Bill as Introduced

SB 436 – AS INTRODUCED

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

10-2853
05/10

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 representative of the office of the governor, appointed by the governor.

(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.

03/17/10 1028s

SB 436 – AS AMENDED BY THE SENATE

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.

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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.

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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.

SB 436 – AS AMENDED BY THE HOUSE

03/17/10 1028s
05May2010... 1694h

2010 SESSION

10-2853
05/10

SENATE BILL ***436***

AN ACT relative to health insurance open enrollment periods and establishing a temporary 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

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.

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.

03/17/10 1028s
05May2010... 1694h

10-2853
05/10

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 temporary commission relative to children's health insurance.

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

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.

(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.

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.

SB 436 – FINAL VERSION

03/17/10 1028s
05May2010... 1694h

2010 SESSION

10-2853
05/10

SENATE BILL ***436***

AN ACT relative to health insurance open enrollment periods and establishing a temporary 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

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.

. . . . . .

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03/17/10 1028s
05May2010... 1694h

10-2853
05/10

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 temporary commission relative to children's health insurance.

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

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.

(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.

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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.

Amendments

Sen. Gilmour, Dist. 12
February 16, 2010
2010-0778s
05/04

Amendment to SB 436

Amend section 2 of the bill by replacing subparagraph I(c) with the following:

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

Commerce, Labor and Consumer Protection
March 16, 2010
2010-1028s
05/04

Amendment to SB 436

Amend section 2 of the bill by replacing subparagraph I(c) with the following:

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

Committee Minutes

Printed: 02/23/2010 at 4:10 pm

SENATE CALENDAR NOTICE

COMMERCE, LABOR AND CONSUMER PROTECTION

Senator Margaret Hassan Chairman
Senator Betsi DeVries V Chairman
Senator Deborah Reynolds
Senator Jacalyn Cilley
Senator Peter Bragdon
Senator Sheila Roberge

For Use by Senate Clerk's Office ONLY
☐ Bill Status
☐ Docket
☐ Calendar
Proof: ☐ Calendar ☐ Bill Status

Date: February 23, 2010

HEARINGS

Tuesday **3/16/2010**

(Name of Committee)	(Place)	(Time)
COMMERCE, LABOR AND CONSUMER PROTECTION	LOB 102	8:30 AM

EXECUTIVE SESSION MAY FOLLOW

8:30 AM	SB408	relative to purchasing alliances.
8:45 AM	SB420	relative to the use of mail-order pharmacies for prescription drug benefits under accident and health insurance policies and plans.
9:00 AM	SB436	relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance.
9:15 AM	SB468	relative to tort reform.

Sponsors:

SB408

Sen. Kathleen Sgambati	Sen. Peggy Gilmour	Sen. Deborah Reynolds	Sen. Bob Odell
Sen. John Gallus	Sen. Michael Downing	Rep. Edward Butler	Rep. Thomas Donovan

SB420

Sen. Jacalyn Cilley	Rep. James Craig	Rep. William Hatch	Rep. Susan Price

SB436

Sen. Peggy Gilmour	Rep. Larry Emerton	Sen. Bob Odell	Sen. John Gallus
Rep. Cindy Rosenwald	Rep. Alida Millham	Sen. Betsi DeVries	Rep. Donna Schlachman
Sen. Martha Fuller Clark			

SB468

Sen. Jeb Bradley	Sen. Michael Downing	Rep. Sherman Packard	Rep. David Boutin
Sen. John Gallus	Rep. Fran Wendelboe	Rep. Gene Chandler	

start: 10:04am
end: 10:27

Danielle Barker 271-3093

Sen. Margaret Hassan
Chairman

Commerce, Labor & Consumer Protection Committee
Hearing Report

To: Members of the Senate
From: Greg Silverman, *Legislative Aide*
Re: Hearing report on **SB436** – relative to health insurance open enrollment periods and establishing a temporary commission relative to children's health insurance.

Hearing date: March 16th, 2010

Members of the Committee Present: Senator Hassan, District 23; Senator DeVries, District 18; Senator Reynolds, District 2; Senator Roberge, District 9; Senator Bragdon, District 11; Senator Cilley, District 6.

Members of the Committee Absent: None.

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

What the bill does: 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.

Who supports this bill: Lisa Kaplan Howe, NH Voices for Health; Tricia Brooks, Georgetown Center for Children and Families; Jackie Cowell, Early Learning NH; Angela Boyle, Oral Health Coalition; Nancy Pederzini, American Heart Assn.; Tom Bonner, Institute for Health; Ellen Fienberg, Children's Alliance of NH; Gail Garceau, NH Healthy Kids; Denise Brewitt, Council for Children and Adolescents with Chronic Health Conditions; Olivia Zink; Sarah Knoy, Granite State Organizing Project; Sen. Gallus, Dist. 1; Rep. Schlachman, Rock 13; Stuart Trachy, NH Chapter-National Assoc. of Social Workers; Peter Ames, NH Voices for Health and American Cancer Society; Vanessa Santarelli, Bi-State Primary Care Assn.; Rep. Emerton, Hills 7; Leslie Melby, NH Hospital Assn.; Sen. Gilmour, Dist 12; Sen. Fuller Clark, Dist. 24.

Neutral: Marilee Nihan, DHHS.

Summary of testimony received:

Senator Gilmour, District 12.

- Prime Sponsor.
- It is important the state explore ways to take advantage of new opportunities and funds to strengthen the HK program.

Sarah Knoy, Granite State Organizing Project.

- Supports SB436.

- This bill allows the state to determine how to make this successful program even stronger.

Olivia Zink, Manchester, NH
- Supports SB436.
- Pre-natal care for expectant mothers is a crucial program for NH's families.

Lisa Kaplan Howe, NH Voices for Health
- Supports SB436.

RP

Date: March 16, 2010
Time: 10:04 a.m.
Room: LOB 102

The Senate Committee on Commerce, Labor and Consumer Protection held a hearing on the following:

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

Members of Committee present:	Senator Hassan Senator DeVries Senator Cilley Senator Bragdon Senator Roberge

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The Chair, Senator Margaret Wood Hassan, opened the hearing on SB 436 and invited the prime sponsor, Senator Peggy Gilmour, to introduce the legislation.

Senator Peggy Gilmour, D. 12: Thank you, Madam Chair. 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. And I am pleased to be here this morning to introduce Senate Bill 436. I filed Senate Bill 436 because it's important that the State find ways to explore advantages of new opportunities and funds that would strengthen our current Healthy Kids Program.

You know, we really have a program to be proud of. 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 to grow into healthy productive adults.

The reauthorization of the Children's Health Insurance Program, the CHIP Program, at the federal level, has provided New Hampshire with a number of new opportunities to make New Hampshire Healthy Kids Gold and Silver stronger. I am not going to describe all the options in detail. If you have specific questions, there are others who will testify behind me. But, the opportunity will come to give us assistance to implement new enrollment and

RP

retention practices and to update our eligibility categories in both Healthy Kids Gold and Silver. Each of the options comes with the enhanced 65% federal funding provided for State CHIP programs. And therefore, we need to spend only 35 cents for every dollar worth of coverage we provide.

Also, if, moving forward, if we improve our enrollment and retention processes, we make our State eligible for federal performance bonuses. Given our current budget situation, moving policy change that costs us any money, even when the vast majority of the funding is from the federal government, is probably going to be incredibly difficult at this moment. That is why Senate Bill 436 will create a study commission to explore the options that would require an investment of State funds.

The commission duties would be to consider the relative benefits and burdens of implementing the options – including possible long-term savings of preventive care, and identifying those potential federal and State sources that could help fund the implementation of the options. If we can be poised when we are in the financial position, I think that will serve us well and we can jump off and implement the new CHIP Reauthorization options.

Senate Bill 436 also proposes a technical change to our current 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 New Hampshire Healthy Kids as those currently 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 gaps in coverage.

Thank you, I appreciate your consideration, members of the Committee, of Senate Bill 436. I know that we are in a time of struggling, but so are our families. And, 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 question. I do have an amendment that I think is being distributed. It is simply a change in, on page 2, line 8, which changes that line to one member appointed as the Governor's designee. So, thank you.

Please see attachment #1 – Senator Gilmour's Amendment #2010-0778s.

Senator Margaret Wood Hassan, D. 23: Thank you.

Senator Peggy Gilmour, D. 12: I will take any questions, or offer up those behind me.

Senator Margaret Wood Hassan, D. 23: Any questions? Thank you very much for your testimony.

Now, we have another sign-up sheet? Okay. Okay, we have a testimony management issue because I just got handed this and I only thought we only had one more speaker on this bill. And, I can't, I can't let this bill go on for more than about ten more minutes. So, because after this we have a bill that wants to do tort reform and we are supposed to be out of here by ten thirty which we won't be.

So, what I am going to ask people to do, let me tell everybody this, there is not a single person signed up in opposition to this bill. Okay? So I don't, the Committee really doesn't need to hear from every person who is signed up in support, unless there is something different from you that the speaker in front of you has not said. If you want to come up and give your name, and say that you support it, and say one sentence as to why, that is fine and we are glad to have you. But, I really will cut you off if you are repeating other people's testimony. Okay?

With that said, Peter Ames please.

Peter Ames: Morning Madam Chair, members of the Committee. My name is Peter Ames. I am the Director of Advocacy for your American Cancer Society here in New Hampshire. I have the pleasure of wearing an overlapping hat this morning, representing the New Hampshire Voices for Health Coalition, which represents 200,000 members, consumers and constituents, dedicated to providing affordable health care to all of New Hampshire. And, we are in support of Senate Bill 436.

I want to highlight what this bill, the opportunity that this bill brings forward for the State as we consider the options before us. Healthy Kids is, by definition, a very successful program and covers 80,000 children in New Hampshire who otherwise would not have access to health care.

A 2007 study found that there is overwhelming support among voters to support this program and expand it with 89% of voters saying they would expand the program even if it would cost more State dollars. The reason for all this is that this is a great deal for the State. And, last year's CHIP

reauthorization, federally, left the states with a number of options that we think are very worthy of consideration, but need some review, so that proposals can be made to the State. Among those are looking at the issue of providing coverage to low and moderate income, pregnant women in New Hampshire. Right now, Medicaid covers a certain number of babies that are born. However, the mothers do not always have prenatal care. And, we believe that looking at the options for providing prenatal care could be an extremely important cost-saving measure.

Additionally, right now there is a five-year arbitrary waiting period for documented immigrant children looking at and pregnant women. Also, there is the option for dental-only coverage options for kids in New Hampshire, which is, of course, every one knows, is a critical issue for many children who do not have oral health options currently. These options all come with an enhanced CHIP payment from the feds, so it is a good bargain for the State. However, we think the State could look at the overall impact of this to make sure that it sounds good for New Hampshire financially and for State services.

Additionally, the bill would also create parity between enrollment, open enrollment practices, between State regulated health insurance plans and the ERISA plans. Right now, State regulated plans, we have a situation where the parents have an enrolled plan, but the kid is on Healthy Kids. If there is a change of income in that family and the kid loses coverage, right now, that family only has 30 days to make the transition from Healthy Kids to the State regulated plan. This bill would bring that in line with the federal standard which is 60 days, which we believe is much more appropriate, and would provide families with that necessary opportunity.

In closing, the New Hampshire Voice of Health strongly supports this bill. We believe that there are good opportunities for the State on the table. There is an appropriate amount of time to look at these options, so that when it is time for the State to make decisions, we can have all of the facts present to us.

Madam Chair, I also have testimony from New Hampshire Voices for Health and a number of our consumer and organization affiliates that I would like to provide for the Committee.

Transcriber's note: Due to the volume of materials submitted by Mr. Ames, those documents are not attached to this transcript, but are available in the original bill file.

Senator Margaret Wood Hassan, D. 23: Thank you very much. Senator Roberge are you all set with questions? Okay, thank you. Tricia Brooks?

Tricia Brooks: Good morning, Madam Chair.

Senator Margaret Wood Hassan, D. 23: Good morning.

Ms. Brooks: Committee members, my name is Tricia Brooks for those of you who don't remember me. I was the long-time President and CEO of New Hampshire Healthy Kids. I now work at the Georgetown University Center for Children and Families. Our mission is to provide policy support and to advance coverage for children and families.

I understand your tight timeframe, so I just want to mention a couple of key points and add a couple of personal experiences. I think it's really important to emphasis that 16,000 uninsured kids are in New Hampshire. Two-thirds of them are likely eligible for Healthy Kids Gold or Silver today. And, looking at some of the new options, what the new tools and incentives in CHIPRA that would enable the State to try to get more of those kids in, is a big part of this bill is all about. You've heard from Peter and Senator Gilmour that all of these options are available at a 65% federal match, which is an important piece to keep in mind.

One significant option in CHIPRA is a performance bonus for enrollment in Medicaid. There are two pieces of that. One piece is that you have to have implemented five of eight specific enrollment and retention measures. And then, if you meet certain enrollment targets, you get a performance bonus. New Hampshire currently has three, or three and a half of those in place. Had New Hampshire had all five in place last year, it would have earned a performance bonus of over $500,000, over half a million dollars.

The other thing that I think is really significant in CHIPRA is, there is a new option to do an electronic data match with the Social Security Administration in lieu of asking for paperwork from families to document their citizenship. When that regulation went into effect with the Deficit Reduction Act of 2005, it wreaked havoc with eligibility systems across the country. And, it did not keep out illegal immigrant, ineligible kids. It really has impacted enrollment of eligible, citizen kids.

The new Cit-Doc match is being worked on by eighteen states, ten, very actively. They are having a 95% success rate, so that it would eliminate the need for the State and families to pass paperwork back and forth in order to document citizenship.

Senator Margaret Wood Hassan, D. 23: Can I just...

Tricia Brooks: Sure.

Senator Margaret Wood Hassan, D. 23: Sorry to interrupt you, but, partly out of the interest in time, and partly, because I'm trying to focus on what the bill does. This bill sets up a commission, right?

Tricia Brooks: Right.

Senator Margaret Wood Hassan, D. 23: To look at whether we should...

Tricia Brooks: Study those issues.

Senator Margaret Wood Hassan, D. 23: Study those issues. So, I am interested in hearing comments about whether the commission is a good idea. But, I think the commission is going to get into a lot of those issues. And, just because we are pressed for time, I would like to skip over that.

Tricia Brooks: No, I understand and I think it's helpful for folks to know that the options are well worth considering by looking at what they are.

I do want to make the point about dental-only coverage, that, that's what families need. And, the one piece in this bill that is immediate action, which is the change in the open enrollment period, is really intended to allow families that are losing their public coverage, Medicaid or CHIP, to have, be on par with what a new change CHIP made at the federal level for the ERISA plan. I know that families often question their loss of eligibility. It takes them time to go back and forth to review that. And that extra 30 days assures that they don't lose the opportunity to enroll in private coverage.

Senator Margaret Wood Hassan, D. 23: Thank you. Senator Roberge, are you all set for questions? Okay. Thank you very much. Miss Nihan, I'm sorry I didn't realize you were signed up to speak. I would have called on you sooner. Please, come on up.

Marilee Nihan: Thank you, Madam Chair. My name is Marilee Nihan and I'm the Director of Finance for the Department of Health and Human Services Office of Medicaid, Business and Policy. For the interest of time, I will modify my statements for you.

Senator Margaret Wood Hassan, D. 23: Thank you.

Ms. Nihan: I want to make four points. The first one being we generally don't oppose study committees, but we are mindful of the strain that study committees make on Department resources, particularly, at a time like this when we are operating so lean. OMBP, my office, has been implementing the mandatory provisions of CHIPRA for the past year. And, we continue to work on those elements of the legislation, most notably a perspective payment system for FQHCs and meeting the expanded dental requirements. The expansion items are not items that DHHS can entertain during a period where, during the period that the CHIPRA appropriations are available, due to the economic strain in our current State.

We are currently juggling various cost containment options for SCHIP program, and are projecting a shortfall of appropriation in State fiscal year 2011. We have spent a significant amount of time assessing the options and what it would take for New Hampshire to adopt them. Many of them come with significant increases in case load and, either administrative, or systems cost. As a note, CMS has already told us that they would not accept a State plan amendment should we put one in to exercise the options. At the same time, we were constraining our current SCHIP program.

And then finally, we do meet three out of the eight bonus options. The five that we do not meet take significant administrative, labor and systems improvements and are a real stretch for us at this time.

So with that, I will entertain questions.

Senator Margaret Wood Hassan, D. 23: Thank you very much. Are there any questions? Thank you very much. And, does the Department have any written testimony or can you provide that?

Ms. Nihan: I have, can I e-mail it to you? I have handwritten notes all over it.

Senator Margaret Wood Hassan, D. 23: Yes, absolutely. And, I don't mean to make it overly formal, I just, if there was anything you weren't able to cover that you wanted to, if you could get it to me, as Chair, I will make sure that it gets disseminated.

Ms. Nihan: I appreciate that.

Senator Margaret Wood Hassan, D. 23: Okay. Angela Boyle, please.

Angela Boyle: Good morning.

Senator Margaret Wood Hassan, D. 23: Good morning.

Ms. Boyle: I will pass you my written testimony after if that is okay?

For the record, my name is Angela Boyle. I am the Director of the New Hampshire Oral Health Coalition. Many of you are aware that tooth decay is the most common chronic childhood disease and five times more common than asthma. We are concerned with that, in that more and more science is linking oral health to overall health. And, we really feel that children deserve a healthy start in life. And obviously, that they are able to learn and grow to their potential.

We are encouraged by the efforts of this legislation, and that will examine some of the feasibility of implementing some of the State options. And, we think it is a smart way to explore some of the cost effective approaches that will fit for New Hampshire's fiscal environment.

So with that, I would like to offer support for this bill, as well as welcome the opportunity to serve as a member on the study commission. So I'll hand in my testimony here.

See attachment #2 – prepared testimony submitted by Angela Boyle, New Hampshire Oral Health Coalition.

