NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

INSURANCE AND HEALTH CARE COMMITTEE

Wednesday, December 10, 1997
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Karen K. Krebsbach, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Karen K. Krebsbach, Jerry Klein; Representatives Michael Brandenburg, Mike Callahan, Ron Carlisle, Al Carlson, Pam Gulleson, Kenneth Kroeplin, Clara Sue Price, Wanda Rose, John M. Warner

Members absent: Senator Judy L. DeMers; Representatives Thomas T. Brusegaard, David Drovdal, Alice Olson

Others present: See Appendix A

It was moved by Representative Carlson, seconded by Representative Carlisle, and carried on a voice vote that the minutes of the October 22, 1997, meeting be approved as mailed.

EMERGENCY MEDICAL SERVICES STUDY

State Services and Funds

Chairman Krebsbach called on Mr. Tim Wiedrich, Director, Division of Emergency Health Services, State Department of Health, for comments regarding the division's current biennium budget, plans for the next biennium budget, and the prioritization of implementing elements of the five-year emergency medical services plan.

Mr. Wiedrich said the current biennial budget for emergency medical services programs is $1,091,475, and is made up of state and federal funds. He said $470,000 of the budget is for training grants and $621,475 is for operational activities. A copy of his written testimony is attached as Appendix B.

In response to a question from Senator Krebsbach regarding critical incident stress debriefing services provided by the state, Mr. Wiedrich said typically a local emergency medical services provider contacts the division, the division evaluates the situation, and the division makes a referral to one of four regional services.

In response to a question from Representative Carlisle regarding the division's use of additional funds for emergency medical services, Mr. Wiedrich said the Governor has not presented his direction to the department, but the division will be working with the Governor to develop the proposed State Department of Health budget for next biennium.

In response to a question from Representative Rose, Mr. Wiedrich said one reason for discrepancies across the state in the amount of mill levies is that emergency medical services systems vary across the state. He said, for example, a county in the western portion of the state can set the maximum mill levy and collect less money than an eastern county with a lower levy; therefore, a uniform mill levy will not work. He said some counties hesitate to increase mill levies because the amount of increased tax funding will be less than the amount of voluntary funding lost from decreased giving to other fundraising activities.

In response to a question from Representative Gulleson, Mr. Wiedrich said an emergency medical services unit needs trained personnel for the unit to benefit from a new ambulance. He said there is a fine line between investing in personnel and investing in equipment.

In response to a question from Representative Carlson, Mr. Wiedrich said local units are not required to match state training funds, although the units are required to make a 50 percent match for equipment grants. He said the state is not making equipment grants because according to expressed legislative intent, training needs must be met before money is provided for equipment.

Mr. Wiedrich provided the committee with information regarding the number of North Dakota ambulance service runs accepted in North Dakota in 1996. A copy of this data is on file in the Legislative Council office. Representative Klein asked for additional information regarding how this acceptance run data was collected.

Training Standards

In response to a question from Representative Warner, Mr. Wiedrich said although each state sets its own training standards, most states have adopted the federal standards for emergency medical technician basic training. If a state's training standards differ from the federal standards, he said, the state is more likely to supplement the standards than detract from or delete training requirements.

In response to a question from Representative Kroeplin, Mr. Wiedrich said the number of continuing education credits required of emergency medical services providers has not increased over the last 20 years, although new medical innovations need to be included in the number of hours, and as a result, the content of the training hours has become more complex.

Mr. Wiedrich said emergency medical services volunteers chose their level of participation, and most volunteers chose to participate at the emergency medical technician basic level. If training requirements were standing in the way of attracting volunteers, he said, the data would reflect that most volunteers chose to be ambulance drivers, who are required only to have vehicle operator's licenses.

Volunteer Ambulance Services

In response to a question from Representative Carlisle, Mr. Wiedrich said the emergency medical services system needs to be improved and it is a struggle to maintain the system. He said the low rate of volunteerism is not unique to emergency medical services.

