NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH AND HUMAN SERVICES COMMITTEE

Tuesday and Wednesday, November 17-18, 2009
Roughrider Room, State Capitol
Bismarck, North Dakota

Representative Robin Weisz, Chairman, called the meeting to order at 1:00 p.m.

Members present: Representatives Robin Weisz, Larry Bellew, Tom Conklin, Kari L. Conrad, Robert Frantsvog, Curt Hofstad, Richard Holman, Gary Kreidt, Vonnie Pietsch, Chet Pollert, Louise Potter, Alon C. Wieland; Senators Robert S. Erbele, Tom Fiebiger, Ralph L. Kilzer, Judy Lee, Tim Mathern, Jim Pomeroy

Members absent: Representatives Jeff Delzer, Mary Ekstrom

Others present: Jim W. Smith, Legislative Council, Bismarck

See attached appendix for additional persons present.

SUPPLEMENTARY RULES OF OPERATION AND PROCEDURE

Mr. Allen H. Knudson, Legislative Budget Analyst and Auditor, reviewed the *Supplementary Rules of Operation and Procedure of the North Dakota Legislative Management*.

COMMENTS BY THE COMMITTEE CHAIRMAN

Chairman Weisz welcomed the members to the Health and Human Services Committee. He said the committee has been assigned studies relating to the effect of federal, state, and county government funding and administration on the social service programs of tribal governments; voucher use and provider choice; services for pregnant minors; unmet health care needs; and the state immunization program.

STUDY OF THE EFFECT OF FEDERAL, STATE, AND COUNTY GOVERNMENT FUNDING AND ADMINISTRATION ON THE SOCIAL SERVICE PROGRAMS OF TRIBAL GOVERNMENTS

The Legislative Council staff presented a memorandum entitled *Effect of Federal, State, and County Government Funding and Administration on the Social Service Programs of Tribal Governments - Background Memorandum*. She said House Concurrent Resolution No. 3003, approved by the 2009 Legislative Assembly, provides for a Legislative Management study of the extent to which the funding mechanisms and administrative structures of the federal, state, and county governments enhance or detract from the ability of the social service programs of tribal governments to meet the needs of tribal members.

The Legislative Council staff reviewed previous studies relating to the effect of federal, state, and county government funding and administration on the social service programs of tribal governments, including studies by the 1997-98 Welfare Reform Committee regarding the issues of welfare reform relating to the relationship between the state and the federally recognized Indian tribes within the state and the 2003-04 Budget Committee on Human Services regarding the administrative costs of human service programs.

The Legislative Council staff said the 2009 Legislative Assembly approved House Bill No. 1540 which amended North Dakota Century Code Section 50-01.2-03.2(3) relating to the funding of economic assistance programs in counties with federally recognized Indian reservation land. The bill provided that effective July 1, 2010, any county with 10 percent or more of the county's supplemental nutrition assistance program caseload on federally recognized Indian reservation land is eligible for a grant. Grants are equal to a county's actual direct costs and indirect costs for locally administered economic assistance programs multiplied by the percentage of a county's average total supplemental nutrition assistance program caseload for the previous state fiscal year which reside on federally recognized Indian reservation land not to exceed 90 percent. The Legislative Assembly provided $3,924,148 for these grants, of which $1,959,541 is from the general fund and $1,964,607 is from retained funds.

The Legislative Council staff presented the following proposed study plan:

1. Gather and review information regarding tribal social service programs that rely on federal, state, and county governments for funding and administration.
2. Receive information from the Department of Human Services regarding its budget processes and the status of Indian county payments and from the Indian Affairs Commission regarding tribal social service programs.
3. Receive information from interested persons, including representatives of the tribal social

service programs, county social service offices, regional human service centers, and the North Dakota County Social Service Directors Association, regarding the involvement of tribal social service offices in the administration and budgeting processes of county social service offices, regional human service centers, and the Department of Human Services.

4. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
5. Prepare a final report for submission to the Legislative Management.

Ms. Brenda M. Weisz, Chief Financial Officer, Department of Human Services, provided information regarding the committee's study of the extent to which the funding mechanisms and administrative structures of the federal, state, and county governments enhance or detract from the ability of the social service programs of tribal governments to meet the needs of tribal members. A copy of the information presented is on file in the Legislative Council office. Ms. Weisz said the coordination of human services programs and tribal governments varies among programs within the department because of the nature of the programs or federal requirements. She said contracts or memorandums of understanding are the predominant methods of coordinating services with the tribes. She said the department collaborates with various tribes to offer economic assistance, child support services, medical services, vocational rehabilitation services, foster care services, aging services, and mental health and substance abuse services. She said every two years the department holds stakeholder meetings in all eight regions of the state and notification letters are sent to the counties and tribes of each region. She said county social service boards meet monthly in Bismarck and various budget issues are addressed.

In response to a question from Representative Conrad, Ms. Weisz said the department does not have a policy in place with regard to memorandums of understanding. She said each division is responsible for negotiating contracts and memorandums of understanding with the tribes. Representative Conrad expressed concern that the tribes may not always understand the implications of the contracts and memorandums of understanding they are presented.

In response to a question from Representative Weisz, Ms. Weisz said contracts and memorandums of understanding may differ by division based on the program, but should not vary much among the tribes for the same program.

Mr. Chad Kramer, Research Analyst, Indian Affairs Commission, said Mr. Scott J. Davis, Executive Director, Indian Affairs Commission, was unable to attend the committee meeting, and therefore, no prepared testimony is available.

In response to a question from Senator Mathern, Mr. Kevin Dauphinais, Director, Spirit Lake Social Services, said the tribe has a memorandum of understanding for foster care with the Department of Human Services.

In response to a question from Representative Conrad, Mr. Dauphinais said the tribe is working with the department but currently does not have a memorandum of understanding for child protective services.

In response to a question from Representative Hofstad, Mr. Dauphinais said the Department of Human Services has been cooperating with the tribes to resolve child protective services issues, but there is a need for more local cooperation with the tribes.

Mr. Vince Gillette, Director, Sioux County Social Services, said a 1983 memorandum of understanding provides the state will not assume jurisdiction over American Indian children. Mr. Gillette said under certain circumstances the state may pay for part of the foster care of American Indian children.

Representative Conrad requested information regarding how the memorandums of understanding with the tribes for child protective services and foster care have changed over the years.

In response to a question from Representative Weisz, Mr. Gillette said when asked, Sioux County will collaborate with tribal social services to assist with foster care and medical care placement.

Senator Mathern suggested the committee gather information regarding contracts and memorandums of understanding relating to child welfare services.

Representative Conrad suggested the committee review:

- Bureau of Indian Affairs contracts;
- How other states provide funding for human services on reservations; and
- How reports of child abuse and neglect are referred.

In response to a question from Representative Kreidt, Ms. Weisz said generally contracts and memorandums of understanding are updated each biennium, but some may be updated more frequently. She said the Attorney General requires contracts to contain certain language, but memorandums of understanding are less prescriptive.

Chairman Weisz asked the department to provide examples of contracts with the tribes, including information on how often the contracts are updated.

It was moved by Representative Kreidt, seconded by Representative Conrad, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information regarding memorandums of understanding and contracts relating to child welfare services and other tribal social service programs that rely on federal, state, and county governments for funding and administration.**
2. **Receive information on Bureau of Indian Affairs contracts relating to social service programs on the reservations.**

3. **Receive information on other states' services provided on Indian reservations, including the use of memorandums of understanding or contracts for services.**
4. **Receive information from the Department of Human Services regarding its budget processes and the status of Indian county payments and from the Indian Affairs Commission regarding tribal social service programs.**
5. **Receive information from interested persons, including representatives of the tribal social service programs, county social service offices, regional human service centers, and the North Dakota County Social Service Directors Association, regarding the involvement of tribal social service offices in the administration and budgeting processes of county social service offices, regional human service centers, and the Department of Human Services.**
6. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
7. **Prepare a final report for submission to the Legislative Management.**

Representative Wieland suggested a summary of services provided on reservations by the state, counties, federal government, and the tribes and the funding sources for the services.

VOUCHER USE AND PROVIDER CHOICE FOR CLIENTS STUDY

The Legislative Council staff presented a memorandum entitled *Voucher Use and Provider Choice for Clients - Background Memorandum*. She said House Bill No. 1573, approved by the 2009 Legislative Assembly, provides for a Legislative Management study of voucher use and provider choice for clients in various human services and other state programs, including programs related to mental health services, addiction treatment, counseling services, transition services, various home services, and other special services. The bill provides that the study explore the extent to which vouchers are currently used in federal and state human services programs and other programs, how voucher systems are implemented, and the advantages and challenges posed by the use of vouchers as a mechanism for expanding service options and maximizing client choices. The study must also include a comprehensive review of funding for human services and other state programs, focusing on the feasibility of improving access to care and providers for clients through the use of a voucher system, including programs related to mental health services, addiction treatment, counseling services, and transition services.

The Legislative Council staff said voucher use or provider choice is a method of providing goods and services to a beneficiary in the form of a voucher. The voucher can be submitted to the beneficiary's provider of choice for the goods or services. Federal, state, and local agencies develop service agreements with providers to supply goods and services in exchange for the vouchers, which are presented to the agencies for payment as provided in the agreement.

The Legislative Council staff reviewed previous studies relating to voucher use or provider choice for clients, including studies by the 2001-02 Budget Committee on Human Services of the issues and concerns of implementing Charitable Choice and the 2007-08 Long-Term Care Committee regarding the long-term care system in North Dakota. She said Charitable Choice is the privatization of federally funded welfare services through faith-based organizations.

The Legislative Council staff provided a summary of programs offered by the Department of Human Services. The summary included program descriptions, eligibility requirements, descriptions of the program's provider choice, and the 2009-11 appropriation for each program.

The Legislative Council staff presented the following proposed study plan:

1. Receive information from the Department of Human Services, State Department of Health, Department of Public Instruction, and Department of Corrections and Rehabilitation regarding various human services and other state programs and their related funding, including programs related to mental health services, addiction treatment, counseling services, transition services, various home services, and other special services.
2. Receive information on the extent to which vouchers are currently used in federal and state human services programs and other programs.
3. Review examples of the use of voucher systems for allowing consumer choice in other states.
4. Receive an update from the Department of Human Services on the money-follows-the-client developmental disabilities service demonstration project.
5. Receive an update from the Department of Human Services on the status of the program of all-inclusive care for the elderly.
6. Consider the feasibility of improving access to care and providers, both for profit and not for profit, through the use of a voucher system; how voucher systems are implemented; and the advantages and challenges posed by the use of vouchers as a mechanism for expanding service options and maximizing client choices.
7. Receive testimony from interested persons, including providers and clients, regarding

voucher use and provider choice for clients in human services and other programs.

8. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
9. Prepare a final report for submission to the Legislative Management.

Ms. JoAnne Hoesel, Director, Division of Mental Health and Substance Abuse, Department of Human Services, provided information regarding voucher use and provider choice for clients in various human services and other state programs. A copy of the information presented is on file in the Legislative Council office. Ms. Hoesel said that while the department does not use the term "vouchers" in its services delivery, the department does use the term "individualized service budgets" in several areas. She said individualized service budgets use the same concept as vouchers. She provided examples of programs using individualized service budgets, including the family caregiver support program, self-directed support waiver, and child care. She said in addition to the programs that use individualized service budgets, client choice is addressed when a service plan is developed in programs such as child welfare and mental health. Regarding vocational rehabilitation, she said, client-informed choice is a regulatory requirement. In the Medicaid program, she said, freedom of choice is required with few exceptions. She said in some regions of the state a voucher system may provide more options, but a lack of available providers may require travel to another region to use a voucher. She said the federal Substance Abuse and Mental Health Services Administration issued a lessons learned document in March 2008. She said lessons were identified as:

- Service provider base - Outreach and communication is required to persuade providers to become part of the voucher network. There is no guarantee of business and reporting, documentation, reimbursement requirements, hands-on training, and support are necessary.
- Client base - States are urged to balance internal business controls and the activity of pursuing clients in order to take advantage of the existing structure and outreach to new options.
- Administrative - Voucher management is required to issue vouchers, manage claims, integrate procedures, reconcile outstanding vouchers, and monitor voucher activity.
- Outcomes - Outreach and training are necessary to assure reporting requirements and data collection procedures are in place.

In response to a question from Senator Kilzer, Ms. Hoesel said the department licenses all public and private substance abuse treatment providers in the state. She said to provide a comprehensive and fair process, licensing is done by a team that includes department staff and outside professionals.

In response to a question from Representative Hofstad, Ms. Hoesel said because private providers are not required to report outcomes, the department is unable to compare the department's outcomes with those of the private providers.

Chairman Weisz asked the department to provide information regarding contracts with private providers for substance abuse services.

Mr. Bob Spencer, Chief of Operations, Center for Solutions, said clients utilizing the state system for services typically have no insurance coverage or are underinsured. Mr. Spencer said while the state system creates a safety net of services, it also creates a class system between those who can afford a choice of treatment providers and those whose only option is to use one of the regional human service centers. He said a voucher system can be as complex as desired or as simple as the system of preauthorization used by health insurance companies. A copy of the information presented is on file in the Legislative Council office.

In response to a question from Senator Mathern, Mr. Spencer said the committee should consider the cost the department incurs to provide services and how it compares to the cost of a private provider.

In response to a question from Representative Weisz, Mr. Spencer said the state should pay for performance. He said a system needs to be developed to allow for the comparison of outcomes.

Representative Weisz expressed concern about how the value of a voucher might be determined, given the complexity of services that may be required by the client.

In response to a question from Senator Mathern, Mr. Spencer said his facility is proud of its outcomes and would be willing to compare its results to other providers.

Senator Mathern suggested the committee receive information on the cost of services provided by private providers compared to the cost of state-provided services and review any available outcome measures of both the state and private providers.

Ms. Lisa Hawley, Licensed Independent Clinical Social Worker and Owner, Advanced Counseling for Change, said even though she is licensed by the state, she may not refer clients to the State Hospital. Ms. Hawley expressed concern regarding delays in treatment and discrepancies in the level of qualifications required for individuals in private practice and those at the human service centers. A copy of the information presented is on file in the Legislative Council office.

Senator Kilzer suggested the committee receive information regarding the Department of Human Services licensure and referral practices.

It was moved by Senator Mathern, seconded by Senator Erbele, and carried on a voice vote that the committee proceed with this study as follows:

1. **Receive information from the Department of Human Services, State Department of Health, Department of Public Instruction,**

and Department of Corrections and Rehabilitation regarding various human services and other state programs and their related funding, including programs related to mental health services, addiction treatment, counseling services, transition services, various home services, and other special services.

2. **Receive information on the extent to which vouchers are currently used in federal and state human services programs and other programs.**
3. **Review examples of the use of voucher systems for allowing consumer choice in other states.**
4. **Receive an update from the Department of Human Services on the money-follows-the-client developmental disabilities service demonstration project.**
5. **Receive an update from the Department of Human Services on the status of the program of all-inclusive care for the elderly.**
6. **Receive information regarding the Department of Human Services licensure requirements and referral practices.**
7. **Consider the feasibility of improving access to care and providers, both for profit and not for profit, through the use of a voucher system, including a comparison of the cost of providing services and program outcomes for both public and private providers; how voucher systems are implemented; and the advantages and challenges posed by the use of vouchers as a mechanism for expanding service options and maximizing client choices.**
8. **Receive testimony from interested persons, including providers and clients, regarding voucher use and provider choice for clients in human services and other programs.**
9. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommend-ations.**
10. **Prepare a final report for submission to the Legislative Management.**

Representative Wieland asked the Department of Human Services to provide the committee with a list of all licensed clinical therapists in the state.

OTHER COMMITTEE RESPONSIBILITIES

The Legislative Council staff presented a background memorandum entitled *Other Duties of the Health and Human Services Committee - Background Memorandum*. She said in addition to the study responsibilities assigned to the Health and Human Services Committee for the 2009-10 interim, the committee has also been assigned to:

- Receive annual reports from the Department of Human Services regarding children's health insurance program (CHIP) statistics (Section 50-29-02);
- Recommend a private entity to contract with for preparing cost-benefit analyses of health insurance mandate legislation (Section 54-03-28);
- Receive annual reports from the Department of Human Services regarding the alternatives-to-abortion services program (Section 2 of 2009 Senate Bill No. 2391);
- Receive periodic reports from the State Health Officer and the Regional Public Health Network Task Force regarding the protocol for the regional public health network (Section 2 of 2009 Senate Bill No. 2333); and
- Receive an accountability report from the North Dakota Fetal Alcohol Syndrome Center before September 1, 2010, regarding the use of funds granted to the center by the State Department of Health (Section 2 of 2009 Senate Bill No. 2412).

State Children's Health Insurance Program Statistics

The Legislative Council staff said Section 50-29-02 provides that the Legislative Management receive annual reports from the Department of Human Services describing enrollment statistics and costs associated with the state CHIP. The Legislative Management assigned this responsibility to the Health and Human Services Committee. The 2009 Legislative Assembly appropriated $21,632,536, of which $5,598,799 is from the general fund and $16,033,737 is from federal funds, for Healthy Steps (North Dakota's CHIP). The 2009 Legislative Assembly made a number of adjustments to the funding for Healthy Steps, including:

- Increasing eligibility for the program from 150 percent to 160 percent of the federal poverty level.
- Adjusting funding to reflect utilization reprojections anticipating an average of 3,941 children per month and a revised premium amount of $228.71 per month.
- Adding funding of $300,000 from the general fund for additional program outreach.

The following schedule provides a comparison of funding for Healthy Steps:

	2007-09 Biennium	2009-11 Executive Budget	2009-11 Legislative Appropriation	2009-11 Legislative Increase (Decrease) to 2009-11 Executive Budget	2009-11 Legislative Increase (Decrease) to 2007-09 Biennium
Total Healthy Steps	$20,204,746	$35,248,129	$21,632,536	($13,615,593)	$1,427,790
General fund	$4,669,885	$9,122,897	$5,598,799	($3,524,098)	$928,914
Federal funds	$15,534,861	$26,125,232	$16,033,737	($10,091,495)	$498,876

The Department of Human Services contracts with Blue Cross Blue Shield of North Dakota for the health insurance coverage for the children in the program. The premium rate for the 2009-11 biennium is anticipated to be $228.71 per child per month, an increase of 13 percent compared to the 2007-09 premium rate of $202.40.

Health Insurance Coverage Mandates

The Legislative Council staff said Section 54-03-28 provides that a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The Health and Human Services Committee has been assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2011 Legislative Assembly. The Insurance Commissioner is to pay the costs of the contracted services and each cost-benefit analysis must include:

1. The extent to which the proposed mandate would increase or decrease the cost of services.
2. The extent to which the proposed mandate would increase the use of services.
3. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of the insured.
4. The impact of the proposed mandate on the total cost of health care.

The section also provides that a legislative measure mandating health insurance coverage must provide that:

1. The measure is effective only for the next biennium.
2. The application of the mandate is limited to the public employees health insurance program and the public employees retiree health insurance program.
3. For the next Legislative Assembly, the Public Employees Retirement System prepare and request introduction of a bill to repeal the expiration date and extend the mandated coverage to apply to all accident and health insurance policies.

The Public Employees Retirement System Board is also required to prepare a report, which is attached to the bill, regarding the effect of the mandated coverage or payment on the system's health insurance program. The board must include information on the utilization and costs relating to the mandated coverage and a recommendation on whether the coverage should continue.

A majority of the members of the standing committee to which the legislative measure is referred during a legislative session, acting through the chairman, determines whether a legislative measure mandates coverage of services. Any amendment to the legislative measure that mandates health insurance coverage may not be acted on by a committee of the Legislative Assembly unless the amendment has had a cost-benefit analysis prepared and attached.

The Insurance Department has categorized and defined mandated health insurance benefits as follows:

1. Service mandates - Benefit or treatment mandates that require insurers to cover certain treatments, illnesses, services, or procedures. Examples include child immunization, well-child visits, and mammography.
2. Beneficiary mandates - Mandates or defines the categories of individuals to receive benefits. Examples include newborns from birth, adopted children from the time of adoption, and handicapped dependents.
3. Provider mandates - Mandates that require insurers to pay for services provided by specific providers. Examples include nurse practitioners, optometrists, and psychologists.
4. Administrative mandates - Mandates that relate to certain insurance reform efforts that increase the administrative expenses of a specific health care plan. Examples include information disclosures, precluding companies from basing policy rates on gender, and precluding insurers from denying coverage for preauthorized services.

