15.0594.02000

FISCAL NOTE
Requested by Legislative Council
01/13/2015

Bill/Resolution No.: HB 1291

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

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$3,611,757		$7,391,266
Expenditures			$3,281,731	$3,611,757	$6,731,214	$7,391,266
Appropriations			$3,281,731	$3,611,757	$6,731,214	$7,391,266

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

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties		$330,026	$660,052
Cities			
School Districts			
Townships			

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

HB1291 requires the Department to seek approval from the Centers for Medicare and Medicaid Services(CMS) to expand medical assistance coverage for pregnant women with income between 147% and 200% of the federal poverty level.

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

Section 1 requires the Department to expand medical assistance coverage for pregnant women with income between 147% and 200% of the federal poverty level. If eligibility level is increased above 185% of the federal poverty level, North Dakota would have to apply for approval under an 1115 waiver, or explore an option through a CHIP targeted low income pregnant women program. As CHIP is currently only funded through September 30, 2015 the availability of funding from this program is uncertain. It is not reasonable to anticipate CMS approval of a 1115 waiver by the January 1, 2016 start date purposed by this bill. All estimates were calculated using a July 1, 2016 anticipated start date.

The Department estimates that 2,706 additional pregnant women would qualify for coverage annually. Due to the Affordable Care Act and mandatory insurance coverage, it was assumed that this population would be covered through other insurance plans and that the state would be the third party payer of coverage. Expanding coverage will also require IT system changes in order to be implemented. The IT cost along with the cost to cover the additional women is estimated to be 6,893,488 of which, $3,281,731 is General Fund and $3,611,757 is other funds. We also included costs for the equivalent of 5 additional County eligibility workers to handle the increase in applications expected for this coverage.

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

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

With approval from CMS, the Department will be able to access federal Medicaid funding in 15-17 biennium of which $3,446,744 is from increased grants and operating expenditures and $165,013 is from retained dollars for the

addition of 5 County staff. The revenues for the 17-19 biennium are estimated to be $7,061,240 due to grants and $330,026 from retained dollars for the addition of 5 County staff.

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

With an effective date of July 1, 2016, estimated expenditures under the Medicaid grants line item for 12 months of the 15-17 biennium would total $6,656,516 and the IT costs are 236,972, of which, $3,281,731 is General Fund and $3,611,757 is Other Funds. In the 17-19 biennium, estimated expenditures would increase to $14,122,479 of which, $6,731,214 is General Fund and $7,391,266 is Other Funds.

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

The Department will need an appropriation increase for the 15-17 biennium of $6,893,488 of which $3,281,731 is General Fund and $3,611,757,is Other Funds. The Department will need an appropriation increase for the 17-19 biennium of $14,122,479 of which, $6,731,214 is General Fund and $7,391,266 is Other Funds.

Name: Debra A. McDermot

Agency: Department of Human Services

Telephone: 70 328-3695

Date Prepared: 01/23/2015

2015 HOUSE HUMAN SERVICES

HB 1291

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1291
1/26/2015
Job #22503

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Medical assistance coverage for pregnant women and provide an availability date.

Minutes: Testimonies 1-3

Chairman Weisz opened the hearing on HB 1291.

Rep. Mooney: From District 20 introduced and supported the bill. (See Testimony #1)

8:46
Rep. Porter: Who is currently being missed?

Rep. Mooney: I don't have the numbers of who is being missed. It is more about families and women who are in the reproductive stages get the necessary care.

Rep. Porter: If they are covered under a private policy why would they need to be on Medicaid or Medicaid expansion if they are already covered?

Rep. Mooney: It provides a greater safety net for these families who are in reproductive stages to ensure they get what they need. Out of 50 states, ND is above the 138% so at 152% of poverty level allows women and families to be brought into the Medicaid expansion at a 152%. Through the list of one of those handouts you have, there is a drive to get up to the 185% to 200% or more to ensure pregnant women have the means necessary for prenatal care so healthy babies are the result. I think ND is in a position to move in that direction as well.

Rep. Porter: My understanding of the ACA is that is one of the mandates inside of it. Why do you want to shift things around an already mandated market?

Rep. Mooney: My understanding of the ACA is that is one of the mandates inside of it. Why expand the Medicaid program when the coverage is already there?

Rep. Mooney: (Turned away from microphone and asked a question of Maggie Anderson in the audience and Maggie answered without a microphone so it was in audible.)

Renee Stromme: Executive Director of the ND Women's Network testified in support of the bill. (See Testimony #2)

15:42
Rep. Fehr: On the fiscal note. It estimated they were talking about 2,706 additional pregnant women. Who are they? Do they not have insurance now or their insurance doesn't cover well enough. Why is there this need?

Stromme: We are talking about women in the service industry and may not have access to insurance through their employer. If we were able to move them into Medicaid, it reduces some of the cost.

Rep. Fehr: Do a lot of these women either have insurance through the marketplace or would be eligible, but choosing not to?

Stromme: I can't generalize what their situation looks like. I can follow up with a breakdown of what it looks like to visit between 152% to 200% and what the demographics look like.

Nicole Walford: Read the testimony for Rebecca Matthews. (See Testimony #3)

22:05
Chairman Weisz: If someone was currently at 175% and they are in the exchange; if this bill passes they would be required to go to Medicaid correct?

Julie Schwab: Director of Medical Services for the DHS. With our fiscal note we assumed the women would have coverage in the exchange within this range.

Chairman Weisz: My question is, would they be required to go to Medicaid? They wouldn't have the option anymore to stay in the exchange?

Maggie Anderson: Director of the DHS. We wrote the fiscal note because of the mandate that went into effect on January 1, 2014 we assumed these women would have coverage. If they have employer sponsored coverage they would be able to keep that and use Medicaid as a wrap around. If they were getting coverage through the marketplace with subsidies, they cannot have Medicaid.

Rep. Oversen: How far does the coverage expand for the pregnant women?

Schwab: I believe it is up to delivery and after the delivery.

M. Anderson: The delivery costs are mom and delivery costs for baby start at birth. The Medicaid coverage now covers 60 days after the month in which the baby was born.

Rep. Mooney: Maggie Anderson told me that there are some difficulties that the department incurs for implementation when it goes above 185%. Could you share some of those with us?

Schwab: CMS allows us to go up to 185% without doing an additional waiver. If we go above that we have to file an 1115 waiver which requires additional work in how it is structured. The notices we have to give and the timeframe is about 18 months to complete an 1115 waiver. The requirements going above 185% could possibly increase the workload extensively.

Rep. Mooney: Would it impact the fiscal note and reduce that.

Schwab: We based the fiscal note on the 200%.

Rep. Mooney: Would it decrease by 15%?

M. Anderson: Yes and no. The first biennium your cost may actually be the same or go up because we could implement sooner than a year. The fiscal estimate is based on the July 1, 2016 implementation if we didn't have to do the 1115, we could implement January 1, 2016. You are going to have an additional six months of costs in the 17-19 estimate would expect that cost to go down because we would cover fewer women.

NO OPPOSITION

Chairman Weisz closed the hearing on HB 1291.

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1291
2/9/2015
Job #23486

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's look at 1291. It is basically expanding the Medicaid coverage for pregnancies up to 200%. That would require an 1115 waiver unless you want to drop it to the 185%. That has a $3.6 million in 15-17. This one here covers the uninsured and would make up the difference in the co-pay and deductibles. You could drop your insurance and go on the Medicaid and not have the co-pays and deductibles which is $6600 under ACA.