Chairman Krebsbach called on Ms. Vicki Berreth, Kidder County Ambulance Service volunteer, for comments regarding volunteer recruitment and fiscal concerns. Ms. Berreth provided a copy of the service's 1996 income and expenses data, a copy of which is on file in the Legislative Council office.

Ms. Berreth said the Kidder County Ambulance Service's 1996 income was $71,713.81 and expenditures were $51,852.74. She said 10 percent of every dollar the unit receives is put into savings for new rigs and in 1996, $19,668.80 was put into savings in anticipation of purchasing a new ambulance.

Ms. Berreth said considerable time and emotional investment is required of volunteers. The ambulance board has considered paying volunteers in an attempt to counter burnout, she said, but the finances are not available to do this. She said Kidder County is the only county in the state which levies the maximum allowable five mills.

In response to a question from Representative Gulleson, Ms. Berreth said some employers pay employees for hours spent volunteering, and she thinks bake sales are good for volunteers' spirits.

In response to a question from Representative Carlisle, Ms. Berreth said ambulance units can accept charitable gaming proceeds.

In response to a question from Representative Price, Ms. Berreth said Medicaid and Medicare clients' bills are frequently written off as uncollectible. She said billable charges were approximately $40,000 in 1996, but only $29,840.54 was collected.

In response to a question from Representative Carlisle, Ms. Berreth said when clients fraudulently avoid payment of emergency medical services bills, the Bureau of Criminal Investigation may pursue the debtor.

Chairman Krebsbach called on Mr. Scott Sayer, Finley Ambulance Service volunteer, for comments regarding volunteer recruitment and fiscal concerns. Mr. Sayer said it costs approximately $375 for initial emergency medical services basic certification training. He said training funds typically come from Finley city funds. He said training is an integral part of the emergency medical services system because it is the emergency medical service providers who give care to patients during the "golden hour" before the patient reaches a hospital.

In response to a question from Representative Carlisle, Mr. Sayer said funding for training is the number 1 need for ambulance units, and equipment is the number 2 need. He said the state should fund training and equipment needs through tax dollars. He said the figures the state uses to determine the amount of the training funds the state distributes are from the late 1980s, and these figures need to be evaluated and updated.

In response to a question from Representative Brandenburg, Mr. Sayer said charges for services provided by the Finley Ambulance Service are set and billed by the city, and Medicare may have special requirements the city is bound to follow. He said the service does not receive county funds.

In response to a question from Representative Callahan, Mr. Sayer said the Finley Ambulance Service cooperates with and receives medical direction from the Mayville Hospital but does not receive money from the hospital.

Chairman Krebsbach called on Mr. Dale Severson, Cooperstown Ambulance Service volunteer, for comments regarding the price of volunteerism in North Dakota.

Mr. Severson addressed the number of ambulance services in the state and the average number of emergency medical technicians per service. He illustrated the number of work hours and expenses volunteer emergency medical technicians incur and the amount of state grant reimbursement. A copy of his written testimony is attached as Appendix C.

In response to a question from Senator Krebsbach, Mr. Severson said in addition to continuing education requirements, ambulance services typically require inservice training.

In response to a question from Representative Rose, Mr. Severson said volunteers are recruited via public relations avenues such as newspapers, public forums, and volunteer networking with local organizations. If an emergency medical technician leaves an ambulance service and does not maintain and keep up to date, he said, the technician must repeat the entire certification to reenter an ambulance service.

In response to a question from Senator Klein, Mr. Severson said when his county tried to set a mill levy at 2.8, it was unsuccessful because the mill levy was perceived to be a tax increase.

In response to a question from Representative Brandenburg, Mr. Severson said the city of Cooperstown annually reviews the service fee schedule, and the schedule is based on the cost of providing services.

In response to a question from Representative Callahan, Mr. Severson said the relationship between the Cooperstown Ambulance Service and the local hospital is strong.

In response to a question from Representative Kroeplin, Mr. Severson said information regarding

how to bill for Medicare and Medicaid services is available from Blue Cross Blue Shield of North Dakota, but the problem is that the Medicare and Medicaid rules change so rapidly that the ambulance services have a hard time keeping up to date.

