularly on the reservation, have experienced a rate 6 times the national average in terms of suicide and mental health issues.

Senator Judy Lee pointed out that one of the challenges has been enrollment on the reservation or among native families. She said any recommendations he could offer to encourage enrollment of native families, even under the current criteria, would be appreciated.

Mr. Nygard said they help to bridge the divide between native and non native and would be happy to assist in any way they can.

Nancy Miller, NASW, provided testimony in support. Attachment #13

There was no opposing testimony.

The hearing on SB 2135 was closed.

Additional information provided by Paul Ronningen – Attachment #14.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2135
2-2-2011
Job Number 13858

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee opened SB 2135 for discussion and to obtain information from Maggie Anderson, Dept. of Human Services.

Maggie Anderson, Dept. of Human Services, provided information on a comparison of ND CHIP level as compared to other states around the country. She provided the committee with two documents: 1. Rank by poverty level. 2. Surrounding states comparison information which showed comparisons for South Dakota, Minnesota, and Montana. She explained both documents. Attachment #15

Senator Judy Lee asked if all parent programs got eliminated or was there something special about the MN one that caused it to be ended.

Ms. Anderson said it was a big discussion during the CHIP reauthorization that it was a children's health insurance program. MN is one that was covering them. She didn't have the answer.

Senator Tim Mathern asked if we had the caretaker adults' coverage in a separate program. He asked if this was part of the comparison of states.

Ms. Anderson replied that perhaps it's the same people but in ND the caretaker coverage group is very low. It's 34% of poverty. 100 – 200 percent would be a significantly higher income bracket. She talked about the MN CHIP program and other programs.

Senator Judy Lee asked what the 250% of poverty would be.

Ms. Anderson said she would provide the committee with information on the 250% for families of 1, 2, 3, and 4.

Discussion took place on a chart provided during hearing testimony and putting a sample family into the different states eligibility process to see if they qualify. There was a request

for the median and mean gross income for a family of four so they could be applied to see the comparisons.

Considering changing from net to gross income was discussed and the effect it would have on changing the eligibility system.

Senator Judy Lee recessed committee work.

Attachment #16 is additional information provided by Ms. Anderson.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2135
2-7-2011
Job Number 14103

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee opened SB 2135 for committee work. She called Maggie Anderson to the podium to give some information on net versus gross.

Maggie Anderson, Dept. of Human Services, explained that it would be a two month project for the computer system changes to change the Vision system, the eligibility system where CHIP is housed. The estimated cost is about $26,000. She explained that there would be children who would lose eligibility under a 200% gross eligibility level.

The Affordable Health Care act was discussed. The way it is written there is a maintenance of effort requirement for CHIP for kids until 2019. However, in 2014 the states are supposed to be going from whatever they are at to modified adjusted gross income. CHIP is funded through 2015.

Senator Tim Mathern recommended amendments which offered a clarification and he saw as a technical amendment. Attachment #17

Senator Tim Mathern moved to **accept the amendment**.

Seconded by **Senator Dick Dever**.

Roll call vote 5-0-0. **Amendment adopted**.

Senator Tim Mathern moved a **Do Pass as Amended and rerefer to Appropriations**.

Motion failed for lack of a second.

Senator Spencer Berry moved a **Do Not Pass as Amended**.

Seconded by **Senator Gerald Uglem**.

Discussion: There are still many families that are not able to get insurance or who have dramatic financial needs, often times in terms of health care. The real breakdown comes when looking at gross, not net.

Roll call vote 4-1-0. **Motion carried**.

Carrier is **Senator Spencer Berry**.

FISCAL NOTE

Requested by Legislative Council
01/06/2011

Bill/Resolution No.: SB 2135

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 be 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 biennium 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:**	01/10/2011

#17

PROPOSED AMENDMENTS TO SENATE BILL NO. 2135

Page 1, line 3, after "program" insert "; and to provide an effective date"

Page 1, after line 8, insert:

"SECTION 2. EFFECTIVE DATE. The change to the net income eligibility limit for the children's health insurance program identified in section 1 of this act becomes effective the first day of the month following the department of human services receiving written notice from the centers for medicare and medicaid services of approval of an increase to the federal allotment to cover that increase to the net income eligibility limit of the children's health insurance program."

Renumber accordingly

This amendment was prepared at the request of Senator Mathern.

2-7-11

Amendments to 11.0057.01000

Date: 2-7-2011

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2135

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 2-7-11 Amendment from Sen. Mathern

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

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Gerald Uglem, V. Chair	✓				
Sen. Dick Dever	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

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

11.0057.01001
Title.02000

Adopted by the Human Services Committee

February 7, 2011

2-7-11

PROPOSED AMENDMENTS TO SENATE BILL NO. 2135

Page 1, line 3, after "program" insert "; and to provide an effective date"

Page 1, after line 8, insert:

"**SECTION 2. EFFECTIVE DATE.** The change to the net income eligibility limit for the children's health insurance program identified in section 1 of this Act becomes effective the first day of the month following the department of human services receiving written notice from the centers for medicare and medicaid services of approval of an increase to the federal allotment to cover that increase to the net income eligibility limit of the children's health insurance program."

Renumber accordingly

Date: 2-7-2011

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2135

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.0057.01001 Title 02000

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

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Berry Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**		✓
Sen. Gerald Uglem, V. Chair	✓				
Sen. Dick Dever	✓				
Sen. Spencer Berry	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment Sen. Berry

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

REPORT OF STANDING COMMITTEE

SB 2135: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (4 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). SB 2135 was placed on the Sixth order on the calendar.

