2013 HOUSE HUMAN SERVICES

HB 1433

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1433
January 29, 2013
Job #17907

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to hospital bad debt relief grants; allocation of tobacco products taxes and health care delivery trust and to provide an appropriation.

Minutes: *Testimonies #1-11*

Chairman opened the hearing on HB 1433.

Rep. Jon Nelson: From District 14 introduced and testified in support of the bill. (See Testimony #1)

10:06 Rep. Porter: On the income side of this, we are doing 45% to the water trust fund and 45% to common schools and 10% to health. Inside of this proposal does this change the percentages at all or does it take the 10% allocation to health and take it into the trust fund?

Rep. Nelson: No, this funding mechanism has nothing to do with the master settlement dollars. This is the cigarette tax that ND collects and distributes into the general fund.

Rep. Porter: This is straight up general fund revenue side of that tax.

Rep. Nelson: Yes it is.

Rep. Porter: When the settlement percentages were figured, I didn't agree with it then and still don't. Was there any discussion in changing those percentages along with this funding mechanism in order to direct some of those dollars back towards this type of trust fund?

Rep. Nelson: No. We haven't talked about that. That conversation could take place at a later date. The money in this fund will address the immediate needs. I agree with you to increase the percentage to health care to a higher number. I don't think we can wait and need to act now or we are going to start losing some hospitals.

Rep. Laning: Regarding bad the debt, do you feel a backup plan like this encourage sloppy administration?

Rep. Nelson: It was brought up to me from another source too. We are comfortable to putting an amendment together to address that. The collection of the bad debt will continue to be pursued.

Chairman Weisz: What about the potential for shifting uncompensated care into bad debt?

Rep. Nelson: Ask one of the administrators that question.

Rep. Mooney: Regarding the fiscal note, the $57.9 million would come from the tobacco tax and another $22.3 million would come from the general fund for a total?

Rep. Nelson: No. All the funding generated into the health care delivery trust fund would come from the cigarette tax. That is the $57.9 million. The $20 million dollars would be appropriated out of there as well as Sections 6-11. They are now funded in the general fund in the executive budget and that funding shift would now come out of this trust fund.

Rep. Mooney: There is nothing in the 2015-17, it would move forward in time?

Rep. Nelson: This would be set in statute so all of the money that is collected from tobacco tax revenues would forever go into that trust fund.

Sen. John Andrist: From District 2 introduced and testified in support of the bill. (See Handout #2) I'm not sure this is the best vehicle, but is a vehicle and for two years.

22:48 Rep. David Rust: From District 2 introduced and testified in support of the bill. (See Testimony #3)

26:01 Rep. Laning: We hear about the high wages paid to those in the oil field and many don't have insurance and drop into the emergency room to get medical attention. Is there anyway or should we look at some legislation to make it easier to garnish their wages to pay these bills?

Rep. Rust: Some come to the clinic and want an appointment and told everyone is booked, so then they go to the emergency room. You have to serve them before you talk money. The hospital sends the bill out and it comes back. The hospitals turn over many debts to collection agencies and they can't find them either.

Rep. Laning: Can you gather employment information from them?

Rep. Rust: The people change jobs quickly. It is not only oil people, but also people from our communities.

30:42 Jerry Jurena: President of ND Hospital Association testified in support of the bill. (See Testimony #4) Handed out testimony for Les Urvand, (See Testimony #5)

31:45 Rep. Porter: I would be interested to know how many situations where a hospital exists where the physician or clinic are not owned and operated by the hospital where they have competition. The way this bill is worded, if it happens once in a community then we

are creating an unleveled playing field for a private practitioner or private individual's business in competition with health care facility by paying up there bad debt. If you could get me that information I would appreciate it.

Jurena: You may hear some of that information from Darrold Bertsch.

33:24: Darrold Bertsch: CEO of Sakakawea Medical Center in Hazen, ND testified in support of the bill. (See Testimony #6) 37:24 Explained charts in testimony.

44:35 Rep. Silbernagel: On the last page you showed an $18 million income. Can you explain that?

Bertsch: There was a net income of $18 million for all 36 critical access hospitals. A net includes foundation donations and investment income. In 2011 there was a positive net income.

Silbernagel: The prior years had significant losses. Was there some significant event that changed that?

Bertsch: There has been a change because of the stock market loss.

Rep. Fehr: On your east and west of highway 83, where do the Bismarck and Minot hospitals fall?

Bertsch: This study does not include Bismarck, Minot, Grand Forks and Fargo. It is just the smaller rural facilities.

Rep. Porter: Looking at your contractual deductions and you are paid at a 101% of Medicare of actual costs; as those allowable costs are plugged, is there a payment at the end of the year or start of next year in that make up for the differences between the normal allowable and the 101%? How does repayment come to you from Medicare?

Bertsch: Medicare pays allowable costs of medical services. Allowable costs are around 92% of actual costs because some things are not included like the TV and telephone, etc. There is retrospective settlement upon completion of the Medicare cost report for the actual costs that are identified in that Medicare cost report.

Rep. Porter: Where does that show up in this report?

Bertsch: It shows up in the contracturals the following year.

Rep. Porter: From your facility the retrospective payment on the Medicare contracturals that happened in 2011 would offset your non-allowed charges are in 2012?

Bertsch: What the contracturals were 2012.

Rep. Porter: On Medicaid side do they just pay you off of an enhanced fee schedule or is there a retrospective payment that comes after each year?

Bertsch: Medicaid pays us in two different ways. For hospitals, Medicaid pays us cost based reimbursement as identified in our Medicare cost report. In the last biennium the legislature approved cost based reimbursement for laboratory and CRNA services. Other services provided through our facilities and to our clinics including physicians are reimbursed based on a fee schedule.

Rep. Porter: An item in your operating expenses is the depreciation and amaturization. In 2007 it was at $7 million and now it shows as a $24 million operating expense. There had to be board action to purchase capital equipment or to do loans or bonds in order to make that move. Could you explain to me if things were that difficult that the boards were doing capital purchasing projects and going into debt at the same time they were having issues with their revenues?

Bertsch: The difference between 2007 and 2012 relates to the number of facilities included in the study. In 2007 there were 27 facilities in the study and in 2012 there were 36. Nine facilities that were added between 2007 and 2012 were larger facilities.

Rep. Porter: Regarding local mil levies that can be used for hospitals, where would that income show up in this sheet?

Bertsch: Under governmental subsidies.

Rep. Porter: The language in the bill seems to create an unfair playing field for the private practice. How do you treat them?

Bertsch: Don't know how it would be equalized.

Rep. Porter: Knowing that in Williston, Jamestown and Dickinson have competitive clinic settings they wouldn't have a fair playing field in this if this bill were to pass in the form that it is in.

Rep. Fehr: Can you tell us what percentage of losses relate to emergency room only?

Bertsch: I don't know.

Rep. Fehr: Can you find out?

Bertsch: Maybe someone in the audience can answer that.

57:16 Daniel Kelly: CEO of McKenzie County Health Care Systems Inc. in Watford City, ND testified in support of the bill. (See Testimony #7).

1:05:36 Rep. Fehr: What percentage of your bad debt is from the ER?

Kelly: More than 90% of bad debt is coming from the emergency room. I can't factor in that additional amount that I told you before that is showing up in the hospital or in the clinic. I don't have that number.

Rep. Porter: In McKenzie Co. the hospital is owned by the county?

Kelly: No.

Rep. Porter: Are there property taxes as a mil levy that comes in as income to you?

Kelly: Not at this time, but we are contemplating that.

Rep. Porter: The effect that oil country has on the state, the hospital seems to be affected the most. In all of the discussions was it looked at to be included in the impact grant formula for something that is already there and in place?

Kelly: We have had discussions with the Governor and Representatives relative to accessing the oil impact tax. The need those communities have, the core needs greatly exceed the dollars that are available. It doesn't appear that is a viable source for us.

Rep. Porter: I found in the budget that there was a $147 million of impact grant money that is being carried forth to the next biennium and weren't able to be spent in the current biennium because there was more money than ability to do the infrastructure and projects.

Rep. Mooney: If it were to go to the local mill process, is that a vote by the people?

Kelly: Yes it is.

1:11 Randall Pederson: President/CEO of Tioga Medical Center in Tioga, ND testified in support of the bill. (See Testimony #8)

1:18:08 Rep. Anderson: How old are your buildings?

Pederson: Fifty years old. No depreciation left on them.

Rep. Porter: As you opened those statements for $78,000, if you would run those through the Medicaid formula, what would that $78,000 really be worth?

Pederson: We have very little Medicaid business in my community. It would be 50% on the dollar if we ran it though the Medicare. Don't know the Medicaid rate, but it is not a lot.

Rep. Fehr: What percentage of bad debt do you have from the ER?

Pederson: Through the ER 75-80%. Six years ago we were averaging about 600 ER visits a year. Now it is over 2500 a year. Ambulance service was averaging 120 patient contacts six years ago. In 2012 we had 315 patient contacts.

Matt Grimshaw: The CEO of Mercy Medical Center in Williston, ND testified in support of the bill. Apartments in Williston that were $1500 are now $2500 a month if you can find them. Everything others have experienced we have at a higher degree. Over the last six months we have seen the bad debts escalate to point where we cannot absorb them as

well. For the first time in 5 years we are operating at a loss. We employ over 25 providers and adding new services as soon as we can to meet the needs. We have invested $30 million in our campus over the last 24 months and through the coming fiscal year. I don't know if we will ever qualify for this, but I do have stats you need to hear as I have answers for your questions about ER. In Williston on a year to year basis, direct bad debt expense for ER charges are 70% of total. It is not just the ER charge; it is also the surgery, and admissions. It is unsustainable. Our bad debts going back to 2007 were 2.1% of gross revenues and 3.6% of net. Fast forward to today, our bad debts are over 9% of gross and 16% of net. We have met with the oil and gas industry and spoken multiple times with members in leadership positions of the industry and it is not the major players. They offer good benefits and have insurance. It is Johnny Hot Shot Service that won't employ people, but have independent contractors. It is the truckers who come from all across the country to drive in the oil fields who are not employed by anybody. I don't know if this is the perfect solution and I don't know if it would benefit us personally, but this has to be addressed for our hospitals in our region. We cannot have Watford City, Crosby or Tioga close or cut back services. We have not yet gone to requiring up front money before you are seen. Your first appointment in our clinic is 90 days out. Our established patients take up all of our slots and we can't take any new patients.

1:25:25 Rep. Mooney: What would you foresee that would be the impact to Williston if you lost the three hospitals you mention?

Grimshaw: It is hard to anticipate that. The first impact would be in the ER. We have gone from less than 800 a month before the boom to over 1500 a month now. We have gone from 6 ER beds to 9 and by the middle of this year we will go to 18 beds.

1:27:19 Keith Heuser: Administrator of Mercy Hospital in Valley City, ND testified in support of the bill. (See Testimony #9) We have to follow different rules and regulations than the private practice does. We are not getting 101% of allowable costs. It is much less.

1:34:24 Sandra Simonson: President of St. Luke's Hospital Board testified in support of the bill. (See Testimony #10)

1:35:39 Rep. Laning: You said you have in 2012 a debt of $312,000 and down below you say you lost over $495,000. I'm not understanding that.

Lester Long: Administrator of the St. Luke's Hospital. That is our operating loss of the $495,000 the bad debts of that is 312,000. The sustainability is not that good at that level.

Robert Black: CEO in testified in support of the bill. We were told we were be further restricted to collect bad debts.

Jeanne Prom: Executive Director of ND Center for Tobacco Prevention and Control Policy testified in support of the bill. (See Testimony #11)

Ken Taupa: From Cancer Society testified in support of the bill. On Section 10 and 11 of the bill for the colorectal cancer screening initiative and Women's Way funding; currently these two items are funded in the executive budget through the Dept. of Health budget this

is not new spending. This will adjust the funding from general funds to the health care delivery trust fund. I would ask for consideration of an amendment on Section 11 that would direct the funding to the Dept. of Health and not Human Services. I think that was a drafting error.

NO OPPOSITION

Chairman Weisz closed the hearing on HB 1433.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1433
February 11, 2013
Job # 18749

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to bad debt relief grants.

Minutes: *See Attachment #1*

Chairman Weisz: Look at HB 1433.

Rep. Jon Nelson: From District 14 asked for consideration on an amendment .02001. (See Attachment #1) There was questions over the debt relief grants and if they were distributed that there would less of an effort to collect bad debts. This amendment is to address that. These grants are retrospective and wouldn't go out until the cost report is completed. You are looking at a year after the billing has taken place. In the bill there are three areas where the debt relief grants are centered around. They are intake, emergency room and clinic revenues. A hospital cannot ask for an emergency room payment up front. That is a federal statute. On the clinical side it is different. You can ask for deductibles or copayments up front. We will stipulate they need to do this to be eligible for a grant. Especially in western ND it is hard to get a handle on the people who give a name and not an address. There are some vendors out there that can find those people's addresses and the coverage they have. This could assist all hospitals in finding that patient and can do it through a computer program. There is a company called Emdeon that would provide that service to all the members of the Hospital Association. There would be an additional charge the hospital would incur as they utilize that service. If this bill can go forward, I'm not opposed to a sunset clause at the end of this biennium. We need to address this issue and we can't wait for two years as some hospitals will close. I do wish we don't sunset the trust fund.

Rep. Mooney: The tobacco tax is still going to fund, correct?

Rep. J. Nelson: Correct.

Rep. Mooney: The $700,000 is coming from that?

Rep. J. Nelson: Yes, the $700,000 grant would go to the Hospital Association and they would distribute this program to all of their members. It would cost 40 cents to run each name through the ringer so to speak.

Rep. Hofstad: I move the Nelson amendment and add to it to Section 6 which sunsets the appropriation for the hospital debt relief grant.

Rep. Anderson: Second.

Rep. Hofstad: Adding to that amendment on page 6, line 10, "to the Dept. of Health" not to the Dept. of Human Services.

Rep. Fehr Second.

Rep. Laning: Enlighten me in the difference of appropriation and sunset clause.

Rep. J. Nelson: The language as it reads now means the $20 million would have to be reauthorized as it runs out on the 15th. The assumption would be that another $20 million would be reauthorized in the next biennium. The sunset in this program at the end of the 2015 biennium and the whole program would have to be reauthorized. This part of the health care delivery trust would have to be reauthorized for the debt relief grants. I wouldn't be opposed to a study resolution for this to go before budget section or study resolution as well.

Rep. Fehr: I think this addition in Section 12 is extremely important.

Rep. Silbernagel: Not knowing what direction we are going in Medicaid expansion, I think that may negate some of the bad debts that we have occurred over the years could have an impact.

VOICE VOTE: MOTION CARRIED

Rep. Fehr: I move a Do Pass as amended and re-referred to Appropriations on HB 1443.

Rep. Silbernagel: Second.

