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ROLL NUMBER

DESCRIPTION

2384

2007 SENATE HUMAN SERVICES

SB 2384

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2384

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 1-30-07

Recorder Job Number: 2232, 2327

Committee Clerk Signature Mary K Mason

Minutes:

Vice Chairman Senator Erbele, opened the hearing on SB 2384 to provide for an appropriation to the state department of health for the purpose of providing health safety grants to local public health units.

Senator Tom Fischer (District #46) introduced SB 2384. He said that an error was made when it was drafted so there would be an amendment proposed.

Senator Mathern (District #11) testified in support of SB 2384. (Attachment #1)

Senator Dever said he also participated in one of the 100% access seminars and recalled it as an initiative of the governor with the proviso that it not have an impact on the state budget. He asked if this money was requested of the governor in his budget process.

Sen. Mathern said he didn't know for sure.

Karen Larson (Dep. Director, Community HealthCare Association of the Dakotas) distributed copies of a requested amendment that basically clarifies the language to the original intent their coalition was seeking. (Attachment #2)

Dr. John Baird (Field Medical Officer with the ND Dept. of Health) testified in support of SB 2384. (Attachment #3)

Senator J. Lee asked for an example of the kind of program they might be considering that may have been successful in other places.

Dr. Baird answered that Tim Cox would also be testifying and mentioning some of the programs. Some examples are what they call the three share or multi share program where 1/3 is paid by the employee, 1/3 is paid by the employer, and 1/3 is paid from a government entity (Meter 17:35)

Tim Cox (President, Northland Healthcare Alliance) testified in support of SB 2384. (Attachment #4)

Testimony from Ronald Volk (President, St. Aloisius Medical Center) was submitted for the record. (Attachment #5)

Rodger Wetzel (Director, Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center in Bismarck) testified in support of SB 2384. (Attachment #6)

Senator Erbele asked if he had a breakdown on the charity care that would have come to their emergency room.

Mr. Wetzel said he did not but could get that information.

Senator Dever asked how this bill would impact that circumstance.

Mr. Wetzel replied that this bill would help them, systematically, bring the broader community together.

Senator Heckaman asked if he was saying they would really help out with this program by supplying some money.

Mr. Wetzel replied that was something they already have had conversations about. That is something they would want to look at.

Senator Heckaman asked if they were seeing more instances where the doctors in their clinics and hospitals are unable to supply the free meds from the drug reps.

Mr. Wetzel said absolutely the supplies of free and low cost are decreasing.

Senator J. Lee asked if they are not making use of the ND prescription services.

Mr. Wetzel replied big time they are. Part of the problem is often folks need immediate prescriptions.

Senator J. Lee asked if they do any communicating with the business community about this.

Mr. Wetzel answered that Fargo has been a model in the state. Absolutely, they have to be involved.

Senator J. Lee said the self insured plans are creating issues with children's health care coverage in custodial, non-custodial parent situations. Primarily they are non-custodial parents supposed to provide health care and if they have a skinny ERISA plan, it's not doing what the kids need. There is more to having a skinny health plan than just the employed worker if they have dependent children who need to be covered as well.

Mr. Wetzel said that is one of the reasons they've tried to expand the awareness on the caring program for children and SCHIPS and Medicaid. At least, to try to encourage folks that might be eligible.

Senator J. Lee said she was disappointed that that there is not 100% enrollment in CHIPs.

Senator Pomeroy asked if the $400,000 the bill asks for is one time or ongoing.

Mr. Wetzel said the intent is basically for one shot demonstration projects.

Mary Kay Herrmann (Chair, South Valley Health Access Coalition) testified in support of SB 2384. (Attachment #7)

Senator Heckaman asked what they use their seed money for.

Ms. Herrmann said they would probably use the new seed money for move forward with a plan that they develop with the support they are getting from Dakota Medical Association.

Senator Heckaman asked if this money would be used for a staff position.

Ms. Herrmann said she would see it being used to staff somebody to coordinate and move forward.

Senator J. Lee asked if she anticipated that there might be a project in each region.

Ms. Herrmann said that right now they have one in Fargo and Bismarck. They would anticipate looking at each region.

Karen Larson (Deputy Director, Community HealthCare Association of the Dakotas) testified in support of SB 2384 as proposed to be amended. (Attachment #8)

Senator J. Lee asked Ms. Herrmann to refresh their memories as to what federally qualified health centers are.