Rep. Mooney: I spent some time with Maggie talking about dropping it down to 185% or 175% which would be the same of what CHIPS is. This is comparable to the CHIPS program. The amount of money it would reduce the fiscal note was fairly marginal. I don't think there is any need to offer the amendment in that context. We still do have uninsured women and families out there. It isn't against the law yet and they only have to pay a penalty. There is the underinsured as well. The idea is for women to get the care they need to ensure the babies and families are as healthy as possible.

Rep. Damschen: I would move a Do Not Pass on HB 1291.

Rep. Hofstad: Second.

Chairman Weisz: There is some difference between this bill and the last bill. The last bill the current ACA coverage should cover all of those costs. Under this bill you do have the deductible to kick in. They figured in the fiscal note that people would drop their insurance and go onto Medicaid.

Rep. Rich Becker: Rep. Mooney, whether it is this particular bill or so many we are talking about there is a matter of choice here. Many people are refusing or not signing up for Obamacare. The penalty is so small people say the heck with it I'll pay it. I'm conflicted as it has a lot of merit to it, but if it has 2,000 or more cases for this. How many of that number are people who don't have the accountability to even sign up for insurance?

Rep. Mooney: I don't disagree that a lot of people haven't followed through with it. I'd counter it with that some people still have an affordability factor. Is there a simple answer to any of this? I would say no.

Rep. Oversen: I think this bill has a lot of merit. It helps women get the care they need.

ROLL CALL VOTE: 8 y 5 n 0 absent

MOTION CARRIED

Bill Carrier: Rep. Weisz

Date: 2-9-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1291

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Damschen Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney		✓
Vice-Chair Hofstad	✓		Rep. Muscha		✓
Rep. Bert Anderson		✓	Rep. Oversen		✓
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert		✓			
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 8 No 5

Absent 2

Floor Assignment Rep. Weisz

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

REPORT OF STANDING COMMITTEE

HB 1291: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (8 YEAS, 5 NAYS, 0 ABSENT AND NOT VOTING). HB 1291 was placed on the Eleventh order on the calendar.

2015 TESTIMONY

HB 1291

TESTIMONY
1-26-15

#1

Mr. Chairman, members of the House Human Services Committee, thank you for this opportunity to introduce you to HB 1291. For the record, my name is Representative Gail Mooney of District 20.

HB 1291 is a short bill with potentially profound implications for the security and well-being of uninsured families in North Dakota. In 2013 the state legislature approved the expansion of Medicaid to include a broader population of uninsured families and individuals within 138% of the federal poverty level. The purpose of this bill is to expand Medicare/Medicaid availability to include pregnant women within 200% of poverty level.

Included in your handouts are two 2012 (most recent available data) reports from KIDS COUNT through NDSU. The first discusses the impacts of low birth weight as it pertains to possible health issues and the resulting physical and financial implications. If I may, I'd like to highlight just a few paragraphs from these reports.

(Handout #1) From the report on **Low Birth Weights in North Dakota**...

> "*Most North Dakota babies are born at a healthy birth weight (i.e., at least 5.5 pounds or 2,500 grams) (93.9% in 2012). For those babies born at less than 5.5 pounds, there is an increased risk for physical, cognitive, and emotional problems that can persist into adulthood. Research indicates that babies with a very low birth weight (i.e., less than 3 pounds 4 ounces or 1,500 grams) have a 22 percent chance of not making it to their first birthday. The costs associated with a low birth weight are numerous and may include higher health care expenses, special education, social service expenses, and decreased productivity in adulthood.*
>
> *In 2012, 619 North Dakota babies were born with a low birth weight, which is 6.1 percent of all live births in the state. This proportion tied with South Dakota and Vermont for the third lowest rate among states. Nationally, 8 percent of children were born at a low birth weight in 2012.*
>
> *... A number of factors contribute to low birth weight including congenital anomalies or chromosomal abnormalities, problems with the placenta, and infection during pregnancy. Risk factors relating to the mother include multiple births (more than one fetus carried to term), previous low birth weight babies, poor nutrition, heart disease or hypertension, smoking, drug addition, alcohol abuse, lead exposure, and insufficient prenatal care.*
>
> *There are preventive measures that will increase the chances of having a healthy baby. These include such things as mothers having access to and receiving appropriate prenatal care, eating healthy, and avoiding known risk factors such as alcohol, tobacco, and drugs."*

Medicaid paid for about 45% of all births in 2010.

Hospital stays associated with pregnancy and childbirth account for seven of the top 20 most expensive conditions for hospitalizations covered by Medicaid.

Babies born weighing less than 5.5 pounds often require significantly more expensive hospital stays at an average cost of $27,200 – compared to the average newborn costs of around $3200 (2011).

Low birth weight babies also often incur higher costs during their entire lives for health care and other services such as special education.

Increased number of healthy pregnancies through preventative care can save valuable state resources by

(Handout #2) From the document **Child Poverty in North Dakota**:

> *"In 2012, a four-person family in the continental United States earning $23,492 or less was considered impoverished. Nevertheless, many researchers agree that, on average, families need an income of about twice the federal poverty level to meet their most basic needs. In North Dakota, 33 percent of children live in families with incomes that do not meet that level, i.e., family incomes are below 200 percent of the*

federal poverty level (49,118 children in 2012). Nationally, 43 percent of children live in families with these lower income levels (31 million children in 2012).

North Dakota's current economy is one of prosperity. In fact, North Dakota leads the nation in growth of gross domestic product and per capita income. Yet, despite North Dakota's fast-paced economy, there has been relatively little change in the overall child poverty rate since 2000. North Dakota also has had the lowest annual unemployment rate of any state in the nation since 2009. This suggests that most children (and most children living in poverty) have working parents. In 2012, 76 percent of impoverished children in North Dakota had a parent in the labor force."

(Handout #3) includes an excerpt from a briefing paper by the National Conference for State Legislatures entitled **Healthy Women, Healthy Babies** and states in part...

"Costs for delivery, hospitalization, and other care for preterm babies (born before 37 weeks of pregnancy) and low-birth weight infants (less than 5.5 pounds) can be significantly more than those for normal weight babies born full term. The average hospital cost in 2011 was $21,500 for a preterm birth, $27,200 for a low-birth weight birth and $76,700 for a very low-birth weight birth (less than 3.3 pounds). In comparison, the average hospital cost for a newborn was $3200, according to the Agency for Healthcare Research and Quality. In addition, preterm and low-birth weight babies are at a higher risk of infant death, as well as long-term physical and developmental disabilities."

(Handout #4 & #5) According to data reported through the National Conference of State Legislatures, as of July 2010 North Dakota was one of only five states in the country at 133% of federal poverty limit for pregnant women. The Kaiser Foundation has reported on data since the implementation of the Affordable Care Act, referencing the newly established 138% FPL (under the MAGI formula) and reports that North Dakota is one of 21 states currently between 138% and 199% of FPL.

Mr. Chairman and committee members - while it is true North Dakota has made significant gains in addressing assurances of healthcare for the working poor through the 2013 Medicaid Expansion, this bill would go a step further to provide health related security for growing families. A move in this direction accomplishes several meaningful goals for our state:

- Encourages prenatal care and healthy living practices for healthy babies
- Lowers the overall costs of healthcare to the state & society
- Promotes health and financial securities of ND families
- Increases the likelihood of productive academics and health for children into adulthood
- Protects life through meaningful and pragmatic measures

Prenatal care is clearly a case where an ounce of prevention is the wise investment for the lifetime of a child - and a family.

part of TESTIMONY #1 #1

kids count north dakota

Insights on Children

A Publication of North Dakota KIDS COUNT at North Dakota State University, an Equal Opportunity Institution

VOLUME 3, NUMBER 1, MARCH 2014

LOW BIRTH WEIGHT BABIES IN NORTH DAKOTA

Most North Dakota babies are born at a healthy birth weight (i.e., at least 5.5 pounds or 2,500 grams) (93.9% in 2012)[1]. For those babies born at less than 5.5 pounds, there is an increased risk for physical, cognitive, and emotional problems that can persist into adulthood. Research indicates that babies with a very low birth weight (i.e., less than 3 pounds 4 ounces or 1,500 grams) have a 22 percent chance of not making it to their first birthday[2]. The costs associated with a low birth weight are numerous and may include higher health care expenses, special education and social service expenses, and decreased productivity in adulthood[3].

