

STUDY OF CURRENT AND FUTURE HEALTH CARE NEEDS IN NORTH DAKOTA - BACKGROUND MEMORANDUM

Section 11 of 2005 House Bill No. 1010 (attached as an appendix) provides for a Legislative Council study of the desirability of proposing a comprehensive health care and health insurance study to be performed during the 2007-08 interim. The 2005-06 interim study is to include consideration of whether there is a need for a comprehensive, long-range study of the state's current and future health care needs in order to address the following issues:

- The aging population in the state;
- The phenomenon of health care cost-shifting to the private sector;
- The trend of uncompensated health care services;
- Shortages in the number of health care professionals;
- Duplication of technology and facilities; and
- Any other factors that might affect the health care system in North Dakota in the year 2020.

If the study results in a recommendation for a comprehensive health care and health insurance study, the proposal is to address the parameters of the proposed study and how the proposed study will be designed in order to allow for significant consumer input. The Budget Committee on Health Care has been assigned this responsibility for the 2005-06 interim.

PREVIOUS LEGISLATIVE COUNCIL STUDIES 1999-2000 Budget Committee on Health Care

During the 1999-2000 interim, the Legislative Council's Budget Committee on Health Care studied various challenges facing the delivery of health care in this state, including changes in hospital reimbursements, technological innovations, and regionalization of services. The committee also studied health care delivery, quality, cost, access to essential health care services and critical providers, and the identification of geographic, demographic, and economic issues relating to health care. The committee did not recommend any legislation as a result of the study.

1997-98 Insurance and Health Care Committee

During the 1997-98 interim, the Legislative Council's Insurance and Health Care Committee studied the development of a strategic planning process for the future of public health within the state. The committee recommended Senate Bill No. 2045, which repealed

four chapters of the North Dakota Century Code (NDCC) regarding public health and created a new chapter that consolidated existing public health law, unified the powers and duties of local public health units, and required statewide participation in some type of public health unit. Senate Bill No. 2045 was passed by the 1999 Legislative Assembly.

The Insurance and Health Care Committee also studied the impact of managed care on the future viability of the health care delivery system in rural North Dakota. The committee did not make any recommendations as a result of this study.

1995-96 Insurance and Health Care Committee

During the 1995-96 interim, the Legislative Council's Insurance and Health Care Committee studied the feasibility and desirability of implementing recommendations of the North Dakota Health Task Force for improving the health status of North Dakotans, the rate of health care cost increases, the impact of newly enacted programs to improve the health status of North Dakotans, and unmet medical needs in rural areas. The committee did not recommend any legislation as a result of the study but did urge the State Health Council to continue studying the implementation of the Health Task Force recommendations for improving the health status of North Dakotans.

1993-94 Health and Communications Committee

During the 1993-94 interim, the Legislative Council's Health and Communications Committee studied the feasibility and desirability of allowing all North Dakota residents to participate in the Public Employees Retirement System (PERS) uniform group insurance program. The committee also studied the feasibility and desirability of pooling all sources of funding for health care benefits in conjunction with the North Dakota Health Task Force study of the control of costs and the redistribution of dollars toward improved access to services through a health care reimbursement system. The committee recommended 1995 Senate Bill No. 2065 to expand the uniform group insurance program administered by PERS to allow voluntary participation for persons who met the medical underwriting requirements of the program. The bill was not passed by the 1995 Legislative Assembly. The committee also recommended House Bill No. 1050, which contained numerous health care reform items,

including health care cooperatives (an arrangement that allows individual providers to act collectively for the purpose of providing health care services without having to merge assets), a health care commission as a permanent subcommittee of the State Health Council, a cost and quality review program, and other health care reform provisions. House Bill No. 1050 was passed by the 1995 Legislative Assembly.