Ms. Herrmann said that federally qualified health centers have been in existence for 41 years. They were begun in urban areas but have expanded greatly into the rural areas of the country. Basically they are primary health care clinics that provide safety net care. They are not free clinics. They are allowed to collect and receive reimbursement through Medicare, Medicaid, private insurance or self pay. She talked about grants (Meter53:00) and sliding fee scales. She also talked about some of the advantages of the centers (Meter 54.50).

There was no opposing or neutral testimony.

The hearing on SB 2384 was closed.

Senator Heckaman moved to accept the amendments by Karen Larson.

Motion was seconded by Senator Warner.

Roll call vote 6-0-0. Motion carried.

The committee was adjourned

Job #2327

Senator J. Lee, Chairman, called the committee back to order to discuss SB 2384. She asked David Martin (President, Fargo-Moorhead Chamber of Commerce) to make comments from

the business person's point of view that would be helpful in the discussion about the cost of health coverage and health care.

Mr. Martin said the top two issues for their members over the last five years have been workforce and health care. They are very closely related. (Meter 1:25) Education is key to helping people realize they do have choices and they do have personal responsibility in terms of their own health and welfare and that, as they work together with health care providers and employers, they are able to take the steps they are able to take. Sometimes they can't do everything they might like to do regarding their own health but then they have the state and employer step into the picture to try to provide a complete picture for the health and welfare of citizens of ND. Employers want to be good employers. Most have health insurance in one of two ways, through government or employers. They want to do what they can to help their employees to have that access to high quality health care. But paying for it sometimes becomes a challenge.

Senator J. Lee asked if they were doing anything in the Chamber as a business community, in general, that focuses on perks and benefits for people who are in wellness programs.

Mr. Martin said more and more employers are doing that because they realize they can provid incentives for employees that will help them to be healthy which will make them more productive. Health education comes for their family members. That's when the community health education programs come into play. It helps to spread the word among the general population.

Senator J. Lee reminded the committee they had adopted the amendment that includes the community based non profit organization. She said the challenge before them was figuring out the money for each of these.

Senator Pomeroy moved a Do Pass as amended and rerefer to Appropriations.

Motion seconded by Senator Heckaman.

(Meter 8:00) Discussion followed that there was support for this with the idea that it is not a continuing thing. Otherwise, it would just be increasing funding for public health units. If that's the case then it should be approached that way. Discussion continued on public health funding.

Roll call vote 6-0-0. Motion carried. Carrier is Senator J. Lee.

Date: 1-30-07
Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2384

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Amendment K. Lonn

Motion Made By Sen. Heckaman Seconded By Sen. Warner

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 1-30-07
Roll Call Vote #: 2

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2384

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DP / amended approp.

Motion Made By Sen. Pomeroy Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2384: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2384 was placed on the Sixth order on the calendar.

Page 1, line 2, replace "safety" with "care access" and after "units" insert "and community-based nonprofit organizations"

Page 1, line 7, replace "safety" with "care access" and after "units" insert "and community-based nonprofit organizations"

Page 1, line 9, after "units" insert "and community-based nonprofit organizations"

Page 1, line 13, after "develop" insert "community-based"

Renumber accordingly

2007 SENATE APPROPRIATIONS

SB 2384

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2384

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 02-09-07

Recorder Job Number: 3278

Committee Clerk Signature

Minutes:

Chairman Holmberg opened the hearing on SB 2384.

Senator Tom Fischer, District 46, Fargo, introduced and asked support of SB 2384, indicating this bill came out of a two year plus effort of many health care providers and interested parties throughout the state trying to find ways for everyone to access health care.

Chairman Holmberg questioned whether this bill is a duplicate of another bill and the response was no.

Senator Kilzer asked if this was an overlap of services of the Center for Rural Health and the response was this is more grass roots, the center is more research.

Senator Tim Mathern, District 11, Fargo, distributed a forum article regarding development of health care policy around the country. He indicated there are big pressures because of cost and access issues and many states are moving forward with plans for their states.

Karen Larson, Deputy Director of the Community Health Care Association of the Dakotas, distributed written testimony and testified in support of SB 2384 and introduced Tim Cox to come forward and speak.