In 2012, 619 North Dakota babies were born with a low birth weight, which is 6.1 percent of all live births in the state[1]. This proportion tied with South Dakota and Vermont for the third lowest rate among states. Nationally, 8 percent of children were born at a low birth weight in 2012[4].

The percentage of low birth-weight babies in North Dakota increased during the 1990s from a low of 4.9 percent in 1991 to a high of 6.9 percent in 2001. Since then, the percentage has shown slight fluctuation from year to year, and has decreased for the last two years in a row to 6.1 percent in 2012 (Figure 1)[1].

For the majority of counties in North Dakota, the number of babies born at a low birth weight was less than six events, in which case the numbers are suppressed for confidentiality reasons. Five counties had percentages that were higher than the national average in 2012 (i.e., Pembina 9.5%, Ransom 9.6%, Stutsman 9.7%, Rolette 10.3%, and Mercer 12.1%) (Figure 2 and Table 1)[1].

A number of factors contribute to low birth weight including congenital anomalies or chromosomal abnormalities, problems with the placenta, and infection during pregnancy. Risk factors relating to the mother include multiple births (more than one fetus carried to term), previous low birth-weight babies, poor nutrition, heart disease or hypertension, smoking, drug addition, alcohol abuse, lead exposure, and insufficient prenatal care[5].

There are preventive measures that will increase the chances of having a healthy baby. These include such things as mothers having access to and receiving appropriate prenatal care, eating healthy, and avoiding known risk factors such as alcohol, tobacco, and drugs[6]. A more complete list of preventive measures is available at http://www.womenshealth.gov. Reducing the number babies born at a low birth weight will improve child outcomes and result in a healthier North Dakota.

FIGURE 1. LOW BIRTH WEIGHT BABIES AS A PERCENT OF TOTAL LIVE BIRTHS IN NORTH DAKOTA AND UNITED STATES: 1990 TO 2012[1,4]

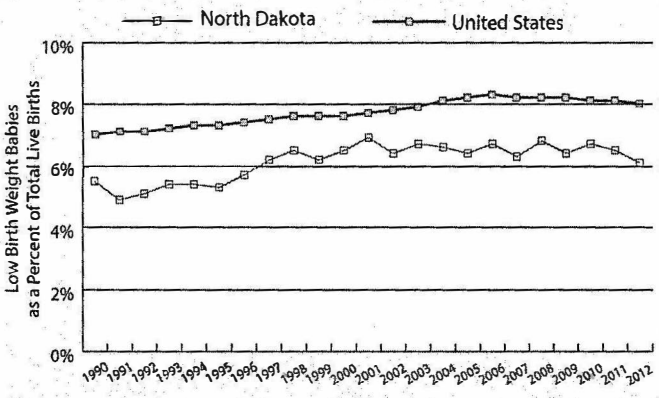
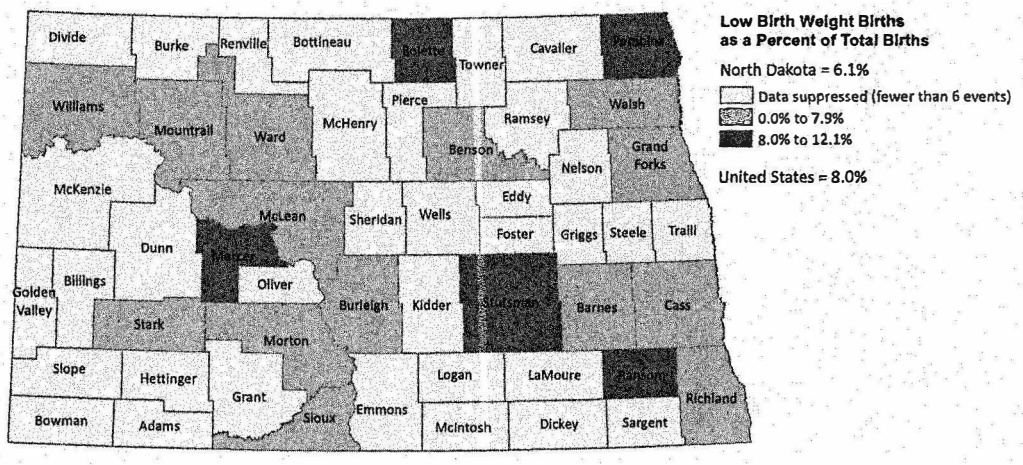


FIGURE 2. LOW BIRTH WEIGHT BABIES AS A PERCENT OF TOTAL LIVE BIRTHS IN NORTH DAKOTA BY COUNTY: 2012[1]



SOURCES: [1]Annie E. Casey Foundation, KIDS COUNT Data Center. 2014. Health. Retrieved from http://bit.ly/1hv1U2X. [2] National Center for Health Statistics. 2013. *National Vital Statistics Report*, 62(8), Table 4. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_08.pdf. [3] Petrou S., Sach, T., Davidson, L. 2001. The long-term costs of preterm birth and low birth weight: Results of a systematic review. *Child: Care, Health and Development, 27(2), 97-115.* [4] National Center for Health Statistics. 2013. *National Vital Statistics Report*, 62(9), Table 1-9. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09_tables.pdf. [5] University of Maryland Medical Center. 2012. *Low Birth Weight*. Retrieved from http://umm.edu/health/medical/pregnancy/labor-and-delivery/low-birth-weight. [6]U.S. Department of Health and Human Services, Office of Women's Health. 2014. *Prenatal Care Face Sheet*. Retrieved from http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html.

TABLE 1. LOW BIRTH WEIGHT BABIES IN NORTH DAKOTA BY COUNTY: 2008-2012[1]