Page 1, line 3, after "program" insert "; and to provide an effective date"

Page 1, after line 8, insert:

"**SECTION 2. EFFECTIVE DATE.** The change to the net income eligibility limit for the children's health insurance program identified in section 1 of this Act becomes effective the first day of the month following the department of human services receiving written notice from the centers for medicare and medicaid services of approval of an increase to the federal allotment to cover that increase to the net income eligibility limit of the children's health insurance program."

Renumber accordingly

2011 TESTIMONY

SB 2135

#1

Testimony on Senate Bill 2135
2011 Legislative Session
January 12, 2011
Sen. Lee HS Committee Chairperson

Senator Lee and Committee Members,

My name is Donene Feist and the state director for Family Voices of North Dakota.
Thank you for the opportunity to testify on behalf of Senate Bill 2135.

I would like to provide you with some important data.

Young children in ND are at greater risk of poverty than most other age groups. Twenty-four percent of ND children live in poor and near poor families. In over half of ND 53 counties, the child poverty rate exceeds the state average of 16.8 percent.

In addition, these statewide trends are not reflective of all populations within the state. Certain segments of North Dakota's population are harder hit by poverty than others.

Income thresholds used to determine poverty are updated annually by the Census Bureau. In 2009, a four-person family earning $21,947 or less was considered impoverished, which is less than the $22,017 threshold established in 2008. Even with the increase in North Dakota's median family income from 2000 to 2008, the child poverty rate has not improved. In 2000, 14 percent of North Dakota children ages 0 to 17 lived in poverty (22,163 children). Current 2008 data indicate that the child poverty rate is still at 14 percent.

While North Dakota has historically ranked well in children's well-being, we recently ranked 47th in the nation for making improvements to children's well-being and is ranked second in the nation for woman working outside of the home. ND is one of the few states in the country with a low unemployment rate and assets income which clearly identifies "one size does not fit all".

Our state's Healthy Steps Children's Health Insurance Plan (CHIP) provided premium-free health coverage to 3,365 children in January 2010. While most children ages 0 to 18 in ND are covered by some form of health insurance, 12,020 children were uninsured in 2006, which is 8 % of all children statewide.

The majority of the uninsured children in ND were living in or near poverty. In 2006, 7,074 ND children ages 0 to 18 were uninsured and living below 200% of poverty, which is 59% of all uninsured children and 5 percent of all children statewide.

This bill is written to authorize SCHIP to 250% of the FPL; I believe this would be adequate to assist in covering more children including those with special health care needs. A family of four at 200% FPL for 2011 is estimated at $44, 100. This has stayed relatively the same as in previous legislative sessions.

Additional data from the Federal Maternal and Child Health Bureau conducted a survey in 2005-2006. This survey identified through the Data Resource Center for North Dakota, http://www.cshcndata.org/Content/StatePrevalence2005.aspx?geo=North%20Dakota has

identified that there are 16, 541 children in North Dakota with special health care needs. Of those children **9.6%** where identified as being uninsured in the same time period. Approximately **1587** children of these children had no insurance and are a family of a child with special health care needs and disabilities.

The data for children in the *general* population http://www.nschdata.org/DataQuery/DataQueryResults.aspx estimated that **7.3% or nearly 11,000 children across the state were uninsured.**

Speaking on behalf of families of a child with special health care needs and the financial strain we ourselves have experienced, know and understand all too well the financial burden this places on families. Our experience was with health insurance. I cannot imagine the strain families are under without health insurance. Considering an office visit is anywhere between $75 and more just to get into the door, how many of the 1587 uninsured children with special health care needs are being deprived an essential need, a need as high as food, clothing and shelter. How many children without a disability are going without coverage and the right to live a healthy and productive life? Our children in North Dakota deserve better.

With more and more employers not able to provide health insurance, the strain to families is great, regardless of whether the child has a disability or not. In these economic times and the many other hardships, $44,000 does not go very far in an overall budget.

For a family of four a health care premium for us would be over $1200/month alone. Health care should not be considered a luxury and yet for many that is exactly what it is. No matter how well you prioritize, families will come up short in meeting this need and often at no fault of their own.

Ongoing dialogue needs to continue to discuss our most vulnerable in this state which is our children. As a state we need to do all that we can to assure our children are taken care of. Health care is a human right not a privilege. For our North Dakota children it is the right thing to do at the right time.

Let us remember as each of us makes decisions that will affect children—whether we are parents, educators, health professionals, or government officials—it is our duty to consider if that decision either affirms or denies a child's most basic human rights. This bill will embrace the needs of families and move us forward in the right direction.

Thank you for your consideration.

Donene Feist
Family Voices of North Dakota
PO Box 163
Edgeley, ND 58433

#2

Testimony
Senate Bill 2135– Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
January 12, 2011

Chairman Lee, members of the Senate Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here to provide information regarding Senate Bill 2135.

Senate Bill 2135 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 Senate Bill 2135 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."

