HEALTH CARE COMMITTEE

The Health Care Committee was assigned five studies:

- Section 8 of House Bill No. 1010 (2021) directed a study of medication optimization. The study required a review of the implementation of clinical pharmacist-led medication optimization programs in individual, large group, and small group plans, including provider credentialing, billing standards and procedures, providing standards of care, patient monitoring, consistent documentation of outcomes and efforts related to deprescribing, and structuring an outcome reporting system for medication optimization programs. The study also required a review of changes necessary to state laws and administrative rules to implement effective medication optimization.
- Senate Bill No. 2212 (2021) directed a study of prescription drug pricing, importation, reference pricing, and the role pharmacy benefit managers play in drug pricing. The study required input from the Public Employees Retirement System (PERS), Workforce Safety and Insurance, the Insurance Commissioner, the State Board of Pharmacy, prescription drug wholesalers in Canada, and the public.
- Section 3 of House Bill No. 1465 (2021) directed a study of health insurance networks, including narrow networks. The study required consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws; a review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974; the impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options; a comparison of health maintenance organizations provider network designs and other health insurer provider network designs; a review of how vertically integrated networks utilize health maintenance organization plans; and a comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.
- House Concurrent Resolution No. 3014 (2021) directed a study of solutions to provider and end-user barriers to access to and utilization of telehealth services in this state.
- House Concurrent Resolution No. 3015 (2021) directed a study of the feasibility and desirability of implementing a community health worker program, including recommendations regarding a definition of a community health worker, the scope of work of a community health worker, the infrastructure for training of community health workers, the development of a community health worker certification process and related training curriculum and continuing education requirements, a strategy for community health worker services being Medicaid-reimbursed services, and private insurers' use of community health workers.

In addition to its study responsibilities, the committee was charged with receiving the following four reports and a directive:

- A biennial report from the State Fire Marshal on the State Fire Marshal's findings and any recommendation for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes, pursuant to North Dakota Century Code Section 18-13-02(6).
- A biennial report from the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS 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 correct complications associated with diabetes, pursuant to Section 23-01-40.
- A biennial report from the State Department of Health regarding progress made toward the recommendations provided in Section 23-43-04 regarding stroke centers and stroke care and any recommendation for future legislation, pursuant to Section 23-43-04.
- An annual report from the Maternal Mortality Review Committee regarding the identification of patterns, trends, and policy issues related to maternal mortality, pursuant to Section 23-51-08.
- A directive to recommend a private entity with which to contract, 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, pursuant to Section 54-03-28.

Committee members were Representatives Robin Weisz (Chairman), Pamela Anderson, Mike Beltz, Ruth Buffalo, Gretchen Dobervich, Clayton Fegley, Zachary Ista, Jim Kasper, Lisa Meier, Marvin E. Nelson, Bob Paulson, Karen M. Rohr, and Greg Westlind and Senators Howard C. Anderson, Jr., Tim Mathern, Dave Oehlke, and Kristin Roers.

Representative George Keiser served on the committee until his death on December 22, 2021.

MEDICATION OPTIMIZATION STUDY

Legislative History

During the 2019-20 interim, the Legislative Management's Health Care Committee studied the health care system in the state and received a report from the Insurance Department indicating on a per-capita basis, hospital expenses in the state were the highest in the nation in 2017, and the growth rate of about 8 percent each year since 2010 was among the fastest in the United States. The report also indicated although the state has higher-than-average hospital expenses, the state's health insurance premium levels compare favorably with those of other states. The comparable premium levels likely are attributed to moderate prescription drug claims, lower-than-average administrative costs, favorable individual market demographics, and health plans with relatively high average deductibles.

One of the suggestions for policy alternatives from the 2019-20 report was the use of care management to deliver better care and health outcomes at a lower cost. Medication optimization is a potential benefit of provider consolidation, hospital system-owned health plans, electronic health records, and other health care changes used to better manage care. The report estimated medication nonadherence costs the health care system in the United States approximately $300 billion each year with the potential impact of medication optimization to be more than $500 billion.

Background

The Center for Medication Optimization through Practice and Policy at the Eshelman School of Pharmacy at the University of North Carolina at Chapel Hill defines medication optimization as a patient-centered, collaborative approach to managing medication therapy which is applied consistently and holistically across care settings to improve patient care and reduce overall health care costs. According to research conducted at the Eshelman School of Pharmacy, when compared to other industrialized countries, the health care system in the United States consistently ranks at the bottom with respect to quality and cost and consumes 18 percent of the United States' gross domestic product, yet that consumption does not lead to better care for the population. It has been estimated 55 percent of Americans regularly take an average of four prescription medications and in 2008, it was estimated more than one-half of Americans take chronic medications. According to the National Health Expenditure Projections 2015-2025, health care spending is projected to be 20 percent of the United States' gross domestic product by 2025, meaning $1 out of every $5 the United States economy produces will be spent on health care.

In 2020, the Centers for Medicare and Medicaid Services estimated prescription drug expenditures in the United States were about $335 billion, not including nonretail expenditures on medications. According to a 2020 editorial in the *Expert Review of Pharmacoeconomics & Outcomes Research*, as the population of the Unites States ages, the importance of optimizing medication usage to realize the maximum potential of medicines to improve patient-centered and cost-sensitive care increases. As a result of the shift from inpatient- and hospital-based care to less expensive outpatient- and community-based care without a reduction in outcome increases, the expansion of pharmacists-delivered care and improved utilization of clinical evidence will be critical to achieve the full benefit of medications.

Testimony and Committee Considerations

The committee received testimony from the Insurance Commissioner and the Insurance Department's consultant, the State Board of Pharmacy, the North Dakota Pharmacists Association, health insurance carriers, the Department of Human Services, PERS, and other interested stakeholders.

Testimony indicated while there are a number of medication optimization efforts that take place in health systems, there are a number of medication optimization efforts that also can take place in community pharmacy settings such as transitions of care, remote patient monitoring using digital health tools, and disease state management. Testimony also indicated comprehensive medication optimization is a patient-centered approach delivered by qualified pharmacists working with the patient, physicians, and other members of the health care team. Testimony indicated providers utilize several programs, including medication therapy management, quality-based performance, value-based design drug lists, guided health, utilization management, drug utilization review, and biosimilars as medication optimization techniques.

Testimony from providers also indicated an important aspect of medication optimization is balancing the needs of the patient while keeping premiums affordable and using refill and patient adherence data to analyze whether a patient is adequately and reliably taking medications. Testimony also indicated there is a 49 percent rate of re-admission when a pharmacist does not speak to a patient posthospital discharge, compared to an 18 to 19 percent rate when a pharmacist speaks to a patient within 48 hours of discharge.