In response to a question from Senator Krebsbach, Mr. Severson said he is not aware of situations of abuse of Medicaid in requesting ambulance services.

Representative Brandenburg said he is concerned about the billing process used by private and volunteer ambulance services. Representative Price asked Mr. Tom Smith and Mr. Dan Ulmer whether they would be willing to provide the committee with information regarding reimbursement of ambulance services.

Medicaid and Medicare Reimbursement

Chairman Krebsbach called on Mr. Todd Porter, Director, Metro Area Ambulance Service, for comments regarding Medicare and Medicaid reimbursements. His testimony included information regarding state laws and administrative rules that affect Medicaid reimbursement; Medicare reimbursement related provisions of the federal 1997 Budget Reconciliation Act; and Blue Cross Blue Shield of North Dakota's 1998 ambulance service fee schedule. A copy of his written testimony is attached as Appendix D. Information regarding Medicaid reimbursement rates is on file in the Legislative Council office.

Mr. Porter said when evaluating the fiscal aspect of ambulance services, it is the rate of reimbursement that is most important, not the amount charged for a particular service. He said bad debt is unbelievably high in the ambulance industry, and nationally 20 to 40 percent of bad debt is written off by ambulance services.

In response to a question from Representative Callahan, Mr. Porter said although Medicare and Medicaid use the same billing codes, the rates established by the state for Medicaid are different from the rates established by the federal government for Medicare. He said the new Medicare rate structure may impact ambulance transportation reimbursement.

Mr. Porter said the nature of ambulance services is that a service cannot refuse to provide services to a patient; therefore, ambulance services sometimes transport individuals with "stubbed toes."

Mr. Porter said because federal law prevents kickbacks, hospitals are not allowed to financially support independent ambulance services. He said private ambulance services may charge more than volunteer ambulance services because of higher overhead costs resulting from having employees rather than unpaid volunteers.

In response to a question from Representative Brandenburg, Mr. Porter said volunteer services may charge as much as private services, but it is important to avoid price fixing. He said the services need to set charges based on the cost of providing the service.

In response to a question from Representative Kroeplin, Mr. Porter said he is not sure whether insurance companies reimburse private services differently from volunteer services.

In response to a question from Representative Carlson, Mr. Porter said whether ambulance services exist which economically should not exist because a large city is nearby which has duplicate services is a decision each community needs to make. He said ambulance services compete with each other for nonemergency services such as nursing home transports but do not compete for emergency services.

Other States

Chairman Krebsbach called on committee counsel to present information on how other states fund emergency medical services programs and to provide updated funding source data.

Committee counsel said Emergency Medical Services Magazine publishes an annual buyer's guide every December, and this guide includes a state and province survey of emergency medical service programs which is a compilation of survey responses from each of the states and several Canadian provinces. She said the Emergency Medical Services Magazine will publish its 1997 state and province survey in December, and unique funding source data information from the survey will be provided to the committee at a future meeting.

Committee counsel distributed a copy of a memorandum entitled *Emergency Medical Services Magazine - Abbreviated 1996 State and Province Survey*, which lists survey responses for the following categories: responsible certification agency, number of permanent state emergency medical services office staff members, federal and government funding, state funds allocated to run emergency medical services offices, unique funding methods, statewide data-gathering system, and important changes and developments within the last year; and a copy of a memorandum entitled *Emergency Medical Services Magazine - 1996 Summary of Unique Funding Methods*, which further condenses the survey results. She said unique funding sources include special education trust funds, revenue from emergency medical services publications, ordinance violations, preventative health services block grants, vehicle registration fees, driver's license fees, seatbelt violation fines, tax levies, sales tax, and emergency medical services licensure fees.

Funding Source Data

Committee counsel presented information regarding possible emergency medical services funding sources: a memorandum entitled *Possible Emergency Medical Services Funding Sources - State Tax Data*; a memorandum entitled *Emergency Medical Services Funding Sources - Telecommunications Relay Service Surcharge Data*; data from the Public Service Commission regarding

the number of state telephone access lines, a copy of which is on file in the Legislative Council office; and a letter from Ms. Rose E. Tibke, North Dakota Insurance Department, regarding possible insurance premium funding sources, a copy of which is on file in the Legislative Council office.