The 2003-04 and 2005-06 interim Budget Committees on Health Care and the 2007-08 interim Human Services Committee recommended that the Insurance Department contract with Milliman USA for cost-benefit analysis services on health insurance mandates during the 2005, 2007, and 2009 legislative sessions. During the 2005 legislative session, two bills were referred for cost-benefit analysis at a total cost of $8,323. In addition, the Insurance Department paid $5,606 to Milliman USA for general project work

during the 2005 legislative session for total payments during the 2005 legislative session of $13,929. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis. The Insurance Department paid a total of $28,070 to Milliman USA for analyses conducted on three bills during the 2009 legislative session.

Alternatives-to-Abortion Services Program Reports

The Legislative Council staff said the 2009 Legislative Assembly approved Senate Bill No. 2391 which requires the Department of Human Services, in consultation with a nongovernmental entity that provides alternatives-to-abortion services, contract to inform the public about the alternatives-to-abortion services program. The bill provides $100,000 from federal temporary assistance for needy families (TANF) block grant funds to the Department of Human Services to inform the public about the alternatives-to-abortion services program. The appropriation bill for the Department of Human Services--House Bill No. 1012 (2009)--includes $400,000 from federal funding for the alternatives-to-abortion services program to provide a total of $500,000 from federal funds for the program.

In addition, Senate Bill No. 2391 requires that during the 2009-10 interim the Department of Human Services make annual reports to the Legislative Management regarding the status of the alternatives-to-abortion services program. The Health and Human Services Committee has been assigned the responsibility to receive these reports.

The program began in 2005 and provides funds to organizations that provide alternatives-to-abortion services and to educate the public about the program. The schedule below presents the appropriations provided by the Legislative Assembly for the 2005-07 through 2009-11 bienniums:

Biennium	Appropriations From Federal Funds
2005-07	$500,000
2007-09	$400,000
2009-11	$500,000

The 2005-06 interim Judiciary Committee received the alternatives-to-abortion services report from the Department of Human Services for the 2005-07 biennium. The report indicated that the Department of Human Services was unable to obtain funding from the federal Office of Faith-Based and Community Initiatives during the 2005-07 biennium for the project. Funds from this office were available only for abstinence programs or grants to agencies that would provide technical assistance to faith-based or community-based programs interested in applying for federal funds. Because funds were not available from that source, the department used federal TANF funds for the program. The department provided alternatives-to-abortion services by making vouchers available to individuals needing the service. Those individuals used the vouchers to access the services, and the service providers used the vouchers to bill the department. This method allowed the department to pay all interested providers for these services. The department contacted all agencies that had been providing alternatives-to-abortion services before implementation of the program. These agencies became partners in developing the program and are receiving payments through the program for their services. Nine agencies were providing services during the 2005-07 biennium, including BirthRight, Catholic Charities of North Dakota, Christian Family Life Services, First Choice Clinic, the Perry Center, the St. Gianna Maternity Home, the Village Family Service Center, the Women's Pregnancy Center, and the YFC Teen Moms. Mental Health America of North Dakota was also a partner by allowing use of its 2-1-1 hotline to direct referrals to the alternatives-to-abortion services program. The department developed a script for the Mental Health America of North Dakota staff to use when a 2-1-1 call was received regarding an unplanned pregnancy. The program became operational shortly before the beginning of 2006. Through May 2007 nine service providers had submitted 12,111 claims for services. Through May 2007 a total of 1,470 clients had been served at a total cost of $150,200.

The 2007-08 interim Human Services Committee received the alternatives-to-abortion services report from the Department of Human Services for the 2007-09 biennium. The committee learned 15 agencies were providing alternatives-to-abortion services. Nine agencies provide outpatient services while two were residential facilities for pregnant women. The committee learned 882 women received services through providers of alternatives-to-abortion services from July 2007 through September 2008. Information on alternatives to abortion was distributed in September 2007 to higher education institutions and larger high schools in the state. The committee learned the department contracted with Mental Health America of North Dakota to allow the alternatives-to-abortion services program to be a part of the 2-1-1 hotline. Mental Health America of North Dakota received 24 2-1-1 calls regarding unplanned pregnancies in 2006 and 1 call in 2007. Total program expenditures for the 2007-09 biennium were $321,202.

Regional Public Health Network Report

The Legislative Council staff said the 2009 Legislative Assembly approved Senate Bill No. 2333 to create regional public health networks. Section 1 of Senate Bill No. 2333 establishes regional public health networks that correspond to the emergency preparedness and response regions established by the State Department of Health. The regional public health networks must share a minimum of three administrative functions and a minimum of three public health services. Participation by local public health units is voluntary. The bill provides $275,000 from the general fund to the State

Department of Health for a regional public health network pilot project.

Section 2 of Senate Bill No. 2333 directs the State Health Officer to appoint a regional public health network task force to meet during the 2009-10 interim to establish protocol for the regional public health network. The task force is to consist of at least seven members, including at least three members representing local public health districts, three members representing private health care providers, and representatives of the State Department of Health. The bill requires the State Health Officer and the Regional Public Health Network Task Force to report periodically to the Legislative Management during the 2009-10 interim regarding the development of the regional public health network. The Health and Human Services Committee has been assigned the responsibility to receive this report.

North Dakota Fetal Alcohol Syndrome Center Report

The Legislative Council staff said the 2009 Legislative Assembly approved Senate Bill No. 2412 providing a $369,900 general fund appropriation to the State Department of Health for a grant to the North Dakota Fetal Alcohol Syndrome Center.

The North Dakota Fetal Alcohol Syndrome Center began diagnosis of fetal alcohol syndrome in 1982. The center received competitive funding to form the Four-State Fetal Alcohol Syndrome Consortium, which included Minnesota, Montana, North Dakota, and South Dakota, to examine rates of alcohol use during pregnancy and identify intervention and prevention strategies. The 1993 Legislative Assembly established the North Dakota Fetal Alcohol Syndrome Center at the University of North Dakota where the Fetal Alcohol Syndrome Clinic evaluates and treats children and adults for fetal alcohol syndrome and related conditions. The center also has multiple ongoing research activities funded by the National Institutes of Health and by the Centers for Disease Control and Prevention.

Section 2 of Senate Bill No. 2412 requires the North Dakota Fetal Alcohol Syndrome Center to provide an accountability report with respect to the use of the funds appropriated. The Health and Human Services Committee has been assigned the responsibility to receive this report.

Senator Lee suggested when the committee reviews the recommendations for a private entity to perform the cost-benefit analysis for the 2011 Legislative Assembly of legislative measures mandating health insurance coverage that the committee also discuss recommendations for legislative rules changes regarding the deadlines for those legislative measures mandating health insurance coverage.

Senator Lee informed the committee that Mental Health America of North Dakota was no longer the designated 2-1-1 hotline provider for North Dakota. She said the North Dakota 2-1-1 calls, including the alternatives-to-abortion calls, are now being handled by FirstLink.

DEPARTMENT OF HUMAN SERVICES UNSPENT APPROPRIATION AUTHORITY

Ms. Weisz provided information regarding the department's unspent general fund appropriation authority for the 2007-09 biennium and on actual Medicaid expenditures compared to appropriated amounts for the 2007-09 biennium. A copy of the information presented is on file in the Legislative Council office. She said the department's unspent general fund appropriation authority for the 2007-09 biennium was $56.8 million, of which $31.9 million was attributable to the federal medical assistance percentage (FMAP) change resulting from the American Recovery and Reinvestment Act of 2009. She said federal stimulus legislation increased the state's FMAP from 63.01 percent to 69.95 percent resulting in larger federal reimbursements and general fund savings. She said other unspent general fund appropriation authority totaled $24.9 million or 4.2 percent, of which $11.7 million related to Medicaid, $3.7 million to institutions, and $3.3 million for other administrative and program funding.

Ms. Weisz presented the following schedule of 2007-09 biennium Medicaid expenditures, including traditional grants, CHIP, and long-term care programs, compared to appropriated amounts, excluding any federal stimulus funding:

	2007-09 Appropriation (In Millions)	2007-09 Actual Expenditures (In Millions)	Variance (In Millions)
General fund	$373.5	$361.8	$11.7
Federal funds/other funds	731.3	685.1	46.2
Total	$1,104.8	$1,046.9	$57.9

MEDICAID MANAGEMENT INFORMATION SYSTEM

Ms. Jennifer Witham, Director, Information Technology Services, Department of Human Services, presented information regarding the status of the Medicaid management information system computer project. A copy of the information presented is on file in the Legislative Council office. Ms. Witham said the vendor--Affiliated Computer Services (ACS)--has proposed a change to the project schedule and has requested the go-live date be extended from the original estimate of July 2009 to April 2011. She said ACS representatives appeared before the Budget Section in September to explain the delay and provided a copy of their testimony to the committee. In addition, she provided a document outlining the impact of the implementation delay on various medical services operations. She said ACS has delivered a

detailed workplan for the revised schedule and the department in the process of assessing the workplan and the effect the revised milestones will have on the department and other third-party vendors. Once the assessment is complete, she said, the department will proceed with proposed contract revisions and request support from the Centers for Medicare and Medicaid Services. She said the department does not anticipate any additional costs to the state for the delay in the schedule.

Ms. Witham provided the following project funding summary through September 2009:

Description	Budget	Spent Through September 2009	Remaining
General fund	$3,643,133	$2,647,533	$995,600
Federal funds	55,218,418	29,340,111	25,878,307
Other funds	3,667,820	1,190,564	2,477,256
Total	$62,529,371	$33,178,208	$29,351,163

In response to a question from Senator Mathern, Ms. Witham said the department will not approve the schedule shift until the detailed workplan has been assessed and approved.

In response to a question from Senator Kilzer regarding the status of Medicaid reimbursements, Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, said approximately 30,000 Medicaid claims are currently outstanding. Ms. Anderson said the department has significantly reduced the number of claims that were outstanding during the 2009 legislative session.

The committee recessed at 4:18 p.m. and reconvened at 9:00 a.m. on Wednesday, November 18, 2009.

SERVICES FOR PREGNANT MINORS STUDY

The Legislative Council staff presented a memorandum entitled *Services for Pregnant Minors Study - Background Memorandum*. She said the 2009 Legislative Assembly approved Senate Bill No. 2394. Section 2 of the bill provides for a Legislative Management study of existing services for minors who are pregnant and whether additional education and social services would enhance the potential for a healthy child and a positive outcome for the minor. The study is to consider the potential benefits of support services for parents of these minors and guardianship for the minor for cases in which parental abuse or neglect may be an issue. The study is also to consider the benefits to the minor of subsidies for open adoptions and supportive housing and child care for single parents enrolled in secondary and postsecondary educational institutions. The study must also determine the most desirable evidence-based service delivery system and the amount and sources of adequate funding.

