Bill as Introduced

SB 436 – AS AMENDED BY THE SENATE

03/17/10 1028s

2010 SESSION

10-2853
05/10

SENATE BILL ***436***

AN ACT relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.

SPONSORS: Sen. Gilmour, Dist 12; Sen. Odell, Dist 8; Sen. Gallus, Dist 1; Sen. DeVries, Dist 18; Sen. Fuller Clark, Dist 24; Rep. Emerton, Hills 7; Rep. Rosenwald, Hills 22; Rep. Millham, Belk 5; Rep. Schlachman, Rock 13

COMMITTEE: Commerce, Labor and Consumer Protection

ANALYSIS

This bill establishes a commission relative to children's health insurance. The bill also extends the mandatory open enrollment period for employer-sponsored health insurance plans following termination of coverage under a public or private plan.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Commission Established. There is established a commission relative to children's health insurance.

2 Membership and Compensation.

I. The members of the commission shall be as follows:

(a) One member of the senate, appointed by the president of the senate.

(b) Two members of the house of representatives, appointed by the speaker of the house of representatives.

(c) One member appointed as the governor's designee.

(d) One representative of the department of health and human services, appointed by the commissioner of the department.

(e) One representative of New Hampshire healthy kids corporation, appointed by that organization.

(f) One pediatrician, appointed by the governor.

(g) One representative of New Hampshire Voices for Health, appointed by that organization.

(h) One representative of the New Hampshire Minority Health Coalition, appointed by that organization.

(i) One representative of the New Hampshire Oral Health Coalition, appointed by that organization.

II. Members of the commission shall serve without compensation, provided, however, that legislative members shall receive mileage at the legislative rate when attending to the duties of the commission.

3 Duties. The commission shall:

I. Analyze and evaluate the feasibility of implementing state options under the federal Children's Health Insurance Program Reauthorization Act of 2009. Such analysis shall include, but not be limited to, projected benefits, projected burdens, projected costs, projected savings, and federal and state financing opportunities for the options.

II. The commission shall solicit information from any person or entity that the commission deems relevant to its study.

III. Issue a report with the commission's findings, and any recommendations for legislation, by November 1, 2010.

4 Chairperson; Quorum. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Six members of the commission shall constitute a quorum.

5 Report. The commission shall report its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2010.

6 Accident and Health Insurance Policy Provisions; Open Enrollment. Amend the introductory paragraph of RSA 415:18, XII(c)(3) to read as follows:

(3) Requests enrollment within [~~30~~] ***60*** days after termination of coverage provided under a public or private health insurance or other health benefit arrangement; or

7 Effective Date. This act shall take effect upon its passage.

Amendments

Sen. Gilmour, Dist. 12
April 2, 2010
2010-1219s
05/04

Amendment to SB 436

Amend the title of the bill by replacing it with the following:

AN ACT relative to health insurance open enrollment periods and establishing a temporary commission relative to children's health insurance.

Amend the bill by replacing all after the enacting clause with the following:

1 New Section; Healthy Kids Corporation; Temporary Commission Relative to Children's Health Insurance. Amend RSA 126-H by inserting after section 9 the following new section:

126-H:10 Temporary Commission Relative to Children's Health Insurance.

I. There is hereby established a temporary commission relative to children's health insurance.

II. The members of the commission shall be as follows:

(a) One member of the senate, appointed by the president of the senate.

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III. Members of the commission shall serve without compensation, provided, however, that legislative members shall receive mileage at the legislative rate when attending to the duties of the commission.

IV. The commission shall analyze and evaluate the feasibility of implementing state options

under the federal Children's Health Insurance Program Reauthorization Act of 2009. Such analysis shall include, but not be limited to, projected benefits, projected burdens, projected costs, projected savings, and federal and state financing opportunities for the options. In the performance of its duties, the commission may solicit information and testimony from any person or entity with expertise or experience relevant to the study.

V. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Six members of the commission shall constitute a quorum.

VI. The commission shall issue an interim report of its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2010 and shall issue a final report on or before November 1, 2011.

2 Accident and Health Insurance Policy Provisions; Open Enrollment. Amend the introductory paragraph of RSA 415:18, XII(c)(3) to read as follows:

(3) Requests enrollment within [~~30~~] *60* days after termination of coverage provided under a public or private health insurance or other health benefit arrangement; or

3 Prospective Repeal. RSA 126-H:10, relative to the commission on children's health insurance and inserted by section 1 of this act, is repealed.

4 Effective Date.

I. Section 3 of this act shall take effect December 31, 2011.

II. The remainder of this act shall take effect upon its passage.

2010-1219s

AMENDED ANALYSIS

This bill establishes a temporary commission relative to children's health insurance. The bill also extends the mandatory open enrollment period for employer-sponsored health insurance plans following termination of coverage under a public or private plan.

Sen. Gilmour, Dist. 12
April 2, 2010
2010-1219s
05/04

Senate amendment adopted & converted to House amendment #1694h

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2010-1219s

AMENDED ANALYSIS

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Commerce and Consumer Affairs
April 28, 2010
2010-1694h
01/09

Amendment to SB 436

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2010-1694h

AMENDED ANALYSIS

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Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # SB 436 Date 4-6-10

Committee Commerce

**** Please Print All Information ****

Name	Address	Phone	Representing	(check one) Pro	Con
Sen. Fuller Clark			Dist. 24	✓	
SEN. GALLUS			DIST. 1	✓	
Melissa Clark	26 Putney Rd Bow	774-0126		✓	
Linda Millham	Belknap Dist 5			✓	
Vanessa Santarelli			Bi-State Primary Care	✓	
TOM BUNNELL			FHLE & RPLC	✓	
Rep. Larry Emerton			Co-Sponsor	✓	
Ellen Fineberg	2 Delta Dr. Concord NH	225-2264	Children's Alliance of NH	✓	
Rep Schlachman	Rock. #13			✓	
Angela Boyle	NH ORW Health Coalition			✓	
Lisa Kaplan Howe	NH Voices for Health 4 Park St Concord	369-4767	NH Voices for Health	✓	
Peter Ames	2 Commerce Drive #110 Bedford NH	471-4110	American Cancer Soc.	✓	
Nikki Murphy	P.O. Box 1092 Concord NH 03302		NHWL (NH Women's Lobby)	✓	
LESLIE MELBY	125 AIRPORT RD CONCORD		NH HOSPITAL ASSOC	✓	

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

PUBLIC HEARING ON SB 436

BILL TITLE: relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.

DATE: April 4, 2010

LOB ROOM: 302 **Time Public Hearing Called to Order:** 1113

Time Adjourned: 1157

(please circle if present)

Committee Members: Reps. Butler, DeStefano, Kopka, McEachern, Hammond, Nord, Winters, Meader, Gidge, Schlachman, Keans, D. Eaton, Hunt, Quandt, Belanger, D. Flanders, R. Holden, Dowling, Headd, Nevins and Palfrey.

Bill Sponsors: Sens. Gilmour, Odell, Gallus, DeVries, Fuller Clark , and Reps. Emerton, Rosenwald, Millham and Schlachman

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Sen. Peggy Gilmour, prime sponsor – Introduced bill. Read from prepared statement. Copy in file. Has an amendment she will introduce to the committee.

Katie Dunn, NH DHHS – Oversees state Medicare program. Had written testimony and read from same; copies sin file.

Tom Bunnell, Institute for Health Law at Franklin Pierce Law Center – Provided written testimony; copy in file. Supports bill.

Q: Rep. Susi Nord - Why create a redundant board?

A: Left question to be answered by NH Healthy Kids.

***Gail Garceau, President, NH Healthy Kids** – Supports the bill. Handed out written testimony. Supports bill; wants to sit on the committee.

Jackie Cowell, Early Learning NH - Supports bill. Says this is a great idea and a lead priority. Believes we really need this commission. Handed out written testimony; a copy in the file.

Olivia Zink, representing self – Supports bill. Hand written testimony and a copy is in the bile.

Angela Boyle, NH Oral Health Coalition – Supports bill. Handed out written testimony including the NH Oral Health plan Booklet.

*Nancy Pederzini, NH Voices for Health – Supports bill. NH Voices for Health and written testimony. Also represents the American Heart Assn. Read from written testimony.

*Timothy Sheedy, March of Dimes – Supports bill. Had written testimony; copy in file.

Respectfully Submitted:

James F. Headd, Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

PUBLIC HEARING ON SB 436

BILL TITLE: relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.

DATE: 4/6/10

LOB ROOM: 302 **Time Public Hearing Called to Order:** ~~1:00~~ 11:13

Time Adjourned: 1157

(please circle if present)

Committee Members: Reps. Butler, DeStefano, Kopka, McEachern, Hammond, Nord, Winters, Meader, Gidge, Schlachman, Keans, D. Eaton, Hunt, Quandt, Belanger, D. Flanders, R. Holden, Dowling, Headd, Nevins and Palfrey.

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TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

#1 Sen Peggy Gilmour - prime sponsor introduced bill. Read from prepared statement. Copy in file.
has an amendment she will introduce to the committee -

#2 Katie Dunn — NH DHHS - oversees ~~Medicaid~~ SOS to Medicare prgms. Had written testimony & read from same - Copies in file -

#3 Tom Bunnell — Institute for Health & Law of Franklin Pierce — Provided written Testimony. Copy in file - Supports Bill

Pg 2

SB 436

Q Rowe - Why create a Redundant Board.

A - Left Question to be answered by NH Healthy Kids

#4 Sara Garceau - NH Healthy Kids - handed out written testimony - President of NH Healthy Kids Supports Bill - wants to site on Ex Committee.

#5 Jackie Cowell - ~~Testify~~ - Early Learning NH - Supports Bill - Says this is a great idea and a Real important priority - believes we really need this Commission Handed out written Testimony a Copy is on File -

#6 Thomas Lienert - Represented IMF left to meeting Before Testifying

#7 Olivia Zink supports Bill Had written Testimony and a Copy is on file.

#3 - HB 436

#8 Angela Boyle - NH Oral Health Coalition -
Supports Bill - Handed out written Testimony -
Handed out the NH Oral Health plan Booklet.

#9 Nancy Pederzini - Supports Bill
NH Voices for Health Hand written Testimony - Also Represents the American Heart Assoc
Read from written testimony -

#10 Timothy Sheedy. Member of DHHS
Supports Bill - had written testimony - Copy in file -

Sub-Committee Actions

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION ON SB 436

BILL TITLE: relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.

DATE: 4-14-10

Subcommittee Members: Reps. Schlachman, Hammond and Nevins

Comments and Recommendations:
Discussion with NH Voices for Health on Katie Dunn's points in testimony. This bill is good because of bonus savings and administrative savings, prenatal coverage – is there some methodology that allows us to break even. The talk would be best handled by a commission? NH has 3½ of the required 5 to 8 requirements for federal funding. Rep. Schlachman the commission will only study the feasibility and is practical. Rep. Nevins – What do we give up in H&HS in an already stressed environment?

Amendments:

Sponsor: Rep. Gilmour — OLS Document #: 2010 ~~1219s~~ 1649h

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP), OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. Hammond

Seconded by Rep. Schlachman

Vote: 3-0

Motions: OTP, (OTP/A), ITL, Retained (Please circle one.)

Moved by Rep. Hammond

Seconded by Rep. Schlachman

Vote: 3-0

Respectfully submitted,

Rep. Chris Nevins
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

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Comments and Recommendations:

Discussion with NH Voices for Health on Katie Dunn's points in testimony. Because of ~~???~~ savings and administrative savings, ~~??~~ coverage – is there some methodology that allows us to break even? The ~~???~~ would be best handled by a commission? NH has ~~??? ??? 5 of 8 requirements~~ for federal funding. Rep. Schlachman the commission will only study the feasibility and is practical. Rep. Nevins – What do we give up in H&HS in an already stressed environment?

Amendments:

Sponsor: Rep. Gilmour — OLS Document #: 2010 1219s

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. Hammond

Seconded by Rep. Schlachman

Vote: 3-0

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. Hammond

Seconded by Rep. Schlachman

Vote: 3-0

Respectfully submitted,

Rep. Chris Nevins
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION ON SB 436

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DATE: 4-14-10

Subcommittee Members: Reps. Schlachman, Hammond, Nevins

Comments and Recommendations:

Amendments:

Sponsor: Rep. Hammond — OLS Document #: 12195

Sponsor: Rep. Nevins — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP), OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. Hammond

Seconded by Rep. Schlachman

Vote: 3-0

Motions: OTP, (OTP/A), ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: 3-0

Respectfully submitted,

Rep. {Type NAME}
Subcommittee Chairman/Clerk

Chris Nevins

4/14/10 SUB

SB 436

DISCUSSION W/ PAT VOICES FOR HEALTH ON KATIE DUNN'S POINTS IN TESTIMONY.

BECAUSE OF BONUS SAVINGS + ADMINISTRATIVE SAVINGS PREMIUM COVERAGE - IS THERE SOME METHODOLOGY THAT ALLOW US TO BREAK EVEN. THE IRR WOULD BE BEST ~~INFORMATION~~ HANDED BY A COMMISSION?

~~BE~~ PAT HAS AT 3 1/2 OF 5 of 8 REQUIREMENTS FOR FEDERAL FUNDING.

SUBCOMMITTEE - THE COMMISSION WILL ONLY STUDY THE FEASIBILITY AND IS PRACTICAL.

NEVINS - WHAT DO WE GIVE UP IN HHS IN AN ALREADY STRESSED ENVIRONMENT?

NOTES BY NEVINS

Commerce and Consumer Affairs
April 28, 2010
2010-1694h
01/09

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II. The remainder of this act shall take effect upon its passage.

2010-1694h

AMENDED ANALYSIS

This bill establishes a temporary commission relative to children's health insurance. The bill also extends the mandatory open enrollment period for employer-sponsored health insurance plans following termination of coverage under a public or private plan.

Testimony

NH CAN
New Hampshire
Child Advocacy Network

Children's Alliance of New Hampshire
Raising Our Voices for Children

Children's Alliance of New Hampshire
Two Delta Drive
Concord, NH 03301
(603) 225-2264

Written Testimony of Children's Alliance of NH
NH Child Advocacy Network (NH CAN)
Ellen Fineberg, President, Children's Alliance and Chair, NH CAN
IN SUPPORT OF Senate Bill 436
Before the House Commerce and Consumer Affairs Committee
April 6, 2010

I am providing testimony, not only as the President of the Children's Alliance of New Hampshire, but also as the Chair of the New Hampshire Child Advocacy Network (NH CAN) Steering Committee *on behalf of* Senate Bill 436. NH CAN designated this initiative as the lead Health and Wellness Priority for 2010 because of its ability to help strengthen the New Hampshire Healthy Kids Silver program.

There is a growing body of research on children's brain development and how healthy brains require healthy bodies. It is documented that prevention is the most efficient and effective approach to health care. Those children who qualify for Healthy Kids Silver receive many preventative services such as routine medical check ups that help identify potential problems and eliminate them. Expanding these services by expanding the eligible population will give more children a better start in life.

As some of you may know, one of the most prevalent health care issues for school-age children is the poor condition of their teeth and mouths. Not only is poor dental health a precursor to other health conditions such as heart attacks and diabetes, it is a major cause of pain and distraction for students in classrooms. By considering a Healthy Kids dental plan, we could prevent and/or manage these oral health problems efficiently.

New Hampshire must ensure the best start in life for all its citizens. Guaranteeing children's continuing access to quality health care is essential to creating future students, workers, and community members who can meet their challenges physically enabled, energetic and enthusiastic.

In this Council

A 2010 Priority for New Hampshire's Children

Children's Alliance of New Hampshire

Raising Our Voices for Children

New Hampshire Child Advocacy Network

NH CAN

A Program of the Children's Alliance of NH

SB 436
Improve Children's Health Insurance

What We Know

- NH Healthy Kids is a successful public-private partnership that provides over 80,000 children with access to the health care they need to learn and grow.
- Children's need for a strong Healthy Kids program is greater now than ever. As an increasing number of NH families are unable to afford health care coverage, it's our children who are most vulnerable.
- New Hampshire could be doing an even better job at covering children. New federal eligibility categories offer opportunities to extend coverage to many low and moderate income children.
- New state options involve either enhanced federal matching payments or federal performance bonuses for NH.

Why SB 436: Good Public Policy for New Hampshire's Children

- Creates study to explore new options and federal financial incentives for strengthening NH NH Healthy Kids.
- Brings state law into parity with federal law by creating a 60 day enrollment period to add children to private insurance when they lose eligibility for Healthy Kids, lessening gaps in coverage for children.

Presented by Ellen Fineberg, President

Children's Alliance of New Hampshire
Two Delta Drive, Concord, NH 03301
EFineberg@ChildrenNH.org
www.ChildrenNH.org
(603) 225-2264

Talkie Comedy

MaryLou Beaver
New England Campaigns Director
Every Child Matters

Senate Bill 436: Establishing a Commission to Explore CHIPRA Options

To the Members of the House Commerce and Consumer Affairs Committee,

I am the State Director of Every Child Matters in NH, a non-profit, non-partisan organization focused on making the needs of children and youth a state and national priority and promoting the adoption of smart policies for children, youth, and families. We are pleased to support SB 436 and believe that this bill will move NH forward in improving access to health care for the children of this state.

I am also the former director of a non-profit childcare center that served a large percentage of low and moderate income children. I am acutely aware of the need for children to have access to the health care they need to learn and grow. While NH Healthy Kids has done a tremendous job of connecting children with health providers in the state, there is still more work that needs to be done to ensure that every child has not only a medical home, but a dentist as well.

Without access to adequate health and dental care, simple problems become major ones. Uninsured children are almost five times more likely to delay medical care and four to five times as likely to go without eyeglasses or medicines. Some lose their hearing because a preventable infection was not treated. Many are not immunized against easily preventable communicable diseases.

Improved health outcomes begin with coverage for every child. The federal CHIP Reauthorization bill that was signed into law in February 2009, provides states with a number of options and financial incentives for improving access to children's health care coverage. SB 436 is the perfect vehicle to allow policy makers and stakeholders to explore these new options and make recommendations for New Hampshire that will better serve our youngest citizens.

In order to grow up healthy and strong, New Hampshire's children need the strongest Healthy Kids program the state can provide. Supporting a study commission to look at all of the options is the right place to start.

TESTIMONY FOR SB 436

I am Dr. Sol Rockenmacher, a resident of Bedford. I apologize for not being able to provide in-person testimony in support of SB 436, a bipartisan bill that seeks to ensure that New Hampshire's children have access to health care that they need. I am unable to attend today because I would not be able to reschedule patients that I am seeing while providing part-time help to my former pediatric cardiology practice at Dartmouth Hitchcock Manchester.

I will not review the specifics of the bill as I am sure this will be well covered (probably many times over) by others providing testimony. Among the important terms to me here are "bipartisan" and "access".

This is an issue that affects both sides of the aisle. As a father and grandfather I feel fortunate that my children are gainfully employed and that my grandchildren have good insurance coverage and access to a "medical home". I have friends whose families have not been so lucky and they cannot report the same favorable answers. Look to your left and right, in front of you and behind you, and, if you ask, you may hear stories of unfortunate outcomes from some of your own colleagues.

Access to health care is so important for our children. The facts are clear. Children who are healthy do better over all, especially in the classroom. I have seen this in my own experience. I have been fortunate enough to have had two careers in pediatrics, having spent my first sixteen years in primary care in Dover and the next twenty-plus years as a pediatric cardiologist with Dartmouth Hitchcock Clinic in Hanover, Lebanon and Manchester.

I am a past President of the New Hampshire Pediatric Society and from 2001-2007 was Chairman of the New Hampshire Covering Kids and Families Coalition. At one time New Hampshire could boast of being number 3 in the nation in percentage of children covered by health insurance. We have seen our ranking drop to number 13. As well, for many years we were at or near the top in ratings of most desirable places to raise one's child. I feel that this is what we want for New Hampshire, in essence to promote the "New Hampshire Way." We want to be able to continue to boost the benefits of living (and moving to) the Granite State. We want to be able to attract more businesses and the best paying jobs to New Hampshire, with the ideal goal, Pollyanna-ish that it may be, of not having to even discuss bills such as this in the future.

Thank you for your service to our state and for taking the time to review this testimony.

Sol Rockenmacher, MD
25 St. Andrews Drive
Bedford, New Hampshire 03110
603-232-3477

Georgetown University Health Policy Institute
Center for Children and Families

House Commerce and Consumer Affairs Committee
April 6, 2010

RE: SB 436, An Act relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance

Chairman Butler and members of the committee,

I want to thank Senator Gilmour as primary sponsor of SB 436 for asking me to share testimony on SB 436. My name is Tricia Brooks. Many of you know me as the founding director and President and CEO of NH Healthy Kids (NHHK) a position I held until August 2008 when I joined the faculty at the Georgetown University Center for Children and Families. CCF is a nonpartisan research and policy center within Georgetown's Health Policy Institute. Our mission is to advance and improve health coverage for America's children and families, particularly those with low and moderate incomes.

I want to commend Senator Gilmour and the bipartisan sponsors of SB 436 for recognizing the importance of the new options available to states through the 2009 reauthorization of the Children's Health Insurance Program (known as CHIPRA). This bill gives the Legislature a mechanism to formally assess how the new CHIPRA opportunities can help New Hampshire maximize access to quality, affordable coverage for children and pregnant women using the enhanced CHIP federal match rate of 65%.

New Hampshire has been very successful in assuring health coverage for children through Medicaid and the Healthy Kids programs. Nonetheless some 16,000 children in New Hampshire are uninsured and about two-thirds are currently eligible but not enrolled in the Healthy Kids Gold or Silver. CHIPRA provides new tools and incentives to enroll eligible uninsured children.

Of significance, CHIPRA provides a performance bonus to states that meet certain enrollment targets for children enrolled in Medicaid (Healthy Kids Gold) and have implemented at least five of eight specific enrollment and retention measures. Nine states qualified for over $73 million dollars in performance bonuses at the end of 2009. New Hampshire currently has three measures in place for both Healthy Kids Gold and Silver and one measure in place for just HK Gold. Had the state had at least five measures in place, it would have likely qualified for a performance bonus of more than a half million dollars in FFY 09 based on enrollment numbers posted by NHHK.

CHIPRA provides a new extremely cost-effective way to document citizenship by electronically exchanging data with the Social Security Administration (SSA). This new CHIPRA provision addresses the substantial paperwork burden placed by the Deficit Reduction Act of 2005 on states and families to document citizenship in order to qualify for Medicaid coverage. This requirement had a substantially negative impact on Medicaid as reported by NH Healthy Kids and a number of other states. The new SSA data match builds on an existing data exchange between all states and the SSA. Eighteen states are actively using or testing the system and report a success rate of over 95%, thereby eliminating the need to

handle complex citizenship paperwork requirements for almost all Medicaid applicants. And the best news of all is that the federal government will pick up 90% of any system development costs. The 10% state share of development costs will be quickly offset by savings administrative costs. California estimates that it will save $26 million per year in administrative costs with the new SSA data match.

CHIPRA has also encouraged seventeen states to taken advantage of enhanced federal funding to cover legally residing immigrant children. Coverage for pregnant women can also be expanded under CHIPRA using the enhanced CHIP match, ensuring that women whose newborns will qualify for Healthy Kids Gold get the prenatal care they need to assure a safe pregnancy and full-term delivery. In the end, this expansion is likely to pay for itself in savings for neonatal intensive care for premature newborns.

Another opportunity is for states to provide dental-only coverage to children who have private health insurance and therefore are not eligible for Healthy Kids Silver. From my tenure at NHHK, I know one of the top questions from insured families is whether they can qualify for dental coverage alone. Just two weeks ago, Iowa became the first state to provide dental-only coverage to insured families who are otherwise CHIP-eligible.

There are other CHIPRA provisions that would help New Hampshire improve its Healthy Kids programs and extend coverage to other low-income children and pregnant women. For the sake of time, I won't go into more detail but would be happy to return to discuss these opportunities with members of the study commission.

I do want to comment on one last CHIPRA provision, which is addressed as an immediate action step in SB 436. CHIPRA assures that families who lose eligibility for Medicaid or CHIP have 60 days to enroll in large group health plans regulated through ERISA. Under current New Hampshire law, families have 30 days to enroll in state regulated small group and individual coverage. I know from experience that families often request an eligibility review when they are informed they are no longer eligible for Healthy Kids, which can take some time. The extra 30 days provided by SB 436 will assure that families don't lose out on the opportunity to maintain coverage for their children in the private market and ensure consistency between state and federal law.

In closing, I commend Senator Gilmour and SB 436 sponsors for prompting the legislature to explore the numerous opportunities in CHIPRA to advance children's coverage and improve access to the Healthy Kids program and coverage for pregnant women. Poll after poll, year after year, show that Granite Staters and all Americans place an very extremely high value (generally in the 90% range) on providing health coverage to all children even if it requires additional state expenditure. SB 436 will allow New Hampshire to thoughtfully consider the new options and tools in CHIPRA to further New Hampshire's success to covering kids.

Thank you for your attention and consideration. I am happy to be a resource as you consider this and other legislation that affects access to quality, affordable health care and coverage. Please do not hesitate to contact me at 202-365-9148 or pab62@georgetown.edu.

Heart Disease and Stroke. You're the Cure.

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American Heart Association / American Stroke Association
2 Wall Street, Manchester NH 03101

April 6, 2010

House Commerce and Consumer Affairs Committee
Testimony of the American Heart Association
In Support of SB 436

Re: SB 436, AN ACT relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.

Chairman Butler and members of the committee, thank you for this opportunity to provide testimony in support of SB 436. I am Nancy Pederzini, Director of Advocacy for the American Heart Association (AHA) in New Hampshire. I appreciate this opportunity to offer support to creating a commission to review options available to New Hampshire regarding health insurance coverage for children who otherwise might not be able to access high-quality healthcare and preventive services.