Senator Margaret Wood Hassan, D. 23: Thank you. Any questions? Seeing none, thank you very much for your testimony. Ellen Fineberg, please.

Ellen Fineberg: Good morning. I am here today to testify on behalf of the bill, both as the President of the Children's Alliance of New Hampshire and as the Chair of the Steering Committee for the New Hampshire Child Advocacy Network. And, the Child Advocacy Network has made this a priority for 2010 and a lead priority for our health and wellness area.

I would like to say that the point of a study commission is to look forward and to see what the best opportunities are to move children in our State forward. And, there may be fiscal restraints at the moment, but that does not mean we should not be studying the best place and the best way to take care of our children. And so, to have the right things in place, when the time is right, I think, is a good policy for our State.

So, with that said, I don't want to repeat what has already been said. But, I do have materials to pass out.

See attachment #3 – prepared testimony submitted by Ellen Fineberg, New Hampshire Child Advocacy Network and Children's Alliance of New Hampshire.

Senator Margaret Wood Hassan, D. 23: That is terrific, thank you, questions? Seeing none, thank you very much. Gail Garceau please.

Gail Garceau: Good morning.

Senator Margaret Wood Hassan, D. 23: Good morning.

Ms. Garceau: I am happy to be here, and I am happy to introduce myself. I am Gail Garceau and I am the new President of New Hampshire Healthy Kids.

Senator Margaret Wood Hassan, D. 23: Welcome.

Ms. Garceau: Thank you very much. I will not repeat what has been said before. We do, at New Hampshire Healthy Kids, believe that the CHIPRA options are something that the State should explore and look at. We are in support of the establishment of the commission, and would be pleased to serve on the commission if asked to participate. I do have written testimony. Thank you very much. It was a pleasure to meet you.

Transcriber's note: No written testimony was submitted by Gail Garceau.

Senator Margaret Wood Hassan, D. 23: Thank you. Olivia Zink please. Good morning.

Olivia Zink: Good morning. Thank you for an opportunity to provide testimony. I was a mother that was covered by Healthy Kids.

Senator Margaret Wood Hassan, D. 23: Okay I need to stop you. You just need to state your name and what town you are from.

Mrs. Zink: Manchester, New Hampshire. Olivia Zink, Manchester, New Hampshire.

And, I am just so grateful for, to have coverage through New Hampshire Healthy Kids. And Miss Elizabeth has coverage through New Hampshire Healthy Kids. As, when, I'm not going to read this, I'm just going to paraphrase. But, it was over $800 to have coverage that included prenatal care when I was pregnant with her, which was out of reach for my financial

RP

situation. And, as a part-time employee, our coverage would have been $945.64 for both of us, which was half of my income at that time. I am so thankful that she qualifies for Healthy Kids and that she is able to go to the doctors on a regular routine and provide the care that she needed to.

So, for that reason I am really grateful for Healthy Kids to be existing, and I do support the commission.

Senator Margaret Wood Hassan, D. 23: Thank you very much. I am just going to note that our Legislative Aide here hasn't been taking very good notes. He has been charmed by Miss Elizabeth.

Senator Betsi DeVries, D. 18: I was just going to say, note to all lobbyists, look at the affect of a really cute baby in front of us.

Senator Margaret Wood Hassan, D. 23: Thank you very much Miss Zink. I appreciate it very much. And, Sarah, is it Sarah Jean or Sarah Jane?

Sarah Jane Kinoy: Oh, Jane.

Senator Margaret Wood Hassan, D. 23: You have a very hard act to follow.

Mrs. Kinoy: I really just want to give you my written testimony. I will be very brief and I will try to stick to the point. My name is Sarah Jane Kinoy and I am with the Granite State Organizing Project. We are a member of the New Hampshire Voices for Health Coalition. We're made up of mostly religious congregations and community groups and some labor unions. And, we have been very active on health care since our inception in 2002.

Through GSOP's relationship with churches, I speak almost daily with New Hampshire families who are struggling to make ends meet in today's economy. And, Healthy Kids is a wonderful aid to these families. However, there are some gaps. And a gap that I see, and that I would like this committee to be formed, in order for this committee to study this issue, is the issue of the five year bar on documented legal immigrants right now, and that includes refugees.

So, right now we have families, particularly in Manchester, Senator DeVries knows, that have, can have very strange insurance situations. So you might have a dad covered through his employer. A mother not eligible for any insurance. A younger child that was born in the U.S. that is eligible for Healthy Kids, and an older child that was born before resettlement, but has not yet been in the country for five years, is not eligible for any coverage at all. And, how does a parent say to a child, I am going to take your baby sister

RP

to the doctor when she is sick, but when you are sick, we can't take you to the doctor because we can't afford it? And, I see that happening every day.

So, I think this study Commission is a really great idea and I hope that it is formed and that it considers gaps in coverage like this one. Because, as you know, New Hampshire has a very good, high rate of covering kids, but we can make it a little bit better. Thank you.

Senator Margaret Wood Hassan, D. 23: Thank you very much. Any questions? Seeing none, thank you very much Miss Kinoy. With that was there anyone else who wanted to testify on Senate Bill 436? Seeing no one else, I am going to close the hearing on Senate Bill 436.

Hearing closed at 10:27 a.m.

Respectfully submitted,

Recorded by Danielle Barker, Senate Committee Secretary
Transcribed by Richard Parsons, Senate Committee Secretary

5/17/10

3 Attachments

ATTACHMENT #1

Sen. Gilmour, Dist. 12
February 16, 2010
2010-0778s
05/04

Amendment to SB 436

Amend section 2 of the bill by replacing subparagraph I(c) with the following:

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

ATTACHMENT #2

NH ORAL HEALTH COALITION

March 16, 2010

To: Senate Commerce, Labor and Consumer Protection 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 Madam Chair 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.

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.

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. 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.

Many of you may be aware that tooth decay is the most common chronic childhood disease, 5 times more common than asthma. More and more science is linking oral health to overall health. Children in New Hampshire deserve a healthy start in life so that they can learn and grow to their potential.

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

ATTACHMENT #3

NH CAN
New Hampshire Child Advocacy Network

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

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 Commerce, Labor and Consumer Protection Committee
March 16, 2010

I am here today 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 to speak *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. As you know, 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 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.

Two Delta Drive, Suite 201
Concord, NH 03301

(603) 225-2264
www.ChildrenNH.org

A 2010 Priority for New Hampshire's Children

Children's Alliance of New Hampshire

Raising Our Voices for Children

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.
- New Hampshire could be doing an even better job at covering children.
- 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 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

Speakers

Senate Commerce, Labor and Consumer Protection Committee: Sign-In Sheet

Date: March 16, 2010 Time: 9:00 a.m. Public Hearing on SB 436

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

Name	Representing			Speaking?		
Lisa Kaplan Howe	NH Voices for Health	Support ☒	Oppose ☐	Speaking?	Yes ☐	No ☒
Tricia Brady	Georgetown Ctr for Children & Families	Support ☐	Oppose ☐	Speaking?	Yes ☑	No ☐
Jackie Cowett	Early Learning NH	Support ☒	Oppose ☐	Speaking?	Yes ☐	No ☑
Angela Boyle	Oral Health Coalition	Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐
Maritee Nihan	Dept of HS	Support ☐	Oppose ☒	Speaking?	Yes ☒	No ☐
Darcy Federzoni	American Heart Assn	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☒
Pat Bunnell	Institute for Health Law	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Ellen Friedberg	Children's Alliance of NH	Support ☒	Oppose ☐	Speaking?	Yes ☒	No ☐
Gail Garceau	NH Healthy Kids	Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐
Denise Drewitt	Council for Children & Adolescents w/ Chronic Health Condition	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Olivia Zink		Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐
Sarah Jane King	C-SOP Granite State Organizing Project	Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐
		Support ☐	Oppose ☐	Speaking?	Yes ☐	No ☐

Senate Commerce, Labor and Consumer Protection Committee: Sign-In Sheet

Date: March 16, 2010 Time: 9:00 a.m. Public Hearing on SB 436

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

Name	Representing	Support	Oppose	Speaking? Yes	Speaking? No
Sen Gallus	Dist 1	☑	☐	☐	☑
Rep. Schlachman	Rock. Dist 13	☑	☐	☐	☑
Stuart Trachy	NH Chapter - Nat. Assoc. of Soc. Workers	☑	☐	☐	☑
Peter Ames	NH Voices for Health American Cancer Society	☑	☐	☑	☐
Vanessa Santarelli	Bi-State Primary Care Assoc.	☑	☐	☐	☑
Rep. Larry Emerton	Co-Sponsor	☑	☐	☐	☒
Leslie Melby	NH Hospital Assoc	☑	☐	☐	☑
Sen. Gilmore	Dist 12	☒	☐	☒	☐
Sen Fuller Clark	Dist 24	☒	☐	☐	☑
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Testimony

Submission 2

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.

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.

SUBMISSION B

Georgetown University Health Policy Institute
Center for Children and Families

Senate Commerce, Labor and Consumer Protection Committee
March 16, 2010
SB 436, An Act relative to health insurance open enrollment periods and establishing a commission relative to children's health insurance

Good morning Madam Chair and members of the committee. I want to thank Senator Gilmour as primary sponsor of SB 436 for asking me to join you today. 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 Healthy Kids Gold or Silver. CHIPRA provides new tools and incentives to states 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. If the state had at least five measures in place, it would have qualified for a performance bonus of more than a half million dollars in FFY 09 based on enrollment numbers posted by NHHK.

CHIPRA also provides a new extremely cost-effective way to document citizenship by electronically exchanging data with the Social Security Administration (SSA). This provision addresses the substantial paperwork burden placed by the Deficit Reduction Act of 2005 on states and families to document citizenship (known as Cit-Doc) in order to qualify for Medicaid coverage. The Cit-Doc requirement has had a negative impact on enrollment of citizen children as reported by NH Healthy Kids and a number of other states. 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. The new SSA data match builds on an existing data exchange with the SSA; and states have reported that it is relatively easy to implement. The best news is that the federal government will pick up 90% of any system development costs. The state's 10% share of system development costs will be quickly offset by reductions in administrative expenses.

California estimates that it will save $26 million per year in administrative costs with the new SSA data match.

CHIPRA has also enabled 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 would likely pay for itself in savings for neonatal intensive care for premature newborns.

Another important CHIPRA 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 the most frequent feedback we received from insured families was their lack affordable dental coverage and the unfairness that their private insurance prevented them from accessing dental only coverage through Healthy Kids. A stand-alone dental plan would give these families access to affordable dental services while encouraging them to maintain their health insurance. Just two weeks ago, despite the tough fiscal environment, 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 with no cost to the state.

In closing, I commend Senator Gilmour and SB 436 sponsors for encouraging the Legislature to explore the numerous opportunities in CHIPRA to advance children's coverage and improve access to the Healthy Kids program. 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 an additional state investment. 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.

SUBMISSION C

MaryLou Beaver
New England Campaigns Director
Every Child Matters

Senate Bill 436: Establishing a Commission to Explore CHIPRA Options

To the Members of the Senate Commerce, Labor and Consumer Protection Committee,

As the former director of a non-profit childcare center that served a large percentage of low-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. NH is doing a good job at covering its children, but it can do better.

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.

March of Dimes Foundation

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

marchofdimes.com

March 15, 2010

Senator Margaret Wood Hassan
Commerce, Labor and Consumer Protection Committee
State House
107 N. Main St., Room 302
Concord, N.H. 03301

Dear Senator Hassan and Members of the Commerce, Labor and Consumer Protection 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 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

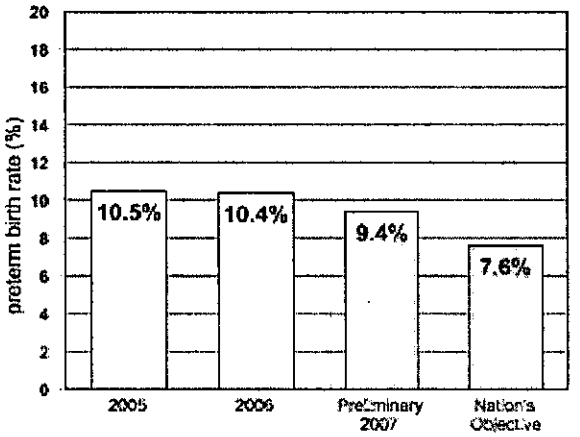
March of Dimes 2009 Premature Birth Report Card

The March of Dimes graded states by comparing each state's rate of premature birth to the nation's objective of 7.6 percent or less by 2010. This year we are also awarding a star when the rate for one of the selected contributing factors (below) is moving in the right direction. We don't yet understand all the factors that contribute to premature birth. The nation must continue to make progress on research to identify causes and prevention strategies, improve the outcomes of preterm infants, and better define and track the problem.

Grade for New Hampshire

C

Preterm Birth Rate: **9.4%**



Status of Selected Contributing Factors

Factor	Previous Rate	Latest Rate	Status	Recommendation
Uninsured Women	**13.9%**	**13.4%**	☆	Health care before and during pregnancy can help identify and manage conditions that contribute to premature birth. We urge federal and state policymakers to expand access to health coverage for women of childbearing age, and we urge employers to create workplaces that support maternal and infant health.
Women Smoking	**21.7%**	**18.7%**	☆	Smoking cessation programs can reduce the risk of premature birth. We urge federal and state support of smoking cessation as part of maternity care.
Late Preterm Birth	**7.5%**	**6.9%**	☆	The rise in late preterm births (34-36 weeks) has been linked to rising rates of early induction of labor and c-sections. We call on hospitals and health care professionals to voluntarily assess c-sections and inductions that occur prior to 39 weeks gestation to ensure consistency with professional guidelines.

☆ = moving in the right direction n/c = no change X = moving in the wrong direction

State Actions:

For information on how we are working to reduce premature birth, contact the March of Dimes New Hampshire Chapter at (603) 228-0317.

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March of Dimes 2009 Premature Birth Report Card Technical Notes

Data Sources and Notes

All calculations were conducted by the March of Dimes Perinatal Data Center.

		Data Sources	
Indicator	Definition	50 states and D.C.	Puerto Rico
Preterm birth (percent)	Percentage of all live births less than 37 completed weeks gestation	National Center for Health Statistics (NCHS), 2007 preliminary, 2006 and 2005 final birth data	Puerto Rico Health Department, 2007 preliminary, 2006 and 2005 final birth data
Late preterm birth (percent)	Percentage of all live births between 34 and 36 weeks gestation	NCHS, 2007 preliminary and 2005 final birth data	Puerto Rico Health Department, 2007 preliminary and 2005 final birth data
Uninsured women (percent)	Percentage of women ages 15 to 44 with no source of health insurance coverage	U.S. Census Bureau, Current Population Survey, 2007 to 2009 and 2006 to 2008	Percentage of women ages 18-44 with no health care coverage, Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), 2008 and 2007 data
Women smoking (percent)	Percentage of women ages 18 to 44 who currently smoke either every day or some days and who have smoked at least 100 cigarettes in their lifetime	CDC, BRFSS, 2008 and 2007 data	CDC, BRFSS, 2008 and 2007 data

Where possible, national data sources were used so that data is consistent for each state and jurisdiction-specific premature birth report card. Therefore, data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies. This could be due to multiple causes. For example, as part of the Vital Statistics Cooperative Program, states are required to send NCHS natality and mortality data for a given year by a specific date. Sometimes states receive data after this date, which may result in slight differences in the rates calculated using NCHS-processed data and state-processed data. Another reason preterm birth rates, in particular, may vary is due to differences in the way NCHS and the states calculate variables and impute missing data. Collaboration among March of Dimes chapters, state and local health departments and other local partners, will provide a deeper understanding of specific contributors to preterm birth. 2007 preliminary data are reported for the percentage of preterm birth and late preterm birth by state. Preliminary data are based on more than 99 percent of the births in 47 states, D.C. and Puerto Rico but are less complete for three states, Louisiana (91.4 percent), Georgia (86.4 percent) and Michigan (80.2 percent). 2007 final preterm and late preterm birth rates are expected to be very similar to the 2007 preliminary rates but may differ for these three states.

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March of Dimes 2009 Premature Birth Report Card Technical Notes, continued

Grading Methodology

Premature birth report card grades are based solely on the distance of a state's rate of preterm birth from the nation's *Healthy People 2010* (HP) objective of 7.6 percent. The grading criteria established for 2008 report cards is used as a baseline and provides for annual preterm birth report card grade comparison. Each jurisdiction was assigned a grade based on the following criteria.

Grade	Preterm birth rate range/Scoring criteria
A	Preterm birth rate less than or equal to 7.6 percent (HP score less than or equal to 0)
B	Preterm birth rate greater than 7.6 percent, but less than 9.4 percent (HP 2010 score greater than 0, but less than 1)
C	Preterm birth rate greater than or equal to 9.4 percent, but less than 11.3 percent (HP 2010 score greater than or equal to 1, but less than 2)
D	Preterm birth rate greater than or equal to 11.3 percent, but less than 13.2 percent (HP 2010 score greater than or equal to 2, but less than 3)
F	Preterm birth rate greater than or equal to 13.2 percent (HP 2010 score greater than or equal to 3)

To determine the above ranges, an "HP 2010 score" was calculated in 2008 using the following formula: (2005 preterm birth rate – HP 2010 objective) / standard deviation of 2005 state and D.C. preterm birth rates. Scores were rounded to one decimal place.

Selected Contributing Factors

The March of Dimes has identified and provided geographically-specific data for three selected contributing factors: uninsured women, women smoking and late preterm births. While these important and potentially modifiable factors represent prevention opportunities for consumers, health professionals, policymakers and employers, they do not represent an exhaustive list of contributors to preterm birth. With the momentum provided by the premature birth report card, states and jurisdictions may likely identify and take action to address other potentially modifiable contributors that play an important role in the prevention of preterm birth.

Status of Contributing Factors

Rates for all contributing factors are rounded to one decimal. Under the status column, changes in rates of contributing factors between the baseline and current year are designated with a star, an X or n/c. A star signifying movement in the right direction indicates a decline in the rates of contributing factors. An X signifying movement in the wrong direction indicates an increase in the rates of contributing factors. No change between the baseline and current year is designated with n/c.