Testimony from the Insurance Department indicated medication optimization, also referred to as comprehensive medication management, would not be a benefit change or increase in benefits to the state's Essential Health Benefit Benchmark plan. Medication optimization would be a programmatic change among issuers to implement comprehensive medication management for eligible disease states to ensure members have access to doctors and pharmacists to review a patient's medications and have the medications adjusted to reduce possible side effects or adverse drug interactions. Testimony also indicated some health plans provide for benefits to access primary care doctors, which would be extended to apply to pharmacists participating in the comprehensive medication management program.

Testimony indicated the report resulting from the Insurance Department's study showed most issuers in the fully insured markets in the state have implemented a form of medication therapy management or comprehensive medication management for their members to engage and opt-in. Testimony also indicated the patient conditions and prevalence rates in the state for which an optimization program should be considered are diabetes, hypertension, hyperlipidemia, smoking cessation, chronic obstructive pulmonary disease, health failure, asthma, transplants, HIV, and mental health. Testimony further indicated although issuers already utilizing a form of medication optimization would not see a meaningful cost increase to hire or contract more pharmacists to build a more robust program, issuers without an integrated approach likely would need to contract with or hire internal pharmacy resources to review high-risk member drug mixes and possible adverse interactions, which likely would result in a premium change.

The committee determined some providers were already optimizing medication optimization techniques and a committee bill was not necessary. Committee members noted the value of providing a broad spectrum of care for patients and supported pharmacists engaging with patients.

Conclusion

The committee makes no recommendation with respect to the medication optimization study.

PRESCRIPTION DRUG PRICING STUDY

Legislative History

As introduced, Senate Bill No. 2212 would have directed the State Department of Health to design a wholesale prescription drug importation program for the importation of prescription drugs from Canada in compliance with Section 804 of the federal Food, Drug, and Cosmetic Act. Section 804 directs the Secretary of the federal Department of Health and Human Services, after consultation with the United States Trade Representative and the Commissioner of Customs, to promulgate regulations permitting pharmacists and wholesalers to import Canadian prescription drugs into the United States. Several states, including Florida, Vermont, Colorado, Maine, New Mexico, and New Hampshire, have enacted laws establishing importation programs for prescription drugs from Canada.

Background

On a per capita basis, the United States spends more on prescription drugs than any other country with prices in the United States averaging at least 2.56 times higher than the prices in 32 other counties. Prices in the United States were higher than those in comparison countries for brand name originator drugs but lower than those in comparison countries for unbranded generic drugs. The price for prescription drugs can be measured at different levels, such as the price at which drugs are sold to wholesalers or the price offered to the public by retail pharmacies, which includes wholesale and retail markups. Although the net price likely reflects rebates and other discounts paid by manufacturers after drugs are dispensed, those prices generally are not available.

Prescription drug spending is forecasted to remain at about 9 percent of national health care spending through 2028, which is down slightly from a previous average of about 10 percent of health care spending. According to the National Conference of State Legislatures, states are using various methods to address prescription drug spending by passing laws to allow for importation of drugs from abroad, limiting consumer cost-sharing to high-priced drugs, and requiring transparency in drug pricing by requiring manufacturers to justify drug price increases or provide data about research, advertising, and other costs.

Drug Pricing

Pharmaceutical companies consider several factors when pricing drugs, including a drug's uniqueness, competition from other companies, a drug's effectiveness, and the research and development costs incurred to bring a drug to market. Unlike other countries, the United States does not regulate the price of prescription drugs extensively, which allows drug companies to set the price the market will bear. According to a May 6, 2021, report from the Congressional Research Service, although drug spending growth moderated in the early 2000s due in part to an economic recession and the expanded use of lower-cost generic drugs, drug spending spiked in 2014, due in part to the introduction of expensive new Hepatitis C drugs, increasing spending 13.5 percent in 2014 and 8.8 percent in 2015, before slowing to an average of 3.4 percent annual growth from 2016 through 2019.

In 2020, Health Affairs reported although generic drugs accounted for 90 percent of the 5.8 billion prescriptions in 2018, generic drugs comprised only 20 percent of drug spending while 10 percent of prescriptions for brand drugs constituted almost 80 percent of outpatient drug spending during the same period. The report further indicated biologic or specialty drugs accounted for one-half of outpatient drug spending while only comprising 2.2 percent of prescriptions.

Most health plans cover outpatient prescriptions through a distinct pharmacy benefit separate from coverage of medical services like physician and hospital care. Health plans typically contract with pharmacy benefit managers (PBMs) to negotiate drug prices with manufacturers and process prescription claims. Pharmacy benefit managers use formularies that contain the brand and generic prescription medications covered by a plan together with the patient cost-sharing requirements and utilization techniques to help control drug prices. Formularies generally have tiers with different out-of-pocket costs for patients based on various factors such as whether a drug is a generic, a preferred brand, or a nonpreferred brand.

Reference Pricing

Reference-based pricing is a health care cost containment model that limits what a group health plan will pay for certain prescription drugs. Under this approach, the insurer covers the prices of low-cost, benchmark prescription drugs in therapeutic clusters, which are deemed to be close substitutes for one another in treating specific illnesses. Patients who prefer a higher priced substitute in a cluster must pay the difference between the retail price of that drug and the reference price covered by the insurer. The practice of international or external reference pricing sets maximum prescription drug prices in one country based on what other countries pay and is used widely outside the United States.

According to an analysis of 16 studies describing nine reference pricing policies from six countries, including Canada, Germany, Norway, and Spain, the *American Journal of Managed Care* found reference pricing policies led to decreases in drug prices and increases in utilization of targeted medications, while also reducing payer and patient expenditures and also determined the policies did not lead to increased use of medical services such as office visits and hospitalization. The use of reference pricing in various countries has been linked to reduced patient out-of-pocket and total payer expenditures and achieved cost-savings without a negative impact on resource consumption. Three studies that evaluated changes in patient expenditures found out-of-pocket savings ranging from 12 to 18 percent per month with four studies reporting a reduction of 14 to 52 percent on targeted drug classes on payer expenditures.

Over the last few years, states have introduced and passed dozens of bills that would reduce prescription drug prices and spending using several strategies, including the use of international reference pricing to set an upper payment limit for purchasers. According to the National Academy for State Health Policy, there are three key design choices that states face as part of the effort to create upper payment limits, including identifying the target populations, the site of the regulated transaction, and the acquisition of information, while also considering which countries to include as reference points, the target price to be paid, which drugs to include in the program, what remedies to impose on manufacturers that resist the structure, and how to ensure cost-savings accrue to patients and plans.

