Prepared by the North Dakota Legislative Council
staff for the Budget Committee on Health Care
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COORDINATION OF HEALTHY STEPS AND MEDICAID PROGRAMS STUDY - BACKGROUND MEMORANDUM

The committee has been assigned responsibility to:

- Study the coordination of the Healthy Steps and Medicaid programs, pursuant to Section 3 of House Bill No. 1441 (attached as Appendix A), including:

  The development of a single application form for both programs.

  Determining whether the Healthy Steps program should be administered by the state or by the counties.

  The effects of eliminating the asset test for determining Medicaid eligibility.

  The standardization of the definition of "income" for all programs administered by the Department of Human Services.

  The feasibility and desirability of seeking a federal waiver to allow the Healthy Steps program to provide family health insurance coverage through an employer-based insurance policy if the employer-based policy is more cost-effective than traditional coverage for the children.
- Receive an annual report from the Department of Human Services regarding the children's health insurance program, pursuant to North Dakota Century Code (NDCC) Section 50-29-02.

STUDY OF COORDINATION OF HEALTHY STEPS AND MEDICAID PROGRAMS

Healthy Steps Program

The children's health insurance program, named Healthy Steps, was authorized by the 1999 Legislative Assembly to provide health insurance coverage to low-income children not eligible for Medicaid. The income eligibility limit for Healthy Steps is set at family net income at or below 140 percent of the federal poverty level; the children's income eligibility limit for Medicaid is 100 percent of the federal poverty level.

The Department of Human Services contracted with Blue Cross Blue Shield of North Dakota to provide the health insurance coverage for the Healthy Steps program. The first contract covered the period October 1, 1999, through June 30, 2001. Insurance coverage is based on the state employee group health insurance plan, with added coverage for dental and vision services. For the 1999-2001 biennium, the premium rate for most policies was $108.60 per member per month with copayments of $2 for each prescription, $50 for each hospital admission, and $5 for each emergency hospital visit. Copayment requirements are waived for American Indian children, and the premium paid by the state for those policies is slightly higher ($109.56).

The current contract covers the period July 1, 2001, through June 30, 2003. The premium rate for most policies is $126.40 per month; the premium for policies without copayments is $127.50 per month. Copayment requirements are unchanged for the 2001-03 biennium.

As of May 2001, 2,441 children are enrolled in the Healthy Steps program plan. The enrollment consists of 49 percent from rural counties and 51 percent from urban counties. The majority of the children enrolled are white (87.6 percent); American Indian children comprise 9.3 percent of the enrolled population, Hispanics 1.5 percent, and others 1.6 percent.

The federal matching assistance percentage (FMAP) for the Healthy Steps program plan is approximately 79 percent, compared to the Medicaid matching rate of approximately 70 percent, as shown on the following table:

Federal Fiscal Year	Healthy Steps FMAP	Medicaid FMAP
1998	79.30%	70.43%
1999	78.96%	69.94%
2000	79.29%	70.42%
2001	78.99%	69.99%
2002 (estimate)	78.91%	69.87%
2003 (estimate)	78.91%	69.87%

Federal allotments for North Dakota for the Healthy Steps program are as follows:

Federal Fiscal Year	Federal Allocation for Healthy Steps
1998	$5,040,741
1999	$5,016,935
2000	$5,655,883
2001	$6,575,656

States have two years after the year of allotment to spend federal funds for the children's health insurance program. Any funds unused after that time are returned to the federal government for reallocation to the states. Of the $5,040,741 fiscal year 1998 allotment,

$1,859,325 was spent and $3,181,416 was returned to the federal government to be redistributed to states. North Dakota subsequently received a redistribution of $2,054,654 from the unspent fiscal year 1998 allocations returned by various states to the federal government. The redistributed amount will be available through September 30, 2001. Through March 31, 2001, the state has spent $1,025,435 of the redistributed 1998 allocation, leaving an unused balance of $1,029,219, which must be used before September 30, 2001. Any of the fiscal year 1999 allocation unspent as of September 30, 2001, will be returned to the federal Department of Health and Human Services and will be subject to redistribution to the states.