Committee counsel said when evaluating possible funding sources, Section 11 of Article X of the Constitution of North Dakota provides that revenue from gasoline and other fuel excise and license taxation, motor vehicle registration, and license taxes may only be used for construction, reconstruction, repair, and maintenance of public highways. If the committee considers tapping into moneys received from noncriminal traffic violations, she said, Section 2 of Article IX of the Constitution of North Dakota limits how fines for violation of state laws may be used. She said a fee paid for a noncriminal traffic violation is considered a bond forfeiture when the violation is not contested in court, and if the violation is contested and then paid, it is considered a statutory fee. North Dakota Century Code Section 29-27-02.1 provides that bond forfeitures are credited to the state general fund, she said, and statutory fees go to the state school fund.

Representative Wardner requested that information be provided at a future meeting regarding the yearly amount of bond forfeitures within the state.

Chairman Krebsbach called on Mr. Mark Haugen, Past President, Emergency Medical Services Association, for comments regarding emergency medical services needs and possible funding sources.

Mr. Haugen addressed North Dakota's emergency medical services system as a statewide public safety network, the current state emergency medical services budget, actual emergency medical services financial needs, and possible funding sources. He proposed that emergency medical services funding shortfalls be met by imposing an excise tax on nongovernmental access telephone lines. A copy of his written testimony is attached as Appendix E.

In response to a question from Representative Gulleson, Mr. Haugen said the Emergency Medical Services Association did not consult with the telephone companies and cooperatives regarding the association's proposal to charge cellular telephone users a fee. He said it is possible the telephone companies and cooperatives will raise the same objections to an emergency medical services charge on cellular telephones as it did last session in response to proposed legislation to charge cellular telephone users. He said a charge on cellular telephone users is especially appropriate considering the use of cellular telephones to report roadside accidents.

In response to a question from Representative Carlisle, Mr. Haugen said the Emergency Medical Services Association plans to meet with the Governor early in 1998.

TELEMEDICINE STUDY

University of North Dakota School of Medicine and Health Sciences

Chairman Krebsbach called on Mr. Bruce Briggs, Assistant to the Dean, University of North Dakota School of Medicine and Health Sciences, for comments regarding telemedicine. Mr. Briggs was the onsite representative from the School of Medicine and Health Sciences, and Dr. H. David Wilson, Dean, University of North Dakota School of Medicine and Health Sciences and Dr. William Mann, Chairman, Family Medicine, University of North Dakota School of Medicine and Health Sciences, were linked into the Roughrider Room via the Internet.

Dean Wilson said that in preparation for the Governor's conference on telemedicine, which was held in Bismarck on October 8-9, 1997, the University of North Dakota School of Medicine and Health Sciences developed a document entitled *Understanding Telemedicine: Ten Basic Concepts*. Copies of this document are on file in the Legislative Council office. He encouraged the committee members to use this document as a telemedicine educational resource.

Dean Wilson said the School of Medicine and Health Sciences uses a variety of forms of technology to reach satellite locations. He said these methods include the Medstar system, which is a satellite system, and Internet telecommunications similar to the technology used today.

Dean Wilson said one of the ongoing hurdles the School of Medicine and Health Sciences must overcome is the lack of resources to implement these technologies. He said the impact of telemedicine in rural areas is significant, and some of the legislative issues related to telemedicine are licensure across state lines and reimbursement for telemedicine services.

Dr. Mann said the goal of the School of Medicine and Health Sciences is to graduate talented, enthusiastic doctors who will practice in rural North Dakota. He said one of the important elements in reaching this goal is to teach medical students while the students are in rural settings, and telemedicine helps accomplish this.

Dr. Mann said the School of Medicine and Health Sciences is using telemedicine technology to provide mental health consultations, provide preventive medical services, provide virtual house calls that connect the school with residents in training, and to allow out-of-state professors to teach students in North Dakota. He said patients are very receptive to telemedicine.

