MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2048

2005 SENATE HUMAN SERVICES

SB 2048

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2048

Senate Human Services Committee

❑ Conference Committee

Hearing Date January 10, 2005

Tape Number	Side A	Side B	Meter #
1		x	0-1008
Committee Clerk Signature			

Minutes:

Chairman Lee opened the hearing on SB 2048

All members were present.

Sen. Lyson: I brought this bill forward at the request of the Northwest Bar Association, possibly called the Upper Missouri Bar Association. This law came into effect in 1887 and the last time it was amended was 1943. Simply states that children are responsible for their children, no matter what their age. It also goes on to say that children are responsible for the debts of their parents, no matter what their age. The bar association says that there are laws on the books now to take care of a great number of problems that are in this law. It's time we repeal this law and work on the modern laws we have now if there's going to be a problem with this.

Sen. Dever: Is there a history of this being enforced?

Sen. Lyson: From what I was given, the last time it was even mentioned was at a hearing in the Supreme Court. A hospital was suing somebody, and the Supreme Court did not uphold the lawsuit, but did mention this law. Senator Trenbeath may have some more information.

Sen. Trenbeath, State Senator from District 10.

Sen. Trenbeath: This was probably a law that was never really used a lot. I feel it's one of those things were we mix legal obligations with moral obligations. I would support my parents if they needed, but the law shouldn't tell me to do this. I don't think that it's part of our modern social norm or requirement from a legal perspective. I do, however, see the last sentence being resurrected which says, "the promise of an adult child to pay for necessaries to the person." That is a modification of common contract law would be binding anyway if it took a particular form was written and signed, etc., but this apparently would dictate that if a person is reasonably satisfied that you promised that you would pay the bill for providing services for that person's parents then you should be held to that obligation whether or not it's in writing. And I don't disagree with that and I don't think the law would disagree with that. But as for the obligation of parents to support adult or for children to support their aging parents, I don't think that should be part of our legal structure.

Chairman Lee: Have you had any communication with the Department of Human Services on whether this would have an impact on long-term care? Do they use that at all when they're looking at providing services?

Sen. Trenbeath: I have not had any input from them except Mr. Fleming who is counsel for Child Support.

Chairman Lee: Does this mean that a parent would be responsible for paying their adult child's child support payment; if the adult child was a non-custodial parent and was supposed to be paying child support?

Sen. Trenbeath: I guess if it's an obligation of the child, it could become an obligation of the parent.

Sen. Lyson: I did call a long-term care facility to see if they ever used this, and they said no.

Sen Dever: After looking at this section I noticed the three or four sections following appeared could be related.

Sen. Trenbeath: I think they are. Each of the next three or four hint of the same type of situation if not obligation. It's where the parent or child are not able to support him or herself. But I don't think they stand in direct substitution for the statute we're looking at.

Sen. Dever: They're not dependent on each other?

Sen. Trenbeath: I don't believe so.

No further testimony for Bill 2048.

Chairman Lee closed the hearing.

Chairman Lee: Maybe we could check with David Zentner with the Department of Human Services, because Medicaid would plug in here. See if there is any time when they would use this law.

Sen. Lyson: The last mention was a Supreme Court ruling in 1953. And the Supreme Court did not uphold it.

Chairman Lee: I recently found out that a health care facility was being creative in considering their finance charge on late bills. They were using credit card law instead of law we

passed last session which limits the charge to 1% per month which is still 12% per year and $25 per month maximum. They have on their forms that you sign annually at their facility, an 18% APR. When I brought it to there attention, they said they were under the credit card statute, because you're paying a finance charge. We'll be seeing a bill to change that. This is my point, is there any use of this bill some other place.

Clarence Daniels, Director of Social Services in Jamestown North Dakota

Daniels: The last mention the Supreme Court made of this bill was in 1963, the year the law on Medicaid was passed and North Dakota instituted it. So, I do not believe the Department is using it, but I would suggest you follow-up with Zentner. I've never seen any reference to Section 14.

Chairman Lee: I would like to find out whether or not there is any impact on that.

Discussion ended on SB 2048.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2048

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 11, 2005

Tape Number	Side A	Side B	Meter #
1	x		00-6200
1		x	00-6150
2	x		00-0613
Committee Clerk Signature	Cathy Hunsinger		

Minutes:

Chairman Lee reopened the hearing on SB 2048

All members were present.

Shelly Peterson, lobbyist for the North Dakota Long Term Care Association

Peterson: I came to share the circumstances that we might use this law. We are looking at introducing on the House side, a piece of legislation that might be a better fit the issue we're trying to address. Medicaid was supposed to be a program for the poor and indigent, for people who don't have income or assets to pay for their care. Over time, many people began using Medicaid to pay for long term care, about 60%. An issue related to asset transfer and Medicaid standing has evolved in long term care. Facilities have $3.8 in receivables in money their trying to collect, because a person has run out of money but Medicaid has denied coverage to. Attorneys were asked to give suggestions on how to lessen receivables. The issue of the law was brought up. The law stating that children are responsible for their parents. It was suggested to

amend that law to state "if you've received a transferred asset and Medicaid has determined that that asset should be available for your care, then whoever received that transferred asset would be responsible for the person's care- if we had an ineligible person for Medicaid. Right now, the only option we have if a person isn't paying their bill, is to discharge them. We have many at any given time in the process of eviction. But we have nowhere to send them. So we have growing accounts because no one is able to take them in, i.e., children or another facility. Another facility won't step up because they've been flagged as not being able to pay. The facility follows through with the eviction up to the last minute, but does not evict because there's no place to send them. A lot of time at the eleventh hour, the person handling the trust will bring in some funds so we won't evict them.

We've quoted this law in the administrative process and only use it if we know someone is responsible for a person's care and they have control of the trust or assets that Medicaid has deemed available for their care. We would never tell children they are responsible for the care of their parents-whether they have the means or not. If you do appropriate estate planning and you transfer your assets according to the Medicaid rules, we don't have problems.

The legislation we're proposing in the House has taken a long time to complete because lawyers on both sides of the issue are coming from different viewpoints.

Chairman Lee: Would the repeal of this section create any problems for you? Would you like us to look at passing this legislation and it not affecting you, or do you want us to amend it so that it doesn't conflict what you're doing in House?

Peterson: I don't have a problem with you repealing this, because I'm hoping with the solutions we're coming up with will better address this issue.

Sen Lyson: You don't have much time left to introduce a bill in the House. We have an additional week; I'd be willing to help if you need it.

Sen. Dever: Aren't most of these things already covered in the North Dakota Century Code?

Peterson: Yes, the problem arises when Medicaid deems the person ineligible and assets or trusts are involved. People thought they did proper planning, but there's a problem with the wording or something else is wrong with the trust.

Sen. Dever: But that's not an issue of the child being responsible, its a matter of the parents assets.

Peterson: We're trying to establish a link to any responsible party that has been a recipient of an asset. If that asset has deemed that person ineligible for Medicaid, we're trying to attach language to the asset--whomever it has been transferred to. This language of children and parents didn't seem to have a lot of support-which is why we didn't try to amend anything in this statute. We are trying to find solutions in other areas of the statute. Rep. Kreidt has been helping us in the House.

Chairman Lee: We've worked in past sessions to establish a law that says if you have long term care insurance that will cover three years of support, your assets are exempted from Medicaid.

Sen. Dever: How are prepaid or preneed funeral expenses looked at?

Peterson: Any Medicaid recipient is allowed to set aside $3000 for their funeral. There is proposed legislation to increase that to $5500. You get $3000 in a preneed funeral and another $3000 for the funeral, a maximum of $6000.

Chairman Lee: Mr. Zentner, did you have any observations on SB 2048, on whether doing anything with that statute would effect our ability to collect under Medicaid?

Zentner: I don't believe so. We've always had the caveat that spouses are responsible for spouses, and parents are responsible for minor children. And those wouldn't change under this law change. If you're 17 and can prove you're emancipate, we don't look to parents either.

Carlee McLeod, Senate Human Services Committee Intern, reviewed Attachment 1 for the committee.

Chairman Lee ended the public hearing on SB 2048.

Mr. David Zentner, Department of Human Services

Gave the committee background information on general Medicaid programs. Mr. Zentner accepted questions on specific areas of the document as they came up.

See Attachment 2

Sen. Brown: Is an amendment and a waiver the same thing?

Zentner: No. State plan amendment is something that can be done within the premise of the program. A waiver is something outside the state plan amendment. In order to do a waiver, you have to submit a separate process and the review process is different. Waivers can take years and the Feds tend to look closely at waivers.

Chairman Lee: Can you give us an example?

Zentner: For our home and community bases service, we have three waivers in place. One for the elderly and disabled, one for the traumatic brain injured and one the developmentally disabled. Basically, it allows us to pay for nonmedical services to keep people at home instead of in an institution.

Mr. Zentner gave other examples of waivers (tape 1, meter 2210-2560)

Mr. Zentner went on to explain pages 2- 3 of Attachment 2 (tape 1, meter 2561-3280).

Attachment 2A (tape 1, meter 3281-3360)

Chairman Lee: I'd like to know the impact has been on the change on SPED and expanded SPED in the last session. I need to know before the last date for bills is. Because if there's a need for a change in the formula that was developed in the last session. We need to address that legislatively and not through Appropriations.

Zentner: You might want to visit with Linda Wright.

Mr. Zentner continued with explaining Attachment 2A, then he was on to page 4 and beyond (beginning with tape 1, meter 3580).

Sen. Warner: Is it common for people to cluster their bills? (refer to pg. 6 Attachment 2)

Zentner: Yes, and this is legitimate.

Sen. Lyson: Is this an annual salary, but you're talking about monthly.

Zentner: Yes, it's monthly. If you're in a nursing home and your income doesn't fluctuate, we'll certify you for a whole year. But if you're out there working, and your job has fluctuating income, that liability will change every month.

Chairman Lee: North Dakota is one of three states that certify income on a monthly basis.

Sen. Warner: Is there a lag time between the beginning of eligibility and when they're no longer eligible? Do they have to demonstrate two or three months of being below the certain amount before they can be eligible?

Zentner: It is on a monthly basis. We have a perspective system, so we're looking forward. We're determining eligibility for February in January. With Medicaid, you can go back three

months. So if you apply in January, you can become eligible for October, November and December.

Chairman Lee: If someone didn't have any medical appointments for six months than did again, they might have to reapply?

Zentner: Right.

Mr. Zentner continued explaining the written testimony. (tape 1 meter 4380-5250). Attachments B and C. Pages 7 - (tape 1 meter 5251-6140)

Sen. Brown: I have a friend who's a dentist and pay isn't his issue. He finds consistently that recipients aren't timely or don't show up at all. He's willing to do the work and wants to help these people, but they need to want to help themselves.

Zentner: That is an ongoing problem and they need to follow through or the services won't be available to them. Northland Alliance has a grant and one of their goals is to provide dental access; and one of the things they're trying to do is make sure people show up. How do you instill responsibility?

Chairman Lee: The urgent care clinic which serves Cass and Clay counties has been well received. Dentist volunteer their time and services are provided at specific times on a first come-first served basis. It works better for dentists to provide their services at a clinic of this sort instead of their offices.

Zentner: Bridging the Dental Gap in Bismarck, is quite an experiment, because it's a full dental clinic and it was put together with grants, some Medicaid and other funds. It's an independent clinic and has no federal support, so it has to rely on grants, donations and Medicaid. We're hoping it works, because its needed here.