Single Application Form

The committee is directed to study the development of a single application form for both the Healthy Steps and Medicaid programs. Section 1 of House Bill No. 1441 directs the Department of Human Services to provide medical assistance benefits to children and families coverage groups and to pregnant women without consideration of assets **if federal approval is obtained** of amendments to the state children's health insurance program (CHIP) plan. The Department of Human Services testified during the 2001 Legislative Assembly that such a change in eligibility criteria will make Medicaid eligibility for families consistent with Healthy Steps eligibility and may make it feasible for the department to create a combined application form for both programs.

Under current law, eligibility for the Healthy Steps program does not include an asset test; eligibility for Medicaid does. If a family applies for Medicaid and is ineligible, they must complete a separate application for Healthy Steps. If a family completes a Healthy Steps application and it appears the children are Medicaid-eligible, the family must complete a separate Medicaid application. The completion of a single application form would simplify the application process. Copies of the current applications for the Healthy Steps program and Medicaid are attached as Appendices B and C, respectively.

County Administration of Healthy Steps

The committee is directed to study whether the Healthy Steps program should be administered by the state or by the counties. The Department of Human Services currently determines eligibility for the Healthy Steps program; counties determine eligibility for Medicaid. The Legislative Assembly considered provisions in 2001 House Bill No. 1441 that would have required counties to administer the Healthy Steps program. The bill as passed did not include these provisions.

Testimony provided to the 2001 Legislative Assembly by the Department of Human Services and the counties indicated administrative costs for the Healthy Steps program would be higher for the counties than for the state. The estimated cost of county administration for the 2001-03 biennium was reported to be $467,544, of which $98,558 would be from the state general fund, compared to current state administrative costs of approximately $90,000, of which approximately $19,000 is from the state general fund. In addition, the Department of Human Services estimated that in order for counties to efficiently administer eligibility determination for the Healthy Steps program, computer programming costs of $415,000, of which $124,541 would be from the general fund, would be required to integrate Healthy Steps eligibility into the VISION computer system used by counties to determine Medicaid eligibility.

Effects of Eliminating Asset Test for Medicaid

The committee is directed to study the effects of eliminating the asset test for determining Medicaid eligibility. Testimony provided to the 2001 Legislative Assembly by the Department of Human Services indicated that, based on a 1998 survey, an additional 1,669 individuals would become enrolled in the Medicaid program as a result of the elimination of the asset test, as follows:

	Number of Persons
Children not previously eligible for Medicaid or Healthy Steps	527
Adults not previously eligible for Medicaid	182
Children previously served under the Healthy Steps program but eligible for Medicaid due to elimination of the asset test	960
Total number of new enrollments in Medicaid	1,669

The fiscal note prepared by the Department of Human Services for 2001 House Bill No. 1441 projected that the elimination of the asset test for Medicaid eligibility would have cost an estimated $1,434,972 ($419,639 from the general fund and $1,015,333 from other funds) for the 2001-03 biennium, as follows:

	Estimated Cost (Savings)
Additional Medicaid costs for children (70 percent federal matching rate)	$3,204,309
Additional Medicaid costs for adults (70 percent federal matching rate)	392,928
Healthy Steps program savings due to children becoming eligible for Medicaid (79 percent federal matching rate)	(2,186,265)
Programming costs	24,000
Total estimated all funds cost	$1,434,972
Less estimated other funds cost	1,015,333
Total estimated general fund cost	$419,639

Standardization of Income Definition

The committee is directed to study the standardization of the definition of income for all programs administered by the Department of Human Services. Income eligibility for the Healthy Steps program is based on net income at or below 140 percent of the federal poverty level. Net income is determined by subtracting child care costs and payroll taxes from gross income. Through March 31, 2002, net income limits in effect are:

Number of People in Family	Maximum Allowable Monthly Net Income
1	$1,003
2	$1,355
3	$1,707
4	$2,060
5	$2,412
6	$2,764
7	$3,117
8	$3,469
9	$3,821
10	$4,174

Establishing eligibility for Medicaid is a more complicated process. For example, the determination of income for an individual who requires nursing care services and who is residing in a nursing facility is calculated by:

- Excluding the following types of income:

  Occasional small gifts.

