

OTHER DUTIES OF THE HEALTH SERVICES COMMITTEE - BACKGROUND MEMORANDUM

In addition to the study responsibilities assigned to the Health Services Committee for the 2015-16 interim, the committee has also been assigned to:

- Receive from the State Fire Marshal a report regarding findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes;
- Receive a report from the Department of Human Services, State Department of Health, Indian Affairs Commission, and Public Employees Retirement System (PERS) before June 1, 2016, 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;
- Receive a report from the State Department of Health before June 1, 2016, regarding progress made toward the recommendations provided in North Dakota Century Code Section 23-43-04 relating to continuous improvement of quality of care for individuals with stroke and any recommendations for future legislation;
- Recommend a private entity to contract with for preparing cost-benefit analyses of health insurance mandate legislation;
- Receive a report from the Tobacco Prevention and Control Advisory Committee and the State Department of Health by September 1, 2016, regarding grant expenditures, the granting process, and reporting requirements of a \$500,000 grant provided to the State Department of Health by the advisory committee to assist in funding the department's Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs* during the 2015-17 biennium; and
- Receive periodic reports from the State Department of Health on the status of the health professional assistance program study. Before July 1, 2016, the State Department of Health must report to the Legislative Management on the outcome of the study, including recommended legislation.

REPORT ON THE EFFECTIVENESS OF LEGISLATION RELATED TO REDUCED IGNITION PROPENSITY STANDARDS FOR CIGARETTES

The Legislative Assembly in 2009 House Bill No. 1368 created Chapter 18-13 relating to reduced ignition propensity standards for cigarettes and penalties for wholesale and retail sale of cigarettes that violate the reduced propensity standards. The bill provides for enforcement of the standards by the State Fire Marshal, Tax Commissioner, and Attorney General and for monetary violations to be deposited in the fire prevention and public safety fund to be used by the State Fire Marshal to support fire safety and prevention programs. No funds were deposited into the fire prevention and public safety fund during the 2013-15 biennium, and the balance in the fund as of June 30, 2015 was \$0. In addition, fees collected for testing cigarettes are to be used by the State Fire Marshal for the purpose of processing, testing, enforcement, and oversight of ignition propensity standards. Cigarette manufacturers are required to pay the State Fire Marshal an initial \$250 fee for certification, which is deposited in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund. Deposits into the fund are estimated to total \$85,000 during the 2013-15 biennium and expenditures are estimated to total \$19,881. The balance in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund is estimated to be \$379,079 as of June 30, 2015. Section 18-13-02(6) ([Appendix A](#)) requires the State Fire Marshal to review the effectiveness of test methods and performance standards and report each interim to the Legislative Management the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. The Health Services Committee has been assigned the responsibility to receive this report.

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

The Legislative Assembly in 2013 House Bill No. 1443 created Section 23-01-40 which requires the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS collaborate to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes. Section 23-01-40(2) ([Appendix B](#)) requires before June 1 of each even-numbered year, the Department of Human Services, State

Department of Health, Indian Affairs Commission, and PERS submit a report to the Legislative Management on the following:

- a. The financial impact and reach diabetes is having on the agency, the state, and localities. Items included in this assessment must include the number of lives with diabetes impacted or covered by the agency, the number of lives with diabetes and family members impacted by prevention and diabetes control programs implemented by the agency, the financial toll or impact diabetes and diabetes complications places on the agency's programs, and the financial toll or impact diabetes and diabetes complications places on the agency's programs in comparison to other chronic diseases and conditions.
- b. An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease. This assessment must document the amount and source for any funding directed to the agency from the legislative assembly for programs and activities aimed at reaching those with diabetes.
- c. A description of the level of coordination existing between the agencies on activities, programmatic activities, and messaging on managing, treating, or preventing diabetes and diabetes complications.
- d. The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the legislative assembly. The plans must identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan must identify expected outcomes of the action steps proposed in the following biennium while also establishing benchmarks for controlling and preventing relevant forms of diabetes.
- e. The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in subdivision d. This blueprint must include a budget range for all options presented in the plan identified in subdivision d for consideration by the legislative assembly.

The Health Services Committee has been assigned the responsibility to receive this report.