The American Heart Association is working at both the federal and state levels to ensure all New Hampshire residents have meaningful, affordable healthcare coverage that provides access to needed health care services. As a mission-driven organization dedicated to reducing death and disability from cardiovascular disease and stroke, the American Heart Association knows that access to high-quality health care in childhood significantly improves cardiovascular health for life.

We are greatly concerned by the epidemic of overweight in children. Overweight children and adolescents may experience various immediate health consequences and may be at risk for weight-related health problems in adulthood. Regular healthcare checkups can help identify and prevent the development of risk factors in children for cardiovascular diseases, such as high blood pressure, high blood cholesterol and diabetes.

Congenital heart defects are the most common of birth defects in the United States, and stroke is among the top ten causes of death in children. The Children's Health Insurance Program (CHIP) helps ensure that children from low-income families who are born with these conditions are not denied the opportunity to lead healthy productive lives simply because their parents cannot afford health insurance. The AHA also supports the expansion of coverage to targeted low-income pregnant women as a way to provide essential prenatal care that can help reduce birth defects. Because all newborns of families below 300% of Federal Poverty Level are covered by Medicaid during their first year of life, expanding prenatal care coverage can help the state avoid the high cost of care for congenital heart defects.

The American Heart Association also supports the provision in SB 436 that extends the enrollment period from 30 to 60 days for parents to add their children to private insurance should their family income level rise to a point where their child is no longer eligible for NH Healthy Kids. This will help prevent possible gaps in coverage which could interrupt needed access to health care services. We also support the elimination of the 5 year waiting period for legal, immigrant children and pregnant women.

Our society benefits long term when children receive the care necessary to lead healthy and productive lives. Expansion of NH Healthy Kids can help bring peace of mind to parents who can't obtain affordable insurance – including those who have lost their jobs and employer-sponsored coverage during these challenging economic times. The commission to be created by SB 436 is a good way for NH lawmakers to take the opportunity to review these options and make recommendations that are right for New Hampshire and our most vulnerable populations.

Thank you for your consideration of this important legislation. Should you wish to reach me with questions or additional information, I can be reached at (603) 518-1555 or at nancy.pederzini@heart.org.

NEW HAMPSHIRE VOICES FOR HEALTH

American Cancer Society • American Heart Association • Early Learning, NH
Georgetown University Center for Children & Families • Granite State Organizing Project
National Alliance on Mental Illness, NH • New Hampshire AFL-CIO EAP Services
New Futures • New Hampshire for Health Care • New Hampshire Minority Health Coalition
New Hampshire Women's Lobby & Alliance • North Country Health Consortium

House Commerce and Consumer Affairs Committee
April 7, 2010
New Hampshire Voices for Health Testimony

RE: SB 436, An Act relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance

Chairman Butler and members of the committee, thank you for this opportunity to provide testimony on Senate Bill 436. NH Voices for Health is a network of consumer and advocacy organizations, individuals and small businesses allied in their commitment to securing quality, affordable health care for all in New Hampshire. The network represents over 200,000 members, consumers and constituents statewide.

NH Voices for Health is pleased to support SB 436, a bipartisan bill that will move the state forward in improving access to health care for New Hampshire children, and would welcome the opportunity to participate as a member of the proposed study commission.

New Hampshire has a long history of prioritizing health care for children. NH Healthy Kids is an incredibly successful, popular and long-standing public-private partnership that provides over 80,000 New Hampshire children with access to the health care they need to learn and grow; health care that, without Healthy Kids, they would go without. A 2007 study found that 96% of New Hampshire voters support Healthy Kids and 89% support expanding it, even if doing so would cost more state dollars.[1]

Children's need for a strong Healthy Kids program is greater than ever today. At the same time that the economy is suffering, premiums are rising faster than wages and faster than overall inflation. As a result, coverage is becoming increasingly out of reach of New Hampshire families. And, when families cannot afford health insurance, their children are at great risk. Children without health care coverage are less likely than their peers to have a usual source of health care and less likely to have access to the health care services they need to stay well and prevent significant health problems later in life.[2] Recent concerns about contagious diseases, such as H1N1, are a particular concern when children, who are frequently in contact with one another in large groups, are unable to get the health care services to prevent and treat those conditions. More broadly, without access to health care, children's ability thrive in school, develop socially and

[1] *Children's Health Coverage Survey.* The New England Alliance for Children's Health, March 2007.
[2] *Children's Health Insurance Programs in New Hampshire Issue Brief.* NH Department of Health and Human Services, January 2006.

emotionally,[3] and grow into healthy productive adults suffers when they don't have access to needed health care.

Despite the many strengths of New Hampshire Healthy Kids, we could be doing a better job of ensuring that New Hampshire children have access to the health care they need. Last year's reauthorization of the federal Children's Health Insurance Program, which provides funding for Healthy Kids Silver, provided New Hampshire with a number of opportunities to use federal funding to strengthen coverage for children.

The study commission proposed by Senate Bill 436 would allow policy makers and stakeholders to explore new the options and financial incentives for strengthening NH Healthy Kids and improving access to children's health care coverage allowed by the federal CHIP Reauthorization Act (CHIPRA) and make appropriate recommendations for New Hampshire.

The study commission would be able to explore new eligibility categories that provide opportunities and federal funding to extend coverage to low and moderate income children who are currently going without needed health care services. Among those is an option to ensure that all low and moderate income pregnant women have access to the preventive, prenatal care they need to give their children a healthy start at life. In addition, the state could consider whether to eliminate the five-year waiting period in Healthy Kids Gold and Silver that currently prevents *documented* immigrant children and pregnant women from getting the health care they need to be healthy, including health care services that prevent more severe and expensive health care needs that they currently are only able to address after the 5-year waiting period for Healthy Kids coverage expires. Finally, the study commission could make recommendations regarding the option to provide dental-only coverage to children who have no access to the oral health care that is critical to overall health and are eligible for Healthy Kids Silver – which provides comprehensive health *and* dental coverage - except for the fact that that are enrolled in private health care coverage.

Importantly, each of these options involves the enhanced CHIP federal matching payments, providing the state with 65% federal funding for implementing the options, even those that relate to Healthy Kids Gold coverage. In addition, implementing these options may result in savings to the state by providing children and pregnant women with care that can prevent more expensive long-term health care needs that may be ultimately paid for by Healthy Kids. For example, all newborns born to families with incomes below 300% of the federal poverty level are covered under Medicaid for their first year of life. If New Hampshire implements the CHIPRA option to allow more of the moms in that income bracket to get access to prenatal care, Medicaid can avoid the high cost of avoidable intensive care for infants born prematurely due to the lack of prenatal care.

The CHIP Reauthorization Act also provides states with the opportunity, support and financial incentives to enact enrollment and retention best practices that remove hurdles to obtaining care for children who are eligible for Healthy Kids Gold and Silver but are not yet enrolled due to enrollment and retention barriers. As a result these *eligible* children are left uninsured and facing

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[3] *Children's Health Insurance Programs in New Hampshire Issue Brief.* NH Department of Health and Human Services, January 2006.

barriers to needed health care. Implementing enrollment and retention best practices would streamline and make efficient procedures for the families and the state and would make New Hampshire eligible for federal performance bonus money; federal funding that New Hampshire has already qualified for as a result of our increased enrollment in Healthy Kids Gold, but is not receiving because the state has not adopted more of these best practices.

Taking into consideration the current state budget constraints, a study commission provides a sensible way to explore the cost-effectiveness of these options and make recommendations. Data and information explored by a study commission will also allow the state and stakeholders to determine which options could result in increased savings and/or administrative efficiencies for New Hampshire.

Senate Bill 436 would also ensure that children's transition from Healthy Kids to private coverage is smooth, by ensuring that parents have an adequate opportunity to enroll their children in their existing state-regulated, employer-sponsored family health insurance when the children lose eligibility for Healthy Kids. Currently, families with state-regulated insurance have a 30-day open enrollment period to add children to private insurance when they lose eligibility for Healthy Kids. When faced with their children losing health coverage, on top of all of the stresses currently facing New Hampshire families, 30 days may not be enough to learn about this option, determine how to pursue it and get a child enrolled in private coverage. Also during this time, parents would have to go through the review process to ensure the appropriateness of the determination that their child is no longer eligibility for Healthy Kids. If they are unable to do everything they need to enroll their child in their private coverage during that short window, they could have to wait up to a year for an opportunity to enroll their child during their regular open enrollment period. Such a significant gap in coverage would put their child at risk of barriers to needed health care, which could have long-term impacts on their health and development. Even brief gaps in health coverage cause people to forego or delay care, which result in preventable illnesses and put children at risk for hospitalization[4] and health problems later in life.

Recognizing the threat of gaps in coverage, the federal CHIP Reauthorization Act ensured that families have 60 days to add their children to federally-regulated, ERISA plans. SB 436 would create parity between state and federal law and ensure that all New Hampshire children have an adequate opportunity for a smooth transition from Healthy Kids to private coverage. Importantly, there is no state cost associated with implementing this option.

We ask you to please support Senate Bill 436, which allows New Hampshire to evaluate the feasibility of implementing important and beneficial new opportunities to use federal funding to build on the strength of the Healthy Kids program and ensure that children have access to the health care they need to be healthy and develop.

Thank you for your attention and consideration. We are happy to be a resource to you as you consider this and other legislation that affects access to quality, affordable health care and coverage. Please do not hesitate to call on us by contacting Lisa Kaplan Howe, Director of New Hampshire Voices for Health, at 369-4767 or lisa@nhvoicesforhealth.org.

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[4] *Program Design Snapshot: 12-Month Continuous Eligibility.* Center for Children and Families. September 2008. *http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/ceprogram%20snapshot.pdf*

March of Dimes Foundation

New England Collaborative
Telephone (401)-454-1911
Fax (401) 454-1970
jgale@marchofdimes.com

marchofdimes.com

April 6, 2010

Representative Edward Butler
House Commerce and Consumer Affairs Committee
State House
107 N. Main St., Room 302 LOB
Concord, N.H. 03301

Dear Chairman Butler and Members of the House Commerce and Consumer Affairs Committee:

March of Dimes supports passage of SB 436, an Act relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance. The mission of the March of Dimes is to improve maternal and child health by preventing preterm birth, birth defects and infant mortality can best be achieved if all women of childbearing age, infants and children have access to health insurance coverage that meets their needs.

The commission created by this bill will analyze and evaluate the feasibility of implementing state options under the federal Children's Health Insurance Program Reauthorization Act of 2009. The commission will analyze projected benefits, projected burdens, projected costs, and projected savings.

One of the new options available to states is covering pregnant women under the Children's Health Insurance Program (CHIP). Given the high federal match available through CHIP, it is advantageous for our state to cover pregnant women through this program instead of bearing the cost of uncompensated care for uninsured pregnant women and their infants. Health coverage is an important factor in determining access to maternity care. Women who receive maternity care are more likely to have access to screening and diagnostic tests that can help to identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors like substance abuse and poor nutrition. Such care can improve the health of both mothers and babies. Postpartum care can help women appropriately space pregnancies, thereby reducing the cost of preterm birth. Average first year medical costs are about 10 times greater for preterm than for term infants.

New Hampshire's rate of uninsured women of childbearing (age 18-44) is 13.9%. Every year March of Dimes produces a prematurity report card for each state (attached). New Hampshire received a "C" grade for 2009. Covering pregnant women under CHIP will help New Hampshire improve the health of pregnant women and children in our state. It's a short-term investment that can pay long-term dividends.

Thank you for your time. March of Dimes strongly urges you to support SB 436. If March of Dimes can be of assistance please call (603) 228-0317 or email jgale@marchofdimes.com

Sincerely,

Jeffrey K. Gale

Jeffrey K. Gale
Director of Program Services, New England Collaborative

march of dimes

Much y Dios
Timothy Sheedy

House Commerce and Consumer Affairs Committee

April 6, 2010

Testimony on SB 436: An Act relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance

Good morning, Mister Chairman and members of the committee, my name is Tom Bunnell. I am Director of the Institute for Health, Law & Ethics at New Hampshire's law school, the Franklin Pierce Law Center.

I want to thank and commend Senator Gilmour, and the bipartisan House and Senate sponsors of SB 436, for recognizing the potential importance of new options that are available to states through the 2009 reauthorization of the federal Children's Health Insurance Program (known as CHIPRA), which the President signed into law in February of this past year.

SB 436 gives the Legislature a mechanism to formally assess how these new CHIPRA opportunities can help New Hampshire to leverage additional federal dollars, and use the enhanced CHIP federal matching rate of 65%, to maximize access to quality, affordable coverage for children and pregnant women under children's Medicaid (known in New Hampshire as "Healthy Kids Gold") as well as CHIP (known as "Healthy Kids Silver").

New Hampshire has been admirably successful at assuring health coverage for children through our Healthy Kids Gold and Silver programs. Nonetheless, some 16,000 children in New Hampshire are still uninsured, and about two-thirds of those children are currently eligible but not enrolled in the Healthy Kids Gold or Silver. CHIPRA provides new tools and state financial incentives to enroll these eligible but uninsured children.

Of significance, CHIPRA provides federal performance bonuses to states that meet certain enrollment targets for children enrolled in Medicaid (Healthy Kids Gold) and that have implemented at least five of eight best practice enrollment and retention measures in Medicaid and CHIP (Silver). Nine states qualified for over $73 million dollars in performance bonuses at the end of 2009. New Hampshire currently has three of these measures in place for both Healthy Kids Gold *and* Silver and one measure in place for just HK Gold. Had our state had at least five measures in place this past year, it would have qualified for a performance bonus of more than a half million dollars in FFY 09 based on enrollment numbers posted by NH Healthy Kids.

CHIPRA also provides a new, extremely cost-effective way to document citizenship by electronically exchanging data with the Social Security Administration (SSA). This new CHIPRA provision addresses the substantial paperwork burden placed by the Deficit Reduction Act of 2005 on states and families to document citizenship in order to qualify for Medicaid coverage. This requirement had a substantially negative impact on Medicaid as reported by NH Healthy Kids and a number of other states. The new SSA data match builds on an existing data exchange

between all states and the SSA. Eighteen states are actively using or testing the system and report a success rate of over 95%, thereby eliminating the need to handle complex citizenship paperwork requirements for almost all Medicaid applicants. And the best news of all is that the federal government will pick up 90% of any system development costs. The 10% state share of development costs will be quickly offset by administrative cost savings. California estimates that it will save $26 million per year in administrative costs with the new SSA data match.

CHIPRA also has enabled seventeen states to take advantage of enhanced federal funding to cover legally residing immigrant children. Coverage for pregnant women can also be expanded under CHIPRA using the enhanced CHIP match, ensuring that women whose newborns will qualify for Healthy Kids Gold get the prenatal care they need to assure a safe pregnancy and full-term delivery. In the end, this expansion is likely to pay for itself in savings from the avoidance and prevention of neonatal intensive care for premature newborns.

Another opportunity is for states to provide dental-only coverage to children who have private health insurance and therefore are not eligible for Healthy Kids Silver. One of the top questions to Healthy Kids from insured families is whether they can qualify for dental coverage alone. Just two weeks ago, as authorized by CHIPRA, Iowa became the first state to provide dental-only coverage to insured families who are otherwise CHIP-eligible.

There are other CHIPRA provisions that would help New Hampshire improve its Healthy Kids programs and extend coverage to other low-income children and pregnant women. For the sake of time, I won't go into more detail but I am and I know others would be happy to discuss these opportunities with members of a study commission.

I do want to comment on one last CHIPRA provision, which is addressed as an immediate action step in SB 436. The federal CHIPRA Act assures that families who lose eligibility for Medicaid or CHIP have 60 days to enroll in self-insured health plans that are regulated through ERISA. Under current New Hampshire law, families have 30 days to enroll in state regulated small group and individual coverage. Families often request an eligibility review when they are informed they are no longer eligible for Healthy Kids, which can take some time. The extra 30 days provided by SB 436 will assure that families don't lose out on the opportunity to maintain coverage for their children in the private market and ensure consistency between state and federal law.

In closing, thank you for considering this legislation to explore opportunities for leveraging additional federal funds and improving access to New Hampshire's Healthy Kids program. SB 436 will allow you to thoughtfully consider the new options and tools in CHIPRA to further New Hampshire's success in covering kids.

Thank you for your attention and consideration. I am happy to be a resource as you consider this legislation. Please do not hesitate to contact me at 513-5180 or tbunnell@piercelaw.edu.

#3 Tom Bunnell

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

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Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Director

SB 436 An act relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.

Testimony of Kathleen A. Dunn, State Medicaid Director before
House Commerce and Consumer Affairs Committee
April 6, 2010 LOB Room 302

Good morning Mr. Chairman and members of the committee. My name is Katie Dunn. I am the NH Medicaid Director in the Department of Health and Human Services. Thank you for the opportunity to speak to you about SB 436 and specifically the provision calling for the creation of a commission "to analyze and evaluate the feasibility of implementing state options under the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009)."

In 1999 I worked along side of Senator Sgambati in her role as DHHS Deputy Commissioner along with Tricia Brooks, the former President of NH Healthy Kids Corp. to design and implement the Healthy Kids Silver program – also known as the NH CHIP program.

As State Medicaid Director it has been and continues to be my responsibility to administer the CHIP program consistent with state and federal regulations. It is a responsibility that I hold near and dear to my heart professionally and personally. Thus my history with this program and my commitment to it over more than a decade is substantial.

The Department does not normally take any position on the establishment of commissions. That is still the case now. However I want to share four points with you that may impact the scope and charge of the commission and/or perhaps the expectations placed on the Department.

First, the Department is well versed in the opportunities that exist under CHIPRA 2009. I have provided you with a copy of a letter (dated April 17, 2009) from CMS that outlines the mandated changes as well as the options for administrative and program expansions that exist.

If you eliminate all of the mandates and the opportunities that the NH CHIP program already has in place it leaves a short list of options that include:

- Bonus Payments for meeting specific enrollment and retention targets (page 2);
- Eligibility expansions for pregnant women, legal immigrants, non-pregnant childless adults and parents of low income children (page 3);
- Option to create "express lane" agencies for eligibility (page 5);
- Premium assistance for employer sponsored insurance (page 6); and

- Create a stand-alone dental benefit for children for children who have medical insurance but don't have access to dental insurance (page 7).

All of these opportunities create a general fund demand in order to satisfy the 35% state match requirement. At the time that CHIPRA was signed into law (February 4, 2009 = SFY 2009), my office was already engaged in preparing for the SFY 2010 and 2011 budget. We prepared estimates for the cost of expanding coverage to pregnant women and creating the stand-alone dental benefit as we felt these held the greatest potential for positive impact as well as receiving support. I included both expansions in my SFY 2010 and 2011 agency request. Policymakers had tough decisions to make and just like other new budget items that we believed were based upon sound public policy, such as an adult dental benefit – the CHIPRA opportunities were set aside due to lack of funding.

That was back in February - June 2009 – before the recession took hold and before the Department had to begin the painful process of reducing our appropriated budget for the current SFY 2010 by 8% ($43M GF) and preparing to reduce the same budget by at least another 10-11% in SFY 2011 ($75M). That totals a reduction of $118M in a 2-year period. Specifically in regards to the CHIP program, there already exists an $800,000 shortfall in the SFY 2011 CHIP budget appropriation. Which brings me to my second point: my earlier enthusiasm for any type of expansion has faded and it has been replaced with a sense of urgency and apprehension as my colleagues and I struggle to hold onto what we will have left after the SFY 10 reductions knowing that there is another $75M in additional reductions to be made in SFY 2011.

This brings me to my third point: I believe the feasibility question has been answered at least for SFY 2011, 2012 and 2013. Let me assure you if not for the lack of funding, the CHIPRA expansions previously noted would have been in place long ago and if I thought there was any chance of having additional funding in the SFY 2012/2013 budget to support the expansions, I would include them in my budget.

I would like to reiterate that the Department is not opposing the creation of the commission. I do however believe the question that the commission is suppose to answer, has been answered at least for the next 3 years. We also can't lose site of the 2014 mandate for the Department to have a significant Medicaid expansion in place, which will cover many if not all of the individuals in the CHIPRA optional groups with 100% federal funds – at least for the first 3 years. This brings me to my final point:

I believe that it is important that the expectations of the Department vis á vis participation and/or administrative support for a commission be examined and adjusted downward accordingly. The Department with its almost 500 vacancies no longer has adequate analytic or program resources to keep up with the demands of managing the current biennium's budget, preparing the SFY 2012/2013 budget – a process that has already begun and meet the demands of health care reform. I truly do not want to find the Department being criticized for disappointing commission members, as was our experience in the recent past, with our inability to be as responsive and nimble as we once were in the past. My staff and I will do our best within the confines of the resources we have available should this bill be passed.

Thank you for the chance to speak. I am happy to take any questions you may have.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid & State Operations

April 17, 2009

SHO #09-002
CHIPRA #1

Dear State Health Official:

On February 4, 2009, the President signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The law contains provisions that directly affect both the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (the Act) and the Medicaid Program under title XIX of the Act. Under CHIPRA, States will be able to strengthen their existing programs and provide coverage to additional low-income, uninsured children and pregnant women. The purpose of this letter is to provide a general overview of the key provisions in the new law, with the understanding that technical issues will be addressed in the coming weeks and months. We want to ensure that States can fully avail themselves of the new options as soon as possible, and the Department of Health and Human Services (HHS) stands ready to assist States in achieving this goal.

The Centers for Medicare & Medicaid Services (CMS) will issue a series of State Health Official and State Medicaid Director letters over the next few months to provide more detailed guidance on CHIPRA provisions. Additionally, we will be having regularly scheduled conference calls with States to listen to questions and implementation concerns related to the new law. If you have any questions regarding CHIPRA, please e-mail them to CMSOCHIPRAQuestions@cms.hhs.gov.

Funding

Sections 101 through 109 of CHIPRA amend existing provisions of the Act related to funding (specific statutory references from the Act are provided in parentheses).

Funding levels (Section 2104(a)). CHIPRA reauthorizes CHIP for four and a half years – through fiscal year (FY) 2013 -- and invests approximately $44 billion in new funding for the program.

Allotments to States (Section 2104(m)). The annual allotment formula is revised to more accurately reflect projected State and program spending. The previous allotment formula accounted for factors such as the number of low-income children and average wages in the health care industry. For 2009, the new allotment formula for each of the 50 States and the District of Columbia is determined as 110 percent of the highest of three amounts:

- Total Federal payments under title XXI to the State for FY 2008, multiplied by an "allotment increase factor" for FY 2009;
- FY 2008 CHIP allotment multiplied by the "allotment increase factor" for FY 2009; or
- The projected Federal payments under title XXI for FY 2009 as determined on the basis of the February 2009 estimates submitted and certified by the States no later than March 31, 2009.

CHIPRA also amends section 2104(e) to maintain the 3-year availability for FY 1998-FY 2008 allotments but changes to a 2-year availability for allotments beginning with FY 2009. Additionally, section 2104(f) is amended so that unexpended allotments for FY 2007 and subsequent years are redistributed to States that are projected to have funding shortfalls after considering all available allotments and Contingency Fund payments (described below).

Child Enrollment Contingency Fund (Section 2104(n)). CHIPRA establishes a "Child Enrollment Contingency Fund" that will provide payments to States that have a CHIP funding shortfall in any fiscal year through FY 2013 where enrollment exceeds target levels. A State may qualify for contingency fund payments for FY 2009 and following fiscal years if it has a funding shortfall for the fiscal year (not counting any redistributed amounts it may receive) and it has exceeded its target average number of enrollees for the State fiscal year. If both of these criteria are met for a fiscal year, the State's Contingency Fund payment for such fiscal year will equal the State's average per capita CHIP payments multiplied by the number of enrolled children above the State's target. Commonwealths and Territories are precluded from Contingency Fund payments until the Secretary has determined they have satisfactory and reliable methods for child enrollment data collection and reporting.

Bonus Payments (Section 2105(a)). CHIPRA provides "CHIP Performance Bonus Payments" (Bonus Payments) for FY 2009 through FY 2013 for purposes of providing additional funds to offset the costs of increased Medicaid enrollment. States are eligible for Bonus Payments only if enrollment and retention conditions are met as provided under new section 2105(a)(4) of the Act.

Qualifying States (Section 2105(g)). CHIPRA allows Qualifying States to use up to 100 percent of their available FY 2009 through FY 2013 allotments for Medicaid expenditures for children under age 19 who are not optional targeted low-income children, and whose family income is in excess of 133 percent of the Federal poverty level (FPL). In fiscal years prior to FY 2009, these Qualifying States could only use up to 20 percent of such available allotment funds for Medicaid expenditures and only for children whose family income level was in excess of 150 percent of the FPL.

Funding for the Territories (Section 1108(g)). Federal matching payments related to improvements to State Medicaid Management Information Systems and incentive payments for electronic health records do not apply against the Medicaid funding cap.

Eligibility under Medicaid and CHIP

CHIPRA amends the Act to add the coverage of pregnant women and legal immigrants, as well as alter the matching rate for the coverage of children in families with incomes above 300 percent of the FPL, and the coverage of non-pregnant adult populations under CHIP demonstrations (per sections 111, 214, 114, and 112 respectively).

Pregnant Women (Section 2112). CHIPRA gives States the option to provide coverage to targeted low-income pregnant women under the CHIP State plan if certain conditions are met. Infants born to these women are automatically eligible for Medicaid or CHIP, through age one. States may choose to apply presumptive eligibility to these pregnant women under CHIP.

Legal Immigrants (Sections 1903(v) and 2107(e)(1)). CHIPRA provides States the option to extend Medicaid/CHIP coverage to qualified alien children and/or pregnant women who are residing lawfully in the United States (such as, for example, lawful permanent residents) and who have not met the 5-year waiting period or "5-year bar" otherwise required under sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as long as the individuals are otherwise eligible for such assistance). Therefore, States now have the option to cover legal immigrant children and/or pregnant women under CHIP and Medicaid during this initial 5-year period.