NH WOMEN'S
LOBBY | ALLIANCE
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Senate Commerce, Labor and Consumer Protection Committee
March 16, 2010
Nikki Tobiasz Murphy, LICSW, MSW - Testimony

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

Madam Chair and members of the committee, thank you for this opportunity to provide testimony on Senate Bill 436. My name is Nikki Tobiasz Murphy and I am the Executive Director of the NH Women's Lobby and Alliance, a statewide nonprofit organization which promotes public policy reforms that benefit women and families throughout NH. I am also on the Leadership Team of NH Voices for Health, 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. In addition, I am an independently licensed psychotherapist with 10 years experience treating the mental health illnesses of low income children and their families.

I am pleased to support SB 436, a bipartisan bill that will move the state forward in improving access to health care for New Hampshire children.

Children's need for the strongest Healthy Kids program not only makes financial sense, but is also a public health issue. Children are constantly in contact with large groups of other children, whether in school settings, athletics or other extracurricular activities. Given the recent concerns over communicable diseases such as H1N1, as a matter of public health it benefits New Hampshire to ensure children who are sick have access to health care coverage.

Without access to health care, children's education and their social and emotional development suffer. In my practice as a clinician, I have seen over and over again how a lack of adequate health care and mental health treatment/coverage multiplies the problems experienced by the child and family, whether it is an increase in mental health problems, family violence, addiction issues or financial concerns. We need to look at the family as a whole unit, each member's health affecting the other's, and understand that by ignoring the health care of the children, we create larger problems for the entire family system.

I strongly urge you to support SB 436. Please do not hesitate to contact me with questions at 603-978-1032 or nikki@nhwomen.org.

Sincerely,
Nikki Tobiasz Murphy, LICSW, MSW
Executive Director

Heart Disease and Stroke. You're the Cure.

American Heart Association. | American Stroke Association.
Learn and Live.

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

March 16, 2010

Senate Commerce, Labor and Consumer Protection Committee
Testimony of the American Heart Association
In Support of SB 436

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

Chairwoman Hassan, Vice Chair DeVries 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 speak in support of 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.

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

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

Senate Commerce, Labor and Consumer Protection Committee
March 16, 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

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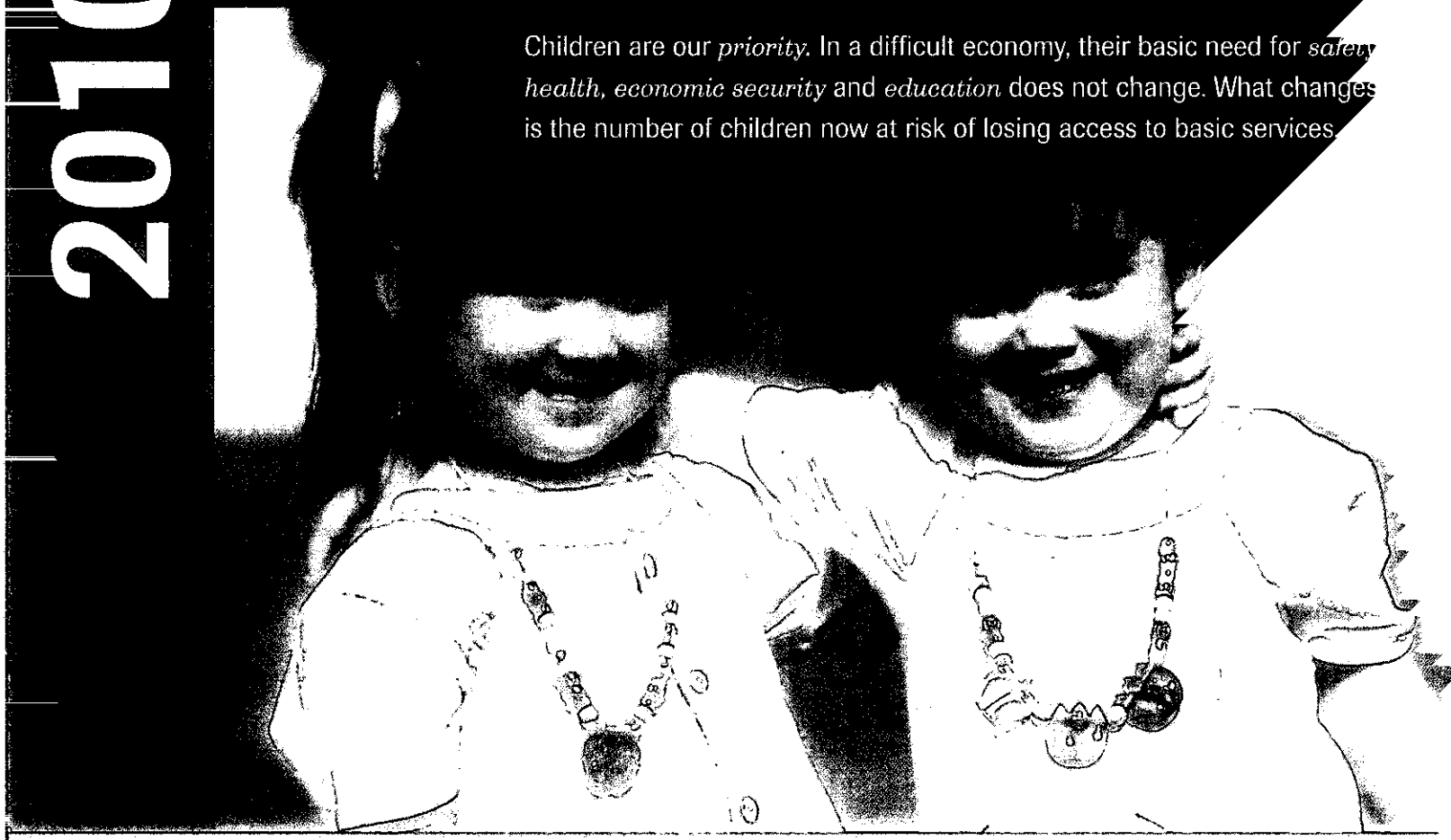
[4] *Program Design Snapshot: 12-Month Continuous Eligibility.* Center for Children and Families. September 2008. *http://ccf.georgetown.edu/index/cms-filesystem-action?file=strategy%20center/ceprogram%20snapshot.pdf*

2010

Priorities for New Hampshire's Children

Children are our *priority.* In a difficult economy, their basic need for *safety, health, economic security* and *education* does not change. What changes is the number of children now at risk of losing access to basic services.



A difficult economy may pose challenges, but together, we **CAN** find solutions. We **CAN** make thoughtful investments. We **CAN** support children through prevention-based legislation. We **CAN** ensure that every child in NH has a safe, educationally challenging, healthy, and economically secure life. And together, we must meet the challenge. *Our future depends on it.*

EDUCATION

- ***Lead Priority:*** Reduce Bullying

Priorities:

- Provide Consistent Education Funding for All Schools
- Maintain Education Aid Programs

SAFETY AND WELL-BEING

- ***Lead Priority:*** Monitor and Protect Essential Children's Services

Priorities:

- Lessen the Use of Restraints on Children
- Protect Children from Parental Abuse and Neglect

HEALTH AND WELLNESS

- ***Lead Priority:*** Improve Children's Health Insurance

Priorities:

- Reduce the Risks of Childhood Obesity
- Increase Treatment of Autism Spectrum Disorders

ECONOMIC SECURITY

- ***Lead Priority:*** Ensure TANF Funds Support Needy Children and Families

Priorities:

- Provide Child Support Laws That Protect Children

NH CAN

The New Hampshire Child Advocacy Network (NH CAN) is a program of the Children's Alliance that strives to drive governmental policy, align budget priorities, and inspire community action to improve the health and well being of all NH's children and youth. The 2010 Priorities for New Hampshire's Children reflect the shared values of NH CAN members, partners and advisors.

Children's Alliance of New Hampshire

Raising Our Voices for Children

The Children's Alliance of New Hampshire, a non-partisan organization with a twenty year history, publishes credible data and advocates collaboratively with partners across the state for effective policies championing what's best for New Hampshire's children, youth and their families.

Priorities for New Hampshire's Children

EDUCATION

NH CAN works to ensure that all children in New Hampshire participate in education programs from birth through early adulthood that are appropriate to their academic and social-emotional needs and promote their optimal growth and development.

Reduce Bullying

Bullying is a pervasive problem for our children, with thirty percent of school age children reporting themselves as victims and a similar number reporting themselves as targets of cyber-bullying. Child victims of bullying are more likely to suffer from depression, traumatic stress disorder, and have a higher risk of suicide than other children. Bullying is most likely to occur at school, yet schools' efforts to curtail bullying are impeded by unclear definitions of what constitutes bullying, lack of clear record keeping requirements, and inconsistent attention to the problem among school districts.

To provide a quality education for all children, NH CAN proposes changes to NH's "Pupil Safety and Violence Prevention Act", which would strengthen NH schools' responsibilities on bullying.

- **Provide Consistent Education Funding for All Schools**

  Over the past five years, the legislature has fulfilled its constitutional obligation to define, cost, fund and create an accountability system for an adequate education. Now, we need to continue our support of fully funded public schools for all NH children.

  NH CAN will protect all children's right to a quality public education. We will monitor legislative efforts aimed at reducing and/or diverting funds from public schools. We support efforts to maintain the constitutional definition of adequacy and to ensure a high quality education sufficiently funded by the state with reliable revenue sources.

- **Maintain Education Aid Programs**

  State categorical aid programs are critically important. These programs fund school construction, reimburse exceptional special education costs, and support vocational education tuition and transportation.

  To ensure a quality education for all children, NH CAN will monitor legislative efforts aimed at reducing and/or diverting public funds from public schools. We support a funding system that provides for all children.

SAFETY AND WELL-BEING

NH CAN works to ensure the safety and well-being of all children. We believe that all children deserve the protection and supports they need to thrive from birth to adulthood.

Monitor and Protect Essential Children's Services

The 2010-11 NH state budget reduces funding in areas critical to child well-being. The Department of Health and Human Services has already sustained serious losses and now faces an additional $21 million in further required budget cuts. We anticipate that this will destabilize families at a time when they most need safety nets.

To ensure the well-being of all children, NH CAN will carefully monitor the implementation of the state budget. We will measure, document and share our findings regarding the impact on children and families.

Lessen the Use of Restraints on Children

Too many NH youth are victims of the misuse of restraints. The findings of an investigation into the use of unnecessary and excessive force at a NH facility mirrors a report issued by the National Disability Rights Network in January, 2009. There is dangerous overuse and misuse of restraints on children, especially prone or face-down restraints. This restricts a child's ability to breathe, and can lead to serious injury, or even death.

To ensure safety for all children, NH CAN proposes legislation aimed at reducing and reforming the state-wide use of restraints.

Protect Children from Parental Abuse and Neglect

The 2005 adoption of NH's *"Parental Rights and Responsibilities Act"* (RSA 461-A) encourages shared parental rights and responsibilities following divorce. This benefits a majority of children, except in cases where child abuse/neglect is present. A parent who alleges abuse by another parent can be perceived as uncooperative and unwilling to co-parent. For some parents, this allegation can cost them primary residential rights, putting their child at risk of physical or sexual abuse. To ensure safety for all children, NH CAN proposes new judicial guidelines in RSA 461-A:6 to provide protections for abused children in these cases.

HEALTH AND WELLNESS

NH CAN works to ensure that all children will receive quality physical, mental, behavioral, developmental, and dental services that keep them free of preventable disease and sustain their health.

Improve Children's Health Insurance

New Hampshire has slipped from 3rd in the Nation for health coverage of children to 12th. Although NH Healthy Kids provides more than 70,000 low and moderate income children with access to quality, affordable care, too many children in need are unable to access the program due to outdated eligibility categories and hurdles in the enrollment process.

As a building block step to quality, affordable care for all children, NH CAN proposes study commission legislation to explore the following changes to NH Healthy Kids: adopt best practice tools for streamlining enrollment and retention processes; expand coverage for pregnant women up to 300% of the federal poverty level; ensure that legal immigrant children and pregnant women do not face waiting periods for coverage; and create dental-only coverage for eligible children with medical but no oral health coverage. Also, we seek to ensure that children who lose their Healthy Kids coverage can immediately enroll in their parents' employer-based private insurance.

■ Reduce the Risk of Childhood Obesity

Childhood obesity is on the rise in NH. A statewide sample of medical charts reveals that one out of three children is overweight or obese. This can lead to lifelong health issues from chronic diseases to psychological and emotional problems. In addition, obese children are about three times more costly to care for and treat than the average child.

To ensure quality healthcare for all children, NH CAN proposes legislation requiring that Body Mass Index (BMI) be assessed for children in grades 1,4,7 and 10, providing anonymity for each child. We also recommend that the NH Board of Education create nutrition standards for all food and beverages sold in elementary, middle and high schools.

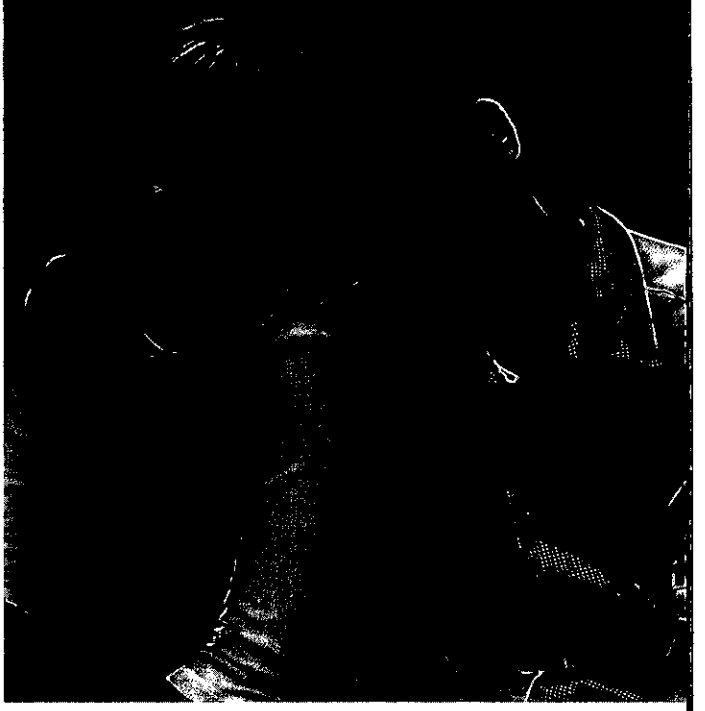
■ Increase Treatment of Autism Spectrum Disorders

Almost 100 NH children born each year will be diagnosed with a form of autism. While not curable, early intensive intervention has repeatedly shown a significant reduction in autism symptoms. This reduces the level of services necessary to support an autistic individual as an adult. The vast majority of NH children do not receive the full range of recommended treatments.

To ensure that all children receive quality healthcare, NH CAN supports passage of HB 569, which clarifies the mental health parity law and aligns NH law with the 2007 guidelines adopted by the American Academy of Pediatrics.

ECONOMIC SECURITY

NH CAN works to ensure that all children will live in situations where they have economic resources for safe and affordable housing, sufficient and nutritious food, adequate transportation and other services necessary for their physical, social, emotional, and cognitive development.



Ensure TANF Funds Support Needy Children and Families

In the late 1990's, a reserve of federal funds for the Temporary Assistance to Needy Families (TANF) program was created. Unfortunately, this "reserve" has been severely depleted over the last decade to fund non-TANF programs amid efforts to balance the state budget. Due to the economy, TANF caseloads are rising and unemployment benefits are running out for thousands of families. The TANF reserve is projected to be empty by 2011 and TANF will be $4 million in the red.

To ensure economic security for all children, NH CAN supports legislation that will restrict the use of TANF funds to promote TANF-related programs and activities, specifically those that support a safety net for children and help move adults from assistance to work.

■ Provide Child Support Laws that Protect Children

Last year (2008), over 2,500 New Hampshire families with minor children were divorced. For many families, child support issues remain highly contentious including for those parents who share equal, or nearly equal, residential responsibility for a child. Current guidelines and laws provide limited guidance.

Therefore, to ensure economic security for all children, NH CAN proposes legislation that would change child support calculations for parents who share equal or near equal residential responsibility by increasing the self support reserve from 100% of poverty to 115% of poverty, removing the cap on child care expenses and clarifying the use of education and training needs as deductions from child care expenses.

NH CAN 2009-2010
Partners, Advisors, Steering Committee

Children's Alliance of New Hampshire

Raising Our Voices for Children

NH CAN is a project of the Children's Alliance of New Hampshire

Partners

Alliance for Community Supports
Appalachian Mountain Teen Project
American Federation of Teachers (AFT) – NH
Belknap County Citizens Council on Children and Families
Bi-State Primary Care Association
Breathe New Hampshire
Casey Family Services
Cedarcrest Center for Children with Disabilities
Child and Family Services
Children First Mediation and Family Bonds
Children's Alliance of NH
Coalition for NH Oral Health Action
Community Loan Fund
Concord Substance Abuse Coalition
Crotched Mountain
Disabilities Rights Center
Early Learning NH
Education-A-Must
Endowment for Health
Episcopal Diocese of New Hampshire
Every Child Matters
Families First of the Greater Seacoast
Families for Justice
Family Assistance Advisory Council
Family Resource Center of Central NH
Family Resource Center at Gorham
Family Support New Hampshire
Familystrength
Foundation for Healthy Communities
Franklin Pierce Institute for Health, Law & Ethics
Girl Scouts of the Green and White Mountains
Granite State Coalition Against Expanded Gambling
Head Start State Parent's Association
Keene Police Officers Association
Nashua Pastoral Care Center, Inc.
National Alliance for the Mentally Ill – NH Chapter
New Futures, Inc.
NFI North
NH Association for the Education of Young Children
NH Association of Special Education Administrators
NH Chapter - National Association of Social Workers
NH Children's Trust Fund
NH Coalition Against Domestic and Sexual Violence
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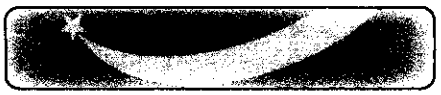

NH ORAL HEALTH COALITION

Promoting optimal oral health for the people of New Hampshire

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New Hampshire Oral Health Plan:

A Framework for Action

Coalition for New Hampshire Oral Health Action

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A Framework for Action

Coalition for New Hampshire Oral Health Action

July 2003

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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

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Table of Contents

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.