I want to mention we do spend $12 million in dental. Dentists are providing services.

Chairman Lee: Some are providing pro bono work without getting Medicaid dollars. Some work with families they know will show up.

Mr. Zentner went on to explain the rest of the document (tape 1 side B meter 390 - 520)

Chairman Lee: The DUR (Drug Utilization Review) Board, physicians and pharmacists have been working together to see how we can limit some of the increasing drug costs. Because on the insurance that most of us would be on, we would be required to use a generic drug first before using a name brand in its place. Medicaid, you can get the name brand right off. Now they've developed a kind of ladder. Unless you can prove you can't take the generic drug, they would be required to use the generic drug first.

Zentner: If you get samples from a doctor's office, they don't have generic. So people try the name brand they ask for it. The companies provide the name brand expensive drugs. We're trying to get some generic samples in the office.

Chairman Lee: Medicaid pays for some over-the-counter drugs if there is a prescription for it.

The committee took a break. (Tape 1 side B meter 855)

Chairman Lee reconvened the meeting.

David Skalsky (unsure of spelling of last name, he did not sign in) Medical Services Division. Mr. Skalsky works with the children's health insurance program and passed out Attachments 3 and 3a regarding the Healthy Steps Program.

Skalsky: There are three programs for children's health insurance. 1-the Medicaid program, 2-the Healthy Steps program. Nationwide, its know as SCHIP the 3- the Caring program is run by Blue Cross Blue Shield.

Mr. Skalsky described the three programs, eligibility, etc. (tape 1 Side b meter 1090-1160)

Chairman Lee: We include vision in North Dakota

Sen. Warner: What is the difference between Healthy Steps and Indian Health Services? In my county there are hardly any Indians on Healthy Steps.

Skalsky: We don't view Indian Health Service as credible health insurance coverage because you can't be on our insurance if you have other coverage, so technically those individuals could be eligible for Health Steps. We might find that the kids on the reservation are eligible for Medicaid.

Mr. Skalsky explained process of applying for the programs. (tape 1 side B meter 1350-1890) There was discussion on who should process the original forms and how the reimbursement should possibly change. The counties process some of the paperwork and want to be reimbursed at a higher level. Chairman Lee said there might be legislation on this issue later on.

Mr. Zentner gave a history of how the state started administrating SCHIP and how they determined how the counties would be paid (tape 1 side b meter 1885-2200).

Sen. Brown: How many children out there aren't covered, but are eligible?

Mr. Skalsky said there was as new study and Mr. Zentner explained the study from University of North Dakota. There are probably thousands of kids out there with income levels below Healthy Steps and Medicaid, maybe 3000-4000 kids. Where they would go, in uncertain.

Sen. Brown: It's sad that there's kids out there not getting into these programs because their parents haven't applied.

Chairman Lee: We want the system to be friendly enough with the application process to encourage families to enroll if they need to. We would like to see more Indian families apply

because the Indian Health Services dollars are finite. This way some of those health care dollars could be freed up for other issues on the reservation. It has been a major challenge getting families on the reservation to apply, because they rely on the fact that IHS is going to supply them with services.

Sen. Warner: I'm not sure about income levels, i.e., gross incomes and net incomes.

Mr. Skalsky explained the formula using the percentage over the poverty level that is used to determine eligibility (tape 1 side B meter 2700-3000).

Zentner: We're seeing a connection between dental health and regular health. If you ignore your dental health, it can often affect your physical health. That will be a coming trend, for people to take care of their dental health. Those services will probably, in the future, become intermeshed, because they're both important.

Skulks: There is a third program we can look at when a person applies for Medicaid and Health Steps--that's the Caring Program from Blue Cross which is funded through donations. So maybe just one application for all three programs.

John Hogan, Department of Human Services, Division of Economic Assistance and Policies. We're responsible for programs child care assistance, energy assistance, food stamps.
Mr. Hogan gave an overview of his division. (tape 1, side B, meter 3500- 4010) and also explained how the food stamp program worked.

Mr.Hogan explained his department's responsibility with the child care assistance program. There has been some changes in the numbers. The child care number have declined, so the agency is getting a smaller piece of the pie. The decision was made to cut coverage for students in higher education. We were covering child care for graduate students, but other states typically

were not. It was decided that other people needed child care more, i.e., the working poor. In the Governor's budget, more money was put into higher education. (tape 1 side B, meter 4011-4645). Another program his department is responsible for is TANF, the old AFDC program. There has been a shift from funding state funds to federal funding. Mr. Hogan explained this program, the funding, and the eligibility. (tape 1 side B meter 4675-end of tape; tape 2 side 1 meter 01-275). Some discussion followed concerning various costs of the program and some problems with it.

Chairman Lee thanked Mr. Hogan and Mr. Zentner for updating the committee.

Chairman Lee adjourned the hearing.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SBA 2048

Senate Human Services Committee

❑ Conference Committee

Hearing Date January 12, 2005

Tape Number	Side A	Side B	Meter #
1	x		2990-3120
Committee Clerk Signature			

Minutes:

Chairman Lee reopened the hearing on SBA 2048.

All members were present.

Motion by Sen. Brown, due pass, seconded by Sen. Dever.

Roll call: 5 yes, 0 no, 0 absent. Carrier Sen. Brown.

Chairman Lee closed the hearing.

Date: 1/12/04
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2048

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Brown Seconded By Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No ϕ

Absent ϕ

Floor Assignment Sen. Brown

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

REPORT OF STANDING COMMITTEE

SB 2048: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2048 was placed on the Eleventh order on the calendar.

2005 HOUSE HUMAN SERVICES

SB 2048

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **SB 2048**

House Human Services Committee

☐ Conference Committee

Hearing Date **March 16, 2005**

Tape Number	Side A	Side B	Meter #
1	X		21 - 1170
2	X		2000 - 2590
Committee Clerk Signature	Jan Pounder		

Minutes:

Chairman Price opened the hearing of SB 2048.

There was not testimony in favor of the Bill.

Shelly Peterson, of the Long Term Care Association, testified in opposition to the bill. We decided late last night that we needed to oppose the legislation. HB 1281 was before your Committee. It was legislation that allows facilities to go after assets that had been transferred where a person was deemed ineligible for Medicaid. We thought the language and provisions were better in that bill. It was amended and took away a lot of the avenues that we felt we needed to go after assets that were transferred. The problem is if a person is in a nursing facility supposedly their money runs out and they apply for Medicaid. Medicaid looks at the application and in many instances says there are assets available for your care so will determine that you are not eligible based on a trust that exists. Generally, it's children that have controlling interest in the trust. Medicaid denies them, the nursing facility isn't getting paid, however a trust exists. A

couple of years ago when we did some research on this an attorney recommended that when a child has controlling interest in a trust, you might want to use this statute upon which you go after the child to pay for the nursing home bill because of that trust. That's the only instance we have ever used it because it's not our position, in a general sense, that children should support their parents. We don't ever go after them just because of that. We have been successful in the last two years in using this statute to go after those instances when a trust exists where the children have controlling interests. Just last Monday when the family was pleading poverty, Medicaid had denied them, it was scheduled to go to court Monday morning. Monday morning they came to the nursing facility with a $98,000 check. In that instance it was very helpful otherwise we don't think we would have every seen the $98,000. There's another case pending in Fargo. They wanted to know where this legislation was because they wanted to hurry and use the statute. The adult child is a physician in Fargo and has control of measurable assets but will not pay the nursing home bill. The mother has been deemed ineligible for Medicaid and all they owe is $6500. They want to use the statute to get the child to pay that bill. As we shared with you in the past we have $3.8 million owed. Under this bill we have more strength to go after the assets. We ask that you keep this on the books a few years longer. It has been helpful. Again I assure you we have never used it for the normal child/parent relationship where assets haven't been purposely transferred.

Rep. Uglem: Do you know of any other groups that have used this in the past?

Peterson: Not to my knowledge. Sen. Lyson brought this forward because of an attorney in the Williston area that said no one uses this statute. We haven't used it very much, but we have used it.

Rep. Kreidt: People probably aren't aware of this provision and where they can use it in those situations. I foresee that it will be used more now than in the past.

Peterson: That's how it worked for us. We weren't aware of it until an attorney brought it to our attention. Now we are trying to use it.

Senator Trenbeath, District 10, spoke in favor of the bill. When I agreed to sponsor this bill, I didn't realize the bill was needed. It never occurred to me that I might be responsible for my parents in their old age or that they might be responsible for me once I reached my adulthood. What I hear from the opposition to this bill is this probably inadvertently addresses a problem that we didn't realize we had a solution to so allow us to keep this so we can solve it. This statute may be over broad and may be misused. We find one small legitimate use for it therefore we promise we will use it only for the purpose we need it if you allow it to remain on the books. I'm sorry, but I don't think that's a good enough reason for legislation. If these folks have a problem with irrevocable trusts then they ought to craft language that addresses that. This catch all is certainly subject to abuse. If the medical profession through the Medicare program needs a statute to take care of a situation, it needs to be taken care of. Let them craft an amendment that will do that and I would support that.

Rep. Kaldor: In looking at the code that is being repealed, there is some case law attached that dealt with the duties of children. What do you suppose the original reason for this statute was?

Senator Trenbeath: Pure speculation on my part--it was first passed in 1877. I can't speculate on what legitimate purpose it would serve in the pioneer days of the state.

Rep. Kaldor: Maybe in 1977 we didn't have the network of human services and nursing home care we do today. I think it's interesting that no one was aware of it for this long.

Chairman Price: So Senator Trenbeath you don't think family has any responsibility.

Senator Trenbeath: Absolutely they do. If my parents were alive today and if I had a dime they would have a nickel. That's just the way it is. I'm sure that's a legal obligation.

Chairman Price: You don't think we should have a law that obligates us to do that.

Senator Trenbeath: No. I don't. I believe being an adult means something.

There was no further testimony on the bill. **Chairman Price closed the hearing on SB 2048.**

Later in the day Chairman Price opened discussion of SB 2048. (Tape 2, MR 2000)

Rep. Kreidt: I move a Do Not Pass.

Rep. Weisz: I second.

Rep. Damschen: As you mentioned, Madam Chairman, let us use this for two years and then come up with something better. Next session the industry will be looking at it. This is a piece of legislation that we need right now.

Chairman Price: If someone has a long term care bill and there is a trust and the children control the trust. This can be used to get the children to pay the nursing home bill.

Rep. Porter: When you look at the case law that happened in the duty of the children in a case with Trinity Medical Center suing. The last paragraph states that this section should not be interpreted that both parents and children have a primary liability to pay the necessaries furnished to a parent by a third part. It doesn't say that if your parents are destitute that the children have to start paying the bills. What it is saying is if you are the trustee of their trust and you control their assets that you have to pay. That's what it's saying. I think it's a necessary tool.

Chairman Price: There are also cases where they have been denied Medicaid based on the assets.

Rep. Damschen: I have to agree with Senator Trenbeath that what we've got there that this repeals is pretty broad language and could be addressed to these specific situations.

Rep. Potter: It does go on and maybe you saw this under "reciprocal duties" at the bottom of the page. "This statute fixes the reciprocal duty and liability between parent and child. Either may maintain an action against the other where necessity there for exists. . . the obligation of a child to his parent or parents does not entirely terminate at majority." It sounds like it has been used.

Rep. Pietsch: They may have just stumbled on to this and didn't even know it existed. It's not something that the long term care people have been aware of.

Rep. Damschen: If an individual gifts land to the university system can they go back on that?