The Legislative Council staff reviewed a study by the 2001-02 Budget Committee on Human Services relating to the feasibility and desirability of establishing an alternatives-to-abortion services program that would provide information, counseling, and support services to assist women to choose childbirth and to make informed decisions regarding the choice of adopting or parenting.

The 2001-02 Budget Committee on Human Services made no recommendation as a result of its study of alternatives-to-abortion services.

The Legislative Council staff said the alternatives-to-abortion services program was created by 2005 Senate Bill No. 2409. The Department of Human Services established and implemented the program to provide funding to nongovernmental entities that provide alternatives-to-abortion services. Services provided under this program promote childbirth instead of abortion by providing information, counseling, and support services that assist pregnant women or women who believe they may be pregnant to choose childbirth and to make informed decisions regarding the choice of adoption or parenting with respect to their children. Professional staff, such as licensed nurses and social workers, and paraprofessional staff, such as nursing and social work interns, provide services that include assessment, counseling, education, and referrals in a confidential manner.

The Legislative Assembly appropriated $500,000 of federal funds for the program during the 2005-07 biennium and $400,000 of federal funds for the 2007-09 biennium. The committee learned 882 women received services through providers of alternatives-to-abortion services from July 2007 through September 2008. Information on alternatives to abortion was distributed in September 2007 to higher education institutions and larger high schools in the state. Total program expenditures for the 2007-09 biennium were $321,202.

Senate Bill No. 2391 (2009) amended Section 50-06-26 relating to the alternatives-to-abortion services program. The bill requires the Department of Human Services, in consultation with a nongovernmental entity that provides alternatives-to-abortion services, to contract to inform the public about the alternatives-to-abortion services program. The bill provided $100,000 from federal TANF block grant funds to the Department of Human Services to inform the public about the alternatives-to-abortion program. In addition, during the 2009-10 interim, Senate Bill No. 2391 requires that the Department of Human Services make annual reports to the Legislative Management regarding the status of the alternatives-to-abortion services program. The Health and Human Services Committee has been assigned responsibility to receive the report.

The Legislative Council staff said the appropriation bill for the Department of Human Services for the 2009-11 biennium--House Bill No. 1012--includes $400,000 of federal TANF funding for the alternatives-to-abortion program; therefore, a total of $500,000 of federal funds is appropriated for the program for the 2009-11 biennium.

The Legislative Council staff said in addition to providing for the Legislative Management study assigned to this committee, Senate Bill No. 2394 (2009) also created a new section to Chapter 14-10 relating to consent for prenatal care and other pregnancy care services provided to minors. The bill provides:

- A physician or other health care provider may provide pregnancy testing and pain management related to pregnancy to a minor without the consent of a parent or guardian.
- A physician or other health care provider may provide prenatal care to a pregnant minor in the first trimester of pregnancy or may provide a single prenatal care visit in the second or third trimester of pregnancy without the consent of a parent or guardian.
- A physician or other health care provider may provide prenatal care beyond the first trimester of pregnancy or in addition to the single prenatal care visit in the second or third trimester if, after a good-faith effort, the physician or other health care provider is unable to contact the minor's parent or guardian.
- The costs incurred by the physician or other health care provider for performing services under this section may not be submitted to a third-party payer without the consent of the minor's parent or guardian.
- If a minor requests confidential services, the physician or other health care professional must encourage the minor to involve her parent or guardian.
- A physician or other health care professional or a health care facility may not be compelled against their best judgment to treat a minor based on the minor's own consent.

The bill allows the physician or other health care professional who provides pregnancy care services to a minor to inform the parent or guardian of the minor of any pregnancy care services given or needed if the physician or other health care professional discusses with the minor the reasons for informing the parent or guardian prior to the disclosure and, in the judgment of the physician or other health care professional:

- Failure to inform the parent or guardian would seriously jeopardize the health of the minor or her unborn child;
- Surgery or hospitalization is needed; or
- Informing the parent or guardian would benefit the health of the minor or her unborn child.

The bill does not authorize a minor to consent to abortion or otherwise supersede the requirements of Chapter 14-02.1.

The Legislative Council staff said Medicaid was authorized in 1966 for the purpose of strengthening and extending the provision of medical care and services to people whose resources are insufficient to meet such costs. Corrective, preventative, and rehabilitative medical services are provided with the objective of retaining or attaining capability for independence, self-care, and support. These services are extended to elderly, blind, or disabled individuals as well as to caretaker relatives and children to age 21. Funding is shared by federal, state, and county governments, with eligibility determined at the county level.

For individuals who qualify, Medicaid may be available to provide aid to those without health insurance or for those whose health insurance does not cover all of their needs. Medicaid pays for health services for qualifying families with children and individuals who are pregnant, elderly, or disabled.

Medicaid eligibility is based on income and, in some cases, assets. Some assets are not counted when determining eligibility. Assets that do not affect eligibility include the home the person is living in, personal belongings and clothing, household goods and furniture, one car, certain burial plans, and property that produces earned income such as a farm or business. There is no asset limit for children, families, or pregnant women in the children and families coverage group or women who apply under the Women's Way program.

The Legislative Council staff said the Oppen Home, located in Minot, is operated by the North Central Human Service Center and can provide services for up to seven young women who are pregnant or in need of residential services through an order of the court for shelter care or short-term foster care. The Oppen Home is supported by the foster care services program and provides the youth with structure and supervision. The Oppen Home provides services for unmarried, pregnant adolescent females, aged 12 through 17, including:

- Individual, group, and family counseling;
- Prenatal classes;
- Parenting education;
- Education through tutoring or correspondence courses; and
- Residential services.

Education is coordinated through Minot Public Schools and onsite tutoring may be arranged if appropriate.

The Oppen Home's primary focus is pregnant teens who need a less-restrictive placement. The pregnant teens may reside at Oppen Home throughout the term of the pregnancy.

The Legislative Council staff presented the following proposed study plan:

1. Gather and review information on existing services for minors who are pregnant.
2. Receive information from interested persons, including North Dakota-approved alternatives-to-abortion program providers, delegate agencies, maternity homes, individuals, families, physicians, and other health care professionals, regarding whether additional education and social services would enhance the potential for a healthy child and a

positive outcome for the minor, the potential benefits of support services for parents of these minors and guardianship for the minor for cases in which parental abuse or neglect may be an issue, and the benefits to the minor of subsidies for open adoptions and supportive housing and child care for single parents enrolled in secondary and postsecondary educational institutions.

3. Receive information from the Department of Human Services and the State Department of Health regarding programs and services available to minors who are pregnant, the most desirable evidence-based service delivery system, and the amount and sources of adequate funding.
4. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
5. Prepare a final report for submission to the Legislative Management.

Ms. Anderson provided information regarding the study and programs and services available to minors who are pregnant, the most desirable evidence-based service delivery system, and the amount and sources of adequate funding. A copy of the information presented is on file in the Legislative Council office. She said CHIP covers prenatal services but does not cover delivery services. She said generally pregnant teens will transfer to Medicaid eligibility to cover the cost of labor and delivery. She said as of July 1, 2009, the income eligibility level for CHIP is 160 percent of the federal poverty level, or $2,940 per month for a family of four. She said 25 teens received prenatal services through CHIP in 2007 and 33 teens received services in 2008. She said individuals eligible for the Medicaid program would receive all "medically necessary" services. She said pregnant women of any age may be eligible for Medicaid if the family income net of deductions and disregards is within 133 percent of the federal poverty level, or $2,444 per month for a family of four. She said families with income above 133 percent of the poverty level may still qualify for Medicaid; however, they will be responsible for a share of the costs based on the amount of their excess income. She said eligibility may begin as early as the first month of pregnancy and can continue through the month 60 days after the pregnancy ends. She said once a pregnant woman becomes eligible for Medicaid, any increase in income is disregarded to ensure the woman stays continuously eligible for coverage. She said there is no asset test for pregnant women, and a baby born to an eligible pregnant woman remains eligible for Medicaid for 12 months. She said in 2008 Medicaid prenatal or delivery services were provided to 87 individuals age 17 and younger and to 569 individuals aged 18 to 20. She said in 2007 services were provided to 113 individuals age 17 and younger and to 492 individuals aged 18 to 20. She said targeted case management services may also be available to pregnant women who qualify by meeting one of several "high-risk" criteria or for whom any three or more risk factors exist. She said one of the high-risk criteria is that the woman is age 17 or younger at the time of assessment. As a result a pregnant minor otherwise qualified under Medicaid would also qualify for targeted case management. She said targeted case management services include assessment, case planning and preparation, case monitoring, care coordination, case evaluation, case reevaluation, health and parenting education, and followup home visits. She said in 2008 targeted case management assessments were completed for 13 individuals age 17 and younger and for 36 individuals aged 18 to 20. She said in 2007 targeted case management assessments were completed for 12 individuals age 17 and younger and for 17 individuals aged 18 to 20.

In response to a question from Representative Conrad, Ms. Anderson said targeted case management services are provided by a nurse, social worker, or tribal case manager.

Senator Lee asked the Department of Human Services to provide information regarding how many pregnant women do not qualify for Medicaid because their income is more than 133 percent of poverty and, to the extent possible, whether they receive adequate prenatal care.

Representative Holman asked the Department of Human Services to provide information regarding the household size of the individuals receiving Medicaid prenatal or delivery services and the income level of those households for 2007 and 2008.

Representative Potter suggested the committee receive information regarding the number of Medicaid-eligible women that receive health and parenting education services.

Senator Fiebiger asked the Department of Human Services for information regarding the number of teens receiving prenatal services through North Dakota CHIP in 2009.

Senator Lee suggested the committee review evidence-based service information.

In response to a question from Senator Lee, Ms. Anderson said 100 percent of the poverty level for a family of one is $903 and 133 percent of the poverty level is $1,201.

Ms. Delores Friedt, Coordinator, Birth and Adoptive Family Services, Department of Human Services, provided information regarding the study and programs and services available to minors who are pregnant, the most desirable evidence-based service delivery system, and the amount and sources of adequate funding. A copy of the information presented is on file in the Legislative Council office. Ms. Friedt said the Children and Family Services Division of the department provides funding and supervision for several child welfare programs administered by the counties to serve children and families, including pregnant minors. She said programs include child protective services; temporary

care, including foster care and shelter care for children; and family preservation services. She said individual and family therapy provided at the eight human service centers are also available to pregnant minors. She said the Crossroads program allows for the payment of the actual cost of child care up to a maximum monthly amount for those age 20 and younger who are pursuing their high school diploma or general educational development diploma. She said the program currently receives between 50 and 60 applicants per year.