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/healthworkforce/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.

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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.

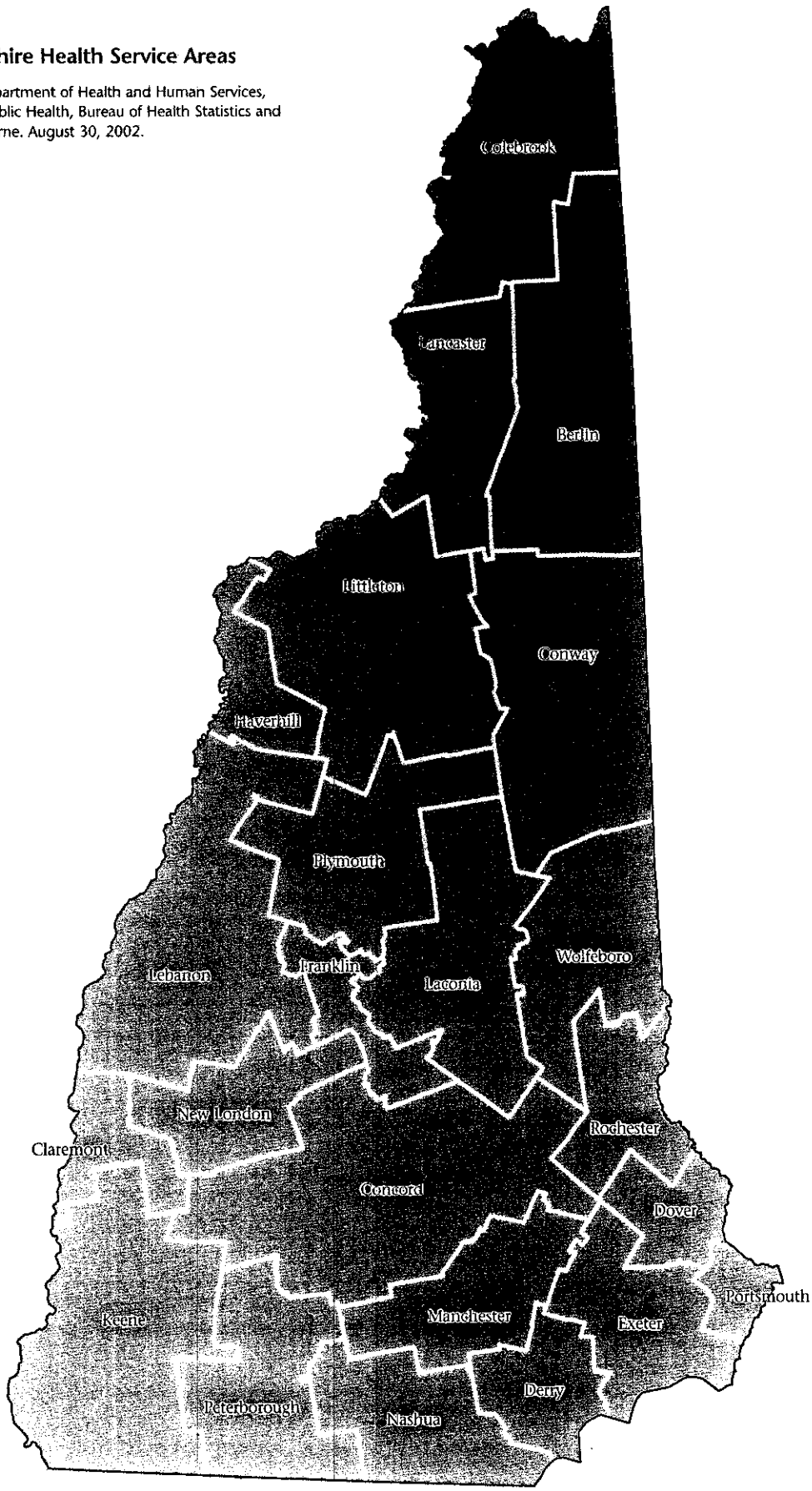
2001 Kids Count Databook Online. Annie E. Casey Foundation, http://www.aecf.org/kidscount/kc2001/ Accessed February 20, 2002.

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.

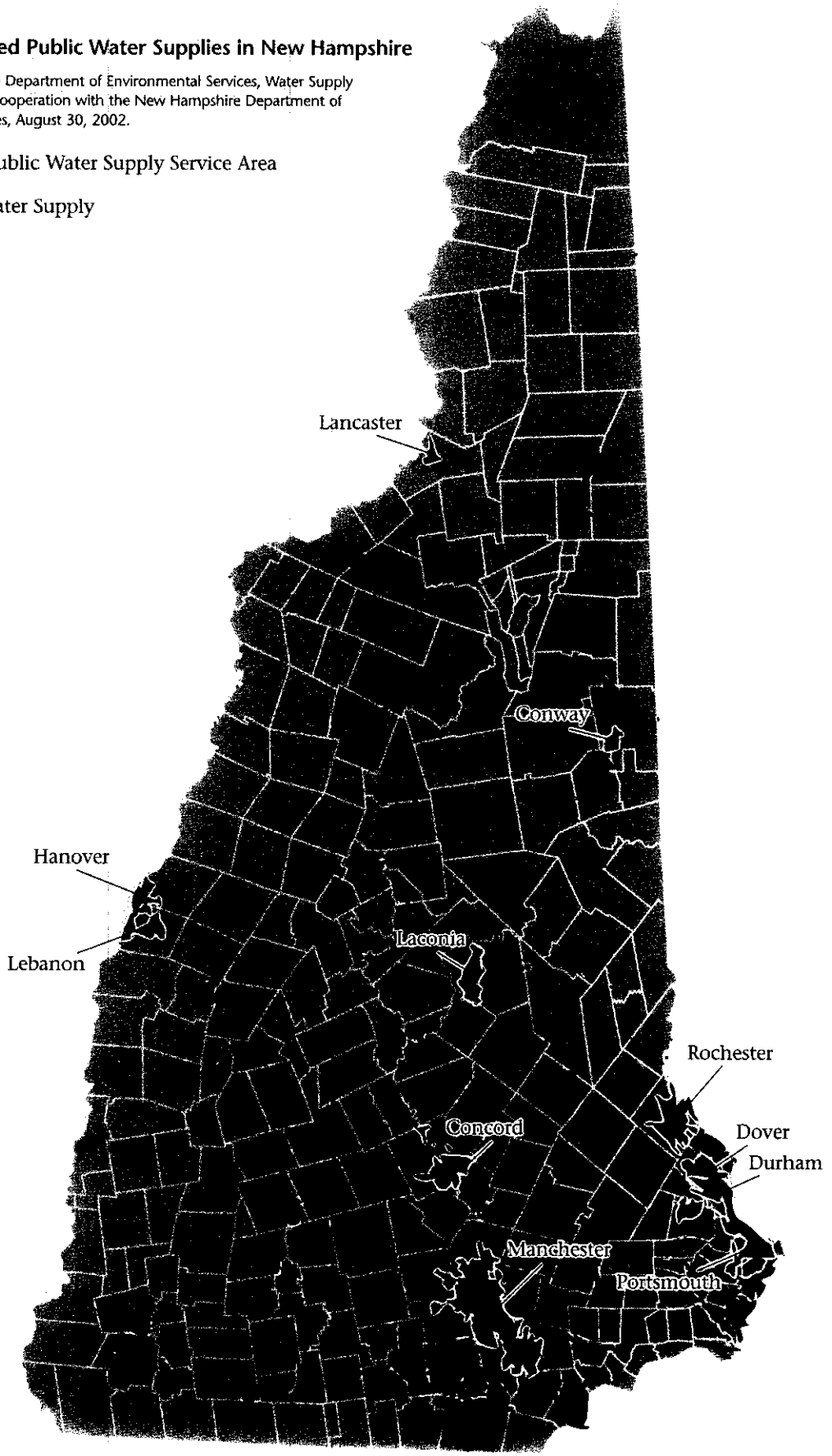


Map 2: Fluoridated Public Water Supplies in New Hampshire

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.

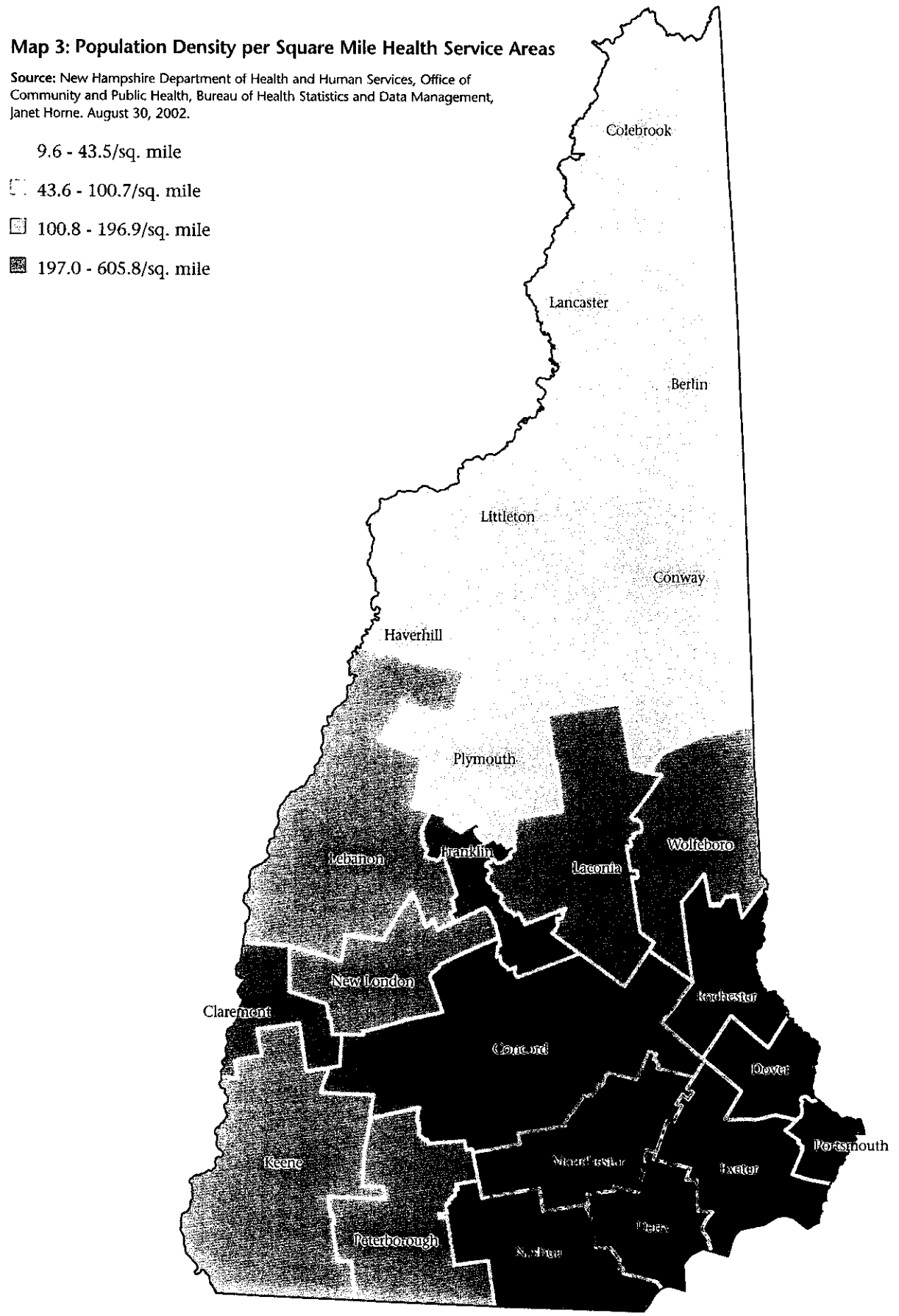
■ Community Public Water Supply Service Area

■ Fluroidated Water Supply



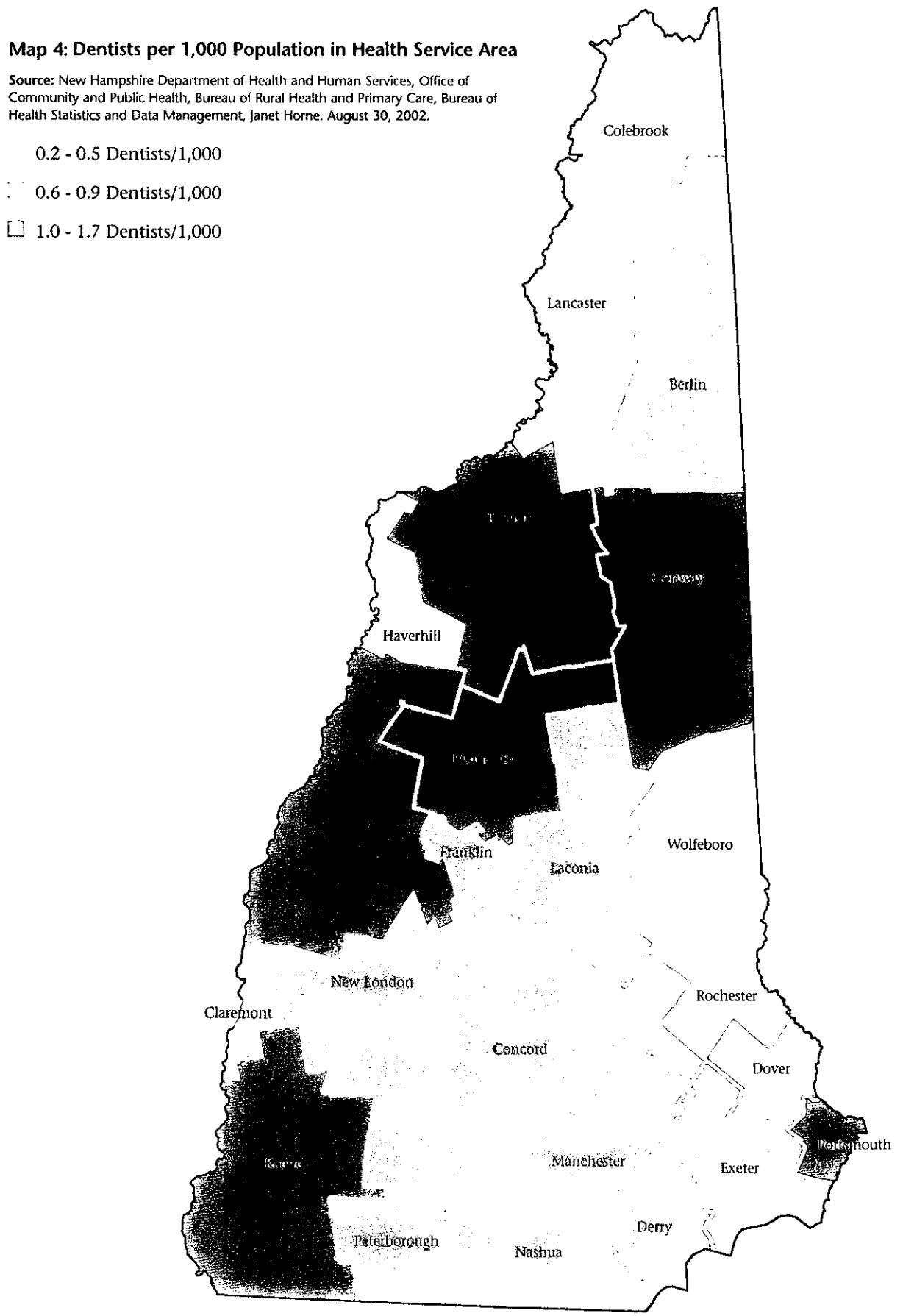
Map 3: Population Density per Square Mile Health Service Areas

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.