Rep. Porter: This concept I have a hard time with. I look at the financial data handed out by the 36 facilities that this money would be directed towards and over the course of one year they went from an $18 million net income to a $2.8 million net income and they are still in the black. The bad debts expenses have changed their revenue streams have stayed fairly consistent. The one thing I did notice their depreciation and amaturization jumped out of the $6.4 million loss they are showing, operating margin loss at $4.45 million and interest expense went up by $1.6 million. That tells me they bought a bunch of stuff and they are paying loans on it. The last thing to do when running a business and wondering how to make ends meet is go and buy capital equipment and take a loan out. I think this is a terrible avenue for the state to get involved in. If you want to fix the revenue side of health care, then bump up the amount you reimburse for Medicaid. The Medicaid program is almost $20 million worth of contractral reductions that we pay less than their cost of doing business. That is where we control what happens to health care. They are not in as dire straights as has been presented.

Rep. Damschen: I can emphasize, but I'm also aware that a number of hospitals have had collection problems for years. I don't know when you start and when you stop on an endeavor like this.

Rep. Mooney: I think it is dire and can't take a risk to lose any medical facilities. I don't think the ND people could take a blow like that. He's offered up a sunset and if we can incorporate interim reporting to be able to understand when we get into the 2015 legislative assembly would be a good thing.

Rep. Muscha: Weren't we told that between the private and the public they are not on a level playing field to start with because they can refuse people?

Rep. Porter: On the clinic level no matter who owns it, they can refuse care. They can't refuse care in the emergency department because that is covered by a federal law called EMTALA.

ROLL CALL VOTE: 10 y 3 n 0 absent

MOTION CARRIED - Do Pass As Amended and Re-referred to Appropriations

Bill Carrier: Rep. Anderson

FISCAL NOTE
Requested by Legislative Council
01/22/2013

Bill/Resolution No.: HB 1433

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

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$(57,953,000)	$57,953,000		
Expenditures						
Appropriations				$22,331,000		

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

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

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

HB 1433 re-allocates cigarette and tobacco tax revenue from the state general fund to the health care delivery trust fund.

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

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

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

If enacted, HB 1433 is expected to reduce state general fund revenues by an estimated $57.953 million in the 2013-15 biennium, re-allocating that revenue to the health care delivery trust fund.

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

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

Sections 6 through 11 appropriate $22.331 million from the health care delivery trust fund.

Name: Kathryn L. Strombeck
Agency: Office of Tax Commissioner
Telephone: 328-3402
Date Prepared: 01/28/2013

13.0767.02002
Title.03000

Adopted by the Human Services Committee

YK
2/12/13

February 12, 2013

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1433

Page 1, line 5, remove "and"

Page 1, line 5, after "appropriation" insert "; and to provide an expiration date"

Page 1, line 15, after "year" insert "and documentation of the hospital's policies requiring collection of copayments and deductibles from patients at the point of service when allowed under federal law and its process of verifying personal and health insurance information of patients"

Page 6, line 10, after the second "the" insert "state"

Page 6, line 10, replace "human services" with "health"

Page 6, after line 12, insert:

"**SECTION 12. APPROPRIATION.** There is appropriated out of any moneys in the health care delivery trust fund in the state treasury, not otherwise appropriated, the sum of $700,000, or so much of the sum as may be necessary, to the state department of health for the purpose of providing a grant to an organization to assist hospitals in verifying personal and health insurance information of patients, for the biennium beginning July 1, 2013, and ending June 30, 2015.

SECTION 13. EXPIRATION DATE. Section 1 of this Act is effective through June 30, 2015, and after that date is ineffective."

Renumber accordingly

Date: 2-11-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1433

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Hofstad Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Adopt amendment 02001
add ~~sunset~~ clause
in section 6
on page 6, line 10
add "to Dept of Health"

Voice Vote
Motion Carried

Date: 2-11-13
Roll Call Vote #: 2

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1433

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☒ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Fehr Seconded By Rep Silbernagel

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. MOONEY	✓	
VICE-CHAIRMAN HOFSTAD	✓		REP. MUSCHA	✓	
REP. ANDERSON	✓		REP. OVERSEN	✓	
REP. DAMSCHEN		✓			
REP. FEHR	✓				
REP. KIEFERT	✓				
REP. LANING	✓				
REP. LOOYSEN		✓			
REP. PORTER		✓			
REP. SILBERNAGEL	✓				

Total (Yes) 10 No 3

Absent 0

Floor Assignment Rep. Anderson

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

REPORT OF STANDING COMMITTEE

HB 1433: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1433 was placed on the Sixth order on the calendar.

Page 1, line 5, remove "and"

Page 1, line 5, after "appropriation" insert "; and to provide an expiration date"

Page 1, line 15, after "year" insert "and documentation of the hospital's policies requiring collection of copayments and deductibles from patients at the point of service when allowed under federal law and its process of verifying personal and health insurance information of patients"

Page 6, line 10, after the second "the" insert "state"

Page 6, line 10, replace "human services" with "health"

Page 6, after line 12, insert:

"SECTION 12. APPROPRIATION. There is appropriated out of any moneys in the health care delivery trust fund in the state treasury, not otherwise appropriated, the sum of $700,000, or so much of the sum as may be necessary, to the state department of health for the purpose of providing a grant to an organization to assist hospitals in verifying personal and health insurance information of patients, for the biennium beginning July 1, 2013, and ending June 30, 2015.

SECTION 13. EXPIRATION DATE. Section 1 of this Act is effective through June 30, 2015, and after that date is ineffective."

Renumber accordingly

2013 HOUSE APPROPRIATIONS

HB 1433

2013 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Committee
Roughrider Room, State Capitol

HB 1433
2/15/13
Job 19073

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to hospital bad debt relief grants; to amend and reenact sections 57-36-25 and 57-36-26, subsection 1 of section 57-36-31, and section 57-36-32 of the North Dakota Century Code, relating to allocation of tobacco products taxes and the health care delivery trust fund; to provide an appropriation; and to provide an expiration date.

Minutes: You may make reference to "attached testimony."

Rep. Robin Weisz, District 14: Introduced the bill.

2:14
Chairman Delzer: Is there anything in there that requires them to do what the plan says?

Rep. Weisz: No. I assume the department would have some kind of flexibility in determining if they were meeting the intent of Section 1, Subsection 2.

Chairman Delzer: But there is no penalty clause that you're aware of?

Rep. Weisz: Correct; there is no penalty. If the Health Department decided they weren't doing their part, they wouldn't have to give them the grant. If you look at the language in Subsection 2, it details the provisions needed in order to qualify.

Chairman Delzer: It says what they have to submit. It does not say that the department would have that option.

Rep. Weisz: It says that they have to submit the documentation of their policy requiring collection of copayments and deductibles. That subsection does say that to qualify, they have to document that they require collection

Chairman Delzer: It says the have to show the documentation of the policy, but it doesn't say they have to do the collection.

Rep. Weisz: It requires they have the policy. I guess enforcement of the policy might be…

Chairman Delzer: The average of what they consider bad debt is 2.7. Other than this language here, what drives them to try to collect any more over that?

Rep. Weisz: The testimony we received is they are limited by federal law that makes it difficult for them to collect bad debt. Their process probably isn't going to change to any large degree with or without this bill because they are already limited?

5:57
Rep. Streyle: Was there a document provided region by region or hospital by hospital showing the outstanding debt of each entity?

Rep. Weisz: We received many documents on outstanding debt. This only applies to the thirty-six CAHs. I can give you some general information. In 2007 with twenty-seven facilities, bad debt charity expense was $3.52 million. In 2012 with thirty-six facilities, bad debt charity expense was $31,662,000. To put it in perspective, in 2011 we also had thirty-six facilities, and the bad debt charity expense was $24,200,000. In 2010 with thirty-six facilities, bad debt charity expense was $15,981,000. Since 2010, bad debt has doubled state wide among the thirty-six facilities.

7:50
Rep. Kempenich: Hospitals did adapt this last year, the way it looks?

Rep. Weisz: I read them out of order. In 2010 bad debt was $15.9 million; in 2012 it was $31.6 milllion.

8:38
Chairman Delzer: The next part of the bill is the part that dedicates tobacco taxes to the special fund and out of the general fund and putting them into a new fund called Healthcare Delivery Trust Fund.

Rep. Weisz: It transfers all the cigarette tax money from the general fund. The last estimate was $59 million that would go into this new Healthcare Delivery Trust Fund. It's established as a special fund in the state's treasury.

Chairman Delzer: How many other places do we do that, other than road tax?

Rep. Weisz: I do not know. There are not too many.

Chairman Delzer: Normally the ones we have set up are very specific. Your understanding of this is the money would be in there, the amount in all the appropriations in it would come out of that fund with the remaining money staying in that fund. No continuing appropriations in the bill?

Rep. Weisz: Yes, that is how it would work. There are no continuing appropriations.

10:40
Rep. Weisz: Discussed section 6

Chairman Delzer: The number you had was enough?

Rep. Weisz: Based on the difference between the 2.7 and then current number, that would cover that gap in the bad debt.

Chairman Delzer: What's the timeframe? When would they apply for the bad debt to be covered, how often? What timeframe are the covering--all of 2013-2015 and for how long? Or are you talking just about bad debt currently out there and nothing for bad debt in the next two years?

Rep. Weisz: According to the bill, the grants would start 7/1/2013, and end at the end of the biennium.

Chairman Delzer: To come up with the amount, all they did was guess what they will have for bad debt?

Rep. Weisz: Yes. They looked at the trend and assumed it would cover that. My understanding is that beginning of July 2013, you could show where your bad debt is, and if it exceeds that 2.7, then....

Chairman Delzer: If they don't use all the funds in the appropriation, what happens? Normally, carryover money goes back to the general fund.

Rep. Weisz: In this case it would stay in the healthcare delivery trust fund.

Chairman Delzer: Does it say that anywhere?

Rep. Weisz: No, it doesn't. From the language so much of the sum is necessary, so I assumed they would never take it out of the delivery trust fund.

Sheila Sandness, Legislative Council: It would stay there unless there was a provision to transfer it somewhere.

13:38
Rep. Nelson: The number of the grant would be based on the latest cost report filed. The problem with getting a hard number for that is of the thirty-six critical access hospitals, they all have different year end provisions.

Rep. Monson: Was there any discussion about if we set this up and did this, a hospital may decide not to pursue the bad debt as hard as they used to because they will get it reimbursed under this bill?

Rep. Weisz: We had a lot of discussion on that. We will talk about this when we go over Section 12. We already talked about the change in the language requiring the collection of copays that are part of the billing process. That was our number one concern.

Rep. Skarphol: In an e-mail from one of the local hospitals in my regions, their impression of this legislation was they would not receive a payment until 7/1/2014. Is that correct?

Rep. Weisz: I don't think that should be the case. It is retrospective, and it starts July 1, 2013. As Rep. Nelson indicated earlier, it would depend on when their year end is.

Rep. Skarphol: How frequently are they going to do the grants?

Rep. Weisz: Each facility has the ability to receive a grant.

Rep. Skarphol: Are they going to do them as they receive the grant applications and evaluate them? Are they going to do it quarterly, monthly, annually?

Rep. Weisz: That would be up to the department. The assumption was that they would process them when they received the grant request.

Rep. Skarphol: What if they run out of money?

Rep. Weisz: Then I suppose it's first come, first served. That is a potential because it is limited to $20 million.

Chairman Delzer: When you say a grant, are you talking one grant per year? It is one grant per facility per year?

Rep. Weisz: Correct. It would be per calendar year that they have they have that falls within the biennium.

Rep. Nelson: It should be pointed out the reason it would be paid out per year is it is conceivable a hospital would qualify one year of a biennium, and not the other. If they reach a breakeven point or a profit, they no longer qualify for the grant. They may not qualify the first year but qualify the second year. That is an integral part of this. There had been a question about the incentive for a facility to collect bad debt. That's where the retrospective payment comes in. No facility can sit a year with a million dollars of bad debt and operate on a cash flow basis. It's in their best interests not to qualify for this grant because that money is not realized for the period of a year at least.

Chairman Delzer: Did you have any discussion that bad debt doesn't go away just because you collect some money on it. Could they collect the money on this and then go out and make an effort and collect the bad debt afterwards? Is there any repayment if they did that?

Rep. Weisz: This grant isn't dependent, for example, on an individual invoice. Generally it's called bad debt after you've written it off. It would not require that facility to come in two years later and repay.

Chairman Delzer: They don't normally write off bad debt for a number of years. Does that bad debt carry forward to the next year, so if the received a grant on it the first year, it would be on the books for the second year.

Rep. Weisz: It will show up for accounts receivable at some point. They take it off the books from the standpoint that it no longer becomes an asset.

Chairman Delzer: But there is nothing in here that says when the grant is received, they must reduce their bad debt by that amount of money.

Rep. Weisz: When you say reduce their bad debt, you're talking about their financial statement?

Chairman Delzer: Their financial statement. What I'm getting at is if you have a $2 million bad debt and receive a grant for $1 million, what's in the bill that says that the next time they apply, they cannot have the $1 million they received still listed in in their bad debt?

Rep. Weisz: I don't think there's anything in the bill, but I cannot image the Health Department giving a grant... They would have a list of the bad debt, and they would know that they had given a grant for $1 million and would know if it was applied against that.

Chairman Delzer: Only if they applied it to it. The grant does not say it has to be applied to the bad debt. It says the grant is for the bad debt, but it doesn't say that they have to take it off their books.

Rep. Weisz: That is correct. But if they're sending their cost report to the Department of Health, they will see if there had been an allocation against bad debt.

23:08
Rep. Streyle: Was there any discussion on why the bad debt mechanism was used? If we want to support these hospitals, why don't we just appropriate the money?

Rep. Skarphol: If there is a second grant application, is there a provision that the amount used in the first application not be reflected in the next application?

Rep. Weisz: The bill does not say anything specifically to that issue. But they have to send their cost report to the Department of Health to see if they qualify.

Rep. Skarphol: So the cost report you are referring to is encompassing a single year. What we should assume is it reflects only the bad debt they have accumulated in that year.

Rep. Weisz: Absolutely.

Rep. Skarphol: When can they expect a payment? If it's based on the hospital's fiscal year, they might wait a considerable amount of time to get a grant based on its fiscal year.

Rep. Weisz: If a facility's fiscal year ended within a few months of this becomes effective, they can submit the application in July 2013. It doesn't mean that they'll have to wait until their next fiscal year ends. I cannot establish how long the grant process will take.

26:38

Rep. Pollert: To answer Rep. Streyle, for those of us who go through the hospitals for the reimbursement, they're going to have that added on to the cost statement. Every year we're going to go through their cost statement. It automatically raises the price we will pay in a supplemental payment. We get what the case loads are; whether it's inpatient, outpatient, or hospital; and the cost statement. Then they would have a line in there for bad debt. If you give them a grant, and if it's going to be ongoing, I'd suspect it would be on the cost statement and then we would be paying that.

27:33
Rep. Kempenich: I'm trying to figure out the timeline of the money. The full $20 million will not be there on July 1. They have to collect the appropriation before it's available, only $1.5 million goes in every month

Chairman Delzer: I'm not sure the bill would allow them to give the grant for prior years. I think their yearend would have to start after July 1, 2013.

Rep. Weisz: The bill is not clear on that subject.

Chairman Delzer: We'll have to look at that.

28:44
Rep. Weisz: Sections 7, 8, 9, and 10 are current appropriations, currently funded out of the general fund. The sponsor intent was that when we set up this new healthcare delivery trust fund, that we would now fund healthcare-related issues out of that fund. Explained sections 7, 8, 9, 10, 11.