	2008		2009		2010		2011		2012	
	Number	% of total live births	Number	% of total live births	Number	% of total live births	Number	% of total live births	Number	% of total live births
North Dakota	610	6.8%	571	6.4%	605	6.7%	602	6.5%	619	6.1%
Adams	<6	--	<6	--	<6	--	0	0.0%	<6	--
Barnes	<6	--	6	5.4%	<6	--	8	7.1%	7	6.0%
Benson	9	6.1%	11	9.0%	10	7.6%	11	7.7%	10	6.2%
Billings	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Bottineau	6	9.4%	<6	--	<6	--	10	13.3%	0	0.0%
Bowman	<6	--	<6	--	0	0.0%	0	0.0%	<6	--
Burke	<6	--	<6	--	<6	--	<6	--	<6	--
Burleigh	86	8.4%	67	6.3%	73	6.7%	72	6.3%	93	7.7%
Cass	141	6.7%	127	5.9%	143	6.6%	151	6.7%	140	5.9%
Cavalier	<6	--	0	0.0%	<6	--	<6	--	<6	--
Dickey	<6	--	6	8.8%	<6	--	<6	--	<6	--
Divide	0	0.0%	<6	--	<6	--	0	0.0%	<6	--
Dunn	<6	--	<6	--	<6	--	<6	--	0	0.0%
Eddy	<6	--	0	0.0%	0	0.0%	0	0.0%	<6	--
Emmons	0	0.0%	<6	--	0	0.0%	<6	--	<6	--
Foster	<6	--	<6	--	<6	--	<6	--	<6	--
Golden Valley	<6	--	0	0.0%	<6	--	0	0.0%	0	0.0%
Grand Forks	63	6.3%	63	6.9%	59	6.0%	56	6.2%	63	6.5%
Grant	0	0.0%	0	0.0%	<6	--	<6	--	0	0.0%
Griggs	<6	--	<6	--	<6	--	0	0.0%	<6	--
Hettinger	<6	--	<6	--	<6	--	0	0.0%	<6	--
Kidder	0	0.0%	<6	--	<6	--	<6	--	<6	--
LaMoure	<6	--	<6	--	<6	--	0	0.0%	<6	--
Logan	0	0.0%	<6	--	<6	--	0	0.0%	<6	--
McHenry	<6	--	<6	--	<6	--	<6	--	<6	--
McIntosh	<6	--	<6	--	<6	--	0	0.0%	0	0.0%
McKenzie	6	7.5%	6	6.6%	<6	--	<6	--	<6	--
McLean	<6	--	<6	--	6	5.9%	7	6.9%	10	7.8%
Mercer	11	14.9%	10	9.3%	7	7.1%	<6	--	12	12.1%
Morton	28	7.7%	24	6.2%	17	4.7%	24	6.0%	22	5.1%
Mountrail	6	4.7%	10	8.8%	13	10.2%	8	5.6%	8	5.0%
Nelson	<6	--	<6	--	<6	--	<6	--	<6	--
Oliver	<6	--	<6	--	<6	--	0	0.0%	<6	--
Pembina	<6	--	<6	--	<6	--	10	12.8%	7	9.5%
Pierce	<6	--	<6	--	<6	--	0	0.0%	<6	--
Ramsey	16	9.9%	6	4.3%	21	12.6%	16	9.3%	<6	--
Ransom	<6	--	<6	--	9	14.8%	<6	--	7	9.6%
Renville	<6	--	<6	--	<6	--	0	0.0%	0	0.0%
Richland	9	4.4%	13	7.1%	15	7.9%	11	11.6%	6	3.3%
Rolette	29	9.1%	27	9.0%	42	13.5%	33	11.1%	30	10.3%
Sargent	<6	--	<6	--	<6	--	<6	--	<6	--
Sheridan	0	0.0%	0	0.0%	<6	--	0	0.0%	<6	--
Sioux	8	8.2%	13	13.3%	10	11.5%	10	10.2%	6	5.6%
Slope	0	0.0%	<6	--	0	0.0%	<6	--	<6	--
Stark	12	4.2%	14	4.6%	15	5.0%	20	5.9%	18	4.5%
Steele	<6	--	0	0.0%	<6	--	0	0.0%	<6	--
Stutsman	23	10.5%	26	11.7%	16	6.9%	14	6.5%	22	9.7%
Towner	<6	--	0	0.0%	0	0.0%	0	0.0%	<6	--
Traill	7	7.1%	<6	--	<6	--	<6	--	<6	--
Walsh	<6	--	<6	--	8	6.6%	<6	--	9	6.3%
Ward	74	7.1%	62	6.0%	66	6.6%	72	6.7%	61	5.5%
Wells	0	0.0%	<6	--	0	0.0%	<6	--	0	0.0%
Williams	13	4.6%	18	5.9%	20	5.7%	22	5.9%	26	5.5%

NOTES: <6 indicates that data are not reported by the North Dakota Department of Health Division of Vital Records for geographies where the number of babies born at a low birth weight (less than 5.5 pounds or 2,500 grams) is less than six. -- Indicates an unknown rate because the event number is suppressed.

Part of Testimony #1 #2

kids count north dakota

Insights on Children

A Publication of North Dakota KIDS COUNT at North Dakota State University, an Equal Opportunity Institution

Volume 3, Number 3, September 2014

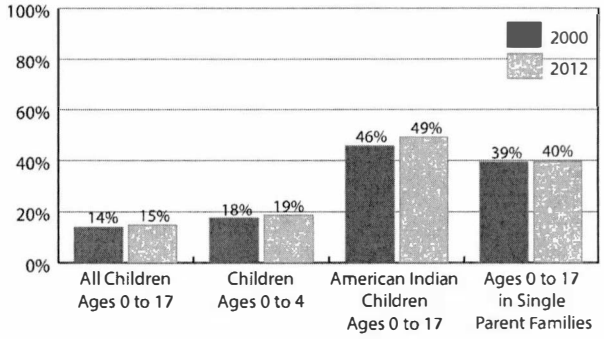
Child Poverty in North Dakota

A family's economic situation has important implications for the health and well-being of a child. Financially stable families have resources to cover their expenses and save for the future. This stability helps provide their children with a foundation for future success. Unfortunately, nearly 22,000 North Dakota children live in families with incomes below the poverty level[1] (Table 1). Growing up in an impoverished family can create cumulative disadvantages that can powerfully influence the direction of a child's life, especially if those disadvantages are not mitigated by other sources of support.

When children lack opportunities to fulfill their potential, the cost to their communities can be steep. Economists estimate that child poverty costs the United States $500 billion annually in lost productivity and spending on health care and the criminal justice system[2]. Fortunately, research also suggests that there are effective ways to intervene at all points in the life course and improve child outcomes. The Brookings Institution highlights four key policy areas that play an important role in addressing poverty in America: promoting early childhood education, supporting opportunities for disadvantaged youth, skill development and job creation, and improving safety net and work supports. Efforts in these areas are shown to improve school readiness; social, emotional, and cognitive development; physical health; school achievement; and adult success[3].

On a national level, North Dakota has one of the lowest child poverty rates of any state. In 2012, 15 percent of all children in North Dakota were impoverished, compared to 21 percent nationwide[1]. While there is continuing debate about the best approach to measuring poverty in the United States, the official poverty measure uses a set of income thresholds that vary by family size and composition, and are adjusted annually for changes in the cost of living (but are the same across the United States). In 2012, a four-person family in the continental United States earning $23,492 or less was considered impoverished[4]. Nevertheless, many researchers agree that, on average, families need an income of about twice the federal poverty level to meet their most basic needs[3]. In North Dakota, 33 percent of children live in families with incomes that do not meet that level, i.e., family incomes are below 200 percent of the federal poverty level (49,118 children in 2012). Nationally, 43 percent of children live in families with these lower income levels (31 million children in 2012)[1].

Figure 1. North Dakota Child Poverty Rates by Age, Race, and Family Type: 2000 and 2012[1,7]



North Dakota's current economy is one of prosperity. In fact, North Dakota leads the nation in growth of gross domestic product and per capita income[5]. Yet, despite North Dakota's fast-paced economy, there has been relatively little change in the overall child poverty rate since 2000[1,7] (Figure 1). North Dakota also has had the lowest annual unemployment rate of any state in the nation since 2009[6]. This suggests that most children (and most children living in poverty) have working parents. In 2012, 76 percent of impoverished children in North Dakota had a parent in the labor force.

Figure 2. Change in the Child Poverty Rate for North Dakota Counties (Difference in Percentages): 2000-2012[1,7]

Figure 2 shows the change in child poverty rates in North Dakota by county from 2000 to 2012.

Child poverty differs by age, race, and family type. Within North Dakota, younger children (i.e., ages 0-4) have a higher poverty rate than children overall (19% and 15%, respectively in 2012). North Dakota children living with a single parent are six times more likely to live in poverty than children living with married parents (40% compared to 6%, respectively in 2012). And half of all American Indian children living in North Dakota were impoverished in 2012 (49%)[1]. Similar to the overall child poverty rate for North Dakota, there has been relatively little change in these rates since 2000 (Figure 1)[1,7].