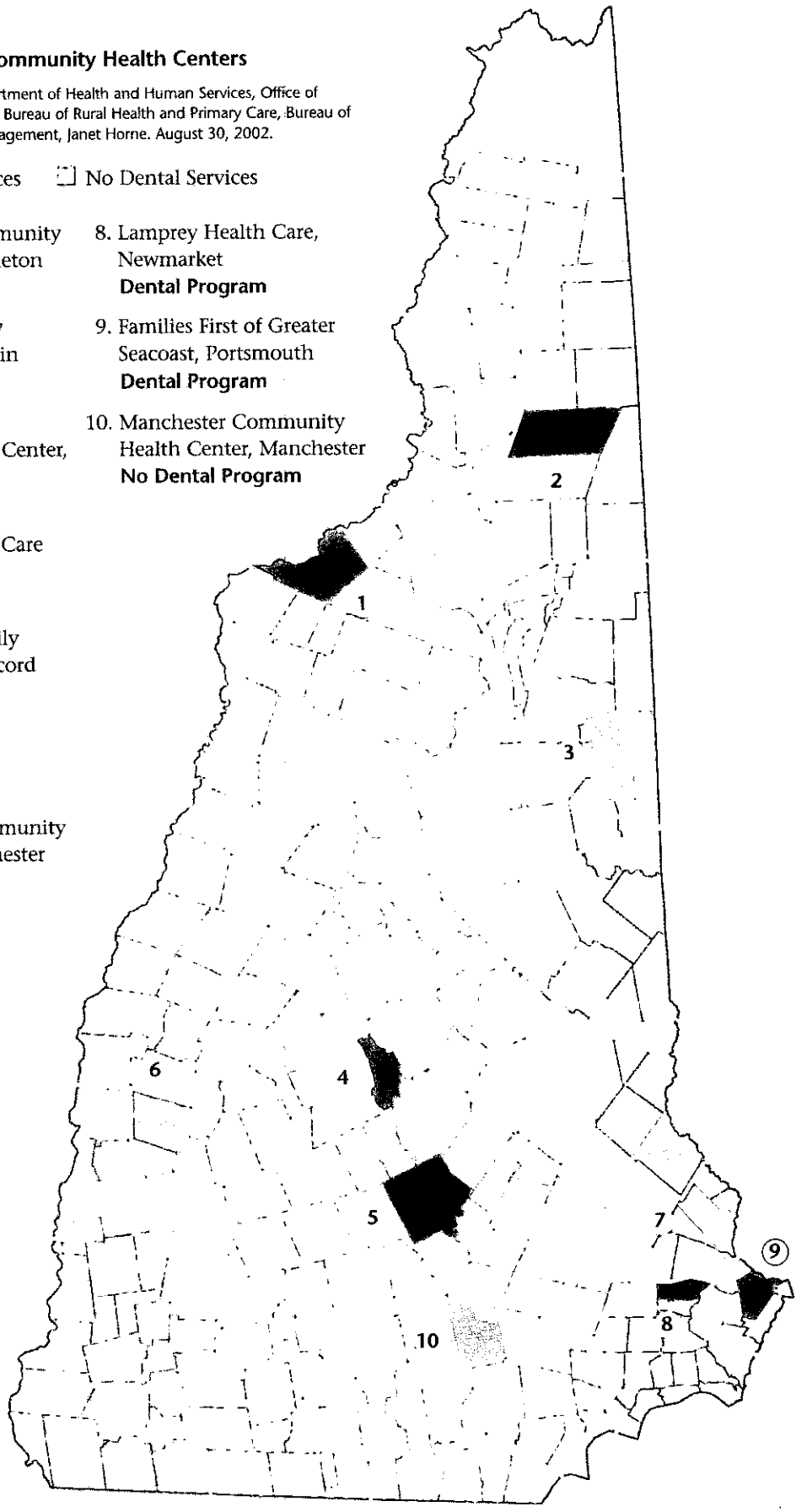


Map 5: Location of Community Health Centers

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

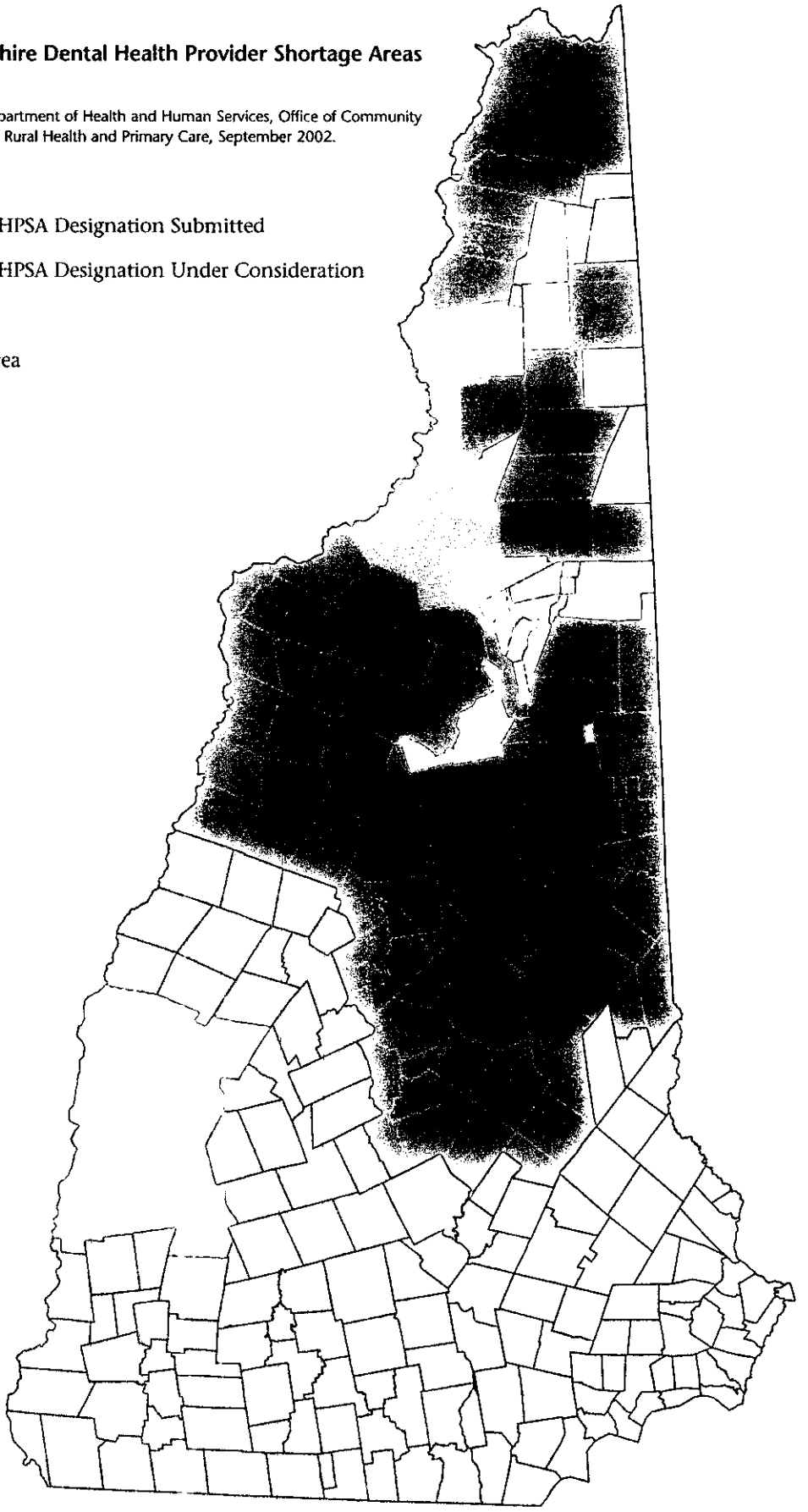
1. Ammonoosuc Community Health Services, Littleton
   Dental Program
2. Coos County Family Health Services, Berlin
   Dental Program
3. White Mountain Community Health Center, Conway
   No Dental Program
4. Health First: Family Care Center, Franklin
   Dental Program
5. Capital Region Family Health Center, 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

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
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)

MEMORANDUM

DATE: November 1, 2011

TO: Honorable John H. Lynch, Governor
Honorable William O'Brien, Speaker of the House
Honorable Peter Bragdon, 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: Final Report on RSA 126-H:10 (SB 436, Chapter 351, Laws of 2010)
Commission Relative to Children's Health Insurance

Pursuant to RSA 126-H:10 (SB 436, Chapter 351, Laws of 2010), enclosed please find the Final Report of the Commission Relative to Children's Health Insurance. Thank you for this opportunity to provide our findings and recommendations relating to health insurance coverage for New Hampshire's children and pregnant women.

This work has been immeasurably strengthened by the tireless efforts of committee member and Secretary, Lisa Kaplan Howe, New Hampshire Voices for Health.

As Chair, I greatly appreciate the tireless effort and non-partisan approach to problem solving displayed by committee members. 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 Commission

Table of Contents

Executive Summary

The federal Children's Health Insurance Program Reauthorization Act of 2009 provides states with options and financial incentives for strengthening their Medicaid (Healthy Kids Gold) and CHIP (Healthy Kids Silver) coverage and improving access to children's health care coverage. In response to these new opportunities the state legislature established the Temporary Commission Relative to Children's Health Insurance ("Commission"), charging it to analyze and evaluate the feasibility of implementing CHIPRA state options.

The Commission members are: Charlotte Houde Quimby (Chair; Governor appointee), Senator Ray White (Senate appointee), Lisabritt Solsky (Department of Health and Human Services appointee), Gail Garceau (NH Healthy Kids Corporation appointee), Dr. Sol Rockenmacher (Governor appointee), Lisa Kaplan Howe (NH Voices for Health appointee), Foqia Ijaz (NH Minority Health Coalition appointee), Gail Brown (NH Oral Health Coalition appointee). Representative John Hunt (House appointee) and Representative Laura Gandia (House appointee) were also named to the Commission, but were unable to participate on a regular basis.

The Commission faced unpredictable obstacles in completing its charge. By the time this report was prepared, major developments had emerged to significantly alter the landscape in ways difficult to believe for just a two-year period. Most notably, were the major developments of significant budgetary shortfalls, the political directional changes that occurred during the time

this commission did its work, the prospective change of the administration of the New Hampshire Children's Health Insurance Program from the private, nonprofit New Hampshire Healthy Kids to the Department of Health and Human Services state agency, and the substantial cutbacks in state spending on social services and programs. Added to all of this were the changes resulting from the Patient Protection and Affordable Care Act, some of which still lack specificity. This commission has done its best to present our findings and recommendations amidst this change.

Following nearly a year of investigation and analysis, the Commission respectfully submits these recommendations, which are outlined in greater detail throughout the report:

1. **Outreach and Education**
    a. We encourage the State and / or appropriate New Hampshire non-profit social service organizations to apply for the CHIPRA Outreach and Enrollment Grant.
    b. Effective education and outreach will require collaboration and creativity between families, community organizations, businesses, health plans, public health and Medicaid agencies, foundations and policy makers.
2. **Streamlining Enrollment / Renewal and Performance Bonuses**
    a. New Hampshire should be taking appropriate steps to streamline the enrollment and renewal process for the State and families and to make itself eligible for CHIPRA Performance Bonuses. The Commission supports the DHHS efforts to explore effective, cost-efficient and appropriate E & R measures and advises that the State provide assistance to make that possible.
    b. The Commission also recommends that the State seek opportunities to work with our Congressional Delegation and other New England states to request that the federal government address inequalities in the calculation of Performance Bonus awards.
3. **Pregnant Women's Coverage**
    a. The Commission recommends that the State take advantage of the federal funds available under CHIPRA to improve access to health care for pregnant women and prevent longer-term health care costs, particularly for those under 300% of the Federal Poverty Level (FPL), including those women currently subject to a five-year waiting period.
    b. In addition, the Commission urges the State to prioritize action to ensure the care being delivered to pregnant women across the state is adequate. Treatment guidelines and protocols developed from evidenced-based practice are currently under review among all obstetrical providers in New Hampshire. Their successful implementation could lead to a significant improvement in the delivery of care, a cost reduction of prenatal care, and better outcomes for mothers and babies across the state. Likewise, attention should be paid to why some women do not avail themselves of available prenatal care.
4. **Covering Legal Immigrant Children**
    a. The Commission recommends that the State avail itself of the federal funds available under CHIPRA to improve access to health care for legal immigrant children who are currently subject to a five-year waiting period. Doing so will

improve the health and wellness of these children and prevent longer-term health care costs.

5. **Stand-alone Dental Coverage**
    a. We urge the State to continue exploring other opportunities to improve children's access to oral health care, including exploring possible non-profit models.

The Commission also presents in this report information learned about potential funding sources for the modest state investment needed to implement certain options.

The Commission thanks the following individuals and organizations for the information they provided during our meetings: (listed in chronological order of presentations with the topic addressed.)

- New Hampshire Department of Health and Human Services and New Hampshire Healthy Kids: Overview of NH Healthy Kids Gold and Silver and CHIPRA state options; existing activities; enrollment and retention
- Georgetown Center for Children and Families: Working with state groups to expand coverage for children; technical assistance on policy; maximizing coverage
- Virginia Department of Medical Services: Outreach to teens and minority populations
- Center On Budget And Policy Priorities; CHIPRA Performance Bonuses, opportunities and incentives for improving access to healthy kids Gold And Silver; Shelby Gonzalez
- New Hampshire Minority Health Coalition: Status of health insurance for immigrant children and women
- Manchester Community Health Center: Report of current activity for immigrant families
- New Hampshire Oral Health Coalition: Opportunity to improve access to oral health care; option to offer Dental-Only coverage
- Kelly LaFlamme (UNH Master in Public Health Candidate): Endowment for Health Background; Wanda Castillo-Diaz, Bright Start Program/HIV Outreach Worker, NH Minority Health Coalition
- NH Division of Maternal Child Health: Status of pregnant women in NH; NH Data on geography of access to prenatal care; mothers requiring care for addiction
- Dartmouth-Hitchcock Medical Center, Department of Obstetrics and Gynecology: Review of current evidence regarding prenatal care, including the role for clinical practice guidelines to improve quality and control cost
- New Hampshire Chapter of the March of Dimes: preterm infants; long term care costs
- New Hampshire Fiscal Policy Institute: Exploring state financing options for opportunities to fund the modest state portion of the required investments to advance the CHIPRA

Background

Medicaid and the children's health insurance program (CHIP) are joint federal-state programs designed to ensure that New Hampshire's children can see the doctor when they are sick and get the health care they need to remain healthy and thrive in school. New Hampshire's Medicaid program for children is Healthy Kids Gold and the state's CHIP program is Healthy Kids Silver.

New Hampshire's federal medical assistance percentage (FMAP) for Medicaid is 50%, meaning for every dollar spent, New Hampshire receives a dollar in federal funding. New Hampshire's CHIP matching rate is currently 65% and will increase to 88% in 2016.

The federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) passed in February of 2009. In addition to reauthorizing and increasing funding for CHIP, CHIPRA provides states with options and financial incentives for strengthening their Medicaid (Healthy Kids Gold) and CHIP (Healthy Kids Silver) coverage and improving access to children's health care coverage. In response to these new opportunities, in 2010 the state legislature established the Temporary Commission Relative to Children's Health Insurance ("Commission"), charging it to analyze and evaluate the feasibility of implementing CHIPRA state options.

During meetings between September 2010 and June 2011, the Commission explored the following state options available to New Hampshire under CHIPRA:

- Opportunities to gain federal funding to improve outreach to, and enrollment of, children who are eligible for Healthy Kids coverage but currently uninsured.
- An opportunity to receive federal performance bonuses if:
    1) NH continues to meet aggressive enrollment targets in Healthy Kids Gold; and
    2) NH adopts at least five of eight enrollment and retention best practice strategies in Medicaid and CHIP, including:
        - eliminating asset tests (already in place);
        - eliminating face-to-face interviews (already in place);
        - using a joint application and same information verification process for both Healthy Kids Gold and Silver (joint application in place, but verification process varies);
        - adopting presumptive eligibility in both Healthy Kids Gold and Silver (in place for Healthy Kids Gold);
        - 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 extend coverage to pregnant women up to 300% FPL, using the enhanced federal CHIP match (65% currently and 88% starting in 2016).
- 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 the enhanced federal CHIP match (65% currently and 88% starting in 2016).
- 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, using the enhanced federal CHIP match for this coverage (65% currently and 88% starting in 2016).

The Commission explored 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, the savings that will result from implementing the options, federal funding available and other possible funding sources.

As part of its work related to the CHIPRA state options, the Commission also considered the impact of important and significant health policy changes that occurred after CHIPRA and SB 436 (which created the Commission) became law. In March of 2010, the Patient Protection and Affordable Care Act (ACA) became federal law. The Commission has explored the impact that changes under the ACA have on the CHIPRA options and their need in New Hampshire. Importantly, the ACA extends federal CHIP funding and significantly increases the federal matching rate that New Hampshire receives for CHIP coverage from 65% to 88% starting in 2016. In addition, despite passage of the ACA, all of the CHIPRA state options remain available and federal funding remains available for each of the options, including performance bonus dollars and federal funding for outreach and enrollment activities.

The Commission is hopeful that some of the uninsured individuals that stand to gain access to quality, affordable coverage as a result of New Hampshire exercising one or more of the CHIPRA options may, instead, be able to gain access to quality, affordable coverage as a result of the ACA. In particular, some of these children and pregnant women may have access to affordable coverage via the health benefit Exchange, possibly with the assistance of federal premium tax credits and cost-sharing reductions, or via a possible New Hampshire Basic Health Plan. Given the importance of these populations having health coverage – not just for themselves, but for the state as a whole – as detailed below, we advise that the State explore opportunities to expand access to quality, affordable coverage to these residents via thoughtful consideration and implementation of opportunities under the ACA. Importantly, however, these changes will not be implemented until 2014. Until then, and for at least some of the individuals in the populations in need of the access to quality, affordable coverage made possible under CHIPRA even afterwards, there will remain a significant need for improved access to quality, affordable health care. While the Commission believes it is important to be cognizant of the impact that the ACA will have on decreasing coverage needs in the longer term – and therefore, decreasing the state cost of implementing any of the options - we also understand that the passage of the ACA has not fully obviated the benefit of implementing the CHIPRA state options to New Hampshire families and the state more generally. As expanded upon below, we advise that the State pursue the available federal funding via the CHIPRA options as a way to fill in the remaining gaps in coverage.

Additionally, the Commission was challenged by two unexpected major events during the course of its work. First, the makeup and political philosophy of the legislature changed dramatically during the November 2010 general election. This change had major implications for the direction of the delivery of children's health insurance and other health-care spending in the state of New Hampshire. Second, New Hampshire Healthy Kids, which has been integral to the operation of New Hampshire's CHIP program, will potentially be eliminated and all of its functions assumed by DHHS within the next year. This represents a major change in how children's health

insurance programs have been administered in New Hampshire. Because this change was mandated close to the preparation of this report and is yet to be implemented, the Commission was not able to address the impact of this major development. It remains to be seen how the NHHK Board, a 501-3-C entity, will move to address this change and its own role within the structure of children's health care in the state. Their exemplary work on improving access to care warrants recognition.

Analysis of CHIPRA Options

I. Outreach and Education

CHIPRA Option: CHIPRA includes a number of provisions increasing outreach funding to enroll eligible, but uninsured children, with a focus on those who are the most difficult to reach. CHIPRA Outreach and Enrollment Grants (totaling $80 million) are expressly for the purpose of providing outreach grant money to find these children and ensure that they are enrolled in Medicaid and CHIP programs and that they retain this coverage while they are eligible.