Rep. Pollert: Are these in the Human Services budget or in the Health Department budget?

Rep. Weisz: Health Department.

Unidentified speaker: Is the reason these are in the general fund because of Measure 3?

Unidentified speaker: We had to put them over to general funds to be in compliance.

Chairman Delzer: We're still putting money into the healthcare trust fund; it's still getting that 10%.

Rep. Nelson: The Community Health Trust Fund is what you're referring to. The money that is appropriated into that fund is now used for the tobacco quit line program and the women's way. There may be one small addition to that.

31:24
Rep. Weisz: Section 12 came about as an amended added by the committee, based on the discussions we've had concerning whether facilities will give up on collecting bad debt. It's in addition over the $20 million. What it does is they are giving $700,000 to the Department of Health for the purpose of providing a grant for a program that does collections. It would be run through their hospital association, and it helps them verify

personal and other health insurance information to give them a better handle on how to collect.

Chairman Delzer: If they're carrying this amount of bad debt, you'd have thought they would have invested in this already.

Rep. Weisz: It isn't cheap, especially for smaller hospitals, and it's relatively new. Gave example of when a person goes to a different hospital.

Chairman Delzer: Isn't a large portion of the bad debt from people coming into the emergency room and the hospital has to treat them anyway?

Rep. Weisz: That is the largest portion. I think that roughly 60% of the bad debt is from the emergency room.

33:45
Rep. Skarphol: Was there any discussion of triaging ER patients in order to avoid a bad debt situation?

Rep. Weisz: That did come up. You can ask for payment in an ER, but you can't require it.

Rep. Skarphol: Is that a best practice as perceived by the industry that should be utilized? Does this bill put in provisions that would require them to begin that practice?

Rep. Weisz: No, the bill does not require that. I don't believe all facilities are looking at that, some due to size. Whether that should be in here, I cannot answer that.

Chairman Delzer: A good share of these hospitals are in the oil industry area. How many have increased their emergency beds?

Rep. Weisz: I can't answer that. Williston had been at six and are now at eighteen. Williston testified that they would not even qualify for a grant under this scenario. When we saw some of the financials, there were concerns that there seemed to be some dramatically increased asset costs in some facilities. It's easy to say not to expand an emergency room, but when a person presents himself or herself for service, the hospital has to serve them regardless of the number of beds in the emergency room.

Rep. Skarphol: Does the hospital applying for this grant have the option of choosing which year to apply for this grant? Can they apply for a previous year, or must they apply for the current year? For example, Stanley had $111,000 more bad debts in 2011 than in 2012. Tioga had $356,000 more in 2012 than in 2011. What options are provided?

Rep. Weisz: The bill does not specifically address that, but it is retrospective. I would assume it would be for the most current year. I assume the Health Department would set those rules to ensure that you would not be able to cherry pick which year.

Chairman Delzer: The expiration date, Section 1. Section 1 is effective for two years then is not, but everything else is? Why?

Rep. Weisz: That is correct. The intent of the rest of the bill was to permanently set up the healthcare delivery trust fund to fund future healthcare needs that the state may have.

Chairman Delzer: But Section 1 is your grant section.

Rep. Weisz: That is correct. So this is a two-year, sunset program for the grant part. But the money that goes in that delivery trust fund will still continue to go there with the intent that at some point in the future, then that fund would be used to take care of those needs.

2013 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Committee
Roughrider Room, State Capitol

HB 1433
2/26/13
Job 19456

☐ Conference Committee

Committee Clerk Signature Meredith Trachsel

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 23-01 of the North Dakota Century Code, relating to hospital bad debt relief grants; to amend and reenact sections 57-36-25 and 57-36-26, subsection 1 of section 57-36-31, and section 57-36-32 of the North Dakota Century Code, relating to allocation of tobacco products taxes and the health care delivery trust fund; to provide an appropriation; and to provide an expiration date.

Minutes: You may make reference to "attached testimony."

Chairman Delzer: HB 1433 is the bill that was brought forward for bad debt in hospitals. It would take $59M out of the general fund stream and dedicate it to a new fund. Part of the compromise on this was done in HB 1358 with the $10M granting situation we put in there.

Rep. **Nelson** moved Do Not Pass on HB 1433, seconded by **Rep**. **Skarphol**.

Chairman Delzer: Discussion? Seeing none, a roll call vote was done. The motion carried 21 Yes, 0 No, 1 Absent. **Rep**. **Skarphol** will be the carrier.

FISCAL NOTE
Requested by Legislative Council
02/19/2013

Amendment to: HB 1433

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

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$(57,953,000)	$57,953,000		
Expenditures						
Appropriations						

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

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

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

Engrossed HB 1433 re-allocates cigarette and tobacco tax revenue from the state general fund to the health care delivery trust fund.

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

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

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

If enacted, engrossed HB 1433 is expected to reduce state general fund revenues by an estimated $57.953 million in the 2013-15 biennium, re-allocating that revenue to the health care delivery trust fund.

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

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

Name: Kathryn L. Strombeck
Agency: Office of Tax Commissioner
Telephone: 328-3402
Date Prepared: 02/19/2013

FISCAL NOTE
Requested by Legislative Council
01/22/2013

Bill/Resolution No.: HB 1433

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

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$(57,953,000)	$57,953,000		
Expenditures						
Appropriations				$22,331,000		

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

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

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

HB 1433 re-allocates cigarette and tobacco tax revenue from the state general fund to the health care delivery trust fund.

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

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

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

If enacted, HB 1433 is expected to reduce state general fund revenues by an estimated $57.953 million in the 2013-15 biennium, re-allocating that revenue to the health care delivery trust fund.

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

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

Sections 6 through 11 appropriate $22.331 million from the health care delivery trust fund.

Name: Kathryn L. Strombeck
Agency: Office of Tax Commissioner
Telephone: 328-3402
Date Prepared: 01/28/2013

Date: 2/26/13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1433

House Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Nelson Seconded By Rep. Skarphol

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X		Rep. Streyle	X	
Vice Chairman Kempenich	X		Rep. Thoreson	X	
Rep. Bellew	X		Rep. Wieland	X	
Rep. Brandenburg	X				
Rep. Dosch	X				
Rep. Grande	X		Rep. Boe	X	
Rep. Hawken			Rep. Glassheim	X	
Rep. Kreidt	X		Rep. Guggisberg	X	
Rep. Martinson	X		Rep. Holman	X	
Rep. Monson	X		Rep. Williams	X	
Rep. Nelson	X				
Rep. Pollert	X				
Rep. Sanford	X				
Rep. Skarphol	X				

Total Yes 21 No 0

Absent 1

Floor Assignment Rep. Skarphol

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

REPORT OF STANDING COMMITTEE

HB 1433, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **DO NOT PASS** (21 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1433 was placed on the Eleventh order on the calendar.

2013 TESTIMONY

HB 1433

#1

Testimony for HB 1433

Rep. Jon Nelson District 14

Chairman Weisz and members of the House Human Services Committee, it is with great honor that I appear before you today to introduce HB 1433.

In Section 1 of the bill, a hospital debt relief grant program is established to provide some relief to the growing concern hospitals are facing with bad debt. The formula for hospitals to qualify for the grants would include the hospital assuming the first 2.7% bad debt from gross revenues from inpatient, outpatient, and clinic revenues. Any debt incurred over that established threshold would qualify for the grant payment until the facility reaches a break even position.

Section 2 of the bill creates the funding mechanism for the Healthcare Delivery Trust Fund that would fund the hospital debt relief grant program as well as a number of other healthcare delivery programs. Currently all revenues generated by tobacco products taxed by the state of North Dakota flow into the general fund. With the passage of HB 1433 those revenues would flow into the Healthcare Delivery Trust Fund. For the 2013-15 biennium, estimated tobacco tax revenues are $57,953,000.

Section 4 of the bill would establish the Healthcare Delivery Trust Fund as a special fund in the state treasury and allows for any interest the fund may generate be deposited in the fund.

Section 6 of the bill appropriates $20,000,000 from the Healthcare Delivery Trust Fund for the 2013-15 biennium.

Section 7 of the bill appropriates $576,788 from the Healthcare Delivery Trust Fund for the expenses of the medical loan repayment program which was funded from the general fund in the executive budget.

Section 8 of the bill appropriates $475,000 from the Healthcare Delivery Trust Fund for expenses incurred by the stroke registry and prevention program which is funded from the general fund in the executive budget.

Section 9 of the bill appropriates $276,000 for expenses of the community paramedic project which is a new proposal this biennium and would be funded by the Healthcare Delivery Trust Fund instead of the general fund that the executive budget included.

Section 10 of the bill appropriates $602,600 from the Healthcare Delivery Trust Fund for expenses incurred by the colorectal cancer screening program, which was funded from the general fund in the executive budget.

Section 11 of the bill appropriates $400,000 from the Healthcare Delivery Trust Fund for expenses incurred by the breast and cervical cancer assistance program which was funded in the executive budget from the general fund.

With passage of this bill, healthcare delivery will put into a position of importance that it deserves. This state and each community in it cannot grow or exist without the ability to provide its citizens access to affordable and dependable healthcare. This bill will allow existing and new proposals access to state funding to meet the growing healthcare needs as well as prepare us for the increasing uncertainty of federal legislative and regulatory effects on our healthcare delivery system in North Dakota.

In conclusion, I appreciate your willingness to work with this proposal. I truly believe we need to address the needs of healthcare in a comprehensive manner and I believe this bill begins to do just that. I would hope that the House Human Services Committee will agree and give HB 1433 a Do Pass recommendation.

Thank you.

#2

NORTH DAKOTA SENATE

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Senator John M. Andrist
District 2
P.O. Box E
Crosby, ND 58730-0660
jandrist@nd.gov

COMMITTEES:
Industry, Business and Labor
Political Subdivisions, Chairman

TO: Governor Jack Dalrymple

FROM: Sen. John Andrist

RE: Hospital Emergency Room Bad Debts

Dear Jack:

I promised I would share with you the bad debt figures I gathered from oil patch hospitals. They all tell the same story -- temporary, uninsured oil field workers showing up, then heading home to Idaho (or elsewhere) with no forwarding address.

Stanley -- $523,000 in 2011, $412,000 in 2012

Tioga -- $347,000 in 2011, $703,000 in 2012

Watford City -- $1.1 million (no dates specified).

Crosby -- $114,000 in 2011, $312,000 in 2013.

Stanley and Tioga have voted for sales tax increases, Crosby will vote soon, but say the tax will only help, not heal the problem. Whether we can do anything I don't know, but they all say they are in crisis. Rep. Rust is chairman of the Tioga Hospital, and might be a good resource for further information.

John

#3

Testimony on HB 1433
Rep. David S. Rust, District 2

Mr. Chairman and Members of the House Human Services Committee:

For the record I am Representative David Rust from District 2 in NW ND. I am one of the co-sponsors of HB1433.

Back home, I serve as President of the Tioga Community Center's Board of Directors. In that position I have been made aware of our rapidly increasing "bad debt," mostly from our patients to our Emergency Room.

The week before coming to the Legislative Assembly, I was asked to come to Crosby to meet with members of their medical center about their bad debt and what they described as a "desperate situation in the making."

My initial thoughts were that this was a problem unique to the oil and gas impacted areas. I still believe it is exacerbated by the oil and gas industry, but not totally unique to it. Each month when the business office sends out bills, a large number of them are returned with a yellow label on them stating, "No such address," "Address unknown," or something similar. The Tioga Medical Center's CEO is here today; I've asked him to give you some details on that and the measures we have taken to address it.

Representative Nelson informed me about similar problems in his area of the state. It didn't take long for us to find out that many rural, critical access hospitals in ND are facing financial situations resulting from bad debt that will place these hospitals in jeopardy in the near future.

When you think of it, what is a more basic need in a community than that of a viable hospital and clinic? If I'm suffering a heart attack or been injured in an accident, "nothing" is more important.

You've already been given the basics of the bill. I know there are individuals here who can give you accurate and timely information on HB1433 and its contents. I won't take more of your time, but will defer to them for that information.

I believe HB1433 is critical to rural health care. I ask for your support and would be willing to answer any questions you may have.

If there are no questions, I will return to the House Education Committee and my duties there.

Thank you.

#4

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1433
House Human Services Committee
Hospital Bad Debt Relief Grant
January 29, 2013

Chairman Weisz and members of the House Human Services Committee; I am Jerry E. Jurena, President of the North Dakota Hospital Association (NDHA). I am before you today in support of HB 1433 and ask that you give a Due Pass on HB 1433.

The average Bad Debt in the years 2007 through 2009 was approximately 2.7%. Today the average Bad Debt stands at 5.8%; these are statewide averages. As you will hear today there are hospitals that have experienced their Bad Debt increasing by unbelievable factors. When you consider several of our hospitals operated at a loss prior to the oil boom and are now having to struggle with the added burden of their Bad Debt rising beyond their control, access to health care in rural areas is in jeopardy.

We all understand that every business has some uncollectable debt; however, hospitals have been hit extremely hard due to: an increase in utilization from out of state workers and regulations mandating we assess, treat and stabilize every individual that comes to our Hospitals. In order for us to continue to meet our mission of providing quality health care to anyone needing health care services we do need some assistances at this time.

Today you will hear from Dan Kelly from McKenzie County Health Care System in Watford City, Matt Grimshaw from Mercy Medical Center in Williston, Randy Pederson from Tioga Medical Center in Tioga, and Darrold Bertsch from Sakakawea Medical Center in Hazen. There are several others who have expressed an interest in testifying; however, I believe you will get the point from these individuals. Other testimony will be submitted in writing.

I ask that you give HB 1433 a Due Pass. If you have question I will be glad to answer them at this time or upon the conclusion of the other testimonies.

Jerry E. Jurena, President
North Dakota Hospital Association

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

St. Luke's Hospital
702 1st Street SW
P. O. Box 10
Crosby, ND 58730
701-965-6384

Crosby Clinic
702 1st Street SW
P. O. Box C
Crosby, ND 58730
Crosby Clinic: 701-965-6349
Lignite Clinic: 701-933-2220

January 29, 2013

Robin Weisz, Chairman
House Human Service Committee

Dear Mr. Chairman:

My name is Les Urvand and I am the Administrator of St. Luke's Hospital & Clinics in Crosby, North Dakota.

My testimony is in favor of **HB 1433**.

Crosby's small 15-bed hospital has been impacted by oil exploration and tremendous growth has occurred in emergency room visits. Bad debts have increased accordingly in both our Hospital and Clinic.

As a Critical Access Hospital, the ER visit increase hurts the hospital two ways:

1. The hospital does not get paid for these visits, thereby bad debt accumulates; and
2. These ER visits are not Medicare visits; therefore, Medicare's share of running the ER is reduced and they pay the Hospital proportionally less.

Number of Emergency Room Visits at St. Luke's Hospital, Crosby:

2008	2009	2010	2011	2012	2013 (Estimated)
288	371	400	541	817	545 (6 months)

ER visits have increased from FY 2010 to FY 2012 by 104%.