Chairman Price: Were they on assistance? It depends on the situation. It depends on the time frame and what the circumstances are. I'm not an attorney, but it depends on the situation if it's within the 36 month look back.

I would say if a nursing home tries this and there are trust assets, land assets, or whatever and it's only the child's assets the courts not going to allow it anyway.

A roll call vote was taken.

Yes: 9 No: 2 Absent: 0

Rep. Kreidt will carry the bill.

Date: 3/14/05 Roll Call Vote #: 1

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 2048

House **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DNP

Motion Made By Rep Kreidt Seconded By Rep Weiss

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S.Price	✓		Rep.L. Kaldor		✓
V Chrm.G. Kreidt	✓		Rep.L. Potter	✓	
Rep. V. Pietsch	✓		Rep.S. Sandvig	✓	
Rep.J.O. Nelson	✓				
Rep.W.R. Devlin	✓				
Rep.T. Porter	✓				
Rep.G. Uglem	✓				
Rep C. Damschen		✓			
Rep.R. Weisz	AB				

Total ( ) 9 No 2

Absent 1

Floor Assignment Rep Kreidt

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

REPORT OF STANDING COMMITTEE

SB 2048: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (9 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). SB 2048 was placed on the Fourteenth order on the calendar.

2005 TESTIMONY

SB 2048

Attachment 1

1 of 1 DOCUMENT

:*** THIS DOCUMENT IS CURRENT THROUGH THE 2003 SESSION ***
*** NO LEGISLATION ENACTED IN 2004 ***
*** ANNOTATIONS CURRENT THROUGH SEPTEMBER 10, 2004 ***

TITLE 14. DOMESTIC RELATIONS AND PERSONS
CHAPTER 14-09. PARENT AND CHILD

GO TO CODE ARCHIVE DIRECTORY FOR THIS JURISDICTION

N.D. Cent. Code, § 14-09-10 (2003)

§ 14-09-10. Reciprocal duty of support -- Support of poor

It is the duty of the father, the mother, and every child of any person who is unable to support oneself, to maintain that person to the extent of the ability of each. This liability may be enforced by any person furnishing necessaries to the person. The promise of an adult child to pay for necessaries furnished to the child's parent is binding.

HISTORY: SOURCE: Civ. C. 1877, § 97; R.C. 1895, § 2787; R.C. 1899, § 2787; R.C. 1905, § 4099; C.L. 1913, § 4431; R.C. 1943, § 14-0910; S.L. 1995, ch. 456, § 2.

ADMISSION TO STATE SCHOOL.

When a father makes application for the admission to the Grafton state school of his son who is unable to maintain himself by work, he impliedly agrees to pay for such care and maintenance as may be furnished by the state school and the fact that section 25-08-22 (since repealed) provides for the extent of the father's liability does not destroy the contractual nature of the father's obligation. Reith v. County of Mountrail, 104 N.W.2d 667 (N.D. 1960).

AGE OF MAJORITY.

A trial court may award child support beyond the age of majority if the child is unable to "maintain himself by work," and a child who has reached age eighteen but is still in high school may, under appropriate circumstances, be considered unable to maintain himself by work. Freyer v. Freyer, 427 N.W.2d 348 (N.D. 1988).

Under this section, a trial court may award child support beyond the age of majority if the child is unable to maintain him or herself by work. Weigel v. Kraft, 449 N.W.2d 583 (N.D. 1989).

CONSTRUING SECTION.

This section is derived from a nearly identical California statute, and thus the Supreme Court may consider judicial interpretation of the California statute as an aid in construing this section. Freyer v. Freyer, 427 N.W.2d 348 (N.D. 1988).

DEATH OF HUSBAND AND FATHER.

The law will imply a pecuniary loss to the wife and children by the death of the husband and father who has been discharging his obligation to support them and was discharging it at, and immediately prior to, his death. Umphrey v. Deery, 78 N.D. 211, 48 N.W.2d 897 (1951).

DIVORCE DECREE.

Modification of divorce decree pursuant to section 14-05-24, whereby father was required to support retarded sons even after they reached their majority provided they continued to be incompetent and unable to care for themselves, was proper, since welfare of children was of prime concern to court and since parents have duty under this section to maintain children unable to maintain themselves. Wiedrich v. Wiedrich, 179 N.W.2d 728 (N.D. 1970).

DUTY OF CHILDREN.

The liability established by this section is a secondary liability, being imposed upon children because of their relationship to their parents. Trinity Medical Ctr., Inc. v. Rubbelke, 389 N.W.2d 805 (N.D. 1986).

The liability imposed upon the children by this section can be likened to the liability of a guarantor. A guarantor, not being a joint contractor with his principal, is not bound to do what the principal has contracted to do, but only to answer for the consequences of the default of the principal. Trinity Medical Ctr., Inc. v. Rubbelke, 389 N.W.2d 805 (N.D. 1986).

This section should not be interpreted so that both parents and children have a primary liability to pay for the necessaries furnished to a parent by a third party. Trinity Medical Ctr., Inc. v. Rubbelke, 389 N.W.2d 805 (N.D. 1986).

RECIPROCAL DUTY AND LIABILITY.

This statute fixes the reciprocal duty and liability between parent and child; either may maintain an action against the other for support where necessity therefore exists. Bismarck Hosp. & Deaconesses Home v. Harris, 68 N.D. 374, 280 N.W. 423, 116 A.L.R. 1274 (1938).

The obligation of a child to his parent or parents does not entirely terminate at majority. Henke v. Peyerl, 89 N.W.2d 1 (N.D. 1958).

RECOVERY BY COUNTY.

Where the state school accepts a child for care and maintenance pursuant to his father's application, a contract is established between the father and the school and where the county has paid for such care over a period of years a claim filed by the county against the father's estate after his decease is a claim arising upon contract. Reith v. County of Mountrail, 104 N.W.2d 667 (N.D. 1960).

COLLATERAL REFERENCES.

Parent and Child 4.

59 Am. Jur. 2d, Parent and Child, § § 104, 105.

67A C.J.S. Parent and Child, § § 257-261.

Reimbursement of public for financial assistance to aged persons, 29 A.L.R.2d 731.

Indigent relatives, nature of care contemplated by statute imposing general duty to care for, 92 A.L.R.2d 348.

Constitutionality of statutory provision requiring reimbursement of public by child for financial assistance to aged parents, 75 A.L.R.3d 1159.

Postmajority disability as reviving parental duty to support child, 48 A.L.R.4th 919.

Attachment 2

General Medicaid Information

- Medicaid is a joint state/federal program designed to pay for the health care of certain low-income citizens.

- The program is voluntary. If states decide to participate, they must abide by the federal law and regulations.

- States are required to maintain a state plan that describes the coverage groups that are included in the program, the types of services that will be provided, the method of payment used for each type of service and many other administrative aspects of the program. The plan is our agreement with the federal government on how we will operate the Medicaid Program in North Dakota.

- Plan amendments can be submitted at any time. The Centers for Medicare and Medicaid Services (CMS) has 90 days to approve, disapprove or stop the process and request additional information. If CMS asks for additional information, the clock stops. Once the state responds, the clock begins again. Plan amendments can take effect no sooner than the beginning of the quarter in which they are submitted. States are not allowed to claim any federal funds for an amendment until approval is received from CMS.

- If a plan is denied the state can appeal to the grant appeals board.

- The federal government has agreed to share in the costs of providing services to recipients based on a complicated formula that uses a three-year average of per capita income in each state compared to the national average. States with lower per capita income in comparison to their peers will receive a higher matching rate. The minimum rate is 50% and the maximum is about 83%. The rate is changed at the beginning of each federal fiscal year.

- The current Federal Medical Assistance Percentage (FMAP) is ~~68.31%~~ 67.49%. Because of a one-time law change, states are receiving an enhanced FMAP amount for a 15-month period ending June 30, 2004. Currently, the Department is receiving 71.31% FMAP. That percentage will drop to 68.31% on July 1 and will further decline to 67.49% for the 2005 fiscal year beginning on October 1, 2004.

Covered Services

- If a state decides to participate in the Medicaid Program, it is required to provide a basic set of services to categorically eligible recipients of the program. These services include inpatient hospital, outpatient hospital, nursing facility services for individuals over 20 years of age, physician services, laboratory and x-ray services, certain nurse practitioner services, nurse midwife services, home health care services including durable medical equipment and supplies, family planning services, Early Periodic Screening Diagnosis and Treatment Services for children under 21 years of age, federally qualified health centers, rural health clinics and pregnancy related services.

- States must also ensure that necessary transportation is available for recipients to obtain needed medical services. States must describe how they will provide the transportation. Because we must assure transportation, the service does become a required service for all recipients of the program if no other transportation alternative is available.

- Medically needy recipients are required to receive prenatal and delivery services, certain post partum pregnancy related services, home health services and specific services in institutions for mental disease and/or intermediate care facilities for the mentally retarded.

- States may include any other array of services for the medically needy and may have different services for different groups of medically needy but all individuals in a particular group must receive the same service unless a waiver is in place. North Dakota provides the same set of services to the categorically needy and the medically needy coverage groups.

- States have an opportunity to provide an additional array of optional services under the Medicaid State Plan. A list of those services is included in the attached handout. Currently, North Dakota includes 34 of the 38 available services. Several of the services have limitations.

- The chart also identifies services covered by other state Medicaid agencies. For example, South Dakota covers 29 of the listed optional services, Montana covers 33 of the services, and Minnesota covers 35 of the optional services.

Attached as chart A is a table that details the services and estimated cost of providing those services based on appropriated amounts for the current biennium.

Eligibility Criteria

- **States are required to provide services to categorically eligible recipients. Those individuals include:**

    a. **Individuals who were eligible under the Aid to Families with Dependent Children (AFDC) program at the time TANF was implemented in 1997. These include children and adult caretakers where deprivation exists because of parental absence, incapacity, unemployment or underemployment. This group is commonly referred to as the Family Coverage Group.**

    b. **Individuals eligible for Supplemental Security Income (SSI) because they are either aged, blind or disabled. North Dakota has opted to be considered a Section 209B state that permits us to be more restrictive in our eligibility criteria for this group. For example, we count certain assets that are considered an asset for SSI eligibility determinations. Therefore, some individuals who are eligible for SSI may not qualify for North Dakota Medicaid because they do not meet our 209B requirements.**

    c. **Children eligible for foster care or subsidized adoption**

    d. **States may cover children over the age of 18, but under 21 as optional categorically needy if they meet the financial eligibility described in a. above.**

- **States must also provide coverage for poverty level eligible children and pregnant women as follows:**

    a. **Children under six years of age with family net income at or below 133% of the federal poverty level.**

b. Children between 6 and 18 years of age with family net income at or below 100% of the poverty level.

c. Pregnant women with family net income at or below 133% of the poverty level.

d. States have the option of increasing the poverty levels for these groups.

- States must also provide coverage for certain households that are eligible for Medicare coverage as follows:

  a. Qualified Medicare Beneficiaries (QMBs). These are individuals with income at or below 100% of the federal poverty level. Coverage limited to Medicare premiums, co-insurance and deductibles.

  b. Special Low-Income Medicare Beneficiaries and Qualified Individuals I with income 100% to 135% of the federal poverty level. Coverage is limited to payment of Part B Medicare Premiums.