[1]U.S. Census Bureau. 2008-2012 American Community Survey 5-Year Estimates, http://factfinder2.census.gov and http://dotoferrett.census.gov/. [2]National Center for Children in Poverty, Ten Important Questions about Child Poverty and Family Economic Hardship, http://www.nccp.org/faq.html. [3]The Brookings Institution, The Hamilton Project, Policies to Address Poverty in America, http://bit.ly/VY7ztx. [4]U.S. Census Bureau. Poverty Thresholds for 2012 by Size of Family and Number of Related Children Under 18 Years, http://1.usa.gov/1z7zD9Z. [5]U.S. Department of Commerce. Bureau of Economic Analysis, Regional Economic Accounts, http://www.bea.gov/regional/. [6]U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, http://www.bls.gov/lau/tables.htm. [7]U.S. Census Bureau. Census 2000 Summary File 3, http://factfinder2.census.gov. [8]U.S. Census Bureau. 2006-2010 American Community Survey 5-Year Estimates, http://factfinder2.census.gov.

TABLE 1. NUMBER AND PERCENT OF CHILDREN LIVING IN POVERTY* IN NORTH DAKOTA BY COUNTY: 2000, 2010, AND 2012[1,7,8]

	Children Ages 0 through 17 Living in Families with Incomes Below Poverty (i.e., below 100% of the federal poverty level)					
	2000		2010		2012	
	Number	Percent	Number	Percent	Number	Percent
North Dakota	22,163	14.0%	20,713	14.2%	21,835	14.8%
Adams	67	11.1%	31	7.1%	60	15.2%
Barnes	286	11.0%	277	12.6%	206	9.5%
Benson	958	39.2%	1,062	48.3%	1,096	50.0%
Billings	23	11.0%	23	11.9%	9	6.3%
Bottineau	192	12.3%	198	16.5%	177	14.4%
Bowman	77	9.9%	17	2.6%	13	1.9%
Burke	81	17.3%	34	9.4%	48	12.1%
Burleigh	1,547	9.1%	2,060	11.6%	2,059	11.3%
Cass	2,699	9.5%	3,451	11.0%	3,766	11.7%
Cavalier	198	16.8%	102	12.8%	58	7.6%
Dickey	283	21.0%	119	9.3%	126	10.3%
Divide	89	19.5%	129	40.7%	87	26.9%
Dunn	221	22.4%	57	7.5%	82	10.6%
Eddy	75	11.5%	121	21.0%	131	26.9%
Emmons	249	23.4%	170	22.0%	142	18.2%
Foster	107	11.2%	39	5.2%	73	9.9%
Golden Valley	103	21.4%	57	17.7%	61	16.7%
Grand Forks	1,926	12.4%	2,046	15.6%	2,092	16.0%
Grant	194	29.1%	63	18.1%	56	12.5%
Griggs	64	10.3%	53	11.4%	28	6.2%
Hettinger	134	21.2%	43	9.3%	49	10.2%
Kidder	133	20.8%	146	29.1%	106	23.3%
LaMoure	191	17.0%	61	6.8%	72	9.0%
Logan	85	16.2%	33	7.5%	22	4.8%
McHenry	264	18.5%	205	17.1%	243	20.5%
McIntosh	99	15.2%	45	9.7%	44	8.9%
McKenzie	390	22.6%	199	12.8%	322	18.5%
McLean	382	17.5%	213	12.5%	268	15.4%
Mercer	128	5.2%	132	7.2%	99	5.5%
Morton	763	11.4%	674	10.8%	694	10.9%
Mountrail	435	23.6%	431	24.2%	296	15.5%
Nelson	100	12.4%	86	14.0%	57	10.0%
Oliver	134	23.6%	55	13.0%	76	17.8%
Pembina	232	11.0%	155	9.5%	167	10.6%
Pierce	142	12.8%	107	11.2%	37	4.3%
Ramsey	546	18.3%	403	16.7%	429	17.8%
Ransom	159	10.9%	178	13.2%	185	14.4%
Renville	85	14.1%	30	5.9%	58	11.0%
Richland	375	8.6%	323	8.8%	512	14.8%
Rolette	1,948	39.5%	1,861	41.5%	2,159	47.5%
Sargent	102	8.9%	97	10.5%	58	6.9%
Sheridan	90	24.9%	56	31.1%	41	25.9%
Sioux	718	45.2%	866	58.4%	881	59.3%
Slope	34	17.2%	15	9.3%	16	10.5%
Stark	688	12.1%	645	12.9%	401	7.6%
Steele	54	8.9%	32	7.1%	25	6.6%
Stutsman	647	13.3%	625	14.5%	610	14.5%
Towner	70	10.0%	80	17.1%	47	8.9%
Traill	204	9.8%	195	10.9%	244	13.6%
Walsh	384	12.6%	271	10.8%	376	15.5%
Ward	2,011	13.3%	1,771	13.0%	2,244	15.6%
Wells	129	11.3%	101	12.5%	85	10.8%
Williams	868	17.1%	470	9.7%	542	10.3%

Note: *Poverty status is determined for all persons except institutionalized persons, persons in military group quarters and in college dormitories, and children under 15 years old in non-relative based foster care settings. Established in the 1960s, the official poverty measure is a specific dollar amount that varies by family size but is the same across the continental U.S. It was based on research indicating that families spent about one-third of their incomes on food. The official poverty level was set by multiplying food costs by three. Since then, the same figures have been updated annually for inflation but have otherwise remained unchanged. For more information on how poverty is measured, visit https://www.census.gov/hhes/www/poverty/about/overview/measure.html.

Part of testimony #1 #3

National Conference of State Legislatures

LEGISBRIEF

BRIEFING PAPERS ON THE IMPORTANT ISSUES OF THE DAY

NOVEMBER 2013

VOL. 21, NO. 44

Healthy Women, Healthy Babies

By Alice Wheet

Seven of the top 20 most expensive conditions requiring hospital stays covered by Medicaid in 2011 were related to pregnancy and births. New data show that Medicaid paid for about 45 percent of all births in 2010, a nearly 4 percent increase since 2008. With such a large amount of state funds paying for childbirth and infant care, state lawmakers are turning their attention to improving infant health and saving money.

Costs for delivery, hospitalization and other care for preterm babies (born before 37 completed weeks of pregnancy) and low-birthweight infants (less than 5.5 pounds) can be significantly more than those for normal-weight babies born full term. The average hospital cost in 2011 was $21,500 for a preterm birth, $27,200 for a low-birthweight birth and $76,700 for a very low-birthweight birth (less than 3.3 pounds). In comparison, the average hospital cost for a newborn was $3,200, according to the Agency for Healthcare Research and Quality. In addition, preterm and low-birthweight babies are at higher risk of infant death, as well as long-term physical and developmental disabilities.

States and the federal government are using preventive strategies to decrease the risk of complications and birth-related costs. They are doing so by focusing not only on high-quality, early prenatal care, but also by promoting women's health before and between pregnancies.

Did You Know?