  Veterans Administration pensions of $90 received by qualifying individuals.

  Certain federal reparation and compensation payments.

- Deducting:

  Mandatory payroll deductions for Social Security and Medicare.

  The nursing care income level ($40 per month).

  Amounts provided to a spouse or family member for maintenance needs.

  Medical expenses for necessary medical or remedial care.

  Medicare and health insurance premiums.

  Long-term care insurance premiums.

  A portion of payments made for services of a guardian or conservator.

- Adding:

  Payments from any source received as a result of medical expenses or increased medical need.

Income eligibility for an individual residing in an individual's own home or in a specialized facility is calculated by:

- Excluding various types of income, including:

  Payments made by the department in connection with foster care of the subsidized adoption program.

  Temporary assistance for needy families (TANF) payments.

  Low-income energy assistance program payments.

  Refugee cash assistance.

  County general assistance.

  Current child support of $50 per month.

  Income earned by a child who is a full-time student.

  Occasional small gifts.

  Income received as a result of participation in the Job Corps program.

  Loan proceeds.

  Income tax refunds.

  Training funds received from vocational rehabilitation.

  Training allowances of up to $30 per week provided through a tribal native employment works program or the job opportunities and basic skills (JOBS) training program.

  Certain federal reparation and compensation payments.

- Deducting:

  Health insurance premiums.

  Medical expenses for necessary or remedial care.

  Food and veterinary expenses for a dog trained to detect seizures.

  Long-term care insurance premiums.

  A portion of remedial care costs for an individual residing in a specialized facility.

  Transportation expenses relating to obtaining medical care.

  Court-ordered child and spousal support payments.

  Child care expenses, if necessary, to engage in employment or training.

Adult dependent care expenses, if necessary, to engage in employment or training.

Any income of $20 per month, except income which is based on need.

A portion of payments made for guardian or conservator services.

A work or training allowance of $30 per month for each individual in the Medicaid unit who is employed or in training.

From earned income for all individuals except aged, blind, or disabled applicants:

Mandatory payroll deductions and union dues, or $90, whichever is greater.

Mandatory retirement plan deductions.

From earned income for aged, blind, or disabled applicants, $65 plus one-half of the remaining monthly gross earned income.

Once the level of income is established, eligibility must be determined. Income eligibility levels are different for each type of recipient--the categorically needy, the medically needy, and poverty income individuals.

The categorically needy consists of two categories of individuals:

1. Those who were eligible for aid to families with dependent children (AFDC) (before the AFDC program was replaced by the TANF program), for whom eligibility for Medicaid is a result of meeting AFDC eligibility requirements.
2. The aged, blind, and disabled recipients, for whom eligibility for Medicaid is based on the income level which establishes supplemental security income.

Medically needy individuals receiving nursing care are subject to an income limit of $40 per month, after the adjustments indicated above. Medically needy individuals residing in their own home are subject to the following income limits:

Number of People in Family	Maximum Allowable Monthly Income
1	$369
2	$428
3	$465
4	$556
5	$625
6	$684
7	$721
8	$760
9	$783
10	$810

Poverty income level eligibility is based on the following categories of eligibility:

Eligibility Category	Maximum Income as a Percent of Federal Poverty Level
Pregnant women and children under age 6	133%
Qualified Medicare beneficiaries	100%
Children age 6-18	100%
Extended Medicaid benefits	185%
Qualified disabled and working individuals	200%
Special low-income Medicare beneficiaries	110%

Other programs to be considered include child care assistance, low-income heating assistance, and the TANF program.