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

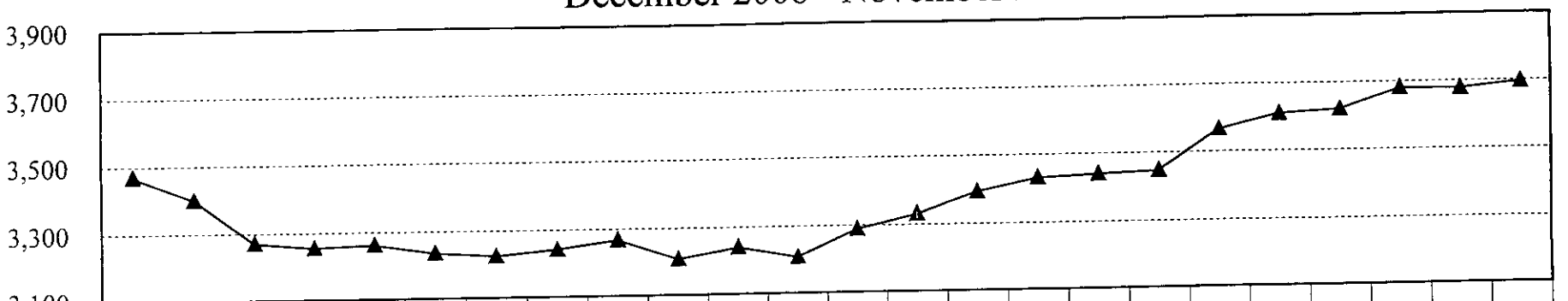
Net Income $4,540 per month – passes net income test at 250% ($4,595)

North Dakota Department of Human Services

Attachment B

Healthy Steps Premiums Paid by Month

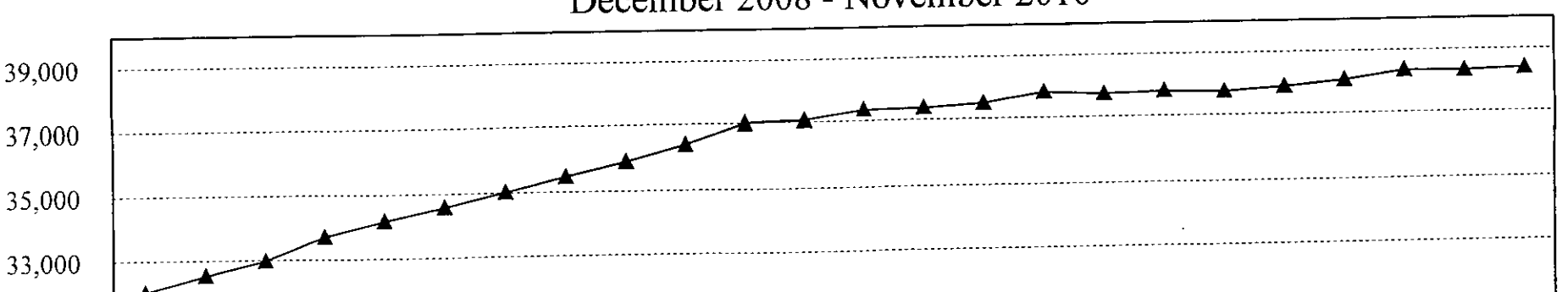
December 2008 - November 2010



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

#3

2135
Maggie Anderson

North Dakota Department of Human Services

Medicaid and CHIP Income Disregards and Deductions

(As of January 2011)

Disregarded Income - *disregards are not considered an income source*

The following types of income are disregarded in determining eligibility for Medicaid/CHIP:

1. State or tribal money payments for foster care, subsidized guardianship, the subsidized adoption program, or the State LTC Subsidy Program ;
2. Temporary Assistance for Needy Families (TANF) benefit and support services payments;
3. Benefits received through the Low Income Home Energy Assistance Program;
4. Refugee cash assistance payments;
5. County general assistance payments;
6. Payments from the Child and Adult Food Program for meals and snacks to licensed families who provide day care in their home;
7. Family subsidy program payments;
8. Housing assistance payments;
9. Money received by Indians from the lease or sale of natural resources, and rent or lease income, resulting from the exercise of federally-protected rights on excluded Indian property. This includes distributions of per capita judgment funds;
10. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114;
11. Income earned by a child who is a full-time student, or a part-time student who is not employed one hundred hours or more per month;
12. Supplemental Security Income (SSI) - *CHIP disregards all SSI. Medicaid disregards lump sum SSI payments. Medicaid counts SSI if the client chooses to be eligible under the children and family category. If they choose to be eligible under the aged and disabled category, they get an income level equal to the level that established SSI eligibility.*
13. Compensation received by volunteers participating in certain federal volunteer programs;

14. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
15. All income, allowances, and bonuses received as a result of participation in the Job Corps Program;
16. Occasional small gifts;
17. In-kind income except in-kind income received in lieu of wages;
18. Income tax refunds and earned income credits;
19. Homestead tax credits;
20. Educational loans, scholarships, grants, awards, Workforce Safety & Insurance vocational rehabilitation payments, and work-study received by a student.
21. Any fellowship or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational institution;
22. Training funds received from Vocational Rehabilitation;
23. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the Job Opportunities and Basic Skills Training program;
24. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Investment Act (WIA), and through the Job Opportunities and Basic Skills program;
25. Training stipends provided to victims of domestic violence by private, charitable organizations, such as the Seeds of Hope Gift Shop, or the Abused Adult Resource Center, for attending their educational programs;
26. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act;
27. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act;
28. Agent Orange payments;
29. Crime Victims Reparation payments;
30. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;
31. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 or some other federal statute, because of a presidentially declared major disaster (but not disaster assistance unemployment compensation);

32. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects;
33. Netherlands Reparation payments based on Nazi, but not Japanese, persecution during World War II, Public Law 103-286;
34. Radiation Exposure Compensation, Public Law 101-426;
35. Interest or dividend income earned on liquid assets;
36. Additional pay received by military personnel as a result of deployment to a combat zone;
37. Fifty dollars per month of current child support, received on behalf of children in the SCHIP unit;
38. All wages paid by the Census Bureau for temporary employment related to census activities;
39. Reimbursements from an employer, training agency or other organization for past or future training, or volunteer related expenses

Income Deductions - ***deductions are subtracted after the income is calculated***

The following income deductions are allowed in determining Medicaid/CHIP eligibility:

1. Mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;
2. Mandatory retirement plan deductions;
3. Expenses of a blind person reasonably attributed to earning income;
4. Reasonable child care expenses, not otherwise reimbursed, that the Medicaid/CHIP Unit is responsible to pay, if necessary to engage in employment or training;
5. Non-voluntary child and spousal support payments if actually paid;
6. For individuals who are employed or in training, thirty dollars may be deducted as a work or training allowance (does not apply to children in school);
7. The cost of premiums for health insurance for members of the unit who are not eligible for Medicaid/CHIP; and
8. Medical expenses for necessary medical or remedial care for members of the unit who are not eligible for Medicaid/CHIP.

Additional Income Deductions allowed for Medicaid

The following additional income deductions are allowed in determining Medicaid eligibility

1. Reasonable expenses, such as food and veterinarian expenses, necessary to maintain a dog that is trained to detect seizures for a member of the Medicaid unit.
2. Premiums for long term care insurance.
3. Transportation expenses necessary to secure medical care.
4. Reasonable adult dependent care expenses.
5. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available.
6. A disregard of $20 per month for aged, blind and disabled applicants or recipients.
7. Guardian or conservator fees, up to a maximum of five percent of countable gross monthly income.
8. For all aged, blind, or disabled applicants or recipients, sixty-five dollars plus one-half of the remaining monthly gross earned income.

SB 2135
Senate Human Services Committee
January 12, 2011

Chairman Lee and members of the Senate 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 families through the Children's Health Insurance Program. North Dakota is now recognized as having the lowest coverage for children in the United States at 160% of the federal poverty level.

Yet, North Dakota is in an era of unprecedented fiscal health. We believe our current situation is an opportunity to expand healthcare coverage to children in a way we would have been unable or unwilling to do before now. We urge this Legislative Assembly to increase the level of CHIP eligibility to 250%.

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
- 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**.

You may hear some Legislators talk about North Dakota's disregards as an explanation for keeping our income eligibility so low. But, most states have disregards and many are the same from state to state. 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 then 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 then 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 then 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' 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 will match one state dollar with three dollars invested in the Children's Health Insurance Program ($3 Federal dollars to 1 state general fund dollar).

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 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 then 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. This information is included on the next two pages.

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 we enjoy as North Dakotans.

Thank you.

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.

North Dakota Economic Security & Prosperity Alliance (NDESPA)
Partners Supporting SB 2135 to
Increase Eligibility for the Children's Health Insurance Program (CHIP)
January 2011

- North Dakota Women's Network
- North Dakota Children's Caucus
- North Dakota Council on Abused Women's Services
- North Dakota Disabilities Advocacy Consortium
- North Dakota Head Start Association
- North Dakota Association for the Education of Young Children
- North Dakota Community Action Partnership
- North Dakota Center for the Public Good
- AARP North Dakota
- American Association of University Women in North Dakota
- Catholic Charities North Dakota
- Mental Health America of North Dakota
- North Dakota Chapter of the National Association of Social Workers
- Children's Defense Fund, North Dakota
- North Dakota County Directors Association
- Prevent Child Abuse of North Dakota
- Rural Dynamics/Northern Plains Initiative

NDESPA VISION STATEMENT: *With the help of supportive policy makers and communities, all North Dakotans will have the tools they need to achieve and maintain economic security for themselves and their families.*

NDESPA MISSION STATEMENT*: The ND Economic Security and Prosperity Alliance works to build and sustain a system of economic security for all through poverty awareness and education, grassroots and community capacity building, research and data development, and promotion of policies and practices to eliminate disparities and obstacles for achieving economic security.*

NDESPA is an alliance of individuals and organizations that share a common concern for building assets for low and moderate-income families in North Dakota. NDESPA receives funding for its work from the Otto Bremer Foundation, the Northwest Area Foundation and the Seattle Foundation.

North Dakota Economic Security & Prosperity Alliance
1003 E. Interstate Ave., Suite #7, Bismarck ND 58503-0500

#5

Testimony in Support of Senate Bill 2135

Senate Human Services Committee

January 12, 2011

Good morning Madam Chair Lee and committee members. My name is Joan Connell. I am a native North Dakotan mother of three, a UND medical student educator, and a community pediatrician in private practice. Today, I am representing North Dakota- American Academy of Pediatrics (NDAAP) to support SB 2135 which will increase the income eligibility limit for the Children's Health Insurance Program from 160% to 250% of the poverty line.