Children in Families with Income Above 300 Percent FPL (Section 2105(c)). CHIPRA provides that, beginning with FY 2009, the regular Medicaid Federal Medical Assistance Percentage (FMAP) will apply for expenditures for children in families with incomes in excess of 300 percent of the FPL (determined without regard to the application of a general exclusion of a block of income that is not determined by type of expense or type of income). For States that, as of February 4, 2009 (the date of enactment of CHIPRA), had an approved State plan or demonstration providing coverage up to this income eligibility level, or for States that had enacted a State law for such coverage, the enhanced FMAP will apply.

Non-pregnant Childless Adults and Parents of Targeted Low-income Children (Section 2111). CHIPRA prohibits new demonstrations for childless adults and terminates existing demonstrations for coverage of childless adults funded through CHIP by December 31, 2009. If a current demonstration would expire prior to that date, an extension is available through December 31, 2009, only if requested by September 30, 2009. Under CHIPRA, States with existing demonstrations may also request, by September 30, 2009, a Medicaid demonstration project that meets statutory budget neutrality standards for continued funding and coverage.

Existing CHIP demonstrations that provide coverage for parents may continue through September 30, 2011. If a State has a demonstration that would expire before October 1, 2011, the State may request an automatic extension of the demonstration through September 30, 2011. The enhanced FMAP is available under title XXI of the Act for coverage of parents under these conditions for the third and fourth quarters of FY 2009, FY 2010, and FY 2011.

CHIPRA then provides payments through a block grant for existing demonstrations covering parents through FY 2012 or FY 2013, subject to the existing demonstration terms and conditions. The Secretary shall set aside an amount equal to the Federal share of 110 percent of the State's projected demonstration expenditures for parents that the State has certified were enrolled in the demonstration as of August 31 of the preceding fiscal year. For fiscal year 2013 the amount set aside shall be computed separately for: the period beginning on October 1, 2012 and ending on March 31, 2013 and the period beginning on April 1, 2013 and ending on September 30, 2013. States will only receive enhanced FMAP for existing parent demonstrations in FY 2012 or FY 2013 if significant child outreach, as defined under CHIPRA, has been achieved.

CHIPRA also does not allow States with existing parent demonstrations to increase the income eligibility level applied as of the date of CHIPRA enactment or February 4, 2009.

Presumptive Eligibility (Sections 1902(e)(4) and 2105(a)(1))

Effective with the quarter beginning April 1, 2009, no Federal matching funding for presumptive eligibility expenditures for Medicaid children under section 1920A of the Act will be deducted from the CHIP allotment.

Match Rate for Medicaid Expansion Expenditures

CHIPRA gives States the option to claim expenditures for Medicaid expansion populations under section 1905(u) of the Act, at the enhanced FMAP using title XXI funds or at the regular FMAP rate using title XIX funds. Under section 2105(a), only expenditures for such populations that the State has elected to claim at the enhanced FMAP are applied against a State's available CHIP allotment.

Outreach and Enrollment

Sections 201 through 203 of CHIPRA provide for increased outreach and enrollment efforts through grants, outreach to Indians, and express lane eligibility.

Outreach Funding (Sections 2113 and 2105(a)(1)). CHIPRA provides $100 million over five years to fund outreach and enrollment efforts that increase coverage of eligible children in Medicaid and CHIP. Ten percent of the funds are for a national enrollment campaign and another 10 percent are set aside for grants to Indian Health Service providers and Urban Indian organizations. Grants may be provided to State, local, and tribal governments, Federal health safety net organizations or other consortia serving children under a Federally-funded program, elementary or secondary schools, and non-profit and faith-based organizations.

Also, section 201(b) of CHIPRA provides enhanced administrative funding for translation or interpretation services under CHIP and Medicaid, equal to 75 percent for Medicaid and the greater of 75 percent or the sum of the enhanced FMAP plus five percentage points for CHIP. The funds are for services in connection with the enrollment

of, retention of, and use of services by children of families for whom English is not their primary language.

Outreach to Indians (Section 1139). CHIPRA requires the Secretary of HHS to encourage States to increase enrollment of Indians, whether living on or off tribal lands, into Medicaid and CHIP. States are encouraged to increase outstationing of eligibility workers and enter into agreements with the Indian Health Service and Tribes to provide outreach, translation services, and education regarding Medicaid and CHIP.

Express Lane Option (Sections 1902(e), 2107(e)(1), 1902(dd), and 1942). The new law allows States to use findings from a specified public agency, to be known as an "Express Lane" agency (e.g., public agencies that determine eligibility for TANF, Food Stamps, National School Lunch, etc.) to evaluate a child's initial eligibility or renewal status for Medicaid or CHIP.

Citizenship Documentation Requirements (Sections 1902, 1903(x) and 2105(c)).

CHIPRA modifies the Deficit Reduction Act of 2005 (DRA) Medicaid citizenship documentation requirements and extends those requirements to CHIP. Effective as if included in the DRA, the new law specifies that documentation from a Federally-recognized Tribe (such as a Tribal enrollment card or certificate of degree of Indian blood) is satisfactory evidence of citizenship and identity. For Tribes having an international border, and whose membership includes non-U.S. citizens, the Secretary is directed to issue regulations as to what documentation will be satisfactory. Until such regulations are effective, however, those from cross-border Tribes may use Tribal enrollment/membership documents for purposes of proving both citizenship and identity.

Also effective as if included in the DRA, States are directed to provide individuals a reasonable opportunity to present satisfactory documentary evidence of citizenship, after a declaration of such citizenship has been made.

Additionally, effective January 1, 2010, States are offered an alternative to meeting the citizenship verification requirements by asking the Social Security Administration to verify names and Social Security numbers and the declaration of citizenship provided by Medicaid and CHIP applicants and recipients. Individuals are given an opportunity to resolve any inconsistencies, or provide documentation of citizenship, before being disenrolled. Certain payments must be returned by the State if a threshold percentage of individuals are erroneously provided Medicaid/CHIP using the alternative process.

Interstate Coordinated Enrollment and Coverage Process (No Specific Reference in the Act)

Section 213 of CHIPRA requires the Secretary of HHS to consult with State Medicaid and CHIP directors and other stakeholders to develop a model process for the coordination of enrollment, retention, and coverage under Medicaid and CHIP of children who frequently change their State of residency because of family migration, emergency evacuations, or educational needs.

Premium Assistance for Employer Sponsored Insurance

Premium assistance subsidies, outreach, and the provision for a special enrollment period under group health plans are described under sections 301, 302, and 311 of CHIPRA.

Premium Assistance Subsidies (Sections 2105(c) and 1906A). CHIPRA allows States to offer premium assistance subsidies to CHIP and Medicaid-eligible children who have access to qualified employer-sponsored insurance to which the employer contributes at least 40 percent of the premium cost.

Outreach, Education, and Enrollment related to Premium Assistance (Section 2102(c)). CHIPRA adds a requirement for States electing to offer premium assistance that they educate eligible families and their employers about the availability of this option, and assist families in enrolling their children in such subsidies.

Special Enrollment Period under Group Health Plans (Amends the Internal Revenue Code of 1986, the Employee Retirement Income Security Act of 1974 and the Public Health Service Act). CHIPRA amends the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act to require employer-sponsored group health plans to permit employees or their dependents to enroll in the plan if they lose eligibility for Medicaid or CHIP, or if they become eligible for premium assistance under Medicaid or CHIP. An individual who requests enrollment within 60 days of losing or becoming eligible for Medicaid or CHIP must be enrolled, even if there is otherwise no open enrollment period, and without any penalties for late enrollment.

Child Health Quality Initiatives

Child Health Quality Measures (Sections 1139A and 1903(a)(3)(A)). Section 401 of CHIPRA requires HHS to develop child health quality measures for children enrolled in CHIP or Medicaid. By January 1, 2010, the Secretary, in consultation with States, providers, and consumer groups, will identify and publish an initial core set of child health quality measures for CHIP and Medicaid. The Secretary of HHS also will develop a standardized report format for reporting information and encourage States to voluntarily report on the measures. The Secretary will disseminate to States best practices for measuring and reporting quality and will provide technical assistance to States to help them adopt and utilize quality measures.

Grants for New Measures. The new law also requires the Secretary to establish a pediatric quality measures program to strengthen the initial core quality measures, expand other measures, and develop new measures. Grants and contracts will be awarded to develop, test, validate, and disseminate new measures. Beginning January 1, 2013, and each year thereafter, recommended changes to the core measures will be published.

Demonstrations to Evaluate Quality Improvement. In addition, grants will be awarded to States and providers to conduct demonstration projects to evaluate quality improvement strategies within four categories. These demonstrations include 1) experimenting with new measures, 2) promoting health information technology, 3) evaluating provider-based models such as care management, and 4) demonstrating the impact of a model electronic health format on improving pediatric health.

Demonstrations to Reduce Childhood Obesity. CHIPRA also authorizes the awarding of demonstration projects to develop systematic models for reducing childhood obesity. These grantees shall develop a curriculum, form partnerships, and carry out community-based activities to reduce childhood obesity.

Model Electronic Health Record for Children. CHIPRA also authorizes the Secretary to develop a program to encourage the development and dissemination of a model electronic health record for children by January 1, 2010.

Managed Care Safeguards in CHIP (Section 2103(f))

Section 403 of CHIPRA adds managed care requirements, which currently are applicable to Medicaid under 1932(a)(4), (a)(5), (b), (c), (d), and (e), to CHIP. These managed care requirements include those related to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations in the same manner as such provisions are applied under Medicaid. This provision applies to contract years for managed care plans beginning on or after July 1, 2009.

Dental Benefits

Dental Benefit Packages (Section 2103). CHIPRA includes new protections to expand coverage of dental services necessary to prevent disease, promote oral health, restore health and function, and treat emergency conditions. These protections may be satisfied through a State-defined dental benefit package or through one of three dental benchmark benefit packages. These dental benchmarks are 1) the supplemental dependent dental plan most frequently selected under the Federal Employees Health Benefit Plan in the past two years (MetLife); 2) the State employee dependent dental benefit that has been selected most frequently by employees seeking dependent coverage in the past two years; or 3) the dental benefit plan provided by the State's largest insured commercial non-Medicaid plan of dependent covered lives that is offered in the State involved.

Supplemental Dental Coverage (Sections 2110(b) and 2102). States have the option under CHIPRA to offer a supplemental dental wrap-around benefit for children who receive primary care services through a parent's employer plan but for whom no dental

services are included. Children eligible for the dental-only coverage must be children who would be eligible for CHIP if they are not enrolled in an employer-sponsored insurance program. Dental-only coverage must comply with all other requirements of the statute regarding cost sharing and income eligibility level, and a State may offer such coverage only if it has no waiting list for its entire CHIP program (not just for dental coverage), and does not provide more favorable treatment for this supplemental dental benefit than for dental benefits for targeted low-income children.

Mental Health Parity (Section 2103)

Section 502 of the new law prevents States that include mental health or substance abuse services in their CHIP plans from imposing financial requirements and treatment limitations for those benefits that are more restrictive than those for medical and surgical benefits. The law, however, does not require coverage of mental health or substance abuse treatment and is effective the first plan year that begins on or after October 4, 2009.

Miscellaneous Provisions

CHIPRA also includes provisions related to payments for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) (section 503), premium grace period requirements (section 504), school-based health centers (section 505), Payment Error Rate Measurement (PERM) (section 601), and improved data collection (section 602).

Federally Qualified Health Centers and Rural Health Clinics (Section 2107(e)(1)). CHIPRA requires States with separate or combination CHIP programs to pay FQHCs and RHCs using the Medicaid prospective payment system. This provision applies to services provided on or after October 1, 2009.

Premium Grace Period (Section 2103(e)(3)). The new law requires States to have at least a 30-day grace period for individuals to make premium payments before losing their coverage. States must provide written notice and the opportunity for the family to challenge the decision before coverage is terminated.

School-Based Health Centers (Section 2103(c)). CHIPRA clarifies that States may cover CHIP services offered through school-based health centers.

Payment Error Rate Measurement (PERM) (Section 2105(c)). CHIPRA provides a 90 percent Federal match for CHIP spending related to PERM administration and excludes such expenditures from the 10 percent administrative cap. As required under CHIPRA, CMS is developing a new regulation on PERM requirements; and a CHIP payment error rate will not be published until 6 months beyond publication of the new regulation.

Improved Data Collection (Section 2109(b)). CHIPRA authorizes $20 million for the Department of Commerce to improve the Current Population Survey and the American Community Survey so that estimates are more reliable.

Again, we look forward to working with you to ensure continued success of the CHIP program in your State.

Sincerely,

/s/
Jackie Garner
Acting Director
Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

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Written Testimony of NH Healthy Kids Corporation
Gail M. Garceau, President and CEO
IN SUPPORT OF Senate Bill 436
Before the House Commerce and Consumer Affairs Committee
April 6, 2010

NH Healthy Kids Corporation supports the concept of Senate Bill 436 to establish a commission relative to children's health insurance. The federal CHIP Reauthorization Bill provides states with a number of options and financial incentives for improving access, and removing barriers to Healthy Kids programs across the country. New Hampshire Healthy Kids believes that it is worthwhile for the state to explore the pros and cons and cost-effectiveness of these options and their applicability to New Hampshire. New Hampshire Healthy Kids would be pleased to participate in a commission fully.

New Hampshire Healthy Kids also supports the technical change that would provide parents already enrolled in private health insurance coverage with 60 days to enroll their children in their state regulated policy if and when their children lost eligibility for Healthy Kids coverage, due to any increase in household income. Current state law provides a 30 day open enrollment period. The federal law provides for a 60 day open enrollment time period. This measure would create parity between state and federal law.

April 6, 2010

The Honorable Edward Butler, Chairman
House Commerce and Consumer Affairs Committee
Legislative Office Building, Room 302
Concord, NH 03301

TESTIMONY: SB 436

Honorable Members of Commerce and Consumer Affairs Committee,

Thank you for the opportunity to provide testimony in support of SB 436.

In early 2009, when I learned that I was expecting the birth of my daughter, I was working as a consultant and did not have health insurance coverage. When I looked into coverage with covers pre-natal care it was well over $800 dollars per month, which I couldn't afford. I am so thankful to receive coverage by NH Healthy Kids coverage for pregnant women.

My daughter is currently enrolled in NH Healthy Kids, and the impact the program has had for the health of my family has been extraordinary. Knowing that a doctor's appointment is more then $200 a visit, and health insurance cost are so out of reach. In November, when I started with part time as a community organizer NH Citizens Alliance for myself and my daughter (single plus child) health coverage was $945.64 per month; my contribution would be $257 per month for myself plus $389 per month for my daughter Elizabeth for a total $646 per month. This would be half of my monthly income. As the only wage earner in our house, I can't spend half of our income on health insurance coverage. But I can't afford to go without coverage.

I feel fortunate that my daughter has access to the health care she need through NH Healthy Kids Gold and I want to ensure as many children as possible have the opportunity to be healthy.

Please support health care for children by supporting SB 436. SB 436 would allow policy makers and stakeholders to explore new options and financial incentives for strengthening NH Healthy Kids and improving access to children's health care coverage allowed by the federal CHIP Reauthorization Act (CHIPRA) and make appropriate recommendations for New Hampshire.

As a community organizer for NH Citizens Alliance, NH Citizens Alliance supports SB 436.

Respectfully submitted,

Olivia Zink
350 Ash Street, Manchester, NH 03104
603-661-8621

SB 436 Testimony

Good morning. For the record, I am Senator Peggy Gilmour. I represent Senate District 12, the towns of Brookline, Hollis, Mason, and Wards 1, 2, 5, and 9 in Nashua. I am pleased to introduce Senate Bill 436.

Along with a bipartisan group of co-sponsors, I filed Senate Bill 436 because it is important that the state explore ways to take advantage of new opportunities and funds to strengthen the Healthy Kids program.

We all should be proud of NH Healthy Kids. For nearly 20 years, this successful public-private partnership has ensured that children from low and moderate income families have access to the health care they need to thrive in school and grow into healthy productive adults.

The reauthorization of the Children's Health Insurance Program (CHIP) at the federal level has provided New Hampshire a number of new opportunities to make NH Healthy Kids Gold and Silver stronger. I am not going to describe each of the options in detail. Those following me will provide specific information, but in general, the CHIP Reauthorization Act provides us with assistance to implement new enrollment and retention practices and to update our eligibility categories in both Healthy Kids Gold and Silver. Each option comes with the enhanced 65% federal funding provided for state CHIP programs. New Hampshire only needs to spend 35 cents for every dollar worth of coverage we provide.

Improving our enrollment and retention processes will also make our state eligible for federal performance bonuses.

I am acutely aware that given our current budget situation, moving any policy change that costs money, even if the vast majority of the funding is from the federal government, is incredibly difficult. That is why SB 436 will create a study commission to explore the options that would require an investment of state funds. The study commission will consider the relative benefits and burdens of implementing the options - including possible long-term savings of preventive care, and identifying potential federal and state sources that could help finance implementation of the options. NH needs to be poised to take advantage of the CHIP Reauthorization Act.

I am introducing an amendment to SB 436 today to ensure that the study commission is structured to conform with the new House rules that resulted from the commission on commissions.

SB 436 also proposes a technical change to our insurance law. The goal is to ensure that New Hampshire families with state regulated private coverage have the same 60-day open enrollment period when they lose eligibility for NH Healthy Kids as those enrolled in federally-regulated ERISA plans. The 30-days currently provided under state law is not in parity with federal law and is not adequate to ensure that children can be added to their families' coverage and not face harmful gaps in coverage. .

I appreciate your consideration of SB 436. I know our state is struggling, but so are our families. . Access to health care - critical for the health, well-being and development of our children - is becoming increasingly out of reach as health care premiums rise and families lose jobs and financial security. Creating this Commission is at least a step to enable us to move forward at the earliest possible financial moment.

Thank you. I will answer any questions, or refer you to others here who can.

NH ORAL HEALTH COALITION

April 6, 2010

To: House Commerce and Consumer Affairs Committee

Re: SB 436 *An act relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance*

Good morning Mr. Chairman and distinguished committee members,

My name is Angela Boyle I am speaking today on behalf of the NH Oral Health Coalition. The NH Oral Health Coalition is a broad representation of individuals, organizations and agencies concerned with oral health. Its members include representatives from the oral health community, the medical community, education, advocacy groups and the insurance industry. The Coalition's mission is to promote optimal oral health for the people of New Hampshire.

Many of you may be aware that tooth decay is the most common chronic childhood disease, 5 times more common than asthma. The NH Oral Health Coalition understands the importance of removing known barriers between people and oral health services, a main goal outlined in the 2003 NH Oral Health Plan.

More and more science is linking oral health to overall health. We are encouraged by the efforts of this legislation which will examine the feasibility of implementing state options, including oral health care, under the Children's Health Insurance Program. SB436 is a sensible way to explore cost-effective options that will fit for New Hampshire's fiscal environment.

Children in New Hampshire deserve a healthy start in life so that they can learn and grow to their potential. **The NH Oral Health Coalition would like to offer support for SB436 as well as welcome the opportunity to participate as a member of the proposed study commission.**

Thank you for the opportunity to speak today. I would be happy to answer any questions you may have.

Respectfully,

Angela Boyle

Angela Boyle, RDH, BS
Director NH Oral Health Coalition

New Hampshire Oral Health Plan:

A Framework for Action

Coalition for New Hampshire Oral Health Action

New Hampshire Oral Health Plan:

A Framework for Action

Coalition for New Hampshire Oral Health Action

July 2003

July 2003

Dear Colleague,

Today, oral diseases affect millions of Americans and dental caries (tooth decay) is the single most common childhood disease. Too often we ignore the fact that good oral health is essential to good health overall, and fail to recognize that oral health problems contribute to other diseases such as heart disease, diabetes and stroke, and are associated with serious problems for newborns. And yet, what is most striking is that most oral disease is preventable.

The Coalition for New Hampshire Oral Health Action was convened by the Endowment for Health and the New Hampshire Department of Health and Human Services in July 2002 to develop a statewide plan to mobilize resources and combat this "silent epidemic". Representing numerous agencies, organizations and professions Coalition members assembled not just to find solutions to New Hampshire's oral health problems, but to take action to bring those solutions to life. The Coalition often engaged in intense debate before coming to consensus on a framework for action. This collaborative spirit overrode individual agendas, as members recognized that broad-based cooperation would be essential to overcoming barriers to achieving good oral health for all New Hampshire citizens. We would like to thank Coalition members for their dedication and commitment to the process.

We are also grateful for the insights and assistance from our consultants, Dr. Burton Edelstein and Dr. Caswell Evans, who generously devoted their valuable time and effort to providing the Coalition with expertise, wisdom and information from a national perspective.

Finally, we would like to thank Wendy Frosh for her numerous contributions to the process. It was Wendy who facilitated the meetings, guided the process, helped us to achieve consensus, and ultimately pulled together the vision of Coalition members into this plan.

The work of the Coalition is not over. Members have committed to working on the implementation of the plan, and have extended invitations to other key stakeholders to contribute to the process. The goals, objectives and strategies enumerated in this document will be the basis for a work plan with responsibilities and timelines assigned.

The Framework for Action is intended to be a "living document" – one that will be revisited and modified as implementation proceeds. We are especially pleased that the publication of this plan coincides with the release of the Surgeon General's National Call to Action to Promote Oral Health. On behalf of the Coalition for New Hampshire Oral Health Action, we invite you to join us in this critical public health initiative.

Sincerely,

William J. Kassler, MD, MPH
State Medical Director
Department of Health and Human Services

Mary Vallier Kaplan
Program Director
Endowment for Health

Coalition for New Hampshire Oral Health Action Participants

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1. Executive Summary

New Hampshire has been ranked as one of the healthiest and wealthiest states in the nation, and is seen by many as relatively homogeneous and problem free. This veneer belies the fact that access to oral health care varies greatly across the state, and oral diseases are a devastating problem among a significant percentage of New Hampshire residents, affecting their overall health and ability to work and learn. While much oral disease is preventable, many in New Hampshire lack access to the basic services that could help them avoid oral pain, infection and dysfunction, dental caries (tooth decay), tooth loss and other oral health problems. Over the past decade, efforts have been made to address these concerns with some measure of success. But these initiatives have had limited effectiveness because of the lack of a comprehensive, coordinated approach among funders and policymakers to addressing the problem.

Responding to a growing concern regarding the oral health of New Hampshire's residents, the New Hampshire Department of Health and Human Services (DHHS) and the Endowment for Health (EFH) collaboratively convened the Coalition for New Hampshire Oral Health Action in July of 2002. The Coalition accepted as its charge the task of developing a blueprint for decision-making, an oral health plan for the state.

The Coalition for New Hampshire Oral Health Action was designed to be broadly representative of the individuals and entities concerned with oral health. Its members included representatives from the oral health community, the medical community, the legislature, education, advocacy groups and the insurance industry, as well as from the New Hampshire DHHS and the Endowment for Health. Its charge was to develop a plan that would address the oral health needs of all New Hampshire residents and communities and the conditions and opportunities specific to New Hampshire, and create a model for action that would build upon the oral health improvement activities already underway across the state.

To begin the process of plan development, the Coalition embarked on an exploration of the elements that constitute the landscape of oral health. These components were categorized as Prevention, Health Promotion, Education and Counseling; Workforce; Financing; Safety Net; Integrating Functions; and Advocacy, Policy and Politics.

To encourage public input to the process, a series of six community "listening sessions" were held across the state. The goal of these sessions was to communicate about the plan development process, elicit community perspectives on local oral health problems and solutions, to prepare the ground for community implementation initiatives, and to incorporate community perspectives into the oral health plan. In addition to the research conducted within the state, the Coalition reviewed a broad spectrum of national initiatives regarding oral health, such as the Surgeon General's report, *Oral Health in America,* and *Healthy People 2010.*

Throughout the planning process, the Coalition for New Hampshire Oral Health Action operated with a set of underlying premises regarding the promotion of oral health and the provision of dental care: While health and health care are ultimately family and community considerations and New Hampshire's regions and communities have unique capacities and constraints, state level activity can support communities in improving oral health and dental care. It was determined that the resulting

plan, therefore, should not only identify a "standard" level of oral health for all residents, but should also articulate priorities for both statewide and community-level action; identify tools and resources to address oral health needs; coordinate and support existing community-based systems; and empower individuals to access and utilize available resources.

It was acknowledged by the Coalition that while there are common underlying issues and problems across New Hampshire, variation exists – in terms of unique needs, available resources and competencies – from region to region, and community to community. This means that there is the need to identify statewide initiatives that will have the capacity to benefit all communities – such as improving Medicaid reimbursement and establishing funding mechanisms for local system development – knowing that these initiatives may create different outcomes community by community.

Using the principles identified in the Surgeon General's report, *Oral Health in America,* as its framework for articulating a plan of action, the Coalition developed a vision for New Hampshire and strategies to reach that vision (the details of which follow in the body of this report). Coalition members committed to the responsibility of implementing the plan and monitoring the success of those initiatives undertaken.

It is not the intent of this report to provide a comprehensive review of the oral health status of New Hampshire's residents, nor a restatement of the scope of the problem. Instead, on the following pages, the Coalition for New Hampshire Oral Health Action offers a vision and discussion of what actions will be necessary to bring oral health and its positive impact on well-being, to the residents of New Hampshire. That there are disparities in the oral health status of New Hampshire residents is undisputed. Finding ways to reduce those disparities is the subject of this report.

Vision

Residents of New Hampshire will have the opportunity to achieve and maintain oral health through access to an effective system of health services which promotes appropriate health behaviors.

These services, which include assessment, prevention, health promotion, education, counseling, and treatment, will be provided through an integrated system of health care that assures accessibility, affordability, high quality, appropriateness to individuals' needs, and responsiveness to individuals' circumstances.

Recommendations

Principle

I. Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.

Goal

I.A. Increase public perception of the importance of good oral health as a component of overall health.