REPORT ON THE CONTINUOUS IMPROVEMENT OF CARE FOR INDIVIDUALS WITH STROKE

The Legislative Assembly approved 2015 House Bill No. 1323 relating to the creation and implementation of a stroke system and to provide for a report to the Legislative Management. The bill amended Section 23-43-04 to provide the State Department of Health establish and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment; establish a data oversight process; and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment. Section 23-43-04(4) ([Appendix C](#)) requires before June 1 of each even-numbered year, the State Department of Health provide a report to the Legislative Management regarding progress made toward the recommendations provided in Section 23-43-04 and any recommendations for future legislation. The Health Services Committee has been assigned the responsibility to receive this report.

HEALTH INSURANCE COVERAGE MANDATES

Section 54-03-28 ([Appendix D](#)) provides a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The Health Services Committee has been assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2017 legislative session. The Insurance Commissioner is to pay the costs of the contracted services, and each cost-benefit analysis must include:

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

The section also provides a legislative measure mandating the health insurance coverage must provide:

1. The measure is effective only for the next biennium.
2. The application of the mandate is limited to the public employees health insurance program and the public employee retiree health insurance program.
3. For the next Legislative Assembly, PERS prepare and request introduction of a bill to repeal the expiration date and extend the mandated coverage to apply to all accident and health insurance policies.

The Public Employees Retirement System Board is also required to prepare a report, which is attached to the bill, regarding the effect of the mandated coverage or payment on the system's health insurance program. The board must include information on the utilization and costs relating to the mandated coverage and a recommendation on whether the coverage should continue.

The 2009-10 interim Health and Human Services Committee learned PERS is not required to use the services of a consultant when evaluating legislative measures mandating health insurance coverage. However, if a future analysis does require additional resources, Section 54-52.1-06.1 provides a continuing appropriation to PERS for consulting services related to the uniform group insurance program.

A majority of the members of the standing committee to which the legislative measure is referred during a legislative session, acting through the chairman, determines whether a legislative measure mandates coverage of services. Any amendment to the legislative measure that mandates health insurance coverage may not be acted on by a committee of the Legislative Assembly unless the amendment has had a cost-benefit analysis prepared and attached.

The Insurance Department has categorized and defined mandated health insurance benefits as follows:

1. Service mandates - Benefit or treatment mandates that require insurers to cover certain treatments, illnesses, services, or procedures. Examples include child immunization, well-child visits, and mammography.
2. Beneficiary mandates - Mandates or defines the categories of individuals to receive benefits. Examples include newborns from birth, adopted children from the time of adoption, and handicapped dependents.
3. Provider mandates - Mandates that require insurers to pay for services provided by specific providers. Examples include nurse practitioners, optometrists, and psychologists.
4. Administrative mandates - Mandates that relate to certain insurance reform efforts that increase the administrative expenses of a specific health care plan. Examples include information disclosures, precluding companies from basing policy rates on gender, and precluding insurers from denying coverage for preauthorized services.

Prior Recommendations

The 2003-04 and 2005-06 interim Budget Committees on Health Care, the 2007-08 interim Human Services Committee, the 2009-10 interim Health and Human Services Committee, and the 2011-12 and 2013-14 interim Health Services Committees recommended the Insurance Department contract with Milliman USA for cost-benefit analysis services on health insurance mandates during the 2005, 2007, 2009, 2011, 2013, and 2015 legislative sessions. During the 2005 legislative session, two bills were referred for cost-benefit analysis at a total cost of \$8,323. In addition, the department paid \$5,606 to Milliman USA for general project work during the 2005 legislative session for total payments during the 2005 legislative session of \$13,929. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis. The department paid a total of \$28,070 to Milliman USA for analyses conducted on three bills during the 2009 legislative session and \$14,982 to Milliman USA for analysis conducted on one bill during the 2011 legislative session. There were no health insurance mandates referred for cost-benefit analysis during the 2013 legislative session. During the 2015 legislative session, the Insurance Department paid a total of \$26,564 to Milliman USA for analyses conducted on three bills.

The 2009-10 interim Health and Human Services Committee received information regarding the length of time necessary to complete cost-benefit analyses for health insurance mandates proposed during each of the last four legislative sessions. The committee learned the number of days required to perform the analyses ranged from 6 to 19 days during the 2003 legislative session and 20 days for one bill proposed during the 2005 legislative session. The number of days required to perform the analyses ranged from 23 to 24 days for the three bills

introduced during the 2009 legislative session. Analysis performed on the one bill introduced during the 2011 legislative session took 14 days. There were no mandates proposed during the 2007 and 2013 legislative sessions. During the 2015 legislative session, the number of days required to perform the analyses of three bills ranged from 14 to 21 days.