Pharmacy Benefit Managers

Section 19-03.6-01 defines "pharmacy benefit manager" as a "person that performs pharmacy benefits management and includes any other person acting for such person under a contractual or employment relationship in the performance of pharmacy benefits management for a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payer, or health program administered by a state agency." Pharmacy benefit managers serve as middlemen and administer prescription drug plans and negotiate prices with pharmaceutical companies for inclusion in health insurance coverage lists, also known as formularies. Pharmacy benefit managers negotiate drug prices and rebates with a drug manufacturer and in exchange for rebates, PBMs will put certain drugs on formularies. The PBM also manages the payer's formulary list, and in exchange, the payer pays the PBM for administrative services for the actual drug and for the dispensing of the drug. In some cases, a PBM contracts with a pharmacy to dispense drugs directly and pays the pharmacy a drug dispensing fee. According to the Kaiser Family Foundation, of the 3.7 billion retail prescriptions in 2019, approximately three-quarters were processed by PBMs.

Although most state laws focus on the role of other actors in the supply chain, some states are imposing additional regulations on PBMs, such as requiring PBMs to register with the state as third-party benefit administrators, prohibiting gag clauses in pharmacy contracts with PBMs which bar pharmacists from telling consumers about less expensive options for filling a prescription, and making public PBM bids for services to provide more transparency. Recent federal laws also have banned gag clauses in Medicare and commercial insurance. In 2016, Vermont approved a law requiring manufacturer disclosure for drugs that underwent large percentage price increases and directing state regulators to compile a list of the drugs used by Vermont residents which experience the largest annual price increases. The Vermont law further required manufacturers to justify the price increase to the state Attorney General.

Importation

Under current law, the importation of unapproved drugs, including foreign-made versions of Food and Drug Administration (FDA)-approved drugs with limited exceptions, generally is prohibited. A drug must be approved by the FDA before it may be sold in the United States. A drug imported by a consumer would not fulfill the detailed and explicit FDA premarket approval requirements. The federal Prescription Drug Marketing Act of 1987 clarified even for a drug the FDA had approved for sale in the United States which had been sold or transferred to a foreign country, only the manufacturer of the FDA-approved prescription drug is authorized to bring the drug back into the United States.

Although Congress enacted the federal Medicine Equity and Drug Safety (MEDS) Act, and subsequently the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003, to allow pharmacists and wholesalers to import unapproved versions of FDA-approved prescription drugs from Canada, the Secretary of the Department of Health and Human Services had not certified to Congress that the promulgation will not pose additional risk to the public's health and safety or result in a significant reduction in the cost of covered products to the American consumer. On September 23, 2020, the Department of Health and Human Services Secretary Alex Azar made the necessary certification to Congress and promulgated the final rule to implement the MEDS Act and allow for the importation of certain prescription drugs from Canada.

Testimony

The committee received testimony from the Insurance Commissioner, the State Board of Pharmacy, the North Dakota Pharmacists Association, health insurance carriers, the Department of Human Services, PERS, PhRMA, Partnership for Safe Medicines, AARP, Prime Therapeutics, PCMA, 3 Axis Advisors, National Academy for State Health Policy, Healthcare Distribution Alliance, and other interested stakeholders.

Importation

The committee received testimony indicating past Canadian drug importation attempts failed to deliver on promises of safety and affordability and the inaccurate savings projections should be considered in light of the serious safety risks posed by third-party drug importation. Testimony indicated states will have to complete inspections of entities in Canada to ensure the production quality meets those of the manufacturing facilities in the United States. Testimony also indicated although some states have enacted legislation to implement drug importation plans, none are active as a result of legal challenges and significant roadblocks enacted by Canada.

Testimony indicated several policy options to help patients pay less for prescription drugs included hard-dollar cost-sharing caps, offering lower cost-sharing options, making coupons count, and sharing the savings from rebates with patients. Testimony indicated pharmacy benefit management services include claims processing, price negotiation, formulary management, pharmacy and provider education, specialty pharmacies, mail-service, drug utilization review, and disease management and adherence initiatives. Testimony also indicated unless a patient is paying out-of-pocket, pharmacists have very little control over the price of a prescription.

Drug Manufacturers

Testimony indicated drug manufacturers conduct the research, development, and marketing, and set prices based on what the market can tolerate and then manage the distribution of drug products to drug wholesalers, specialty pharmacies, hospitals, government entities, some health plans, and PBM-owned retail and mail order pharmacies. Testimony also indicated the main role of drug wholesalers is to make the purchasing of products more efficient by connecting pharmacies, hospitals, PBMs, and others to allow for easier access to medications. Testimony indicated the drug wholesale market is highly concentrated with three main entities maintaining 85 to 90 percent of total distribution in the United States. Testimony also indicated most of a drug wholesaler's revenue is generated by the difference between what the wholesaler pays to purchase a drug and what the wholesaler sells the same drug for to downstream entities.

Pharmacy Benefit Managers

The committee received testimony indicating PBMs originated as claims processors and have morphed into complicated organizations, with the top three PBMs controlling 80 percent of the prescription drug market. Testimony indicated PBMs contract either directly with an employer or through a health insurance plan to manage the prescription drug benefit for enrolled beneficiaries while also contracting with drug manufacturers to secure steep discounts and rebates for formulary placement and contracting with drug wholesalers and manufacturers. Testimony also indicated PBMs generate revenue through various means, including fees charged to health plans and employers for managing prescription drug benefits, the difference between the purchase price and selling price of brand name, generic, and specialty medications, and rebates generated from drug manufacturers for formulary placement.

The committee received testimony indicating although the Insurance Department could regulate PBMs, the department lacks the subject matter expertise and would request additional staff. Testimony indicated the state's Medicaid program is part of the Sovereign States Drug Consortium for negotiation of supplemental rebates. Testimony also indicated rather than establishing a PBM run by the state, the state could benefit from joining a PBM consortium

like the one created by Washington, Oregon, and Nevada. Additional testimony indicated if the state became its own PBM through the use of the existing Medicaid claim system, there would be some limitations because the system is within a federal certified Medicaid Management Information System and numerous changes would be necessary, including to eligibility systems, provider enrollment, changes for benefit design, and contracts for formulary design and a rebate aggregator.

Pharmacies

Testimony indicated pharmacies contract with wholesalers to purchase and stock their locations with medications and have little choice but to contract with a PBM to serve insurance beneficiaries. Testimony also indicated contract negotiations often are one-sided with the PBM having the leverage to set the terms, conditions, and reimbursement rates because the PBM has access to the pharmacy's patient information and can steer patients to specific pharmacies. Testimony indicated PBMs also use their leverage to extract other discounts or pharmacy price concessions from pharmacies, such as effective rates and claw-backs with pharmacy price concessions growing more than 91,500 percent between 2010 and 2019.

Committee Considerations

The committee considered a bill draft relating to value-based purchasing for pharmaceuticals. The bill draft would require the North Dakota Department of Health and Human Services (DHHS) to study value-based purchasing to determine whether it is a feasible and cost-effective option for the state, including whether the state should join a consortium and, if so, which consortium would be the most effective for the state to join, and whether the state should establish a value-based purchasing program.

The committee considered a bill draft relating to value-based drug purchasing for medical assistance. The bill draft would require DHHS to participate in current and future innovative rebates and other program options.