Current Status

Outreach has been an important aspect of the Children's Health Insurance Program (CHIP) and the NH Healthy Kids (NHHK) Program from the very beginning. Over the last five years, in excess of $900,000 has been invested in education and outreach annually.[1] The purpose of outreach is to inform families of availability of coverage. Outreach targets families that are likely to be eligible for CHIP or another public or private health insurance program.

Outreach includes the following components: educating people about the importance of health insurance coverage for their children; developing and distributing literature (i.e. flyers, pamphlets, and posters); describing the available programs and their eligibility requirements; partnering with community-based organizations whose direct connection with clients provides the best opportunity to inform clients, conducting media campaigns, and referring people to enrollment personnel.

Federal guidelines limit the amount of a state's funding allotment that can be used for outreach, stating that not more than ten percent can be used for the total costs of outreach, the provision of direct health services to eligible children (as opposed to services covered through the CHIP-funded insurance plan), and administrative costs. Many states and communities engaged in

[1] In the most recent biennial budget process, monies earmarked for education and outreach were removed due to the impending transition to Medicaid managed care. It is important that the Department of Health and Human Services maintain the integrity of education and outreach with continued financial support at a minimum of what the program is currently funded (FY12 PETA contract $926,924).

outreach efforts are supplementing these funds with grants from charitable foundations and other private donors – and now through CHIPRA grants.

NH Healthy Kids' Outreach Program

NHHK created a community-based outreach and education program comprised of partner agencies and trained volunteers that promote the state's CHIP program. The program has ensured unique and exceptional outreach, education and coverage retention work – currently taking place in thousands of settings across the state. In some cases, agencies that provide additional follow-up and application assistance to families receive a small reimbursement for their work to get applications completed and children enrolled. Many NHHK application assistors/community partners are culturally and linguistically competent and are able to reach and engage individuals and families that are not easily reached through mainstream efforts.

NHHK works with hospitals and safety net providers to help identify potential applicants at the time they access health care services. Hospitals and other health care practitioners, in addition to patients, benefit when the care they provide to enrolled applicants is reimbursed. Outreach workers engage extensively with schools, school nurses and athletic coaches to enroll children through a number of activities such as: free/reduced lunch programs, sports, enrollment events at kindergarten registrations, open school nights, after school program registrations and at Head Start sites. Outreach workers also provide promotional materials, information and applications to support all school engagement. NHHK continues to build "informal" relationships with local churches, clubs and libraries that are willing to distribute material.

Outreach workers also educate the public about health programs and the enrollment process through their participation at community events such as health fairs and street festivals; by making presentations at clubs, churches, work sites, and other gatherings; and by placing enrollment workers at camp registrations. While this process is labor intensive, the key ingredient is not just to "show up," but really to engage with potential applicants.

NHHK goals have been:

- To ensure continuity of coverage: Enrolling in healthcare coverage can be challenging; staying enrolled is even harder. Outreach workers assist enrollees with the annual re-application process. They help consumers who have been wrongfully terminated, denied coverage, or bounced between different programs in the system. Outreach workers also help individuals transition to other qualifying health insurance programs if their circumstances change (such as after a job loss).
- To connect people to care: Outreach workers help consumers navigate our complex health care system to ensure they get necessary care. Such assistance helps prevent episodic care based in emergency rooms and ultimately contains cost.
- To provide local resources to residents at all income levels: Outreach workers provide expert information and guidance about health care coverage to individuals and partners in their communities, from low-income people enrolling in Medicaid/CHIP to moderate-income individuals enrolling in the Buy In program. Outreach workers provide the

support and education individuals and community partners need to understand the rules and take appropriate actions.

Remaining Barriers and Needs

While much progress has been made, there are thousands of children who are eligible and are still not enrolled. Data gathered by the Urban Institute shows that New Hampshire ranks 18th in the country in the state's rate of eligible children enrolled in Medicaid and CHIP.

All states have worked to enroll eligible children in Medicaid with mixed results. While research into why families do not enroll is quite limited, experience has shown that there are many reasons. Parents may not come forward to enroll children because:

- they may not know they are eligible;
- they do not see having health insurance coverage (Medicaid coverage) as important;
- they cannot complete the application process as the application itself can be long and may require documentation that the family does not have or does not produce in the time required to complete the process;
- the program information may not be in the language they speak; and/or,
- The parents may be undocumented residents, resulting in their being unable to complete the entire process or being afraid to come forward, even if their children are citizens.

In addition, they may want to avoid the stigma of Medicaid as a "welfare" program. The Medicaid-welfare connection has long been a problem and many states have renamed their Medicaid program to help de-stigmatize its welfare image. New Hampshire Healthy Kids (NHHK) administering the CHIP program is a case in point that has helped families overcome the stigma associated with its connection to Medicaid-welfare.

Outreach and education are the keys to surmounting barriers. Outreach can be thought of as a continuum: first, identify the target population and barriers families face to enrollment and services; second, develop strategies to facilitate enrollment and re-enrollment; and third, ensure that children have access to a high-quality primary care provider. If all these steps are not completed, the efforts will fail and Medicaid and/or other children's health insurance programs will not realize their goals. We must continue to find effective ways of getting the message to low-income families and encouraging them both to apply and, once covered, to use appropriate services to keep their children healthy.

In recognition of the importance of, and challenges inherent in outreach, Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services, has issued the *Connecting Kids to Coverage* challenge to federal officials, states, governors, mayors, schools, community and faith-based organizations, health care providers, businesses and concerned individuals to enroll the remaining uninsured children who are eligible for Medicaid or CHIP. This five year campaign is a call to action that asks us to build on our success and take the next step to find and enroll these children who are in harder to reach populations – adolescents/teens, multi-cultural/minority populations, and the newly unemployed.

Adolescent/Teen population – In New Hampshire, 5.8% of 13-18 year olds are uninsured, as opposed to 4.8% of 6-12 year olds and 4.3% of 0-5 year olds. Teens living on their own are uninsured at an even higher rate of 13%. It is vital that outreach efforts be aimed at reaching uninsured adolescents who might be eligible. This could mean targeting printed materials to adolescents, making information available at places frequented by adolescents, conducting media campaigns aimed at adolescents and permitting eligibility determinations at service sites – such as family planning clinics that see large numbers of young people. In addition, it means that materials developed for parents need to make clear that all their children, adolescents as well as younger children, have a source of affordable insurance coverage.

Multi-cultural/minority populations - Western medicine and the structure of health insurance in the U.S. are not necessarily culturally relevant to many of New Hampshire's minority groups. This reality necessitates a tailored approach to outreach to New Hampshire's diverse populations that is culturally sensitive and relevant. As the immigrant population in New Hampshire is increasing and immigrants are enrolling in Medicaid and CHIP, outreach to these groups is becoming more important. Outreach must be culturally competent and responsive to their special needs and characteristics. It is necessary to approach individuals with an understanding of their historical and cultural backgrounds – from using outreach materials in languages and at educational levels that are specific to communities involved, to ensuring that community workers speak the languages and/or are of the same ethnic background as target populations, to addressing the fears and misconceptions many immigrant families have about enrolling in public programs.

Newly unemployed – There is no question that state lawmakers are in a bind having to close deep budget gaps. But the recession that is putting their backs to the wall also means that there is a growing number of unemployed parents whose children are without medical coverage. Many of these children are eligible, but their parents do not know they are because they have never before needed this type of public help. In New Hampshire, the rate of uninsured children increases in families whose income is greater than 200% of FPL and is highest in families with incomes greater than 250% of FPL. Children from families with incomes of over 200% of FPL currently make up 8% of overall enrollment in the health insurance programs.

Increasing premiums for employer-sponsored health insurance—Surveys by the Kaiser Family Foundation have identified an increase for premiums of family health care plans of 9% in 2011, an increase of 22% in the past five years. Employers faced with such premiums have moved to plans requiring workers to pay more out of pocket, well ahead of wage and inflation increases. The Center for Studying Health System Change has found that one in five families are now spending more than a tenth of its income on out of pocket health costs. Many families now find health insurance out of their reach, sacrificing insurance for basic necessities.

Funding through CHIPRA To Support Additional Efforts

CHIPRA Outreach and Enrollment Grants are available to all states, including New Hampshire, to help support states' efforts find eligible and uninsured children and ensure that they are enrolled in Healthy Kids coverage and that they retain this coverage while they are eligible.

The Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations released invitations to apply for Cycles I and II of the CHIPRA Outreach and Enrollment Grant. Awards for the project period for Cycle I was September 30, 2009 – September 29, 2011. Awards for the project period for Cycle II are July 30, 2011 through July 29, 2013.

CMS has been contacted to see whether or not they anticipate a Cycle III, which - if available - would be released in early 2013. If awarded, the project period would most likely cover July 2013 – July 2015.

Recommendation

We strongly encourage either the State or an appropriate New Hampshire non-profit social service entity (as described below) to apply for the CHIPRA Outreach and Enrollment Grant. Our goal is to reduce the number of uninsured children in New Hampshire and improve children's health status by providing access to health care. The challenge is to find, enroll, and serve as many children as possible. This goal will not be achieved unless the state purposefully commits itself to initiate effective education and outreach strategies to enroll eligible children and assure that they receive services. Without effective outreach to find, enroll and ensure services for these children, well-intentioned efforts will fail. Simply making coverage available does not guarantee that all, or even most, eligible children will receive health coverage. We must use effective outreach strategies to reach low-income families, encouraging them both to apply and, once covered, to use appropriate preventive and primary care services to keep their children healthy. But this costs money: Funding from CHIPRA could significantly advance the state's efforts to address the needs of New Hampshire families.

At the same time, outreach is not a traditional activity for Medicaid and public welfare programs. Effective education and outreach will require collaboration and creativity between families, community organizations, businesses, health plans, public health and Medicaid agencies, foundations and policy makers. These players share a common mission of ensuring that children have access to high-quality, cost-effective health care. Education and outreach strategies must be carefully designed to meet the target population's needs, but they also must be flexible and adaptable as these needs or the population changes.

It may be necessary for multiple entities, including nonprofit social service agencies with an interest and expertise in children's health care issues to work collaboratively with DHHS, as this agency assumes control over Healthy Kids Silver, to achieve the objectives of education, outreach, and ensuring continued enrollment and participation in these programs. Collaborating and making education and outreach a top priority will help fulfill the promise of CHIP to improve children's health.

II. Streamlining Enrollment / Renewal and Performance Bonuses

CHIPRA Option: CHIPRA provides financial support to states that meet set targets for increasing enrollment of eligible children into Medicaid (Healthy Kids Gold) coverage in the form of Performance Bonuses. In order to be eligible for a bonus in any given year the state must have:

- exceeded the set enrollment targets; and
- implemented five of eight enrollment and renewal (E & R) best practices specified in CHIPRA:
    - **Eliminating asset tests:** According to Georgetown University, few low- and moderate-income families have substantial assets. As a result, not requiring an asset test should not significantly impact eligibility, but does relieve a paperwork burden on both families and the State.
    - **Eliminating face-to-face interviews:** Again according to Georgetown University, requiring parents who often lack flexibility to leave work to appear in person to apply for or renew coverage for their children makes it more difficult for parents to seek or retain that coverage.
    - **Using a joint application and same information verification process for both Medicaid and CHIP:** To implement this measure a State must have the same application, renewal and supplemental forms for the Medicaid and CHIP program and the same process for verifying information. According to the Government Accountability Office, such uniformity makes it easier for families to understand the procedures and prevents children from falling between the cracks. Research completed by the Center for Budget and Policy Priorities demonstrates that implementing this measure also reduces costly hospitalizations.
    - **Adopting presumptive eligibility:** Presumptive eligibility allows states to authorize health care providers, community-based organizations, schools, and other selected entities to screen for Medicaid and CHIP eligibility and make temporary eligibility determinations in urgent health care situations. According to Georgetown University, entities assisting with presumptive eligibility assist families and reduce the administrative burden on the State to by obtaining information and documentation.
    - **Implementing 12 month continuous coverage:** States with continuous coverage (also known as continuous eligibility) guarantee 12 months of coverage for children enrolled in Medicaid and CHIP regardless of changes in their financial circumstances, just as employer-sponsored insurance works. According to Georgetown University, changes of income in this population tend to be small. Continuous coverage promotes continuity of care and reduces State administrative costs that result from the cycling of individuals in and out of Medicaid and CHIP. In addition, according to the Commonwealth Fund, the enrollment stability that results from continuous coverage encourages managed care plans to participate in Medicaid and CHIP.
    - **Conducting administrative renewals:** States using administrative renewals use the information already available to the state through other programs or databases to complete pre-printed forms, which are sent to the family at

renewal time. The family is required to report changes to that information; if there are no changes, the state's information is used to process an eligibility renewal. According to the Kaiser Commission for Medicaid and the Uninsured, administrative renewals can stem the frequency of children losing coverage at renewal time and reduce administrative costs to the State.

- **Implementing express lane eligibility:** This option allows the State to use eligibility for other public programs to determine that a child satisfies one or more components of eligibility for Medicaid or CHIP. According to the Kaiser Commission for Medicaid and the Uninsured, express lane eligibility can help states avoid unnecessary and repetitive requests for information that can add to the paperwork burden for both families and states.
- **Providing premium assistance to Medicaid and CHIP-eligible families to purchase private insurance:** Premium assistance offers states a way to subsidize qualified group health and employer-sponsored coverage using Medicaid or CHIP funds. Premium assistance can be a useful strategy for combining employer and public funding for coverage. Unfortunately, according to the Urban Institute, relatively few families with uninsured children have access to cost-effective private coverage.

Recognizing that an increase in enrollment that may result from implementing E & R measures would likely raise costs for the state, the federal bonus is calculated based on the number of children enrolled in Medicaid coverage above set enrollment targets to help states meet that cost.

Current Status

Performance Bonus Eligibility

New Hampshire has met its enrollment target for qualifying for a CHIPRA Performance Bonus each of the last two years. Based on enrollment alone, New Hampshire was eligible for a bonus of $560,000 in 2009 and $1.3 million in 2010.

However, New Hampshire only has two of the eight E & R best practices in place (New Hampshire has no asset test and no face-to-face interview) and, therefore, does not qualify for the Performance Bonus. New Hampshire has partially implemented two additional measures (New Hampshire has a joint application for Healthy Kids Gold and Silver coverage, which promotes a more seamless enrollment process for families, but does not have the same information verification processes for both programs; in addition, New Hampshire has presumptive eligibility for Healthy Kids Gold, through which it works with trusted entities in the community to help children with urgent medical needs enroll through an abbreviated process and address those needs as quickly as possible, but does not have that in place for Healthy Kids Silver). In order to qualify for a bonus, New Hampshire must fully implement at least three additional measures.

If additional E & R measures are fully adopted in both Healthy Kids Gold and Silver, the resulting increase in enrollment from implementing the measures will likely support New

Hampshire's continued ability to meet the enrollment targets required for eligibility for the Performance Bonuses, which will help the state absorb the cost of that increased enrollment.

Streamlining the Enrollment and Renewal Process:

In addition to making New Hampshire eligible for Performance Bonuses, adopting further E & R best practices will help to streamline and improve the enrollment and renewal process for the State and families. During these times of limited state resources and following significant cuts in the DHHS budget – and, as a result, staff capacity – it is more important than ever that state programs be administered as efficiently as possible. The Commission heard from just a few of the dedicated workers that help families enroll and renew their children in Healthy Kids coverage, and we learned of the incredible work that goes into those processes. For just enrollment alone, the state received over 8,350 applications in SFY 2010 (nearly 700 per month) and must process each of those applications within 45 days. The best practices available to the state, will allow DHHS to give the workers the tools they need to make their work as efficient as possible.
At the same time, New Hampshire families are facing unprecedented challenges, particularly as they face times of fiscal instability. For them as well, ensuring the enrollment and renewal process is as user-friendly and streamlined as possible may make the difference of whether parents have the time needed to enroll their child in coverage on top of the other issues facing their family.

E & R best practices can also help to support improved accuracy in the eligibility process. According to the Centers for Medicare and Medicaid Services, Louisiana, which has led the nation in implementing E & R best practices, has also benefitted from improved accuracy in the eligibility process as a result of implementing these practices. Louisiana's Medicaid eligibility error rate is 1.54 percent, compared to the significantly higher national average of 6.74 percent. Louisiana credits its efforts to streamline the eligibility determination and renewal processes with improving retention and allowing them to reduce staff by 15 percent without sacrificing the integrity of the program.

<u>Pursuing CHIPRA Performance Bonuses</u>

New Hampshire currently operates a Combination program (part Medicaid Expansion part Separate Program), which has created barriers to implementing certain E & R measures in both Medicaid and CHIP. Efforts underway at DHHS are expected to make the state eligible for Performance Bonuses in future years. HB2 (2011) directs DHHS to transition CHIP from a Combination program to a Medicaid Expansion program concurrent with commencing managed care for Medicaid, expected in July 2012. Upon the transition to Medicaid Expansion CHIP model of administration, two more E & R measures will be adopted fully (joint application/renewal forms and procedures and presumptive eligibility). At that time, New Hampshire will then meet four of the eight E & R measures required to qualify for a Performance Bonus.

NH will still need to adopt one more E & R measure in order to qualify for the Performance Bonus. Express lane eligibility is a promising option that would allow DHHS to share data

findings across its programs to process eligibility. The Department of Health and Human Services currently does the reverse to help Medicaid children enroll in food stamps. Other E & R options are also being explored such as 12 months continuous eligibility (which mirrors how enrollment works for employer-sponsored insurance) and administrative renewal (which allows the state to send enrollees renewal forms pre-populated with the information it has to streamline the renewal process). DHHS continues to explore the scope of the increased expenditures related to these best practices and balance those against anticipated administrative efficiencies.

In order to have the Performance Bonus available for SFY 13 as contemplated in the State budget, any new E & R measures would need to be in place by April 1, 2012. Any State Plan Amendments related to these E & R changes would also need to have an effective date of April 1, 2012. It is not likely that New Hampshire will have the five of eight E & R measures in place by April 1, 2012 to qualify for a Performance Bonus in Federal Fiscal Year 12 (SFY 13) because the transition of the NH CHIP to Medicaid Expansion is not expected to occur until July 1, 2012. Transitioning to Medicaid Expansion on this date should however, allow for collection of a CHIPRA Performance Bonus during SFY 14.

