OTHER DUTIES OF THE HEALTH SERVICES COMMITTEE - BACKGROUND MEMORANDUM

In addition to the study responsibilities assigned to the Health Services Committee for the 2017-18 interim, the committee has also been assigned to:

- Receive a report from the State Fire Marshal on the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes (North Dakota Century Code Section 18-13-02(6) (Appendix A));
- Receive a report from the Department of Human Services (DHS), State Department of Health, Indian Affairs Commission, and Public Employees Retirement System (PERS) before June 1, 2018, on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes (Section 23-01-40 (Appendix B));
- Receive a report from the State Department of Health before June 1, 2018, regarding progress made toward the recommendations provided in Section 23-43-04 relating to continuous improvement of quality of care for individuals with stroke and any recommendations for future legislation (Section 23-43-04 (Appendix C));
- Contract with a private entity, after receiving recommendations from the Insurance Commissioner, to provide a cost-benefit analysis of every legislative measure mandating health insurance coverage of services or payment for specified providers of services, or an amendment that mandates such coverage or payment (Section 54-03-28 (Appendix D));
- Receive a report from DHS before September 1, 2018, regarding the status of the children's prevention and early intervention behavioral health services pilot project (Section 3 of 2017 House Bill No. 1040 (Appendix E));
- Receive a report from the State Department of Health on the results of the independent review of the tobacco prevention and control plan's effectiveness and implementation (Section 16 of 2017 Senate Bill No. 2004 (Appendix F));
- Receive a report during the 2017-18 interim from the North Dakota Board of Social Work Examiners, Board of Addiction Counseling Examiners, Board of Counselor Examiners, and North Dakota Marriage and Family Therapy Licensure Board on the status of implementation of supervision and training requirements (Section 5 of 2017 Senate Bill No. 2033 (Appendix G));
- Receive a report from the Task Force on Children's Behavioral Health every 6 months regarding the task force's efforts (Section 4 of 2017 Senate Bill No. 2038 (Appendix H); and
- Receive a report from the Task Force on Children's Behavioral Health on its findings and recommendations and any proposed legislation necessary to implement the recommendations (Section 5 of 2017 Senate Bill No. 2038 (Appendix I)).

STATE FIRE MARSHAL REPORT - IGNITION PROPENSITY STANDARDS FOR CIGARETTES

The 2009 Legislative Assembly approved House Bill No. 1368, which created Chapter 18-13 related to reducing ignition propensity standards for cigarettes and penalties for wholesale and retail sale of cigarettes that violate the reduced propensity standards. This chapter provides for the enforcement of ignition propensity standards for cigarettes by the State Fire Marshal, Tax Commissioner, and Attorney General and for monetary violations to be deposited in the fire prevention and public safety fund to be used by the State Fire Marshal to support fire safety and prevention programs. Fees collected for testing cigarettes are to be used by the State Fire Marshal for the purpose of processing, testing, enforcement, and oversight of ignition propensity standards. Cigarette manufacturers are required to pay the State Fire Marshal an initial $250 fee for certification, which is deposited in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund. In addition, Section 18-13-02(6) requires the State Fire Marshal to review the effectiveness of test methods and performance standards and report each interim to the Legislative Management the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. The committee was assigned the responsibility to receive this report.

During the 2015-17 biennium, the committee received a report from the State Fire Marshal, including a summary of test methods, performance standards, and certification results. According to the data collected from North Dakota's National Fire Incident Reporting System from January 2014 to September 2016, 147 fires within the state

were caused by smokers, placing smoking as the 6th leading cause of fires in the state. There were 1,659 man hours invested in extinguishing these fires. From 2004 to 2013, North Dakota reduced its ranking from 6th to 26th for the greatest number of fire deaths. There are 27 different manufacturers that certify cigarettes and 14 different laboratories that test these cigarettes. As of January 1, 2016, there have been 692 cigarettes certified, which raised $173,000. The State Fire Marshal made no recommendation regarding changes to Chapter 18-13 during the 2015-17 biennium.