The committee combined both bill drafts relating to value-based purchasing into a single bill draft.

The committee considered a bill draft relating to a prescription drug reference rate pilot program. The bill draft would require the Insurance Commissioner to design and implement a prescription drug reference rate pilot program to study the possibility of controlling excessive prices for prescription drugs.

Testimony received in support of the bill draft indicated the bill draft does not set a price but rather a limit on what purchasers pay. Testimony also indicated the bill draft uses reference pricing and does not create an importation mechanism. Testimony received in opposition to the bill draft indicated the program will adversely impact the people of the state because the real issues lie with the misaligned incentives in the supply chain and PBMs. Testimony also indicated Canadian prices are based on a policy that is discriminatory to individuals with disabilities and the bill draft infringes on the core of the free market philosophy.

The committee expressed concerns about the rising cost of prescription medications and the increasing level of influence of PBMs. The committee had differing opinions relating to how best to proceed but determined recommending a bill draft relating to a study of value-based purchasing and directing participation in rebate programs and a bill draft establishing a prescription drug reference rate pilot program would allow for additional discussion on these topics during the 2023 legislative session.

Recommendations

The committee recommends a bill draft [23.0104.02000] directing a study of value-based purchasing and directing DHHS to participate in current and future innovative rebates and other program options.

The committee recommends a bill draft [23.0092.01000] to establish a prescription drug reference rate pilot program.

HEALTH INSURANCE NETWORK STUDY

Legislative History

As introduced, House Bill No. 1465 would have created an any willing provider (AWP) provision for health insurance policies, providing an insurer's policy may not deny a health care provider the right to participate as a participating provider for any policy on the same terms and conditions as are offered to any other provider of health care services under the policy. As amended in conference committee, the bill was hoghoused to provide for this study.

Background

Generally, North Dakota health insurers are either organized as a preferred provider organization (PPO) or a health maintenance organization (HMO). Medica Health Plan and Sanford Health Plan are organized as HMOs, and Blue Cross Blue Shield of North Dakota, United Healthcare, and Medica are organized as PPOs. The type of entity--HMO or PPO--dictates what type of health plan the health insurance company can issue in the state. An HMO can issue both

HMO and PPO plans, whereas a PPO can issue a PPO plan or exclusive provider organization (EPO) plan. In North Dakota a PPO has limitations on issuing EPO plans. A primary difference between HMO, PPO, and EPO plans is the treatment of out-of-network coverage.

Broad and Narrow Networks

Generally, health insurers may define and adjust the number, qualifications, and quality of providers in the insurer's network. To provide greater consumer value through lower premiums, a health insurer may sell a "narrow network" health plan that covers fewer providers, such as an HMO or EPO. Typically, providers negotiate rebated reimbursement rates with the expectation of higher volume due to the narrow network. Additionally, the narrower network may facilitate coordination of care.

In addition, network adequacy requirements, which refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network providers, may limit an insurer's ability to issue narrow network plans. The federal Affordable Care Act included many reforms intended to make health care more affordable and accessible, including network adequacy standards for qualified health plans sold on the exchange. For example, under Section 26.1-47-03(1)(d), PPO organization health plans must offer health care services within a 50-mile radius of a covered person's residence. This section, in effect, has made EPO plans unfeasible in this state.

The National Association of Insurance Commissioners (NAIC) reports the insurance industry trend toward narrow network health plans caught the attention of state insurance regulators, and in 2015 the NAIC revised its model language for network adequacy. North Dakota has not enacted this NAIC model language.

Employee Retirement Income Security Act of 1974 Plans

The federal Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that establishes minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. There are two types of ERISA health plans--the "self-funded" or "self-insured" plan, and the "fully insured" or "unfunded" plan. If a plan is self-funded, the employer pays the benefits directly through the employer's general assets or through a trust fund established for that purpose. If a plan is fully insured, the employer does not pay the benefits, but instead, the employer purchases an insurance policy, and an insurance company recognizes any profit or pays the losses. A health plan that falls completely outside the scope of ERISA, or that is otherwise excluded from ERISA coverage, is considered a non-ERISA plan, such as a government or church plan. Although ERISA provides for federal preemption under 29 U.S.C. 1144(a), which provides all state law is preempted to the extent the state law "relates to employee benefit plans," ERISA also provides for a savings clause under 29 U.S.C. 1144(b)(2)(A), which provides the savings clauses saves from preemption state laws that "regulate insurance." Additionally, ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B), prevents states from opting out of federal preemption of employee benefit law by deeming self-funded plans to be subject to the state law for purposes of the savings clause. The deemer clause essentially creates a distinction between self-funded and fully insured ERISA plans, providing a state cannot deem a self-funded ERISA plan an insurance company and thereby regulate the plan. Although the ERISA preemption provision limits the ability of states to regulate ERISA health plans, multiple states have enacted AWP laws that appear to meet the ERISA preemption standard for fully-funded ERISA health plans. For example, by initiated measure in 2014, South Dakota enacted South Dakota Codified Laws Section 58-17J-2, which provides:

> **Patient choice--Health care provider participation.** No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

Vertical Integrated Network Utilization of Health Maintenance Organization Plans

An HMO plan network may be vertically integrated, through common ownership, or may be virtually integrated, through contractual networks. According to the Insurance Department, Sanford Health Plan, organized as an HMO, primarily uses vertical integration through common ownership for its narrow network for its HMO plans, whereas Medica Health Plan, also organized as an HMO, uses virtual integration through contractual networks for its narrow network for its HMO plans.

Premiums and Value-Based Purchasing

In a broad sense, value-based purchasing (VBP) is the linking of health care provider payments to improved performance by the health care provider. The primary purpose of VBP is to hold health care providers accountable for both the cost and the quality of care provided. Benefits recognized by patients might include reduced costs, increased patient satisfaction, a reduction in medical errors, and the promotion of healthy habits.

Multiple reimbursement models exist under the umbrella of VBP, including pay-for-performance, under which providers typically are reimbursed for services using a fee-for-service structure, but providers also can qualify for value-based incentive payments or penalties based on quality and cost performance; shared savings arrangements, under which a provider is reimbursed under a fee-for-service model, but if a provider can reduce health care spending below an established benchmark set by the payer, the provider can retain a portion of the savings produced; and capitation payments, under which the provider takes on full financial risk for care quality and health care spending.

An HMO plan is designed based on capitated payments. The differences between fee-for-service payments and capitated payments were discussed in a 1996 Health Affairs article, which noted:

> Under retrospective fee-for-service payment, every component of the health care delivery system is both a cost center and a revenue center. Services are reimbursed a la carte, with more cost bringing in more revenue. The profit centers are those services and facilities that can price highest above cost; historically, this glory has accrued to specialist physicians and acute care hospitals. Under prospective capitation payment, however, every component of the delivery system is a cost center and not a revenue center. Revenues are received on a monthly per capita basis regardless of the level of services used. The profitability of the health care provider organization now depends on its ability to win contracts from HMOs, to attract patients, and to manage care so that expenditures are held below the capitated payment rate. All three of these objectives require the organization have an adequate number of primary care physicians and physicians to cooperate in managing the costs and the quality of care.