1990-94 Health Task Force

The State Health Council established the North Dakota Health Task Force in 1990 to identify and address the major health issues facing the state and to develop appropriate recommendations for change. In 1992 the task force received a grant of \$671,337 from the Robert Wood Johnson Foundation to address health care reform in this state. The task force identified six critical areas in its review of the health care crisis--cost, education/prevention, access, regulation, manpower, and health care policy and delivery systems. In June 1994 the task force submitted its final recommendations on health care reform to the State Health Officer, the State Health Council, and the Governor. The final recommendations provide suggestions for improving the health status of North Dakotans, including the following principles:

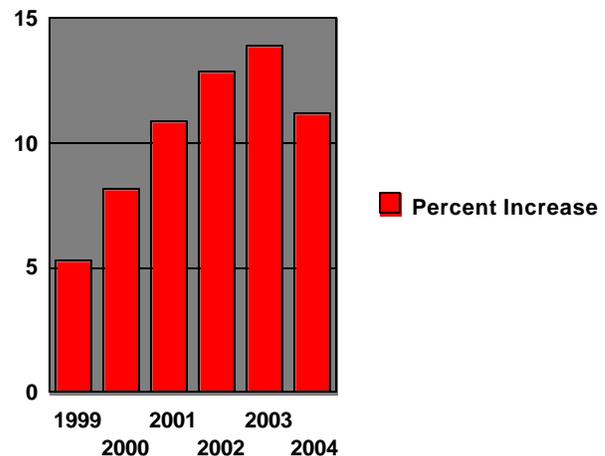
1. Emergency medical services should be available within 5 minutes to 90 percent of the population in urban areas and within 10 minutes to 90 percent of the population in rural areas.
2. A 911 emergency number system should be extended statewide.
3. Access to primary care should be available within 30 minutes at least once per week to at least 90 percent of the rural population.
4. The Insurance Commissioner and the Health Insurance Advisory Committee should establish common standards for healthy lifestyle incentives and health promotion options for health insurance policies with appropriate areas for discounts.
5. The State Health Officer should establish a broad-based Health Education Committee to develop instructional objectives for a health education curriculum for kindergarten through grade 12.
6. The State Health Council should develop a comprehensive statewide assessment of North Dakotans health status and health care services. This information will be used to identify and prioritize areas that require actions to enhance North Dakotans health status.

BACKGROUND ON CURRENT AND FUTURE HEALTH CARE CONCERNS

The committee's responsibility is to determine whether a future study of health care needs in North Dakota should be conducted. The following is a general overview of information available regarding various health care services and needs in the state.

Health Insurance Coverage and Costs

According to the Kaiser Family Foundation, employer-sponsored health insurance premiums rose by 11.2 percent nationally in 2004, as compared to 13.9 percent for 2003. Premiums continued to



increase much faster than overall inflation (2.3 percent) and wage gains (2.2 percent). Since 2000 premiums for family coverage have increased by 59 percent compared with inflation growth of 9.7 percent and wage growth of 12.3 percent. The percentage increase in health insurance premiums from 1999 to 2004 are:

Approximately 64 percent of North Dakota's population under age 65 is covered by an employer-sponsored health insurance program, as compared to the national average of 65.5 percent. The national average cost of annual premiums for employer-sponsored coverage (all plan types) increased to \$3,695 for single coverage and \$9,950 for family coverage. Almost 80 percent of covered workers with single coverage and 90 percent of covered workers with family coverage made a contribution toward premiums in 2004. Workers on average contributed \$558 of the \$3,695 annual cost of single coverage (15 percent) and \$2,661 of the \$9,950 annual cost of family coverage (26.7 percent) toward premiums.

In addition to their premium contributions, most workers make additional payments when they access health care services. Approximately 51 percent of workers are in a health plan that requires a **deductible** be met before most plan benefits are provided. In 2004 the average **single coverage deductible** for a preferred provider organization (PPO)--a managed care plan in which preferred rates are available when using doctors, hospitals, and providers that belong to the

network--is \$287 for services from preferred providers and \$558 for services from nonpreferred providers. These deductibles are statistically the same as 2003.