Amount of Bad Debts per year:

2008	2009	2010	2011	2012	2013 (Estimated)
$65,681	$77,353	$88,146	$114,799	$312,092	+$450,000

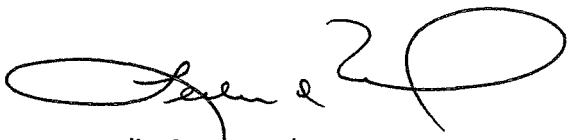
Bad debts have risen from FY 2010 to FY 2012 by 254%.

All bad debts written off by St. Luke's Hospital are turned over to a collection agency. St. Luke's has also added credit card availability to collect co-pays and deductibles.

The Emergency Room is much harder to collect from due to federal restrictions called EMTLA and the stipulations on seeing the patient before any collection efforts can be made.

St. Luke's Hospital's Board of Directors and its Administration are very much in favor of passing HB 1433.

Sincerely,



Leslie O. Urvand
Administrator

#6

Testimony
House Bill 1433 – House Human Services Committee
Representative Weisz, Chairman
January 29, 2013

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Darrold Bertsch and I am the CEO of Sakakawea Medical Center in Hazen and the Interim CEO of Coal Country Community Health Center in Beulah. I am here to present testimony in support of House Bill 1433.

Sakakawea Medical Center is a 25 bed Critical Access Hospital that also owns and operates a variety of services including Basic Care Services and a Rural Health Clinic. Sakakawea Medical Center, as the majority of CAHs in the state, has experienced an increase in uncompensated care relating to Bad Debt and Charity Care, which in our case currently exceeds 7% of Hospital Inpatient, Outpatient and Clinic patient revenue.

Critical Access Hospitals are designated as such, by meeting certain licensure requirements of CMS (Centers for Medicare and Medicaid Services) and being an important facility for rural residents to access primary care services. When designated as a CAH, facilities are reimbursed 101% of allowed cost for providing services to Medicare beneficiaries. Medicaid in North Dakota reimburses CAHs the cost of providing services and/or a fee schedule which often falls below the cost of providing services. BCBS in our state reimburses via an aggressive fee schedule for the services provided. All this being said, when facilities experience an increase in bad debt, an already challenging ability to generate a positive or break even operating margin becomes even more difficult. This is the current case with the CAHs in North Dakota, with 25 of 36 facilities having experienced operating losses in 2012.

We are not advocating for the state to make facilities whole through this legislation, but instead are here to advocate that this could be but one of several areas that could assist facilities in maintaining services to their local communities. Increased Medicaid reimbursement being proposed in the Governor's proposed budget and increased reimbursement to rural providers from BCBS of North Dakota in 2012 will also aid with the financial challenges the CAHs are facing. Additionally, communities and counties are stepping up to the plate locally by initiating City Sales Tax provisions or mill levies to support local health care. Facilities are enhancing collection procedures in their

hospitals and clinics and facilities are expanding the work of their foundations to increase local financial support. All of these are an important broad brush approach to addressing the financial challenges being faced by the state's rural hospitals and clinics.

Bad Debt/Charity Care expense for the state's CAHs has doubled in the last 2 years, and for some facilities located in the heart of the oil activity, this expense has grown by 500% and in the case of one facility, by 10 fold over the last 3years. As I gather data for completing the annual financial analysis of the state's CAH's, facility CEOs are indicating to me that this problem continues to get worse. But I must emphasize that this is not just a western North Dakota issue, it is a statewide concern though the impact to the areas in or near the oil activity is greater.

Financial Analysis of North Dakota CAHs: To help validate the importance of this proposed assistance in Bad Debt/Charity expense being incurred, I'd like to provide some additional information relating to a recently completed financial analysis of the state's Critical Access Hospitals.

First of all, in *Slide 2,* I have included a map of the hospitals in North Dakota. This map shows the 6 larger acute care hospitals located in Bismarck (2), Minot, Grand Forks, and Fargo (2). The map also shows the 36 CAH locations throughout the state.

In *Slides 3 through 9* you will see the results of the most recently completed financial analysis of the state's CAHs. This analysis was completed in September of 2012. For the last 6 years I have requested financial information from the state's CAHs and have summarized the data for various purposes, including advocacy with individuals and constituencies including CEOs, Boards, Associations, Legislators, the Insurance Commissioner, the Department of Human Services, BCBS of ND, etc. In the information that I have included with my testimony, I have compared financial information for calendar years 2011 and 2012. I have also compared information for facilities located east of Highway 83 and those located west of Highway 83 that have a greater impact from the oil activity.

On S*lide 3,* I have highlighted that 36 facilities were included in the study, and that these 36 CAHs also own and operate 14 nursing homes, 45 Rural Health Clinics and 9 their local ambulance service. On *Slide 4,* I have included a summary Statement of Operations. There you will see that the gross patient revenue generated by providing care to patients and the net revenue realized increased by 8% while expenses increased

by 10%. You will also notice that Bad Debt/Charity Care expense grew by a staggering 30 % from 2011 to 2012. All this resulted in an increase in the median operating loss for all CAHs from 2011 to 2012, -.2% to -2.3% respectively.

Slides 5 and 6 provide graphs comparing the operating margins of the state's Critical Access Hospitals for 2011 and 2012. You will see that more facilities experienced operating losses in 2012 than 2011 with 25 of the state's 36 CAHs experiencing operating losses in 2012. Fifteen of these 25 CAHs have experienced operating losses in at least 5 of the 6 years that I have completed my analysis. Nine of the facilities have experienced operating losses in all 6 years.

In *Slide 7,* I have provided a Statement of Operations that compares CAHs located west of Highway 83 with those located east of Highway 83. Though facilities on both sides of the state experienced operating losses, you will notice that those west of Highway 83 incurred a more significant median operating loss, that being -5.3% compared to a median loss of -2.0% for facilities in eastern North Dakota

Slide 8 compares financials for 2011 and 2012 for facilities located in western North Dakota. While patient revenue increased by 12% from 2011 to 2012, Bad Debt/Charity Expense increased by **46%**, resulting in a net revenue increase of only 10%. With the increase in expenses of 15%, the resultant median operating loss was -5.3% in 2012.

In *Slide 9,* I again show the same graph of 2012 operating margins for all CAHS, but have highlighted the facilities from western North Dakota in red bars on the graph.

Attachments following the slides provide the detail information relating to the financial analysis, including a listing of CAHs and the services they provide. A summary trended analysis for the 6 years of the study is also included.

In reviewing the financial information that I have provided, you can see that the state's CAHs are experiencing increasing financial challenges. Facilities are working diligently to maintain services while facing these challenges. A concerted effort is being made to reduce costs where possible, advocating with payers for increased reimbursement, increasing the work of foundations and soliciting local city and county governments for financial support. We are also becoming more aggressive in collection processes than we have ever been before. We can't raise the rate of what we charge for our services in order to offset these increases in the uncompensated care that we provide, due to the fixed fee schedule and cost based reimbursement we receive for the services provided.

The assistance being proposed in HB1433 will aid those facilities experiencing operating losses and those with excessive Bad Debt/Charity Care expense. I would ask for your support of HB 1433. Thank you for the opportunity to provide this testimony. I would be happy to answer any questions you may have.

Darrold Bertsch, CEO
Sakakawea Medical Center
510 8th Ave NE
Hazen, North Dakota 58545
Coal Country Community Health Center, Interim CEO
Email address: dbertsch@sakmedcenter.org,
Telephone 701-748-7240, Cell phone 701-880-1440

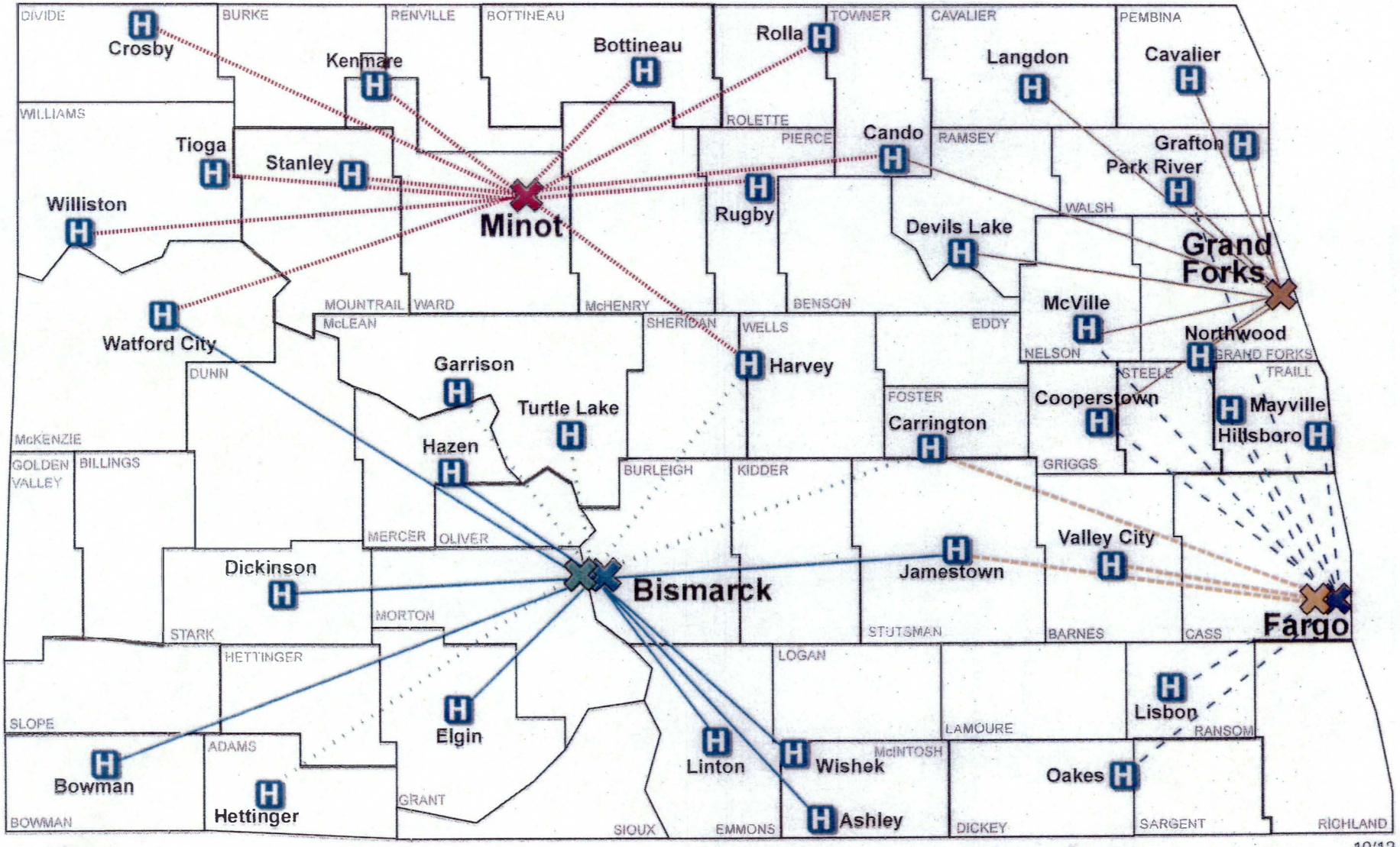
North Dakota

36 Critical Access Hospitals (CAH)

Financial Analysis Information!

Compiled September 2012

North Dakota Critical Access Hospitals & Referral Centers



10/12

Referral Centers

Trinity Hospital ..... Altru Hospital ———

St. Alexius Medical Center . . . . . Sanford Health - - - - - - -

Sanford Bismarck Medical Center & St. Alexius ——— Sanford & Essentia Health ———

Critical Access Hospitals H

Center *for* Rural Health

The University of North Dakota School of Medicine & Health Sciences

North Dakota CAH Financial Analysis

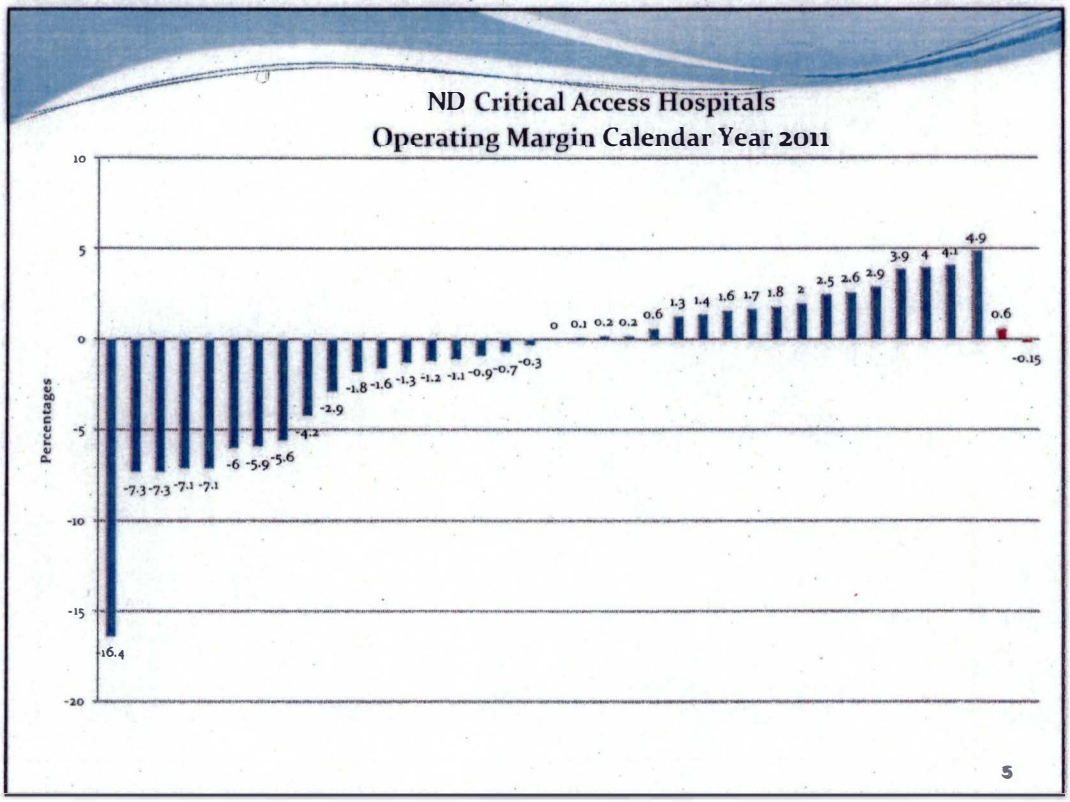
- Observations
  - Financial Analysis Done for Last 6 Years
  - 36 Facilities Reported Their Financial Information in 2012
  - 14 of 36 Facilities Own/Operate a Nursing Home – 697 Beds
  - 9 Facilities Own and Operate the Local Ambulance
  - 30 of 36 Facilities Own/Operate a Clinic
    - 30 Facilities Who Own/Operate Clinics, Operate 60 Clinics
      - 45 Are Rural Health Clinics (RHCs)
      - There are 59 Total RHCs in North Dakota
      - Current Average Medicaid RHC Reimbursement is $81.30
      - Current Average Medicare RHC Cost is $134.50