Tim Cox, President of Northland Healthcare Alliance, distributed written testimony and testified in support of SB 2384 and health insurance coverage. He distributed a chart showing

what is happening in other states. He specifically discussed the Three Share Model, started as an experiment in Michigan, the second is the Grant Program and the benefits to the state.

Senator Bowman indicated to go into a small business and tell owners they have to participate in this plan. The response was that this program is not mandated for any community but it has the flexibility to use it if they should chose to.

Dr. John Baird, field medical officer, ND Dept of Health distributed written testimony in support of SB 2384.

Rodger Wetzel, Director, Eldercare, Community Health and Foundation Programs, St. Alexius Medical Center, Bismarck, presented written testimony in support of SB 2384.

Chairman Holmberg closed the hearing on ST 2384.

Senator Fischer moved a DO PASS, Senator Mathern seconded. Discussion was held. A roll call vote was taken resulting in 7 yes, 9 no, 1 absent and Senator Judy Lee will carry the bill.

Date: 2/9/07
Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2384

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Fischer Seconded By Mathern

Senators	Yes	No	Senators	Yes	No
Senator Ray Holmberg, Chrm		✓	Senator Aaron Krauter	✓	
Senator Bill Bowman, V Chrm		✓	Senator Elroy N. Lindaas	✓	
Senator Tony Grindberg, V Chrm		✓	Senator Tim Mathern	✓	
Senator Randel Christmann		✓	Senator Larry J. Robinson	✓	
Senator Tom Fischer	✓		Senator Tom Seymour	✓	
Senator Ralph L. Kilzer		✓	Senator Harvey Tallackson		
Senator Karen K. Krebsbach		✓			
Senator Rich Wardner	✓				

Total (Yes) 7 No 6

Absent 1

Floor Assignment HMS

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2384, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (7 YEAS, 6 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2384 was placed on the Eleventh order on the calendar.

2007 HOUSE HUMAN SERVICES

SB 2384

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2384

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 5, 2007

Recorder Job Number: 4324

Committee Clerk Signature Judy Schoch

Minutes:

Chairman Price: We will open the hearing on SB 2384.

Senator Tom Fischer, District 46: The bill is to appropriate 400,000 dollars for health care access grants. I attended 2 state wide meetings and, you would be surprised in just the word access in the different areas of the state. There are areas you need to drive 80 miles for a provider.

Dr. John Baird, field medical officer for the ND Department of Health: See attached testimony.

Rodger Wetzel, Director of the Eldercare, Community Health and Foundation Programs at St. A's Medical Center in Bismarck: See attached testimony. Also attached brochure.

Representative Conrad: What kinds of things are you envisioning this to do?

Mr. Wetzel: We really want to expand our efforts and we need some resources, and some staff time. We are open to looking at any option. WE would be looking at some of the options that Mr. Cox will be present subsidized health foods, some volunteers. We really want to look at the broad range. We obviously have see some of our success. You will see some in the brochure. I have also brought **testimony from Kay Hermann,** who was not able to be here.

Tim Cox, President of Northland Healthcare Alliance: See attached testimony. The coalition is in place, we just don't have the resources to move them forward.

Representative Hofstad: Under the project access, is that program (could not understand) by the physicians being done outside the umbrella of the provider?

Mr. Cox: They do under a separate organization that they have formed in those communities. I also have testimony from **Karen Larson, Deputy Director of the Community Healthcare Association of the Dakotas**. I also have a hand out on the do's and don'ts of the bill.

Chairman Price: We have more information dropped off for the committee to look over. See attached. Anyone else to testify for SB 2384? Any opposition? Hearing none we will close the hearing on SB 2384.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2384

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 7, 2007

Recorder Job Number: 4601

Committee Clerk Signature Judy Schock

Minutes:

Rep. Price: Did other people get different messages on this bill from what they were saying? Some talked about insurance and some talked about the access to providers.

Rep. Conrad: It seemed to me that it is one of those things where they are trying to encourage new ideas. They want small grants to do those things which may help them. Sometimes it's just little things, though. That is why they were talking about all those different things that they wanted to do like subsidize insurance in small businesses.

Rep. Kaldor: I have two questions. First of all when I look at the appropriation I'm trying to figure out how that is going to be real meaningful. But one of the testifiers did talk a little bit about what can be accomplished with these funds. He also talked a little bit about helping individuals. He talked about helping families find programs. I don't know if something like that already exists in the health department.