Objectives

I.A.1. Develop a statewide oral health awareness and education campaign.

I.A.2. Integrate oral health with general medical care.

I.A.3. Integrate comprehensive oral health curricula in general health curricula and promote in all New Hampshire schools.

Principle

II. Apply science effectively to improve oral health.

Goal

II.A. Assess the oral health status of New Hampshire residents.

Objective

II.A.1. Develop and maintain a comprehensive epidemiological oral health surveillance system to identify, investigate and monitor oral health and oral health services.

Goal

II.B. Reduce the burden and progression of oral diseases in New Hampshire by integrating best available science and evidence-based treatment into clinical practice and policy.

Objective

II.B.1 Access and disseminate leading edge information on oral health science.

Goal

II.C. Reduce the incidence of dental caries through evidence-based public health interventions.

Objectives

II.C.1. Maximize the benefits of fluoride in preventing and controlling dental caries.

II.C.2. Implement and maintain the capacity for a statewide school-based sealant program.

Goal

II.D. Increase early detection and reduce the incidence of oral and pharyngeal cancers.

Objective

II.D.1. Support efforts to reduce tobacco and alcohol use among New Hampshire residents.

Goal

II.E. Reduce the incidence of oral and facial injuries.

Objective

II.E.1. Recommend the requirement of the use of face-masks and mouthguards in all school and other sports programs.

Principle

III. Build an effective health infrastructure that meets the oral health needs of all and integrates oral health effectively into overall health.

Goal

III.A. Enhance the existing workforce to meet the diverse oral health needs of all New Hampshire residents.

Objectives

III.A.1. Maximize the capacity of the oral health workforce to address the needs of the population.

III.A.2. Integrate, improve, expand and sustain the oral health component of the health care safety net.

Principle

IV. Remove known barriers between people and oral health services.

Goal

IV.A. Eliminate barriers and enhance access to good oral health.

Objectives

IV.A.1. Create system-level improvements to treat high risk populations such as children, the elderly, uninsured adults, the developmentally disabled, the mentally ill and those with HIV/AIDS.

IV.A.2. Enhance the competency of the oral health workforce to treat high risk populations.

IV.A.3. Build a care coordination and case management system especially for those at high risk.

IV.A.4. Improve access to dental insurance among all sectors of the population.

Principle

V. Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

Goal

V.A. Further integrate the efforts between the public and private sectors to address the oral health needs of the residents of New Hampshire.

Objectives

V.A.1. Create a statewide clearinghouse to serve as a resource for information on existing oral health programs, technical support, funding consultation and successful public health models.

V.A.2. Promote regional and community-based collaborative efforts among agencies, organizations and individuals to address oral health needs.

V.A.3. Monitor the implementation of the New Hampshire Oral Health Plan.

V.A.4. Review and revise the New Hampshire Oral Health Plan as necessary.

2. Introduction

The Surgeon General's report, *Oral Health in America,*[1] defines oral health as more than healthy teeth, more than being free from disease. Oral health is a positive condition that is integral to general health and well-being. An individual who does not have the ability to perform certain essential functions – to speak, taste, chew and swallow – may have compromised ability to work, learn or function effectively within the community. The Surgeon General goes further to say that oral health is not only essential to general health, but can be achieved by everyone. However, while we have made substantial improvements in the nation's oral health over the past several decades, there continues to be a significant segment of the population for whom oral health remains elusive.

New Hampshire has been ranked as one of the healthiest and wealthiest states in the nation, and is seen by many as relatively homogeneous and problem free. This veneer belies the fact that access to oral health care varies greatly across the state, and oral diseases are a devastating problem among a significant percentage of New Hampshire residents, affecting their overall health and ability to work and learn. While much oral disease is preventable, many in New Hampshire lack access to the basic services that could help them avoid oral pain, infection and dysfunction, dental caries (tooth decay), tooth loss and other oral health problems. Over the past decade, efforts have been made to address these concerns with some measure of success. But these initiatives have had limited effectiveness because of the lack of a comprehensive, coordinated approach among funders and policymakers to addressing the problem.

Because of the far reaching impact of these problems, the New Hampshire Department of Health and Human Services and the Endowment for Health have both identified improving New Hampshire's oral health as a priority for action. Citing their mutual commitment to reducing the devastation of oral disease, New Hampshire DHHS and the Endowment for Health worked collaboratively to convene a statewide coalition to develop an oral health plan for New Hampshire, which would identify and prioritize the actions necessary to address the problems and serve as a blueprint for decision-making.

1. US Department of Health and Human Services. *Oral Health In America: A Report of the Surgeon General.* Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

3. The Oral Health Plan Development Process

The Coalition for New Hampshire Oral Health Action was convened by the Endowment for Health and the New Hampshire Department of Health and Human Services in July of 2002. It was designed to be broadly representative of individuals and entities concerned with oral health, and included members from the oral health community, the medical community, the legislature, education, advocacy groups and the insurance industry, as well as from the New Hampshire DHHS and the Endowment for Health. Its charge was to develop a plan that would address all New Hampshire residents and communities, the conditions and opportunities specific to New Hampshire and create a model for action that would add value to the oral health improvement activities already underway across the state.

By assembling these individuals from across New Hampshire, the conveners sought to build commitment, raise awareness and promote collaboration among key stakeholders whose participation in both the planning and implementation processes would be critical. Both the Endowment and the New Hampshire DHHS participated actively in the Coalition's proceedings on an equal footing with other invitees. Nationally-recognized oral health policy experts were retained to serve as consultants to the Coalition and an experienced facilitator and advocate for oral health service and policy issues served as Project Director and meeting facilitator. This enabled the assembled members to engage in lively and often provocative discussion. All Coalition members were asked to commit to the intensive six-month process.

Discussion at the initial session led to refinement and elaboration of the original charge. Consensus was quickly reached as the Coalition agreed to pursue the development of a plan that would address both oral health and dental care; be realistic and sustainable; capitalize on all available resources; include measurable goals and outcomes; acknowledge the unique conditions across New Hampshire; utilize the best available national and state information and data; and provide flexibility to meet local/community needs.

To begin the process of plan development, the Coalition embarked on an exploration of the elements that comprise the landscape of oral health. These components, which will be explored in more detail in the Findings section of this report, were categorized as

- Prevention, Health Promotion, Education and Counseling
- Workforce
- Financing
- Safety Net
- Integrating Functions
- Advocacy, Policy and Politics

Prevention, Health Promotion, Education and Counseling

The focus of the Coalition's discussion was on the potential for true disease prevention through widespread public and professional education regarding the importance of oral health to general health and interventions such as community water supply fluoridation and sealants. Also addressed was the opportunity for effective disease management through early intervention, education, counseling and

services designed to empower the individual to take action to promote good oral health, such as programs to reduce transmission of oral infection from mother to infant and reduce the incidence of "baby bottle decay" among infants and toddlers. As a principle, the Coalition endorsed the idea that types and intensities of interventions be matched to risk levels for disease in both individuals and populations.

Workforce

The Coalition dissected the issue of workforce adequacy, looking at current and projected numbers of oral health professionals; their types, diversity and distribution across the state; their competency training for the unique needs of the underserved populations; the potential to utilize "non-dental" providers to expand the reach of oral health services; and the interactions between and among providers of oral health services.

Financing

In this session, Coalition members examined the design and experience of the state's Medicaid fee-for-service program, Healthy Kids Gold; the State Children's Health Insurance Program (SCHIP), Healthy Kids Silver; and the managed care program, Northeast Delta Dental (NEDD) Kids. They also reviewed the commercial insurance market and self-pay components of the financing system.

Safety Net

Defining the safety net as the providers of care who have a priority commitment to deliver affordable [oral] health services to vulnerable and underserved populations; where people with economic, social and cultural barriers to care can obtain [oral] health services, the Coalition considered the experience and potential of programs delivered by Community Health Centers, school-based programs and hospital-based programs.

Integrating Functions

Coalition members explored the role of data collection, reporting and evaluation in building an accountable oral health system. Care coordination and case management were also considered as the Coalition discussed the functions that are required to link and integrate the components of an oral health system.

Advocacy, Policy and Politics

Acknowledging the essential role of advocacy, policy and politics in implementing an oral health plan, the Coalition members considered the approaches to necessary policy development and building political will to support required policy and funding changes.

Public Input to the Planning Process

A series of six community "listening sessions" were held across the state to encourage public input to the planning process. The goals of these sessions were to communicate about the plan development process, elicit community perspectives on local oral health problems and solutions, to prepare the groundwork for community implementation initiatives and to incorporate community perspectives into the Oral Health Plan. The listening sessions were held in Concord, Dover, Keene, Lancaster, Manchester and Nashua, in collaboration with community-based health consortiums, Healthy Manchester

Leadership Council, Greater Nashua Healthy Community Collaborative, Alliance for Community Health, Strafford Network, North Country Health Consortium, Monadnock Partnership and Pilot Health.

While specifics varied from locale to locale, among the observations expressed by those in attendance at these meetings several consistent themes emerged. Although these perceptions may not be validated by data, their repetition from site to site was noteworthy.

- There was a perception that the general population does not value oral health as a priority.
- Many said that populations at risk for increased incidence of oral diseases because of a lack of access to prevention and treatment include children, elderly, low income, disabled, and homeless.
- It was suggested that there is a shortage of dental personnel – dentists, hygienists, and assistants – available to treat not only the indigent and high risk populations, but also the general population, as evidenced by the fact that in many areas of the state there is a lengthy waiting period for treatment, regardless of source of payment.
- Many felt that general dentists aren't adequately trained to handle the extreme need in the indigent population and often don't know how to manage this need with the limited resources available.
- It was suggested that proposed New Hampshire legislation and regulation regarding treatment and environmental concerns may further impede access by putting constraints on dental practice.
- Many expressed concerns that business and industry do not recognize the impact of poor oral health on economic performance.
- It was the sense of many that low Medicaid payment for dental services continues to be a barrier to dentists' participation in the program.
- Concerns regarding the sustainability of publicly-funded programs were expressed.
- It was noted that the fact that fluoridation of drinking water is not consistent throughout New Hampshire has contributed greatly to the oral health disparities within the population.
- Many felt that public education regarding the importance of good oral health needs to be a priority.
- The success of school-based programs in introducing good oral health behaviors in children was cited.
- It was suggested that communication between the Legislature and oral health professionals should be improved.

Stakeholder Input to the Planning Process

While the Coalition members actively participated in the planning process, each was invited to discuss his or her views with the Project Director individually and in confidence. The goal of these meetings was to ensure that every member was able to express individual priorities and/or concerns, and contribute to the process and substance of the plan. These meetings generated a short list of issues which required additional discussion at Coalition meetings. Of particular concern were topics including:

At-risk populations – children, the elderly, the developmentally disabled, and those with HIV/AIDS;
Workforce – numbers, capacity and roles;
Fluoride and sealants;
Sustainability of safety net services;
Medicaid reimbursement; and
Plan implementation.

As planning sessions continued, these topics were reopened and discussed in more detail. Concerns and controversies punctuated the dialogue, and led to a fuller appreciation of individual opinions.

4. Findings of the Coalition for New Hampshire Oral Health Action

The Coalition met regularly over a six-month period in an effort to review key issues in oral health. Their meetings were focused topically on the elements that comprise the oral health landscape:

- Prevention, health promotion and education
- Workforce
- Financing
- Safety Net
- Integrating Functions
- Advocacy, policy and politics

Prevention, Health Promotion and Education

Prevention, health promotion and education clearly represent the most cost-effective means to improving New Hampshire's oral health. Not all individuals and populations are at the same risk for oral diseases, therefore a principle of the Coalition's plan is to target intensity and types of interventions to match the levels of risk. Initiatives such as early intervention, disease management and risk-based interventions need to be directed to the individuals and populations at highest risk.

The importance of fluoridation as a preventive measure is widely recognized and long-standing. Sixty-six percent of the US population who are on public water supplies receives fluoridated water. This represents 58% of the total US population. In New Hampshire, while two thirds of the population uses public water supplies, only 10 communities have fluoridated their water supply. This results in only 25% of the total New Hampshire population having access to fluoridated water. When assessing the percentage of a state population on public water supply receiving fluoridated water, New Hampshire ranks tenth lowest in the country.

The Coalition recognized that to fluoridate 65% of those communities who use public water supplies, the Healthy New Hampshire 2010 goal, tremendous political will and grassroots support will be required. Absent universal fluoridation across the state, other interventions such as the prescribing of fluoride by primary care medical providers and school-based fluoride programs in communities where residents do not have access to fluoridated public water supplies take on added importance, but it will be necessary to simplify the process of well-water testing in order to facilitate the prescribing of fluoride by medical providers.

Application of sealants on the teeth of school-aged children has also been proven effective in the prevention of some types of dental caries. Very few school-based sealant programs are underway in New Hampshire, although oral health education, screening and cleaning programs are in place in numerous school districts across the state. The Coalition deliberated at length regarding the most effective approach to provide sealants to those school-aged children who do not access regular dental care. In New Hampshire, although hygienists can place sealants on the teeth of children who have been examined by a dentist, the availability of financial resources to reimburse dentists to provide those examinations was a concern. While the majority of Coalition members noted that this could limit the number of high risk children who receive sealants through school-based programs,

the pursuit of an expansion of school-based sealant programs through the use of volunteer dentists, rather than a change in the rules regarding supervision was agreed to as a compromise. The New Hampshire Dental Society offered to coordinate this volunteer initiative, in an effort to not only expand the reach of this program, but also to expose dentists to the extent of oral disease in school-aged children. The Coalition also agreed to monitor the success of this initiative and to pursue other approaches if this does not generate the necessary delivery of sealants to at-risk children.

Education and health promotion will also need to play a major role in improving New Hampshire's oral health. A common thread throughout the planning process was the acknowledgement that a significant number of New Hampshire residents do not value oral health. Many people believe that the loss of teeth is a natural, unavoidable process, and that treatment, let alone prevention, screening, and early diagnosis, is unnecessary. It will take an enormous public health education effort to begin to change that mentality, but an effort that the Coalition deemed critical.

Workforce

Much of the discussion regarding workforce focused on the perceived shortage of dentists in New Hampshire. Currently there are just under 900 licensed dentists in the state, the majority of whom, like the population, are concentrated in the southern tier, although within that geography there are populations who are relatively underserved. Of that number, two-thirds are general dentists, and one-third, specialists. Almost 50% of the New Hampshire Dental Society's members are over 50 years old. The number of dentists is projected to begin declining over the next five years, as the number of dentists graduating from dental schools is outstripped by those retiring from active practice. As there are no dental schools and few residency training slots in New Hampshire, recruitment remains a significant challenge, as dentists commonly locate their practices near where they are educated. The number of dentists who actively treat New Hampshire's highly vulnerable populations – children, developmentally disabled, the elderly, and those with HIV/AIDS – is relatively small.

Registered Dental Hygienists are also in short supply in New Hampshire. There is one training program with the capacity to graduate 28 hygienists each year. While federal projections anticipate an increase in the number of hygienists over the next five years, currently, there is reported difficulty in filling positions in the public health sector as well as those in private practice. Hygienists are able to provide an array of key preventive services including fluoride treatments and sealants, but some of those services must be provided under supervision of a dentist. Previously, the Dental Society offered financial resources to increase capacity to train hygienists at the state's Technical Institute, but corresponding funding was eliminated from the state's budget. This approach has recently been reinitiated.

Another member of the oral health workforce, the Dental Assistant, was discussed by the Coalition in some detail. No formal training program or licensure is required for those in this field, except for certification to expose radiographs. New Hampshire does have one formal education program for Dental Assistants, but many receive their training "chair-side," on the job. Various states have enabled the creation of a "new" category of provider – the Expanded Function Dental Assistant (EFDA) – to enhance dentists' productivity. It was suggested that the Coalition investigate the potential for moving in that direction. The relatively short training period and cost of labor may provide a cost-effective approach to addressing the impending reduction in dentist-to-population ratios.

In addition to the traditional oral health workforce, the Coalition examined the potential for utilizing "non-dental" providers to perform certain oral health functions. The merits of integrating

oral screening and oral health promotion into general medical care – health history, physical examination and health counseling – were widely accepted as the discussions focused on the feasibility of pediatricians, family practitioners, nurse practitioners and other primary medical care providers providing oral screening, fluoride varnishes, and other preventive interventions. The Coalition considered the creation of training protocols for these non-dental providers as a means to improve access to basic preventive oral health care, and debated the financial impact of expanding the workforce in this manner.

As the Coalition members evaluated the roles and functions of the traditional and non-traditional workforce members, they discussed the need for a new type of provider, one who had a combination of skills – those of a hygienist, a case manager and a health educator. Using the Certified Diabetes Educator as the model for this new provider, the Coalition considered the formalization of the role of an Oral Health Educator.

Again moving beyond the bounds of the traditional oral health workforce, the Coalition considered the merits of using those who are in day-to-day contact with children – parents, day care workers, educators – as promoters of oral health and oral health education.

The Coalition concluded that flexibility is a desirable component of workforce policy. Creative methods must be developed to assure an "elastic" workforce that can adjust to the changing needs of the population in a timely and effective manner. Creating a subgroup of appropriate leaders and policymakers to monitor and address these issues was deemed a priority.

Financing

Financing for oral health services in New Hampshire comes from a number of sources – commercial dental insurance, individual payment, Medicaid (traditional fee-for-service, as well as voluntary managed care) and the State Children's Health Insurance Program (SCHIP). Benefits under Medicaid are federally mandated for children, with treatment for adults limited to emergency care for pain and infections.

The Medicaid program for oral health covered 115,864 New Hampshire residents in Fiscal Year 2002. While 49.2% of licensed New Hampshire dentists were contracted Medicaid providers in 2001, 34.8% were active Medicaid providers (having seen at least one patient during CY01), only 7.7% were high volume providers (treating 100 or more patients in CY01). Total expenditures in FY02 on the Medicaid fee-for-service dental program were $4,584,933, with the vast majority (89.5%) spent on care for the 56,000 children enrolled in the program's fee-for-service and voluntary managed care plans. Dentists' participation in Medicaid has been hampered by the limited reimbursement for services, the majority of fees for which have not changed since 1994, and a burdensome administrative process.

The Medicaid program for oral health has evolved in a number of significant ways over the past several years. Though no new funding has been allocated by the legislature, the state convened a Dental Policy Advisory Committee, which conducted an evaluation of Medicaid reimbursement rates. In January 2000, they recommended increasing fluoride treatments to twice a year, a reimbursement rate increase for 12 procedures (predominantly those that are preventive and widely performed). Effective July 1, 2003, 27 codes were increased by an average of 64%. Also in response to suggestions from the dental community, many of the administrative components of the program have begun to be streamlined.

Additionally, in August, 2000, the state initiated a voluntary managed care program, NEDD-Kids, which was subcontracted to Northeast Delta Dental (NEDD) and administered through Anthem. Almost 90% of New Hampshire licensed dentists participate with Northeast Delta Dental, greatly

increasing access for children in this Medicaid program. The initial enrollment of 3,945 – approximately 7% of the total children enrolled in Medicaid – more than doubled in the program's two years of operations and expenditures on this population in FY02 – for the 8,717 enrolled – were in excess of $3,500,000, with reimbursement for care limited to $2,500 per year per child. In July 2003, the NEDD program was eliminated when DHHS did not renew its contract with Anthem for the voluntary managed care program.

The SCHIP dental program, Healthy Kids Silver, is also handled by NEDD through a contract with New Hampshire Healthy Kids Corporation. With 5,167 children enrolled as of August, 2002, SCHIP dental spending was approximately $1,000,000 (FY02). This program, for children from modest income families who have been uninsured for at least six months, has a family income-based premium, subsidized with both state and federal funds. Benefits through the program are limited to $600 per year.

A compilation of results from these programs shows that New Hampshire is making progress in providing oral health services to low income children, although the majority of covered children do not access dental care in a year. But a complete analysis of the program data has yet to be done, and the true impact on enrollees' oral health status remains unanswered.

Evidence that there is a preference among dentists for treating the Medicaid population through NEDD Kids indicates that reimbursement and simplified administration are drivers in ensuring access to care. This puts pressure on the state to increase fees in the traditional fee-for-service program, a move that will require legislative initiative. In addition to addressing the direct costs of its Medicaid programs, the state is also looking at ways to improve the effectiveness of services delivered by enhancing the case management and care coordination system used by program participants.

Safety Net

The safety net was defined by the Coalition as those care providers who have a priority commitment to deliver affordable oral health services to vulnerable and underserved populations. They noted that because both state and private funding is limited, resources for care are often constrained. The result is that the safety net is as vulnerable as many of its patients and cannot function as a true system, where care is integrated and coordinated among the various providers.

The Coalition examined the components of New Hampshire's safety net for oral health services. There are eight oral health clinics in the state – some community-based, some hospital-based, and others integrated into New Hampshire's community health centers – that provide a range of oral health care to the indigent. Many of these clinics also provide school-based services, while other school-based services are delivered as free-standing programs. Hospital emergency departments deliver services as well, to those with economic, social and cultural barriers to obtaining care, although the nature of these services is generally limited to treating pain and infection through medication. The NH Technical Institute serves approximately 1,200 elderly on an annual basis, providing prophylaxis, diagnosis and restorative care.

The Coalition also noted that many New Hampshire dentists provide pro bono care in their offices. Often the work of these dentists is coordinated through a case management system or community program, but many dentists offer services directly to specific at-risk patients. Some private practices have been developed and grant-funded by local health collaboratives or private entities to extend care to the indigent.

In reality, New Hampshire's safety net is unstructured and discontinuous, and ultimately unable to adequately serve the growing number of individuals in need of oral health services.

Integrating Functions

The Coalition reflected at length on the importance of a "system" of oral health care services. The ideal system would provide a continuum of services – from prevention and health promotion through restorative care – and would enable a user to move seamlessly among its components, regardless of his or her point of entry. Comprised of a variety of programs and clinicians – school-based screenings, private practitioners, community health centers, etc. – these components would be integrated through care coordination, reporting and accountability.

The group differentiated between disease management – managing the risk for and process of a disease; and care coordination – assisting an individual to receive necessary services, such as social, medical, educational, transportation, and translation by linking that individual with provider(s), so that the he or she can function within a community at an optimal level. The importance of integrating oral health into the health and human services system – for care coordination as well as service delivery – was reiterated in those discussions. Additionally, it was noted that care coordination could often be extremely effective in promoting health and encouraging compliance through counseling and education.

With regard to reporting and accountability, it was the sense of the Coalition that data were needed for two distinct purposes: to document progress in addressing unmet need, and to improve the efficacy of oral health interventions. The importance of "need" data was deemed essential as the basis for programmatic decision-making, as well as for educating the public (and the legislature) about the extent of the problem.

The state's Oral Health Program has conducted a representative oral health survey of New Hampshire's population. For third grade children, the survey measures the number of children with untreated decay, history of decay and the number of children with sealants. For adults, incidence of oral cancers, tooth loss, teeth cleaning and dental visits are measured, and the number of communities with fluoridated water is tracked. Annual assessments of established school, hospital and community-based dental programs' data are also performed. And because of the sample size, much of the data cannot be extrapolated to the local level.

Advocacy, Policy and Politics

The roles of advocacy, public policy and politics in moving the oral health agenda forward was deliberated by the Coalition. It was determined that there is a clear need to build constituencies concerned and committed to improving New Hampshire's oral health – within the general public, the dental and medical professions, and the legislature, as well as among advocacy groups who are already skilled in promoting the goals of their constituents. Shaping public policy to recognize the importance of oral health will also be critical to attaining the objectives in the Plan.

5. National and Regional Perspectives

Oral health has become a major topic on the national health agenda. Because much oral disease is preventable, it has been the focus of numerous studies and publications over the past several years. As its relationship to overall health has been more widely acknowledged, oral health has emerged as a priority public health concern.

Surgeon General's Report

Published in 2000, *Oral Health in America: A Report of the Surgeon General,* was notable for a number of reasons, but principal among them was the strong statement correlating oral health to general health. The report examined oral health status across the nation, evaluated how oral health can be promoted and maintained, and also identified opportunities for action designed to enhance oral health.

The Surgeon General's report detailed major findings which will have bearing on national, regional and local initiatives to address oral health:

- Oral diseases and disorders in and of themselves affect health and well-being throughout life.
- Safe and effective measures exist to prevent the most common dental diseases – dental caries and periodontal diseases.
- Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.
- There are profound and consequential oral health disparities within the US population.
- More information is needed to improve America's oral health and eliminate health disparities.
- The mouth reflects general health and well-being.
- Oral diseases and conditions are associated with other health problems.
- Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth, and teeth.

Additionally, the Surgeon General's report creates a "framework for action" that will serve as the framework for New Hampshire's Oral Health Plan. The principles articulated in that report are:

- Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.
- Accelerate the building of the science and evidence base and apply science effectively to improve oral health.
- Build an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health.
- Remove known barriers between people and oral health services.
- Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.[2]

2. US Department of Health and Human Services. *Oral Health In America: A Report of the Surgeon General.* Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

Recommendations of the Surgeon General's Workshop

Prior to release of the Surgeon General's Report, nearly 100 invitees representing dentistry and dental hygiene, medicine and nursing, law and government, business and industry, child and family advocacy, special needs populations, academe, communications, and foundations convened to consider disparities in oral health and dental care for America's children. Participants considered six approaches to these problems including:

1. increasing public awareness in order to promote public policy changes and impact individual behaviors;
2. promoting development and application of science and evidence-based care to enhance both consumer and practitioner behaviors;
3. integrating service delivery in order to meet the comprehensive health promotion and treatment needs of US children;
4. involving a range of health workers who come into contact with vulnerable children and their families in promoting oral health and dental care;
5. promoting public policies that lead to programmatic and funding support for oral health interventions; and
6. maximizing the role of public and private dental delivery systems to encourage positive oral health behaviors and provide essential services to all children.[3]

Eight major sets of recommendations emerging from the deliberations were presented at the June 2000 Surgeon General's Conference entitled, *The Face of a Child*:[4]

1. **Start early and involve all:** This set of recommendations includes establishing a dental home at age one; identifying high risk children early and promoting individualized preventive regimens in both medical and dental practice; developing community-based health coordinators to promote ongoing integration of oral health with general health care; developing day-care accreditation standards on oral health; and addressing the oral health needs of caregivers in order to promote more widespread attention to oral health.
2. **Assure competencies:** Recommendations include developing common core curricula for all health professionals on oral health that is comprehensive and integrative; and developing accreditation standards, guidelines, and performance measures that assure the inclusion of oral health promotion and, where appropriate, treatment in professional training and practice.
3. **Be accountable:** Recommendations include promoting school-based prevention, education, screening and referral programs on oral health; and developing performance measures and tracking systems to ensure that these programs are effectively implemented.
4. **Take public action:** Recommendations include developing activist coalitions that ensure stable-funded, community-based comprehensive health promotion and disease prevention; and crafting messages that specifically target providers, policymakers, and the public.
5. **Maximize the utility of science:** Recommendations include expanding the range and utility of science-based interventions; developing an evidence base on the effectiveness of oral disease management techniques; and developing a coordinated agenda across basic, applied, and health services research to promote oral health and effective dental care.