The percentage of small firms (less than 200 workers) offering health insurance has gradually declined from 68 percent in 2001 to 63 percent in 2004. Employers offering health benefits vary substantially by firm size, with only 52 percent of the smallest companies (3 to 9 workers) offering health benefits, while 74 percent of firms with 10 to 24 workers, and 87 percent of firms with 25 to 49 workers, and nearly all firms with 50 or more workers offer health benefits. The percentage of workers receiving health coverage from their own employer (including those working both for firms that offer and firms that do not offer coverage) declined from 65 percent in 2001 to 61 percent in 2004.

Health Care Services for the Uninsured

According to AARP, 11.2 percent of North Dakota's population under age 65 was without health insurance, as compared to the national average of 16.5 percent. Medicare is a health insurance program for people 65 years of age and older and some disabled people under age 65. Low-income individuals under age 65 may receive their health care in several ways, including:

- Uncompensated care pooling programs offered by states;
- The medical assistance program (Medicaid);
- Clinics or community health centers whose mission is to serve the low-income population; and
- Hospitals and private doctors' offices provided as free charity care or written off as unpaid medical debts.

North Dakota Century Code Section 50-01-01 provides that the obligation to support the poor is placed on county government, within the limits of the county human services appropriation. In addition, Section 50-03-01 provides county governments with the ability to levy a tax that supports the county human services fund for the needy. Money from this fund is spent by each county's social services board, which supervises and directs county public assistance programs. Health care and hospitalization are support services that may fall within the scope of the social services board responsibilities.

North Dakota Century Code Section 50-01-13 provides that county social services boards are to provide, within the limits of the county human services appropriation, necessary medical services for any poor person in the county who is not provided for in a public institution. The necessary medical services include medicines prescribed by a physician and hospitalization, upon approval or subsequent ratification by the board. If the person is a nonresident of the state, the

county furnishing the medical services is to be reimbursed by the Department of Human Services for 80 percent of the expenses incurred.

Public health units are local organizations formed to provide public health services in a city, county, or designated multicounty or city-county area and include city public health departments, county public health departments, and health districts. Pursuant to NDCC Section 23-35-03, a city's or county's governing body may establish a public health unit by creating and appointing a board of health, which must consist of at least five members. The State Department of Health is to advise each board of health.

Fees for services provided by public health units are determined primarily by the individual's income level based on a sliding fee scale. Services that may be offered by public health units include:

- Blood pressure, eye, hearing, and tuberculosis screenings;
- Child wellness;
- Tobacco prevention;
- Child and overseas immunizations;
- Drug monitoring;
- HIV/AIDS testing and counseling sites; and
- Carseat safety programs.

North Dakota's Medicaid program pays for medical care and services eligible to people unable to pay for such services and preventive and rehabilitative services to help people to retain or attain capability for independence or self-care. According to AARP, approximately 7 percent of North Dakota's population under age 65 is on the Medicaid program, as compared to the national average of 9.3 percent.

The community health center program is a federal grant program funded under Section 330 of the Public Health Service Act to provide regular access to comprehensive primary and preventive care, regardless of an individual's ability to pay. Community health centers are core safety net providers, although they are not present in all communities. According to the Community Health Care Association of North Dakota, community health centers in North Dakota include Coal Country Community Health Center (Beulah, Center, and Halliday), Family HealthCare Center (Fargo), Migrant Health Services, Inc. (Grafton), Northland Community Health Center (McClusky, Rolette, and Turtle Lake), and Valley Community Health Centers (Northwood and Larimore).

According to the North Dakota Healthcare Association, North Dakota hospitals provided approximately \$50 million in uncompensated services during 2003, based on normal billing rates, to people who cannot or will not pay the full cost for services. Uncompensated care does not include any consideration for other community benefits provided by hospitals, including free screenings for blood pressure and blood sugar, well baby clinics, foot care, etc.