Testimony and Committee Considerations

The committee received testimony from the Insurance Department, health insurance agents, health care providers, and health insurance carriers.

The committee received testimony regarding unintended consequences that may arise if AWP legislation is enacted. Testimony indicated narrow network plans offer a premium cost saving to the consumer and AWP legislation may result in the loss of this cost savings. Testimony indicated when narrow network plans are offered to a group, the insurance companies require both the broad and narrow networks be offered, so AWP legislation may result in less consumer choice.

The committee received testimony in support of AWP legislation. Testimony indicated consolidated market power reduces competition and patient choices. Testimony indicated AWP legislation increases patient choice by allowing patients to choose their health care provider without network limitations; guarantees access to lower cost providers, such as ambulatory surgery centers; and lowers patient costs and travel.

The committee received testimony comparing North Dakota's individual, small group, and large group markets to those markets in South Dakota, which codified AWP in 2014. The testimony indicated:

- South Dakota's health insurance administrative costs have not increased due to AWP, but instead are lower than North Dakota's;
- South Dakota's health insurance premium rate of increase in the small and large group markets is lower than North Dakota's;
- Any willing provider legislation in South Dakota has not negatively impacted hospital operating revenues; and
- Any willing provider legislation in South Dakota has not impacted hospital operating expenses.

The committee received testimony in opposition to AWP legislation. The testimony indicated:

- A narrow network plan saves a consumer 20 percent in premiums as compared to a broad network;
- Broad and narrow networks empower consumers with different options and allow the consumer to choose a health plan that meets the needs of the consumer;
- Market regulations and business practices protect consumer choice through benefit design, access and availability standards, network adequacy regulations, and employer groups and health plan options;
- South Dakota's AWP law passed in 2014, and through litigation and a settlement, the result is South Dakota's AWP law is very similar to that of North Dakota;
- Narrow networks should be encouraged, not eliminated, because narrow networks offer consumers choice; and
- Any willing provider legislation in North Dakota would impact nearly 25 percent of the health insurance market.

The committee received testimony regarding the use of narrow networks by integrated insurance networks. Testimony indicated broad and narrow networks are not unique to integrated insurance networks. The committee was informed in one integrated insurance narrow network in the state, 50 to 60 percent of the claims volume comes from the network's providers.

The committee received testimony regarding accountable care organizations (ACOs). Testimony indicated an ACO is a group of health care providers and facilities that come together voluntarily to provide coordinated high-quality care to their patients.

The committee recognized the value of retaining the broad and narrow networks utilized in this state. The committee determined there is no need to revise the law to provide for AWP.

Conclusion

The committee makes no recommendation with respect to the health insurance network study.

TELEHEALTH SERVICES STUDY

Legislative and Executive History

Section 26.1-36-09.15, which was enacted in 2017, provides for health insurance coverage parity for telehealth services. The 2017 legislation was an expansion under Section 54-03-28 of the 2015 legislation that provided for telemedicine coverage under the state's PERS health benefits coverage. As introduced, House Bill No. 1038 (2015) may have provided for coverage parity and payment parity; however, as enacted, the bill clearly was limited to coverage parity.

Senate Bill No. 2179 (2021), as introduced, would have provided for payment parity for telehealth services. As amended by the Senate, the bill would have provided for a Legislative Management study of telehealth. The amendments passed by the House would have provided for a telehealth payment parity pilot project. The bill failed to pass in the House.

House Bill No. 1465 (2021) amended Section 26.1-36-09.15, codifying several provisions of Governor Doug Burgum's Executive Order 2020-05.1. Specifically, the bill defines the term "secure connection," provides the term "telehealth" includes audio-only telephone for the purpose of an e-visit or a virtual check-in, and defines the terms "e-visit" and "virtual check-in."

In response to the declared state of emergency related to the Coronavirus (COVID-19) pandemic, on March 20, 2020, Governor Burgum issued Executive Order 2020-05.1. This order included the following provision addressing telehealth services:

> For purposes of expanding health care and behavioral health services across the State, certain statutory and regulatory requirements must be suspended as follows:
>
> a. The "secured connection" provision of NDCC § 26.1-36-09.15(1)(g)(1) is hereby expanded to include the guidance issued by CMS on March 17, 2020.
>
> b. The "audio-only" provision of NDCC § 26.1-36-09.15(1)(g)(3) is hereby suspended. Telehealth services shall be provided as defined by NDCC § 26.1-36-09.15(1)(g)(1) and (2) to include audio-only telehealth services.
>
> c. Insurance carriers shall cover virtual check-ins and e-visits for established patients in accordance with the guidance issued by CMS on March 17, 2020.
>
> d. The provisions of NDCC § 26.1-36-09.15(4) are hereby suspended. Insurance carriers shall not subject telehealth coverage, including virtual check-ins and e-visits for established patients, to deductible, coinsurance, copayment or other cost sharing provisions.
>
> e. No insurance carriers shall impose any specific requirements on the technologies used to deliver telehealth, virtual check-in and e-visit services (including any limitations on audio-only or live video technologies) that are inconsistent with these requirements.
>
> f. The North Dakota Insurance Commissioner may issue guidance on the implementations of these requirements.

This executive order remained in effect until the expiration of the state's declared State of Emergency, which occurred on April 30, 2021.

Background

State Activities

Legislation addressing health insurance coverage of telehealth generally addresses coverage parity or payment parity. Coverage parity, also known as service parity, occurs when the law requires health services covered for in-person visits be the same as those covered for health services provided by telehealth visits. Payment parity provides for equal insurance reimbursement for in-person and telehealth visits. The Kaiser Family Foundation reports as of fall 2019, 41 states and the District of Columbia had laws covering health insurance reimbursement for telehealth. In approximately one-half of the states, coverage parity is codified and in fewer than one-half of the states, payment parity is codified. Telemedicine typically is reimbursed at lower than equivalent in-person care; however, in response to COVID-19, more states are enacting payment parity legislation.

Federal Activities

Before the COVID-19 pandemic, Medicare coverage of telehealth services under traditional Medicare was limited. However, in response to the COVID-19 pandemic, the federal Centers for Medicare and Medicaid Services issued guidelines and a related fact sheet to broaden access to Medicare telehealth services so beneficiaries would be able to receive a wider range of services from providers without having to travel to health care facilities. These broadened telehealth services remain in effect during the federal public health emergency, which was most recently renewed in April 2021.