- States have an option to provide services to the families, pregnant women, and aged, blind and disabled individuals who have income that exceeds the above guidelines but do not have enough funds to meet their medical needs. These individuals and families may be eligible under the medically needy category. North Dakota is one of 35 states that offer coverage under this category. In Region VIII, South Dakota, Wyoming, and Colorado do not have a medically needy program. Each state is allowed to establish their medically needy income levels. The difference between the monthly net income and the medically needy income level is called the recipient liability amount. Recipients must incur that amount in medical expenses each month before Medicaid begins paying for services. Once the liability is met, Medicaid pays for the remaining medical services during the month.

- The Legislature added another coverage group to the program during the last Legislative session. Coverage will become available on June 1, 2004 for workers with disabilities that have income that does not exceed 225% of the federal poverty level.

The attached chart B details the income levels for each coverage group included in the Medicaid program. Also, chart C shows the number of Medicaid recipients eligible for each eligibility group for each month during the current biennium.

Other eligibility issues include the following:

- If households who are eligible under the Family Coverage Group lose Medicaid eligibility due to increased earned income, many can remain on the program for an additional 12 months. The federal government mandates Medicaid coverage for these transitional eligible recipients if income does not exceed 185% of the poverty level.

- Households applying for coverage through the children and family coverage groups are no longer subject to an asset test.

- Aged, blind and disabled households are still subject to an asset test. The limits are $3,000 for a one-person household, $6,000 for a two-person household and $25 for each additional member of the household. In addition, each eligible individual can have up to $3,000 for burial costs.

- Assets that are exempt include the home if occupied, one vehicle of any value, personal effects, household goods, furniture, property used as part of a self-employment business and property not saleable at a fair price.

- If a spouse enters long-term care, the non-institutionalized spouse may be able to retain additional assets and income beyond the above limits. The non-institutional spouse may keep half of the couple's assets up to $92,760 in assets and up to $2,760 in monthly income. These maximum amounts are inflated each year by the federal government. Total countable assets are split between the two spouses and the non-institutional spouse can keep the additional assets up to the maximum allowed amount. Prior to July 1, 2003, assets were first allocated to the non-institutional spouse up to the household maximum amount. Any remainder amount was then allocated to the spouse in long-term care. This change was made to reduce expenditures and comply with federal interpretation of the regulations relating to this policy. Income up to the maximum monthly allowable amount can be deemed to the non-institutional spouse from the institutionalized spouse.

- The federal government has established guidelines for the transfer of assets in order to become eligible for Medicaid. It is considered disqualifying to transfer assets at less than fair market value. Depending on the value and the date of the disqualifying transfer, Medicaid coverage for long-term care services could be delayed. Medicaid has a required look-back period for transfers for 36 months or 60 months if a trust is involved. The Department is in the process of pursuing a waiver to extend the look-back period to 60 months as directed by the Legislature.

- Several deductions are available to households when income is calculated. Aged, blind and disabled individuals are allowed a deduction of the first $65 plus one-half the remainder of their earned income. As of September 1, 2003 the Department changed the earned income deductions for the family coverage group to the first $120 plus

one-third the remaining earned income. Previous to that date, the first $180 or 27% whichever was greater plus 50% of the remainder for six months was allowed. These changes were made to reduce the number of eligible recipients in response to cost containment efforts by the Department.

- The Department also reinstituted the 100-hour rule as of January 1, 2003. Adults in intact families who work more than 100 hours a month were no longer eligible after that date no matter how much money they made. This change was also made to contain program costs.

- Other allowed deductions include childcare expenses, health and long term care insurance premiums, court ordered child support payments, $20 unearned income disregard for aged, blind and disabled individuals etc.

- When determining eligibility, parents are financially responsible for their children under 21 years of age and spouses are financially responsible for each other.

- Medicaid recipients must be citizens or meet certain criteria if they are aliens in order to enroll in Medicaid. They must also be residents of North Dakota. Residence is generally defined as indicating your intent to reside in the state on a permanent basis. Residency for a child is based upon the child's parent's residency.

- Coverage for the Medicaid program is available for up to three months prior to the date of application if all other eligibility requirements are met except households eligible for Medicare savings programs do not qualify for the three-month prior coverage option.

- County Social Service Board staff determines eligibility for Medicaid. State staff has responsibility to develop and implement program policies and ensure that they are followed by county staff.

Access to Services

For the most part, access to needed medical services is available to recipients of the Medicaid Program in North Dakota. All hospitals in the state fully participate in the program. All of the major clinics provide physician and other related services to Medicaid recipients. With rare exception, all pharmacies in the state participate in the program. All nursing facilities with the exception of those based in large hospitals fully participate in Medicaid. Most optometrists provide services to our recipients. Most ambulance services participate in the program. While all these providers continue to provide services, there is concern that current payment amounts need to be increased. As you are aware, fees were frozen in 2002 and the Legislature did not provide any funds for fee increases in the current biennium. The Department made these and other program reductions in order to control the cost of the program that required a large deficit appropriation in the last biennium. We hope that these fine providers will continue to provide services to our recipients; but they could become reluctant if payments remain low and the administrative burden associated with additional co-payments and limitations add to the cost of providing services to recipients of the program.

Dental access has been an issue for Medicaid recipients for a number of years. It is difficult for newly eligible recipients, especially adults, to find a dentist who is willing to see new Medicaid recipients. Several reasons have been given for this access issue including low payment rates, recipients not keeping appointments, a general shortage of dentists in the state and non-compliance with oral health. Most dentists in the state

participate in the program, but many will not see new patients or will limit new recipients to a small number.

While access continues to be an issue, it should be noted that it is estimated that payments to dentists will exceed $12 million in this biennium. For the first five months of the biennium, an average of 3,900 recipients received a dental service each month. In a report dated June 2001, North Dakota was ranked 9th highest of 45 states for fees paid to providers by the Medicaid Program. A report published by Oral Health America based on 2000 year data gave the North Dakota Medicaid Program an A based on the number of dentists that participate in the state, the payment structure within the state and the type of coverage available to adult recipients. North Dakota was only one of six states to receive this grade. Another report that was completed by Medstat in August 2003 compared us to four other states that they do business with and a comparison with commercial coverage for children under 21 years of age. The study, which is attached as chart D, indicates access in North Dakota is better than the other four states in the aggregate and although it does not match the commercial utilization, the percentages are good considering the issues surrounding the provision of dental services in North Dakota.

While we do experience problems with dental access for Medicaid recipients, we compare very favorably with other states. The Department will continue to work with the dental community and others to try and improve access to dental services for low-income citizens. One initiative that should assist the access issue locally is the Bridging the Dental Gap project. A dental clinic designed to provide services to low-income residents should be operational later this year in Bismarck. While such clinics will be helpful in dealing with the access issue, we must still rely on private practice dentists to deliver the bulk of services.

Medicaid Payment System

- States are required to utilize a certified Medicaid Management Information System (MMIS) to process claims, monitor utilization and produce reports. The current system was implemented in the fall of 1978, more than 25 years ago. At that time it was state of art technology. By today's standard, it is a dinosaur. While it continues to process claims, it is very difficult to maintain and requires "hard coding" for even the most elementary changes. The Department has experienced a claims backlog ever since we implemented the first phase of HIPAA last April. We are just in the process of fixing some of the problems associated with the problems that were created when the system was implemented. An example of the antiquated process concerns the implementation of new limits and co-payments that were requested by the last Legislature. We have been struggling to implement these fairly simple changes for the past six months working with the Information Technology Division. The new technology will allow program staff to make these changes in the matter of minutes.

- The Legislature did provide seed money in the current biennium to start the development process of $1.6 million of which only 10% is state funds. The federal government will finance 90% of the cost of implementing a new system. While a new system is expensive, the costs of maintaining a system that no longer meets our needs and does not have the tools necessary to ensure that claims are processed in a timely and accurate fashion is not good business. We are hopeful that the next Legislature will see fit to provide the necessary funds to implement a new system during the 2005-2007 biennium.

- Utilization of services has increased as the number of recipients has increased over the past two bienniums. Attached is chart E that shows the growth in the number of individuals eligible for the program and the number of individuals who received a service plus average monthly expenditures during that period. In addition, chart F details utilization trends for specific services paid through the Medicaid program from the 2000 to the current 2004 fiscal year.

Medicaid Waivers

- There are two types of waivers granted by the federal government. They are referred to as Section 1915 and Section 1115 waivers.

- Section 1915(b) waivers are commonly known as freedom of choice waivers. They permit states to operate managed care programs through either a primary case management system or a "capitated" process where an entity is paid a per member per month amount to provide services. These entities are generally at risk if their costs exceed expenditures. It must be demonstrated that these waivers will not result in any increased expenditures for the federal government. North Dakota had a a waiver from 1994 to 2001 that allowed us to require most of our children and adult caretakers to select a primary care provider who provides primary services and must authorize certain other services before payment can be made. In addition, the waiver allowed the Department to contract with an Altru Health Care for a "capitated" program in Grand Forks County. This entity received a set payment per month depending on the age and gender of the recipient to provide all needed care contained in the contract for children and caretakers.

- In 2001, CMS permitted states, in some instances, to switch from a waiver to a state plan amendment for these services. Waivers consume a great

deal of resources and time, so the Department converted the waiver to a state plan option. Presently, there are about 33,000 individuals enrolled in the primary care case management program and about 800 in the capitated program that is now operated by Noridian Mutual Insurance Company. We recently expanded the capitated program to Walsh and Pembina counties, so we expect the number of individuals choosing this program to increase.

- Section 1915(c) waivers are commonly referred to as home and community-based care waivers. They permit states to include as medical services home and community based services (HCSB) who would otherwise require care in a nursing facility, hospital or Intermediate Care Facility for the Mentally Retarded (ICF/MR). The waiver must show that it is cost effective to allow payment for these services. North Dakota operates three such waivers including the Aged and Disabled Waiver that permits the Department to pay for HCBS for individuals who otherwise would meet nursing facility admission criteria, the Developmentally Disabled Waiver which permits the Department to pay for HCBS for individuals who would meet ICF/MR admission criteria, and the Traumatic Brain Injured (TBI) waiver that permits the Department to pay for HCBS for individuals who would meet nursing facility criteria. The first two waivers have been in existence since the mid-1980's and the TBI waiver was approved in 1996.

- Section 1115 waivers are demonstration waivers designed to alter Medicaid eligibility standards, benefit rules, payment provisions and other rules and must be approved by the federal government. It must meet cost neutrality requirements in that the waiver will not result in any additional expenditures to the federal government than would have been expended if the waiver were not implemented. States have generally used the waiver process to cover additional individuals who would otherwise not be eligible for the Medicaid program through projected savings usually related to manage care savings. Recently, the federal government has introduced the

Health Insurance Flexibility and Accountability (HIFA) waivers, which are part of the 1115 process, and are designed to cover more individuals. Also, some states have used this process to provide drug coverage to individuals not otherwise eligible for Medicaid. Governor Hoeven's proposal during the last legislative session to provide drug coverage to certain low-income seniors would have required such a waiver in order to obtain federal funds.