Rep. Price: I'm not sure what the duties are except for steer families towards that.

Rep. Kaldor: So that doesn't really sustain?

Rep. Price: We don't have those everywhere. I understand that not every community has them.

Rep. Kaldor: Will this ensure that they are in every community?

Rep. Price: No.

Rep. Conrad: Well we don't have many things that we are doing to encourage new options and new things. This is one very small to help cultivate some of these ideas. We have to pass this $4 million out of here to do that in appropriations.

Rep. Price: Yes that is true.

Rep. Conrad: This is a big issue. I know when I was going door to door this year that it was often a top thing that was asked dealing with health insurance.

Rep. Price: Along with health insurance cost?

Rep. Conrad: Yes. They were looking for different ways you can pay covering that cost. It's a stretch.

Rep. Weisz: To me the bill is talking about access. In the testimony it was about insurance and who was insured. The difference if you are looking at it is the insurance part of it.

Rep. Price: Over $840,000 goes to that.

Rep. Weisz: That is the thing. If we get something that is actually going to insure a bunch of kids. If they are talking about access, I don't think that is an issue. Again, the testimony sent out mixed signals about the price and if we have access out there.

Rep. Price: Well what do you want to do?

Rep. Weisz: I move a do not pass.

Rep. Damschen: I second that.

Rep. Price: Is there any discussion?

Rep. Uglem: My only concern about this is if we are talking about the uninsured and under insured; will the state end up paying that anyways when we do that? I have real mixed feelings on that.

Rep. Price: This access coalition that you got the membership list from, they are meeting on a regular basis already. I have been at one of their meetings. They aren't going to stop meeting regardless of what this bill does. It won't totally disappear.

Rep. Conrad: If they are going to come up with new ideas, they are a group. They do have a lot of business people involved in them as well as advocates. They need a little money to try some of those new ideas. We should be a partner in that and we don't really have another vehicle in participating in finding solutions.

Rep. Price: They have only met for two years. The other way I look at it is that the medical foundation is funded to try some of those access programs. They have funded the outreach programs.

Rep. Pietsch: The Department I am looking at is looking for $38,500 for administrative oversight.

Rep. Kaldor: Do we know what the original appropriation was?

Rep. Price: I'm not sure.

Rep. Kaldor: The reason I ask that question is because as I read the testimony they have some fairly optimistic outcomes for what this is going to do. I just wanted to square that away.

Rep. Price: Is there any more discussion? If not we will take a role call vote on SB 2384. The do not pass motion passes with a vote of 9-3-0. Is there a volunteer to carry this bill?

Rep. Damschen: I will.

Rep. Conrad: I have talked to some of the people who have received these grants. The message they are getting from the foundation is that the state of ND needs to start coming up with some participation in these. It is good to use the foundation so that they can't get to the point where they say they are the only ones funding this, it should have some government responsibility at some point.

Date: 3/1
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES SB 2384 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Not Pass

Motion Made By Rep. Weisz Seconded By Rep. Damschen

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad		✓
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor		✓
Chuck Damschen	✓		Louise Potter		✓
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) 9 No 3

Absent 0

Floor Assignment Rep. Damschen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2384, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (9 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2384 was placed on the Fourteenth order on the calendar.

2007 TESTIMONY

SB 2384

Attachment # 1

SB 2384
Human Service Committee
January 30, 2007

Madam Chairman Lee and Members of the Human Service Committee,

My name is Tim Mathern. I am the Senator from District 11 in Fargo and here in support of SB2384. This bill provides an appropriation to the state department of health for the purpose of providing grants to local public health units.

This past year I participated in discussions with our local chamber of commerce, insurance companies, health care providers, and health care advocates regarding the dramatic increase of health care costs. The goal was to get all the stakeholders together to find solutions. The meetings brought recognition to each of the interests involved of the complicated nature of this issue.

I attach a January 21, 2007 Forum article for a synopsis of the health care debate before us.

If we do not find local solutions regarding health care a federal system will likely be put in place. Grants from the health department will help us find local solutions to the challenges before us. This bill makes that possible.

SB 2384 sets some parameters for what is to be discussed and permits local people to get the right stakeholders to the table. I urge a do pass recommendation for SB2384.