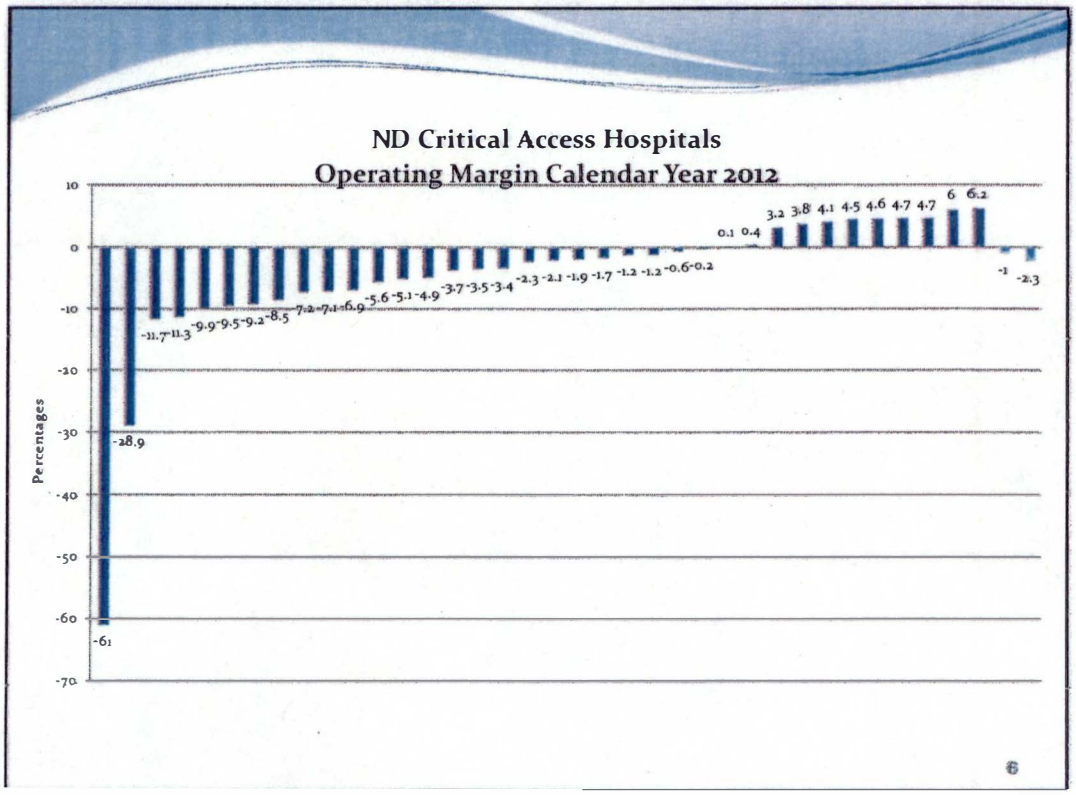
3

North Dakota Critical Access Hospitals
Statement of Operations Analysis

	36 Facilities 2011 Total	% Change	36 Facilities 2012 Total
Patient Revenue	$591,453,259	+8%	$638,294,819
Deductions	$164,386,960	+4%	$171,454,221
Bad Debt/Charity	$24,225,505	+30%	$31,662,236
Net Revenue	$402,840,794	+8%	$435,178,362
Expenses	$399,293,917	+10%	$441,580,857
Operating Margin	$3,546,877		-$6,402,495
Operating Margin Median%	**- 0.2%**		**-2.3%**
Non Operating Rev.	$14,870,838		$9,263,386
NET Income/Loss	$18,417,715		$2,860,891
Net Margin Median %	*1.2%*		*-0.5%*

4


ND Critical Access Hospitals
Operating Margin Calendar Year 2011
Percentages
10
5
0
-5
-10
-15
-20
-16.4
-7.3 -7.3 -7.1 -7.1
-6 -5.9 -5.6
-4.2
-2.9
-1.8 -1.6 -1.3 -1.2 -1.1 -0.9 -0.7
-0.3
0 0.1 0.2 0.2 0.6 1.3 1.4 1.6 1.7 1.8 2 2.5 2.6 2.9 3.9 4 4.1 4.9 0.6
-0.15
5


ND Critical Access Hospitals
Operating Margin Calendar Year 2012
Percentages
10
0
-10
-20
-30
-40
-50
-60
-70
-61
-28.9
-11.7 -11.3
-9.9 -9.5 -9.2 -8.5
-7.2 -7.1 -6.9
-5.6 -5.1 -4.9
-3.7 -3.5 -3.4
-2.3 -2.1 -1.9 -1.7 -1.2 -1.2 -0.6 -0.2
0.1 0.4 3.2 3.8 4.1 4.5 4.6 4.7 4.7 6 6.2
-1 -2.3
6

North Dakota Critical Access Hospitals
Statement of Operations Analysis
Comparing CAHS East of 83 with Those West of 83

	East of 83 2012 Total	West of 83 2012 Total
Patient Revenue	$351,627,335	$286,667,484
Deductions	-$103,229,146	-$ 99,887,311
Net Revenue	$248,398,189	$186,780,173
Expenses	$250,621,791	$190,959,066
Operating Margin	- $2,223,602	- $4,178,893
Operating Margin Median %	**-2.0%**	**-5.3%**
Non Operating Rev.	$6,582,282	$2,681,104
NET Income/Loss	$4,358,680	-$1,497,7989
Net Margin Median %	*0.9%*	*-2.1%*

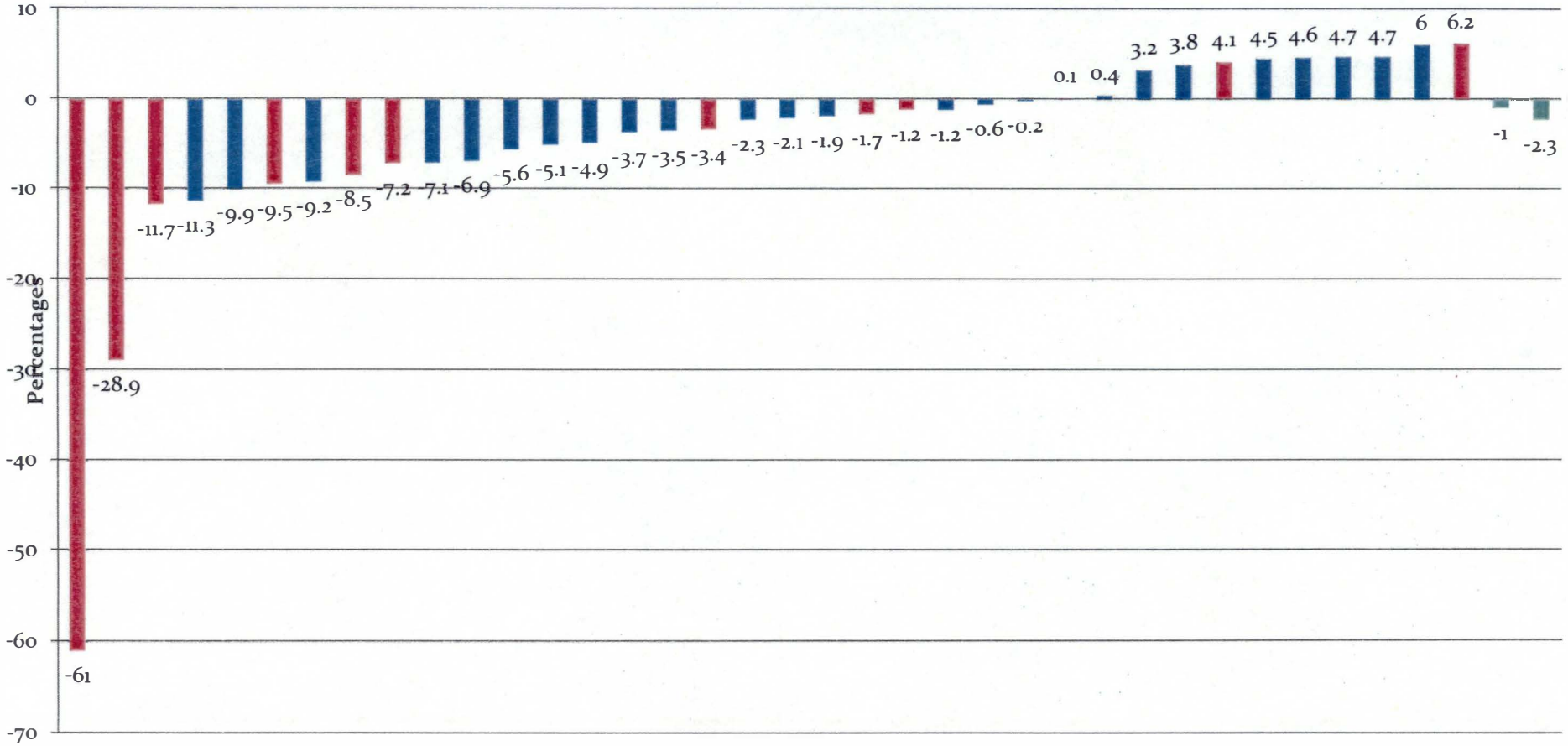
7

North Dakota Critical Access Hospitals
Statement of Operations Analysis
2011 and 2012 Comparison of CAHs West of 83

	West of 83 2011 Total	West of 83 2012 Total	2011-2012 Variance %
Patient Revenue	$255,979,823	$286,667,484	+12%
Bad Debt Expense	-$12,791,293	-$18,716,859	**+46%**
Deductions	-$73,801,994	-$81,170,452	+11%
Net Revenue	$169,386,536	$186,780,173	+10%
Expenses	$166,079,261	$190,959,066	+15%
Operating Margin	$3,307,275	- $4,178,893	-226%
Operating Margin Median %	**0.1%**	**-5.3%**	
Non Operating Rev.	$5,657,930	$2,681,104	-53%
NET Income/Loss	$8,965,205	-$1,497,789	
Net Margin % Median	*0.8%*	*-2.1%*	

8

ND Critical Access Hospitals
Operating Margin Calendar Year 2012
Facilities West of Hiway 83 in Red



North Dakota Critical Access Hospitals
Services That Are Owned/Operated
lendar 2012

10/07/2012

Margin	Community	CAH Hospital	Nursing Home Beds		Basic Care	Assisted Living	Apartments	Clinic	Ambulance	Home Care
	Ashley	20 Beds	44 Beds				34 Units	RHC - 2		Yes, Term
	Bottineau	25 Beds					14 Units	Jointly Own		
	Bowman	23 Beds	59 Beds	<		12 Units	14 Units	RHC	Yes	
	Cando	20 Beds	37 Beds	<	7 Beds		10 Units	RHC - 1 of 2		
	Carrington	25 Beds			24 Beds			RHC - 2	Yes	
	Cavalier	25 Beds	50 Beds				20 Units	RHC		
	Crosby	25 Beds						RHC - 3		
	Cooperstown	18 Beds	48 Beds			12 Units		RHC		
	Devils Lake	25 Beds								
	Dickinson	25 Beds						RHC 2 of 5		
	Elgin	21 Beds	25 Beds					RHC - 2		
	Garrison	22 Beds	28 Beds					RHC		
	Grafton	14 Beds	<					RHC		
	Harvey	25 Beds	95 Beds	<			16 Units			
	Hazen	25 Beds			30 Beds			RHC		Yes
	Hettinger	25 Beds						RHC - 5 of 7	Yes	
	Hillsboro	16 Beds	48 Beds	>		16 Units			Yes	
	Jamestown	25 Beds						Yes		Yes
	Kenmare	25 Beds						RHC		
	Langdon	25 Beds						RHC - 1 of 2	Yes	
	Linton	14 Beds				11 Units		RHC - 2 of 3	Yes	
	Lisbon	25 Beds								
	Mayville	25 Beds						Yes		
	McVille	19 Beds	39 Beds			12 Units		RHC - 2		
	Northwood	12 Beds	56 Beds	<	5 Beds	6 Units	10 Units		Yes	
	Oakes	20 Beds						Yes- 2		
	Park River	14 Beds						RHC		
	Rolla	25 Beds						RHC		
	Rugby	25 Beds	80 Beds		68 Beds	37 Units		RHC 3 of 4	Yes	
	Stanley	11 Beds						RHC		
	Tioga	25 Beds	30 Beds				22 Units	RHC - 3		
	Turtle Lake	25 Beds						RHC		
	Valley City	25 Beds								
	Watford City	24 Beds	47 Beds		9 Beds	16 Units	8 Units	RHC		
	Williston	25 Beds						Yes 2		
	Wishek	24 Beds						RHC - 4	Yes	Yes
13 18 11	**Facilities**	36	14		6	8	9	30	9	4
27 27 34 36 36 36	**Total**	792	697		143	122	148	60 45 RHCs		

CAH Financials Analysis 01/21/2013

Facility Statement of Operations Summary

Description	27 Facilities Calendar 2007 Total	27 Facilities Calendar 2008 Total	34 Facilities Calendar 2009 Total	36 Facilities Calendar 2010 Total	36 Facilities Calendar 2011 Total	36 Facilities Calendar 2012 Total
Patient Revenue						
Inpatient	31,578,867	33,974,027	95,710,180	111,727,623	107,759,922	105,751,786
Outpatient	82,825,552	93,034,353	224,786,849	275,106,239	312,236,770	357,270,585
Clinic	20,417,754	23,112,679	45,060,581	58,665,595	70,204,748	77,427,522
Swingbed	11,586,688	10,843,808	19,904,926	18,988,857	22,318,665	23,308,887
Long Term Care	38,005,155	39,418,947	42,195,113	44,825,255	48,741,407	48,526,505
Basic Care	2,444,099	2,746,861	3,587,444	3,375,736	3,524,517	3,686,750
Ambulance	2,233,006	2,319,363	3,075,332	3,362,294	4,164,004	4,324,743
Home Care	795,043	817,536	4,885,086	5,841,217	4,688,454	1,299,445
Independent Apartments	1,106,897	1,149,345	1,245,684	980,470	976,118	1,074,358
Assisted Living	491,532	520,662	667,172	1,520,586	1,906,486	1,787,821
Total Patient Revenue	191,484,592	207,937,581	441,118,367	524,393,872	576,521,091	624,458,402
Other Operating Revenue	3,121,043	3,505,845	10,217,579	13,007,817	14,932,168	13,836,417
Total Operating Revenue	**194,605,635**	**211,443,426**	**451,335,946**	**537,401,689**	**591,453,259**	**638,294,819**
Contractual Deductions						
Medicare Contractuals	19,161,621	23,960,975	73,884,354	82,703,151	78,561,206	74,775,074
Blue Cross Contractuals	8,837,453	9,957,376	31,994,643	39,848,307	45,594,173	53,285,498
Medicaid Contractuals	4,213,832	4,384,599	13,240,118	15,685,230	19,626,838	19,793,566
Other Contractuals	3,358,512	4,268,129	14,063,340	18,154,134	20,604,743	23,600,083
Bad Debt/Charity Expense	3,522,554	3,789,830	13,931,728	15,981,219	24,225,505	31,662,236
Total Deductions	39,093,971	46,360,909	147,114,183	172,372,041	188,612,465	203,116,457
NET PATIENT REVENUE	**155,511,664**	**165,082,517**	**304,221,763**	**365,029,648**	**402,840,794**	**435,178,362**
Operating Expenses						
Salaries, Wages, Benefits	95,239,590	100,472,352	180,338,765	203,861,579	223,964,331	240,129,356
Purchased Service/Other	24,302,246	26,011,704	67,727,995	87,063,450	85,623,149	110,994,817
Supply Expense	29,592,066	31,969,946	43,357,593	46,288,863	58,065,215	51,899,319
Utilities	3,428,846	3,614,698	8,523,082	8,653,528	8,028,247	8,885,511
Depreciation & Amortization	7,473,330	8,413,273	14,882,424	18,990,211	19,312,081	23,767,115
Interest Expense	1,429,793	1,728,740	3,287,894	3,796,192	4,300,894	5,904,739
Total Expenses	161,465,871	172,210,713	318,117,753	368,653,823	399,293,917	441,580,857
Net Operating Margin	**(5,954,207)**	**(7,128,196)**	**(13,895,990)**	**(3,624,175)**	**3,546,877**	**(6,402,495)**
Operating Margin % (Median)	***-3.8%***	***-3.2%***	***-2.0%***	***-1.4%***	***-0.2%***	***-2.3%***
Non Operating Revenue						
Governmental Subsidies	114,157	389,535	596,601	922,418	662,899	871,565
Foundation Gifts	496,680	666,254	1,150,255	1,095,878	1,050,091	2,406,629
Grants	748,966	1,225,573	1,408,766	1,046,609	1,202,943	2,443,263
Other Donations	1,445,665	1,593,705	1,654,742	1,448,276	1,643,462	1,344,863
Other Non Operating Revenue	1,307,103	1,375,828	604,541	(7,153,102)	10,311,443	2,197,066
Total Non Operating Rev.	4,112,571	5,250,895	5,414,905	(2,639,921)	14,870,838	9,263,386
NET INCOME/LOSS	**(249,444)**	**(1,877,301)**	**(8,481,085)**	**(6,264,096)**	**18,417,715**	**2,860,891**
Net Margin % (Median)	***-1.7%***	***-2.0%***	***-0.6%***	***-0.7%***	***1.2%***	***-0.5%***