Long Term Care
Comparison of 2003-2005 Appropriation to the 2005-2007 Budget to OMB

		2003-2005 Appropriation					2005-2007 Budget to House					Increase / (Decrease)				
	Service	Total	State	Federal	County	Other	Total	State	Federal	County	Other	Total	State	Federal	County	Other
2	Nursing Homes	318,444,621	102,073,218	216,371,403	0	0	348,777,523	122,590,332	226,187,191	0	0	30,332,902	20,517,114	9,815,788	0	0
3	Basic Care	8,395,725	747,857	5,363,506	0	2,284,362	12,812,722	5,188,369	5,339,991	0	2,284,362	4,416,997	4,440,512	(23,515)	0	0
3a	Basic Care - Personal Care	7,892,551	725,870	5,363,506	0	1,803,175	8,232,711	1,089,545	5,339,991	0	1,803,175	340,160	363,675	(23,515)	0	0
3b	Basic Care - Room & Board	503,174	21,987	0	0	481,187	4,580,011	4,098,824	0	0	481,187	4,076,837	4,076,837	0	0	0
4	SPED	14,703,198	13,749,819	225,720	727,659	0	14,423,230	13,487,628	225,720	709,882	0	(279,968)	(262,191)	0	(17,777)	0
5	Expanded SPED	834,541	834,541	0	0	0	1,188,889	1,188,889	0	0	0	354,348	354,348	0	0	0
6	TBI - Waiver	2,274,072	728,514	1,545,558	0	0	2,330,357	818,187	1,512,170	0	0	56,285	89,673	(33,388)	0	0
7	Aged & Disabled - Waiver	9,478,112	3,036,121	6,441,991	0	0	2,573,636	903,520	1,670,116	0	0	(6,904,476)	(2,132,601)	(4,771,875)	0	0
8	TCM - Aged & Disabled	1,107,750	354,878	752,872	0	0	3,789,824	1,329,900	2,459,924	0	0	2,682,074	975,022	1,707,052	0	0
9	Personal Care Services	2,800,273	897,208	1,903,065	0	0	14,661,108	5,152,114	9,508,994	0	0	11,860,835	4,254,906	7,605,929	0	0
	TOTAL	358,038,292	122,422,156	232,604,115	727,659	2,284,362	400,557,289	150,658,939	246,904,106	709,882	2,284,362	42,518,997	28,236,783	14,299,991	(17,777)	0

Attachment 2A

Traditional Medicaid

Comparison of 2003-2005 Appropriation to the 2005-2007 Budget to OMB

		2003-2005 Appropriation				2005-2007 Budget to House				Increase / (Decrease)			
	Service	Total	State	Federal	Other	Total	State	Federal	Other	Total	State	Federal	Other
2	Inpatient Hospital	63,421,191	19,335,605	44,085,586	0	80,035,720	28,095,264	51,940,456	0	16,614,529	8,759,659	7,854,870	0
3	Outpatient Hospital	36,582,648	11,417,695	25,164,953	0	33,808,948	11,868,121	21,940,827	0	(2,773,700)	450,426	(3,224,126)	0
4	Ambulance Svcs.	1,442,293	450,168	992,125	0	1,635,136	573,998	1,061,138	0	192,843	123,830	69,013	0
5	Breast and Cervical Cancer	552,087	0	438,474	113,613	1,034,784	0	780,428	254,356	482,697	0	341,954	140,743
6	Children's Health Ins. Program	891,178	248,779	642,399	0	4,575,612	1,124,264	3,451,348	0	3,684,434	875,485	2,808,949	0
7	Chiropractic Svcs.	347,650	107,688	239,962	0	436,884	153,369	283,515	0	89,234	45,681	43,553	0
8	Collections from Estates	0	(582,548)	(1,235,860)	1,818,408	0	(1,405,268)	(2,597,764)	4,003,032	0	(822,720)	(1,361,904)	2,184,624
9	Dental Svcs.	12,224,891	3,793,163	8,431,728	0	13,148,796	4,615,680	8,533,116	0	923,905	822,517	101,388	0
10	DJS - Intensive in-home	28,751	0	28,751	0	0	0	0	0	(28,751)	0	(28,751)	0
11	Drugs - NET (Includes rebates)	96,050,044	16,156,935	66,017,625	13,875,484	107,930,917	24,327,956	69,515,658	14,087,303	11,880,873	8,171,021	3,498,033	211,819
11a	Drugs (Excludes rebates)	117,125,433	22,739,897	80,510,052	13,875,484	131,623,069	32,270,893	85,264,873	14,087,303	14,497,636	9,530,996	4,754,821	211,819
11b	Drug Rebates	(21,075,389)	(6,582,962)	(14,492,427)	0	(23,692,152)	(7,942,937)	(15,749,215)	0	(2,616,763)	(1,359,975)	(1,256,788)	0
12	Durable Medical Equipment	3,322,319	1,036,948	2,285,371	0	4,161,208	1,460,714	2,700,494	0	838,889	423,766	415,123	0
13	Family Planning	2,174,928	210,154	1,964,774	0	2,573,064	257,304	2,315,760	0	398,136	47,150	350,986	0
14	Federally Qualified Health Centers	1,397,447	436,065	961,382	0	1,728,600	606,797	1,121,803	0	331,153	170,732	160,421	0
15	Healthy Steps	9,486,384	2,127,162	7,359,222	0	10,039,224	2,466,808	7,572,416	0	552,840	339,646	213,194	0
16	Home Health Svcs.	4,904,731	1,530,822	3,373,909	0	5,078,120	1,782,597	3,295,523	0	173,389	251,775	(78,386)	0
17	Hospice Svcs.	1,302,689	402,656	900,033	0	1,105,300	388,005	717,295	0	(197,389)	(14,651)	(182,738)	0
18	Indian Health Svcs.	18,413,788	0	18,413,788	0	22,325,368	0	22,325,368	0	3,911,580	0	3,911,580	0
19	Inter-governmental Transfer	27,495,655	8,682,211	18,813,444	0	0	0	0	0	(27,495,655)	(8,682,211)	(18,813,444)	0
20	Laboratory & Radiology	1,893,301	590,875	1,302,426	0	1,822,428	639,734	1,182,694	0	(70,873)	48,859	(119,732)	0
21	N.D. Health Tracks	1,403,879	438,328	965,551	0	2,193,936	770,156	1,423,780	0	790,057	331,828	458,229	0
22	Occupational Therapy	43,342	13,624	29,718	0	2,900	1,018	1,882	0	(40,442)	(12,606)	(27,836)	0
23	Optometry Svcs.	2,015,616	628,999	1,386,617	0	2,376,328	834,176	1,542,152	0	360,712	205,177	155,535	0
24	Physical Therapy	350,202	109,322	240,880	0	297,456	104,426	193,030	0	(52,746)	(4,896)	(47,850)	0
25	Physician Svcs.	49,282,381	15,381,192	33,901,189	0	55,395,968	19,445,985	35,949,983	0	6,113,587	4,064,793	2,048,794	0
26	Premiums - AIDS	57,564	57,564	0	0	90,044	90,044	0	0	32,480	32,480	0	0
27	Premiums - Group Health	328,420	102,448	225,972	0	455,224	159,790	295,434	0	126,804	57,342	69,462	0
28	Premiums - H.M.O.	2,835,398	886,592	1,948,806	0	2,858,701	1,003,906	1,854,795	0	23,303	117,314	(94,011)	0
29	Premiums - Qualified Individual 1	278,909	0	278,909	0	550,188	0	550,188	0	271,279	0	271,279	0
30	Premiums - Qualified Individual 2	6,756	0	6,756	0	0	0	0	0	(6,756)	0	(6,756)	0
31	Premiums - QMB	2,521,240	787,386	1,733,854	0	3,678,142	1,295,022	2,383,120	0	1,156,902	507,636	649,266	0
32	Premiums - SLMB	1,086,395	339,336	747,059	0	1,556,072	547,871	1,008,201	0	469,677	208,535	261,142	0
33	Premiums - SSA	4,901,248	1,530,383	3,370,865	0	6,224,037	2,191,394	4,032,643	0	1,322,789	661,011	661,778	0
34	Private Duty Nursing	3,888	1,244	2,644	0	6,656	2,339	4,317	0	2,768	1,095	1,673	0
35	Psychological Svcs.	629,214	196,370	432,844	0	568,180	199,457	368,723	0	(61,034)	3,087	(64,121)	0
36	Refugee Assistance	1,031,350	0	1,031,350	0	75,396	0	75,396	0	(955,954)	0	(955,954)	0
37	Rural Health Clinics	3,840,343	1,198,550	2,641,793	0	3,855,040	1,353,252	2,501,788	0	14,697	154,702	(140,005)	0
38	SED Partnership Grant	76,894	0	76,894	0	0	0	0	0	(76,894)	0	(76,894)	0
39	Special Education	1,501,066	0	1,501,066	0	1,533,252	0	1,533,252	0	32,186	0	32,186	0
40	Speech & Hearing Svcs.	1,192,521	372,121	820,400	0	698,416	245,168	453,248	0	(494,105)	(126,953)	(367,152)	0
41	TCM - DJS Alt. Care	557,050	0	557,050	0	716,436	0	716,436	0	159,386	0	159,386	0
42	TCM - Pregnant Women & Infants	122,574	38,736	83,838	0	263,820	92,609	171,211	0	141,246	53,873	87,373	0
43	Transportation Svcs.	2,417,024	754,357	1,662,667	0	2,164,272	759,776	1,404,496	0	(252,752)	5,419	(258,171)	0
44	Treatment Svcs. For Children	9,317,229	2,907,982	6,409,247	0	10,660,644	3,742,253	6,918,391	0	1,343,415	834,271	509,144	0
45	Foster Care Family Support Services	962,045	300,236	661,809	0	930,384	326,586	603,798	0	(31,661)	26,350	(58,011)	0
46	Federal Funding Reimbursement Option	0	(5,838,000)	0	5,838,000	0	(7,085,400)	0	7,085,400	0	(1,247,400)	0	1,247,400
47	Medicaid Buy-In Program	1,325,262	413,823	911,439	0	1,314,336	461,262	853,074	0	(10,926)	47,439	(58,365)	0
50	Funeral Setaside	0	0	0	0	1,262,500	445,915	816,585	0	1,262,500	445,915	816,585	0
	TOTAL	370,019,785	86,564,971	261,809,309	21,645,505	391,168,437	103,942,348	261,795,998	25,430,091	21,148,652	17,377,377	(13,311)	3,784,586
	IGT	(27,495,655)	(8,682,211)	(18,813,444)	0	0	0	0	0	27,495,655	8,682,211	18,813,444	0
	TOTAL	342,524,130	77,882,760	242,995,865	21,645,505	391,168,437	103,942,348	261,795,998	25,430,091	48,644,307	26,059,588	18,800,133	3,784,586

Attachment B

INCOME LEVELS EFFECTIVE JANUARY 1, 2005

Family Size	Family Coverage (1931)	Med. Needy	SSI	Children Age 6 to 19 and QMB 100% of Poverty	SLMB 120% of Poverty	Preg. Women Child to Age 6 133%of Poverty	QI-1 135%of Poverty	Healthy Steps 140% of Poverty	Transi-tional Medicaid 185% of Poverty	Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$311	$ 500	$ ~~564~~	579 $ 776	$ 932	$1032	$1048	$ 1087	$ 1436	$ 1552	$1745
2	417	516	~~846~~	869 1041	1250	1385	1406	1458	1926	2082	2341
3	523	666		1306	1568	1737	1763	1829	2416	2612	2938
4	629	800		1571	1886	2090	2121	2200	2907	3142	3534
5	735	908		1836	2204	2442	2479	2571	3397	3672	4130
6	841	1008		2101	2522	2795	2837	2942	3887	4202	4726
7	947	1083		2366	2840	3147	3194	3313	4377	4732	5323
8	1053	1141		2631	3158	3500	3552	3684	4868	5262	5919
9	1159	1200		2896	3476	3852	3910	4055	5358	5792	6515
10	1265	1250		3161	3794	4204	4268	4426	5848	6322	7111
+1*	107	57		266	139	353	358	372	491	531	596