Expansion of Healthy Steps to Include Subsidies for Adding Family Coverage to Employer-Based Health Insurance Plans

The committee is directed to study the feasibility and desirability of expanding the Healthy Steps program to provide family coverage through employer-based health insurance plans. A February 13, 1998, letter from the Health Care Financing Administration to state health officials outlines the parameters under which states may use children's health insurance program (CHIP) funds to provide health insurance coverage through employer-sponsored group health plans. The letter outlines the agency's concern that there is a potential for CHIP coverage to be substituted for private group health coverage by individuals and employers currently purchasing such coverage with private funds. The letter expresses a concern that CHIP programs that furnish coverage through employer-sponsored group health plans have greater potential to allow the substitution of private funds with public funds. The letter indicates that states that use CHIP funds to subsidize employer-sponsored group health plans should incorporate provisions in their state CHIP plan that are substantially equivalent to the following:

1. **Six-month waiting period** - To ensure that coverage is targeted to children in families that previously were unable to afford dependent coverage, subsidies through an employer-sponsored group health plan will not be available to a family whose children had employer-sponsored coverage within the previous six months. States may impose a longer required period of uninsurance, but the period may not exceed 12 months. Exceptions may be allowed if the coverage was involuntarily terminated by an employer other than the applicant's current employer. Newborns are not subject to the waiting period.
2. **Required employer contributions** - To discourage employers from lowering their

existing contributions for dependent coverage, subsidies for employer-sponsored group health insurance will only be available in cases when the employer contributes at least 60 percent of the cost of the family coverage (60 percent is the median employer contribution nationwide). A lower level of contribution may be considered if a state has additional provisions in place to limit an employer's ability to lower contribution levels.

3. **Limitation on costs** - To ensure that the provision of child health assistance through employer-sponsored group health plans is cost-effective and that the state is not inappropriately subsidizing coverage for the adults in a family, a state's payment for a child enrolled in an employer-sponsored group health plan may not exceed the payment the state would make to provide coverage for the child through the state's CHIP plan. If subsidized health insurance coverage through employer-sponsored group health plans is provided only to children, no family coverage waiver is needed. If coverage is provided to adults, the state must obtain a family coverage waiver under Section 2105(c)(3) of Title XXI of the Social Security Act. Section 2105(c)(3) provides that federal funds may be paid to a state for the purchase of family coverage under a group health plan if the state establishes that:
   a. The purchase of such coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage of the targeted low-income children involved.
   b. Such coverage may not be provided if it would substitute for health insurance coverage that would otherwise be provided to the children involved.
4. **Full premium contribution from employer** - To promote cost-effectiveness by reducing the required CHIP contribution to the cost of the premium, families electing to receive child health assistance through an employer-sponsored group health plan will be required to apply for the full premium contribution available from the employer.
5. **Evaluation** - To demonstrate cost-effectiveness, the state must collect information and conduct an evaluation that examines the amount of substitution that has occurred under the program and the effect of these provisions on access to the program.

The National Conference of State Legislatures reported in June 2000 that, as of that date, three states (Massachusetts, Mississippi, and Wisconsin) had instituted programs to provide health insurance coverage through CHIP subsidies of employer-sponsored group health insurance plans.

ANNUAL REPORT REGARDING HEALTHY STEPS PROGRAM

North Dakota Century Code Section 50-29-02 requires the Department of Human Services to present an annual report to the Legislative Council on the children's health insurance program, including enrollment statistics and costs associated with the plan. The Legislative Council has assigned this duty to the Budget Committee on Health Care.

RECENT LEGISLATIVE STUDIES

1995-96 Budget Committee on Human Services

Pursuant to 1995 House Concurrent Resolution No. 3045, the 1995-96 Budget Committee on Human Services conducted a study of the responsibilities of county social services agencies, regional human service centers, and the Department of Human Services. As a result of the study, the committee recommended House Bill No. 1041, which required counties to assume financial responsibility for the costs of administering certain economic assistance programs and required the state to assume financial responsibility for the grant costs of Medicaid, TANF, child care assistance, and basic care and to contribute additional support for administrative costs of counties with Indian land.