The COVID-19-related changes to Medicare include:

- Which traditional Medicare beneficiaries can receive telehealth services and where;
- What technologies traditional Medicare beneficiaries can use to access telehealth services;
- What type of providers can get reimbursed by Medicare for telehealth visits;
- What services traditional Medicare beneficiaries can receive through telehealth;
- Additional services, other than telehealth, which are delivered virtually and covered by traditional Medicare;
- How Medicare pays for telehealth services;
- What traditional Medicare beneficiaries pay for telehealth services;
- How telehealth is covered under Medicare for beneficiaries and providers participating in alternative payment modes; and
- How coverage of telehealth services differs in Medicare Advantage plans.

Benefits

There are perceived benefits to using telehealth which may be especially relevant in rural states such as North Dakota. The National Conference of State Legislatures reports that "[b]y improving access to lower-cost primary and specialty care, telehealth can provide timely, accessible care in lower-cost environments and help reduce expensive emergency room (ER) visits. Aside from primary care settings, telehealth is also used in a variety of specialty areas such as behavioral and oral health." In addition, "[t]elehealth also allows for consultation between providers, which can build capacity among practitioners in rural areas, where recruiting and retaining providers remains challenging. It also can allow providers to offer care in various settings, using the full extent of their education and training within their scopes of practice, with remote supervision or other support." Although there may be perceived benefits to telehealth, the National Conference of State Legislatures recognizes the research on the effectiveness of telehealth is evolving.

Barriers

A reliable and affordable Internet connection for both the patient and the provider is necessary for many telehealth platforms. In its 2019 report, the North Dakota Broadband Plan, the Information Technology Department noted that although the state has a large land area and a small population, the state is ranked high for Internet access and overall infrastructure. The Information Technology Department report specified goals and opportunities to grow and support the state's broadband capacity and infrastructure.

Americans are connected to the world of digital information via smartphones and other mobile devices. These devices can be used by patients to participate in telehealth. The Pew Research Center reports 85 percent of Americans own a smartphone, and although cell phone ownership crosses a wide range of demographic groups, smartphone ownership varies based on age, household income, and education. A person is less likely to own a smartphone as the age of the person increases, the income of the household decreases, and the person's residence becomes more rural.

The Kaiser Family Foundation reports as of fall 2019, 41 states and the District of Columbia had laws governing reimbursement for telemedicine services in fully insured private plans. In approximately one-half of the states, including

North Dakota, the law provides for "service parity," which provides the plan must cover telemedicine services if it covers the service in-person. Fewer states require "payment parity," which provides telemedicine services must be reimbursed at the same rate as equivalent in-person services.

Unlike a fully insured plan, which must comply with both state and federal laws, a self-insured health plan is regulated by federal law. These plans may choose whether to cover telemedicine services. The Kaiser Family Foundation reports the majority of large-employer plans, including self-insured plans, cover some telemedicine services.

Typically, a provider must be licensed in the state the patient receiving services is located. Each state addresses these situations based on state law. However, multiple states participate in licensure compacts, allowing providers of participating states to practice in other compact states.

Testimony

The committee received testimony from the Insurance Department, health insurance carriers, health care providers, the National Conference of State Legislatures, the Information Technology Department, the Center for Rural Health, and other interested stakeholders.

Health Insurance Carriers

The committee received testimony from health insurance carriers regarding legislative and executive trends; the utilization of telehealth, including the telehealth mental health experience; and future policy and market outlooks.

The committee received testimony indicating all 50 states implemented some sort of telehealth policy change due to the COVID-19 pandemic. Testimony indicated North Dakota was one of multiple states that used executive authority to require health insurers enact multiple telehealth coverage changes. Testimony indicated North Dakota was one of multiple states that enacted legislation to make some of the temporary telehealth benefit enhancements permanent.

The committee received testimony that during 2020, the top diagnoses through telehealth were related to behavioral and mental health. Testimony indicated for anxiety, depression, and trauma, about 70 percent of the claims were telehealth visits; ages 35-49 used telehealth most when seeking mental health care; and for mental health telehealth services women outnumbered men by a 3-to-2 ratio.

The committee received testimony indicating telehealth will continue to be evaluated at the state and federal levels. Testimony indicated there is a focus on monitoring how patients will utilize telehealth postpandemic.

Health Care Providers

The committee received testimony from health care providers. Telehealth and virtual care can increase access to care for rural communities, underserved and vulnerable patient populations, and individuals unable to secure in-person care, ensuring everyone has access to safe, effective, and appropriate care when and where they need it. Benefits of telehealth include improved access to health care services, cost efficiencies, improved quality of health care services, meeting consumer demand, and support of rural health care and local economies.

The committee received testimony indicating the unanswered questions relating to telehealth include:

- Where are the health care disparities?
- Can telehealth relieve any of these disparities?
- Where are the broadband "deserts" and how can these be addressed?
- What kind of telehealth services are North Dakotans using and where are they located?
- Why providers are and are not limiting their use of telehealth?

The committee received testimony regarding the eAsthma clinic, a program that uses telehealth to treat pediatric patients. The testimony indicated telehealth processes can be designed to improve health care delivery to North Dakotans.

Behavioral Health

The committee received testimony telehealth is a tool to increase access to mental health services and make these services more convenient and accessible to populations that previously had difficulty accessing the service delivery system.

Testimony indicated for consumers and families, telebehavioral health services led to increased access to experienced providers and high-quality care for individual needs; improved access to continuity of care; increased

convenience that removes traditional barriers to care, including geography, accessibility, employment, child care, and caregiver responsibilities; and easier coordination of care among many specialists. Testimony indicated telebehavioral health services also reduce stigma for those living in rural communities by giving comfort that their experiences will remain confidential. Telebehavioral health services made it easy to reduce psychological barriers to treatment access for people who have difficulty leaving their homes.

National Conference of State Legislators

The committee received testimony identifying the following telehealth policy levers: Medicaid; private insurance, including payment parity and coverage parity; cross-state licensing, including licensure compacts; telehealth modalities; authorized telehealth providers; authorized services for telehealth; site restrictions; teleprescribing; and patient-provider relationships.

The committee received testimony providing an overview of payment parity trends. Testimony indicated the neighboring states of Iowa, Minnesota, and Nebraska have enacted telehealth payment parity legislation.

Center for Rural Health

The committee received testimony summarizing a 2022 survey of 14 critical access hospital chief executive officers and 4 representatives of association, consulting groups, and academic centers. Testimony indicated the survey provided that during the COVID-19 pandemic, utilization of telehealth peaked and following the pandemic, utilization returned to prepandemic levels. The barriers identified included:

- Payment and reimbursement;
- Local provider culture and attitude;
- Specialist provider culture and attitude;
- Patient culture and attitude; and
- Broadband availability.

The recommendations resulting from the survey included addressing inadequate payment for telehealth services, the need for support in patient education on using simple technology, the need for technology funding, and addressing the rural health care workforce shortage.