Sometimes one needs to spend money to make money... Providing health care to children is a wise investment for North Dakota. We as North Dakotans are eager to grow this state and retain a healthy adult work force, which will continue to grow our economy and make our state prosper. A foundational element to this is a healthy young generation which can grow into strong, intelligent, hardworking adults. Providing healthcare to children is an essential component of this foundation. Access to healthcare, including preventative care, allows healthcare providers to detect many problems early, which often enables us as healthcare providers to optimize outcomes at a lesser cost. A recent study shows that providing children with health insurance decreased their future cost of hospitalization. This same access to healthcare will also often lead to immunization, which will prevent illness on a larger scale. Surely, we as North Dakotans want to make sure insurance is available for all possible youth, to create a robust generation that can carry on our great traditions.

On a personal note, you do not have to look far to find families in the same situation as the Andersons. My children attend a private daycare while I teach and see patients. One of my daycare providers is a single mother of two boys. They have been without insurance since she left her alcoholic, abusive husband a few years ago. This daycare provider employee "makes too much money" to qualify for CHIP in North Dakota, yet certainly cannot afford healthcare insurance for her family. Is it in North Dakota's best interest that someone whose vocation is helping grow *our* children into future productive North Dakotans cannot take *her* children to the doctor?

Thank you for your time. Please support SB 2135 to improve the foundation of our future.

#6

PRAIRIE ST. JOHN'S™

January 12, 2011

RE: Senate Bill 2135

Dear Members of the 62ND Legislative Assembly of North Dakota:

I am Dr. Emmet Kenney, a Child and Adolescent Psychiatrist, CEO of Prairie St. John's, and a member of the Governing Board of the North Dakota Hospital Association.

I stand before you today to advise you that the North Dakota Hospital Association stands in full support of Senate Bill 2135. The CHIP statute being amended has already had practical experience:

- This has enabled many families to ensure necessary medical treatment for their children, families that otherwise would not have been eligible for Medicaid.
- This legislation would further enable families to be able to seek care prior to major deteriorations in their children's health in a cost-effective manner.
- This access to care takes full advantage of matching federal funds to soften the financial implications for the State of North Dakota, bringing revenue into the state, supporting jobs and sustaining our healthcare system.

Ms. Susan Rae Helgeland, the Executive Director of Mental Health America of North Dakota, has requested that I advise you they also support this bill. MHA is the largest advocacy group for persons with mental illness and addictions in North Dakota.

In summary, I urge you to support and pass Senate Bill 2135. If there are any questions, I would be happy to address them.

Sincerely,

Emmet M. Kenney, Jr., M.D., CEO

EMK/skr

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#7

Testimony in Support of SB2135 in front of the Senate Human Service Committee

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

Chair Lee, members of the Senate 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 SB 2135, 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. SB2135 moves ND forward in achieving that goal and we support SB2135.

I appreciate your time today and we urge you to support SB2135!

#8

Wednesday, January 12, 2011

SB 2135: relating to the income eligibility limit for the children's health insurance program

To: Senator J. Lee and members of the senate human services committee

My name is JoAnn Brager and I am the Vice President of Public Policy for the North Dakota Association for the Education of Young Children. NDAEYC represents approximately 400 members who work with or on behalf of children ages birth to eight years of age.

NDAEYC strongly supports SB 2135 and considers this bill an opportunity to help families who struggle with keeping their children healthy but are over the 160% federal poverty income guidelines. We know that when children are healthy, parents are able to work more consistently. Those of us who have employees know the importance of consistent work attendance and the positive impact we can make every day.

Child care providers are small business owners who rarely have access to affordable health care for themselves much less their children. Increasing the income eligibility limit from 160% to 250% of the federal poverty guideline would assist those small business owners with health care for their children.

Thank you for your time today and I am happy to answer any questions you may have.

#9

Testimony on Senate Bill 2135
Senate Human Services Committee
January 12, 2011

Presented by Marlowe Kro
Associate State Director, AARP North Dakota

Chairwoman Lee, members of the Senate 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 Senate Bill 2135.

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.

#10

Testimony
Senate Bill 2135
Senate Judiciary Committee
Senator Judy Lee, Chairman
January 12, 2011

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

NDFFCMH Supports 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

#11

TESTIMONY
SB 2135
Red River Room - Senate Human Services Committee
Senator Judy Lee - Chairman
January 12, 2011

Chairman Lee 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 SB 2135 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.

#12

Senate Human Services Committee
SB2135
January 12, 2011

Good morning, Chair Lee and members of the Senate Human Services Committee. My name is Renee Stromme, and I am the Executive Director of the North Dakota Women's Network. Thank you for the opportunity to testify in support of Senate Bill 2135.

The North Dakota Women's Network serves as a catalyst for improving the lives of women through communication, legislation and increased public activism. We are a statewide organization with members from every corner of the state.

At its core, CHIP was designed to provide health care for children living in families stuck between the proverbial rock and a hard place: earning too much for Medicaid, but too little to afford health coverage. We know that women are more likely to work in low-wage jobs that don't provide health coverage and are faced with impossible choices during tough economic times: whether to put food on the table, or take their kids to the doctor when they're sick. Increasing CHIP eligibility will end this dilemma for more families. More working women will be helped by providing this critical health coverage to their children.

Thank you for allowing me to speak this morning and I urge a recommendation of DO PASS on Senate Bill 2135. I will answer any questions.

Renee Stromme

Executive Director

North Dakota Women's Network

13

Senate Human Services Committee
January 12, 2011
SB 2135

Good morning, Chairman Lee and members of the Senate 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, I am here today to offer support of SB2135, 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 suffers.