3. Edelstein B.L. "Forward to the Background Papers from the US Surgeon General's Workshop on Children and Oral Health." *Ambulatory Pediatrics,* 2(2 Supplement) 2002.

4. *The Face of a Child: Surgeon General's Conference on Children and Oral Health,* June 12-13, 2000, Washington, DC Conference agenda, abstracts and proceedings available at www.nidcr.nih.gov/sgr/children/children.htm

6. **Fix public programs:** Recommendations include demonstrating cost-benefits of prevention and disease management; overhauling Medicaid EPSDT dental programs; encouraging provider participation in Medicaid through various incentives; and enhancing the strength and viability of the dental safety net.
7. **Grow an adequate workforce:** Recommendations promote prioritizing community-based educational experiences for dentists and hygienists in training; expanding the numbers of pediatric and public health dentists; engaging allied personnel more effectively especially in health promotion and disease prevention; and encouraging an expanded number of minority providers in the dental professions.
8. **Empower families and enhance their capacities:** Recommendations include media and key-contact campaigns to translate oral health needs into demands for dental educational and treatment services; and using risk-based methods to tailor care to the individual needs of children and their families while respecting family and cultural determinants of health and health behaviors.

While these recommendations focused particularly on children, they are useful strategies for addressing almost all under-served populations.

Healthy People 2010

Published by the Office of Disease Prevention and Health Promotion, US DHHS, *Healthy People 2010* is the "prevention agenda" for the nation. It includes a comprehensive set of disease prevention and health promotion objectives for the US, designed to identify and reduce preventable threats to health and identifies two broad goals for achievement by 2010:

1. Increase quality and years of health life; help individuals of all ages increase life expectancy and improve quality of life.
2. Eliminate health disparities among all segments of the population.[5]

Healthy People 2010 includes oral health among its principal areas of focus, and sets the following as its goal: Prevent and control oral and craniofacial diseases, conditions and injuries and improve access to related services. Additionally, the document details a number of objectives specific to oral health, in areas such as dental caries experience and untreated tooth decay; tooth loss; periodontal diseases; sealants; fluoridation; school-based services; health centers with oral health services; and use of the oral health care system.

Summary of National Surveys

Healthy People 2010 data are derived from a number of national surveys fielded by various US Department of Health and Human Services agencies. These include Head Start surveys, National Health Interview Surveys, Medical Expenditure Panel Surveys, and National Health and Nutrition Examination Surveys among others. Taken together they tell a story of mixed oral health and profound disparities in oral health and access to dental care for children, adults, and those with special health care needs.

In summarizing oral health findings, the *Healthy People 2010* document reports that the oral health of US citizens is still of concern and that oral health varies widely by socioeconomic status

5. US Department of Health and Human Services. *Healthy People 2010.* Washington, DC: US Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

and general health condition. For example, 39% of people aged 65 or older with only a high school education are missing all of their teeth while only 13% of people with some college education are edentulous. National surveys reveal that the three primary diseases of the mouth – tooth decay, periodontal disease, and oral/pharyngeal cancer – remain too common, especially given that all are amenable to prevention.[6]

Tooth decay continues to be the single most common chronic disease of childhood with nearly one in five preschoolers, one in two second graders and three in four adolescents experiencing tooth decay. Caries continues into adulthood with one in three US adults reportedly having untreated tooth decay. Unmet need for dental care has been reported for children with the finding that 73% of all children with one or more unmet health care needs has a parentally reported unmet need for dental care – three times greater than unmet needs for medical care. Nationally, among children covered by Medicaid, only one in four obtains a dental service in a year. This is a particularly significant finding because young children living in poor families (including those eligible for Medicaid) are nearly twice as likely to have tooth decay, have twice as many cavities when they do, and experience pain twice as often as children living in affluent families (>400% of poverty). Children of color are also more likely to experience tooth decay and are generally less likely to receive dental services.

Periodontal (gum) disease is highly prevalent and is increasingly recognized to impact significantly and negatively on general health. *Healthy People 2010* reports that one in five adults has destructive periodontal disease – disease that frequently leads to tooth loss.

National surveys show that "some 31,000 new cases of oral and pharyngeal cancer were expected to be diagnosed in 1999, and approximately 8,100 persons were expected to die from the disease. Oral and pharyngeal cancer occurs more frequently than leukemia, Hodgkin's disease, and cancers of the brain, cervix, ovary, liver, pancreas, bone, thyroid gland, testes, and stomach. Oral and pharyngeal cancer is the 7th most common cancer found among white males (4th most common among black men) and the 14th most common among US women. The 5-year survival rate for oral and pharyngeal cancer is only 52 percent and most of these cancers are diagnosed at late stages."[7]

Federal and private surveys of dental insurance coverage reveal that having dental insurance is strongly associated with having more dental care – even for high-income individuals and families. Yet two and a half times more children are without dental coverage than medical coverage and over 100 million Americans have no dental coverage at all. Similarly expenditures on dental care vary significantly by family income. Not surprisingly, low income families expend disproportionately more of their income on dental care than higher income families.

Taken all together, these national studies reflect observations in New Hampshire that oral health continues to be problematic for many and that the benefits of good oral health are not uniformly enjoyed by all of its citizens.

Significant Legislative Initiatives

Recent years have seen significant federal and state legislation related to oral health and access to dental care – legislation that may help shape and inform initiatives undertaken in response to this plan. Additionally, a variety of public-private partnerships (including this one) are underway and national organizations of state policymakers have increasingly attended to this issue. Among organi-

6. *Healthy People 2010* Chapter 21 Oral Health op cit.

7. Edelstein B.L. "Disparities in Oral Health and Access to Care: Findings of National Surveys." *Ambulatory Pediatrics,* 2(2 Supplement) 2002.

zations involved in this process are the National Governors Association, the Conference of State Legislatures, the Association of State and Territorial Health Officers, and the Association of Maternal and Child Health Programs. Many recent advances, however, have been dampened significantly by the current economic downturn with its stringent demands on state budgets.

President Bush signed the Safety Net Amendments Act in January 2003 which includes authorization for matching grants to states (states must contribute 40% in cash or in-kind sources to access one million dollars in federal grants) to improve dental access, particularly in rural areas. In 2000, the Child Health Act authorized grants to states to address novel preventive strategies around early childhood tooth decay. Neither of these federal programs has yet been funded in the current budget process.

When last considered by Congress, the Health Professions Training program was expanded to include funds to train not only advanced-practice general dentists and public health dentists but also pediatric dentists. This has resulted in a nearly 10% increase in the number of children's dentists being trained. Current lobbying efforts seek to expand another federal training program for pediatric dentists from training 9 dentists per year to 60 per year. Also under consideration is the Children's Dental Health Act which would provide additional grants to states to improve dental access for children. Similarly, the recently enacted Children's Hospital Graduate Medical Education program allows for training additional pediatric dentists in specialty hospitals.

More ominous for ensuring access to care are recent state changes in Medicaid programs. As of March 2003 only 14 states continue to provide reasonably comprehensive dental benefits to poor adults through Medicaid. More than half of the states, including New Hampshire, provide only minimal care for relief of pain and infection or no dental care at all. The trend toward erosion of dental benefits is beginning to impact children as well. Increasing numbers of states are cutting dental benefits in their state child health insurance plans and the Administration has recently advanced two programs that would allow reduction in dental coverage for poor children in Medicaid.

Among state-level initiatives of note are efforts to extend the roles of dental hygienists and dental assistants, to increase community water fluoridation, to engage medical providers in oral health promotion, to license foreign dental school graduates, to encourage post-doctoral dental training, to expand the availability of sealants, and to provide incentives to encourage dentists to practice in geographically underserved areas.

Healthy New Hampshire 2010

Using the national *Healthy People 2010* framework, *Healthy New Hampshire 2010* is the state's agenda for health promotion and disease prevention for the first decade of the 21st century. Developed collaboratively by the Healthy New Hampshire 2010 Leadership Council and the New Hampshire Department of Health and Human Services, "it represents a shared vision and acknowledges a shared responsibility for improving the health and quality of life for all New Hampshire citizens."[8] With regard to oral health, this document identifies barriers to good oral health. These include cost of care, lack of dental insurance, lack of public programs, a shortage of dentists and dental hygienists, language and cultural barriers, and fear of dental visits. It also sets as its objectives an increase in the percentage of third grade children with dental sealants on their teeth and an increase in the percentage of New Hampshire residents served by a fluoridated public water supply.

8. New Hampshire Department of Health and Human Services. *Healthy New Hampshire 2010.* Concord, NH, 2001.

Vision and Recommendations: A Framework for Actions

Throughout the planning process, the Coalition for New Hampshire Oral Health Action operated with a set of underlying premises regarding the promotion of oral health and the provision of dental care: While health and health care are ultimately family and community considerations and New Hampshire's regions and communities have unique capacities and constraints, state level activity can support communities in improving oral health and dental care. It was determined that the resulting plan, therefore, should not only identify a "standard" level of oral health for all residents, but should articulate priorities for both statewide and community-level action; identify tools and resources to address oral health needs; coordinate and support existing community-based systems; and empower individuals to access and utilize available resources.

It was acknowledged by the Coalition that while there are common underlying issues and problems across New Hampshire, variation exists from region to region, community to community – in terms of unique needs, available resources and competencies. This means that there is the need to identify statewide initiatives that will have the capacity to benefit all communities – such as improving Medicaid reimbursement and establishing funding mechanisms for local system development – knowing that these initiatives may create different outcomes community by community.

This plan establishes a vision and model for a community-based integrated oral health system, which is designed to improve oral health and dental care for New Hampshire residents by emphasizing where needs are unmet and care inaccessible, and prioritizing resource distribution to address those issues. This community-based model implies that local systems will be built around functional geographical areas, and will be both internally and externally accountable. It will also require collaboration and communication among community-based systems to ensure that the future is informed and shaped by both successes and failures. The model envisions an on-going role for the Coalition for New Hampshire Oral Health Action to advocate for and initiate state-level action and monitor and support community-level implementation.

It is not the intent of this report to provide a comprehensive review of the oral health status of New Hampshire's residents, nor a restatement of the scope of the problem. Instead, on the following pages, the Coalition for New Hampshire Oral Health Action offers a vision and discussion of what actions will be necessary to bring oral health and its positive impact on well-being, to the residents of New Hampshire. That there are disparities in the oral health status of New Hampshire residents is undisputed. Finding ways to reduce those disparities is the subject of this report.

The goals and objectives identified by the Coalition have been presented in the framework outlined in the Surgeon General's Report, *Oral Health in America,* and are organized under the principal components identified in that document. This plan is intended to be a "living document" and, as such, will be revised from time to time as necessary and appropriate. Initial responsibilities for the implementation of primary objectives have been assigned. Further responsibilities and timelines will be developed as the implementation process begins.

Vision

Residents of New Hampshire will have the opportunity to achieve and maintain oral health through access to an effective system of health services which promotes appropriate health behaviors.

These services, which include assessment, prevention, health promotion, education, counseling, and treatment, will be provided through an integrated system of health care that assures accessibility, affordability, high quality, appropriateness to individuals' needs, and responsiveness to individuals' circumstances.

Recommendations

Principle

I. Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.

Goal

I.A. Increase public perception of the importance of good oral health as a component of overall health.

Objective

I.A.1. Develop a statewide oral health awareness and education campaign.

Strategies

I.A.1.a. Develop a public education campaign.

I.A.1.b. Develop a strong advocacy campaign for elected officials, government, private sector leaders and charitable foundations, to create public policy for improving oral health.

Objective

I.A.2. Integrate oral health with general medical care.

Strategies

I.A.2.a. Provide educational guidelines for the prevention, identification and treatment of oral diseases to primary medical care providers.

I.A.2.b. Provide oral assessment, health promotion and referrals as necessary to patients in all primary care settings.

I.A.2.c. Support recommendations that by the age of one year, all children receive an oral assessment, and referral to a dentist as necessary.

I.A.2.d. Engage and empower families in establishing basic oral health, from the prenatal period on.

I.A.2.d.(i). Utilize existing programs such as Home Visiting NH and Parents as Teachers to reinforce principles of good oral health.

I.A.2.e. Include oral health objectives in all published health promotion and prevention protocols and guidelines.

Objective

I.A.3. Integrate comprehensive oral health curricula in general health curricula and promote in all New Hampshire schools.

Strategies

I.A.3.a. Complete the development of oral health curricula for all grades.

I.A.3.a.(i). Maintain and update oral health curricula as necessary.

I.A.3.b. Coordinate efforts among the Department of Education, oral health providers, school administration, school nurses and school health educators to promote appropriate implementation of curricula.

I.A.3.c. Work toward the elimination of unhealthy snacks and drinks from school vending machines.

I.A.3.c.(i). Promote the use of the Task Force of NH Health Professionals for Healthy School Nutrition Tool Kit.

Principle

II. Apply science effectively to improve oral health.

Goal

II.A. Assess the oral health status of New Hampshire residents.

Objective

II.A.1. Develop and maintain a comprehensive epidemiological oral health surveillance system to identify, investigate and monitor oral health and oral health services.

Strategies

II.A.1.a. Identify critical data elements and standards needed for effective planning and program development.

II.A.1.b. Continue school-based oral health surveys every three years to assess trends in the oral health status of children enrolled in New Hampshire schools.

II.A.1.c. Develop data collection and analysis capacities at the local level through training and technical support.

Goal

II.B. Reduce the burden and progression of oral diseases in New Hampshire by integrating best available science and evidence-based treatment into clinical practice and policy.

Objective

II.B.1. Access and disseminate leading edge information on oral health science.

Strategy

II.B.1.a. Establish and maintain linkages with selected regional dental schools, research institutes and oral health policy centers.

Goal

II.C. Reduce the incidence of dental caries through evidence-based public health interventions.

Objective

II.C.1. Maximize the benefits of fluoride in preventing and controlling dental caries.

Strategies

II.C.1.a. Develop a statewide community action campaign to achieve fluoridation of public water supplies.

II.C.1.b. Simplify the process for prescribing and using systemic and topical fluoride by primary care physicians.

II.C.1.b.(i). Simplify access to and reporting of well water testing for fluoride.

Objective

II.C.2. Implement and maintain the capacity for a statewide school-based sealant program.

Strategies

II.C.2.a. Create the capacity for a universal school-based sealant program.

II.C.2.a.(i). Engage hygienists, dental assistants and volunteer dentists to implement school-based sealant program.

Goal

II.D. Increase early detection and reduce the incidence of oral and pharyngeal cancers.

Objective

II.D.1. Support efforts to reduce tobacco and alcohol use among New Hampshire residents.

Strategies

II.D.1.a. Increase awareness of the link between tobacco and alcohol use and oral and pharyngeal cancers.

II.D.1.b. Coordinate efforts among oral health providers, school administration, school nurses, school health educators, alcohol and tobacco prevention task forces, etc., to implement comprehensive educational programs regarding the dangers of tobacco and alcohol use.

II.D.1.c. Educate primary care providers regarding the importance of early detection and treatment of oral and pharyngeal cancers.

II.D.1.d. Enlist oral health and primary care providers to participate in alcohol and tobacco education and cessation programs.

II.D.1.d.(i). Provide continuing education to oral health and primary care providers regarding effective approaches to reduce the use of alcohol and tobacco.

Goal

II.E. Reduce the incidence of oral and facial injuries.

Objective

II.E.1. Recommend the requirement of the use of face-masks and mouthguards in all school and other sports programs.

Strategy

II.E.1.a. Coordinate efforts among school personnel, coaches, and recreation programs regarding the importance of injury prevention.

Principle

III. Build an effective health infrastructure that meets the oral health needs of all and integrates oral health effectively into overall health.

Goal

III.A. Enhance the existing workforce to meet the diverse oral health needs of all New Hampshire residents.

Objective

III.A.1. Maximize the capacity of the oral health workforce to address the needs of the population.

Strategies

III.A.1.a. Establish a task force comprised of appropriate leaders and policymakers to monitor and address the changing needs of the population.

III.A.1.a.(i). Conduct periodic evaluations of the workforce model, and refine as necessary to address the evolving needs and demands of the population.

III.A.1.a.(ii). Develop flexibility in workforce policies to assure that population needs can be met in a timely and effective manner.

III.A.1.b. Develop and promote career counseling at all New Hampshire high schools to encourage students to pursue careers in oral health.

III.A.1.c. Recruit more dentists, especially those who see high risk and vulnerable populations such as the economically disadvantaged, young children, the elderly, the developmentally disabled, and those with HIV/AIDS, to offset a provider shortage in New Hampshire.

III.A.1.c.(i). Pursue the potential to fund positions for New Hampshire students at New England dental schools.

III.A.1.c.(ii). Continue to provide loan repayment to dentists willing to serve New Hampshire's indigent and high risk populations.

III.A.1.d. Pursue the use of dental externs and residents by establishing training programs at safety net facilities.

III.A.1.e. Expand the number of dental hygienists in New Hampshire working in both public health and private office settings.

III.A.1.e.(i). Expand the facilities and training program for dental hygienists at the New Hampshire Technical Institute, and maximize their use.

III.A.1.e.(i).(a). Create a partnership with the New Hampshire Dental Society to fund the training program.

III.A.1.e.(ii). Recruit more dental hygienists to New Hampshire.

III.A.1.e.(ii).(a). Pursue state and private foundation support for recruitment and training of public health hygienists.

III.A.1.f. Pursue the use of new dental and non-dental providers to enhance the oral health workforce.

III.A.1.f.(i). Create the capacity to use expanded function dental assistants (EFDA) in dental practices and safety net facilities to improve productivity.

III.A.1.f.(ii). Use primary medical care practitioners to provide oral assessment and preventive services.

III.A.1.f.(ii).(a). Establish training and protocols for basic oral examination for primary care medical providers.

III.A.1.f.(iii). Build the capability among prenatal care providers to provide patients with oral assessment, education and appropriate referral for oral health services.

III.A.1.f.(iv). Develop a new professional category of Oral Health Educator.

Objective

III.A.2. Integrate, improve, expand and sustain the oral health component of the healthcare safety net.

Strategies

III.A.2.a. Advocate for funding for those organizations that provide oral health services to high risk and underserved populations from New Hampshire's public and private funders.

III.A.2.b. Pursue federal and private foundation funding to augment state-funded oral health initiatives.

III.A.2.c. Encourage all community health centers to provide oral health services.

III.A.2.d. Encourage private dentists and hygienists to provide services within the safety net.

III.A.2.e. Utilize the state loan repayment program for dentists and hygienists who agree to practice in underserved areas.

III.A.2.f. Encourage New Hampshire hospitals to play a major role in supporting the safety net.

III.A.2.f.(i). Advocate that all New Hampshire hospitals participate in establishing, financing and maintaining safety net oral health services in their communities.

III.A.2.f.(ii). Encourage New Hampshire hospitals to prioritize oral health services in the allocation of community benefit dollars.

III.A.2.f.(iii). Advocate that all New Hampshire hospitals develop and maintain a dental on-call system through their Emergency Departments.

Principle

IV. Remove known barriers between people and oral health services.

Goal

IV.A. Eliminate barriers and enhance access to good oral health.

Objective

IV.A.1 Create system-level improvements to treat high risk populations such as children, the elderly, uninsured adults, the developmentally disabled, the mentally ill and those with HIV/AIDS.

Strategies

IV.A.1.a. Increase the capacity of the Medicaid program.

IV.A.1.a.(i). Reinstitute the managed care option to NH Medicaid.

IV.A.1.a.(ii). Streamline procedures for dental provider participation in Medicaid.

IV.A.1.b. Pursue an increase in Medicaid reimbursement rates for dental and hygiene services to encourage more provider participation in the Medicaid program.

IV.A.1.c. Establish coding for Medicaid reimbursement for primary care providers to deliver oral health procedural services.

Objective

IV.A.2. Enhance the competency of the oral health workforce to treat high risk populations.

Strategies

IV.A.2.a. Develop dental residency programs within programs that focus on high risk populations.

IV.A.2.b. Develop continuing education programs for the oral health workforce that focus on the unique issues of treating high risk populations.

Objective

IV.A.3. Build a care coordination and case management system especially for those at high risk.

Strategies

IV.A.3.a. Implement a care coordination model that uses education and prevention to improve oral health.

IV.A.3.a.(i). Provide a link between individuals and all service providers.

IV.A.3.a.(ii). Reimburse for care coordination.

IV.A.3.b. Provide oral health services at sites used by high risk populations, such as adult/child day care centers.

Objective

IV.A.4. Improve access to dental insurance among all sectors of the population.

Strategies

IV.A.4.a. Encourage New Hampshire employers to offer dental insurance.

IV.A.4.a.(i). Increase the awareness among New Hampshire business and industry of the importance of good oral health to productivity.

IV.A.4.b. Maintain and increase participation in current programs such as Healthy Kids Gold and Healthy Kids Silver, and reinstate NEDD Kids.

IV.A.4.c. Maintain and expand Medicaid to cover non-emergent oral health services for adults.

Principle

V. Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

Goal

V.A. Further integrate the efforts between the public and private sectors to address the oral health needs of the residents of New Hampshire.

Objective

V.A.1. Create a statewide clearinghouse to serve as a resource for information on existing oral health programs, technical support, funding consultation and successful public health models.

Strategies

V.A.1.a. Conduct a baseline assessment of all current models of oral health service delivery.

V.A.1.b. Establish best practices for oral health service delivery.

V.A.1.c. Develop a toolbox for building community collaboratives for oral health service delivery.

Objective

V.A.2. Promote regional and community-based collaborative efforts among agencies, organizations and individuals to address oral health needs.

Strategies

V.A.2.a. Establish funding priorities that require collaboration and coordination within communities.

V.A.2.b. Develop and maintain linkages to local and regional business/industry groups.

Objective

V.A.3. Monitor the implementation of the New Hampshire Oral Health Plan.

Strategies

V.A.3.a. Convene and maintain a subgroup of the Coalition to oversee the monitoring of implementation of the New Hampshire Oral Health Plan.

V.A.3.b. Identify funding sources to assure ongoing support for implementation activities.

Objective

V.A.4. Review and revise the New Hampshire Oral Health Plan as necessary.

Appendices

Appendix 1.
Commitment to the Implementation of the Oral Health Plan

The following letter of commitment will be signed by all Coalition members.

The Coalition for New Hampshire Oral Health Action has worked collaboratively on the development of the New Hampshire Oral Health Plan: A Framework for Action, a plan for improving the oral health of New Hampshire Residents.

Implementation of the plan will require continued management and collaboration among the stakeholders. To ensure that the work of the Coalition moves forward to achieve its goals and objectives, the members hereby affirm that they will agree to use best efforts to:

1. Promote and participate in the implementation of the Framework for Action.
2. Serve as liaison to inform their organizations and constituencies about Coalition initiatives.
3. Agree to report periodically to the Coalition on the progress toward achieving those recommendations in the Plan relevant to their organizations and constituencies.
4. To continue as a member of the Coalition.
5. To consider an investment in the sustainability of the Coalition and the implementation of the Framework for Action.

Name: _____

Organization: _____

Date: _____

Signature: _____

Appendix 2.
Executive Summary, Oral Health in America: A Report of the Surgeon General

A Framework for Action

All Americans can benefit from the development of a National Oral Health Plan to improve quality of life and eliminate health disparities by facilitating collaborations among individuals, health care providers, communities, and policymakers at all levels of society and by taking advantage of existing initiatives. Everyone has a role in improving and promoting oral health. Together we can work to broaden public understanding of the importance of oral health and its relevance to general health and well-being, and to ensure that existing and future preventive, diagnostic, and treatment measures for oral diseases and disorders are made available to all Americans. The following are the principal components of the plan:

Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.

- Change public perceptions. Many people consider oral signs and symptoms to be less important than indications of general illness. As a result, they may avoid or postpone needed care, thus exacerbating the problem. If we are to increase the nation's capacity to improve oral health and reduce health disparities, we need to enhance the public's understanding of the meaning of oral health and the relationship of the mouth to the rest of the body. These messages should take into account the multiple languages and cultural traditions that characterize America's diversity.
- Change policymakers' perceptions. Informed policymakers at the local, state, and federal levels are critical in ensuring the inclusion of oral health services in health promotion and disease prevention programs, care delivery systems, and reimbursement schedules. Raising awareness of oral health among legislators and public officials at all levels of government is essential to creating effective public policy to improve America's oral health. Every conceivable avenue should be used to inform policymakers – informally through their organizations and affiliations and formally through their governmental offices – if rational oral health policy is to be formulated and effective programs implemented.
- Change health providers' perceptions. Too little time is devoted to oral health and disease topics in the education of nondental health professionals. Yet all care providers can and should contribute to enhancing oral health. This can be accomplished in several ways, such as including an oral examination as part of a general medical examination, advising patients in matters of diet and tobacco cessation, and referring patients to oral health practitioners for care prior to medical or surgical treatments that can damage oral tissues, such as cancer chemotherapy or radiation to the head and neck. Health care providers should be ready, willing, and able to work in collaboration to provide optimal health care for their patients. Having informed health care professionals will ensure that the public using the health care system will benefit from interdisciplinary services and comprehensive care. To prepare providers for such a role will involve, among other factors, curriculum changes and multidisciplinary training.