Information Technology

The committee received testimony providing an overview of federal legislation, including the federal Infrastructure Investment and Jobs Act and the related Broadband Equity, Access, and Deployment (BEAD) program, Affordable Connectivity program, and the Digital Equity programs. The BEAD program consists of $42 billion that will be distributed to states and territories to help finance broadband deployment projects. The testimony indicated the BEAD program focuses on underserved areas first. The Affordable Connectivity program helps low-income households pay for Internet services and connected devices. The goal of the Digital Equity programs is to ensure all people and communities have the skills, technology, and capacity needed to reap the full benefits of a digital economy.

Committee Considerations

The committee considered whether to recommend legislation to provide for telehealth payment parity. The committee did not reach a consensus on whether to pursue telehealth payment parity legislation.

Conclusion

The committee makes no recommendation with respect to the telehealth services study.

COMMUNITY HEALTH WORKER STUDY

Legislative History

North Dakota does not regulate community health workers (CHWs), define CHW or CHW scope of practice, provide medical assistance reimbursement for CHW services, or have a state CHW training or certification program. Senate Bill No. 2321 (2015) would have provided for medical assistance reimbursement of certified CHWs, but failed to pass in the House. However, in Indian Country, community health representatives (CHRs) may bill Medicaid for targeted case management services provided to recipients of long-term care services.

Background

The United States Department of Health and Human Services Health Resources and Services Administration (HRSA) provides:

Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as)," outreach educators, community health representatives, peer health promoters, and peer health educators. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.

Although the scope of practice of a CHW likely is related directly to how the term "community health worker" is defined in the jurisdiction of practice, there are some traditional roles CHWs fill. Community health workers typically work in the communities in which they live, working in community health facilities providing case management, client education, and followup care. Services provided by CHWs often include:

- Creating connections between vulnerable populations and health care systems;
- Providing health education on topics related to chronic disease prevention, physical activity, and nutrition;
- Performing health screenings, informal counseling, and referrals; and
- Facilitating health care and social service system navigation.

A CHW national employer inventory of all 50 states was conducted as part of a HRSA study in 2007. This survey provided the most frequently reported health issues for which employers chose interventions that included CHWs: women's health (46 percent of respondents); nutrition (48 percent); children's health (41 percent); pregnancy/prenatal care (41 percent); immunizations (37 percent); and sexual behavior (34 percent).

As of 2019, at least nine states had enacted laws or passed regulations for CHW certification. Training requirements for CHWs vary widely from state to state, ranging from formal education to on-the-job experience. Almost half of the states have CHW training programs, some of which are connected to certification and were established by state agencies.

Testimony

The committee received testimony from the Indian Affairs Commission and tribal representatives, health care providers, the National Academy for State Health Policy, the Department of Human Services, representatives of other states, and other interested stakeholders.

Overview

The committee received an overview of CHWs, including a survey of how many states' Medicaid programs reimburse for CHW services; what type of Medicaid payment mechanism is used by states for Medicaid reimbursement of CHW services, such as state plan amendment, Section 1115 demonstration, fee-for-service reimbursement, and managed care contracts; how CHWs have been used in response to the COVID-19 pandemic; and how states can partner with CHW associations in supporting CHWs, such as certification and training to qualify for Medicaid reimbursement. Testimony indicated areas of consideration for states considering support of CHWs include:

- Defining reimbursable services and considering "medicalization" of CHW services;
- Setting standards for CHW qualifications for enrollment with Medicaid;
- Considering utilization and eligibility for Medicaid-reimbursable services;
- Considering opportunities for partnership with managed care and existing care coordination services;
- Considering workforce development needs; and
- Setting community priorities to shape strong, fair CHW programs.

Other States

The committee received an overview of how Oregon implemented CHWs. In 2014, the Oregon Integrated and Coordinated Health Care Delivery System was established through a Section 1115 waiver which prompted the launch of coordinated care organizations and required development of traditional health workers. Testimony indicated the five types of traditional health workers in Oregon are CHWs, peer support specialists, peer wellness specialists, personal health navigators, and birth doulas.

The committee was informed the Oregon Health Authority Office of Equity and Inclusion is charged with partnering with communities to eliminate health gaps and promote optimal health in Oregon and with oversight for the traditional health worker program, including training, continuing education, and certification.

In Oregon, CHWs are financed differently based on the setting. In community-based organizations, CHWs generally are funded through grants and contracts, and in health care settings, CHWs are funded through health-related services, fee-for-service, and value-based payments.

The committee received an overview of the CHW infrastructure in place in South Dakota. The timeline for implementing a CHW system in South Dakota was:

- In 2015, the South Dakota Department of Health conducted an environmental scan and statewide analysis of the CHW workforce.
- In 2016, the South Dakota Department of Health and South Dakota Department of Social Services co-facilitated a workgroup to develop recommendations for CHWs in South Dakota.
- In 2019, the South Dakota Department of Social Services announced CHW services as a covered service of South Dakota Medicaid.
- In 2020, the South Dakota Department of Health launched Community Health Workers of South Dakota (CHWSD) to promote and develop the CHW workforce in South Dakota and developed the CHWSD 2021-23 Strategic Plan.
- In 2021, CHWSD received additional funding through the Centers for Disease Control and Prevention (CDC) Health Disparities Grant.

The committee received testimony regarding CHWSD training programs and how training relates to reimbursement, including Medicaid reimbursement.

Medicaid

The committee received testimony from the Department of Human Services regarding steps to be taken before Medicaid could enroll or reimburse CHWs, which would take approximately 2 to 3 years to establish and would include:

- Implementing a scope of practice for CHWs in law or rule;
- Implementing a standardized licensure or certification system for CHWs;
- Developing a Medicaid fiscal estimate based on CHW scope of practice, CHW availability in the workforce, and the utilization of CHWs by enrollees; and
- Adopting administrative rules and possibly state plan updates, system changes, and provider enrollment updates, which would be dependent on appropriation of funds and increasing Medicaid staff resources.

Health Care Providers

The committee received testimony from a health care provider network regarding how it utilizes CHWs in Bismarck, Fargo, Hillsboro, and Mayville. Testimony indicated CHW program goals include strengthening the bridge between ambulatory care and community, increasing social determinants of health assessments and support, securing stable funding and reimbursement for CHW work to support sustainability, and increasing referrals to chronic disease self-management programming.

The committee received information regarding allowing community paramedics to operate as an extension of public health, primary care, or other stakeholder partnership to improve the health of the community. The committee received testimony on the status of adoption of administrative rules regarding community paramedics.

The committee received testimony from a representative of a community health center regarding the value of CHW services in the community health center setting. The testimony was in support of providing grant funding for CHWs as well as Medicaid and private insurance reimbursement for CHW services.

Community Health Representatives

The committee received testimony regarding the community health representatives (CHR) system used by the Indian tribes in the state. Testimony indicated although the CHR programs differ from tribe to tribe, a majority of the CHR workforce live in and are active members of the communities they serve. Testimony indicated this integration builds trust, a key element of the CHR program.