#7

Testimony In Favor of House Bill 1433
Human Services Committee
January 29, 2013

Chairman Weisz and members of the House Human Services Committee, I thank you for the opportunity to offer a real time observation of the difficulties healthcare facilities are presently experiencing. My name is Daniel Kelly, and I am the Chief Executive Officer of the McKenzie County Healthcare Systems, Inc. in Watford City, North Dakota. The McKenzie County Healthcare Systems, Inc. consists of the Critical Access Hospital, Skilled Nursing Facility, Basic Care Facility, Assisted Living Facility, Rural Health Clinic and the Connie Wold Wellness Center. My testimony this morning pertains to the hospital.

Healthcare systems in general and the McKenzie County Healthcare System specifically are facing the following operational challenges:

Staff Recruitment and Retention
Increased Staffing Expense
Housing
Increased Utilization of Emergency Services
Increased Emergency Room Provider Costs
Significant Rise in Bad Debt
A Lack of Day Care

I will briefly address each of these.

Staffing Recruitment and Retention-We are experiencing an increase in open positions principally in dietary, housekeeping, maintenance and certified nurse aid positions. At any one time we have had a high of 32 to a low of 17 open positions. Long term employees that have come into oil income have retired or quit, their children are not seeking employment and individuals are leaving the area. In concert with the diminished workforce we are experiencing an inability to offer competitive wages. Despite having increased the starting wage of a housekeeper to $11.00 they can work at the local gas station for $14.00 per hour or elect to clean oil employee housing units for $20.00 per hour.

Increased Staffing Expense-To maintain quality healthcare we have used "traveler staff." Our November Human Resources report notes that for that one month at the hospital alone we incurred traveler staff expense of $24,648.27. This figure does not include the traveler staff expense we incur for the nursing home, rural health clinic or physician coverage in the emergency room. For the month of November the healthcare system incurred $175,426.23 in traveler or locum physician expense.

Housing- There is a shortage of affordable apartments and/or homes to purchase. Apartments easily rent for $1500.00 and those few homes that are listed for sale have asking prices of in excess of $250,000.00. I currently have staff that have accepted an employment offer but have not started working given they cannot find an affordable place to live.

Increased Utilization of Emergency Services-Thus far, the report notes an increase in open positions, a lack of reasonably priced apartments and/or homes and to that mix is added the appreciable increase in the utilization of emergency services currently experienced by the healthcare system.

In fiscal year 2011 we averaged 256 emergency room visits per month. We averaged 159 emergency room visits per month in fiscal year 2010. In contrast to the above presently average in excess of 400 visits per month. For many months we are seeing in excess of 500 patients.

This increased activity results in two areas of concern.

> **Physical Space-**At times the healthcare system is seeing four patients present at the same time as a result of traffic accidents. The emergency room was not designed to handle that volume of patients.
>
> **Trauma-**While this facility is equipped to handle trauma cases, the frequency with which those cases are presenting has increased creating a strain on our physical and manpower resources.

Increased Emergency Room Provider Costs-Prior to the marked increase in Emergency Room visits the hospital would staff the department by having a clinic physician leave the clinic and come to the emergency room. With this increase in activity and especially given the increase in trauma or cases of a more serious nature, our clinic physician frequently had to spend their “clinic hours” covering the emergency room. Thus the clinic patients were frustrated given the difficulty they experience in scheduling a clinic visit exasperated by the possibility that they would not get to see the physician as their provider was providing coverage in the emergency room.

To address this growing community discontent we are now covering the emergency room with contracted emergency room physicians. Until we can recruit permanent providers to fill this need we are using the services of locum tenens physicians at appreciable expense.

Significant Rise in Bad Debt- For the 2012 fiscal year the healthcare system wrote off $1,218,185 in bad debt compared to $659,284 for the prior fiscal year and $300,151 for the preceding year. This despite our investing approximately

$50,000.00 in verification software and implementing up front collection processes. This impacts our hospital and clinic operations more than our nursing home.

Day Care- Our City and County are presently seeking ways to address this shortage. If we are able to overcome the obstacles of starting salary and housing often times the lack of day care for working mothers precludes our hiring much needed employees.

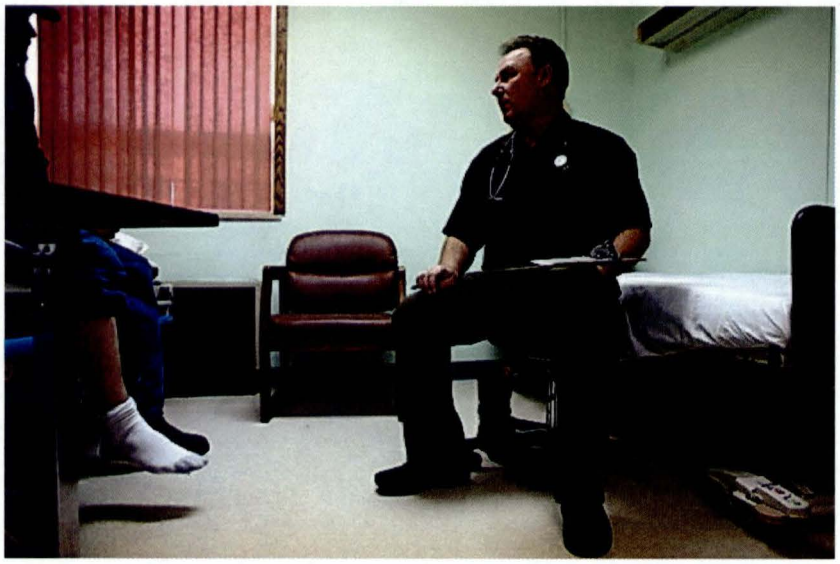
I, as Chief Executive Officer, am trying everything I know possible to address these operational issues. Despite our investment in verification software and the implementation of upfront collections we have not stemmed the tide of increases in bad debt. The assistance afforded us in House Bill 1433 will make the difference between our continuing to offer healthcare services in the region over the next three years or our closing.

I thank you for affording me this opportunity to share with you what is happening not only in western North Dakota but throughout the State. I would be happy to explain any of these items further or to answer any questions the committee may have.

Daniel Kelly, CEO
McKenzie County Healthcare Systems, Inc.
516 North Main Street
Watford City, North Dakota 58854
(701) 842-3000

Email: dkelly@mckenziehealth.com

An Oil Boom Takes a Toll on Health Care



Matthew Staver for The New York Times

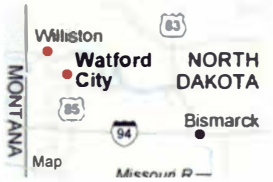
Dr. Gary Ramage treating a patient at McKenzie County Hospital in Watford City, N.D. The hospital now averages 400 emergency room visits per month. More Photos »

By JOHN ELIGON
Published: January 27, 2013

WATFORD CITY, N.D. — The patients come with burns from hot water, with hands and fingers crushed by steel tongs, with injuries from chains that have whipsawed them off their feet. Ambulances carry mangled, bloodied bodies from accidents on roads packed with trucks and heavy-footed drivers.

Multimedia

Hospitals and the Oil Boom in North Dakota



The furious pace of oil exploration that has made North Dakota one of the healthiest economies in the country has had the opposite effect on the region's health care providers. Swamped by uninsured laborers flocking to dangerous jobs, medical facilities in the area are sinking under skyrocketing debt, a flood of gruesome injuries and bloated business costs from the inflated economy.

The problems have been acute at McKenzie County Hospital here. Largely because of unpaid bills, the hospital's debt has climbed more than 2,000 percent over the past four years to $1.2 million, according to Daniel Kelly, the hospital's chief executive. Just three years ago, Mr. Kelly

FACEBOOK
TWITTER
GOOGLE+
SAVE
E-MAIL
SHARE
PRINT
SINGLE PAGE
REPRINTS

MOST E-MAILED RECOMMENDED FOR YOU

1. INDIA INK
Share Your Views on Violence Against Women in India

2. Lopez Declines to Testify on Allegations That He Sexually Harassed Aides

3. Looking to Israel for Clues on Women in Combat

4. AT WAR
Roundup: Israel and Canada Provide Lessons on Women in Combat

5. NICHOLAS D. KRISTOF
She's (Rarely) the Boss

6. For 3 Women, Combat Option Came a Bit Late

7. Married to the Plan. Still Looking for a Possible Groom.

8. Chinese Party and Business Officials Fired in Sex Scandal

9. NICHOLAS D. KRISTOF
Getting More Women in Leadership

added, the hospital averaged 100 emergency room visits per month; last year, that average shot up to 400.

Over all, ambulance calls in the region increased by about 59 percent from 2006 to 2011, according to Thomas R. Nehring, the director of emergency medical services for the North Dakota Health Department. The number of traumatic injuries reported in the oil patch increased 200 percent from 2007 through the first half of last year, he said.

The 12 medical facilities in western North Dakota saw their combined debt rise by 46 percent over the course of the 2011 and 2012 fiscal years, according to Darrold Bertsch, the president of the state's Rural Health Association.

Hospitals cannot simply refuse to treat people or raise their rates. Expenses at those 12 facilities increased by 15 percent, Mr. Bertsch added, and nine of them experienced operating losses. Costs are rising to hire and retain service staff members, as hospitals compete with fast food restaurants that pay wages of about $20 an hour.

"Plain and simple, those kinds of things are not sustainable," he said.

Many of the new patients are transient men without health insurance or a permanent address in the area. In one of the biggest drivers of the hospital debt, patients give inaccurate contact information; when the time comes to collect payment, the patients cannot be found. McKenzie County Hospital has invested in new software that will help verify the information patients give on the spot.

Mr. Kelly has pushed for the state, which has a surplus of more than $1 billion, to allocate money intended for the oil region specifically to health care facilities in the area. He has also asked for the state to grant low-interest loans so hospitals can borrow money for facility improvements and for the governor to convene a task force to study health care issues in the oil patch.

Aides to Gov. Jack Dalrymple say he is taking steps to bolster medical training in the state, proposing to spend $68 million on a new medical school building at the University of North Dakota and $6 million to expand the nursing program at Lake Region State College. Mr. Dalrymple, a Republican, has also increased Medicaid financing for the state's rural hospitals.

"Health care is certainly one of those areas that was targeted early on as we've seen growth out west," said Jeffrey L. Zent, a spokesman for the governor.

Public utility numbers suggest that the population of Watford City has more than quadrupled to 6,500 over the past two years, Mr. Kelly said. In nearby Williston, considered the heart of the oil boom, the population, including temporary workers, has swelled to 25,000 to 33,000 from fewer than 15,000 in 2010, according to a study by North Dakota State University.

The huge population growth has produced new communities virtually overnight, creating logistical problems that affect the quality of medical care.

After a recent emergency call, Kelly Weathers, who has worked as a paramedic in the region for nearly 25 years, drove in circles with his team for about 15 minutes, searching for the address where they had been sent to treat a man who had hurt his back falling off a piece of equipment. But they could not find the street because a sign had not yet been erected. Eventually, a colleague of the injured man met the ambulance at the highway and escorted them to the site.

Mr. Weathers, who works for the Mountrail County Health Center in Stanley, said that in the past, "all the volunteers, they didn't go by street signs."

1 | 2 NEXT PAGE »

A version of this article appeared in print on January 28, 2013, on page A9 of the New York edition with the headline: An Oil Boom Takes a Toll on Health Care.

#8

Testimony of HB 1433
House Human Services
January 29, 2013

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Randall Pederson. I am the President/CEO of Tioga Medical Center in Tioga ND for almost eight years, and prior to becoming the CEO, I was the CFO at Tioga Medical Center for twenty five years. Tioga Medical Center is located in Tioga ND in eastern Williams County. Tioga Medical Center comprised of a 25 bed Critical Access Hospital, a 30 bed skilled nursing facility, three Rural Health Clinics in Tioga, Ray and Powers Lake ND, and a 22 unit independent living unit. We presently employ 1 full-time physician and 2.5 physician assistants. We also contract with an outside clinic to provide additional physician services for our clinics and hospital.

I am here today to testify in support of HB 1433 that will establish grant funds for eligible hospitals to help offset bad debts incurred by hospitals.

"The mission statement of Tioga Medical Center is to address the health care needs of the community through providing quality health care and promoting education and wellness."

Tioga Medical Center Hospital opened its doors in 1961 and recently celebrated 50 years of providing quality health care to the community in 2011. As we continue to strive to meet our mission, the amount of bad debt that our hospital and clinics are incurring is putting that mission in jeopardy.

In FY2012 our hospital gross revenue per our audited financial statement was $5,960,714 and our clinic gross revenue was $1,897,543. In FY2011, the hospital gross revenue was $5,420,233 and our clinic gross revenue was $1,394,611.

Listed below are the bad debts amounts from our audited financial statements:

FY2012	$703,181
FY2011	$341,562
FY2010	$167,018
FY2009	$133,745
FY2008	$140,323
FY2007	$103,014

You can see the trend of bad debt that our Medical Center has seen over the past six years. Bad debt amounts like these, especially in the past two years, have prevented our Medical Center from giving needed raises in pay to our employees to meet the ever increasing cost of living in western North Dakota, especially in the area of rent or housing. We are also challenged with not being able to recruit entry level positions, especially in nursing, dietary and housekeeping.