Spousal Impoverishment Levels

Community Spouse Minimum Asset Allowance (effective 01/01/05)	Community Spouse Maximum Asset Allowance (effective 01/01/05)	Community Spouse Income Level (effective 01/01/04)	Income Level for each Additional Individual (effective 04/01/04)
$19,020	$95,100	$2,267	$521

Average Cost of Nursing Care

Average Monthly Cost of Care (effective 01/01/05)	Average Daily Cost of Care (effective 01/01/05)
$4395.00	$144.48

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

Attachment C

Rev. 01/2005

MEDICAID ENROLLED - 2001-2003 Biennium (August 2004 - January 2005)

Third 6 months of Biennium

	Aug '04	Sept '04	Oct '04	Oct '04
Computer Printout Run Date	8/1/2004	9/1/2004	10/1/2004	11/1/2004
State Hospital Over 65	7	6	5	6
State Hospital Under 21	0	0	0	0
Refugee Assistance	81	85	84	86
Total Categorically Needy	16,575	15,776	15,624	15,915
Caretaker of Deprived Child	67	62	67	67
Deprived Child	154	180	169	179
Parent Under 21 (Intact Family)	0	0	0	0
Pregnant Women	0	0	0	0
Transitional Medicaid Benefits Caretaker	3,125	2,909	2,835	2,846
Transitional Medicaid Benefits Child	4,879	4,412	4,416	4,473
IV-E Foster Care (In State)	518	512	511	501
IV-E Foster Care (Out of State)	24	23	19	24
IV-E Adoption Assistance (In State)	385	385	383	379
IV-E Adoption Assistance (Out of State)	43	44	50	48
SSI-Aged	1,740	1,744	1,732	1,725
SSI-Blind	7	6	6	6
SSI-Disabled	5,635	5,880	5,636	5,666
Optional Categorically Needy Under 21	2,231	2,271	2,217	2,214
Workers with Disabilities	180	209	229	241
Deprived Child	659	659	663	625
Child from Intact Family	811	830	771	781
Parent Under 21 (Intact Family)	0	0	0	0
Regular Foster Care	440	433	423	444
State Adoption Assistance	141	140	141	143
Total Medically Needy	11,668	11,284	11,233	11,287
Caretaker of Deprived Child	1,479	1,391	1,571	1,621
Deprived Child	1,084	1,088	1,080	1,111
Child from Intact Family	880	886	1,019	985
Parent Under 21 (Intact Family)	0	0	0	0
Pregnant Women	71	87	77	86
Regular Foster Care	15	16	16	16
Aged	4,977	4,984	4,997	4,978
Blind	2	1	2	2
Disabled	2,908	2,480	2,461	2,476
Poverty Level Clients	7,737	8,095	8,089	8,188
Poverty Level Clients - 100% - Aged	487	491	482	481
Poverty Level Clients - 120% - Aged	418	419	423	430
Poverty Level Clients - 135% - Aged	206	208	203	197
Poverty Level Clients - 175% - Aged	0	0	0	0
Poverty Level Clients - 100% - Blind	1	1	1	1
Poverty Level Clients - 100% - Disabled	288	287	280	291
Poverty Level Clients - 120% - Disabled	139	134	131	141
Poverty Level Clients - 135% - Disabled	64	62	58	60
Poverty Level Clients - 175% - Disabled	0	0	0	0
Poverty Level Clients - 100% - Deprived Child	2,811	2,928	2,938	2,981
Poverty Level Clients - 133% - Deprived Child	1046	1163	1158	1177
Poverty Level Clients - 100% - Child from Intact Family	2	2	4	4
Poverty Level Clients - 133% - Child from Intact Family	1,810	1,804	1,890	1,907
Poverty Level Clients - 133% - Pregnant Women	466	497	516	506
Medicaid Aid Categories - Total	**37,627**	**37,437**	**37,481**	**37,674**

Family Coverage				
Unemployed Parent - Caretakers	988	1,060	1,008	1,054
Unemployed Parent - Children	1,347	1,409	1,381	1,418
Non Unemployed Parent - Caretakers	3,958	4,088	3,982	3,924
Non Unemployed Parent - Children	9,180	9,380	9,288	9,234
Pregnant Women	643	642	616	608
Family Coverage Categories - Total	**16,136**	**16,837**	**16,256**	**16,238**

Total Medicaid Enrolled - Medicaid & Family Coverage Aid Categories	**53,763**	**53,874**	**53,706**	**53,912**
Less QMB's (Qualified Medicare Beneficiary) Only 1/	(778)	(779)	(773)	(783)
Less SLMB's (Special Low-Income Medicare Beneficiary) Only 2/	(551)	(553)	(554)	(571)
Less QI & Q2 (Qualifying Individuals Aged & Disabled) 2/	(268)	(272)	(262)	(258)
NET MEDICAID PERSONS ENROLLED	**52,170**	**52,370**	**52,117**	**52,300**

QMB/Medical Persons Enrolled*	1,389	1,398	1,413	1,418
SLMB/Medical Persons Enrolled*	274	282	286	286

Total Cases Enrolled (Includes QMB, SLMB, and Q Only Cases)	*31,944*[3]	*32,147*[3]	*32,087*[3]	*32,078*[3]

1/ The group receives premium payments, Co-Insurance and Deductible Payments. No other Medical Payments are received by this group.

2/ This group only receives Premium payments from Medical. No other Medical services are received by this group.

3/ This includes QS Cases Which may not be Medicaid Eligible.

*This count is included in the above detail. And not adjusted in total count as they receive both Medical and Premium payments.

Source of Figures: RE 3980-88 page 54 counts of Medicaid Enrolled by Aid Category and Coverage Group.

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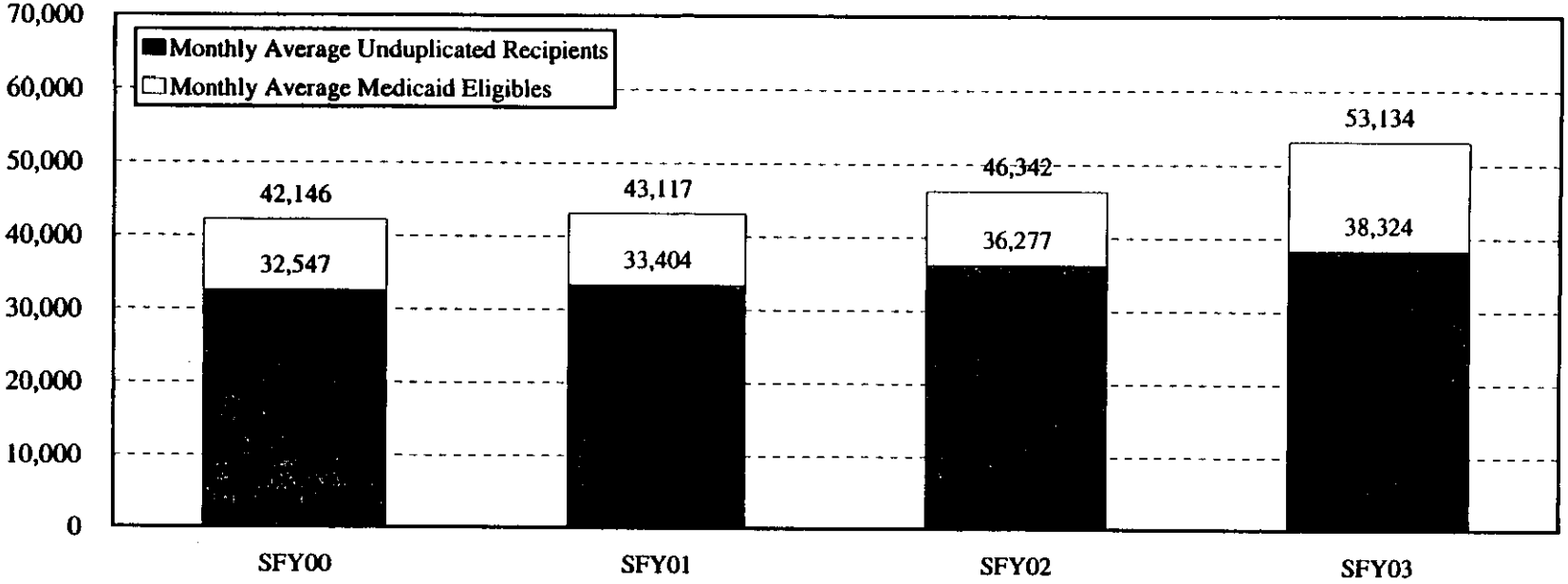
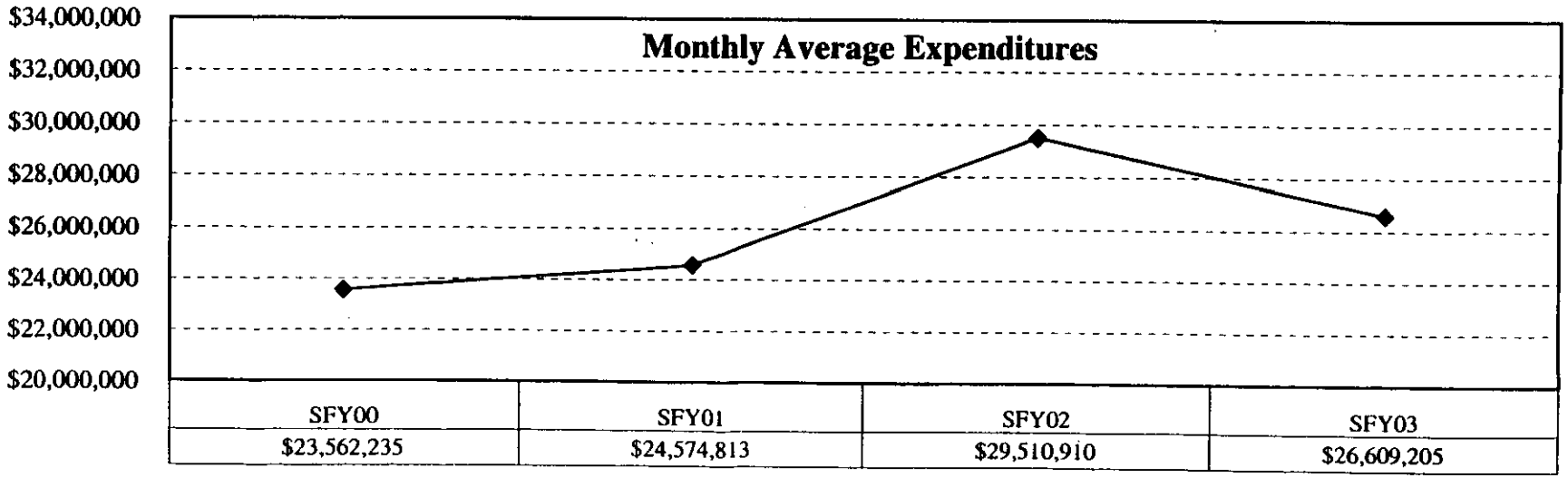
12/30/2004

North Dakota Department of Human Services

Medicaid

Monthly Average Number of Eligibles, Recipients and Expenditures by State Fiscal Year