The committee received testimony regarding CHRs who work on the Mandan, Hidatsa, and Arikara Nation as frontline public health workers who facilitate access to quality and culturally competent services. The CHRs are funded through a 638 contract with Indian Health Services (IHS) and are trained through an IHS training program. Testimony indicated challenges faced by the CHRs include staffing, funding, reimbursement for services, and the Medicaid enrollment process. Activities and services provided by the CHRs include:

- Home visits, which may include blood pressure and blood sugar checks, certified nurse assistant services, light cleaning, and food shopping and preparation assistance;
- Medication pickup and delivery;
- Car seat and crib safety demonstrations;
- Transportation to and from health care appointments;
- First aid and cardiopulmonary resuscitation training services;
- Community health education; and
- Safety services at powwows.

Committee Considerations

The committee recognized the value CHWs provide in the health care delivery system. The committee considered a bill draft that would establish a CHW taskforce to develop a data-driven plan for CHW education and training, regulation of CHWs, and medical assistance reimbursement for CHW services. Some members of the committee were concerned the bill draft would delay implementation for 2 years. Other committee members viewed the taskforce activities as a tangible step forward in working with stakeholders to develop CHW, education, training, and regulation standards.

The committee considered a bill draft that would provide for certification of CHWs and a Medicaid state plan amendment to provide for medical assistance reimbursement for CHW services. Some members of the committee were concerned the bill draft lacked sufficient guidance for CHW education and regulation. Other committee members recognized the Department of Health and Human Services has the necessary expertise to develop regulatory provisions for the practice of CHWs and should move forward on a Medicaid state plan amendment as soon as possible. In considering the two bill drafts, the committee did not reach consensus on which approach to develop a CHW initiative had more merit.

Recommendations

The committee recommends a bill draft [23.0069.01000] to establish a CHW taskforce to develop a data-driven plan for CHW education, training, regulation, and medical assistance reimbursement.

The committee recommends a bill draft [23.0103.02000] to provide for certification of CHWs and a Medicaid state plan amendment to provide for medical assistance reimbursement for CHW services.

STATE FIRE MARSHAL REPORT

Section 18-13-02 directs the State Fire Marshal to review the effectiveness of the section and report any findings and recommendations to the Legislative Management. Section 18-13-02 requires all cigarettes sold or offered for sale in the state to be tested in accordance with the American Society of Testing and Materials (ASTM) E2187-04. The report indicated although the number of reported fires caused by cigarettes has increased in recent years, so has the overall number of fires reported. The report also indicated the effectiveness of the fire safe cigarette program is difficult to decipher with the data collected.

The report recommended consideration be given to updating the language of Section 18-13-02 to include "ASTM E2187-04 or the most current standard test method under designation E2187 (Standard test method for measuring the ignition strength of cigarettes)." The change would clarify the standard to be used and enable the State Fire Marshal's office to enforce the safest and most current standards.

DIABETES REPORT

The committee received a report, pursuant to Section 23-01-40, from a representative of the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS 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. The report indicated each of the contributing agencies agreed diabetes can best be prevented through a cross-sector, community-based approach with goals to increase:

- Access to nutritious food options, addressing availability, affordability, food security, and knowledge among communities;

- Wellness programming for youth, including physical activity and cooking instruction;
- Equitable access to quality medical care that is aligned with best practice guidelines; and
- Mental and behavioral health services for individuals with diabetes or at risk for diabetes.

The report indicated the following action items:

- Institute minimum health insurance policy coverage requirements for diabetes treatment and services;
- Support a comprehensive transition toward value-based care and reimbursement models designed to increase utilization of preventive care, improve quality of services, and reduce incurred costs related to the treatment of chronic disease;
- Support cities and counties implementing transformation projects that encourage year-round, healthy living and physical recreation for residents;
- Develop sustainable food systems at the community level; and
- Implement policy and system changes at the state and local level which address socioeconomic factors contributing to rising obesity rates.

The report indicated the following action items have a fiscal element:

- Development of a community grant fund to support strategies to reduce diabetes and risk factors and to identify root causes, and implementation of policy, system, and environmental change.
- Development of a statewide, multi-agency committee to review and approve community grant fund applications and to provide in-depth technical assistance for implementation.

STROKE REPORT

The committee received a report from the State Department of Health regarding progress made toward the recommendations provided in Section 23-43-04, relating to stroke centers and stroke care. The report indicated the department has established and maintained a comprehensive stroke system that ensures nationally recognized guidelines and protocols are followed with the intention to improve outcomes and reduce mortality and morbidity related to strokes.

MATERNAL MORTALITY REPORT

The committee received a report from the Maternal Mortality Review Committee (MMRC) as required by Section 23-51-08. The report indicated although MMRC was founded in 1954 as a subcommittee of the North Dakota Society of Obstetrics and Gynecology and is one of the oldest MMRCs in the country, House Bill No. 1205 (2021) established a maternal mortality review committee and provided a continuing appropriation. The Maternal Mortality Review Committee's objectives include remaining nonpartisan and performing an annual review of maternal deaths in the state and providing education. The Centers for Disease Control and Prevention's definition of maternal death defines a pregnancy-related death as the death of a woman while pregnant or within 1 year of the end of the pregnancy from any cause related to or aggravated by the pregnancy. The World Health Organization defines maternal death as the death of a woman within 42 days of termination of pregnancy, from any cause related to pregnancy. North Dakota ranks 21st out of 50 states with 20.1 maternal deaths per 100,000 births, California ranks 1st with 4 maternal deaths per 100,000 births, and Louisiana ranks 46th with 58.1 maternal deaths per 100,000 births. In 2021, North Dakota had a total of 10 maternal deaths, 8 of which had possible pregnancy association, and 2 of which met the CDC's definition of maternal death.

HEALTH INSURANCE MANDATE COST-BENEFIT ANALYSIS RECOMMENDATION

Section 54-03-28, which requires a cost-benefit analysis on a legislative measure providing for a health insurance mandate, was amended by Senate Bill No. 2130 (2021). The bill sought to provide additional time in which to conduct the cost-benefit analysis. Section 54-03-28 provides a measure may not be referred to committee unless the cost-benefit analysis is appended to the measure. A standing committee may request a cost-benefit analysis if the analysis is missing or the measure is amended.

The Insurance Commissioner received proposals from Milliman, Inc., NovaRest, Inc., and Wakely to provide the cost-benefit analysis required under Section 54-03-28. The Insurance Commissioner recommended, based on the proposals received, the Legislative Management contract with NovaRest to perform cost-benefit analyses of legislative measures to be considered by the 68th Legislative Assembly.

Recommendation

The committee recommends the Legislative Council contract with NovaRest, Inc., for cost-benefit analyses of legislative measures to be considered by the 68th Legislative Assembly mandating health insurance coverage pursuant to Section 54-03-28.