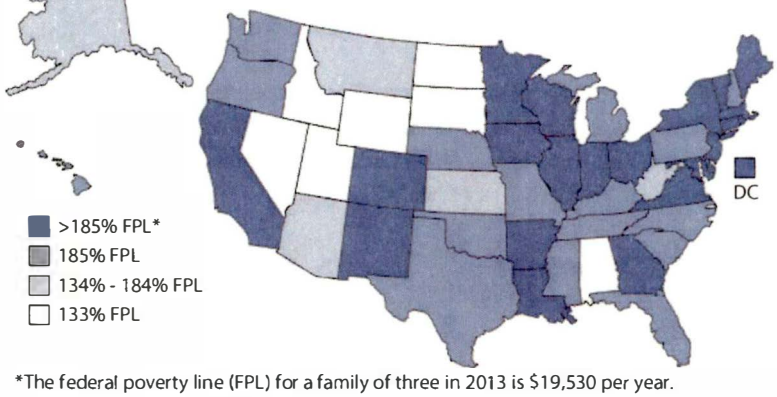
- Medicaid paid for about 45 percent of all births in the United States in 2010.
- Preventive health care for women of reproductive age has been shown to reduce risky behaviors and treat chronic conditions, in turn reducing the risk of expensive pregnancy complications and improving infant health.
- Prenatal care provides health care services for pregnant women, "preconception" care provides pre-pregnancy services, and "interconception" care counsels women between pregnancies.

State Action

Medicaid and the Children's Health Insurance Program (CHIP) are the predominant state-administered programs—jointly funded by the federal government and states—that finance and deliver prenatal care for low-income pregnant women.

State Medicaid programs must cover pregnant women with incomes of up to 133 percent of federal poverty guidelines ($15,282 for an individual in 2013). States have the option to increase the income eligibility level; 38 states and the District of Columbia have expanded Medicaid or CHIP eligibility for pregnant women with incomes of 185

Eligibility for Pregnant Women in Medicaid/CHIP by Income, January 2013



*The federal poverty line (FPL) for a family of three in 2013 is $19,530 per year.
Source: Kaiser Family Foundation.

National Conference of State Legislatures

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percent of poverty ($21,256 for an individual) or greater as of January 2013. At least 31 states and the District of Columbia have established "presumptive eligibility" under Medicaid, which allows pregnant women to access prenatal care services while eligibility is determined. Medicaid requires that pregnant women receive coverage for care related to pregnancy and delivery, follow-up care for 60 days after birth and, since 2010, smoking cessation benefits.

At least three states—Alabama, Georgia and Louisiana—have used waivers specifically to provide "interconception" care (between pregnancies) under Medicaid, targeting women who previously gave birth to a preterm or low-birthweight infant or had other complications, and who may be losing coverage postpartum or are otherwise ineligible for Medicaid. Such programs usually provide case management services to encourage participating women to establish a primary provider to manage their health needs, as well as other services to help them achieve their desired spacing between pregnancies.

Under the Affordable Care Act (ACA), states have the option to expand Medicaid eligibility to all adults with incomes up to 138 percent of poverty, including women of reproductive age. The ACA requires insurance plans to cover not only maternity care but also certain preventive services without cost sharing (such as copayments or co-insurance), including well-woman visits. These efforts are designed to help ensure that women are healthy before they become pregnant.

States have also crafted a number of innovative programs to improve prenatal and "preconception" (before pregnancy) care. The Preconception Health Council of California is a public-private partnership for preconception health activities in the state, providing information and guidelines for the public, peer educators and health professionals. A statewide pregnancy medical home program in North Carolina offers a system of coordinated, comprehensive prenatal care and other services for pregnant women in Medicaid, including case management. Pregnancy medical home providers agree to adhere to specific guidelines in exchange for financial incentives, such as receiving an additional fee per patient. Less than a year after the launch of the program, preliminary data indicate fewer emergency room visits by pregnant women and less use of neonatal intensive care units.

Federal Action

In addition to Medicaid and CHIP, a number of federal programs provide services and support for women during pregnancy and reproductive years. For example, the Title V Maternal and Child Health Services Block Grant supports state efforts to promote the health of women, children and families.

In 2012, the Maternal and Child Health Bureau launched the Collaborative Improvement and Innovation Network (COIIN) to Reduce Infant Mortality. This public-private partnership has identified several strategies to improve the health of pregnant women and infants, including expanding access to interconception care through Medicaid waivers.

The Centers for Disease Control and Prevention (CDC) funded a peer-to-peer learning program in 2010 for seven state Medicaid agencies to work toward improving primary and interconception care for women enrolled in Medicaid. As a result of the program, participating state agencies produced a policy checklist for state leaders.

NCSL Contact

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Additional Resources

Strong Start, Centers for Medicare and Medicaid Services

CDC Show Your Love preconception health campaign

Medicaid and CHIP Eligibility Table by State

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Federal Standards for Medicaid

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CONTACT

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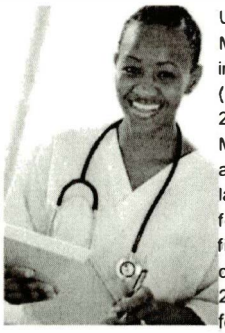

Under the new federal health reform legislation, Medicaid will be expanded to all Americans with incomes up to 133 percent of federal poverty guidelines ($29,327 a year for a family of four in 2010) effective in 2014. This represents a significant change for state Medicaid programs, which will expand to cover additional people who do not currently qualify. The new law provides states with 100 percent federal financing for all those who are newly eligible for Medicaid for the first three years through 2016. The federal match decreases to 95 percent in 2017; 94 percent in 2018; 93 percent in 2019 and 90 percent for 2020 and beyond. Currently the states share the cost of the Medicaid program with the federal government. The federal government share, called the federal medical assistance percentage or FMAP, is calculated based on a three-year average of state per capita personal income compared to the national average. A state with average per capita personal income receives an FMAP of 55 percent; no state may receive less than 50 percent.

The Children's Health Insurance Program (CHIP), provides insurance for certain children who are ineligible for Medicaid but cannot afford private insurance. States receive a higher federal match to pay for CHIP coverage than for their Medicaid programs. This match can either be used to create a separate CHIP program or to create an expansion of the state's Medicaid program, which raises the Medicaid eligibility level for children.

Listed below are the Medicaid (M) and CHIP (C) eligibility levels for eligible populations in each state as of **July 1, 2010**.

State	Infants % FPL	Children 1-5 % FPL	Children 6-19 % FPL	Pregnant Women % FPL	Parents of Medicaid Eligible kids % FPL	Childless Adults % FPL
Federal Minimum level	133	133	100	133	N/A	N/A
Alabama	133 M 300 C	133 M 300 C	100 M 300 C	133	24	
Alaska	175 M+	175 M+	175 M+	175	81	
Arizona	140 M 200 C	133 M 200 C	100 M 200 C	150	106	110
Arkansas	200 M+	200 M+	200 M+	200	200#	200#
California	200 M 250 C	133 M 250 C	100 M 250 C	200	106	
Colorado	133 M 205 C	133 M 205 C	100 M 205 C	200	66	
Connecticut	185 M 300 C	185 M 300 C	185 M 300 C	250	300#	**
Delaware	200 M	133 M 200 C	100 M 200 C	200	121	110
Florida	200 M	133 M 200 C	100 M 200 C	185	53	
Georgia	200 M 235 C	133 M 235 C	100 M 235 C	200	50	
Hawaii	300 M+	300 M+	300 M+	185	200#	200# (closed)
Idaho	133 M 185 C	133 M 185 C	133 M 185 C	133	185#	185#