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 SB2135 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 SB2135. 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

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 (06411) 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 one of thousands of North Dakota's uninsured?
If so, they may be eligible 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

e questions?
Want to apply?

Thre ograms
One toll-free helpline

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

#14

Additional Testimony to the Senate Human Services Committee
Regarding SB 2135

Paul Ronningen

January 21, 2011

Chairman Lee and members of the Committee, I am submitting this additional testimony in response to a Committee question about the allocation of federal funds for the Children's Health Insurance Program (CHIP) that was raised during the hearing on January 12, 2011.

The question was whether or not the state of North Dakota would be *guaranteed* an increased federal allotment if the legislature raised the eligibility limit on CHIP to 250% of the Federal Poverty Level (FPL).

The short answer is that North Dakota's current federal CHIP allotment probably wouldn't be enough if the state were to expand the program. However, the state can simply ask the federal government for an increase, after it is demonstrated that we are indeed expanding eligibility.

The long answer is that, unlike Medicaid, which is an open-ended federal matching program, CHIP is essentially a block grant program. Previously, a state's block grant (called an "allotment") was determined using a formula based on the number of low-income children in a state. This resulted in unpredictability and a lot of unevenness in funding. A few years ago, Congress reformed the way CHIP allotments are provided, and at the same time increased the total federal pool of money available for all state programs. Now, state allotments are based mostly on a state's historic CHIP expenditures and projected future costs. There are a number of mechanisms in place, however, to encourage states to expand their programs, so that they aren't stuck at their current allotment levels. States can request a higher allotment, based on plans to expand CHIP eligibility. There is also a contingency fund that any state can tap, should enrollment exceed anticipated levels and a state run out of its allotment. Lastly, there is a separate pool of bonus money that states can receive for hitting certain targets for enrolling a certain level of low-income children in either Medicaid or CHIP. When CHIP allotments are re-calculated, which happens every few years, much of this is information (except for the bonuses) gets

automatically incorporated into the formula, permanently pushing up a state's allotment.

Note that even today, North Dakota doesn't spend all of its allotment, currently spending about 83%.

I am hopeful that this information responds to the question and I would be happy to answer any further questions you may have.

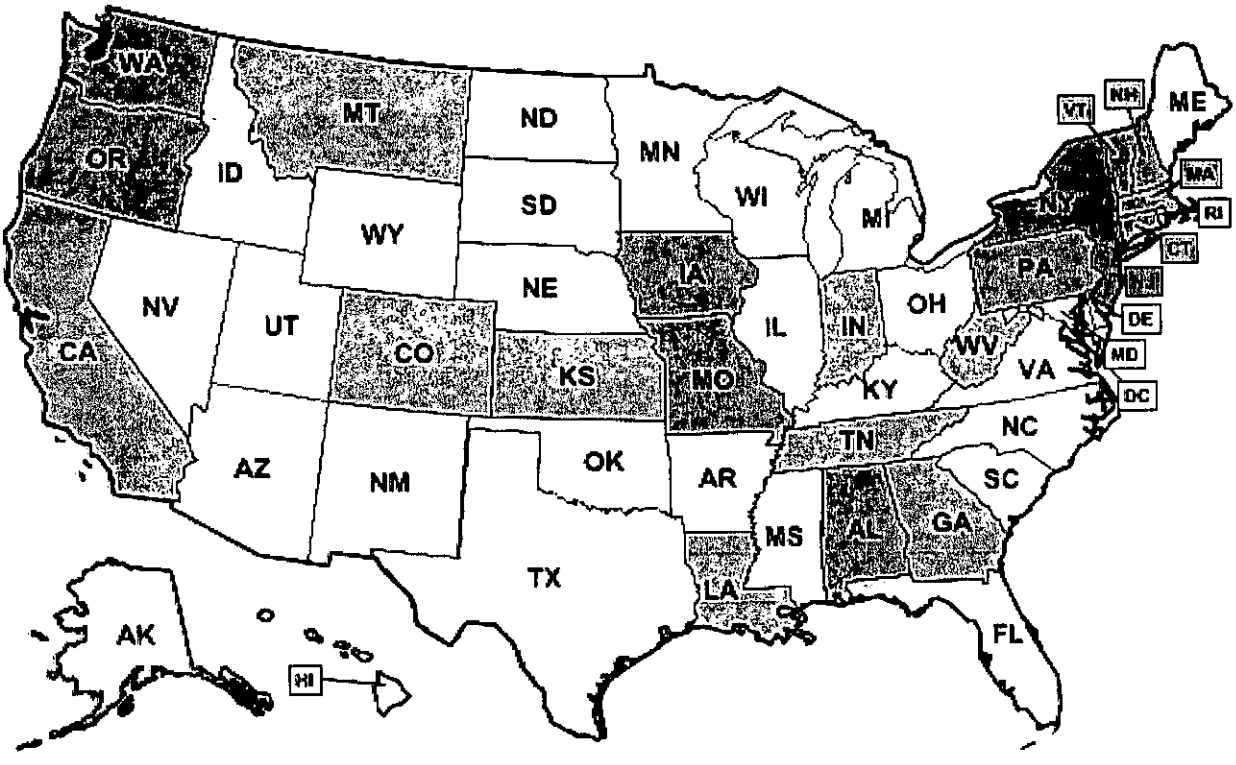
Paul Ronningen, Children's Defense Fund – North Dakota and ND Economic Security & Prosperity Alliance (NDESPA)

Email: pronningen@childrensdefense.org
Phone: 701.400.1827

#15

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

KAISER FAMILY FOUNDATION **statehealthfacts.org**
Your source for state health data

Rank (1=low | 51=high)	Income Eligibility -- Separate CHIP Prog
United States	NA1
1. Alaska	NA
1. Arkansas	NA
1. District of Columbia	NA
1. Hawaii	NA
1. Maryland	NA
1. Minnesota	NA5
1. Nebraska	NA
1. New Mexico	NA
1. Ohio	NA5
1. Oklahoma	NA
1. Rhode Island	NA
1. South Carolina	NA11
1. Wisconsin	NA5
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.