Accelerate the building of the science and evidence base and apply science effectively to improve oral health.

Basic behavioral and biomedical research, clinical trials, and population-based research have been at the heart of scientific advances over the past decades. The nation's continued investment in research is critical for the provision of new knowledge about oral and general health and disease for years to come and needs to be accelerated if further improvements are to be made. Equally important is the effective transfer of research findings to the public and health professions.

However, the next steps are more complicated. The challenge is to understand complex diseases caused by the interaction of multiple genes with environmental and behavioral variables – a description that applies to most oral diseases and disorders – and translate research findings into health care practice and healthy lifestyles.

This report highlights many areas of research opportunities and needs in each chapter. At present, there is an overall need for behavioral and clinical research, clinical trials, health services research, and community-based demonstration research. Also, development of risk assessment procedures for individuals and communities and of diagnostic markers to indicate whether an individual is more or less susceptible to a given disease can provide the basis for formulating risk profiles and tailoring treatment and program options accordingly.

Vital to progress in this area is a better understanding of the etiology and distribution of disease. But as this report makes clear, epidemiologic and surveillance databases for oral health and disease, health services, utilization of care, and expenditures are limited or lacking at the national, state, and local levels. Such data are essential in conducting health services research, generating research hypotheses, planning and evaluating programs, and identifying emerging public health problems. Future data collection must address differences among the subpopulations making up racial and ethnic groups. More attention must also be paid to demographic variables such as age, sex, sexual orientation, and socioeconomic factors in determining health status. Clearly, the more detailed information that is available, the better can program planners establish priorities and targeted interventions.

Progress in elucidating the relationships between chronic oral inflammatory infections, such as periodontitis, and diabetes and glycemic control as well as other systemic conditions will require a similar intensified commitment to research. Rapid progress can also occur with efforts in the area of the natural repair and regeneration of oral tissues and organs. Improvements in oral health depend on multidisciplinary and interdisciplinary approaches to biomedical and behavioral research, including partnerships among researchers in the life and physical sciences, and on the ability of practitioners and the public to apply research findings effectively.

Build an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health.

The public health capacity for addressing oral health is dilute and not integrated with other public health programs. Although the *Healthy People 2010* objectives provide a blueprint for outcome measures, a national public health plan for oral health does not exist. Furthermore, local, state, and federal resources are limited in the personnel, equipment, and facilities available to support oral health programs. There is also a lack of available trained public health practitioners knowledgeable about oral health. As a result, existing disease prevention programs are not being implemented in many communities, creating gaps in prevention and care that affect the nation's neediest populations. Indeed, cutbacks in many state budgets have reduced staffing of state and territorial dental programs and curtailed oral health promotion and disease prevention efforts. An enhanced public health infrastructure would facilitate the development of strengthened partnerships with private practitioners, other public programs, and voluntary groups.

There is a lack of racial and ethnic diversity in the oral health workforce. Efforts to recruit members of minority groups to positions in health education, research, and practice in numbers that at least match their representation in the general population not only would enrich the talent pool, but also might result in a more equitable geographic distribution of care providers. The effect of that change could well enhance access and utilization of oral health care by racial and ethnic minorities.

A closer look at trends in the workforce discloses a worrisome shortfall in the numbers of men and women choosing careers in oral health education and research. Government and private sector leaders are aware of the problem and are discussing ways to increase and diversify the talent pool, including easing the financial burden of professional education, but additional incentives may be necessary.

Remove known barriers between people and oral health services.

This report presents data on access, utilization, financing, and reimbursement of oral health care; provides additional data on the extent of the barriers; and points to the need for public-private partnerships in seeking solutions. The data indicate that lack of dental insurance, private or public, is one of several impediments to obtaining oral health care and accounts in part for the generally poorer oral health of those who live at or near the poverty line, lack health insurance, or lose their insurance upon retirement. The level of reimbursement for services also has been reported to be a problem and a disincentive to the participation of providers in certain public programs. Professional organizations and government agencies are cognizant of these problems and are exploring solutions that merit evaluation. Particular concern has been expressed about the nation's children, and initiatives such as the State Children's Health Insurance Program, while not mandating coverage for oral health services, are a positive step. In addition, individuals whose health is physically, mentally, and emotionally compromised need comprehensive integrated care.

Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

The collective and complementary talents of public health agencies, private industry, social services organizations, educators, health care providers, researchers, the media, community leaders, voluntary health organizations and consumer groups, and concerned citizens are vital if America is not just to reduce, but to eliminate, health disparities. This report highlights variations in oral and general health within and across all population groups. Increased public-private partnerships are needed to educate the public, to educate health professionals, to conduct research, and to provide health care services and programs. These partnerships can build and strengthen cross-disciplinary, culturally competent, community-based, and community-wide efforts and demonstration programs to expand initiatives for health promotion and disease prevention. Examples of such efforts include programs to prevent tobacco use, promote better dietary choices, and encourage the use of protective gear to prevent sports injuries. In this way, partnerships uniting sports organizations, schools, churches, and other community groups and leaders, working in concert with the health community, can contribute to improved oral and general health.

Conclusion

The past half century has seen the meaning of oral health evolve from a narrow focus on teeth and gingiva to the recognition that the mouth is the center of vital tissues and functions that are critical to total health and well-being across the life span. The mouth as a mirror of health or disease, as a sentinel or early warning system, as an accessible model for the study of other tissues and organs, and as a potential source of pathology affecting other systems and organs has been described in earlier chapters and provides the impetus for extensive future research. Past discoveries have enabled Americans today to enjoy far better oral health than their forebears a century ago. But the evidence that not all Americans have achieved the same level of oral health and well-being stands as a major challenge, one that demands the best efforts of public and private agencies and individuals.

Appendix 3.
Dental and Medical Primary Care Workforce and Education Data

Prepared by David M. Krol, M.D.

Contents

DENTISTS

Table 1: Number of Dentists 1998-2008 (projected)

Reflecting national trends, the number of dentists serving New England's population is reasonably stable. Recent years have seen significant increases (~25% from 1998-2001), perhaps reflecting Boston dental school graduates' movement outward from the more dentist-congested population rings surrounding the core metropolitan area and growth of New Hampshire's southern population. Federal health professional workforce projections out to 2008 suggest a decline in absolute numbers of New Hampshire dentists of ~8% between 2001 and 2008, even as the state's population is anticipated to increase.

Number of Dentists 1998 - 2008 (projected)

	1998	2000	2001	2008
Connecticut	3,400	2,981	2,669	3,750
Maine	600	584	608	700
Massachusetts	4,250	NA	4,500	4,850
New Hampshire	**700**	**825**	**868**	**800**
Rhode Island	750	NA	719	800
Vermont	300	350	347	300

Source: State occupational projections: 1998-2008; http://dws.state.ut.us/occ/projections.asp Accessed March 5, 2002.

Table 2: Ratio of Dentists per 100,000 population 1998

New England enjoys a dentist-to-population ratio that is nearly 9% higher than the US average but shows wide variation between states — from Maine with the fewest to Connecticut with the most. New Hampshire's dentist-to-population ratio ranks third lowest for New England. It's dentist availability is 6.4% higher than the US average but 5% lower than the NE average. These findings are not adjusted for age which may be a significant factor, given the overall "graying" of US dentists and the migration of younger professionals to western states where population growth is most dramatic.

Ratio of Dentists per 100,000 Population 1998

	Dentists/1000 population 1998	Rank Order
Connecticut	65.9	1
Maine	43.9	6
Massachusetts	61.6	2
New Hampshire	**51.5**	**4**
Rhode Island	50.1	5
Vermont	52.7	3
United States	48.4	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/health-workforce/profiles/default.htm

Table 3: Percent Change in Dentist Population per 100,000 population 1991-1998

Between 1991 and 1998 New Hampshire experienced a 9% decrease in the number of dentists for every 100,000 people compared to a national decline of 12% and New England average decline of 7%. At 9%, New Hampshire lost relatively more dentist workforce for its population than did Rhode Island, Maine, and Vermont.

Change in Dentists per 100,00 Population: 1991-1998

	Percent change 1991-1998	Rank Order
Connecticut	-11%	1
Maine	-3%	5
Massachusetts	-11%	2
New Hampshire	**-9%**	**3**
Rhode Island	-6%	4
Vermont	-2%	6
United States	-12%	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002.

Table 4: Percentage of Female Dentists 1998

In 1998 10.8% of the dentists in New Hampshire were women. This figure is less than the national average of 12.6%, but average for New England.

Over recent years, the percentage of new dentists who are women has steadily increased, raising questions regarding future dental workforce productivity as women elect to balance family and profession. Initial evidence about women's career patterns suggests that over a lifetime, female dentists are as productive as male dentists, but that their peak productivity tends to occur later in their practice careers.

Some suggest that women dentists may be more attuned to addressing the needs of the underserved – although there is no empirical evidence to support that belief at this time.

Percentage of Female Dentists 1998

	Percentage of female dentists 1998	Rank Order
Connecticut	10.8%	4
Maine	8.9%	6
Massachusetts	14.4%	1
New Hampshire	**10.8%**	**3**
Rhode Island	11.3%	2
Vermont	10.0%	5
United States	12.6%	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002.

Table 5: Dental Schools and Advanced Dental Education

Of New England's four dental schools, three are located in Boston (Boston University, Tufts University, Harvard University) and one is in Connecticut (University of Connecticut). Boston schools are private, while the University of Connecticut is publicly supported.

Dentistry does not require advanced training beyond dental school, although some elect advanced training in either general dentistry or one of the eight recognized dental sub specialties. Advanced dental education programs included in this table are General Practice Residencies (one- or two-year programs, typically in hospitals, that further the training of general dentists); Advanced Education Programs in General Dentistry (like General Practice Residencies, except typically based in dental schools); and Pediatric Dentistry training programs that prepare dentists as specialists in the care of children. Pediatric dentistry residencies are affiliated with each of the four dental schools identified here, and a new pediatric dentistry residency has been started (in 2002) at Yale University.

Dental Schools and Advanced Dental Education

	Number of Dental Schools and Advanced Training Programs	Rank Order
Connecticut	9	2
Maine	0	4
Massachusetts	14	1
New Hampshire	**1**	**3**
Rhode Island	1	3
Vermont	1	3

Source: Directory of ADEA Institutional Members and Association Officers 2001-2002. American Dental Education Association.

DENTAL HYGIENISTS

Table 6: Number of Hygienists 1998 -2008 (projected)

Federal dental workforce data suggests a reasonably steady supply of Registered Dental Hygienists between 1998 and 2001 with an anticipated major increase of 50.7% between 2001 and 2008.

Registered Dental Hygienists are licensed dental professionals who provide an array of preventive services including health education, prophylaxis, and fluoride treatments as well as additional preventive treatments as authorized by individual state statutes and regulations. Depending upon the state, hygienists may function under the "direct" or "indirect" supervision of a dentist or may function independently of dentists in specific sites or in all sites.

Services provided by hygienists represent one important component of comprehensive dental care. Unlike nurse practitioners in medicine, who provide a comprehensive range of services to their level of expertise, dental hygienists' purview is specifically related to preventive (rather than corrective) care.

Number of Hygienists 1998 - 2008 (projected)

	1998	2000	2001	2008
Connecticut	2,700	3,060	2,700	3,400
Maine	700	715	912	950
Massachusetts	4,750	5,596	6,600	7,050
New Hampshire	**1,000**	**900**	**995**	**1,500**
Rhode Island	750	NA	795	900
Vermont	550	450	450	750

Sources: Synopses of state dental public health programs, Centers for Disease Control, 2000; http://www2.cdc.gov/nccdphp/doh/synopses/index.asp Accessed February 20, 2002

State occupational projections: 1998-2008; http://almis.dws.state.ut.us/occ/projections.asp Accessed March 5, 2002.

Table 7: Ratio of Hygienists per 100,000 Population 1998

All New England states enjoy a hygienist-to-population ratio higher than the United States, with nearly 50% more hygienists to population than the United States average. New Hampshire ranks second only to Vermont among New England States and has a hygienist-to-population ratio that is 62% higher than the United States mean. These findings suggest a potentially greater availability of preventive services in New Hampshire than in most other states.

Ratio of Hygienists per 100,000 Population 1998

	Dental Hygienists/1000 Population 1998	Rank Order
Connecticut	81.9	3
Maine	56.1	6
Massachusetts	77.3	5
New Hampshire	**84.3**	**2**
Rhode Island	78.0	4
Vermont	89.7	1
United States	52.1	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 8: Percent Change in Ratio of Hygienist Graduates 1985-86 to 1995-96

This table anticipates future hygienist availability in New Hampshire and New England. Additional information is needed for the period after 1996 for workforce projection and planning purposes, especially to reconcile these numbers with federal estimates of the hygienist workforce in 2008.

Percent Change in Ratio of Hygienist Graduates per 100,000 population 1985-86 to 1995-96

	Percent change in hygienist graduates per 100,000 Population	Rank Order
Connecticut	-8%	4
Maine	-36%	1
Massachusetts	-8%	5
New Hampshire	**-17%**	**3**
Rhode Island	150%	6
Vermont	-28%	2
United States	9%	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 9: Dental Hygienists: Permitted Functions and Supervision Levels by State, 2001

KEY		
	P	Physical presence of dentist is required
	N	Physical presence of dentist is not required
	U	Physical presence not required. No prior authorization by dentist required but there may be requirement for type of cooperative arrangement with a dentist(s). Some states require experience or special education by RDH.
	/	Where two letters are present in a box the first indicates the supervision level in the private dental office and the second in a "safety-net" site.
	—	Service is not a permitted function of RDH

	Prophytaxis	X-Rays	Local Anesthesia	Topical Anesthesia	Fluoride	Pit/fissure Sealants
Connecticut	N/U	N/U	—	N/U	N/U	N/U
Maine	N	N	P	N	N	N
Massachusetts	N	N	—	N	N	N
New Hampshire	**N**	**N**	—	**N**	**N**	**N**
Rhode Island	N	N	—	N	N	N
Vermont	N	N	P	N	N	N

	Root Planing	Soft Tissue Cuettage	Administer N2O	Study Cast Impressions	Place Perio Dressings	Remove Perio Dressings
Connecticut	N/U	—	—	N/U	N/U	N/U
Maine	N	N	—	N	P	N
Massachusetts	N	N	—	N	N	N
New Hampshire	**N**	—	—	**N**	—	**N**
Rhode Island	N	—	—	P	P	P
Vermont	N	—	—	N	N	N

	Place Sutures	Remove Sutures	Apply Cavity-liners and bases	Place Temporary Restorations	Remove Temporary Restorations	Place Amalgam Restorations
Connecticut	—	N/U	—	—	—	—
Maine	—	N	—	N	—	—
Massachusetts	—	N	—	N	P	P
New Hampshire	—	**N**	—	—	—	—
Rhode Island	—	P	P	P	P	—
Vermont	—	N	—	N	N	—

	Carve Amalgam Restorations	Finish Amalgam Restorations	Polish Amalgam Restorations	Place and Finish-Composite Resin Silicate Restore
Connecticut	—	—	N/U	—
Maine	—	—	N	—
Massachusetts	—	—	N	—
New Hampshire	—	—	**N**	—
Rhode Island	—	—	P	—
Vermont	—	N	N	—

Source: American Dental Hygienist Association. ADHA practice act overview chart of permitted functions and supervision levels by state. 2002.

Table 10: Ratio of Hygienists to Dentists 1998

Because dental hygienists provide one significant set of services and because of state legal requirements, they are typically collocated with dentists. The hygienist to dentist ratio suggests the preventive services capacity of dental offices.

Ratio of Hygienists to Dentists 1998

	Dental Hygienists/ Dentist Ratio 1998	Rank Order
Connecticut	1.2	6
Maine	1.3	5
Massachusetts	1.3	4
New Hampshire	**1.6**	**3**
Rhode Island	1.6	2
Vermont	1.7	1
United States	1.1	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 11: Entry Level Hygienist Programs 2002

Dental Hygiene programs vary by type and size. Some are "entry level" associates degree or bachelor degree programs, some are bachelor degree completion programs, and a few provide a "masters" level education. The "masters" level programs are typically for those seeking careers in teaching or administration. This table shows the number of "entry level" programs (Associate and Bachelor Degree programs) available in New England.

Entry Level Hygienist Programs 2002

	Number of entry level dental hygiene programs 2002	Rank Order
Connecticut	3	2
Maine	2	3
Massachusetts	7	1
New Hampshire	**1**	**4**
Rhode Island	1	4
Vermont	1	4

Source: Degree Completion Dental Hygiene Programs, American Dental Hygienists Association, 2002; http://www.adha.org/careerinfo/degree.htm Accessed March 5, 2002.

DENTAL ASSISTANTS

Table 12: Number of Dental Assistants 1998 & 2008 (projected)

Dental assistants refer to "chairside" auxiliaries who provide direct procedural assistance to dentists through "four handed dentistry." Their training may be through a short-term community college or proprietary course or "on-the-job."

Various states have developed either legislative or regulatory criteria to expand dental assistant functions as "EFDAs," (Expanded Function Dental Assistants). These additional authorizations may be modest (typically exposure of dental radiographs/x-rays) or extensive (including placement of fillings into teeth prepared by the dentist.)

Typically, a dentist works with one chairside assistant when serving a patient and may engage multiple chairside assistants in order to facilitate efficiency within and between operatories.

Number of Dental Assistants 1998 and 2008 (projected)

	1998	2008 (projected)
Connecticut	2,900	3,650
Maine	1,100	1,550
Massachusetts	5,300	8,000
New Hampshire	**900**	**1,400**
Rhode Island	700	850
Vermont	550	800

Source: State occupational projections: 1998-2008; http://slmis.dws.state.ut.us/occ/projections.asp

Table 13: Ratio of Dental Assistants per 100,000 Population 1998

Ratio of Dental Assistants per 100,000 Population 1998

	Dental Assistants per 100,000 population 1998	Rank Order
Connecticut	88.3	2
Maine	87.4	3
Massachusetts	87.1	4
New Hampshire	**77.6**	**5**
Rhode Island	72.9	6
Vermont	96.5	1
United States	85.6	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 14: Ratio of Dental Assistants to Dentists 1998

Although the absolute differences between states are small, the impact of additional assistants on practice productivity can be significant, and New England generally falls below the national mean in dentist-to-assistant ratio. This may reflect the fact that many states outside of New England typically allow dental assistants to perform some functions of a dental hygienist (partial prophylaxis), whereas New England dentists employ more hygienists than do their colleagues in other parts of the country.

Ratio of Dental Assistants to Dentists 1998

	Dental Assistants/ Dentists 1998	Rank Order
Connecticut	1.3	6
Maine	2.0	1
Massachusetts	1.4	5
New Hampshire	**1.5**	**3**
Rhode Island	1.5	4
Vermont	1.8	2
United States	1.8	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 15: Dental Assistant Programs 2001

Not all dental assistants are trained in formal programs. However, formal programs tend to ensure comprehensive training and relieve the dentist of responsibilities for instructing new staff. EFDA authorizations typically require formal training.

Dental Assistant Programs 2001

	Number of dental assistant education programs, 2001	Rank Order
Connecticut	6	2
Maine	1	3
Massachusetts	7	1
New Hampshire	**1**	**3**
Rhode Island	1	3
Vermont	1	3

Source: Dental Assisting, Dental hygiene and Dental Laboratory Technology Education Programs, American Dental Association, 2001 http://www.ada.org/prof/ed/programs/dahlt/index.html Accessed March 5, 2002.

MEDICAL PERSONNEL

Table 16: Medical Personnel

Primary medical care providers can be engaged in oral health promotion and disease prevention - particularly for pediatric populations- since dental caries (tooth decay) is initiated in the early toddler years when young children are frequently seen by medical personnel. Availability of primary care medical personnel for children is shown in the following chart.

Medical Personnel

	Number of general pediatricians in direct patient care 1998	Number of FP/GP in direct patient care 1998	Number of child health/ pediatric nurse practitioners active licences 2000	Rank Order
Connecticut	688	514	NA	2
Maine	147	402	70	3
Massachusetts	1,366	977	NA	1
New Hampshire	**174**	**340**	**78**	**4**
Rhode Island	199	166	NA	5
Vermont	108	218	33	6

Sources: Cull, W.L.. Physician Workforce Ratios for Child Health, 1998. American Academy of Pediatrics, June, 2000. http://www.aap.org/research/complete.pdf Accessed February 20, 2002.

Crawford, L.; Marks, C.; Gawel, S.H.; White, E.; Obichere, L. 2000 Licensure and Examination Statistics. National Council of State Boards of Nursing Inc. http://www.ncsbn.org/public/regulation/re/2000lic_exam_statistics_report_on-line.pdf Accessed February 20, 2002.

Appendix 4.
Utilization and Insurance

Contents

Table 1: Percent of Children (under age 19) with a Preventive Dental Visit – Estimations for 2000-2001

All population numbers in thousands.

		With a Preventive Visit		With NO Preventive Visit	
	Total Number of Children < 19	Number	Percent of Total	Number	Percent of Total
Connecticut	922	433	47.0%	489	53.0%
Maine	320	145	45.5%	174	54.5%
Massachusetts	1,646	712	43.3%	933	56.7%
New Hampshire	**357**	**168**	**47.0%**	**189**	**53.0%**
Rhode Island	242	106	43.8%	136	56.2%
Vermont	174	78	44.6%	96	55.4%
New England	3,660	1,642	44.9%	2,018	55.1%
United States	76,476	31,351	41.0%	45,125	59.0%

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 2: Average Number of Dental Visits for Children (under age 19) – Estimations for 2000-2001

Populations and aggregate dental visits in thousands.

		Number Visiting a Dentist During the Year		Number of Dental Visits During the Year	
	Total Number of Children <19	Number	Percent with a Visit	Total Visits	Average Visits by by those with a Visit
Connecticut	922	468	50.8%	1,351	2.88
Maine	320	164	51.2%	460	2.81
Massachusetts	1,646	765	46.5%	2,155	2.82
New Hampshire	**357**	**184**	**51.4%**	**524**	**2.85**
Rhode Island	242	115	47.7%	333	2.89
Vermont	174	91	52.1%	259	2.86
New England	3,660	1,787	48.8%	5,083	2.84
United States	76,476	34,395	45.0%	93,191	2.71

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 3: Dental Insurance Coverage of Children (under age 19) by Source of Coverage Estimations for 2000-2001

All population numbers in thousands.

	Number of Children < 19			Number of Children by Type of Insurance Coverage				Percent of Total Children < 19			
				No Dental Coverage		With Dental Coverage		No Dental		With Dental	
	Total population	Number Without Dental Insurance	Percent of Total	No Health Insurance	Private Insurance	Private Insurance	Public Insurance	No Health Insurance	Private Insurance	Private Insurance	Public Insurance
Connecticut	922	304	33.0%	65	239	500	118	7.0%	26.0%	54.2%	12.8%
Maine	320	104	32.4%	25	79	139	77	7.9%	24.6%	43.6%	24.0%
Massachusetts	1,646	508	30.9%	156	352	661	477	9.5%	21.4%	40.1%	29.0%
New Hampshire	**357**	**115**	**32.1%**	**24**	**91**	**176**	**67**	**6.6%**	**25.5%**	**49.1%**	**18.8%**
Rhode Island	242	75	31.2%	14	62	122	45	5.7%	25.5%	50.4%	18.4%
Vermont	174	49	28.3%	16	33	56	69	9.1%	19.2%	32.1%	39.6%
New England	3,660	1,155	31.6%	299	856	1,653	852	8.2%	23.4%	45.2%	23.3%
United States	76,476	25,404	33.2%	10,499	14,905	33,734	17,338	13.7%	19.5%	44.1%	22.7%

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 4: Aggregate Annual Dental Expenditures for Children (under age 19) – Estimations for 2000-2001

All population numbers in thousands. Aggregate exependiture numbers in millions.

	Population		Aggregate Expenditures by Source				Distribution of Expenditures			Average Expenditure for Those with a Visit	
	Number Of Children	Number with a Visit	Total Expenditures	Insurance		Out-of-Pocket	Insurance		Out-of-Pocket	Total	Out-of-Pocket
				Private	Public		Private	Public			
Connecticut	922	468	$218	$100	$4	$114	46%	2%	52%	$466	$243
Maine	320	164	$56	$20	$4	$32	36%	7%	57%	$342	$194
Massachusetts	1,646	765	$325	$136	$19	$171	42%	6%	52%	$425	$223
New Hampshire	**357**	**184**	**$74**	**$31**	**$3**	**$40**	**42%**	**4%**	**54%**	**$403**	**$219**
Rhode Island	242	115	$53	$23	$2	$28	44%	3%	52%	$457	$239
Vermont	174	91	$28	$10	$3	$16	35%	11%	55%	$314	$172
New England	3,660	1,787	$755	$321	$35	$400	42%	5%	53%	$422	$224
United States	76,476	34,395	$15,157	$7,069	$736	$7,352	47%	5%	49%	$441	$214

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 5: Number and percent of children (under 19) at or below 200% of poverty – by health insurance coverage and state

All population numbers in thousands. SCHIP allocation formula.
Based on a November 2001 weighting correction.