Recommendation

New Hampshire should take steps to appropriately streamline the enrollment and renewal process for the State and families, without undermining the program, and to make itself eligible for CHIPRA Performance Bonuses. New Hampshire has met the required Medicaid enrollment targets for the CHIPRA Performance Bonus for Federal Fiscal Years 2009 and 2010 but did not have five of the eight E & R measures in place to qualify for the bonus and, therefore, lost out on nearly $2 million. Implementing further E & R best practices will bring New Hampshire into eligibility for the CHIPRA Performance Bonuses. At the same time, implementing further E & R measures will also streamline the enrollment and renewal process for the State and families at a time when doing so is particularly important. The Commission supports the DHHS efforts to explore the opportunities to implement effective, cost-efficient and appropriate E & R measures and advises that the State to provide assistance to make that possible.

At the same time, in looking at the remaining tools available to streamline enrollment and renewal, the legislative members of this commission had substantial concerns about the political will of New Hampshire to pursue several of these, because they are in conflict with the general philosophical outlook New Hampshire has historically had concerning these federal requirements. For this reason, the Commission also recommends that the State work with our Congressional Delegation and other New England states to advance changes to existing laws and rules into how these measures translate into bonus eligibility.

The Commission has explored concerns that New Hampshire is treated inequitably relative to other states, given our superior performance in covering children overall. Over the fiscal years 2009 and 2010 a total of $281,530,119 was awarded to 15 states in the form of Performance Bonuses. Alabama, for example, received almost $100 million of the total dollar awards. New Hampshire and our fellow New England states were not awarded any of these funds, despite our historical success in enrolling eligible children. Even if New Hampshire brings itself into

eligibility for the funds, we are projecting to be eligible for a $1.3 million bonus per year, far less than has been awarded to other states. This is particularly troublesome given that our taxpayer dollars help to fund the bonuses.

The key reason New Hampshire did not qualify is because we have not enacted enough required enrollment and retention best practices. These bonuses have served the very important purpose of offering substantial incentives to states to insure more children, and many children and families across the country have benefitted. Part of the disparity is also due to population size[2]. Some of the inequity, however, is due to the way enrollment targets are set. The federal allotment also fails to reward maintenance of effort, for states – like New Hampshire – that have been at the head of the pack for years. Alabama saw an increase of 56.3% in its CHIP enrollment in 2009 because it had poor enrollment leading up to that year. Because New Hampshire has historically done a good job in covering eligible children, the best we can and need to do is to see a far smaller percentage increase in our enrollment (in 2010, for example, our enrollment increased by 2.9%), which directly impacts the size of the bonus for which New Hampshire can qualify.

It is important that the federal government not lose track of a state's historical and overall success in covering children when calculating Performance Bonuses. Our state has certainly been a leader in providing healthcare insurance coverage for our children. For example,

- The Agency for Healthcare Research and Quality has ranked New Hampshire Number One in Health Care Quality.
- The Commonwealth Fund had New Hampshire in the top quartile for Child Health Care (which, Alabama, for example, was in the second quartile)
- The Children's Defense Fund's most recent report, released June 27, 2011, listed New Hampshire as having 4.7% of all children uninsured, compared with Alabama's 6.8% rate of uninsured children. Both New Hampshire and Alabama have CHIP eligibility up to 300% FPL. For Medicaid eligibility, however, New Hampshire is at 185% FPL, compared to Alabama at 133% FPL.
- Kaiser Family Foundation reports that New Hampshire has 4% of children uninsured, compared with Alabama's children's uninsurance rate of 7%.
- The Annie E. Casey Foundation National KIDS COUNT Program rated New Hampshire Number One in overall ranking, with Alabama at 47.

We have not finished the task; there are still many left behind – as highlighted in this report. We do not want to see New Hampshire going backwards by not maintaining our effort. We should pursue all reasonable federal funding options, grants and otherwise, by meeting all performance bonus criteria, while at the same time encouraging federal authorities to recognize past and present performance and maintenance of effort. To lose out on some of a $281,530,119 award shows a lack of recognition for work, though incomplete, still *consistently* well-done in comparison to other states.

[2] For example, Alabama has a population of ~4,709,000, compared to New Hampshire's population of ~1,325,000.

III. Pregnant Women's Coverage

CHIPRA Option: CHIPRA provides states with the opportunity for expanded federal funding to improve access to prenatal care through the state's CHIP program. Specifically, by:

- Expanding coverage for pregnant women up to 300% FPL, using the enhanced federal CHIP match.
- Eliminating the waiting period for coverage of documented/legal immigrant pregnant women, using the enhanced federal CHIP match.

Current Status

Currently, New Hampshire provides CHIP coverage for pregnant women up to 185% FPL. These women have access to health care, including prenatal care and labor and delivery, while they are pregnant and for 60-days after delivery. Documented immigrant women are subject to a five-year waiting period; income-eligible women who are documented immigrants only have access to CHIP coverage while they are pregnant if they have been in the country for at least five years.

Barriers Facing Families

New Hampshire, with nearly 14,000 births per year, ranks 19th in the country for the percent of women receiving prenatal care. The NH March of Dimes report states that 10.1% of New Hampshire women do not receive adequate care; that is, care that begins early in the first trimester of pregnancy, the goal of Healthy People 2010.

This is not surprising given that, while overall birth rates are decreasing in New Hampshire, the rates of babies being born into low-income families are increasing. Pregnant women with Medicaid as a payer source increased to a rate of 31% in 2009 and 14% of women in child-bearing age are uninsured.

Immigrant pregnant women are also at particular risk. These women often receive delayed prenatal care because of lack of insurance, since they are denied access to publicly funded prenatal care if they are undocumented or if they have been residing legally in the United States for fewer than five years.

Impact of the lack of access to prenatal care

In July 2010, the Maternal and Child Health Section, Division of Public Health Services completed a major needs assessment of NH Title V documenting NH's status as it relates to maternal child health:

- New Hampshire has ranked the lowest in teen birth rate
- New Hampshire has ranked lowest in the percentage of children under age 18 in poverty
- New Hampshire has ranked highest in the percentage of immunized children, and

- New Hampshire has a low infant mortality rate

While still high, the cesarean birth rate does not appear to be continuing the upward trend seen in previous years.

However, important markers of health have begun trending in the wrong direction, including a decrease in immunization levels from 93.2% in 2008 to 85% in 2009 and an increase in infant mortality from 4.4 to 5.7 per thousand births in five years. Increased rates of preterm and low-birth weight babies are related both to lack of prenatal care and high rates of untreated alcohol, tobacco and substance use. In fact, according to a cost/benefit analysis published in the *American Journal of Obstetrics and Gynecology*, women who lack prenatal care can be as much as four times more likely to deliver a low-birth weight baby and seven times more likely to deliver a premature baby. The health impacts on infants who are born too early, too small, and / or addicted carry both short term and long term costs for the baby, the family, and the health care system.

Premature birth is the number one killer of newborns and cost ten times more than healthy babies. According to the March of Dimes, babies born just a few weeks too soon face many physical and neurological challenges and are at risk of life-long disabilities, including cerebral palsy, lung disease, blindness and hearing loss. The heartbreaking toll of mental retardation and/or developmental delays creates a constant state of anxiety and expense. The emotional toll to parents whose baby is in the neonatal intensive care unit and goes on to require continued extra care and services can be emotionally and physically exhausting. Multiple specialists, doctors and nurses, and multiple repeated tests leave parents feeling bewildered and out of control.

Children with special needs incur costs that are far beyond the average for health care, learning, and disability care. Special equipment, wheelchairs, braces and special clothing costs can be staggering to a family, even one with means.

Additionally, women with inadequate prenatal care are over-represented in the group of women who die within a year of giving birth. The maternal mortality rate in New Hampshire, traditionally low, is rising and alarming. Though small in number overall, New Hampshire's maternal mortality rate has risen over the last five years, including postpartum suicides. Until 2004, our death certificates did not require identification of the deceased as being pregnant or newly delivered. In 2010, NH passed legislation creating a maternal mortality review committee to address systems issues related to these maternal deaths. The death of a mother is always a catastrophic event. In addition to the premature loss of a young woman to her family, friends, and community, the children of women who die in childbirth suffer from life-long multiple emotional, physical, and intellectual difficulties.

There is serious concern about these continuing negative trends given the drastic cuts to DHHS essential health and social services in the current State budget.

<u>Funding through CHIPRA to Support Improved Access to Prenatal Care</u>

Adjusting the eligibility level

The Department of Health and Human Services projects that 300 pregnant women would newly qualify for temporary health care coverage during their pregnancy if the income eligibility were raised from 185% FPL to 300% FPL. This estimation is based on the fact that 300 children under the age of 1 are currently eligible for Medicaid expansion coverage given their family income of between 186% of 300% FPL. Based on that estimate, DHHS has calculated the total cost of that coverage to be $1.8 million per year. Because CHIPRA provides that the federal government will pay 65% of that cost, the federal government will contribute nearly $1.2 million toward the coverage per year, limiting the annual state cost to $630,000. When the federal CHIP matching rate increases to 88% in 2016, the federal share will increase to $1.05 million per year, with the annual state share decreasing to $144,000.

Eliminating the five year waiting period

Estimates by policy experts indicate the magnitude of eliminating the five-year waiting period for documented immigrant pregnant women would be similarly small. Some policy advocates believe that the cost of expanding coverage for all legal immigrants could be less than would be spent on immediate and long term health care costs of a single premature infant. Again, the federal government would pay the enhanced CHIP match (65% until 2016 and 88% starting in 2016) for this coverage.

Impact

Giving women access to prenatal care enrolls a woman in 24/7 health care and "connects the dots," sometimes for the first time in a young woman's life: past medical history; family history; mental health assessment; personal risk assessment for violence; injury prevention; smoking; drug and alcohol use; communicable disease prevention, diagnosis and treatment.
Prenatal care delivers a system of care, which provides for the health of mothers across the spectrum from conception to 60 days postpartum and includes:

a. Vaccine for H1N1, which has higher mortality rates for pregnant women
b. Violence prevention programs (violence increases in battering relationships in pregnancy)
c. Prenatal care improvements, including use of medications to delay preterm births and improve birth outcomes
d. New models of prenatal care, such as group prenatal care, known as Centering Pregnancy. Documented data in rigorous peer-reviewed journals found a resulting 33% reduction in preterm birth and an increase in patient perceived satisfaction and readiness to parent.

Providing quality health care for pregnant women is not only the right thing to do, it is also the most logical cost-effective strategy. By delaying preterm births and improving birth outcomes, prenatal care saves significant money on preterm nursery care, including expensive intensive care, and long term care of children. According to the March of Dimes, the cost of a preterm

infant averages $50,000 dollars. At the current preterm birth rate of 12.7 %, U.S. preterm births cost $24.7 billion. At the goal rate of 7.6% pre-term births, a savings of $9.9 billion could be realized. A study published in *Health Services Research* also shows that every dollar spent on prenatal care in New Hampshire saves $2.57 in cost caused by low-weight births. Importantly, these expensive and avoidable costs are being borne by the state. Children born to the women in question are covered by Healthy Kids Gold (children age 0-1 year olds are covered by Healthy Kids Gold up to 300% FPL; infants born to immigrants are citizens and are also covered by Healthy Kids Gold). It would be better to invest in consistent prenatal care to prevent more intensive health care among these Medicaid-eligible children.

Prenatal care also helps to prevent unnecessary and expensive emergency room care and costly negative outcomes in labor and delivery. Women who have regular visits for prenatal care learn the normal pregnancy-related minor discomforts and how to determine what requires immediate attention. They are connected to health providers who assist them in determining what requires immediate treatment (unexpected bleeding) from those issues which can be discussed at the next regularly scheduled visit. These emergency costs are often borne by the state since legally-present immigrants in the five-year waiting period receive Medicaid services for life-sustaining hospital care for labor and delivery, but not for more efficient prenatal care. Federal law requires that emergency labor and delivery care be provided and for Medicaid to fund these emergency services for women who are otherwise eligible except for the five-year waiting period. How much more logical to use the federal funds now available to provide comprehensive prenatal care to avoid costly negative outcomes?

Recommendation

The Commission recommends that the State take advantage of the federal funds available under CHIPRA to improve access to health care for pregnant women, particularly those under 300% FPL, including those women currently subject to a five-year waiting period. The relatively small state funding needed would be a wise investment in light of the much more significant benefit to children and the state more broadly – including long-term cost-savings.

In addition, the Commission urges the State to prioritize action to ensure the care being delivered to pregnant women across the state is adequate. Prenatal care in New Hampshire varies across the state and across providers. Multiple studies show that those at greatest risk for adverse health outcomes continue to receive the least adequate prenatal care. According to the NH March of Dimes, only 83% of New Hampshire women receive adequate prenatal care in this state. Seventy-five to 85% of what NH Medicaid pays for is labor and delivery, an end-point without the benefit of health care, education, diagnosis or treatment. In rural areas, the number of providers does not tell the whole story. Women from large rural areas are more likely to be younger than 18 years, unmarried, and have an unintended pregnancy. Women from small rural areas were more likely to use tobacco during pregnancy. Rural women tend to be poorer and less educated, with higher tobacco use.

The Maternal Child Health Needs Assessment and the NH Chapter of the March of Dimes have identified and outlined prenatal and perinatal care priorities:

a. Reducing use and abuse of alcohol, tobacco and substance abuse. Thirty-three percent of NH births are to smokers and 16% of pregnant women enrolled in the Home Visiting program have documented substance abuse.
b. Reducing preterm births by improving access to health care, insurance, and obstetrical care providers.
c. Care should continue to be provided through the state's thirteen community health centers.

NH saw a 400% increase in neonatal drug-related hospitalizations between 2000 and 2007 (from 21 to 114 women.) Sixty-five percent of these women were covered by Medicaid (estimated cost $578,869.00). The average Medicaid payment for the birth of an infant whose mother shows evidence of substance use is $7812, compared to the average Medicaid payment for a typical birth of $1921. As New Hampshire's Title V 2010 Needs Assessment notes, the Medicaid program does not offer substance abuse treatment, yet outcomes are a huge determinant of long-term health. (In a recent study, 50% of New Hampshire high school students currently use alcohol, 28% are binge drinking, and 23% used marijuana in the past 30 days. New Hampshire is equipped to treat fewer than 10% of those students.) According to the Robert Wood Johnson Foundation, there is an 11-1 ratio of benefits in health care costs from treating substance abuse. In addition, pregnant women with substance use should be cared by providers with experience in substance abuse treatment.

Obstetrical treatment guidelines and protocols developed from evidenced-based practice are currently under review among all obstetrical providers in New Hampshire. Their successful implementation could lead to a significant improvement in the delivery of care, a cost reduction of prenatal care, and better outcomes for mothers and babies across the state. It is anticipated they will be available as practice guidelines by January 1, 2012.

Likewise, attention should be paid to why some women do not avail themselves of available prenatal care. Low-income women with inadequate prenatal care perceive a great number of barriers to be severe:

- Financial / lack of insurance / unwillingness of some providers to accept pregnant women insured by Medicaid
- Fear of support from others around issues such as substance abuse, acceptance of pregnancy, lack of transportation contributing to lack of access
- Belief regarding the value of prenatal care (more experienced women see less value)
- Tenuous connection to the health care system in general, often related to how they were treated in the past and how culturally comfortable they are in the health care system. Women without insurance tend to come into Medicaid coverage with poorer health.

IV. Covering Legal Immigrant Children

CHIPRA Option: Prior to the passage of CHIPRA, federal funding could not be used to provide coverage through Medicaid or CHIP for legal immigrants until they had been in the country for

at least five years. CHIPRA allows states to use federal funds to eliminate that 5-year waiting period. In addition, it provides that the enhanced CHIP match will be provided, even for children enrolled in Medicaid coverage, for which there is usually a smaller federal match provided.

Current Status

According to 2005-2009 American Community Survey in New Hampshire, there were 3,564 children under the age of 18 in New Hampshire who are not U.S. citizens. Using that data, policy analysts at the George Washington University School of Public Health and Health Services estimated that 780 New Hampshire children in families with incomes below 200% FPL are currently in the five-year waiting period for coverage. According to New Hampshire enrollment workers, they often hear from the parents of these children and have to refer them to the NH Healthy Kids Buy In program. Unfortunately, for many of them, the cost is unaffordable.

The erosion in health insurance coverage has hit immigrant children particularly hard. Data from the Census Bureau shows that between 1995 and 2006 the percentage of low-income citizen children (with incomes below 200% FPL) whose parents are native born citizens without health insurance declined from 19% to 15%. This was primarily because millions of children were able to enroll in Medicaid or CHIP. In contrast low-income immigrant children and pregnant women had even less insurance than the previous decade. The percentage of immigrant children who are uninsured rose from 44% in 1995 to 49% in 2006. Legal immigrants are less likely to have employer-sponsored health insurance. According to the Kaiser Commission, though non-citizen immigrants are just as likely to have at least one full-time worker in their family as citizens, they tend to be employed in low-wage jobs that do not offer health insurance. Language barriers, confusion about the health care system and fear of reprisals from immigration officials are also factor.

The impacts of these barriers to coverage are far-reaching. Uninsured immigrant children face economic barriers to medical care that limit their ability to prevent or resolve health problems. These children are far less likely to have a regular source of health care or to get the well-child visits recommended by the American Academy of Pediatrics. They also suffer from chronic conditions that can be averted with regular and preventive care. This has long-term ramifications as these children are far more likely to miss school and, as a result, have poorer academic performance. Children who are uninsured are also 24% less likely to be fully immunized, threatening their own health and the state's public health.