In response to a question from Senator Lee, Ms. Friedt said in cases where the father has chosen to parent the child, the father may receive child care assistance.

Senator Lee suggested the committee receive information regarding county services provided to pregnant minors.

Ms. Carol Cartledge, Director, Public Assistance, Department of Human Services, provided a report regarding the status of the alternatives-to-abortion services program pursuant to 2009 Senate Bill No. 2391. A copy of the information presented is on file in the Legislative Council office. Ms. Cartledge said under this program, counseling and support services are provided that assist pregnant women or women who believe they may be pregnant to choose childbirth instead of abortion and to make informed decisions regarding the choice of adoption or parenting with respect to their children. She said from July 1, 2009, through October 31, 2009, 254 women received services through the program, and since its inception, the program has served 2,585 women. She said the alternatives-to-abortion budget is as follows:

	2009-11 Biennium Budget
Printing and poster design	$2,163
2-1-1 hotline services	10,800
Provider services	387,037
Advertising	100,000
Total	$500,000

In response to a question from Senator Lee, Ms. Cartledge said in addition to the information available on the department's website, the program has information posted on both the Facebook and MySpace websites.

In response to a question from Representative Bellew, Ms. Cartledge said of the 2,585 women served since the program began, 3 or 4 have chosen abortion.

Senator Mathern suggested the committee determine what data is available to measure the most desirable evidence-based service delivery system.

Representative Conrad suggested the committee receive information, to the extent available, regarding evidence-based outcome data on programs and that the committee receive information from the Oppen Home regarding the successful aspects of its program.

In response to a question from Representative Wieland, Ms. Anderson provided a list of income disregards and deductions used in determining eligibility for Medicaid and CHIP to the committee. A copy of the information presented is on file in the Legislative Council office.

Representative Conrad suggested the committee receive information from the Department of Public Instruction regarding referrals; information collected by guidance counselors; and, if available, the results of any needs assessment they may have performed and from the Department of Corrections and Rehabilitation regarding the needs of pregnant women within the corrections system.

It was moved by Senator Mathern, seconded by Representative Potter, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information on existing services for minors who are pregnant.**
2. **Determine available data to measure the most desirable evidence-based service delivery system.**
3. **Receive information from interested persons, including North Dakota-approved alternatives-to-abortion program providers, delegate agencies, maternity homes, individuals, families, physicians, and other health care professionals, regarding whether additional education and social services would enhance the potential for a healthy child and a positive outcome for the minor, the potential benefits of support services for parents of these minors and guardianship for the minor for cases in which parental abuse or neglect may be an issue, and the benefits to the minor of subsidies for open adoptions and supportive housing and child care for single parents enrolled in secondary and postsecondary educational institutions.**
4. **Receive information from the Department of Public Instruction, Department of Corrections and Rehabilitation, Department of Human Services, and State Department of Health regarding programs and services available to minors who are pregnant, the most desirable evidence-based service delivery system, and the amount and sources of adequate funding.**
5. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
6. **Prepare a final report for submission to the Legislative Management.**

In response to a question from Senator Lee, Ms. Kim Senn, Director, Division of Family Health, Community Health Section, State Department of Health, said the State Department of Health administers the maternal and child health grant and maintains various statistics, including low birth

weights, breastfeeding rates, and injury rates. She said statistics are maintained from birth to adolescence.

In response to a question from Senator Mathern, Ms. Senn said for the optimal pregnancy outcome program, the State Department of Health maintains statistics regarding number of clients; services received; and outcomes, including full-term pregnancies, birth weights, and breastfeeding.

Senator Lee asked the State Department of Health to provide a summary report of the outcomes measured and their relationships to services provided at a future meeting.

In response to a question from Representative Potter, Ms. Senn said many of the State Department of Health programs provide followup care, including in-home visits and developmental screenings. She said research shows home visits provide good outcomes but are expensive. She said local public health units provide home visits on a limited basis.

In response to a question from Representative Conrad, Ms. Senn said the department monitors clients and can identify those that are minors. She said less than 1 percent are minors. She said the Division of Vital Records of the State Department of Health could provide information regarding the number of births to minor mothers.

Representative Conrad suggested the committee receive information from the Division of Vital Records of the State Department of Health regarding the number of births to minor mothers.

UNMET HEALTH CARE NEEDS STUDY

The Legislative Council staff presented a memorandum entitled *Unmet Health Care Needs Study - Background Memorandum*. She said the 2009 Legislative Assembly approved House Bill No. 1391 providing for a Legislative Management study of the unmet health care needs in the state. The study must include an assessment of the needs of underinsured and uninsured individuals and families, consider federal health care initiatives, and include consultation with the State Department of Health, the Insurance Commissioner, and the Department of Human Services. Testimony regarding the bill indicated the study should identify the reasons individuals are uninsured or underinsured and how to make health insurance more accessible to North Dakota residents.

The Legislative Council staff reviewed previous studies relating to unmet health care needs in the state, including studies by the 1999-2000 Budget Committee on Health Care of the various challenges facing the delivery of health care in the state, the 2001-02 Budget Committee on Health Care regarding the coordination of the medical assistance and CHIP programs, the 2005-06 Budget Committee on Health Care regarding the need for a comprehensive long-range study of the state's current and future health care needs, and the 2005-06 Budget Committee on Human Services regarding state programs providing services to children with special health care needs.

The Legislative Council staff provided information regarding forms of health care coverage available for those individuals who cannot afford or who cannot purchase health insurance.

Medicaid

Medicaid was authorized in 1966 for the purpose of strengthening and extending the provision of medical care and services to people whose resources are insufficient to meet their medical-related costs. Corrective, preventative, and rehabilitative medical services are provided with the objective of retaining or attaining capability for independence, self-care, and support. These services are extended to elderly, blind, or disabled individuals as well as to caretaker relatives and children to the age of 21. Funding is shared by federal, state, and county governments, with eligibility determined at the county level.

For those that qualify, Medicaid may provide aid to individuals without health insurance or for those whose health insurance does not cover all of their needs. Medicaid pays for health services for qualifying families with children and people who are pregnant, elderly, or disabled. According to the Department of Human Services, over 40,000 people in North Dakota are receiving this health coverage.

To qualify for Medicaid coverage, an individual must be a state resident and must qualify financially. The individual must also be:

- Pregnant;
- Blind, disabled, or age 65 or older;
- A member of a family with children;
- Age 21 or younger or age 65 or older and receiving services at the State Hospital;
- Younger than age 21 and living independently or in a licensed foster home;
- An adopted child younger than age 21 who has special health needs or meets other criteria; or
- A woman screened through the State Department of Health's Women's Way program who needs treatment for breast or cervical cancer.

Medicaid eligibility is based on income and, in some cases, assets. Some assets are not counted when determining eligibility. Assets that do not affect eligibility include the individual's primary home, personal belongings and clothing, household goods and furniture, one car, certain burial plans, and property that produces earned income such as a farm or business. There is no asset limit for children, families, or pregnant women in the children and families coverage group or women who apply under the Women's Way program. Generally, a person who is blind, disabled, or age 65 or older can have up to $3,000 in countable assets, such as savings accounts, checking accounts, stocks, bonds, or other types of assets, and up to $6,000 in funeral expense contracts, prepayments, or deposits to qualify for

Medicaid. The asset limit for couples is $6,000. Giving property or income away or selling property for less than its value within five years of applying for Medicaid may affect a person's eligibility for long-term care services such as nursing care services, home and community-based services, or swing-bed care in a hospital.

If approved for Medicaid, the Medicaid program may pay for health services provided up to three months before the month the county social service office received the signed application. Medicaid may use the estate recovery process on estates of people who were age 55 or older when they received Medicaid coverage. When those individuals die, Medicaid may recover the cost of benefits paid out, but only if there is not a surviving spouse or a child who is younger than age 21 or is blind or permanently and totally disabled.

Healthy Steps

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

There are no monthly premiums in the Healthy Steps program, but most families are required to pay copayments for emergency room visits, hospitalizations, and prescriptions. Copayments are not required for American Indian children.

Healthy Steps-covered services include inpatient hospital stays, medical and surgical services, outpatient hospital and clinic services, mental health and substance abuse services, prescription medications, routine preventative services such as well baby checkups and immunizations, dental and vision services, and prenatal services.

The 2009 Legislative Assembly increased eligibility for the program from 150 percent to 160 percent of the federal poverty level instead of an increase to 200 percent of the federal poverty level as provided for in the executive budget. To qualify, a family's net income after deducting child care costs and payroll taxes such as Social Security, Medicare, and income must be greater than the Medicaid level but cannot exceed 160 percent of the federal poverty level. The following is a summary of the maximum net income allowed based on 160 percent of the federal poverty level:

	Net Income After Deducting Child Care Costs and Payroll Taxes	
Family Size	Annual	Monthly
1	$17,328	$1,444
2	$23,312	$1,943
3	$29,296	$2,442
4	$35,280	$2,940

When a child is enrolled in Healthy Steps, the child receives coverage for a 12-month period or until the end of the month in which the child becomes age 19.

The 2009 Legislative Assembly provided funding of $21.6 million, of which $5.6 million is from the general fund, for the Healthy Steps program.

Caring for Children

Caring for Children is a benefit program for eligible North Dakota children up to age 19 who do not qualify for Medicaid or Healthy Steps and have no other insurance. Benefits include primary and preventative medical and dental care. Caring for Children is a program of the North Dakota Caring Foundation, Inc., a nonprofit 501(c)(3) foundation established by Blue Cross Blue Shield of North Dakota in 1989. Primary and preventative care includes:

- Routine and primary medical care.
- Limited inpatient (hospital) care.
- Immunizations.
- Mental health and substance abuse.
- Primary and preventative dental care.

Children are eligible for Caring for Children if they are:

1. A resident of the state of North Dakota;
2. A United States citizen or legal permanent resident;
3. Under age 19;
4. Unmarried and whose guardians have an annual income of between 151 percent and 200 percent of the federal poverty level;
5. Without comprehensive medical coverage through Medicaid, Healthy Steps, or a private insurance carrier; and
6. Within household income guidelines of the North Dakota Caring Foundation, Inc.