North Dakota Health Care Professionals

According to the United States Department of Labor, the health care industry is predicted to add 3.5 million new jobs between 2002 and 2012, an increase of 30 percent. Projected rates of employment growth for the various segments of the industry range from 12.8 percent in hospitals, the largest and slowest-growing industry segment, to 55.8 percent for home health care services. In 2000 the national supply of full-time equivalent registered nurses was estimated at 1.89 million while the demand was estimated at 2 million, a shortage of 110,000, or nearly 6 percent. The shortage is expected to grow by 12 percent through 2010.

Based on the Center for Rural Health, North Dakota has 71 active primary care physicians per 100,000 people as compared to 69 physicians per 100,000 people nationally. Twenty-three North Dakota counties had fewer physicians per 1,000 people than the national average of .69 per 1,000 people. Ten of these counties had no resident physicians. Assuming the state's current physician population will retire at age 65, 25 percent will retire by 2015 and 42 percent by 2020.

According to the North Dakota nurse licensure data base, there are 533 advanced practice nurses (APNs), 7,906 registered nurses (RNs), and 3,262 licensed practical nurses (LPNs) in North Dakota. National data indicates an average of nearly 8 registered nurses per 1,000 people. Nine North Dakota counties have over 10 registered nurses per 1,000 people. Twenty-five North Dakota counties have less than 8 registered nurses per 1,000 people, including four counties with less than 3.4 registered nurses per 1,000 people. The average age of the advanced practical nurses is 50 years, registered nurses is 45 years, and licensed practical nurses is 46 years. Shortages of nurses and physicians are primarily in the most rural areas of North Dakota.

Current and Projected Population in North Dakota by Age Groups

Based on the United States Census Bureau, estimated population groups by age are:

Total Population by Age Group and Percentage of Total Population - 2004				
	0 to 17 Years	18 to 64 Years	65 Years and Older	Total Population
North Dakota	138,955 (21.9%)	402,240 (63.4%)	93,171 (14.7%)	634,366
United States	73,277,998 (25%)	184,083,421 (62.6%)	36,293,985 (12.4%)	293,655,404

Projected Population Over 65 Years of Age		
	Number	Percentage of Total Population
North Dakota		

2000	94,478	14.7%
2010	97,108	15.3%
2030	152,358	25.1%
United States		
2000	34,991,753	12.4%
2010	40,423,713	13.0%
2030	71,453,471	19.7%

Healthy North Dakota

Healthy North Dakota is a statewide public health initiative announced by Governor John Hoeven in January 2002 to inspire North Dakotans to improve physical, mental, and emotional health for all North Dakotans by building innovative statewide partnerships. The framework of the program is to provide a support structure, education, and encouragement to assist individuals to make healthy choices by focusing on wellness and prevention in schools, workplaces, senior centers, homes, and anywhere people live, work, and play. In August 2002 the Healthy North Dakota Summit was held in Bismarck which included more than 130 individuals from more than 75 agencies/organizations to define wellness and identify priorities for North Dakota. The Healthy North Dakota priority areas identified were tobacco use, substance abuse/mental health, healthy weight-nutrition, healthy weight-physical activity, health disparities, worksite wellness, community engagement, and third-party payers/insurance. In 2004 additional priority areas were identified relating to immunizations, aging, injury, cancer, cardiovascular health, school health, early childhood, oral health, and diabetes.

The Healthy North Dakota Advisory Committee provides general oversight to the Healthy North Dakota program and consists of individuals, appointed by the Governor, from state government and the private sector. In addition, committees have been established for each priority area. These committees are chaired by representatives of the private sector and include a liaison from the State Department of Health to provide administrative support. The chairs and liaisons from each Healthy North Dakota committee make up the Healthy North Dakota Coordinating Committee. The Healthy North Dakota program has developed and supported various projects, including:

- The tobacco "quit line" in collaboration with the State Department of Health, Blue Cross/Blue Shield of North Dakota, and the North Dakota Public Employees Retirement System.
- A wellness institute developed with the University of North Dakota School of Medicine and Health Sciences to provide training, evaluation, and preventive case management to businesses, schools, communities, and individuals across the state to encourage healthy lifestyles.
- The Tribal/Health State Task Force to examine health issues affecting North Dakota's tribal nation.