Thank you.

Support for universal health care grows

By Robert Tanner
AP National Writer

Health care for all – an elusive goal that has tantalized presidents and governors for decades – is roaring back this year with ambitious proposals in a handful of prominent states.

The promise: Cover millions of uninsured adults and children. Improve the quality of care at hospitals and doctors' offices. Rein in rising costs that are eating up workers' wages, company profits and state budgets.

The problem: Someone's got to pay. And getting those with a stake in health care – doctors, insurers, hospitals, workers, employers, government – to agree on who and how much won't be easy.

The most influential effort is undoubtedly in California, the nation's most populous state, where GOP Gov. Arnold Schwarzenegger this month introduced a bold plan that would provide health-care coverage for 6.5 million residents without insurance.

With less fanfare, Pennsylvania has proposed a similar step and a half-dozen more states are actively debating the idea. All are building on a Massachusetts program that began this year – it likens health insurance to car insurance, making it a requirement for everyone.

If successful, the states could carve out a long-sought path for universal health care, a goal that's been politically dead since the Clinton administration. But that's a big "if" – passage won't be easy and the programs aren't cheap.

The Associated Press looked at proposals in front of state legislatures to break down the contentious issue.

Why issue is hot now

It's been talked about and debated for years, but wide agreement is emerging over the problem of health care's rising costs, which swallow wage increases and have threatened to overtake state spending on primary education. Businesses say they're at a disadvantage with global competitors.

The system can't survive another few years on the same track without collapsing, said Pennsylvania Gov. Ed Rendell, a Democrat.

"If California, Pennsylvania and Massachusetts prove it's doable – and Maine has already to some extent – it will create an unstoppable momentum," he said.

Maine brought the issue back in 2003, with a law seeking to provide universal coverage.

Massachusetts' law last year – guaranteeing universal coverage – jump-started the action in state capitols.

In the past month, governors, legislative leaders and blue-ribbon commissions have declared universal coverage an attainable goal in Iowa, Kansas, Minnesota, New Mexico, Oregon, Washington state and Wisconsin. Massachusetts and Vermont are to put their programs into effect this year, while Maine is tweaking its existing system. Many more are considering significant expansions.

How it would work

The overall goal is to get everyone, or nearly everyone, health insurance. The plans also aim to cut costs by improving efficiency, and to improve the quality of care. The plans being discussed would accomplish that in the following ways.

▶ All would build on the existing public and private insurance system to provide insurance and health-care access to most or all the uninsured in their states – now some 46 million people nationwide.

▶ All aim to expand existing Medicaid programs to cover more of the poor and working poor who don't have insurance. They would require employers who don't provide insurance to do so. They seek some financial contributions or savings from doctors and insurers.

▶ They would establish a state mechanism that creates an insurance product, or sets up a marketplace, so that small businesses and individuals can get reasonably priced insurance.

▶ Some plans mandate that every individual must have insurance – not unlike mandatory auto insurance for every driver – with financial help for those too poor to buy it outright.

The biggest barrier

The biggest stumbling block is money. Who pays?

In California, doctors and hospitals are already unhappy with Schwarzenegger's plan to levy a 2 percent fee on doctors and a 4 percent fee on hospitals. He would cap profits for insurers by requiring that 85 percent of revenue be devoted to treating patients: That idea alone sent the stock of health insurer Wellpoint Inc., with 34 million members, down 3.5 percent.

"He made enemies of every doctor and hospital in California when he did that," said Helen Darling, president of the National Business Group on Health, a consortium of companies trying to lower health costs.

In California, Pennsylvania, Massachusetts and Maine, state leaders said they were spreading the pain to every player, so every critic should stay on board.

"That's always been the biggest challenge in health care reform. There is no pain-free solution," said Drew Altman, president of the Henry J. Kaiser Family Foundation, a Washington-based health group.

Chance of success

The next few months will determine whether enthusiasts like Rendell or Schwarzenegger win the argument.

In Minnesota, GOP Gov. Tim Pawlenty warns that simply focusing on getting everyone insurance ignores deeper problems, even as some leaders of the Legislature's new Democratic majority say this is the year for universal health care.

"Many policymakers around the country are so fixated on more access, they're losing sight of the need to simultaneously focus on cost and quality," Pawlenty said. "Expanding access to a broken system is no solution. ... In the long run, that will be a failure."