REPORT ON PLANS TO REDUCE THE INCIDENCE OF DIABETES IN THE STATE, IMPROVE DIABETES CARE, AND CONTROL COMPLICATIONS ASSOCIATED WITH DIABETES

House Bill No. 1443 (2013) requires DHS, the State Department of Health, the Indian Affairs Commission, and PERS to collaborate to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes. Section 1 of the bill requires before June 1 of each even-numbered year, DHS, the State Department of Health, the Indian Affairs Commission, and PERS submit a report to the Legislative Management on the following:

1. The financial impact and effect diabetes is having on the agency, the state, and localities.
2. An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease.
3. A description of the level of coordination existing between the agencies on activities; programmatic activities; and messaging on managing, treating, or preventing diabetes and diabetes complications.
4. The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the Legislative Assembly.
5. The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in item 4.

The committee was assigned the responsibility to receive this report.

During the 2015-16 interim, the committee learned agency representatives shared information and examined data on the prevalence of diabetes and its financial impact. Agencies reviewed the status and benefits of current diabetes-related programs, funding, and collaborative efforts among agencies. Agencies identified action plans and recommendations to improve health outcomes in the state related to diabetes. The committee learned type 2 diabetes can be prevented with behavior changes at the individual level and at the population level. Agencies must collaborate to enact and support policies that make the healthy choice the default choice. The committee learned those living with diabetes need policies that support the proper care and management of the disease in order to prevent costly complications and to improve the quality of life. The committee learned 49,000 adults in the state have diabetes and 202,000 have prediabetes. The committee received a summary of current efforts to address diabetes in the state, including programs provided through the State Department of Health, DHS, and PERS. The report contained a number of goals and strategies to reduce diabetes in the state, including:

- Improve access to the diabetes prevention program by increasing the number of sites where the program can be administered, personal awareness of prediabetes risk factors and self-referral to the program, medical provider referral to the program, and training opportunities for lifestyle coaches;
- Improve the quality of life for those with diabetes by promoting the use of accredited diabetes self-management education programs and offering continuing education for health professionals; and
- Leverage chronic disease initiatives through partnerships and coalition building by promoting collaboration among state agencies and with those working to prevent chronic diseases in the community.

REPORT ON THE CONTINUOUS IMPROVEMENT OF QUALITY OF CARE FOR INDIVIDUALS WITH STROKE

House Bill No. 1323 (2015) relates to the creation and implementation of a stroke system and provides for a report to the Legislative Management. The bill amended Section 23-43-04 to provide for the State Department of Health to establish and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment, establish a data oversight process, and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment. Section 23-43-04(4) requires before June 1 of each even-numbered year, the department provide a report to the Legislative

Management regarding progress made toward the recommendations provided in Section 23-43-04 and any recommendations for future legislation. The committee was assigned the responsibility to receive this report.

During the 2015-17 biennium, the committee received a report from the State Department of Health and learned the North Dakota stroke system was created in 2009 to establish a comprehensive, coordinated, efficient system, along the continuum of health care for individuals suffering a stroke. The program is administered by the Division of Emergency Medical Services and Trauma and stroke partners, including the American Heart Association, critical access hospitals, tertiary hospitals, the North Dakota Emergency Medical Services Association, and the State Department of Health's Division of Chronic Disease. The committee received a summary of responsibilities assigned to the State Department of Health in Section 23-43-04 and the department's activities related to its responsibilities and the continuous improvement of quality of care for individuals with stroke. The committee learned there are 24 critical access hospitals and 6 tertiary hospitals in the stroke registry and others are expected to join. Data is shared at quarterly Stroke Task Force meetings and at regional critical access hospital quality meetings where it is used by the Stroke Task Force to make recommendations for interventions to improve stroke care delivery in the state. Improvements in the stroke system include:

- All six tertiary hospitals in the state are now primary stroke centers;
- 22 of 36 critical access hospitals are designated as acute stroke-ready hospitals;
- The Division of Emergency Medical Services and Trauma has contracted with the North Dakota Emergency Medical Services Association to offer stroke education to all North Dakota emergency medical services providers;
- The Division of Emergency Medical Services and Trauma collaborates with primary stroke center coordinators to provide education to critical access hospitals;
- Each emergency medical services provider will soon be required to submit detailed stroke transport plans;
- The stroke protocols will address the transport of acute stroke patients to the nearest stroke-designated hospital within a specific time of onset of symptoms; and
- Last year the Division of Emergency Medical Services and Trauma created a stroke campaign, and materials from the campaign continue to be used in public education efforts across the state.

The committee learned in 2010 that emergency medical services providers gave advanced notification to the destination hospital of a potential stroke patient being transported from the scene in 56 percent of cases. In 2015, hospitals received advance notification 77.4 percent of the time compared to 55.9 percent nationally. The percentage of acute ischemic stroke patients who arrived at the hospital within 2 hours of the time the patient was last known to be without the signs and symptoms of the current stroke, and for whom intravenous thrombolytic therapy was initiated within 3 hours of the time the patient was at his or her prior baseline, increased from 30.9 percent of patients that qualified in 2010, to 80 percent of eligible patients in 2015. The State Department of Health made no recommendation regarding future legislation.

MANDATED HEALTH INSURANCE COVERAGE COST-BENEFIT ANALYSIS

Section 54-03-28 provides a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The committee was assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2019 legislative session. The Insurance Commissioner must pay the costs of the contracted services, and each cost-benefit analysis must include:

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

Section 54-03-28 also provides that any legislative measure mandating health insurance coverage may only be effective for the next biennium and is limited to the public employees health insurance program. For the subsequent Legislative Assembly, PERS must prepare and request introduction of a bill to repeal the expiration date and expand the mandated coverage to all accident and health insurance policies. In addition, PERS is required to prepare a

report, to attach to the bill, regarding the effect of the mandated coverage or payment on the system's health insurance program. The Public Employees Retirement System must include information on the utilization and costs relating to the mandated coverage and a recommendation on whether the coverage should continue. The 2009-10 interim Health and Human Services Committee learned PERS is not required to use a consultant when evaluating legislative measures mandating health insurance coverage. However, if a future analysis does require additional resources, Section 54-52.1-06.1 provides a continuing appropriation to PERS for consulting services related to the uniform group insurance program.

Health Insurance Mandate Analysis Costs

The committee received the following information regarding recent costs incurred by the Insurance Department for health mandate-related cost-benefit analyses:

- During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis;
- During the 2009 legislative session, the Insurance Department paid a total of $28,070 to Milliman USA for analyses of three bills;
- During the 2011 legislative session, the Insurance Department paid a total of $14,982 to Milliman USA for analysis of one bill;
- During the 2013 legislative session, there were no health insurance mandates referred for cost-benefit analysis;
- During the 2015 legislative session, the Insurance Department paid a total of $26,564 to Milliman USA for analyses conducted on three bills; and
- During the 2017 legislative session, the Insurance Department paid a total of $17,200 to Acumen Actuarial LLC for analysis of one bill.

Legislative Rules Regarding Bills That Include Health Insurance Mandates

Beginning with the 2009 legislative session, the House changed House Rule 402 relating to bill introduction deadlines for measures subject to cost-benefit analysis under Section 54-03-28. The rule, as changed, provides a current legislator may submit a mandated health insurance bill to the Employee Benefits Programs Committee no later than April 1 of the year before a regular legislative session. Any new legislator taking office after November 30 of the year preceding the legislative session may submit a mandated health insurance bill for consideration by the Employee Benefits Programs Committee no later than the first Wednesday following adjournment of the organizational session. The Senate has not yet adopted this change relating to mandated health insurance bills.