In response to a question from Representative Gulleson, Dean Wilson said the education system needs funding to purchase equipment, and it would be helpful if users of telemedicine technology coordinated their efforts to increase universality between systems. He said the mental health consultations performed by the School of Medicine and Health Sciences do not

charge for the telemedicine aspect of the consultation because the program is in the pilot project phase. He said the Medstar system requires hospitals to make a modest investment to be part of the system, but the actual use of the system satellite is very expensive.

In response to a question from Senator Krebsbach, Dr. Mann said out-of-state licensure issues are hot topics in several states. Dean Wilson said telemedicine promotes high quality of care and cost savings. Mr. Briggs said the issue of licensure is not unique to telemedicine; with advancing technology, licensure is relevant to all licensed professionals.

In response to a question from Representative Price, Dean Wilson said although he is not very familiar with the technology South Dakota used to build a statewide system for telemedicine and teleeducation, he sees the benefits a statewide system could have for the School of Medicine and Health Sciences.

In response to a question from Representative Callahan regarding the cost-effectiveness of technology, Dr. Mann said the type of technology required by a user is dictated by the needs of the situation. He said real-time technology is more appropriate for urgent situations, whereas store-and-forward technology is more appropriate for nonemergency situations. Cost-effectiveness is also impacted by joint use of technology, he said, for example, a hospital and a library using the same system. Mr. Briggs said the free market or legislation can address infrastructure issues, allocation issues, and budget issues. Mr. Don Larson, Computer Services Coordinator, University of North Dakota School of Medicine and Health Sciences, said use of telemedicine and teletechnology does not have to be limited to one type of infrastructure; for example, for purposes of this committee meeting, the telephone and Internet system is used, but for other situations different technology may be appropriate. Dean Wilson said technology is for the public good, such as the highway system, which is made available as a common good and precious resource.

In response to a question from Representative Rose, Dean Wilson said security and confidentiality are being addressed by encryption.

TeleCare Network

Chairman Krebsbach called on Ms. Shari Frueh, Project Director, TeleCare Network, St. Alexius Medical Center, for comments regarding telemedicine, telemedicine-related legislative needs, and barriers relating to telemedicine. Ms. Frueh distributed copies of written material regarding the TeleCare network system, copies of which are on file in the Legislative Council office. Ms. Frueh said approximately 59 percent of the use of the TeleCare network is for clinical services, with the other 41 percent split between a variety of uses.

Ms. Frueh said barriers related to telemedicine include the high cost of technology, licensing and credentials, malpractice concerns, acceptance of technology, and reimbursement issues. She said generally Medicaid and Blue Cross Blue Shield of North Dakota reimburse for telemedicine services, and procedures are being established at the federal level to establish reimbursement for Medicare.

In response to a question from Representative Carlson, Ms. Frueh said St. Alexius Medical Center is dealing with the issue of licensure by requiring medical providers who provide services to out-of-state patients to have a second license for the patient's state. She said, for example, a North Dakota doctor providing telemedicine services to a South Dakota patient is licensed in North Dakota and South Dakota.

Dakota Telemedicine System

Chairman Krebsbach called on Dr. Craig Lambrecht, Medical Director, Dakota Telemedicine System, Medcenter One Health Systems, for comments regarding telemedicine, telemedicine-related legislative needs, and barriers relating to telemedicine. Dr. Lambrecht distributed a map that illustrates where the Dakota Telemedicine System locations are in North Dakota. A copy of this handout is on file in the Legislative Council office. He said system locations cover almost all regions of the state, and the basic line charge for the telemedicine system is $1,400 per site per month. He said one of the problems regarding line charges is determining who is in charge of the different telephone lines. He said the bridge technology used by Dakota Telemedicine, which allows simultaneous use of the system between a variety of sites, costs approximately $400,000.

Dr. Lambrecht said the creation of a state telemedicine system is not necessary. He said with Medcenter One and other health care providers covering the state with telemedicine services, the state can meet its telemedicine and teletechnology needs by buying time from existing systems, and thus rely on a free market to avoid duplication of services.