Caring for Children Income Guidelines Effective Through March 31, 2010		
Eligible Individuals April 1, 2009, to March 31, 2010, Household Size	Children (Birth up to Age 19) Minimum - 151 Percent of the Federal Poverty Level Monthly Net Income[1]	Children (Birth up to Age 19) Maximum - 200 Percent of the Federal Poverty Level Monthly Net Income[1]
1	$1,355	$1,805
2	$1,823	$2,429
3	$2,290	$3,052
4	$2,758	$3,675
5	$3,225	$4,299
6	$3,693	$4,922
7	$4,160	$5,545
8	$4,628	$6,169
9	$5,095	$6,792
10	$5,563	$7,415

[1]Deductions may apply for payments made out of the household such as child support, child care, and health care.

Individuals who have voluntarily canceled medical insurance are not eligible to participate in Caring for Children for six months after the date the coverage was canceled.

Health Tracks

North Dakota Health Tracks (formerly early periodic screening diagnosis and treatment) is a

preventative health program that is free for children aged 0 to 21 who are eligible for Medicaid. Health Tracks pays for screenings, diagnosis, and treatment services to help prevent health problems from occurring or help keep health problems from becoming worse. Health Tracks also pays for orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling, and other important health services.

Comprehensive Health Association of North Dakota

The Comprehensive Health Association of North Dakota (CHAND) was created by the Legislative Assembly in 1981 and became operational in 1982. Its initial purpose was to provide comprehensive health insurance benefits to residents of the state who have been denied health insurance or have been given restricted coverage or excessive health premiums because of high-risk health problems.

The 1997 Legislative Assembly modified CHAND to comply with federal law--the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Now, in addition to its traditional role of insuring the uninsurable population of North Dakota, CHAND issues, on a guaranteed basis, its major medical contracts to certain people eligible under HIPAA.

To be eligible for coverage under HIPAA, an applicant must:

1. Be a resident of North Dakota.
2. Meet the federally defined eligibility guidelines that require the applicant to:
   a. Have had 18 months of qualifying previous coverage, the most recent of which is coverage under a group health benefit plan, government plan, Medicaid, church plan, or health insurance coverage offered in connection with any of these plans (verification of previous health insurance is required);
   b. Have applied for coverage within 63 days of the termination of the qualifying previous coverage;
   c. Not be eligible for coverage under Medicare or a group health benefit plan;
   d. Not have any other health insurance coverage;
   e. Not have the most recent qualifying previous coverage terminated for nonpayment of premiums or fraud; and
   f. Have declined continuation coverage offered by the employer or have elected continuation coverage through the employer and have exhausted the coverage extension (verification of previous health insurance is required).
3. Not be enrolled in health benefits with the state of North Dakota's medical assistance program (Medicaid).
4. Not have health insurance premiums paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or employer.

The Health Care Financing Administration has certified that CHAND meets the federal requirement of HIPAA.

The 2003 Legislative Assembly added language that allows CHAND to be utilized as an insurance vehicle for North Dakota residents that are eligible for assistance with health premiums through the federal Trade Adjustment Assistance Reform Act of 2002 (TAARA) or Pension Benefit Guaranty Corporation assistance. These individuals are able to receive reimbursement of 65 percent of their health premiums on a monthly pretax basis or through a special federal income tax credit at yearend.

To be eligible for coverage under TAARA, an applicant must:

1. Be a resident of North Dakota.
2. Be eligible for federal trade adjustment assistance and a health insurance tax credit or for Pension Benefit Guaranty Corporation assistance as provided by TAARA.
3. Have had three or more months of previous health insurance coverage.
4. Have applied for coverage within 63 days of termination of previous coverage.
5. Not be imprisoned under federal, state, or local authority.
6. Not be enrolled in health benefits with the state of North Dakota's medical assistance program (Medicaid).
7. Not have been insured through CHAND during the last 12 months.
8. Not have health insurance coverage through any of the following:
   a. The applicant's or the applicant's spouse's employer plan that provides for employer contribution of 50 percent or more of the cost of coverage for the applicant, the applicant's spouse, and eligible dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan;
   b. Healthy Steps;
   c. A government plan;
   d. Chapter 55 of the United States Code Title 10 relating to armed forces medical and dental care; or
   e. Medicare.
9. Be eligible for health insurance coverage through one of the following but electing to obtain coverage as a TAARA/Pension Benefit Guaranty Corporation-qualified individual:
   a. Continuation coverage;
   b. An employer plan in which the employer contribution is less than 50 percent; or
   c. An individual marketplace plan, including continuation or guaranteed issue.

With passage of the 1997 and 2003 legislation, the program now offers coverage to four types of eligible

residents--standard, HIPAA, TAARA, and age 65 and over or disabled. The standard, HIPAA, and TAARA comprehensive major medical policies offer $500 and $1,000 deductibles with or without a chiropractic endorsement, each with a $3,000 out-of-pocket maximum. The age 65 and over or disabled policy offers a basic or standard supplemental plan. The maximum lifetime benefit of a CHAND comprehensive plan is $1 million which closely resembles major medical contracts sold by commercial health insurance carriers doing business in North Dakota. An individual is not eligible for CHAND if:

- Eligible for the state's medical assistance program;
- The Comprehensive Health Association of North Dakota has paid $1 million in benefits on behalf of the individual;
- The individual previously terminated CHAND coverage within the last 12 months (not applicable to HIPAA individuals);
- The individual is an inmate or a resident of a public institution (not applicable to HIPAA individuals); or
- The individual's premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or the individual's employer (not applicable to TAARA individuals).

The Comprehensive Health Association of North Dakota is composed of those accident and health insurance companies selling a minimum of $100,000 of health insurance annually in North Dakota. The original legislation was intended to create a self-supporting pool funded by participants' premiums. In 1983, however, the original legislation was amended to limit the premiums charged by CHAND to 135 percent of the average amount charged for standard coverage in the state. Rates for the CHAND program are reviewed annually. Losses in excess of the premium are paid by participating companies in the form of assessments. Companies are allowed a credit against the premium tax they would otherwise pay to the state in an amount equal to the assessment paid to CHAND. The Comprehensive Health Association of North Dakota Board of Directors consists of eight members, including the Insurance Commissioner, the State Health Officer, the director of the Office of Management and Budget, one senator, one representative, and one representative from each of the three insurers with the highest premium volumes--currently, Blue Cross Blue Shield of North Dakota, Medica Health Plans, and Assurant. Blue Cross Blue Shield of North Dakota is currently under contract with the state of North Dakota to administer the day-to-day business of CHAND. Premiums are collected and claims are paid through the Blue Cross Blue Shield of North Dakota Fargo office. The Comprehensive Health Association of North Dakota has grown from 78 insureds in December 1982 to about 1,678 insureds as of June 30, 2006. Of these, 411 individuals were covered under an age 65 and over or disabled supplement contract. Enrollment in the program has leveled off and the expectation is that it will remain between 1,200 and 1,800 participants.

The Legislative Council staff said in November 2008, the Dakota Medical Foundation and the University of North Dakota School of Medicine and Health Sciences Center for Rural Health formed a partnership to conduct an assessment of health and health care in North Dakota. The study was conducted from December 2008 to February 2009. Issued in May 2009, the report, entitled *An Environmental Scan of Health and Health Care in North Dakota*: *Establishing the Baselines for Positive Health Transformation*, provides an overview of selected health and health care issues in North Dakota. The report addresses environment, health-related behaviors, and chronic diseases. In addition, the report provides information regarding health care infrastructure, quality, access, and financing of health services.

The Legislative Council staff presented the following proposed study plan:

1. Gather and review information on programs available to individuals unable to acquire private health care coverage and the current status of those programs and unmet health care needs in the state.
2. Gather and review information on the number of uninsured and underinsured individuals in North Dakota.
3. Gather and review information on the needs of underinsured and uninsured individuals and families.
4. Gather and review information on federal health care initiatives, including how they will affect current programs.
5. Receive information from interested persons, including AARP, the North Dakota Healthcare Association, the North Dakota Medical Association, the North Dakota County Social Service Directors Association, the North Dakota Health Information Technology Office and advisory committee, the University of North Dakota School of Medicine and Health Sciences Rural Opportunities in Medicine, and Blue Cross Blue Shield of North Dakota, regarding the availability and affordability of health care services in the state, the role of telemedicine in providing health care services in the state, and efforts to bring health care to rural North Dakota.
6. Receive information from the Department of Human Services, the State Department of Health, and the Insurance Commissioner regarding programs and services available to underinsured and uninsured individuals and families in the state.
7. Receive information from the University of North Dakota School of Medicine and Health Sciences Center for Rural Health regarding its

recent report on health and health care in North Dakota as it relates to the needs of underinsured and uninsured individuals and families in the state.

8. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
9. Prepare a final report for submission to the Legislative Management.

Senator Lee suggested the committee receive information from a representative of the Dakota Medical Foundation regarding the foundation's assessment of health and health care in North Dakota.

Ms. Anderson provided information regarding the study and programs and services available to underinsured and uninsured individuals and families in the state. She distributed brochures outlining the eligibility requirements and services provided by Medicaid, Healthy Steps, and Caring for Children. A copy of the information presented is on file in the Legislative Council office. Regarding children, she said, the department reviews for eligibility first under Medicaid, then under Healthy Steps. She said if the child does not qualify under either Medicaid or Healthy Steps, the department refers the child to the Caring for Children program. She said as of October 2009, 55,236 individuals in the state were covered by Medicaid in various coverage groups as follows:

	Individuals Covered October 2009
Family	18,631
Medically needy	9,263
Supplemental security income	7,473
Children aged 6 to 19	6,240
Children aged 0 to 6 years (2,983) and pregnant women (3,623)	6,606
Transitional Medicaid	6,430
Medicaid buyin for children (12) and breast and cervical cancer early detection (47)	59
Workers with disabilities	534
Total	55,236

Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, presented information for Dr. John Baird, Field Medical Officer and Section Chief, State Department of Health, regarding the study and programs and services available to underinsured and uninsured individuals and families in the state. A copy of the information presented is on file in the Legislative Council office. Ms. Smith said a 2004 United States Health Resources and Services Administration survey found that approximately 52,000 people or 8.2 percent of North Dakota's population are uninsured. She said the survey found:

- The uninsured were more likely to be young, unmarried male adults with a lower income but who were employed;
- American Indians were far more likely to be uninsured than Caucasians; however, the study did not consider Indian Health Service insurance;
- The majority of uninsured adults were employed (71.7 percent);
- The majority of insured adults were employed (82.3 percent); and
- Employees of smaller businesses were more likely to be uninsured, especially in businesses with 10 or fewer employees.