SFY00	SFY01	SFY02	SFY03
$23,562,235	$24,574,813	$29,510,910	$26,609,205

ATTACHMENT E

North Dakota Medicaid
Utilization Statistics for Fiscal Years 2000 – 2004

SERVICE	2000	2001	2002	2003	2004	2004 Projected
Nursing Facilities (Days)	1,325,000	1,348,000	1,334,000	1,325,000	543,000	1,310,000
Inpatient Hospital (Admissions)	7,722	7,943	7,739	9,255	4,254	9,072
Outpatient Hospital (Services)	385,210	395,400	471,200	569,400	237,900	548,100
Dental (Services)	118,600	123,600	160,300	152,400	73,700	152,800
Drugs (Prescriptions)	930,500	977,100	1,078,600	1,062,700	487,400	1,165,400
Physicians (Services)	938,100	1,042,600	1,102,200	1,193,700	542,000	1,193,000
Optometry (Services)	59,500	62,900	70,100	82,500	31,400	76,400

ATTACHMENT F

Attachment 3

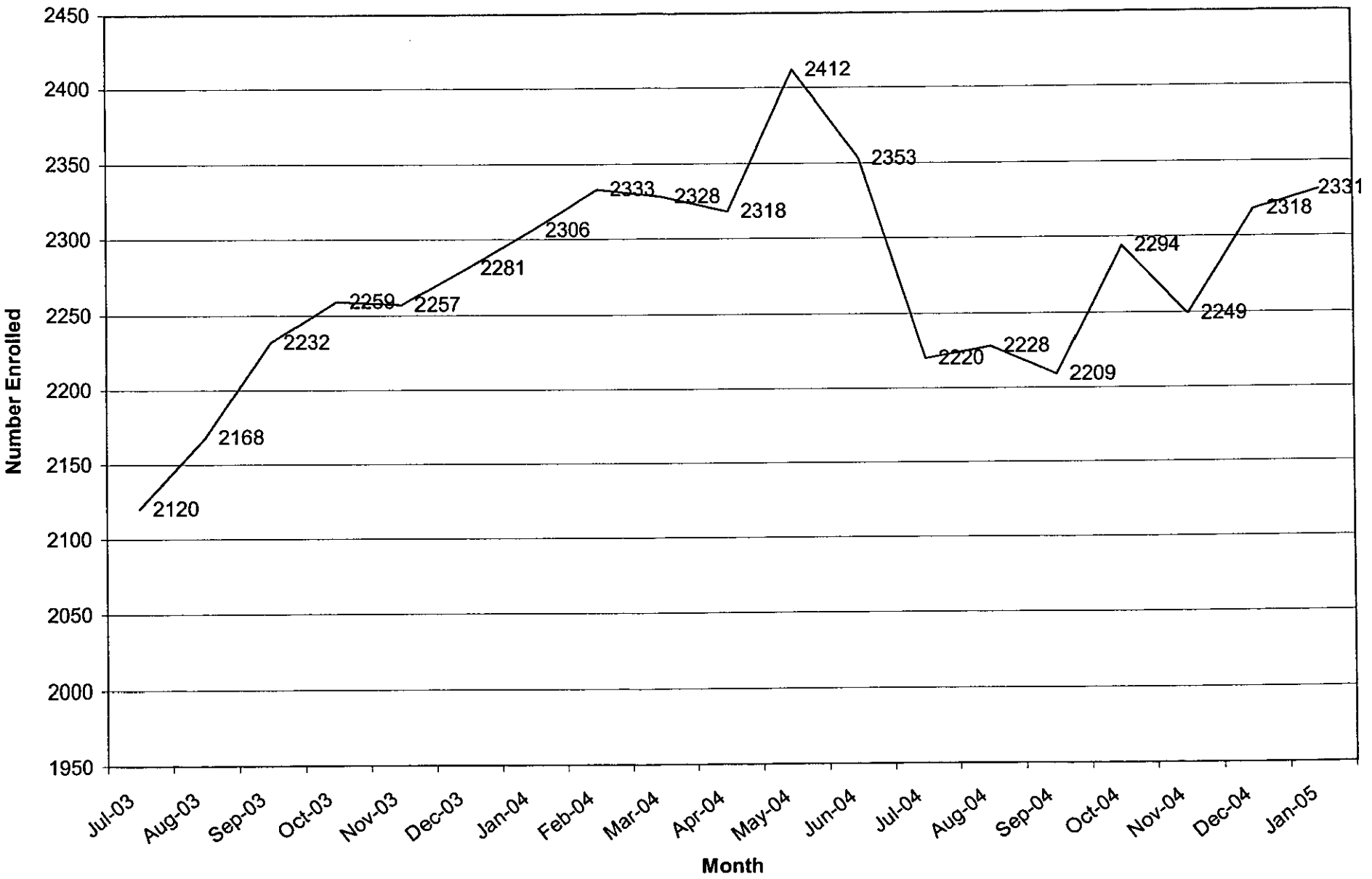
Healthy Steps Individual Eligible as of December 1, 2004
Source: SB261010, SB261020 & SB261030 Files

NUMBER	COUNTY	REGION	INDIVIDUAL COUNT	RACE					
				WHITE	AI/AN	BLACK	ASIAN	HAWAIIAN / PACIFIC ISLANDER	HISPANIC / LATINO
1	Adams	8	42	42	0	0	0	0	0
2	Barnes	6	44	42	2	0	0	0	0
3	Benson	3	61	22	39	0	0	0	0
4	Billings	8	11	9	2	0	0	0	0
5	Bottineau	2	22	22	0	0	0	0	0
6	Bowman	8	25	25	0	0	0	0	2
7	Burke	2	1	1	0	0	0	0	0
8	Burleigh	7	166	146	17	2	2	0	6
9	Cass	5	255	241	4	16	3	0	5
10	Cavalier	3	19	18	1	0	0	0	0
11	Dickey	6	21	19	0	0	0	0	6
12	Divide	1	17	15	2	0	0	0	0
13	Dunn	8	30	29	2	0	1	0	0
14	Eddy	3	10	9	1	0	0	0	0
15	Emmons	7	67	67	0	0	0	0	0
16	Foster	6	11	11	2	0	0	0	0
17	Golden Valley	8	12	12	0	0	0	0	0
18	Grand Forks	4	64	57	4	2	2	0	2
19	Grant	7	38	38	0	0	0	0	0
20	Griggs	6	14	13	1	0	0	0	0
21	Hettinger	8	13	13	0	0	0	0	0
22	Kidder	7	42	42	0	0	0	0	0
23	LaMoure	6	27	27	0	0	0	0	0
24	Logan	6	24	24	0	0	0	0	0
25	McHenry	2	38	38	0	0	0	0	2
26	McIntosh	6	21	21	0	0	0	0	0
27	McKenzie	1	72	48	24	0	0	0	0
28	McLean	7	59	47	12	0	0	0	0
29	Mercer	7	25	25	0	0	0	0	0
30	Morton	7	116	111	5	0	0	0	0
31	Mountrail	2	27	15	14	0	0	0	0
32	Nelson	4	18	18	0	0	0	0	0
33	Oliver	7	10	10	0	0	0	0	0
34	Pembina	4	45	41	5	0	0	0	0
35	Pierce	2	65	65	0	0	0	0	0
36	Ramsey	3	39	31	8	2	0	0	1
37	Ransom	5	5	5	0	0	0	0	0
38	Renville	2	5	5	0	0	0	0	0
39	Richland	5	31	25	4	0	2	0	0
40	Rolette	3	60	35	25	2	0	0	0
41	Sargent	5	15	15	0	0	0	0	3
42	Sheridan	7	17	17	0	0	0	0	0
43	Sioux	7	11	5	6	0	0	0	0
44	Slope	8	19	19	0	0	0	0	0
45	Stark	8	129	128	1	0	0	0	0
46	Steele	5	17	17	0	0	0	0	0
47	Stutsman	6	92	92	0	0	0	0	0
48	Towner	3	21	21	0	0	0	0	0
49	Traill	5	16	16	0	1	0	0	1
50	Walsh	4	49	48	1	0	0	0	2
51	Ward	2	130	120	10	5	0	0	1
52	Wells	6	31	31	0	0	0	0	0
53	Williams	1	99	83	22	0	0	0	1
			2,318	2,096	214	30	10	-	32

REGION TOTALS								
REGION	% of Total	INDIVIDUAL COUNT	WHITE	AI/AN	BLACK	ASIAN	HAWAIIAN / PACIFIC ISLANDER	HISPANIC / LATINO
Region 1	8.11%	188	146	48	-	-	-	1
Region 2	12.42%	288	266	24	5	-	-	3
Region 3	9.06%	210	136	74	4	-	-	1
Region 4	7.59%	176	164	10	2	2	-	4
Region 5	14.62%	339	319	8	17	5	-	9
Region 6	12.30%	285	280	5	-	-	-	6
Region 7	23.77%	551	508	40	2	2	-	6
Region 8	12.12%	281	277	5	-	1	-	2
Total	100.00%	2,318	2,096	214	30	10	-	32

Attachment C

Healthy Steps Enrollment By Month



Attachment 4

5. This section does not apply to any portion of a lump sum payment that must be paid to satisfy an income withholding order issued under section 14-09-09.15.

14-09-10. Reciprocal duty of support - Support of poor. It is the duty of the father, the mother, and every child of any person who is unable to support oneself, to maintain that person to the extent of the ability of each. This liability may be enforced by any person furnishing necessaries to the person. The promise of an adult child to pay for necessaries furnished to the child's parent is binding.

14-09-11. Allowance to parent for support of child. The district court may direct an allowance to be made to a parent of a child out of its property for its past or future support and education on such conditions as may be proper, whenever such direction is for its benefit.

14-09-12. Support by county - Liability of parent's estate. If a parent chargeable with the support of a child dies leaving it chargeable upon the county and leaving an estate sufficient for its support, the board of county commissioners of the county, in the name of the county, may claim provision for its support from the parent's estate by civil action, and for this purpose may have the same remedies as any creditor against that estate and against the heirs, devisees, and next of kin of the parent.

14-09-13. Neglect of child - Parent liable to third person. If a parent neglects to provide articles necessary for that parent's child who is under that parent's charge, according to that parent's circumstances, a third person in good faith may supply such necessaries and recover the reasonable value thereof from the parent.

14-09-14. When parent not liable for support of child. Repealed by S.L. 1999, ch. 141, § 25.

14-09-15. Support of children after majority. When a child, after attaining majority, continues to serve and to be supported by the parent, neither party is entitled to compensation in the absence of an agreement therefor.

14-09-16. Control of property of child. The parent, as such, has no control over the property of the child.

14-09-17. Child's earnings - Relinquished by parent. The parent, whether solvent or insolvent, may relinquish to the child the right of controlling the child and receiving the child's earnings. Abandonment by the parent is presumptive evidence of such relinquishment.

14-09-18. Wages of minors. The wages of a minor employed in service may be paid to the minor until the parent or guardian entitled thereto gives the employer notice that the parent or guardian claims such wages.

14-09-19. Parental abuse. The abuse of parental authority is the subject of judicial cognizance in a civil action in the district court brought by the child, or by its relatives within the third degree, or by the county social service board of the county where the child resides, and when the abuse is established the child may be freed from the dominion of the parent and the duty of support and education may be enforced.

14-09-20. When parent's authority ceases. The authority of a parent ceases:

1. Upon the appointment by a court of a guardian of the person of a child;

2. Upon the marriage of a child; or

3. Upon its attaining majority.

14-09-21. Parent and child not liable for acts of other. Neither parent nor child is answerable as such for the act of the other.

SB 2048

5. This section does not apply to any portion of a lump sum payment that must be paid to satisfy an income withholding order issued under section 14-09-09.15.