- A worksite wellness nutrition education and incentive program in collaboration with the North Dakota Public Employees Retirement System.

The 2005-07 biennium appropriation for the Healthy North Dakota program is \$485,746 from federal and other funds as compared to the 2003-05 biennium appropriation of \$288,196 from federal funds. The 2005-07 appropriation includes \$135,000 of other funds spending authority for the State Department of Health to use federal funding to match nonstate funding and contract with a nonstate entity for a worksite wellness pilot project.

DUTIES AND MEMBERSHIP OF THE STATE HEALTH COUNCIL

Pursuant to NDCC Section 23-01-03, the State Health Council is responsible for establishing standards, rules, and regulations for the maintenance of public health, including sanitation and disease control. In addition, the State Health Council is to provide for the development, establishment, and enforcement of basic standards for hospitals and related medical institutions which render medical and nursing care, including sanitation, building construction, fire protection measures, nursing procedures, and preservation of medical records. The State Health Council may hold hearings on all matters brought before the council by applicants and licensees of medical hospitals with reference to the denial, suspension, or revocation of licenses and make appropriate determinations.

Additional duties of the State Health Council include monitoring overall health care costs and quality of health care in the state, recommend to the appropriate interim legislative committees changes to the health care system in the state, and publish an annual report on health care in the state.

The State Health Council consists of 11 members appointed by the Governor for three-year terms. Four members of the council must be from the health care field, five members representing consumer interests, one member from the energy industry, and one from the manufacturing and processing industry. The officers of the State Health Council are elected annually. Any state agency may serve in an advisory capacity to the State Health Council at the discretion of the council. The State Health Council must meet at least twice each year and at other times as the council or its chairman may direct.

PARAMETERS OF A POTENTIAL FUTURE STUDY

If a study of future health needs in North Dakota is recommended, the committee is to address parameters of the proposed study and how the proposed study

will be designed in order to allow for significant consumer input. Various issues relating to the parameters and design of the study may include the following:

- The potential cost;
- Possible funding sources;
- The timeframe;
- The departments, organizations, individuals, and/or consultants that will be involved;
- The organization and structure of the oversight committee;
- Whether the focus of the study should be on recipient or provider needs;
- Major issues to be addressed;
- The frequency and location of meetings; and
- Goals and objectives of the committee.

PROPOSED STUDY PLAN

The following is a study plan the committee may want to consider in its study of the desirability of proposing a comprehensive health care and health insurance study to be performed during the 2007-08 interim. The testimony will also include information relating to the need for a study of health care issues in the state.

1. Receive testimony from representatives of the Insurance Department, the State Department of Health, and Department of Human Services regarding a general overview of present and future health care issues and concerns in North Dakota, including the aging population in the state, health care cost-shifting to the private sector, and the trend of uncompensated health care services.
2. Receive testimony from the University of North Dakota School of Medicine and Health Sciences regarding information and statistics available on access, quality, and cost of health care within the state, including shortages of health care professionals in North Dakota, and technological innovations affecting the delivery of health care in rural areas.
3. Receive information from the North Dakota Healthcare Association and other interested individuals and organizations regarding uncompensated health care services provided in North Dakota and duplication of technologies and facilities.
4. Receive information from individuals and organizations involved in the Health Task Force conducted from 1990 to 1994 regarding methodology and results of the study.
5. Receive a status report from a representative of the State Department of Health regarding the Healthy North Dakota program.
6. Receive information from interested organizations, entities, and individuals regarding the

desirability of and ideas for a potential comprehensive, long-range study of the state's current and future health care needs.

7. Develop committee recommendations and any related bill drafts, if it is determined that there is a need for a comprehensive, long-range study of the state's current and future health care needs, including addressing the

parameters of the proposed study and how the proposed study will be designed in order to allow for significant consumer input.

8. Prepare a final report for submission to the Legislative Council.

ATTACH:1