CHILDREN'S PREVENTION AND EARLY INTERVENTION BEHAVIORAL HEALTH SERVICES PILOT PROJECT

Section 3 of 2017 House Bill No. 1040 appropriates $150,000 from the general fund to DHS for the purpose of establishing a children's prevention and early intervention behavioral health services pilot project in the school system of the department's choice, including services relating to children suffering from the effects of behavioral health issues. The bill also requires DHS to provide a report to the Legislative Management before September 1, 2018, regarding the status of the children's prevention and early intervention behavioral health services pilot project. The committee has been assigned to receive this report.

RESULTS OF EFFECTIVENESS AND IMPLEMENTATION OF THE TOBACCO PREVENTION AND CONTROL PLAN

Section 16 of 2017 Senate Bill No. 2004 requires the State Department of Health to provide a report to the Legislative Management by July 31, 2017, regarding the development of a statewide tobacco prevention and control plan that is consistent with the five components of the Centers for Disease Control and Prevention *Best Practices for Comprehensive Tobacco Control Programs*. The five components of the program include state and community interventions, mass-reach health communication interventions, cessation interventions, surveillance and evaluation, and infrastructure administration and management. In addition, the State Department of Health must provide for an independent review of the tobacco prevention and control plan at least once during the 2017-19 biennium to evaluate the effectiveness of the plan and its implementation. The bill also allows any costs related to the independent review to be paid from the tobacco prevention and control trust fund. The committee has been assigned to receive this report.

REPORT ON IMPLEMENTATION OF SUPERVISION AND TRAINING REQUIREMENTS FOR BEHAVIORAL HEALTH PROFESSIONAL BOARDS

Senate Bill No. 2033 (2017) provides that a portion of the supervised experience to qualify for licensure as a clinical social worker, counselor, or marriage and family therapist may be provided by a licensed behavioral health professional other than the profession being licensed. The bill allows an applicant for licensure as a clinical social worker to meet the supervised experience requirement through experience in the practice of clinical social work, and allows the Board of Social Work Examiners additional flexibility in accepting licensure from other jurisdictions. Section 5 of the bill requires the North Dakota Board of Social Work Examiners, Board of Addiction Counseling Examiners, Board of Counselor Examiners, and North Dakota Marriage and Family Therapy Licensure Board to provide a report to the Legislative Management regarding the status of implementing these changes. The committee was assigned the responsibility to receive this report.

REPORT ON EFFORTS OF THE TASK FORCE ON CHILDREN'S BEHAVIORAL HEALTH

Section 4 of 2017 Senate Bill No. 2038 creates the Task Force on Children's Behavioral Health for the purpose of assessing and guiding efforts within the children's behavioral health system to ensure a full continuum of care is available in the state. The task force includes the Superintendent of Public Instruction, or the Superintendent's designee, the Executive Director of DHS, or the Executive Director's designee, the State Health Officer, or the State Health Officer's designee, the Executive Director of the Indian Affairs Commission, or the Executive Director's designee, and the Director of the Committee on Protection and Advocacy, or the Director's designee. The task force is to:

- Assess and guide efforts within the children's behavioral health system to ensure a full behavioral health continuum of care is available in the state;
- Make recommendations to ensure the children's behavioral health services are seamless, effective, and not duplicative;
- Identify recommendations and strategies to address gaps or needs in the children's behavioral health system;
- Engage stakeholders from across the continuum to assess and develop strategies to address gaps or needs in areas including education, juvenile justice, child welfare, community, and health; and
- Provide a report to the Legislative Management every 6 months regarding the task force's efforts.

The committee was assigned the responsibility to receive this report.

REPORT ON FINDINGS AND RECOMMENDATIONS OF THE TASK FORCE ON CHILDREN'S BEHAVIORAL HEALTH

Section 5 of 2017 Senate Bill No. 2038 requires the Task Force on Children's Behavioral Health to provide a report to the Legislative Management regarding its findings and recommendations and any proposed legislation necessary to implement the recommendations. The committee was assigned the responsibility to receive this report.