Source: S.L. 2003, ch. 125, § 10.

Effective Date.
This section became effective July 1, 2003.

14-09-10. Reciprocal duty of support — Support of poor. It is the duty of the father, the mother, and every child of any person who is unable to support oneself, to maintain that person to the extent of the ability of each. This liability may be enforced by any person furnishing necessaries to the person. The promise of an adult child to pay for necessaries furnished to the child's parent is binding.

Source: Civ. C. 1877, § 97; R.C. 1895, § 2787; R.C. 1899, § 2787; R.C. 1905, § 4099; C.L. 1913, § 4431; R.C. 1943, § 14-0910; S.L. 1995, ch. 456, § 2.

Admission to State School.
When a father makes application for the admission to the Grafton state school of his son who is unable to maintain himself by work, he impliedly agrees to pay for such care and maintenance as may be furnished by the state school and the fact that section 25-08-22 (since repealed) provides for the extent of the father's liability does not destroy the contractual nature of the father's obligation. Reith v. County of Mountrail, 104 N.W.2d 667 (N.D. 1960).

Age of Majority.
A trial court may award child support beyond the age of majority if the child is unable to "maintain himself by work," and a child who has reached age eighteen but is still in high school may, under appropriate circumstances, be considered unable to maintain himself by work. Freyer v. Freyer, 427 N.W.2d 348 (N.D. 1988).

Under this section, a trial court may award child support beyond the age of majority if the child is unable to maintain him or herself by work. Weigel v. Kraft, 449 N.W.2d 583 (N.D. 1989).

Construing Section.
This section is derived from a nearly identical California statute, and thus the Supreme Court may consider judicial interpretation of the California statute as an aid in construing this section. Freyer v. Freyer, 427 N.W.2d 348 (N.D. 1988).

Death of Husband and Father.
The law will imply a pecuniary loss to the wife and children by the death of the husband and father who has been discharging his obligation to support them and was discharging it at, and immediately prior to, his death. Umphrey v. Deery, 78 N.D. 211, 48 N.W.2d 897 (1951).

Divorce Decree.
Modification of divorce decree pursuant to section 14-05-24, whereby father was required to support retarded sons even after they reached their majority provided they continued to be incompetent and unable to care for themselves, was proper, since welfare of children was of prime concern to court and since parents have duty under this section to maintain children unable to maintain themselves. Wiedrich v. Wiedrich, 179 N.W.2d 728 (N.D. 1970).

Duty of Children.
The liability established by this section is a secondary liability, being imposed upon children because of their relationship to their parents. Trinity Medical Ctr., Inc. v. Rubbelke, 389 N.W.2d 805 (N.D. 1986).

The liability imposed upon the children by this section can be likened to the liability of a guarantor. A guarantor, not being a joint contractor with his principal, is not bound to do what the principal has contracted to do, but only to answer for the consequences of the default of the principal. Trinity Medical Ctr., Inc. v. Rubbelke, 389 N.W.2d 805 (N.D. 1986).

This section should not be interpreted so that both parents and children have a primary liability to pay for the necessaries furnished to a parent by a third party. Trinity Medical Ctr., Inc. v. Rubbelke, 389 N.W.2d 805 (N.D. 1986).

Reciprocal Duty and Liability.
This statute fixes the reciprocal duty and liability between parent and child; either may maintain an action against the other for support where necessity therefore exists. Bis-

marck Hosp. & Deaconesses Home v. Harris, 68 N.D. 374, 280 N.W. 423, 116 A.L.R. 1274 (1938).

The obligation of a child to his parent or parents does not entirely terminate at majority. Henke v. Peyerl, 89 N.W.2d 1 (N.D. 1958).

Recovery by County.

Where the state school accepts a child for care and maintenance pursuant to his father's application, a contract is established between the father and the school and where the county has paid for such care over a period of years a claim filed by the county against the father's estate after his decease is a claim arising upon contract. Reith v. County of Mountrail, 104 N.W.2d 667 (N.D. 1960).

Collateral References.

Parent and Child ⇐ 4.

59 Am. Jur. 2d, Parent and Child, §§ 104, 105.

67A C.J.S. Parent and Child, §§ 257-261.

Reimbursement of public for financial assistance to aged persons, 29 A.L.R.2d 731.

Indigent relatives, nature of care contemplated by statute imposing general duty to care for, 92 A.L.R.2d 348.

Constitutionality of statutory provision requiring reimbursement of public by child for financial assistance to aged parents, 75 A.L.R.3d 1159.

Postmajority disability as reviving parental duty to support child, 48 A.L.R.4th 919.

14-09-11. Allowance to parent for support of child. The district court may direct an allowance to be made to a parent of a child out of its property for its past or future support and education on such conditions as may be proper, whenever such direction is for its benefit.

Source: Civ. C. 1877, § 92; R.C. 1895, § 2782; R.C. 1899, § 2782; R.C. 1905, § 4094; C.L. 1913, § 4426; R.C. 1943, § 14-0911.

Collateral References.

Parent and Child ⇐ 3.1(9).

59 Am. Jur. 2d, Parent and Child, §§ 185-190.

67A C.J.S. Parent and Child, §§ 63, 64.

14-09-12. Support by county — Liability of parent's estate. If a parent chargeable with the support of a child dies leaving it chargeable upon the county and leaving an estate sufficient for its support, the board of county commissioners of the county, in the name of the county, may claim provision for its support from the parent's estate by civil action, and for this purpose may have the same remedies as any creditor against that estate and against the heirs, devisees, and next of kin of the parent.

Source: Civ. C. 1877, § 96; R.C. 1895, § 2786; R.C. 1899, § 2786; R.C. 1905, § 4098; C.L. 1913, § 4430; R.C. 1943, § 14-0912.

Parents Killed by Child.

Child who had feloniously and intentionally killed his parents was precluded by section 30.1-10-03 from receiving any benefit, including support payments until the age of majority, from his parents' estates. In re Estates of Josephson, 297 N.W.2d 444 (N.D. 1980).

Collateral References.

Death of obligor parent as affecting decree for support of child, 14 A.L.R.5th 557.

14-09-13. Neglect of child — Parent liable to third person. If a parent neglects to provide articles necessary for that parent's child who is under that parent's charge, according to that parent's circumstances, a third person in good faith may supply such necessaries and recover the reasonable value thereof from the parent.

Source: Civ. C. 1877, § 98; R.C. 1895, § 2788; R.C. 1899, § 2788; R.C. 1905, § 4100; C.L. 1913, § 4432; R.C. 1943, § 14-0913.

Collateral References.

Parent and Child ⇐ 3.1(13).

Do I have to choose a Primary Care Provider for my child?

Healthy Steps insurance does not require families to select a primary doctor or provider for their children.

Do I need a referral to bring my child to a specialist?

A child covered by Healthy Steps insurance does not need a referral to a specialist, but parents may want to contact the insurance company (Noridian Mutual Insurance 1-800-342-4718) for details on any coverage question especially if the specialist is out of state.

What happens if our income changes?

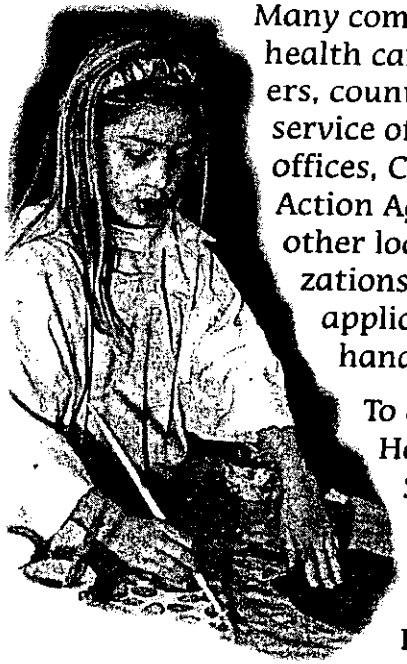
When a child is enrolled in Healthy Steps insurance, he or she is enrolled for a 12-month period, or until the end of the month in which the child turns 19 years old. This helps assure that children receive consistent access to health care. Household income is not reviewed for twelve months.

If after that 12-month period, a family's income decreases to the point that the children are determined eligible for the North Dakota Medicaid Program, the family would be referred to the county social service office to apply for Medicaid. Medicaid, which also provides comprehensive health coverage for low-income families, has different rules and requirements. When a child has health coverage under Medicaid, the family's income may be reviewed monthly to determine if the child is fully covered (poverty level eligible) or if the family is responsible for part of their medical bills.

How do I apply for Healthy Steps insurance coverage for my child?

To apply, families must fill out a short two-page application and provide copies of all pay check stubs from the preceding month.

Applications are available by calling toll-free at 1-800-755-2604, or can be printed from the Internet at www.state.nd.us/childrenshealth.



Many community health care providers, county social service offices, WIC offices, Community Action Agencies and other local organizations also have applications on hand.

To contact Healthy Steps insurance by mail, write to Healthy Steps, Department 325, 600 E. Boulevard Avenue, Bismarck, ND 58505-0250.

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Attachment 3a

ENGLISH

Healthy Steps

Children's Health Insurance Plan

Low cost health insurance plan for children

Healthy Steps, North Dakota's children's health insurance plan, provides premium-free health coverage to uninsured children in qualifying families. It is intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage, but not enough to afford private insurance.

Healthy Steps insurance is for children who:

- Do not have health insurance coverage
- Are 18 years of age or younger (covers children through the month they turn 19)
- Do not qualify for Medicaid
- Live in families with qualifying incomes

Healthy Steps insurance features comprehensive coverage.

Some of the Covered Services:

- Inpatient hospital stay, medical & surgical services
- Outpatient hospital and clinic services
- Mental health and substance abuse services
- Prescription medications
- Routine preventive services (such as well-baby check-ups and immunizations)
- Dental and vision services
- Prenatal services

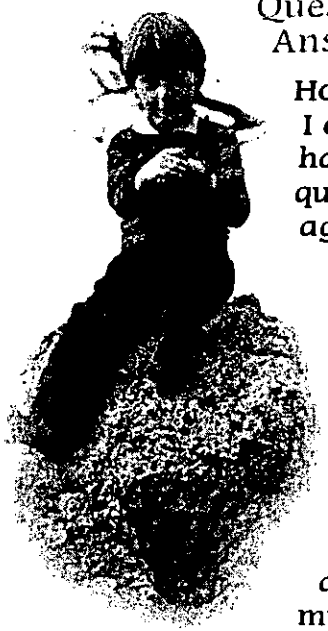
Cost of care:

- There are no monthly premiums
- Most families are required to pay modest copayments when a child receives certain services.

The only copayments for Healthy Steps are:

- Emergency Room -- $5 per visit
- Hospitalization -- $50 per hospitalization
- Prescription -- $2 per prescription

NOTE: Due to the unique relationship that exists between the federal government and tribal governments, the co-payment requirement has be aived for Native American ch... en.



Questions & Answers

How much can I earn and still have my children qualify for coverage?

Your NET income (after subtracting childcare costs and payroll taxes such as social security tax, Medicare tax, and income tax) must be greater than the Medicaid level, but it cannot exceed the monthly/annual income levels listed below.

Qualifying Income Levels

Family Size	Annual Net Income	Monthly Income
1	$13,034	$1,087
2	$17,486	$1,458
3	$21,938	$1,829
4	$26,390	$2,200
5	$30,842	$2,571
6	$35,294	$2,942

NOTE to farmers and self-employed families: Eligibility is based on adjusted gross inco