In response to a question from Representative Gulleson, Dr. Lambrecht said it would be helpful if telephone carriers would streamline the process regarding the responsibility of telephone lines.

Dr. Lambrecht said under the current licensing system, it takes a doctor approximately eight months to get a North Dakota medical license, and it would be helpful if this process could be streamlined. He said telemedicine providers are still establishing standards for consultations. He said matters to consider include what type of peripheral equipment is appropriate, the band width required, and the resolution required.

Radiology Consultants

Mr. Don Windmueller, Radiology Consultants, addressed the telemedicine-related positions of the American College of Radiology, North Dakota Chapter of the American College of Radiology, and National Chapter of the American Medical Association. A copy of his written testimony is attached as Appendix F. Written information Mr. Windmueller provided

regarding how other states regulate out-of-state physicians is on file in the Legislative Council office.

U S West

Chairman Krebsbach called on Mr. Mark Lester, Manager, Sales and Service, US West, for comments regarding the universal service fund. Mr. Lester played a portion of a video that addressed how telephone service providers can access universal service fund money. He said U.S. West has received a lot of questions regarding the universal service fund and it appears that the money is being distributed consistently throughout the country.

Mr. Lester said telephone expenses are set by tariff and are a matter of public record. He said the amount of the tariffs do not change very often. Telemedicine networks are very complex; therefore, he said, these networks are very expensive and smaller purchasers find it more difficult to participate, although bulk purchasing is less expensive. He said U S West possesses the required technology for telemedicine and is offering it to customers that are able to afford it.

In response to a question from Representative Rose, Mr. Lester said the issue of whether the Legislative Assembly can encourage cooperation between telemedicine providers, for example, sharing of T-1 lines into small communities, largely depends on competition as well as turf protection issues.

In response to a question from Representative Callahan, Mr. Lester said digital communication technology is integral to telemedicine, and several independent telephone companies in the state are capable of dealing with this digital technology.

MANAGED CARE STUDY

Critical Access Hospitals

Chairman Krebsbach called on Mr. Fred Gladden, Director, Division of Health Facilities, State Department of Health, for comments regarding the status of critical access hospitals in the state.

Mr. Gladden said since the committee's last meeting on October 22, 1997, parties interested in the critical access hospital plan have been holding meetings, and a tentative timeline has been established for submitting a draft plan to the Health Care Financing Administration regional office in Denver, Colorado. A copy of his written testimony is attached as Appendix G and a copy of the tentative timeline is on file in the Legislative Council office.

In response to a question from Representative Callahan, Mr. Gladden said emergency medical services are integral to the critical access hospital plan, and the individuals involved in creating the plan are actively seeking comment from the Division of Emergency Health Services.

In response to a question from Representative Price, Mr. Gladden said the hospitals' interest in critical access hospitals is optimistically guarded. Mr. Arnold Thomas, President, North Dakota Health Care Association, said he is aware of four facilities in the Red River Valley area which are considering critical access hospitals as part of their long-range plans, although these facilities are waiting for more information on the plan before they make any commitments.

Grand Forks Medicaid Health Maintenance Organization Pilot Project

Chairman Krebsbach called on Mr. Tom Solberg, Administrator, Managed Care, Department of Human Services, for comments regarding the implementation of the Grand Forks Medicaid Health Maintenance Organization project and prevention and wellness services offered by the project.

Mr. Solberg said as of December 1, 1997, there were 1,543 eligible recipients and 55.2 percent of these recipients enrolled in the health maintenance organization plan. In addition to quality, access, and cost measures, he said, the health maintenance organization project will be monitoring specific diseases that will be targeted for management and review. A copy of his written testimony is attached as Appendix H.

In response to a question from Representative Callahan, Mr. Solberg said information regarding capitated rates for the project is being calculated at this time, and he will offer it to the committee as it becomes available.

Community Investment Incentives

Chairman Krebsbach called on committee counsel to provide information regarding incentives used to encourage for-profit health care providers to invest in communities and a description of Minnesota's approach to managed care.