He wants universal coverage, he insisted, but warns that government can't end up with the bill. His plan would broaden coverage to more uninsured children and have the state create a marketplace where insurers can provide a more affordable product. It wouldn't mandate that everyone get coverage.

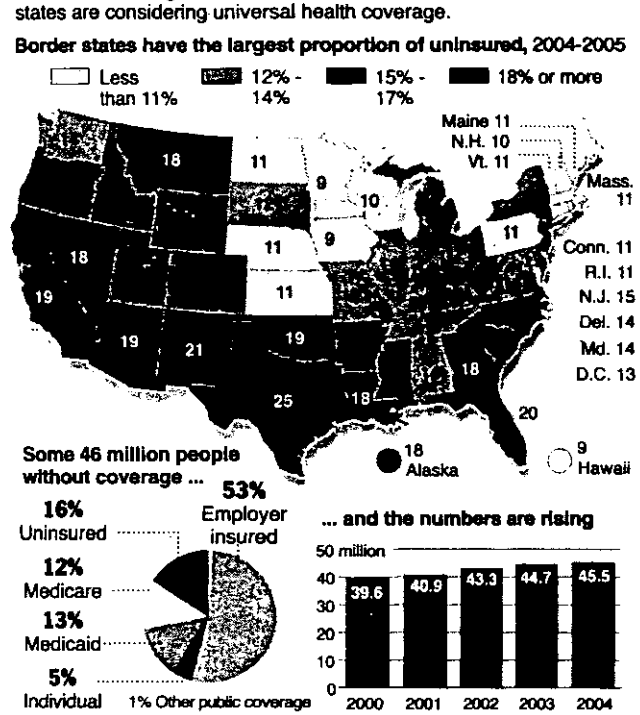
There are even deeper philosophical differences in other parts of the country, particularly more conservative states which have emphasized cutting Medicaid costs rather than expanding coverage.

But the new ideas are even getting an airing there.

In Florida, where the biggest health care change under former Gov. Jeb Bush emphasized cutting costs of Medicaid, the new surgeon general talked enthusiastically of Massachusetts' universal health coverage law – and new GOP Gov. Charlie Crist said he wouldn't rule out considering something along those lines.

Number of uninsured Americans increases

With an increasing number of uninsured Americans each year several states are considering universal health coverage.



Source: Kaiser Commission on Medicaid and the Uninsured AP

OBITUARIES

BIRTHS

COURT ROUNDUP

Attachment #2 Koren Lawson

SB 2384
Requested Amendments

Senate Human Services Committee
Senator Judy Lee, Chair
January 30, 2007

Line 2: purpose of providing health ~~safety~~ care access grants to local public health units or community-based non-profit organizations.

Line 7: administering and funding health ~~safety~~ care access grants to local public health units or community-based non-profit organizations.

Line 9: establish criteria and application materials for local public health units or community-based non-profit organizations to apply for competitive

Line 13: workers, to develop community-based collaborative projects to reduce the number of uninsured and underinsured,

Attachment #3

Testimony

Senate Bill 2384

Senate Human Services Committee

Tuesday, January 30, 2007; 9 a.m.

North Dakota Department of Health

same testimony to Senate approps and to House Human Services

Good morning, Madam Chair and members of the Senate Human Services Committee. My name is Dr. John Baird, and I am a field medical officer for the North Dakota Department of Health. I am here to provide information about Senate Bill 2384.

2004 Health Insurance Coverage Study

In 2004, the Department of Health received a federal state planning grant from the U.S. Health Resources and Services Administration to study health insurance coverage in North Dakota and to look at potential options for expanding health insurance coverage. On behalf of the North Dakota Department of Health, I supervised the study, and the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences was contracted to do the research for this grant.

Rate of Uninsured

In the spring of 2004, information about health insurance coverage was gathered through a telephone survey, collecting information from a random sample of 3,199 individuals in North Dakota households. The survey indicated that 8.2 percent of people in our state did not have health insurance, either private insurance such as employer-sponsored policies or public insurance such as Medicaid, CHAND or Healthy Steps. Although this compares favorably with the national rate of 15.2 percent uninsured, it still represents about 52,000 people, or approximately the population of Bismarck. The survey indicated that more than 11,000 children younger than 18 were uninsured, as were about 41,000 adults. Native Americans were far more likely to be uninsured at 31.7 percent, compared to the Caucasian rate of 6.9 percent. The survey did not consider the Indian Health Service to be health insurance, which is consistent with the accepted method of reporting statistics nationally.