The operational losses of the Medical Center for FY2012 and FY2011 have been $124,005 and $334,624 respectively. These losses include the entire operation, including the hospital, nursing home, clinics and independent living units.

Operational Losses for Hospital/Clinic
FY 2012 = ($274,775)
FY 2011 = ($466,473)

As a point of note, the last monthly statement run for hospital accounts were mailed out on January 18, 2013. From that statement file that was printed and mailed out, Tioga Medical Center has had the United State Postal Service (USPS) return 50 envelopes stating that the address on our statement is undeliverable. Of those 50 statements that have been received back, there is $78,324.78 for services rendered owed to our hospital. Many times the Medical Center will receive many statements back in the mail at the same time because the patient kept their mail box, left and didn't provide a forwarding address. When the box rent comes due, the USPS will return those statements to us. This doesn't even include the statements that are returned when our clinics send out their statements. As of December 2012, the accounts receivable owed to the Tioga Medical Center has increased by $1,021,231 compared the previous year.

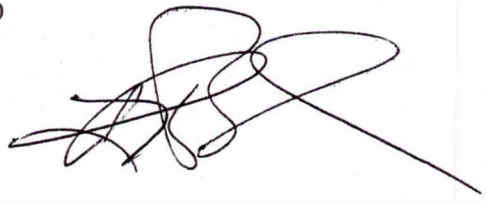
These kinds of numbers have forced Tioga Medical Center to develop a "payment up-front collection and payment arrangement" policy in our clinic and for non-emergency type services in our hospital. While this has helped to a certain extent, we still struggle with patients not paying their bills for the services we provide in good faith. We have also hired two more office personnel as follow up collectors for the Medical Center. Unfortunately, both have left Tioga to relocate. So we continue to look for an office/accounts receivable clerk to assist with collecting funds owed to the Medical Center.

We are finding that a number of patients have no insurance or are under-insured with large deductibles/co-insurances. We are treating patients who are far from their home town and have come to western North Dakota in order to try to get their feet back on the ground. In many instances, when Tioga Medical Center initially treats patients in our emergency room or hospital, we get our charges applied to the patient's deductible/coinsurance set by their policy.

Every day, our administration and office staff is trying to collect funds owed to the Tioga Medical Center in order to pay our bills. In talking with patients about their debt to the Medical Center, I use the phrase that "we can't pay our vendors and employees with promissory notes...we need the cash from our patients for the services we render." Patients that are unable to pay for their services at the time of service are asked to complete an acceptable payment agreement. Although some patients will honor their payment agreement, many times the agreement is broken by the patient. We ultimately revert to using collection agencies that have more resources at their disposal to find patients that owe funds to the Medical Center.

In conclusion, I would like to thank you for your consideration to support HB 1433 and also thank you for the opportunity to tell you of the issues facing Tioga Medical Center. I would be happy to try answering any questions of the committee.

Randall K. Pederson, President/CEO
Tioga Medical Center
PO Box 159
Tioga ND 58852-0159
(701) 664-3305 (work)
(701) 641-1271 (cell)
Email: randyp@tiogahealth.org



#9

CATHOLIC HEALTH INITIATIVES®

Mercy Hospital

1/28/2013

Re: **HB 1433**

To Whom It May Concern:

My name is Keith Heuser and I am the Administrator of Mercy Hospital in Valley City ND. I am here to demonstrate my support for HB 1433 sponsored by Representative Jon Nelson. HB 1433 offers grant access to hospitals with negative margins to offset losses from bad debt up to an organizational break even (if the bad debt amount exceeds the hospital's total loss).

Mercy is a Critical Access Hospital (CAH) and has struggled for the last 5 years to achieve a positive margin (reaching that goal only twice in the last 5 years). Mercy has seen increasing bad debt levels over the past several years and it is expected that we are only seeing the start. This is a great initial effort to keep healthcare viable in the communities that so desperately need health services. As you know, distances can be long in North Dakota and a community hospital can, literally, be a life saver for those who need it. HB 1433 begins the process of recognizing the pressures that our health system is bearing, and that we will only see increase as the Affordable Care Act is further implemented. The reason I say "initial effort" is that this opportunity to offset bad debt should be offered regardless of a hospital's operating margin and should also be offered to physician practices associated with CAHs. The reason I believe that this is appropriate is that we are already funding other services at a loss due to federal and state payment schedules. It is a rare business in our state and nation where the purchaser of services tells the provider of services what they are going to pay, regardless of the cost of the service. A state offset of bad debt costs will at least allow all hospitals to remove that expense from consideration when planning new services for their community.

I thank you for this opportunity to share my support of HB 1433 and urge you to support this Bill as it works through the process. It could have dramatic positive impact on the health services offered in North Dakota and allow creation of new services in small communities who so desperately need them.

Respectfully,

Keith Heuser
Market President
Mercy Hospital

570 Chautauqua Blvd. Valley City, ND 58072-3145
Phone 701.845.6400 Toll Free 800.371.9177

#10

Mr. Chairman—Members of the Committee:

My name is Sandra Simonson. I reside in Crosby and serve as President of the St. Lukes's Hospital Board. Our Hospital has suffered an increasing amount of bad debt due to the Bakken Oil Play.

St. Luke's has provided Emergency Room services for many people due to illness and injury. It is important for our small hospital to continue providing these services. Examples of our increase in bad debt are as follows:

2010- $88,146.00

2011-$114,799.00 and

2012 had a dramatic increase to-$312,092.00

2013 is projected to be more than $400,000.00

St. Luke's cannot continue to sustain these types of losses. These losses from bad debts reflect a deterioration of our operating position. In 2012 we lost over $495,000.

I urge you to pass House Bill 1433.

Thank you for your time

Sandra Simonson

Sandra Simonson

North Dakota Tobacco Prevention and Control Executive Committee
Center for Tobacco Prevention and Control Policy
4023 State Street, Suite 65 • Bismarck, ND 58503-0638
Phone 701.328.5130 • Fax 701.328.5135 • Toll Free 1.877.277.5090

Testimony
House Bill 1433
9:15 a.m., January 29, 2013, House Human Services Committee

Good morning, Chairman Weisz and members of the House Human Services Committee. I am Jeanne Prom, executive director of the N.D. Center for Tobacco Prevention and Control Policy.

Allocating the tobacco tax for heath care is appropriate, as tobacco use is the leading cause of preventable disease and death in our state, and a burden on our health care delivery systems:

- Annual health care costs in North Dakota directly caused by smoking: $247 million
- Portion paid by the state Medicaid program annually: $47 million

These costs far exceed yearly tobacco taxes collected and deposited in the state general fund (estimated at about $27 million/year, 2011-13 revised forecast from OMB).

The North Dakota Tobacco Prevention and Control Advisory Committee, in its plan, *Saving Lives – Saving Money, North Dakota's Comprehensive State Plan to Prevent and Control Tobacco Use*, calls for a significant increase in all tobacco taxes – to $2/pack with a comparable amount for all other tobacco. As you can see on the attachments, North Dakota's tobacco tax is one of the lowest in the country, at 44 cents/pack. This tax hasn't been increased since 1993. The low tax contributes to inexpensive tobacco that is affordable to youth and populations with limited incomes and high smoking rates. High tobacco taxes work even more effectively to cut use among lower-income smokers and male smokeless tobacco users – two groups that suffer more from the harms of tobacco.

Raising the tobacco tax to $2/pack with a comparable increase on all other tobacco products can be expected to:

- Decrease youth smoking by: 24%
- Reduce the number of kids from becoming addicted adult smokers by: 9,900
- Reduce the number of adults in the state who smoke by: 8,200
- Save the state millions of dollars in smoking-related health care costs over just 5 years.

Please consider HB 1433 with an amendment to increase the tobacco tax to $2/pack and a comparable tax on all other tobacco products.

Thank you for your time and consideration. I am happy to respond to any questions.

NEW REVENUES, PUBLIC HEALTH BENEFITS & COST SAVINGS FROM A $1.56 CIGARETTE TAX INCREASE IN NORTH DAKOTA

Current state cigarette tax: 44 cents per pack (46th among all states and DC)
Smoking-caused health care costs in North Dakota: $10.48 per pack

Annual health care expenditures in North Dakota directly caused by tobacco use: $247 million
Smoking-caused state Medicaid program spending each year: $47 million

New Annual Revenue from Increasing the Cigarette Tax Rate by $1.56 Per Pack: $41.09 million

New Annual Revenue is the amount of additional new revenue over the first full year after the effective date. The state will collect less new revenue if it fails to apply the rate increase to all cigarettes and other tobacco products held in wholesaler and retailer inventories on the effective date.

Projected Public Health Benefits from the Cigarette Tax Rate Increase	
Percent decrease in youth smoking:	24.0%
Kids in North Dakota kept from becoming addicted adult smokers:	9,900
Current adult smokers in the state who would quit:	8,200
Smoking-affected births avoided over next five years:	1,500
North Dakota residents saved from premature smoking-caused death:	5,400
5-Year health care cost savings from fewer smoking-caused lung cancer cases:	$1.26 million
5-Year health care cost savings from fewer smoking-affected pregnancies & births:	$3.33 million
5-Year health care cost savings from fewer smoking-caused heart attacks & strokes:	$2.33 million
5-Year Medicaid program savings for the state:	$380,000
Long-term health care cost savings in the state from adult & youth smoking declines:	$350.66 million

12.21.12 TFK / January 8, 2013

- Small tax increase amounts do not produce significant public health benefits or cost savings because the cigarette companies can easily offset the beneficial impact of such small increases with temporary price cuts, coupons, and other promotional discounting. Splitting a tax rate increase into separate, smaller increases in successive years will similarly diminish or eliminate the public health benefits and related cost savings (as well as reduce the amount of new revenues).
- Raising state tax rates on other tobacco products (OTPs) to parallel the increased cigarette tax rate will bring the state more revenue, public health benefits, and cost savings (and promote tax equity). With unequal rates, the state loses revenue each time a cigarette smoker switches to cigars, roll-your-own tobacco, or smokeless tobacco products. It is important to consider all aspects of state tax policy related to OTPs (including the new generation of smokeless tobacco products), including tax definitions, minimum pack sizes, tax rates, and whether the rates are based on price or weight, in order to ensure that they are adequately taxed to protect public health. To parallel the new $2.00 per pack cigarette tax, the state's new OTP tax rate should be at least 60% of the wholesale price with minimum tax rates for each major OTP category linked to the state cigarette tax rate on a per-package or per-dose basis.

More information available at http://www.tobaccofreekids.org/facts_issues/fact_sheets/policies/tax/us_state_local/ and http://www.acscan.org/tobaccopolicy.

For more on sources and calculations, see http://www.tobaccofreekids.org/research/factsheets/pdf/0281.pdf.

Campaign for Tobacco-Free Kids
Ann Boonn

American Cancer Society Cancer Action Network
Melissa Maitin-Shepard

Explanations & Notes

Health care costs listed at the top of the page are from the U.S. Centers for Disease Control and Prevention.

Projections are based on research findings that each 10% cigarette price increase reduces youth smoking by 6.5%, adult rates by 2%, and total consumption by about 4% (adjusted down to account for tax evasion effects). Revenues still increase because the higher tax rate per pack will bring in more new revenue than is lost from the tax-related drop in total pack sales.

The projections incorporate the effect of both ongoing background smoking declines and the continued impact of the 61.66-cent federal cigarette tax increase (effective April 1, 2009) on prices, smoking levels, and pack sales.

These projections are fiscally conservative because they include a generous adjustment for lost state pack sales (and lower net new revenues) from possible new smuggling and tax evasion after the rate increase and from fewer sales to smokers or smugglers from other states. For ways that the state can protect and increase its tobacco tax revenues and prevent and reduce contraband trafficking and other tobacco tax evasion, see the Campaign for Tobacco-Free Kids factsheet, *State Options to Prevent and Reduce Cigarette Smuggling and to Block Other Illegal State Tobacco Tax Evasion*, http://tobaccofreekids.org/research/factsheets/pdf/0274.pdf.

Kids stopped from smoking and dying are from all youth ages 17 and under alive today. Long-term cost savings accrue over the lifetimes of persons who stop smoking or never start because of the tax rate increase. All cost savings are in 2013 dollars.

Projections for cigarette tax increases much higher than $1.00 per pack are limited, especially for states with relatively low current tax rates, because of the lack of research on the effects of larger cigarette tax increase amounts on consumption and prevalence. Projections for cigarette tax increases much lower than $1.00 per pack are also limited because small tax increases are unlikely to produce significant public health benefits.

Ongoing reductions in state smoking rates will, over time, gradually erode state cigarette tax revenues (in the absence of any new rate increases). But those declines are more predictable and less volatile than many other state revenue sources, such as state income tax or corporate tax revenues (which can drop sharply during recessions). In addition, the smoking declines that reduce tobacco tax revenues will simultaneously produce much larger reductions in government and private sector smoking-caused costs. See the Campaign for Tobacco-Free Kids factsheet, *Tobacco Tax Increases are a Reliable Source of Substantial New State Revenue*, http://tobaccofreekids.org/research/factsheets/pdf/0303.pdf.

For other ways states can increase revenues (and promote public health) other than just raising its cigarette tax, see the Campaign factsheet, *The Many Ways States Can Raise Revenue While Also Reducing Tobacco Use and Its Many Harms & Costs*, http://tobaccofreekids.org/research/factsheets/pdf/0357.pdf.

For more on sources and calculations, see http://www.tobaccofreekids.org/research/factsheets/pdf/0281.pdf.

Needed State Efforts to Protect State Tobacco Tax Revenues

Having each of the following measures in place will maintain and increase state tobacco tax revenues by closing loopholes, blocking contraband trafficking, and preventing tax evasion.