At the request of Chairman Krebsbach, committee counsel presented additional information relating to the memorandum entitled *Managed Care - Profit Versus Nonprofit*. Committee counsel said Mr. Harry Nelson, author of the Milbank Memorial Fund Publication Nonprofit and For-Profit HMOs: Converging Practices But Different Goals, described community investment by care providers as follows:

The extent to which either nonprofit or for-profit HMOs enhance the public good is largely undocumented. Nevertheless, considerable data compiled over time by researchers who explore the behavior of nonprofit and for-profit enterprises indicates that for-profits in general track incentives more closely than do nonprofits and that nonprofits perform more activities that economic incentives do not reward. Nonprofit executives say this is because their organizations are more oriented to meeting the expectations of management, not stockholders, and their boards are forbidden by law from sharing in profits. Economists who have studied nonprofit organizations say that nonprofits are more likely than private firms to be providing benefits that are difficult to measure and evaluate.

Committee counsel said that during a telephone conversation with Mr. Nelson, he said this statement is based on information he received from Mr. Mark Schlesinger, Ph.D., and Mr. Bradford Gray, Ph.D. She said she contacted Mr. Schlesinger, and he provided her with a revised draft of an article he was writing, "A Broadened Vision for Managed Care, Part 1: Community Benefits As a Measure of Plan Performance," in which he states that nonprofits have always been assumed to invest in the good of the community but as more for-profit managed care providers enter the health care market, nonprofits are becoming more and more like for-profits in order to compete with for-profit health care providers. She said the authors say this change in the behavior in nonprofits is a good reason to impose some type of public policy to ensure that both nonprofit and for-profit managed care providers invest in communities. She said ideas offered by the authors include performance criteria, building government oversight into health care provider licensure laws, increasing the market share of nonprofit health maintenance organizations, encouraging a concentration of local markets under the auspices of a limited number of plans, or increasing the overall market share of managed care in the local community.

Minnesota Health Maintenance Organizations

Committee counsel reported that Minnesota is the only state that restricts health maintenance organization's to nonprofit organizations. She said she contacted Mr. Kent Peterson, Director, Managed Care Systems, Minnesota Health Department, regarding the legislative history of the nonprofit health maintenance organization statutes. She said the Minnesota Health Maintenance Organization Act of 1973 was enacted with the intent of keeping health care costs down and making health care more available to Minnesotans. She said the legislative history of this Act indicates the two primary actors involved in the creation of the Act were capital and competition supporters versus labor supporters. She said that according to Mr. Peterson, the labor-friendly position was that for-profits would misuse dividends in order to compete. She said Minnesota has a very complex and thorough quality assurance and data collection system. According to Mr. Peterson, she said, the health maintenance organization market in Minnesota is saturated at this time, so even if legislation were changed and for-profits were allowed, it would make very little difference. She said Mr. Peterson expressed his concern about the impact of Minnesota's nonprofit laws on cities bordering Minnesota, such as Grand Forks, Fargo, Sioux Falls, and Hudson, Wisconsin.

Health Care Data Collection

At the request of Chairman Krebsbach, committee counsel presented a memorandum entitled *Health Care Data Collection and Health Care Quality Review*. She said there are primarily two periods of statutory enactment regarding health care data collection--1987, with the creation of the Health Care Data Collection Committee; and 1995, when the State Department of Health was given direct duties to collect health care data. She said when evaluating the statutes regarding data collection and quality assurance data, it is important to distinguish between the powers given to the agency and the duties of the agency, because powers are discretionary and the duties are mandatory.

Chairman Krebsbach called on Mr. Michael J. Mullen, Policy Analyst, Division of Health Information Systems, State Department of Health, for comments regarding physician and managed care organization data collection and the evolution of managed care quality of care evaluation in this state.

Mr. Mullen reviewed the legislative authority of the State Department of Health to gather and disseminate information relating to health care claims data and to develop a program to review and improve the quality of health care in the state. A copy of his written testimony is attached as Appendix I.

Chairman Krebsbach said the next meeting of the committee will address the hail suppression study and will be either at the end of February or the first week of March.

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Jennifer S. N. Clark
Committee Counsel

ATTACH:9