NAVIGATE

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Other Research Topics

Illinois	200 M	133 M 200 C	133 M 200 C	200	185	
Indiana	200 M 250 C	150 M 250 C	150 M 250 C	200	200#	200# (closed)
Iowa	300 M	133 M 300 C	133 M* 300 C	300	250#	250#
Kansas	150 M 241 C	133 M 241 C	100 M 241 C	150	32	
Kentucky	185 M 200 C	150 M 200 C	150 M 200 C	185	62	
Louisiana	200 M 250 C	200 M 250 C	200 M 250 C	200	25	
Maine	200 M	150 M 200 C	150 M* 200 C	200	206	100# (closed)
Maryland	300 M+	300 M+	300 M+	250	116	116#
Massachusetts	200 M 300 C	150 M 300 C	150 M 300 C	200	133#	100#
Michigan	185 M 200 C	150 M 200 C	150 M 200 C	185	64	
Minnesota	280 M+	275 M+	275 M+	275	275#	
Mississippi	185 M 200 C	133 M 200 C	100 M 200 C	185	44	
Missouri	185 M 300 C	150 M 300 C	150 M 300 C	185	25	
Montana	133 M 250 C	133 M 250 C	133 M 250 C	150	56	
Nebraska	200 M+	200 M+	200 M+	185	58	
Nevada	133 M 200 C	133 M 200 C	100 M 200 C	185	200#	
New Hampshire	300 M	185 M 300 C	185 M 300 C	185	49	
New Jersey	200 M 250 C	133 M 250 C	133 M 250 C	200	200	
New Mexico	235 M+	235 M+	235 M+	235	250#	250# (closed)
New York	200 M 400 C	133 M 400 C	100 M 400 C	200	150	100
North Carolina	200 M	200 M	100 M 200 C	185	49	
North Dakota	133 M 160 C	133 M 160 C	100 M 160 C	133	59	
Ohio	200 M+	200 M+	200 M+	200	90	
Oklahoma	185 M+	185 M+	185 M+	185	200#	213#
Oregon	133 M 300 C	133 M 300 C	100 M 300 C	185	185#	185#
Pennsylvania	185 M 300 C	133 M 300 C	100 M 300 C	185	34	
Rhode Island	250 M+	250 M+	250 M+	250	181	
South Carolina	185 M 200 C	150 M 200 C	150 M 200 C	185	89	
South Dakota	140 M 200 C	140 M 200 C	140 M 200 C	133	52	
Tennessee	185 M 250 C	133 M 250 C	100 M 250 C	250	$55,000/year#	$55,000/year#
Texas	185 M 200 C	133 M 200 C	100 M 200 C	185	26	
Utah	133 M 200 C	133 M 200 C	100 M 200 C	133	44 150#	150#
Vermont	225 M	225 M	225 M	200	191~#	160~#

	300 C	300 C	300 C			
Virginia	133 M 200 C	133 M 200 C	133 M 200 C	200	29	
Washington	200 M 300 C	200 M 300 C	200 M 300 C	185	74	
West Virginia	150 M 250 C	133 M 250 C	100 M 250 C	150	33	
Wisconsin	300 M+	300 M+	300 M+	300	200#	200#^ (closed)
Wyoming	133 M 200 C	133 M 200 C	133 M 200 C	100	52	
District of Columbia	300 M+	300 M+	300 M+	300	207	211#**

*** These states are rolling elgible individuals from a state-only funded program into the early Medicaid expansion option offered through the Affordable Care Act, more information to come.*
 # Waiver program, limited coverage program, and/or premium assistance program.
M Medicaid offers coverage to children up to this percentage of the federal poverty guidelines.
M+ State's Medicaid program has a CHIP expansion.
C State has a separate CHIP program offers coverage to children up to this percent of the federal poverty guidelines.
** Children up to age 21 are eligible.*
~ The state also has a premium subsidy plan, called Catamount Health that is offered to parents and childless adults up to 300 percent of the federal poverty guidelines.
^ Wisconsin offers a more limited coverage plan called the BadgerCare Plus Core Plan for Childless Adults which is currently at maximum capacity and is closed for enrollment. The governor has a 2010 bill to allow those on this waiting list to fully purchase the coverage.

Federal Standards for Medicaid

Categorically eligible populations:

Pregnant women up to 133 percent of federal poverty guidelines.

Infants under age one are covered if their mother is on Medicaid at the time of birth or up to 133 percent of federal poverty guidelines; children ages 1 through 5 are covered up to 133 percent; and children ages 6 through 18 are covered up to 100 percent.

Parent/guardian below Aid to Families with Dependent Children (AFDC) levels in 1996. There is no federal standard for income eligibility for this group. (National average of approximately 40 percent of federal poverty guidelines).

People who receive Supplemental Security Income (SSI) due to a disability.

Children who are adopted or in foster care are covered.

Low-income recipients of Medicare are eligible. Once enrolled these people are known as "dual-eligible" enrollees.

Federal Matching Funds

In addition to these mandatory coverage categories of people, several optional populations can be covered with federal matching funds:

Infants and pregnant women up to 185 percent of federal poverty guidelines.

Parents of eligible children.

Medicare recipients at higher income levels than required.

Those who have high medical expenses relative to their income.

Those with disabilities but who would lose eligibility based on income.

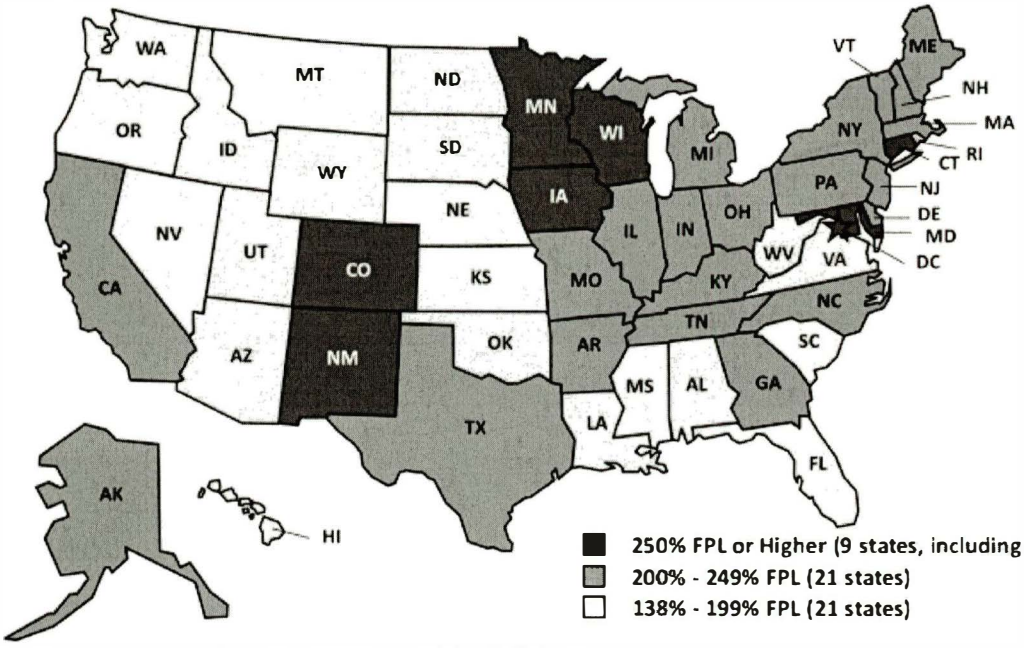
Low-income, uninsured women diagnosed with breast or cervical cancer by the National Breast and Cervical Cancer Early Detection Program can be covered for cancer-related treatment.

Through the Children's Health Insurance Program (CHIP), children can be covered, through Medicaid, up to 200 percent of federal poverty guidelines.

part of Testimony #1 #5

Figure 2

Eligibility for Pregnant Women in Medicaid/CHIP by Income, April 2014



NOTE: Thresholds include the standard 5 percentage point of the FPL disregard.
SOURCE: Based on data from the Centers for Medicare and Medicaid Services, available at http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html as of January 1, 2014.