Funding through CHIPRA to Support Improved Coverage for Legal Immigrants

Adjusting the George Washington University School of Public Health and Health Services estimate for New Hampshire's CHIP eligibility level of 300% FPL and New Hampshire's participation rate of 85.6%[3], results in an estimate of 1,001 immigrant children in the 5-year waiting period who are likely to enroll in coverage. In reality, this estimate is likely to be even

[3] No public program has 100% participation. Census data, analyzed by the Urban Institute, shows that 85.6% of eligible children in New Hampshire are enrolled in Medicaid and CHIP.

lower because some of these children are enrolled in employer-sponsored coverage. Using the average annual New Hampshire Medicaid expenditure of $2,816 and the average cost of CHIP coverage (adjusting for family contribution) of $2,328, the total fund cost of that coverage is estimated to be less than $2.6 million per year. Because CHIPRA provides that the federal government will pay 65% of that cost even for those children who will qualify for Medicaid, the federal government will contribute nearly $1.7 million per year toward the coverage, limiting the annual state cost to $901,100. When the federal CHIP matching rate increases to 88% in 2016, the federal share will increase to nearly $2.3 million per year, with the annual state share decreasing to $312,000.

The children who gain access to coverage as a result of the State exercising this option will gain access to regular preventive care, improving their health, their ability to succeed in school, and the state's public health.

There are also fiscal benefits to expanding access to these children. Researchers at the George Washington University School of Public Health and Health Services found that, as a result of barriers to coverage, uninsured immigrant children are almost four times more likely to have used an emergency room more than once during the prior year as are immigrant children who are insured. In many cases, children used emergency rooms as a result of illnesses (such as asthma or flu) that could have been prevented or better controlled if they had access to a regular source of primary health care services. The emergency room services can cost two to four times more than a preventive office visit. These are costs that are borne by the Medicaid program under Emergency Medicaid coverage, which provides coverage for treatment to screen and stabilize immigrants in the five-year waiting period who otherwise meet all of the Medicaid eligibility requirements during emergencies.

Additionally, the barriers these children face to addressing their preventive and acute health care needs results in pent up health care needs, which can result in higher Medicaid costs when they complete their five-year waiting period and are eligible to enroll. While immigrants typically have had care in their home country, their health tends to decline when they have been in the U.S. for some time without access to care. Eliminating the five-year waiting period will allow children to address acute health care needs in a timely manner and avoid the long-term health care costs that result from pent up health care needs.

Recommendation

The Commission recommends that the State avail itself of the federal funds available under CHIPRA to improve access to health care for legal immigrant children who are currently subject to a five-year waiting period. The number of children in the waiting period is relatively small. While eliminating the waiting period will not add a large number of children to CHIP and Medicaid, it will provide access to critical health care services for children who otherwise would have no other way to get that care at a time of life that is particularly important for future health, growth, and development and allow them to avert preventable longer-term costs to the state.

V. Stand-alone Dental Coverage

CHIPRA Option: CHIPRA makes the enhanced CHIP federal match funding available to states to create CHIP dental-only coverage for children who have private medical coverage, but no dental coverage, and are otherwise eligible for Healthy Kids Silver.

Current Status

Dental services for Medicaid-covered children are federally-mandated under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that focuses on prevention, early diagnosis, and treatment of medical conditions. EPSDT requires that services be provided at intervals that meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health, and at such other intervals, as indicated by medical necessity, to determine the existence of a suspected illness or condition. Services must include at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services for EPSDT recipients. If a condition requiring treatment is discovered during a screening, the state must provide the necessary services to treat that condition, whether or not such services are included in the state's Medicaid plan. As a result, New Hampshire had 122,381 dental visits for children covered by Medicaid in 2009.

Unlike Medicaid, CHIP did not require dental services until the passage of CHIPRA. CHIPRA dental standards are aimed at improving oral health by requiring comprehensive dental benefits defined as coverage necessary to prevent disease and promote oral health, restore oral structure to health and function, and treat emergency conditions, or provide benefits equivalent to those found in a benchmark package the federal employees health benefit pack, the most frequently selected state employee dependent dental over in the last two years, or the largest commercial non-Medicaid dependent dental plan in the state. Other CHIP required elements include education for new parents, better access to benefit and provider information, and enhanced reporting on the quality of dental health services provided by both CHIP and Medicaid.

Unfortunately, these services are not available to children who are enrolled in employer-sponsored private health insurance – and, therefore, do not need access to Healthy Kids Silver medical coverage – but do not have access to private dental coverage. Though these children are eligible for Healthy Kids Silver, because they have enrolled in private health insurance, they are forced to go without access to oral health care. This is not a limited problem. Experts estimate that 1/3 of low-income children have medical insurance but no dental coverage. As a result, each year we have more than 15,000 emergency department visits for children and adults that are due to avoidable and preventable dental conditions, at a cost of over $5 million. This also puts families in the position of only being able to get dental coverage for their children if they forgo private health insurance for their children so they can enroll in Healthy Kids Silver.

Impact of the Lack of Access to Oral Health Care

The impacts of lack of dental coverage are devastating and far-reaching. Tooth decay, a progressive disease, is the single most common chronic disease in New Hampshire children. Caused by bacteria, decay can be easily passed from a caring parent or caregiver, to a child. Untreated decay leads to pain, swelling, infection, and risk of death.

Subsequent destruction of the teeth and surrounding tissue can result in illness, difficulty eating, problems in school, and higher dental expense.

Funding through CHIPRA to Support Improved Access to Oral Health Care

CHIPRA provides the enhanced federal CHIP match for a federally-defined *separate* CHIP program to offer a dental-only plan for children who would otherwise qualify for CHIP but who have a private health plan from another source but lack sufficient dental coverage, thereby making a child "whole" in terms of dental coverage. Coverage would need to be consistent with the state-defined dental package or be equal to the dental benefit plan provided to children who are eligible for the entire CHIP benefit package. The CHIP coverage would pay secondary to the private plan and the family can be required to pay premiums or co-pays toward the additional coverage.

Recommendation

Access to oral health is central to overall health and too many children in New Hampshire continue to face barriers to needed oral health care, many because they lack insurance coverage for dental services. Unfortunately, because New Hampshire is currently working to transition our state CHIP program from a separate program to Medicaid Expansion program, the option for a child-only supplemental dental coverage plan will no longer be available. We urge the State to continue exploring other opportunities to improve children's access to oral health care. A possible solution could be for a nonprofit social service agency to create a dental program to address this population funded through charitable contributions and foundations (and independent of public funding sources). This arrangement could be truly innovative and flexible, as it would be unfettered by legislative rules because of its private, nonprofit governance. Creation of child-only supplemental coverage would reduce unmet dental need, decrease the number of children without coverage, decrease the amount of untreated decay, save on the amount spent on untreated decay and related disease, and maintain families on private medical insurance.

Overview of Potential Funding Sources

As noted above, significant federal funding is available to the state to fund implementation of the state CHIPRA options, and many of the options represent investments that will lower costs for the state in the longer-term. The Commission presents the following state financing options as opportunities to fund the modest state portion of the required investments to advance the CHIPRA options.

This part of our work was the most controversial for the Commission, due to the varying political philosophies in the makeup of the Commission members. However, we feel it necessary to include this in the report, since our charge was to present facts in an unvarnished manner. We do not believe that it is part of our charge to advise the State of which of these opportunities are best suited for New Hampshire and the underlying need. As a result, we do not make any recommendations around these findings. Instead, we present our assessment of the importance of pursuing the CHIPRA state options in New Hampshire and present the following as possible ways to increase General Funds if needed. Further, we do not think that implementation of state options should be contingent on our identification of specific funding for the state portion of the investment needed to implement CHIPRA recommendations and actions.

In considering these options, it is important to keep in mind the following

- Relative to the size of New Hampshire's economy and the state's aggregate ability to pay, taxes in New Hampshire are relatively low. State and local taxes in New Hampshire amount to 8.7% of personal income, the second lowest level in the nation and far lower than the national mark of 10.9%.
- New Hampshire's state and local tax system is regressive. Residents in the lowest 20% of income distribution face highest effective tax rates (at 8.3%), while residents in the highest 1% of income distribution face lowest effect tax rates (at 2%).
- New Hampshire's tax revenue struggles to keep pace with economic growth. For example, between FY 2000 and FY 2009, personal income in New Hampshire – one proxy for the size of the state's economy – climbed 1.2% per year on average. Yet, tax revenue within the General Fund and the Education Fund declined by about 0.6% on an average annual basis, while motor fuel tax revenue within the Highway Fund *dropped* as quickly as incomes have *grown* – 1.2% per year on average.
- Modifications to existing taxes may require only relatively short implementation timeframes and, therefore, could allow revenue to be generated in the near term.

We also note that most of these opportunities are of a far greater scale that is needed. As a result, all could be used to increase General Funds generally and / or could be adjusted as appropriate.

Modifying existing taxes

The existing **interest and dividends tax** could be broadened to include capital gains. Following the federal definition of taxable capital gains income under this approach would ensure that the assets most commonly held by working families - homes and retirement savings - would remain exempt from taxation in New Hampshire, and the impact of taxing capital gains would be concentrated on the most affluent Granite Staters (the top fifth of income earners). In fact, 88% of federally taxable capital gains are realized by people with adjusted annual gross incomes in excess of $200,000. This change could bring $88 million more into New Hampshire's General Fund.

Excise tax rates could be indexed to keep up with inflation. For instance, the revenue produced by New Hampshire's beer tax has fallen noticeably in real terms, as the beer tax rate has gone unchanged since 1983. If the beer tax rate were changed to compensate for inflation over the last

two and a half decades, the revenue it would produce would be more than double what it currently is, bringing in an additional $15 million to the New Hampshire General Fund per year.

New Hampshire currently has a number of tax expenditures in the form of **business tax incentives**, which cost the state several million dollars per year. The State should look into these incentives to determine if they are achieving their desired end. If not, they could be reformed or repealed. These include:

- Community development finance authority investment tax credit
- Research & development tax credit
- Economic revitalization zone tax credit
- Coos County job creation tax credit

Importantly, relative to the size of its economy, the taxes paid by New Hampshire businesses are in the middle of the pack nationally. What's more, extensive economic research suggests that, at most, they have a very modest impact on companies' decisions to move to, or expand in, New Hampshire. Reforming or ending these incentives could increase New Hampshire General Fund revenue by $36,000 to $6 million per year.

New Hampshire's **meals and rooms tax** may be vulnerable to revenue losses arising from the taxation of transactions executed through online travel companies (OTCs). In some instances, OTCs, such as Expedia and Travelocity, may pay room rental taxes only on the discounted wholesale prices they pay for hotel rooms, rather than the full price that consumers pay for the room. Other states and municipalities have begun addressing this vulnerability by either suing OTCs for lost revenue or instituting legislative changes. By enacting statutory changes to its meals and rooms tax, New Hampshire could increase General Fund revenue by $1 million per year.

Finally, New Hampshire could convert our **electricity consumption tax** to a production tax and increase the state's General Fund revenue by $5.6 million per year.

Reinstating former taxes

New Hampshire had an **estate tax** for most of the twentieth century that, since 1990, had produced 3 to 5% of the state's General Fund revenue in any given year. The State no longer collects this revenue due to the repeal of the legacies tax in 2001 and changes in the federal estate tax. The estate tax is borne almost exclusively by the state's wealthiest residents; it applies to fewer than 2% of deaths (or around 200 deaths) in the state and could bring $16 million to $32 million to the state's General Fund annually.

Implement new taxes

New Hampshire could consider instituting a **sugar-sweetened beverage (SSB) tax**. SSBs are drinks sweetened with sugar, high-fructose corn syrup, or other caloric sweeteners, and are a significant source of "empty" calories. These drinks contribute to the obesity epidemic, a driver of poor health and high health care spending. A 0.1 cent per ounce tax could have brought in $7.2 million in 2011. This revenue is regressive, impacting the poorer residents in New

Hampshire most significantly. Like any excise tax, a sugar-sweetened beverage tax would need to be regularly adjusted to keep pace with inflation.

Other

Other potential sources of funds, which the Commission did not discuss in detail, are higher than budgeted existing revenues, an increase in the recently lowered tobacco tax and / or taxes on gambling revenue.

End Note: readers will appreciate that in some portions of this report citations are thoroughly noted, while in others, they are not. This reflects the fact that some presenters gave considerable references with their presentations, while others did not. The Commission felt that it was beyond the scope of the mandate for members to research each citation.

Voting Sheets

Senate Commerce, Labor & Consumer Protection Committee

EXECUTIVE SESSION

Bill # SB 436

Hearing date: 3/16/10

Executive session date: 3/16/10

Motion of: OTP **VOTE:**

Made by Senator:	Hassan	☐	**Seconded by Senator:**	Hassan	☐	**Reported by Senator:**	Hassan	☐
	DeVries	☑		DeVries	☐		DeVries	☐
	Reynolds	☐		Reynolds	☐		Reynolds	☐
	Cilley	☐		Cilley	☑		Cilley	☐
	Bragdon	☐		Bragdon	☐		Bragdon	☐
	Roberge	☐		Roberge	☐		Roberge	☐

Motion of: OTP/A **VOTE:** 4-0

Made by Senator:	Hassan	☐	**Seconded by Senator:**	Hassan	☐	**Reported by Senator:**	Hassan	☐
	DeVries	☑		DeVries	☐		DeVries	☑
	Reynolds	☐		Reynolds	☐		Reynolds	☐
	Cilley	☐		Cilley	☑		Cilley	☐
	Bragdon	☐		Bragdon	☐		Bragdon	☐
	Roberge	☐		Roberge	☐		Roberge	☐

Committee Member	*Present*	Yes	No	*Reported out by*
Senator Hassan, Chairman	☑	☐	☐	☐
Senator DeVries, Vice-Chair	☑	☐	☐	☑
Senator Reynolds	☐	☐	☐	☐
Senator Cilley	☑	☐	☐	☐
Senator Bragdon	☐	☐	☐	☐
Senator Roberge	☑	☐	☐	☐

***Amendments:** 2010/188 1028s

Notes:

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: March 16, 2010

THE COMMITTEE ON Commerce, Labor and Consumer Protection

to which was referred Senate Bill 436

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

Having considered the same, the committee recommends that the Bill:

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 4-0

AMENDMENT # 1028s

Senator Betsi DeVries
For the Committee

Danielle Barker 271-3093

New Hampshire General Court - Bill Status System

Docket of SB436

Docket Abbreviations

Bill Title: (New Title) relative to health insurance open enrollment periods and establishing a temporary commission relative to children's health insurance.

Official Docket of **SB436**:

Date	Body	Description
01/06/2010	S	Introduced and Referred to Commerce, Labor and Consumer Protection; **SJ 1**, Pg.15
02/24/2010	S	Hearing: March 16, 2010, Room 102, LOB, 9:00 a.m.; **SC9**
03/16/2010	S	Committee Report: Ought to Pass with Amendment 1028s, 3/17/10; **SC11**B
03/17/2010	S	Committee Amendment 1028s, AA, VV; **SJ 10**, Pg.161
03/17/2010	S	Ought to Pass with Amendment 1028s, MA, VV; OT3rdg; **SJ 10**, Pg.161
03/17/2010	S	Passed by Third Reading Resolution; **SJ 10**, Pg.169
03/18/2010	H	Introduced and Referred to Commerce and Consumer Affairs; **HJ 27**, PG.1441
03/24/2010	H	Public Hearing: 4/6/2010 11:00 AM LOB 302
03/24/2010	H	Executive Session: 4/13/2010 10:00 AM LOB 302 ==RECESSED==
04/13/2010	H	Subcommittee Work Session: 4/14/2010 1:00 PM LOB 302
04/13/2010	H	Continued Executive Session: 4/22/2010 10:00 AM LOB 302
04/28/2010	H	Committee Report: Ought to Pass with Amendment #1694h (NT) for May 5 (Vote 15-0; CC); **HC 34**, PG.1623
04/28/2010	H	Proposed Committee Amendment #1694h (New Title); **HC 34**, PG.1648-1649
05/05/2010	H	Amendment #1694h (New Title) Adopted, VV; **HJ 38**, PG.1888-1889
05/05/2010	H	Ought to Pass with Amendment #1694h (NT): MA VV; **HJ 38**, PG.1888-1889
05/19/2010	S	Sen. Hassan Concurs with House Amendment 1694h, NT, MA, VV; **SJ 20**, Pg.642
06/02/2010	S	Enrolled; **SJ 21**, Pg.775
06/02/2010	H	Enrolled; **HJ 51**, PG.2322
07/20/2010	S	Signed by the Governor on 07/20/10; Chapter 0351
07/20/2010	S	I. Section 3 Effective 12/31/11
07/20/2010	S	II. Remainder Effective 07/20/10

Other Referrals

COMMITTEE REPORT FILE INVENTORY

SB436 ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE SECRETARY AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

✓ **DOCKET (Submit only the latest docket found in Bill Status)**

✓ **COMMITTEE REPORT**

✓ **CALENDAR NOTICE on which you have taken attendance**

✓ **HEARING REPORT (written summary of hearing testimony)**

✓ **HEARING TRANSCRIPT (verbatim transcript of hearing)**
List attachments (testimony and submissions which are part of the transcript) by number [1 thru 4 or 1, 2, 3, 4] here: _____

✓ **SIGN-UP SHEET**

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

✓ - AMENDMENT # 07785 ____ - AMENDMENT # _____

✓ - AMENDMENT # 10285 ____ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

✓ AS INTRODUCED ____ AS AMENDED BY THE HOUSE

✓ FINAL VERSION ____ AS AMENDED BY THE SENATE

✓ **PREPARED TESTIMONY AND OTHER SUBMISSIONS (Which are not part of the transcript)**
List by letter [a thru g or a, b, c, d] here: a thru d

✓ **EXECUTIVE SESSION REPORT**

____ **OTHER (Anything else deemed important but not listed above, such as amended fiscal notes):**

IF YOU HAVE A RE-REFERRED BILL, YOU ARE GOING TO MAKE UP A DUPLICATE FILE FOLDER

DATE DELIVERED TO SENATE CLERK 9/9/10

COMMITTEE SECRETARY