~ OVER ~

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

~ OVER ~

#16

From: Anderson, Maggie D.
Sent: Wednesday, February 02, 2011 1:23 PM
To: Lee, Judy E.; Uglem, Gerald P.; Dever, Dick D.; Berry, Spencer D.; Mathern, Tim
Cc: Hulm, Jodi M.
Subject: SB 2264 (CHIP at 200%) and SB 2135 (CHIP at 250%)

Senator Lee and Senate Human Services Committee members:

This morning you requested information on income level at 250% of the federal poverty level.
Following is a table with the information.
Please let me know if you have additional questions.

	250% FPL	250%
Family Size	Monthly	Annual
1	$ 2,257	$ 27,075
2	$ 3,036	$ 36,425
3	$ 3,815	$ 45,775
4	$ 4,594	$ 55,125

SB2135

Senate Human Services Committee -- Median/Mean Incomes in North Dakota

The U.S. Department of Health & Human Services, Administration for Children & Families estimated median and average incomes for North Dakota for the years of 2009-2010 and 2010-2011.

2009-2010 Estimates

-Average income for a 4 person family→ $67,183.

-Median income for 1 person family→ $27, 411.

-Median income for a 2 person family→ $33,860.

-Median income for a 4 person family→ $40,310.

-Median income for a 5 person family→ $46,760.

-Median income for a 6 person family→ 53,209.

-Median household income overall in 2009→ $47,827.

2010-2011 Estimates

-Average income for a 4 person family→ $73,101.

-Median income for a 1 person family→ $22,808.

-Median income for a 2 person family→ $ 29,824.

-Median income for a 3 person family→ $36,843.

-Median income for a 4 person family→ $43,861.

-Median income for a 5 person family→ $50, 878.

-Median income for a 6 person family→ $ 57,896.

INCOME LEVELS EFFECTIVE * JANUARY 1, 2011

Family Size	Family Coverage (1931)	Medically Needy 83% of Poverty	SSI (Effective 01/01/09)	Children Age 6 to 19 and QMB 100% of Poverty	SLMB 120% of Poverty	Pregnant Women & Child to Age 6 133% of Poverty	QI-1 135% of Poverty	Healthy Steps 160% of Poverty	Transitional Medicaid 185% of Poverty	Caring for Children & Children with Disabilities & Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$311	$ 750	$674	$ 903	$1,083	$1,201	$1,219	$1,444	$1,670	$1,805	$2,031
2	417	1008	1011	1,215	1,457	1,615	1,640	1,943	2,247	2,429	2,732
3	523	1267		1,526	1,831	2,030	2,060	2,442	2,823	3,052	3,434
4	629	1526		1,838	2,205	2,444	2,481	2,940	3,400	3,675	4,135
5	735	1784		2,150	2,579	2,859	2,902	3,439	3,976	4,299	4,836
6	841	2,043		2,461	2,953	3,273	3,323	3,938	4,553	4,922	5,537
7	947	2,302		2,773	3,327	3,688	3,743	4,436	5,130	5,545	6,239
8	1,053	2,560		3,085	3,701	4,102	4,164	4,935	5,706	6,169	6,940
9	1,159	2,819		3,396	4,075	4,517	4,585	5,435	6,283	6,792	7,641
10	1,265	3,078		3,708	4,449	4,931	5,006	5,935	6,859	7,415	8,342
+1*	107	259		312	374	415	421	500	577	624	702

Spousal Impoverishment Levels

Community Spouse Minimum Asset Allowance (Effective 01/01/09)	Community Spouse Maximum Asset Allowance (Effective 01/01/09)	Community Spouse Income Level (Effective 01/01/03)	Income Level for each Additional Individual (Effective 04/01/09)
$21,912	$109,560	$2,267	$607

Average Cost of Nursing Care

Average Monthly Cost of Care (Effective 01/01/11)	Average Daily Cost of Care (Effective 01/01/11)
$6577	$216.23

Note: LTC income level increased from $40 to $50 effective with the benefit month of 01/01/02

*Caring for Children eligibility guidelines changed from 141-170% FPL to 151-200% FPL as of 11/01/08

(Due to Healthy Steps eligibility guidelines change to 160% as of 07/01/09) There has been no change in income levels since 07-01-09.

Rev 01/2011

north dakota department of human services

Fact Sheet

July 2010

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

Medicaid Disqualifying Transfer: *Hardship Provisions*

All or part of a disqualifying transfer penalty period may be waived if the person can show that an undue hardship exists for him or her. A **person may apply for an exception** to the transfer penalty period, and must provide proof to support that claim, within 90 days of being notified of the transfer penalty, or within 90 days of a change that may now cause a hardship.

The facility in which a person lives may apply for an exception to the transfer penalty on behalf of the person if they have the consent of the person or his or her personal representative.