Ms. Smith said the 2004 survey estimated that, in addition to the 8.2 percent of North Dakota's population that is uninsured, another 8.5 percent were underinsured, using the definition that the underinsured spend more than 10 percent of their family income on health care. She provided a list of State Department of Health activities that directly or indirectly provide services to the uninsured and underinsured, including the colorectal cancer screening initiative; comprehensive cancer prevention and control program; Women's Way program; oral health program; maternal and child health block grant; family planning program; child passenger safety program; special supplemental nutrition program for women, infants, and children; Tobacco Quitline; specialty care diagnostic and treatment program; Russell-Silver Syndrome program; metabolic food program; Vaccines for Children program; Section 317 vaccine program; Ryan White program; physician loan repayment program; and the primary care office program.

Senator Lee asked Ms. Smith to determine if veterans who access Veterans' Administration health services were identified as insured or uninsured for the purposes of the 2004 survey.

Mr. Rod St. Aubyn, Blue Cross Blue Shield of North Dakota, said the Industry, Business, and Labor Committee is studying the factors impacting the cost of health insurance and health insurance company reserves. Mr. St. Aubyn said the Industry, Business, and Labor Committee, through the Insurance Commissioner, gathered information regarding the number of individuals insured in the state and compared the total to the state's population to determine how many North Dakotans were uninsured.

Senator Mathern suggested the committee receive information from tribal health care providers and the Veterans' Administration regarding the availability and affordability of health care services in the state, the role of telemedicine in providing health care services in the state, and efforts to bring health care to rural North Dakota.

It was moved by Senator Mathern, seconded by Senator Fiebiger, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information on programs available to individuals unable to acquire private health care coverage and the current status of those programs and unmet health care needs in the state.**

2. **Gather and review information on the number of uninsured and underinsured individuals in North Dakota.**
3. **Gather and review information on the needs of underinsured and uninsured individuals and families.**
4. **Gather and review information on federal health care initiatives, including how they will affect current programs.**
5. **Receive information from interested persons, including AARP, the North Dakota Healthcare Association, the North Dakota Medical Association, the North Dakota County Social Service Directors Association, the North Dakota Health Information Technology Office and advisory committee, the University of North Dakota School of Medicine and Health Sciences Rural Opportunities in Medicine, tribal health care providers, the Veterans' Administration, and Blue Cross Blue Shield of North Dakota, regarding the availability and affordability of health care services in the state, the role of telemedicine in providing health care services in the state, and efforts to bring health care to rural North Dakota.**
6. **Receive information from the Department of Human Services, the State Department of Health, and the Insurance Commissioner regarding programs and services available to underinsured and uninsured individuals and families in the state.**
7. **Receive information from the University of North Dakota School of Medicine and Health Sciences Center for Rural Health and the Dakota Medical Foundation regarding a recent report on health and health care in North Dakota as it relates to the needs of underinsured and uninsured individuals and families in the state.**
8. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
9. **Prepare a final report for submission to the Legislative Management.**

CHILDREN'S HEALTH INSURANCE PROGRAM

Ms. Anderson provided information regarding the state's CHIP annual report pursuant to Section 50-29-02. A copy of the information presented is on file in the Legislative Council office. She said the 2009 Legislative Assembly provided $21.6 million for CHIP, of which $2.2 million was expended through October 2009. She said as of October 2009, there were 3,239 premiums paid for children enrolled in CHIP, 329 fewer children than in November 2008. She said while fewer children are enrolled in CHIP than one year ago, there has been a significant increase in the number of children enrolled in Medicaid. She said this indicates that as children are renewing their coverage, they are being covered under Medicaid instead of CHIP. In addition, she said, in June 2008 the department implemented 12-month continuous eligibility for children in the Medicaid program. She said the 2009 Legislative Assembly increased the income eligibility level for CHIP to 160 percent of the federal poverty level effective July 1, 2009, and provided $753,000 for outreach, $300,000 more than the 2007-09 biennium. She said the department has contracted with the Dakota Medical Foundation for $650,000 to engage in a variety of outreach activities to inform families who may not be aware of the health insurance coverage programs offered by the department. She said the reauthorization of CHIP in February 2009 resulted in many changes and the department may, depending on the costs associated with each change, consider requesting a delayed implementation on certain provisions.

Representative Bellew suggested the committee receive information regarding the number of children provided continuous eligibility under Medicaid since the department implemented the 12-month continuous eligibility policy for children in June 2008 and the estimated fiscal impact on cost of the change.

Representative Pollert suggested the committee receive information on the number of clients receiving services within Department of Human Services programs at a future meeting.

Senator Lee requested the Department of Human Services provide a copy of a summary report prepared by the counties regarding the effects of the change in income reporting for Medicaid resulting from 12-month continuous eligibility for children.

IMMUNIZATION PROGRAM STUDY

The Legislative Council staff presented a memorandum entitled *Immunization Program Study - Background Memorandum*. She said the 2009 Legislative Assembly approved Senate Bill No. 2004. Section 10 of the bill provides for a Legislative Management study of the state immunization program. The study is to identify pharmacists' or other providers' ability and interest in immunizing children and include a review of the effect of the program on public health units, including billing, billing services, fee collections, and uncollectible accounts.

The Legislative Council staff said the 2007 Legislative Assembly, in House Bill No. 1435, provided for an immunization program and the Immunization Task Force. The bill provided that:

1. During the period beginning July 1, 2007, through December 31, 2007, the State Department of Health distribute vaccines to local public health units and other immunization providers for the purpose of continuing the immunization services

previously funded through the immunization grant program authorized under Section 317 of the federal Public Health Service Act while transitioning to a provider choice immunization program.

2. During the period beginning January 1, 2008, through June 30, 2009, the State Department of Health may distribute vaccines to local public health units and other immunization providers for the purpose of continuing the transition to a provider choice immunization program. The department was to distribute the vaccines in accordance with the department's protocol established in consultation with the Immunization Task Force.

The bill appropriated $2 million from the general fund to the State Department of Health for the 2007-09 biennium for the purpose of providing vaccines to public health units and other immunization providers. Of the total amount appropriated, $500,000 was only available if the State Department of Health determined that vaccines needed to be purchased after December 31, 2007.

In addition, House Bill No. 1435 provided the State Health Officer appoint an immunization task force to meet during the 2007-08 interim to establish a protocol on how to transition from a universal-select immunization program to a provider choice immunization program and to recommend to the State Department of Health that this protocol be implemented. The protocol must seek to retain the state's high rates of vaccinations using the most cost-effective protocol. The task force must consist of at least seven members, including at least three members representing local public health districts, three members representing private health care providers, and representatives of the State Department of Health.

The 2007-08 Human Services Committee received periodic reports on the immunization program transition and learned that in 2005, due to increasing costs of vaccinating children, North Dakota moved from a universal state in which all vaccines are provided to all children, even those insured, to a universal-select state in which all vaccines are provided to all children eligible for a federal program called Vaccines for Children, which generally includes children that are uninsured, underinsured, Medicaid-eligible, or American Indian, and most vaccines are provided to most insured children. The Provider Choice program is a program to manage and cost-effectively pay for all recommended vaccines for all children. Since 2005 significant changes have occurred in childhood immunization programs, including a decline in federal funding for immunizations and the introduction of several very expensive, newly recommended vaccines. The Provider Choice program continues the provision of federal vaccines to providers for eligible children and gives providers the choice of purchasing all other vaccines through the State Department of Health where they can achieve lower vaccine costs through multistate, large-volume purchasing agreements. Vaccines for all children are provided either through the federal Vaccines for Children program or through an individual's health insurance. Some copayments may apply. House Bill No. 1435 delayed the implementation of the Provider Choice program until December 31, 2007, and provided a $2 million general fund appropriation to pay for the nonfederal vaccine costs until the program was implemented and paid through private insurance companies.

The 2007-08 Human Services Committee received information regarding the uses of federal "317" vaccine allocations by the State Department of Health. The committee learned the department receives a yearly allocation of vaccine through Section 317 direct assistance grants. The grants are intended to allow grantees to provide vaccines for populations at the greatest risk for undervaccination and disease. The emphasis has historically been placed on children whose health insurance does not provide for immunizations, but the program may be used to provide vaccines for all children and adults. Children who do not have health insurance or are eligible for Medicaid receive vaccinations through the federal Vaccines for Children program rather than the "317" program.

The 2007-08 Human Services Committee learned the immunization transition project required the development of a billing process for local public health units. Two local public health units were chosen as testing sites and completed testing of the billing system in February 2008. On March 31, 2008, all local public health units began billing insurance companies. Local public health units electronically submit information to the University of North Dakota School of Medicine and Health Sciences through the North Dakota immunization information system. The University of North Dakota School of Medicine and Health Sciences provides billing services on behalf of the health units, including the collection of insurance copayments and deductibles, and withholds $2 from each vaccination payment for administrative costs. Two local public health units have computer systems that are not interfaced with the North Dakota immunization information system which requires the entry of data in two separate computer systems.

Of the $2 million general fund appropriation, $500,000 was available only if the department determined it necessary to continue to purchase vaccines after December 31, 2007. The department spent approximately $1,993,000 of the $2 million 2007-09 general fund appropriation.

The 2007-08 Human Services Committee received additional information regarding the impact of the immunization program transition. Concerns expressed regarding the transition included:

- The difficulty of local public health units in obtaining insurance information.

- The large amount of vaccine required to be stored by local public health units.
- Excessive administrative costs incurred by local public health units for providing immunizations.

The Legislative Council staff said Senate Bill No. 2333 (2009) created regional public health networks to share administrative functions and public health services and provided $275,000 from the general fund to the State Department of Health for a regional public health network pilot project. The bill also provided one-time funding of $1.2 million from federal stimulus funds made available to the state under the federal American Recovery and Reinvestment Act of 2009 to the State Department of Health to provide funds to local public health units for immunization services and included a contingent general fund appropriation for $1.2 million if the federal funds are not available to provide for this purpose. The department anticipates the assistance under the federal American Recovery and Reinvestment Act of 2009 will be in the form of either funding, vaccine, or some combination of vaccine and funding.