1997-98 Welfare Reform Committee and Insurance and Health Care Committee

Both the Welfare Reform Committee and the Insurance and Health Care Committee received reports from the Department of Human Services during the 1997-98 interim regarding the establishment of a state children's health insurance program in two phases:

- Phase I - Expand the Medicaid program to include children up to 18 years old with a family income at or below 100 percent of the federal poverty level.
- Phase II - Provide private insurance coverage for uninsured children who are not Medicaid-eligible and who meet family income requirements.

1999-2000 Budget Committee on Health Care

Section 12 of 1999 Senate Bill No. 2012 established a children's health insurance program and directed the Department of Human Services to present an annual report on the program to the Legislative Council. This duty was assigned to the Budget Committee on Health Care.

The committee received various reports during the 1999-2000 interim regarding the status of the program. The committee learned that although the department

had taken steps to simplify the complexity of the Medicaid eligibility application form, the asset test adds complexity to the application. The committee also learned that if the asset test for children and pregnant women is eliminated from Medicaid eligibility requirements, the department could combine the Healthy Steps and Medicaid applications. The committee also learned that although income eligibility for the Healthy Steps program is determined on an annual basis, it is determined on a monthly basis for the Medicaid program. The committee considered but did not recommend a bill draft that would have:

- Eliminated the asset test for Medicaid eligibility for children and pregnant women.
- Changed the Medicaid income review period from monthly to annually for children and pregnant women.

The committee recommended 2001 House Bill No. 1036, which failed to pass. The bill would have provided for a quarterly rather than annual review period for children and pregnant women receiving Medicaid benefits; the fiscal note indicated a general fund cost of $374,737 for the 2001-03 biennium.

RELATED 2001 LEGISLATION

House Bill No. 1036, which failed to pass, would have required the Department of Human Services to review on a quarterly, rather than annual, basis the income eligibility of children and pregnant women receiving medical assistance.

House Bill No. 1441 provides that the Department of Human Services should seek an amendment to its children's health insurance state plan to provide maximum federal reimbursement for the cost of removing the asset test for the Medicaid program. If the state plan amendments receive federal approval, the department shall remove the asset test requirements for the Medicaid program through June 30, 2003. The bill also:

- Allows the department to accept and spend any gift, grant, or donation for the Healthy Steps program.
- Provides for a Legislative Council study of the coordination of the Medicaid and Healthy Steps programs.

Senate Bill No. 2414, which failed to pass, would have provided for the coverage of child delivery under the children's health insurance program and would have eliminated the family cap under the TANF program.

PROPOSED STUDY PLAN

The following is a study plan the committee may want to consider in its study of the coordination of the Healthy Steps and Medicaid programs:

1. Receive annual reports from the Department of Human Services regarding the Healthy Steps program, as required by NDCC Section 50-29-02, including enrollment statistics and costs.
2. Review information from other states regarding county or state administration of the children's health insurance program, the elimination of the asset test for Medicaid eligibility, and the expansion of the children's health insurance program to include subsidies for adding family coverage to employer-based group health plans.
3. Receive information from the Department of Human Services, county social services agencies, and other interested organizations, entities, and individuals regarding the costs and benefits of:
   a. Developing a single application form for the Healthy Steps and Medicaid programs;
   b. Providing for county administration of the Healthy Steps program;
   c. Eliminating the asset test for determining Medicaid eligibility;
   d. Standardizing the definition of income for all programs administered by the Department of Human Services; and
   e. Obtaining a federal waiver to allow the Healthy Steps program to provide family health insurance coverage through an employer-based insurance policy.
4. Develop recommendations and any related bill drafts regarding the coordination of the Healthy Steps and Medicaid programs.
5. Prepare a final report to the Legislative Council.

ATTACH:3