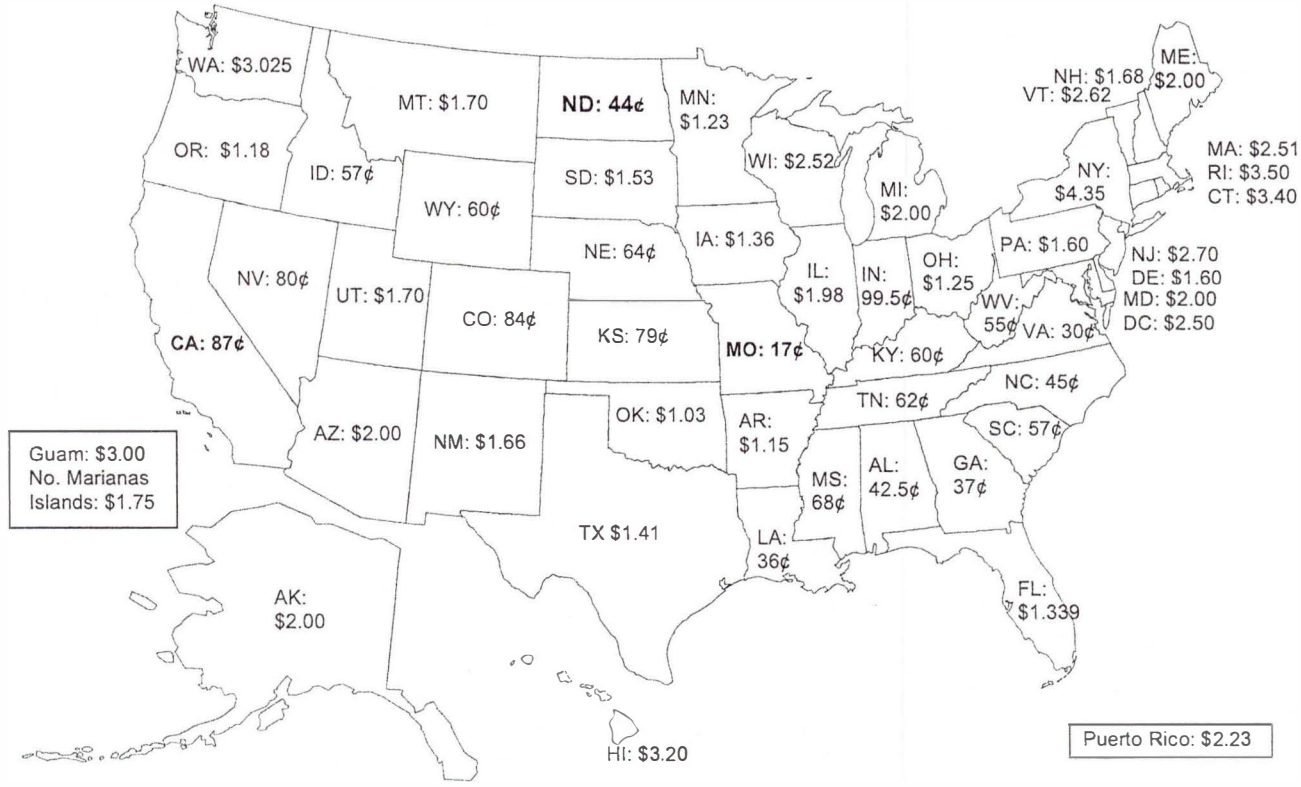
State tax rate on RYO cigarettes equals the state tax rate on regular cigarettes	Yes
State tax rates on other tobacco products match the state cigarette tax rate	Yes
State definitions of "cigarette" block cigarettes from wrongfully qualifying as "cigars"	No
State definitions of "tobacco product" reach all tobacco products	No
Minimum taxes on all tobacco products to block tax evasion and promote tax equity	No
"High-tech" tax stamps to stop counterfeiting and other smuggling and tax evasion	No
Retailers lose license if convicted of contraband trafficking	Yes
Street sales and mobile sales of cigarettes and other tobacco products prohibited	No
Non-Tobacco nicotine products without FDA approval banned	No

MAP OF STATE CIGARETTE TAX RATES

Average State Cigarette Tax: $1.48 per Pack

Average Cigarette Tax in Major Tobacco States: 48.5 cents per Pack

Average Cigarette Tax in Non-Tobacco States: $1.61 per Pack



Map shows state cigarette tax rates in effect now.* The three states that have not increased their cigarette tax rate since 1999 or earlier are marked in bold. Currently, 30 states, DC, Puerto Rico, the Northern Marianas, and Guam have cigarette tax rates of $1.00 per pack or higher; 14 states, DC, Puerto Rico, and Guam have cigarette tax rates of $2.00 per pack or higher; five states and Guam have cigarette tax rates of $3.00 per pack or higher; and one state (NY) has a cigarette tax rate more than $4.00 per pack. The state averages listed above do not include Puerto Rico (with a population larger than those in 20 states) or any of the U.S. territories (such as Guam). The major tobacco states with extensive tobacco farming and, often, cigarette manufacturing, are NC, KY, VA, SC, TN, & GA. Federal cigarette tax is $1.01 per pack. Not shown are the special taxes or fees some states place on cigarettes made by Non-Participating Manufacturers (NPMs), the companies that have not joined the Master Settlement Agreement (MSA) between the states and the major cigarette companies. Some local governments also have their own cigarette taxes, such as Chicago (68¢), Cook County, IL ($3.00), New York City ($1.50), and Anchorage, AK ($2.206). The U.S. Centers for Disease Control & Prevention estimates that smoking-caused health costs and productivity losses total $10.47 per pack sold.

Campaign for Tobacco-Free Kids, December 5, 2012 / Ann Boonn

For more information on state cigarette taxes and the benefits from increasing them, see http://www.tobaccofreekids.org/facts_issues/fact_sheets/policies/tax/us_state_local/.

* Previous versions of this factsheet listed cigarette tax rates for Washington, DC and Minnesota that included the per-pack cigarette sales tax rates that are collected at the wholesale level with the excise tax. Now the listed tax rates are purely the excise tax portion, exclusive of the sales tax. This is not a change in the actual excise tax rates, just the way that the rates are listed.

1400 I Street NW · Suite 1200 · Washington, DC 20005.
Phone (202) 296-5469 · Fax (202) 296-5427 · www.tobaccofreekids.org

STATE CIGARETTE EXCISE TAX RATES & RANKINGS

Overall All States' Average: $1.48 per pack
Major Tobacco States' Average: 48.5 cents per pack
Other States' Average: $1.61 per pack

State	Tax	Rank
Alabama	$0.425	47th
Alaska	$2.00	11th
Arizona	$2.00	11th
Arkansas	$1.15	30th
California	$0.87	33rd
Colorado	$0.84	34th
Connecticut	$3.40	3rd
Delaware	$1.60	21st
DC*	$2.50	10th
Florida	$1.339	26th
Georgia	$0.37	48th
Hawaii	$3.20	4th
Idaho	$0.57	42nd
Illinois	$1.98	16th
Indiana	$0.995	32nd
Iowa	$1.36	25th
Kansas	$0.79	36th
Kentucky	$0.60	40th

State	Tax	Rank
Louisiana	$0.36	49th
Maine	$2.00	11th
Maryland	$2.00	11th
Massachusetts	$2.51	9th
Michigan	$2.00	11th
Minnesota*†	$1.23	28th
Mississippi	$0.68	37th
Missouri	$0.17	51st
Montana	$1.70	17th
Nebraska	$0.64	38th
Nevada	$0.80	35th
New Hampshire	$1.68	19th
New Jersey	$2.70	6th
New Mexico	$1.66	20th
New York	$4.35	1st
North Carolina	$0.45	45th
North Dakota	$0.44	46th
Ohio	$1.25	27th

† Tax stamp includes 75¢ health impact fee

State	Tax	Rank
Oklahoma	$1.03	31st
Oregon	$1.18	29th
Pennsylvania	$1.60	21st
Rhode Island	$3.50	2nd
South Carolina	$0.57	42nd
South Dakota	$1.53	23rd
Tennessee	$0.62	39th
Texas	$1.41	24th
Utah	$1.70	17th
Vermont	$2.62	7th
Virginia	$0.30	50th
Washington	$3.025	5th
West Virginia	$0.55	44th
Wisconsin	$2.52	8th
Wyoming	$0.60	40th
Puerto Rico	$2.23	NA
Guam	$3.00	NA
Northern Marianas	$1.75	NA

Table shows all cigarette tax rates in effect now. Since 2002, 47 states, DC, and several U.S. territories have increased their cigarette tax rates more than 105 times. The three states in **bold type** have not increased their cigarette tax since 1999 or earlier. Currently, 30 states, DC, Puerto Rico, the Northern Marianas, and Guam have cigarette tax rates of $1.00 per pack or higher; 14 states, DC, and Guam have cigarette tax rates of $2.00 per pack or higher; five states and Guam have cigarette tax rates of $3.00 per pack or higher; and one state (NY) has a cigarette tax rate more than $4.00 per pack. Tobacco states are KY, VA, NC, SC, GA, and TN. States' average includes DC, but not Puerto Rico, other U.S. territories, or local cigarette taxes. The median tax rate is $1.34 per pack. AK, MI, MN, MS, UT also have special taxes or fees on brands of manufacturers not participating in the state tobacco lawsuit settlements (NPMs).

The highest combined state-local tax rate is $5.85 in New York City, with Chicago, IL second at $5.66 per pack. Other high state-local rates include Evanston, IL at $5.48 and Anchorage, AK at $4.206 per pack. For more on local cigarette taxes, see: http://tobaccofreekids.org/research/factsheets/pdf/0267.pdf.

Federal cigarette tax is $1.01 per pack. From the beginning of 1998 through 2002, the major cigarette companies increased the prices they charge by more than $1.25 per pack (but also instituted aggressive retail-level discounting for competitive purposes and to reduce related consumption declines). In January 2003, Philip Morris instituted a 65-cent per pack price cut for four of its major brands, to replace its retail-level discounting and fight sales losses to discount brands, and R.J. Reynolds followed suit. In the last several years, the major cigarette companies have increased their product prices by almost $1.00 per pack. ***The U.S. Centers for Disease Control & Prevention estimates that smoking-caused health costs total $10.47 per pack sold and consumed in the U.S.***

The average price for a pack of cigarettes nationwide is roughly $6.00 (including statewide sales taxes but not local cigarette or sales taxes, other than NYC's $1.50 per pack cigarette tax), with considerable state-to-state differences because of different state tax rates, and different manufacturer, wholesaler, and retailer pricing and discounting practices. AK, DE, MT, NH & OR have no state retail sales tax at all; OK has a state sales tax, but does not apply it to cigarettes; MN & DC apply a per-pack sales tax at the wholesale level; and AL, GA & MO (unlike the rest of the states) do not apply their state sales tax to that portion of retail cigarette prices that represents the state's cigarette excise tax.

Campaign for Tobacco-Free Kids, December 13, 2012 / Ann Boonn

For additional information see the Campaign's website at http://www.tobaccofreekids.org/what_we_do/state_local/taxes/.

Sources: Orzechowski & Walker, *Tax Burden on Tobacco*, 2011; media reports; state revenue department websites.

* Previous versions of this factsheet listed cigarette tax rates for Washington, DC and Minnesota that included the per-pack cigarette sales tax rates that are collected at the wholesale level with the excise tax. Now the listed tax rates are purely the excise tax portion, exclusive of the sales tax. This is not a change in the actual excise tax rates, just the way that the rates are listed.

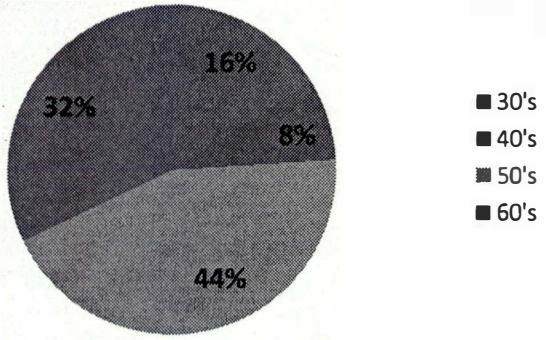
1400 I Street NW - Suite 1200 - Washington, DC 20005
Phone (202) 296-5469 · Fax (202) 296-5427 · www.tobaccofreekids.org

*HB 1433
Testimony: Bryan Reinhardt
Research Analyst
NDPERS

NDPERS Diabetes Management Program
2011 Summary

Demographic

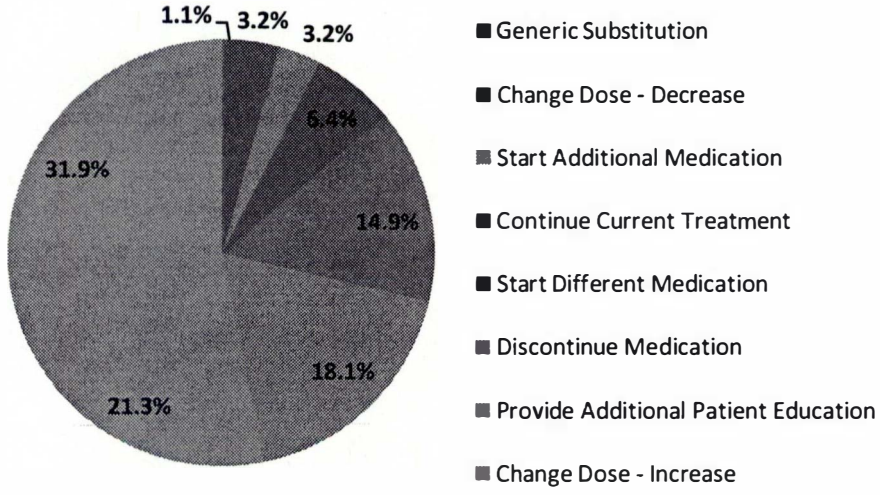
During 2011, 76% of the actively participating patients were female. Age distribution is demonstrated below:



Cities in which patient participated in management program: Bismarck, Dickinson, Fargo, Grafton, Grand Forks, Jamestown, and Minot.

Interventions

In 2011 there were 94 interventions made by the providers in collaboration with the patients in order to manage diabetes and prevent costly complication. Descriptions of intervention are listed below:



The most common medications where the provider recommended an increase in dose were insulin (both basal and rapid acting) and metformin. The most common reasons for providing additional patient education were to increase adherence and minimize common side effects associated with insulin use. Evaluating hemoglobin A1Cs of patients that were active in the program in 2011 enrollment A1C average was 7.3 (Range 6.1 – 8.9) or an estimated average glucose of 163mg/dl and with pharmacist intervention improved to an average of 6.8 (Range 5.9-8.5) with an estimated average glucose of 148 mg/dl.

Patient Satisfaction with Program

Based on a 5 point Likert scale where 5 is excellent and 1 is poor.

1.) Professional appearance of the provider	4.7
2.) Appearance of the meeting area	4.3
3.) System for scheduling your appointment	4.7
4.) The provider's interest in your health	4.7
5.) How well the provider helps you manage your medications	4.3
6.) How well the provider explains possible side effects	4.3
7.) The provider's efforts to solve problems that you have with your medications	4.3
8.) The responsibility that the provider assumes for your drug therapy	4.3
9.) Ability of the provider to answer your questions about your medications	4.3
10.) Ability of the provider to answer your questions about your health problems	4.3
11.) The provider's efforts to help you improve your health or stay healthy	4.7
12.) The program services overall	4.7
13.) Ability of the provider to see you at your scheduled time	4.3
14.) Courtesy and professionalism of the staff	4.7
15.) Follow-up after the appointment	4.3
16.) The educational materials provided	4.3
17.) The program website	4.0

"As a newly diagnosed adult with type 1 diabetes, this has been a great program because it offered the opportunity to talk with a health care professional about diabetes in a relaxed atmosphere (not the clinic)." *38 year old Male Patient*

13.0767.02001
Title.

Prepared by the Legislative Council staff for
Representative J. Nelson
February 11, 2013

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1433

Page 1, line 15, after "year" insert "and documentation of the hospital's policies requiring collection of copayments and deductibles from patients at the point of service when allowable under federal law and its process of verifying personal and health insurance information of patients"

Page 6, after line 12, insert:

"**SECTION 12. APPROPRIATION.** There is appropriated out of any moneys in the health care delivery trust fund in the state treasury, not otherwise appropriated, the sum of $700,000, or so much of the sum as may be necessary, to the state department of health for the purpose of providing a grant to an organization to assist hospitals in verifying personal and health insurance information of patients, for the biennium beginning July 1, 2013, and ending June 30, 2015."

Renumber accordingly