		Total children at or below 200% of poverty					
				Insurance Coverage		No Insurance Coverage	
	Total children < 19	Total	Percent	Total	Percent	Total	Percent
Connecticut	905	181	20.0%	162	17.9%	19	2.1%
Maine	301	92	30.6%	75	25.0%	17	5.6%
Massachusetts	1,663	606	36.5%	537	32.3%	70	4.2%
New Hampshire	**335**	**79**	**23.6%**	**66**	**19.9%**	**13**	**3.7%**
Rhode Island	211	59	28.0%	54	25.6%	5	2.4%
Vermont	184	77	41.7%	65	35.6%	11	6.2%
United States	75,994	28,135	37.0%	22,574	29.7%	5,562	7.3%

Source: Current Population Survey. Annual Demographic Survey, March Supplement, Accessed February 8, 2002 at http://ferret.bls.census.gov/macro/032001/health/toc.htm

Appendix 5.
Medicaid and SCHIP

Prepared by David M. Krol, M.D.

Contents

ENROLLMENT & ELIGIBILITY

Table 1a: Number of Medicaid-eligible and CHIP-enrolled children

	Medicaid Eligible Children 2000	Rank Order	CHIP Enrollment 2000	Rank Order
Connecticut	217,468	2	10,572	3
Maine	78,283	3	60,854	1
Massachusetts	435,059	1	9,519	4
New Hampshire	**60,794**	**5**	**3,897**	**5**
Rhode Island	65,622	4	10,619	2
Vermont	60,629	6	2,485	6

Source: The Kaiser Commission on Medicaid and the Uninsured. CHIP program enrollment: December, 2000. http://www.kff.org/content/2001/4005/4005.pdf Accessed February 20, 2002.

Table 1b: Eligibility

	CHIP Federal Matching Rate FY2002[1]	Rank Order	Medicaid Federal Matching Rate FY2002[2]	Rank Order	CHIP upper income limit (%FPL) 2001[3]	Rank Order	CHIP Eligibility level (0-1) Dec. 2000[4]	Rank Order	CHIP Eligibility level (1-19) Dec. 2000[5]	Rank Order
Connecticut	65%	4	50%	4	300%	1	185%	5	185%	3
Maine	77%	1	50%	4	200%	3	250%	2	150%	4
Massachusetts	65%	4	67%	1	200%	3	225%	3	150%	4
New Hampshire	65%	**4**	50%	**4**	300%	**1**	200%	**4**	185%	**3**
Rhode Island	67%	3	52%	3	250%	2	300%	1	250%	1
Vermont	74%	2	63%	2	300%	1	200%	4	225%	2

Source: 1. Federal Register, November 17, 2000 (Vol. 65, No. 223), pp. 69560-69561.
2. Ibid.
3. Center for Medicare and Medicaid Services. The State Children's Health Insurance Program Annual Enrollment Report fiscal year 2001: October 1, 2000 - September 30, 2001. http://www.hcfa.gov/init/schip01.pdf Accessed February 20, 2002.
4. The Kaiser Commission on Medicaid and the Uninsured. CHIP program enrollment: December, 2000. http://www.kff.org/content/2001/4005/4005.pdf Accessed February 20, 2002.
5. Ibid.

DENTIST PARTICIPATION

Table 2: Dentist Participation

While these data suggest high levels of participation in Medicaid, the percentage accepting new patients and the percentage actively treating significant numbers of patients is considerably lower.

Dentist Participation

	Percent of dentists enrolled in CHIP 2001	Rank Order	Percent of dentists participating in the Medicaid dental program 2001	Rank Order
Connecticut	86%	1	88%	1
Maine	49%	4	20%	6
Massachusetts	NR	—	49%	3
New Hampshire	76%	3	35%	5
Rhode Island	NR	—	46%	4
Vermont	84%	2	84%	2

Source: Synopses of state dental public health programs, Center for Disease Control. http://www2.cdc.gov/nccdphp/doh/synopses/index.asp 2000 (unless otherwise noted) Accessed February 20, 2002.

Table 3: Dental Participation by Reimbursement

	Percentage of active dentists enrolled in Medicaid 1998	Rank Order	Percentage of active dentists receiving payment from Medicaid 1998	Rank Order	Percentage of active dentists receiving more than $10,000 from Medicaid 1998	Rank Order
Connecticut	32%	5	21%	5	4%	5
Maine	96%	1	25%	4	15%	3
Massachusetts	61%	4	56%	2	16%	2
New Hampshire	**81%**	**3**	**55%**	**3**	**15%**	**4**
Vermont	88%	2	88%	1	39%	1
Rhode Island	—	—	—	—	—	—

Source: Data collected by the National Conference of State Legislatures, Forum for State Health Policy Leadership; 1999. In States approaches to increasing Medicaid beneficiaries access to dental services, Epstein, CA November 2000.

Table 4: Medicaid Payment Rates as a Percentage of Average Regional Dental Fees for Selected Procedures, 1999

Region and state	Periodic oral examination	Dental cleaning child	Metal filling, 2 surfaces	Root canal, treatment	Extraction, single tooth	Of 15 Procedures number for which Medicaid exceeded 2/3 of average regional fees	Range of Medicaid rates as % of average regional fees
Connecticut	67%	52%	48%	46%	46%	1	45-67%
Maine	52%	72%	56%	49%	63%	2	50-75%
Massachusetts	36%	46%	47%	30%	52%	0	30-64%
New Hampshire	**73%**	**68%**	**61%**	**44%**	**46%**	**2**	**43-73%**
Rhode Island	40%	53%	43%	58%	45%	1	40-77%
Vermont	68%	63%	68%	65%	75%	5	53-85%

Source: General Accounting Office. Factors contributing to low use of dental services by low-income populations. GAO/HEHS-00-149. September, 2000.

EXPENDITURES

Table 5: Medicaid Total Expenditures

	MEDICAID Total Expenditures FY1998	Rank Order
Connecticut	$2,420,791,474	2
Maine	$747,027,618	4
Massachusetts	$4,609,360,933	1
New Hampshire	**$606,004,232**	**5**
Rhode Island	$919,353,410	3
Vermont	$351,341,290	6

Source: Health Care Financing Administration. HCFA-2082 Reports for Federal Fiscal year 1998, HCFA, CMSO, HCFA, 2082 REPORT, January 27, 2000. http://www.hcfa.gov/medicaid/msis/2082%D98.htm Accessed February 20, 2002.

Table 6: Medicaid Dental Expenditures

	MEDICAID Dental Expenditures FY1998	Rank Order
Connecticut	$7,461,733	4
Maine	$4,500,980	6
Massachusetts	$53,661,108	1
New Hampshire	**$4,589,120**	**5**
Rhode Island	$9,372,139	2
Vermont	$7,965,583	3

Source: Health Care Financing Administration. HCFA-2082 Reports for Federal Fiscal Year 1998, HCFA, CMSO, HCFA-2082 REPORT, January 27, 2000. http://www.hcfa.gov/medicaid/msis/2082%D98.htm Accessed February 20, 2002.

Table 7: New Hampshire Dental Medicaid Expenditures

Average Dental Payment per User and Percent of Enrollees Using Each Service

	New Hampshire				New England				United States			
	Children < 21		Adults		Children < 21		Adults		Children < 21		Adults	
	Per-user	% Use	Per-user	% Use	Per-user	% Use	Per-user	% Use	Per-user	% Use	Per-user	% Use
1995	$187	46.0%	$159	9.0%	$173	43.0%	$193	31.0%	$151	22.0%	$177	14.0%
1996	$195	44.7%	$153	8.5%	$159	37.7%	$184	28.8%	$161	21.0%	$186	12.8%
1997	$197	36.8%	$173	7.2%	$164	27.3%	$186	24.6%	$166	17.5%	$191	11.0%
1998	$185	37.3%	$246	12.7%	$170	23.1%	$209	17.6%	$172	13.7%	$204	7.7%

Source: AAP Medicaid State Reports based on State submissions of form 2082 to HCFA/CMS.

Table 8: Medicaid Utilization by Age 1998

	Rank Order	Medicaid recipients under age 1 year, FY 1998	Rank Order	Medicaid recipients ages 1-5 years, FY1998	Rank Order	Medicaid recipients ages 6-14 years, FY1998	Rank Order	Medicaid recipients ages 15-20 years, FY1998	Rank Order	Medicaid recipients over age 20 years FY 1998	Rank Order	Total Medicaid Recipients FY1998
Connecticut	2	11,337	2	61,527	2	91,304	2	38,712	2	178,328	2	381,208
Maine	4	4,257	4	22,420	3	36,703	3	18,827	3	86,525	3	170,456
Massachusetts	1	36,321	1	126,727	1	178,469	1	79,006	1	487,715	1	908,238
New Hampshire	**6**	**2,499**	**5**	**16,657**	**6**	**24,433**	**6**	**9,903**	**6**	**39,975**	**6**	**93,970**
Rhode Island	3	4,288	3	25,004	4	34,289	4	13,617	4	73,234	4	153,130
Vermont	5	2,410	6	15,757	5	26,550	5	12,569	5	65,047	5	123,992

Source: Health Care Financing Administration. HCFA-2082 Reports for Federal Fiscal Year 1998, HCFA, CMSO, HCFA, 2082 REPORT, January 27, 2000. http://www.hcfa.gov/medicaid/msis/2082%2D98.htm Accessed February 20, 2002.

Table 9: Actuarial Estimates of SCHIP Monthly Costs per Child Based on Market Rates

	Comprehensive Benefits Package Including Dental				Dental Benefits			
	Urban	Rank Order	Rural	Rank Order	Dental	Rank Order	% Dental	Rank Order
Connecticut	$119.36	1	$113.36	1	$25.62	1	21.5%	2
Maine	$105.96	5	$94.05	5	$19.80	5	18.7%	6
Massachusetts	$110.98	3	$94.02	6	$25.62	2	23.1%	1
New Hampshire	**$109.95**	**4**	**$99.76**	**3**	**$22.13**	**4**	**20.1%**	**4**
Rhode Island	$111.95	2	$105.93	2	$23.30	3	20.8%	3
Vermont	$102.27	6	$95.63	4	$19.80	6	19.4%	5
United States	$101.47	—	—	—	$21.35	—	21.0%	—

Source: American Academy of Pediatrics (paper): AAP summary of 1998 Total Projected Health Care Cost State & National Average Population: 0 - 21 Year Olds.

Appendix 6.
New Hampshire Demographics

Prepared by David M. Krol, M.D.

Contents

Table 1: Child Population by Race

	Black		White		Hispanic		Other		Total
Connecticut	93,061	11.3%	585,559	71.4%	115,659	14.1%	26,247	3.2%	820,526
Maine	2,450	0.8%	284,824	96.2%	3,590	1.2%	5,364	1.8%	296,228
Massachusetts	97,671	6.7%	1,128,792	77.4%	157,726	10.8%	75,053	5.1%	1,459,242
New Hampshire	**2,477**	**0.8%**	**289,164**	**94.9%**	**7,787**	**2.6%**	**5,288**	**1.7%**	**304,716**
Rhode Island	13,585	5.9%	180,075	78.4%	35,002	15.2%	1,011	0.4%	229,673
Vermont	1,020	0.7%	139,667	96.4%	1,836	1.3%	2,383	1.6%	144,906

Sources: QT-P1. Age groups and sex: 2000. Census 2000 Summary File 1 (SF1) 100 percent data. United States Census Bureau. http://factfinder.census.gov/servlet/QTTable? ts=32352659041 Accessed February 20, 2002.

2001 Kids Count Databook Online. Annie E. Casey Foundation, http://www.aecf.org/kidscount/kc2001/ Accessed February 20, 2002.

Table 2: Child Population by Age

	Under 5		5 to 9		10 to 14		15 to 18		Total
Connecticut	223,344	26.5%	244,144	29.0%	241,587	28.7%	132,613	15.8%	841,688
Maine	70,726	23.5%	83,022	27.6%	92,252	30.6%	55,238	18.3%	301,238
Massachusetts	397,268	26.5%	430,861	28.7%	431,247	28.7%	240,688	16.0%	1,500,064
New Hampshire	**75,685**	**24.4%**	**88,537**	**28.6%**	**93,255**	**30.1%**	**52,085**	**16.8%**	**309,562**
Rhode Island	63,896	25.8%	71,905	29.0%	71,370	28.8%	40,651	16.4%	247,822
Vermont	33,989	23.0%	41,101	27.9%	45,397	30.8%	27,036	18.3%	147,523

Sources: QT-P1. Age groups and sex: 2000. Census 2000 Summary File 1 (SF1) 100 percent data. United States Census Bureau. http://factfinder.census.gov/servlet/QTTable? ts=32352659041 Accessed February 20, 2002.

2001 Kids Count Databook Online. Annie E. Casey Foundation, http://www.aecf.org/kidscount/kc2001/ Accessed February 20, 2002.

Table 3: Percentage of Children in Poverty

	Poverty rate for children 18 and under 1999-2000 (%)	Rank Order
Connecticut	11	6
Maine	16	3
Massachusetts	23	1
New Hampshire	**12**	**5**
Rhode Island	16	4
Vermont	21	2
US	21	—

Sources: QT-P1. Age groups and sex: 2000. Census 2000 Summary File 1 (SF1) 100 percent data. United States Census Bureau. http://factfinder.census.gov/servlet/QTTable? ts=32352659041 Accessed February 20, 2002.

2001 Kids Count Databook Online. Annie E. Casey Foundation, http://www.aecf.org/kidscount/kc2001/ Accessed February 20, 2002.

Appendix 7.
Distribution of New Hampshire Oral Health Resources

Contents

Map 1: New Hampshire Health Service Areas

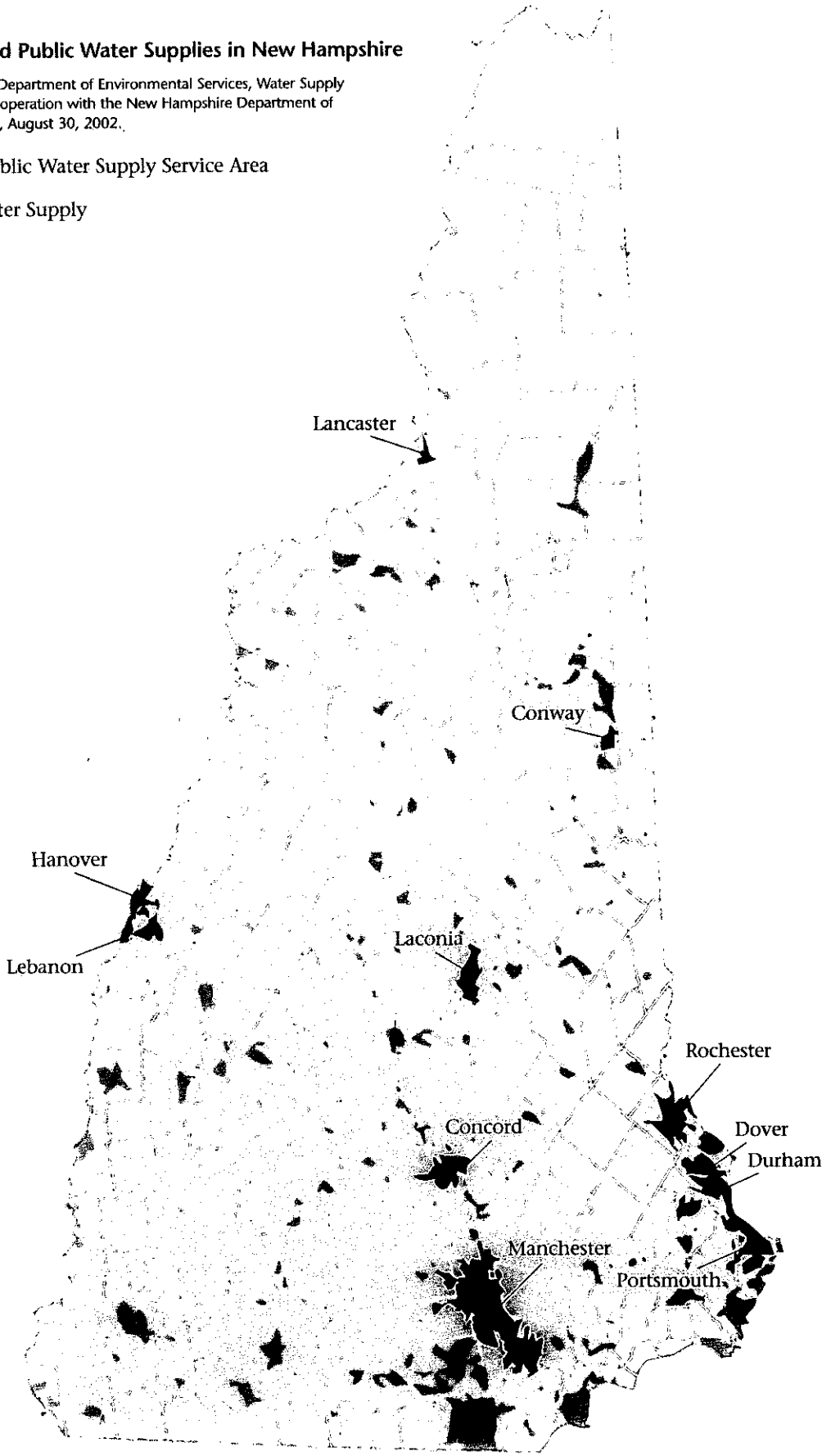
Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.

Map 2: Fluoridated Public Water Supplies in New Hampshire

Source: New Hampshire Department of Environmental Services, Water Supply Engineering Bureau, in cooperation with the New Hampshire Department of Health & Human Services, August 30, 2002.

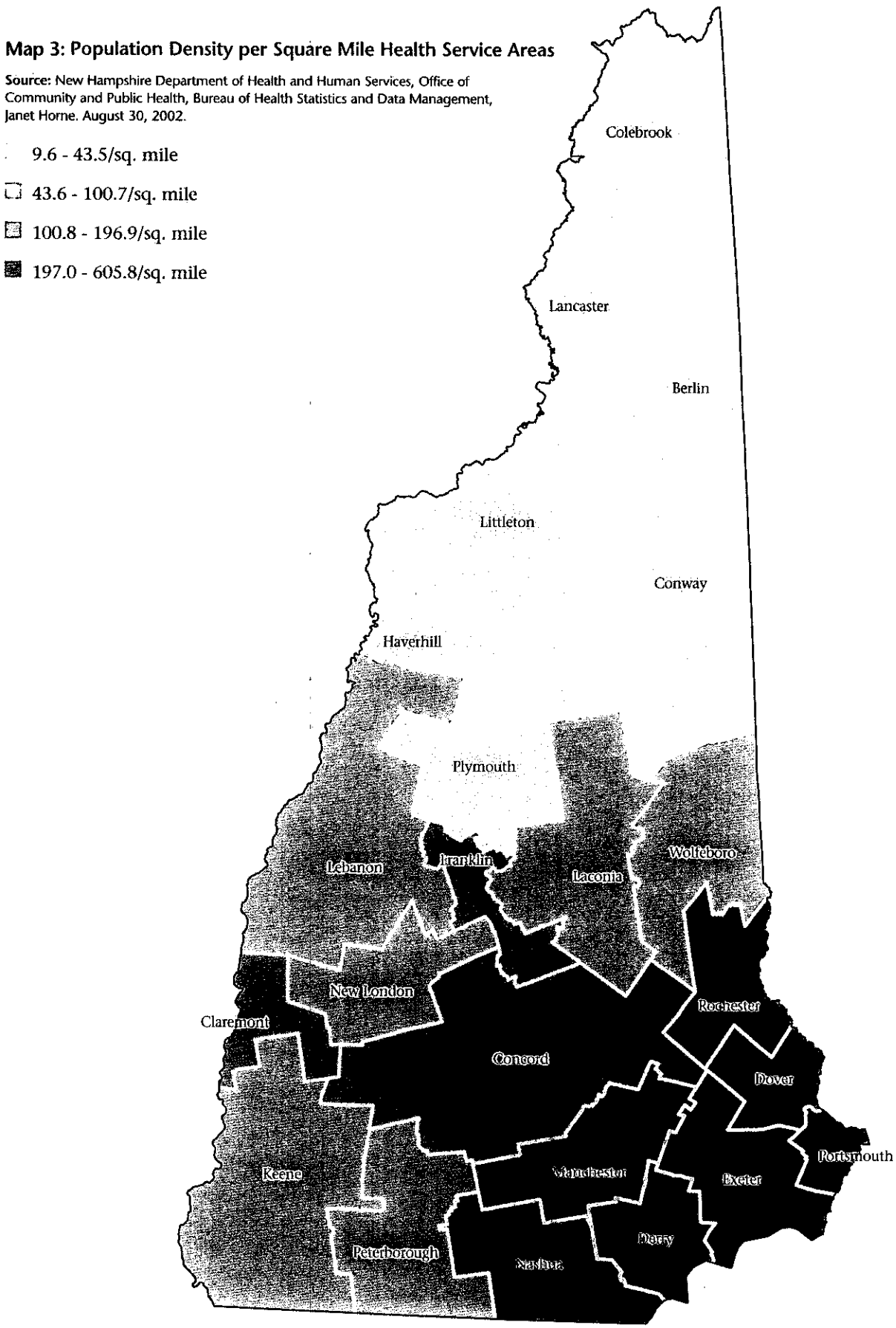
☐ Community Public Water Supply Service Area

■ Fluroidated Water Supply



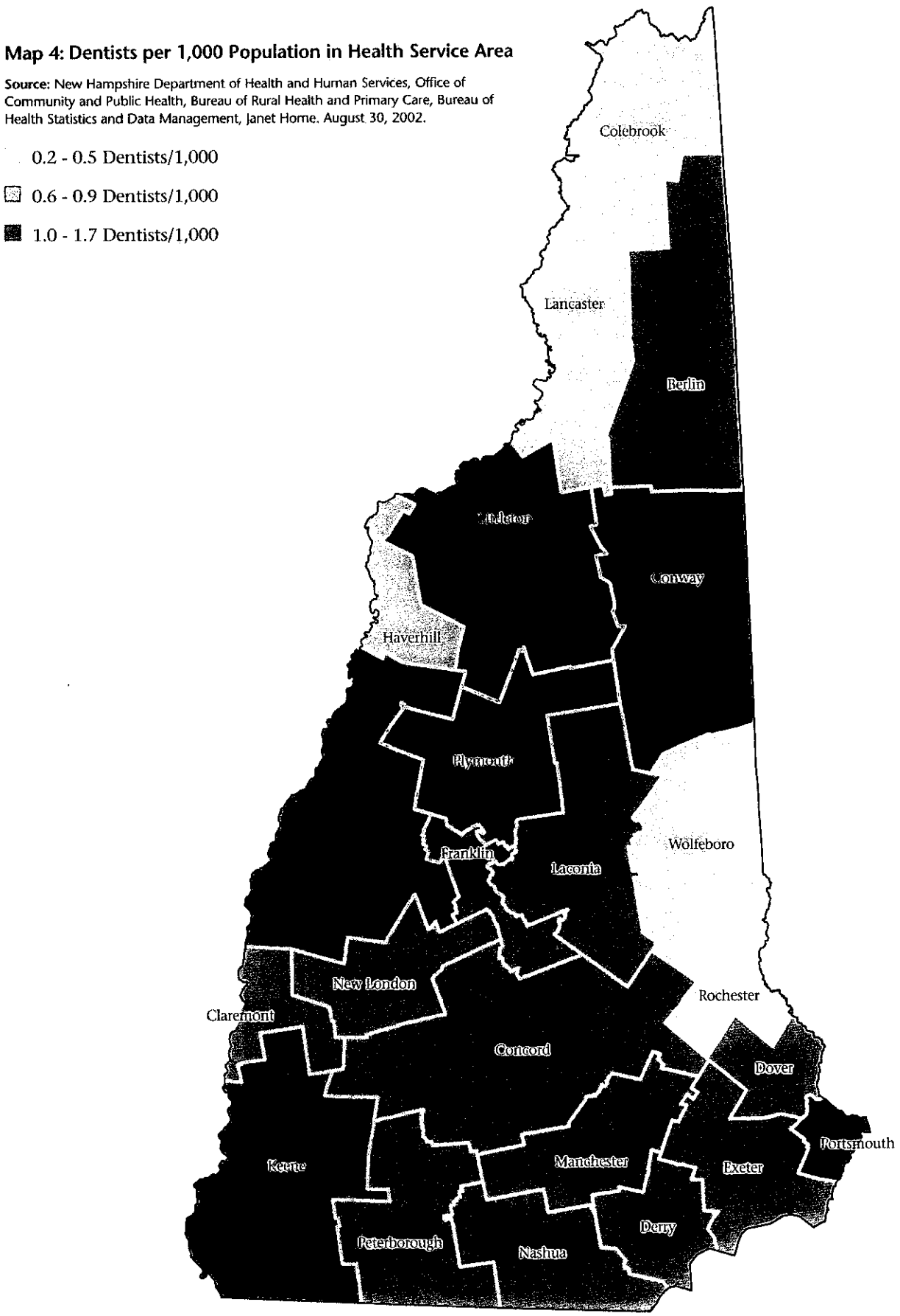
Map 3: Population Density per Square Mile Health Service Areas

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.



Map 4: Dentists per 1,000 Population in Health Service Area

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Rural Health and Primary Care, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.