An undue hardship exception may be requested by contacting a county social services office. A hardship request form with instructions can be found on the Web at http://www.nd.gov/dhs/info/pubs/docs/medicaid/form-medicaid-hardship-provision-application.pdf. The form and proof need to be provided to the county social services office.

An undue hardship exists only if the person proves that all of the following conditions are met:

- Applying the penalty period would deprive the person of medical care such that the person's health or life would be endangered; or deprive the individual of food, clothing, shelter, or other necessities of life.
- The transfer was not made after a previous request for a hardship exception;
- All lawful means to recover the transferred assets or income, or the value of the transferred assets or income have been exhausted;
- The provider or facility who would provide care has no legal options, or has exhausted all legal options, against the transferee of the assets or income under the Uniform Fraudulent Transfers Act, or any similar law; and
- The remaining available assets of the person and his or her spouse are less than the Medicaid asset limit. The **value of all assets are counted except**:
    - The home; however, if the equity in the home is more than $125,000, the extra equity is counted as an asset;
    - Exempt personal effects, clothing, household goods, and furniture;
    - One motor vehicle (if the vehicle is mainly used to serve the needs of the person, spouse, or their minor children who live with them), and
    - Funds for burial of $6,000 or less for the person and his or her spouse.

If Undue Hardship Exception Request is Denied: The affected person may request an appeal to the N.D. Department of Human Services.

For information: Contact your local county social service office. Address and phone numbers are online at www.nd.gov/dhs/locations/countysocialserv/index.html.

north dakota department of human services

Fact Sheet

SEPTEMBER 2010

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

Medicaid Disqualifying Transfer of Assets and Income

Person does not qualify for Medicaid coverage of nursing care services if that person or his or her spouse makes a disqualifying transfer. A normal transfer of assets or income for which fair market value is received is not considered a disqualifying transfer. A transfer is only disqualifying if fair market value is not received.

> **One Example of Disqualifying Transfer:** A person gives land and equipment to his adult children without receiving payment equal to its fair market value. *NOTE: There are many other types of disqualifying transfers.*

Transfers are generally reviewed to see whether a disqualifying transfer occurred if a person applies for coverage of nursing care services within 5 years of making the transfer.

Nursing care services include services received in a nursing home, swing bed services in a hospital, nursing care in any other medical institution such as the State Hospital, the Anne Carlsen Center, Prairie St. John's, Stadter Psychiatric Center, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the developmentally disabled (ICF-MR), or a home and community based services setting.

Penalty Periods:

If a disqualifying transfer has occurred, a penalty period is established. The penalty period is the length of time that Medicaid will not cover the cost of nursing care services. The length of the penalty period is determined by the amount of the disqualifying transfer divided by the average monthly cost of nursing facility care in North Dakota as of the individual's first application for Medicaid.

Penalty periods generally begin on the latest of:

- The first day of the month in which the transfer occurred; or
- The first day on which the person is receiving nursing care services and is "otherwise eligible" for Medicaid.

When deciding if an individual is "otherwise eligible" for Medicaid:

- The person must have applied for Medicaid and meet all nonfinancial eligibility criteria;
- Countable assets must be within Medicaid asset levels; and
- The monthly cost of nursing care and other medical care the person is responsible for, must be equal to or greater than the person's recipient liability.

OVER ⟹

Transfers that do not cause penalty periods:

Some transfers of property are not treated as disqualifying even when no money is received. For instance:

- Transfer of the home to a spouse, a child who is disabled or a minor child; to a sibling who has partial ownership who has lived there and cared for a person for at least 1 year before that person entered nursing care; or to an adult child who lived there and cared for a person for at least 2 years before that person entered nursing care.
- Some transfers of other property to a spouse.
- Transfers to a trust solely for the benefit of a child who is disabled.

Frequently Asked Questions:

Q: If both spouses enter long term care and one spouse already has a disqualifying transfer penalty period set up, can the other spouse be eligible for Medicaid coverage for nursing care services?

A: If both spouses are receiving nursing care services, any penalty period is split between the two spouses.

Q: The fact sheet addresses nursing care services. Can other services be covered by Medicaid when someone has a disqualifying transfer?

A: Yes, non-nursing care services may be covered by Medicaid even if a person has a penalty period set up.

Q: What if I made a transfer and now I have no money to pay for my care?

A: In rare cases, a Hardship waiver may be granted. A link to the fact sheet titled, "Medicaid Disqualifying Transfer Hardship Provisions," provides more information. http://www.nd.gov/dhs/info/pubs/docs/medicaid/fact-sheet-medicaid-disqualif-transfer-hardship-exemption.pdf

For information, contact your local county social service office. County contact information is at www.nd.gov/dhs/locations/countysocialserv/index.html.

#17

PROPOSED AMENDMENTS TO SENATE BILL NO. 2135

Page 1, line 3, after "program" insert "; and to provide an effective date"

Page 1, after line 8, insert:

"SECTION 2. EFFECTIVE DATE. The change to the net income eligibility limit for the children's health insurance program identified in section 1 of this act becomes effective the first day of the month following the department of human services receiving written notice from the centers for medicare and medicaid services of approval of an increase to the federal allotment to cover that increase to the net income eligibility limit of the children's health insurance program."

Renumber accordingly

This amendment was prepared at the request of Senator Mathern.

2-7-11

Amendments to 11.0057.01000