The Legislative Council staff presented the following proposed study plan:

1. Gather and review information to identify pharmacists' or other providers' ability and interest in immunizing children, including information from the State Board of Pharmacy and the North Dakota Pharmacists Association.
2. Receive information from local public health units; the North Dakota Medical Association; the University of North Dakota School of Medicine and Health Sciences; and insurance providers in the state, including Blue Cross Blue Shield of North Dakota, regarding the effect of the program on public health units, including billing, billing services, fee collections, and uncollectible accounts.
3. Receive information from the Immunization Task Force and the State Department of Health regarding the implementation of the immunization program, including the number of children being immunized, the status of public health units' immunization programs, the status of 2009-11 funding for the immunization program, and the status of assistance anticipated under the federal American Recovery and Reinvestment Act of 2009.
4. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
5. Prepare a final report for submission to the Legislative Management.

Ms. Molly Sander, Immunization Program Manager, State Department of Health, provided information regarding the state immunization program. A copy of the information presented is on file in the Legislative Council office. Ms. Sander said the most recent National Immunization Survey data for North Dakota is for 2008 and includes children born between January 2005 and June 2007. She said the vaccination rate for North Dakota for the immunization series most often reported for children who have reached age 19 to 35 months is 69.8 percent, compared to the national rate of 76.1 percent. She said increases in the number of vaccines recommended, combination vaccines, and increases in vaccine pricing have driven the cost to vaccinate a child through age 18 from $186 in 1999 to $1,519 in 2009 ($1,991 private sector pricing). She said the State Department of Health does not receive funding for the purchase of vaccines, but receives an allocation of various vaccines. She said the Vaccines for Children program provides all recommended vaccines for children who are Medicaid-eligible, American Indian, uninsured, or underinsured. She said 34.8 percent of children age 18 and younger in North Dakota are Vaccines for Children program-eligible and 54.1 percent of those eligible are vaccinated in local public health units, rural health centers, federally qualified health centers, and by the Indian Health Service. She said insured children receive privately purchased vaccine. She said local public health units or private providers bill insurance for the cost of the vaccine plus an administration fee. She said local public health units contracted with the University of North Dakota School of Medicine and Health Sciences to perform billing and accounts receivable on behalf of the local public health units. She said the "317" program is discretionary, and the state can decide which vaccines to offer through the program. She said the department is anticipating the vaccine allocation for October 2009 through September 2010 will total $1.5 million, but the federal allocation of vaccine through this program has been decreasing. She said the transition of the state immunization program was necessary to respond to the decline in federal vaccine allocations. She said the department will receive a vaccine allocation worth $345,220 through the American Recovery and Reinvestment Act of 2009. In addition, she said, the department also received the following American Recovery and Reinvestment Act of 2009 grants:

1. A noncompetitive immunization grant of $310,296 for:
   a. Forecasting and reminder recall in the state registry;
   b. A media campaign;
   c. An immunization conference; and
   d. Grants to local immunization coalitions.
2. A competitive immunization information system sentinel site grant of $146,360 to:
   a. Monitor children in the state registry;
   b. Improve immunization messaging between the state registry and electronic medical records;
   c. Provide a school immunization module; and

d. Provide enhancements to state registry immunization rate reports.

Ms. Sander said local public health units have encountered challenges, including the increased cost for vaccinating a child and the decreased availability of federal vaccine. She said the State Department of Health has an opportunity to conduct a quality improvement study of the state's immunization program.

In response to a question from Senator Lee, Ms. Sander said the State Department of Health could collaborate with the Department of Human Services to coordinate immunization and CHIP outreach.

In response to a question from Senator Lee, Ms. Sander said the reduction in North Dakota's immunization rates may be a result of recent misconceptions in the media regarding immunization safety, additional immunization recommendations that result in a confusing immunization schedule, and the extension of the immunization schedule beyond 12 months of age. She said the state registry reminder recall provided in a recent grant could increase immunization rates by as much as 10 percent.

In response to a question from Representative Pollert, Ms. Sander said immunization payment processing has improved, and information is transmitted electronically between the University of North Dakota School of Medicine and Health Sciences and Blue Cross Blue Shield of North Dakota. Ms. Laura Olson, State Department of Health, said the department anticipates outstanding claims will be current by December 2009.

Ms. Lisa Clute, First District Public Health Unit, said in the past local public health units provided free vaccine to everyone, but an increase in vaccine requirements and a decrease in federal vaccines available have made it necessary to only provide free vaccine to children who are Medicaid-eligible, American Indian or Alaskan Native, uninsured, or underinsured. Ms. Clute said others must purchase vaccines privately and the public health units bill insurance for children who have immunization coverage. The transition has created a system where local public health units have become responsible for collecting insurance information, performing accounts receivable processes, and coordinating with billing and payment entities. She suggested the State Department of Health be encouraged to proceed with its quality improvement study. She said a review of the immunization system by a consultant would identify areas needing improvement. She said the review would provide a:

- Written evaluation of current business processes and actual costs of administering the PROtect ND Kids program;
- Written model for improvement plan;
- Written business plan; and
- Model for regional billing.

A copy of the information presented is on file in the Legislative Council office.

In response to a question from Senator Lee, Ms. Smith said the State Department of Health is considering the review of the immunization system and has discussed it with entities that may partner with the department to provide financial and intellectual support. She anticipated the cost may range from $50,000 to $100,000. She said the department may also have funds available to pay for the review.

In response to a question from Representative Conrad, Ms. Clute said North Dakota ranks 44th in the nation in its immunization rate.

Mr. Keith Johnson, Administrator, Custer Health Unit, said he supports a review of the immunization system by a consultant. Mr. Johnson said he anticipates larger public health units will become self-sustaining during the 2009-11 biennium and that continued appropriations will not be necessary. He said the review could be paid for with funds already appropriated.

Mr. Kirby Kruger, Director, Division of Disease Control, Medical Services Section, State Department of Health, updated the committee regarding H1N1 influenza conditions in the state. Mr. Kruger said surveillance has shown the disease is declining and is approaching what the state would see in a normal influenza season. He said the State Department of Health is continuing to promote influenza vaccination because it is early in the season and it is not uncommon for the disease to come in waves. He said the department anticipates an adequate supply of vaccine to provide vaccinations to the general public.

In response to a question from Senator Lee, the legislative budget analyst and auditor said the committee could approve a motion to ask that the Legislative Management chairman encourage the State Department of Health to contract with a consultant for a review of the state's immunization system.

It was moved by Representative Conrad, seconded by Senator Pomeroy, and carried on a roll call vote that the Legislative Management chairman encourage the State Department of Health to contract for an independent quality improvement evaluation of the state's immunization program. Representatives Bellew, Conklin, Conrad, Frantsvog, Hofstad, Kreidt, Pietsch, Pollert, Potter, and Wieland and Senators Erbele, Fiebiger, Kilzer, Lee, Mathern, and Pomeroy voted "aye." No negative votes were cast.

Senator Lee requested the State Department of Health continue to update the committee regarding the independent quality improvement evaluation of the state's immunization program.

It was moved by Representative Kreidt, seconded by Representative Pollert, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information to identify pharmacists' or other providers' ability and**

interest in immunizing children, including information from the State Board of Pharmacy and the North Dakota Pharmacists Association.

2. **Receive information from local public health units; the North Dakota Medical Association; the University of North Dakota School of Medicine and Health Sciences; and insurance providers in the state, including Blue Cross Blue Shield of North Dakota, regarding the effect of the program on public health units, including billing, billing services, fee collections, and uncollectible accounts.**
3. **Receive information from the Immunization Task Force and the State Department of Health regarding the implementation of the immunization program, including the number of children being immunized, the status of public health units' immunization programs, the status of 2009-11 funding for the immunization program, and the status of assistance anticipated under the federal American Recovery and Reinvestment Act of 2009.**
4. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
5. **Prepare a final report for submission to the Legislative Management.**

REGIONAL PUBLIC HEALTH NETWORK TASK FORCE

Ms. Smith presented information regarding the development of the regional public health network pursuant to 2009 Senate Bill No. 2333. A copy of the information presented is on file in the Legislative Council office. She said Senate Bill No. 2333 provides $275,000 to fund a regional public health network pilot project and requires the department to work with the Regional Public Health Network Task Force, the Health Council, and the local public health units to distribute the funds. She said a regional public health network is defined as a group of local public health units that have entered a joint powers agreement or an existing lead multidistrict health unit identified in the emergency preparedness and response region that has been reviewed by the State Health Officer and verified as in compliance with the following criteria:

- The geographical region corresponds to one of the emergency preparedness and response regions.
- The regional network shares emergency preparedness and response and environmental health services and shares a regional public health network health officer.
- The joint powers agreement:

  Includes sharing at least three administrative functions and at least three public health services identified in Section 23-35.1-02(3)(b).

  Provides for the future participation of public health units that were not parties to the original joint powers agreement and an appeal process for any application denials.

  Provides the structure of the governing body of the network.
- The regional network complies with other requirements adopted by the Health Council by rule.
- The regional network meets maintenance of effort funding requirements.

Ms. Smith said each regional public health network must prepare an annual plan regarding the provision of required and optional public health services that must be approved by the State Health Officer and may receive and expend money for the provision of services. She said the State Health Officer has appointed the Regional Public Health Network Task Force, which will be chaired by Ms. Theresa Will, Director, City-County Health District, Valley City. She said the task force will seek to strengthen the local public health infrastructure, more efficiently use limited funding and staff, and provide more equitable access to quality public health services.

In response to a question from Senator Kilzer, Ms. Smith said two regions have expressed interest in applying for the pilot project. She said the task force will determine selection criteria for the application process. She said the task force may not redraw local public health unit boundaries, but could form joint powers and regional networks to gain efficiencies. She said the regional public health network language is permissive, not mandatory.

Ms. Will presented information regarding the development of the regional public health network pursuant to Senate Bill No. 2333. A copy of the information presented is on file in the Legislative Council office. She said a 2008 National Association of County and City Health Officials survey indicated 54 percent of local health departments in North Dakota serve fewer than 10,000 people. She said small local public health units do not have the capacity to meet national accreditation standards on their own. She said regional arrangements allow smaller health units to meet the standards, ensuring their jurisdictions are receiving all essential public health services. She said the primary duty of the task force is to set the protocol for the regional public health network pilot project. She said the task force is currently considering tentative dates for its first meeting.

The committee adjourned subject to the call of the chair at 2:20 p.m.

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Sheila M. Sandness
Fiscal Analyst

_____
Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:1