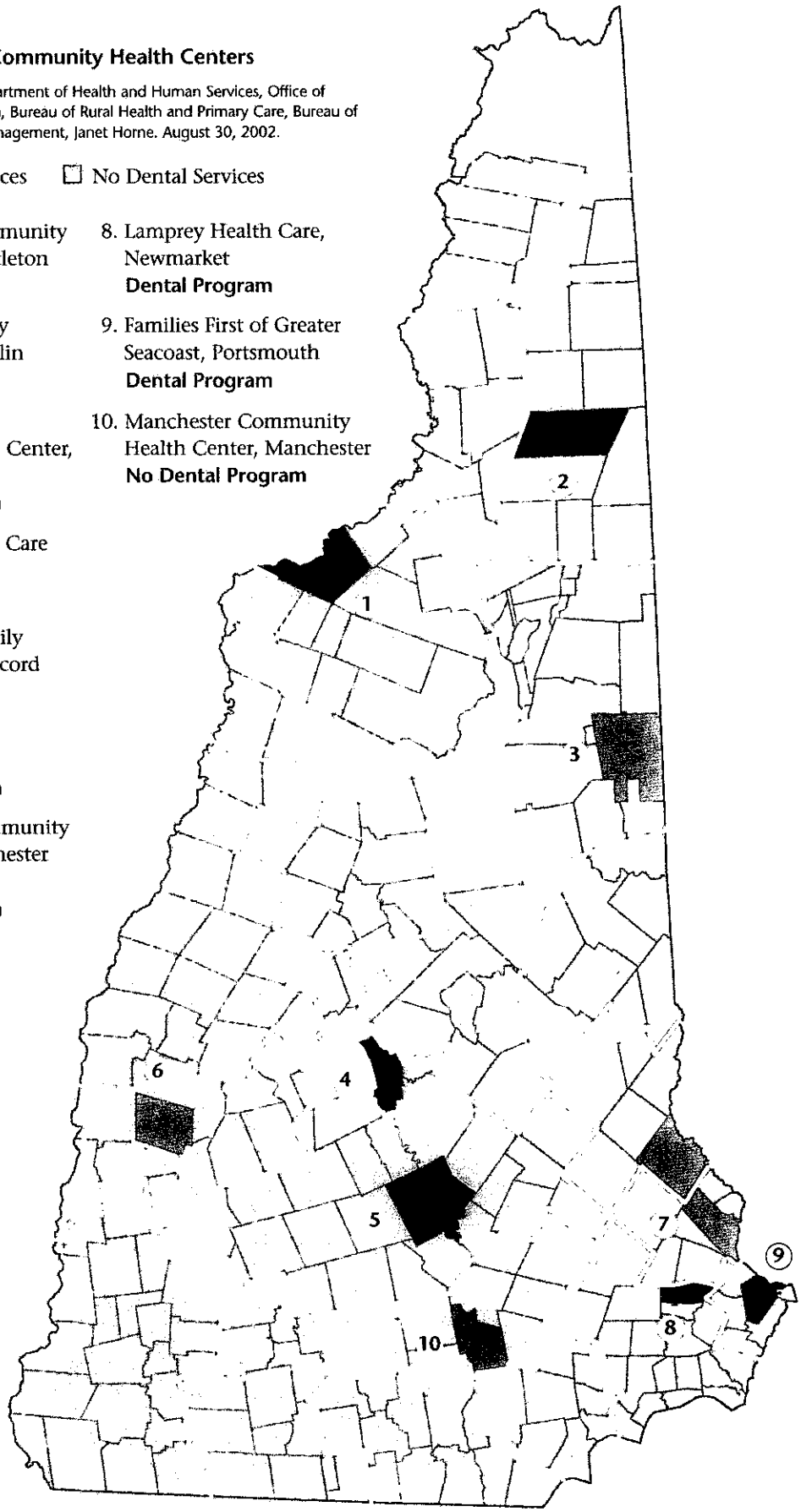


Map 5: Location of Community Health Centers

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Rural Health and Primary Care, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.

■ Offers Dental Services ☐ No Dental Services

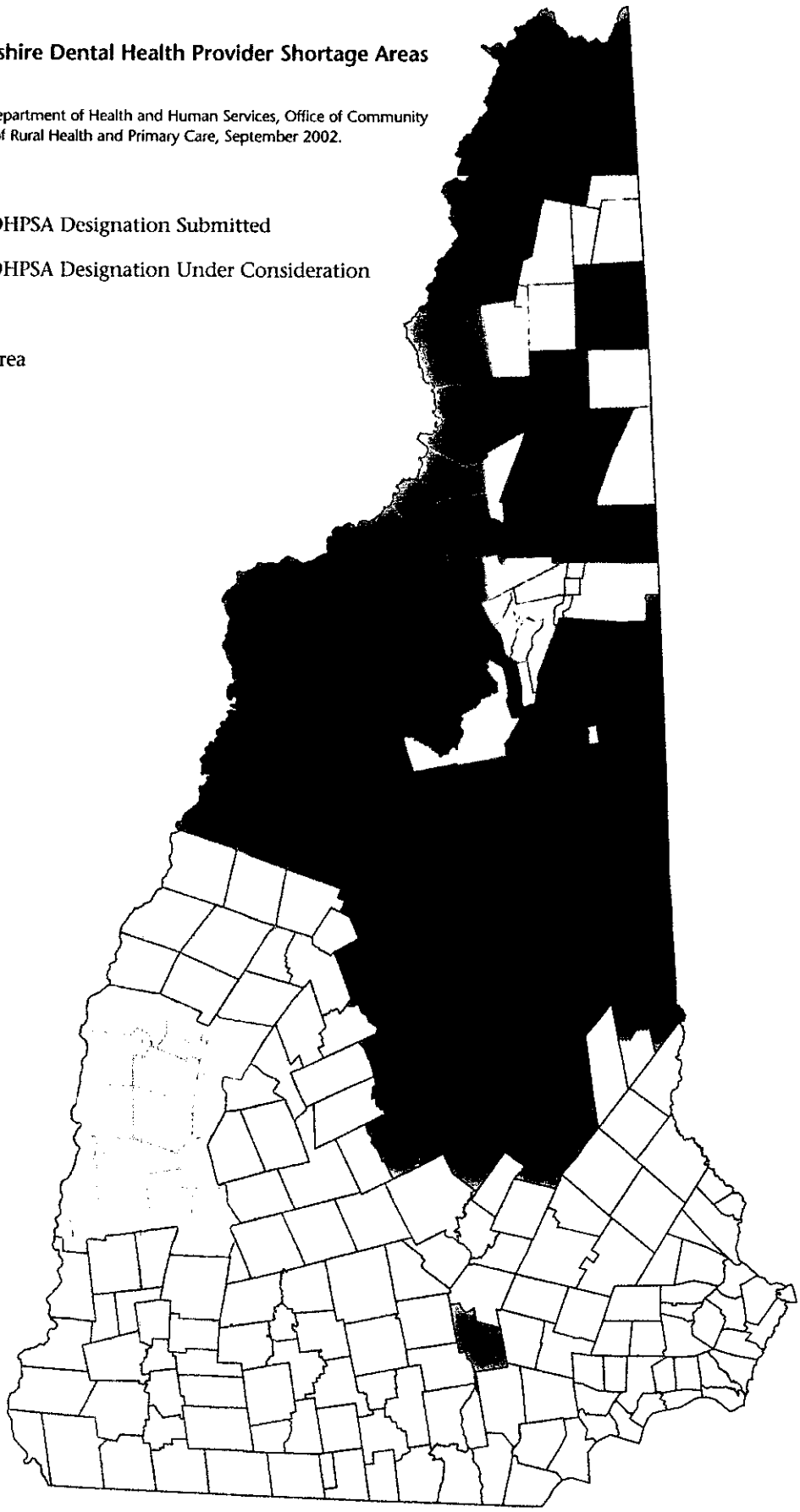
1. Ammonoosuc Community Health Services, Littleton
   Dental Program
2. Coos County Family Health Services, Berlin
   Dental Program
3. White Mountain Community Health Center, Conway
   No Dental Program
4. Health First: Family Care Center, Franklin
   Dental Program
5. Capital Region Family Health Center, Concord
   Dental Program
6. Partners in Health, Newport
   No Dental Program
7. Avis Goodwin Community Health Center. Rochester and Dover
   No Dental Program
8. Lamprey Health Care, Newmarket
   Dental Program
9. Families First of Greater Seacoast, Portsmouth
   Dental Program
10. Manchester Community Health Center, Manchester
    No Dental Program



Map 6: New Hampshire Dental Health Provider Shortage Areas (DHPSA)

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Rural Health and Primary Care, September 2002.

- DHPSA
- Application for DHPSA Designation Submitted
- Application for DHPSA Designation Under Consideration
- Unpopulated
- Not a Shortage Area



If you would like to receive additional copies of the *New Hampshire Oral Health Plan: A Framework for Action,* and learn more about the Coalition for New Hampshire Oral Health Action contact:

Coalition for New Hampshire Oral Health Action
c/o The Endowment for Health
14 South Street • Concord, NH 03301
Phone: 603-228-2448 • E-Mail: info@endowmentforhealth.org

This report is also available online at: www.endowmentforhealth.org and www.dhhs.state.nh.us/DHHS/ORALHEALTH/default.htm

SB 436, 2010

MEMORANDUM

DATE: October 27, 2010

TO: Honorable John H. Lynch, Governor
Honorable Terie Norelli, Speaker of the House
Honorable Sylvia B. Larsen, President of the Senate
Honorable Karen O. Wadsworth, House Clerk
Tammy L. Wright, Senate Clerk
Michael York, State Librarian

FROM: Charlotte Houde Quimby, Chair

SUBJECT: Interim Report on ~~SB 436, Chapter 351, Laws of 2010~~ RSA 126-H:10
Commission Relative to Children's Health Insurance

Pursuant to SB 436, Chapter 351, Laws of 2010, enclosed please find the Interim Report of the Commission Relative to Children's Health Insurance. Thank you for this opportunity to provide an interim report on the progress and plans of the Commission.

If you have any questions or comments regarding this report, please do not hesitate to contact me.

Respectfully,
Charlotte Houde Quimby, Chair

Enclosures

cc: Members of the Committee

Commission Relative to Children's Health Insurance
Chapter 351, SB 436, Laws of 2010
Interim Report

Background

Through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the federal government has provided states with options and financial incentives for strengthening children's Medicaid and CHIP (NH Healthy Kids Gold and Silver) coverage and improving access to children's health care coverage. The Temporary Commission Relative to Children's Health Insurance ("Commission") was established to analyze and evaluate the feasibility of implementing state options under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Members of the Commission include:

- Senator Peggy Gilmour
- Representative Donna Schlachman
- Representative Roger Wells
- Representative Charlotte Houde Quimby, Governor's designee
- Lisabritt Solsky, representing the Department of Health & Human Services
- Gail Garceau, representing NH Healthy Kids
- Dr. Sol Rockenmacher, pediatrician
- Lisa Kaplan Howe, representing NH Voices for Health
- Richard Doran, representing NH Minority Health Coalition
- Angela Boyle, representing the NH Oral Health Coalition

Progress To Date

The Commission had its first meeting on September 30th. During that meeting, Commission members elected Representative Charlotte Houde Quimby as Chair of the Commission and Lisa Kaplan Howe as Clerk. The Commission decided to meet on a monthly basis going forward and plans to submit a final report on or before November 1, 2011, as required.

The Commission also spent time discussing the issues it will explore going forward. The state options available to New Hampshire under CHIPRA include:

- An opportunity to extend coverage to pregnant women up to 300% of the federal poverty level, using the 65% federal CHIP match.[1]
- An opportunity to waive the current 5-year waiting period for coverage of documented / legal immigrant children and pregnant women in Healthy Kids Gold and Healthy Kids Silver using

[1] The federal CHIP match will increase to 88% starting in 2016.

the 65% federal CHIP match[1] regardless of whether coverage is through Healthy Kids Gold or Healthy Kids Silver.

- An opportunity to provide dental coverage to children who have private medical coverage, but no dental coverage, and are otherwise eligible for Healthy Kids Silver. New Hampshire will receive the 65% federal CHIP match[1] for this coverage.
- An opportunity to receive federal performance bonuses if:
  1) NH meets aggressive enrollment targets in Healthy Kids Gold; and
  2) NH adopts at least 5 of 8 enrollment and retention best practice strategies in Medicaid and CHIP, including:
     - eliminating asset tests;
     - eliminating face-to-face interviews;
     - using a joint application and same information verification process for both Medicaid and CHIP;
     - adopting presumptive eligibility;
     - implementing 12 month continuous coverage;
     - conducting administrative renewals, which allows states to send pre-printed forms to family and automatically renew eligibility unless changes are reported by the family;
     - implementing express lane eligibility, which allows identification and enrollment of eligible children by working through other public programs; and
     - providing premium assistance to Medicaid and CHIP-eligible families to purchase private insurance.
- An opportunity to use an electronic connection to the Social Security Administration to verify applicants' identity and citizenship.

The Commission intends to explore the status of each of these options and best practices in New Hampshire, including how implementing each of these options will benefit the children and families of New Hampshire as well as the state as a whole, the cost of implementing these options to the state and the savings that will result from implementing the options. In addition, the Commission also discussed the importance of understanding the intersection between CHIPRA and the recently passed Patient Protection and Affordable Care Act (PPACA) and, in particular, any impact that the PPACA may have on the CHIPRA options. The Commission also intends to explore opportunities for strengthening outreach to, and enrollment of, hard to reach populations and possible opportunities for funding implementation of the CHIPRA options.

Planning for the Remainder of our Term

The Commission has compiled the attached workplan to guide its work over the coming year. At our next meeting we will adopt a timeline for completing each of these tasks to ensure a full exploration of the issues in time for our final report.

We have invited Tricia Brooks (Senior Fellow at Center for Children & Families and former / founding CEO of NH Healthy Kids), Lisabritt Solsky (Medicaid Deputy Director) and Gail

Garceau (CEO, NH Healthy Kids) to make presentations at our next meeting to provide us with a general overview of:

- New Hampshire's Healthy Kids Gold and Silver programs
- The CHIPRA options, their status in New Hampshire and work done to-date by the Department of Health and Human Services to explore implementing the options
- What, if any, impact the PPACA has on the CHIPRA options
- Models and lessons for implementing the CHIPRA options from other states

Coming out of that meeting, we expect to have a shared understanding of how New Hampshire is doing in covering children through New Hampshire Healthy Kids Gold and Silver and the opportunities available to us. We then look forward to exploring each of the CHIPRA options in more detail at the upcoming meetings. As part of that, we intend to invite a number of experts to testify at our meetings, as outlined in the attached workplan.

Thank you for the opportunity to provide this interim report on the progress and plans of the Temporary Commission on Children's Health Insurance. Please do not hesitate to be in touch with us with any questions.

We look forward to providing a final report and legislative recommendations by November 1, 2011.

SB 436 Study Commission Workplan

Issues to Explore	Questions	Possible Testifiers / Data Sources
General overview	- What are the options and where NH does stand - What, if any, is the impact of the ACA on the CHIPRA options? - What are other states doing? - Where is DHHS in exploring the options and what data do we have?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member* - Gail Garceau (CEO, NH Healthy Kids) – *commission member*
Opportunities to Enhance Enrollment of Eligible Children		
Outreach strategies / Secretary's challenge	- What is the challenge? - What are the opportunities? - What are the best practices NH should consider implementing?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director)
Establishing an electronic data link with the Social Security Administration	- What is the opportunity and how would it help? - What would the cost be in implementing this? - How will this impact enrollment / retention? - What savings would result? - Where is DHHS in exploring this?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director)
CHIPRA options for streamlining enrollment & retention (CHIPRA options that NH doesn't have in place)		

Performance Bonuses	- How close is NH to meeting? - Likely bonus size - Impact of the ACA - What, if any, is the impact of the ACA?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids)
Joint application / same information verification process for both Medicaid and CHIP	- Where does NH stand? - What would the cost be in implementing this? - How will this impact enrollment / retention? - What savings would result? - What, if any, is the impact of the ACA?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member* - Gail Garceau (CEO, NH Healthy Kids) – *commission member*
Presumptive eligibility	- Where does NH stand? - How does this work in Medicaid? - What would the cost be in implementing this? - How will this impact enrollment / retention? - What savings would result? - What, if any, is the impact of the ACA?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member* - Gail Garceau (CEO, NH Healthy Kids) – *commission member*
12 month continuous coverage	- Where does NH stand? - How does this work in Medicaid? - What would the cost be in implementing this? - How will this impact enrollment / retention? - What savings would result? - What, if any, is the impact of the ACA?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member* - Gail Garceau (CEO, NH Healthy Kids) – *commission member*
Administrative renewals	- Where does NH stand?	- Tricia Brooks (Center

	- How does this work in Medicaid? - What would the cost be in implementing this? - How will this impact enrollment / retention? - What savings would result? - What, if any, is the impact of the ACA?	for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member* - Gail Garceau (CEO, NH Healthy Kids) – *commission member*
Express Lane Eligibility	- Where does NH stand? - How does this work in Medicaid? - What would the cost be in implementing this? - How will this impact enrollment / retention? - What savings would result? - What, if any, is the impact of the ACA?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member* - Gail Garceau (CEO, NH Healthy Kids) – *commission member*
Premium assistance to Medicaid and CHIP-eligible families to purchase private insurance	- Where does NH stand? - How does this work in Medicaid? - What would the cost be in implementing this? - How will this impact enrollment / retention? - What savings would result? - What, if any, is the impact of the ACA?	- Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member* - Gail Garceau (CEO, NH Healthy Kids) – *commission member*
CHIPRA Options to Expand Eligibility		
Expanding coverage for pregnant women	- Where does NH stand? - How many people will benefit? - What would the cost	- March of Dimes - Divisions of Public Health Services / Maternal Child Health

	be? - What savings would result? - What, if any, is the impact of the ACA?	Section - Maternal Child Health Nurse (Tina Smith – Concord VNA) - Representative from CHAD / Dartmouth-Hitchcock or Elliot Hospital - Steve Norton (NH Center for Public Policy Studies) - Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member*
Eliminating waiting period for legal immigrant children & pregnant women	- Where does NH stand? - How many people will benefit? - What would the cost be? - What savings would result? - What, if any, is the impact of the ACA?	- Richard Doran (NH Minority Health Coalition) – *commission member* - Member of immigrant / refugee community - Tess Keunnig (Bi-State Primary Care Association) or representative of community health center - Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member*
Creating a dental-only plan	- Where does NH stand? - How many people will benefit? - What would the cost be?	- Angela Boyle (NH Oral Health Coalition) – *commission member* - Representative from the Dental Society

	- What savings would result? - What, if any, is the impact of the ACA?	- Representative from Delta Dental - Tricia Brooks (Center for Children & Families and former / founding CEO NH Healthy Kids) - Lisabritt Solsky (Medicaid Deputy Director) – *commission member*
Financing Options	- What are the possible financing sources?	- Jeff McLynch (NH Fiscal Policy Institute)

Voting Sheets

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on SB 436

BILL TITLE: **relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.**

DATE: 4-22-10

LOB ROOM: 302

Amendments:

Sponsor: Rep. Commerce — OLS Document #: 2010 1694h

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Schlachman

Seconded by Rep. Nevins

Vote: 15-0 (Please attach record of roll call vote.)

Motions: OTP (OTP/A) ITL, Interim Study (Please circle one.)

Moved by Rep. Schlachman

Seconded by Rep. Nevins

Vote: 15-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: Consent or Regular (Circle One)

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. James F. Headd, Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on SB 436

BILL TITLE: **relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.**

DATE: 4-22-13-10

LOB ROOM: 302

Amendments: converted to: 2195 / 1694h Commerce

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Schlachman

Seconded by Rep. ~~Hunt~~ Nevins

Vote: 15-0 (Please attach record of roll call vote.)

Motions: OTP (OTP/A) ITL, Interim Study (Please circle one.)

Moved by Rep. Schlachman

Seconded by Rep. Nevins

Vote: 15-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: Consent or Regular (Circle One)

(Vote to place on Consent Calendar must be unanimous.) 15-0

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. James F. Headd, Clerk

OFFICE OF THE HOUSE CLERK 2010 SESSION

COMMERCE AND CONSUMER AFFAIRS

Bill #: SB 436 Title: Commission Relative to Children's Health

PH Date: ___/___/___ Exec Session Date: 4/13/10

Motion: OTP Amendment #: 2195 1694h

MEMBER	YEAS	NAYS
Butler, Edward A, Chairman	✓	
Schlachman, Donna L, V Chairman	✓	
DeStefano, Stephen T	✓	
Kopka, Angeline A	✓	
Meader, David R	—	
McEachern, Paul	✓	
Hammond, Jill Shaffer	✓	
Nord, Susi	✓	
Winters, Joel F	✓	
Keans, Sandra B	—	
Gidge, Kenneth N	✓	
Hunt, John B	—	
Quandt, Matt J	✓	
Belanger, Ronald J	—	
Flanders, Donald H	✓	
Holden, Rip	—	
Dowling, Patricia A	✓	
Headd, James F, Clerk	✓	
Nevins, Chris F	✓	
Palfrey, David J	✓	
	15 -	0

TOTAL VOTE:

Printed: 12/18/2009

OFFICE OF THE HOUSE CLERK 2010 SESSION

COMMERCE AND CONSUMER AFFAIRS

Bill #: SB 436 Title: Commission Re Children Health

PH Date: / / Exec Session Date: 4 / 22 / 10

Motion: OTP/A Amendment #:

MEMBER	YEAS	NAYS
Butler, Edward A, Chairman	✓	
Schlachman, Donna L, V Chairman	✓	
DeStefano, Stephen T	✓	
Kopka, Angeline A	✓	
Meader, David R	—	
McEachern, Paul	✓	
Hammond, Jill Shaffer	✓	
Nord, Susi	✓	
Winters, Joel F	✓	
Keans, Sandra B	—	
Gidge, Kenneth N	✓	
Hunt, John B	—	
Quandt, Matt J	✓	
Belanger, Ronald J	—	
Flanders, Donald H	✓	
Holden, Rip	—	
Dowling, Patricia A	✓	
Headd, James F, Clerk	✓	
Nevins, Chris F	✓	
Palfrey, David J	✓	
	15-0	

TOTAL VOTE:

Printed: 12/18/2009

Committee Report

CONSENT CALENDAR

May 5, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on COMMERCE AND CONSUMER AFFAIRS to which was referred SB436,

AN ACT relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. Donna L Schlachman

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**COMMERCE AND CONSUMER AFFAIRS**
Bill Number:	**SB436**
Title:	**relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.**
Date:	**April 28, 2010**
Consent Calendar:	**YES**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT**

STATEMENT OF INTENT

New Hampshire's Healthy Kids program is a successful private-public partnership currently serving over 80,000 children who would not otherwise have access to health care. This statutory commission will study how best to take advantage of and implement additional options available to states through the federal Children's Health Insurance Program Reauthorization Act of 2009. These include expanded coverage for eligible pregnant women and newborns as well as a dental-only program for children with private health insurance but no dental coverage. The Department of Health and Human Services testified programs, a lack of funding for the state match and staff to manage and implement new programs make it impossible to do so. The Commerce Committee believes this is a good time to consider and plan for new approaches to services, to realize cost-savings, and to prioritize program components under this program so NH can be in a position to take advantage of federal funds when our economy recovers. Interim report to be made in November 2010 with final report and repeal of the commission by the end of 2011. In addition, this bill changes the Healthy Kids enrollment eligibility period from 30 to 60 days for children wholose coverage underanother health plan.

Vote 15-0.

Rep. Donna L Schlachman

Original: House Clerk
Cc: Committee Bill File

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

CONSENT CALENDAR

COMMERCE AND CONSUMER AFFAIRS

SB436, relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance. **OUGHT TO PASS WITH AMENDMENT.**

Rep. Donna L Schlachman for COMMERCE AND CONSUMER AFFAIRS. New Hampshire's Healthy Kids program is a successful private-public partnership
currently serving over 80,000 children who would not otherwise have access to health care. This statutory commission will study how best to take advantage of and implement additional options available to states through the federal Children's Health Insurance Program Reauthorization Act of 2009. These include expanded coverage for eligible pregnant women and newborns as well as a dental-only program for children with private health insurance but no dental coverage. The Department of Health and Human Services testified programs, a lack of funding for the state match and staff to manage and implement new programs make it impossible to do so. The Commerce Committee believes this is a good time to consider and plan for new approaches to services, to realize cost-savings, and to prioritize program components under this program so NH can be in a position to take advantage of federal funds when our economy recovers. Interim report to be made in November 2010 with final report and repeal of the commission by the end of 2011. In addition, this bill changes the Healthy Kids enrollment eligibility period from 30 to 60 days for children wholose coverage underanother health plan.

Vote 15-0.

Original: House Clerk
Cc: Committee Bill File

Stapler, Carol

From: EdoftheNotch@aol.com
Sent: Tuesday, April 27, 2010 6:02 PM
To: Stapler, Carol
Cc: Schlachman, Donna
Subject: Fwd: Take 2: blurbs

Carol,

These are OK to go. And will you please let me know which bills are still outstanding for blurbs?

Thanks,
Ed

From: schlbeck@comcast.net
To: EdoftheNotch@aol.com
Sent: 4/26/2010 8:38:03 P.M. Eastern Daylight Time
Subj: Take 2: blurbs

Ed,
I just reread my blurbs and made slight corrections in each one. If
you have not sent them to Carol will you send these instead?
Donna
>
> BLURBS - Donna Schlachman
>
> HB 436
> NH's Healthy Kids program is a successful private-public partnership
> currently serving over 80,000 children who would not otherwise have
> access to health care. This statutory commission will study how best to take
> advantage of and implement additional options available to states
> through the federal Children's Health Insurance Program
> Reauthorization Act of 2009. These include expanded coverage for
> eligible pregnant women and newborns as well as a dental-only
> program for children with private health insurance but no dental
> coverage. The Department of Health and Human Services testified
> that while it agrees that NH should take advantage of these other
> programs, a lack of funding for the state match and staff to manage
> and implement new programs make it impossible to do so. The
> Commerce Committee believes this is a good time to consider and
> plan for new approaches to services, to realize cost-savings, and
> to prioritize program components under this program so NH can be in
> a position to take advantage of federal funds when our economy
> recovers. Interim report to be made in November 2010 with final report and repeal of the
commission by the end of 2011. In addition, this bill changes the Healthy Kids
> enrollment eligibility period from 30 to 60 days for children who
> lose coverage under another health plan.
>
> HB 459
>
> New Hampshire is one of the few states that mandates "Med Pay"
> coverage be issued with all its motor vehicle liability policies.
> Such coverage is "no-fault" and is to be used solely for the