THE HENRY J. KAISER FAMILY FOUNDATION

Figure 2: Eligibility for Pregnant Women in Medicaid/CHIP by Income, April 2014

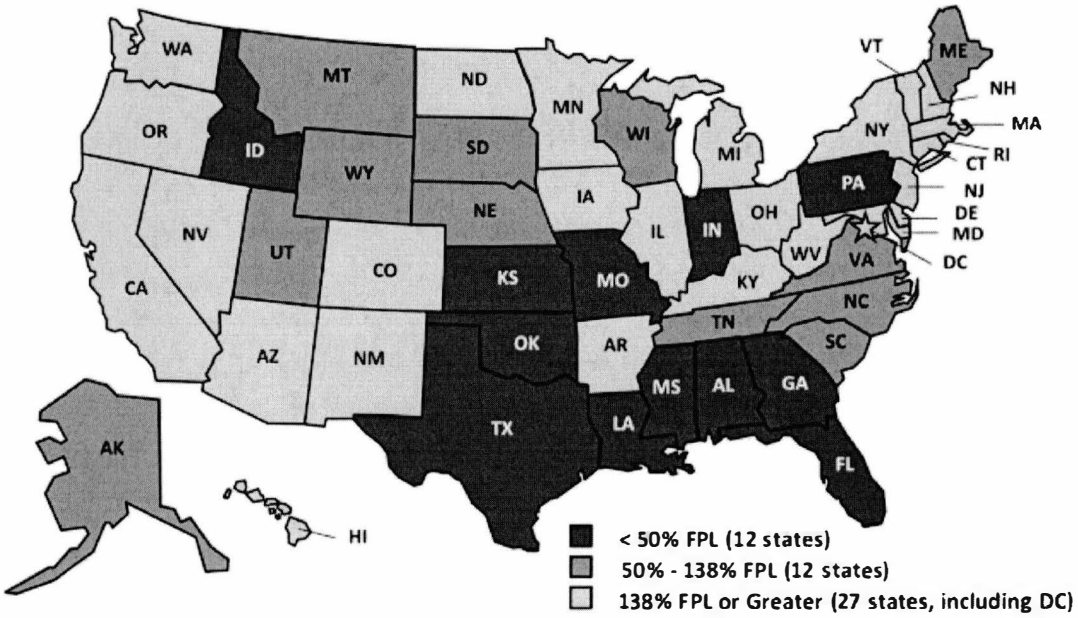
The Medicaid expansion significantly increased eligibility for adults in the 27 states implementing the expansion. Prior to 2014, 15 of the 27 states implementing the Medicaid expansion already covered parents at or above the poverty level through Medicaid, but only nine (9) states provided full Medicaid coverage to adults without dependent children. In the states implementing the Medicaid expansion in 2014, eligibility levels increased for parents in 16 states and for childless adults in 24 states. Overall, in these states, the median eligibility threshold for parents rose from 106% in January 2013 to 138% FPL as of April 2014, while the median threshold for childless adults jumped from 0% to 138% FPL. As of April 2014, three (3) states (CT, DC, and MN) cover parents above 138% FPL and two (DC and MN) cover childless adults above this level.

Many poor adults remain ineligible for coverage in the 24 states not expanding Medicaid at this time. As of April 2014, eligibility levels for parents are below poverty in 20 of these states and below half of poverty in 12 states (Figure 3, Table 3-3A), and childless adults generally remain ineligible for Medicaid at any income level (Figure 4, Table 3). Overall, among the 24 states not implementing the

Medicaid expansion at this time, the median eligibility level for parents is just 49% FPL, with only four (4) states (AK, ME, TN, and WI) covering parents with incomes at or above poverty. Only Wisconsin is providing full Medicaid coverage to adults without dependent children. Parents and other adults with incomes above these limited Medicaid eligibility levels but below 100% FPL fall into a coverage gap; they remain ineligible for Medicaid but do not earn enough to qualify for the premium tax credits for new Marketplace coverage. This gap leaves nearly five million uninsured adults without a new coverage option.[4]

Figure 3

Medicaid Eligibility for Parents of Dependent Children by Income, April 2014



Thresholds include the standard 5 percentage point of the FPL disregard. MI does not plan to implement the Medicaid expansion until April 2014. WI received approval for a waiver to provide full coverage to parents up to 100% FPL as of April 2014.
SOURCE: Based on data from the Centers for Medicare and Medicaid Services available at http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html as of April 1, 2014.

THE HENRY J. KAISER FAMILY FOUNDATION

Figure 3: Medicaid Eligibility for Parents of Dependent Children by Income, April 2014

#2

House Human Services Committee
HB1291
January 26, 2015

Good morning, Chairman Weisz and members of the House Human Services Committee. My name is Renee Stromme, and I am the Executive Director of the North Dakota Women's Network. Thank you for the opportunity to testify in support of House Bill 1291.

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

NDWN believes strongly that women need access to medical care in order to have healthier lives for themselves and their children. I am here today to testify in favor of HB 1291, which would increase medical assistance eligibility to low-income pregnant women at a rate of 200% of Federal Poverty Level. A woman at the 200% of Federal Poverty Level makes less than $23,340 per year. The average cost of a low-risk pregnancy for delivery alone is $6,000-$7000 – nearly a third the income of a woman at 200% of poverty. Complications and a cesarean-section can increase that cost to $15,000.

Prenatal care is vital for all pregnant women. Coverage is necessary for that care to occur. Women who see a health care provider regularly during pregnancy have healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems related to pregnancy. For the health of women and their children, increasing access to prenatal care is vital. According to research on the cost-benefit analysis of prenatal care, each dollar spent on prenatal care could save up to $3.33 more in neonatal care (Guttmacher).

Thank you for allowing me to speak to you this morning. The North Dakota Women's Network strongly urge you to pass SB 1291. I will answer any questions.

Renee Stromme
Executive Director
North Dakota Women's Network

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#3

Testimony from

Rebecca Matthews

House Bill No. 1291

January 26,2015

Rep Weisz and members of the House Human Services Committee, I am Rebecca Matthews. I am here to speak in favor of House Bill 1291 and 1295.

I am a mother to four living children and stillborn twins. I understand the value and need of family planning and prenatal care. At the age of 22 I was diagnosed with high blood pressure. Family planning was very important to my husband and me because we wanted to make sure I was in good health and also that I switched to a high blood pressure medication that was safe during pregnancy. In addition I had additional ultrasounds to check for fetal growth and health. Because of my access to prenatal care, my 1st born was born 6 weeks early but without monitoring he would not have survived.

To add to the need for prenatal care is cost of a high risk pregnancy. When I was pregnant with our twins, which was a high risk pregnancy, we had to fly to a fetal care center in OH. The cost of the flight, hotel, and medical bills for testing was very expensive. Upon returning home we needed weekly visits with a maternal-fetal specialist; however, there are NO maternal- fetal specialists in the state of ND. We lost the twins before those visits started, but we feared the cost and stress on our family.

These are my experiences with family planning and pregnancy. However, my husband and I are blessed to have health insurance and my husband makes a very good living. For many families in ND proper prenatal care puts into question their ability to put supper on the table or afford a doctor visit. To imagine something as simple as diagnosing gestational diabetes or eclampsia would not happen and could lead to death to a women and a child is unacceptable to me.

In an even more difficult situation would be a high risk pregnancy with need to travel to see specialists. The cost of travel, lodging, and missed work may be something many families financially cannot afford. I would hate to see a family not receive the prenatal care they need because they could not afford it. Or that a family is forced into bankruptcy due to the bills accrued to maintain the health of mother and child in a high risk pregnancy.

These bills provide women and families the ability to plan for pregnancies and once pregnant have prenatal care to monitor maternal and fetal health. Because isn't the end goal to have a healthy mother and a healthy baby. With that I urge a do pass for women and families in North Dakota.

Rebecca Matthews

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