In September 2008, the 2007-08 interim Legislative Management Committee recommended proposed amendments to House and Senate Rules 402 relating to bill introduction deadlines for measures subject to cost-benefit analysis under Section 54-03-28. The proposed rules amendment provided a current legislator may submit a mandated health insurance bill to the Employee Benefits Programs Committee no later than April 1 of the year before a regular legislative session. Any new legislator taking office after November 30 of the year preceding the legislative session may submit a mandated health insurance bill for consideration by the Employee Benefits Programs Committee no later than the first Wednesday following adjournment of the organizational session. During the December 2008 organizational session, the House adopted the proposed amendment to House Rule 402, but the Senate has not yet adopted the rule.

REPORT ON THE TOBACCO PREVENTION AND CONTROL ADVISORY COMMITTEE GRANT TO THE STATE DEPARTMENT OF HEALTH

The Legislative Assembly approved 2015 House Bill No. 1024, the funding bill for the Tobacco Prevention and Control Advisory Committee, which included \$500,000 from the tobacco prevention and control trust fund for a grant to the State Department of Health to be used for the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs* during the 2015-17 biennium. Section 2 of the bill ([Appendix E](#)) requires the Tobacco Prevention and Control Advisory Committee and the State Department of Health report to the Legislative Management by September 1, 2016, regarding grant expenditures, the granting process, and reporting requirements of the grant. The Health Services Committee has been assigned the responsibility to receive this report.

The Legislative Assembly, in 2015 House Bill No. 1004, provided a total tobacco prevention appropriation of \$6,910,177 to the State Department of Health, of which \$3,440,864 is from the community health trust fund, \$2,969,313 is from federal funds, and \$500,000 is from a grant provided by the Tobacco Prevention and Control Advisory Committee from the tobacco prevention and control trust fund. Funding from the community health trust fund provides for community health tobacco programs, the Tobacco Quitline, and a tobacco prevention coordinator. Certain tobacco-related programs currently provided through the State Department of Health qualify as best practices as outlined by the Centers for Disease Control and Prevention. As a result, the funding for the Tobacco Prevention and Control Executive Committee is adjusted accordingly. However, because the State Department of Health anticipates reductions in federal funding available for tobacco prevention and control, the Legislative Assembly increased 2015-17 biennium authority for the Tobacco Prevention and Control Executive Committee and the State Department of Health to provide for a \$500,000 grant from the tobacco prevention and control trust fund to the State Department of Health. Funding for the comprehensive statewide tobacco prevention and control program is summarized as follows:

2015-17 Biennium	Community Health Trust Fund	Tobacco Prevention and Control Trust Fund	Federal Funds	Total
State Department of Health (SB 1004) Tobacco prevention and control	\$3,440,864	\$500,000 ¹	\$2,969,313	\$6,910,177 ¹
Tobacco Prevention and Control Executive Committee (SB 1024) Tobacco prevention and control	0	16,548,039 ¹	0	16,548,039 ¹
Total 2015-17 biennium funding	\$3,440,864	\$17,048,039 ¹	\$2,969,313	\$23,458,216 ¹

¹Includes \$500,000 provided as a grant from the Tobacco Prevention and Control Advisory Committee to the State Department of Health to be used for the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*.

REPORTS ON STATE DEPARTMENT OF HEALTH STUDY OF HEALTH PROFESSIONAL ASSISTANCE PROGRAMS

The Legislative Assembly approved 2015 House Bill No. 1036 ([Appendix F](#)) which requires the State Department of Health evaluate state programs to assist health professionals, including behavioral health professionals, with a focus on state loan repayment programs for health professionals. The study must include:

- a. Identification of state programs to assist health professionals;

- b. Consideration of whether elements of the identified state programs could be standardized;
- c. Evaluation of funding and usage of the identified state programs;
- d. Evaluation of the effectiveness of these identified programs and how these programs could be revised to be more effective; and
- e. Consideration of whether there are gaps or duplication in programs designed to assist health professionals.

Section 1 of the bill requires, during the 2015-16 interim, the State Department of Health make periodic reports to the Legislative Management on the status of the study. In addition, before July 1, 2016, the State Department of Health must report to the Legislative Management on the outcome of the study, including presentation of recommended legislation. The Legislative Management may introduce legislation recommended by the State Department of Health as part of the department's study report. The Health Services Committee has been assigned the responsibility to receive these reports.

ATTACH:6