Income Levels of Uninsured

A resident living in a household with an income of less than $10,000 was more than twice as likely to be uninsured (16.6%), compared to the overall state rate of 8.2 percent. Nearly three-quarters of uninsured North Dakotans resided in a household

with an income below 200 percent of the federal poverty level, which is currently $38,700 for a family of four.

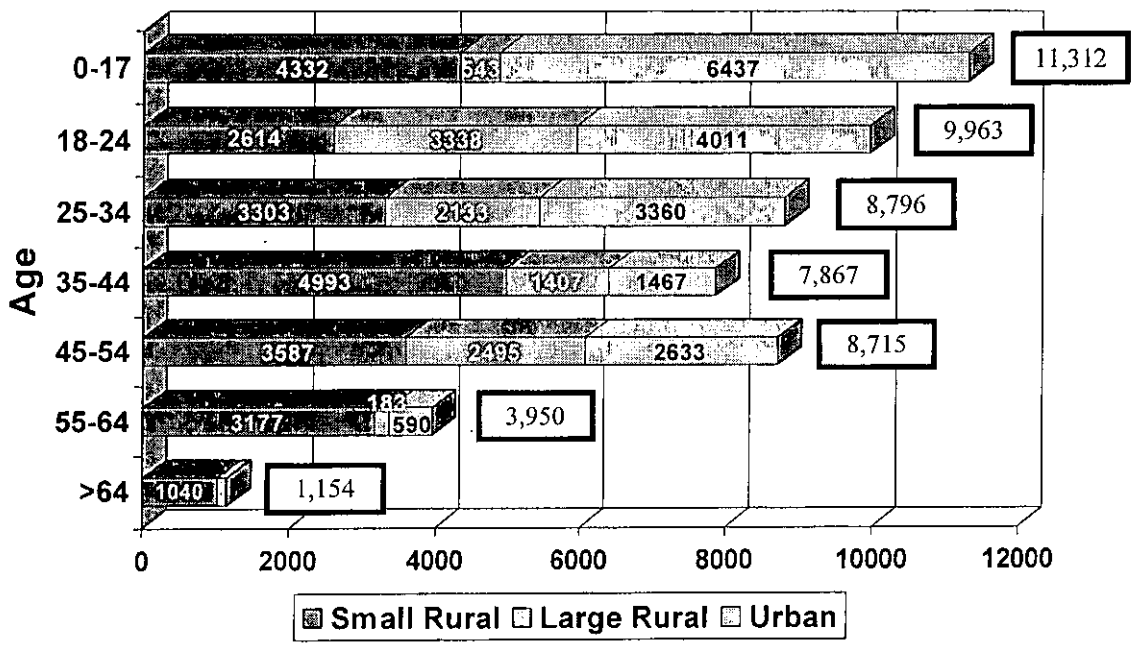
Areas of Residence of Uninsured

To look at how insurance rates varied by population density, the state was divided into three population groups:

- Urban (population more than 16,700 people) – including Bismarck, Fargo/West Fargo, Grand Forks and Minot
- Large Rural (5,000 to 16,699 people) – including Devils Lake, Dickinson, Jamestown, Minot AFB, Valley City, Wahpeton and Williston
- Small Rural (less than 5,000 people) – the remainder of the state

Of the 52,000 people who were uninsured, 44 percent lived in small rural areas, 36 percent in urban areas and 20 percent in large rural areas. The study also showed that 9.1 percent of individuals residing in small rural areas were uninsured, as were 7.7 percent of those in urban areas and 7.4 percent of those large rural areas.

The study looked at the number of uninsured individuals by age groups and areas of residence. The following chart gives a graphic representation of the geographic and age distribution of the uninsured in North Dakota. It illustrates that a large portion of the uninsured are young adults and children.



The following table shows the percentage of uninsured, either as a percentage of all the uninsured in the state or as a percentage of the individuals in the particular age group. Of all the uninsured, 17 percent are between the ages of 25 and 34, 19 percent are between 18 and 24, and 22 percent are younger than 18. Of all the young adults in North Dakota between the ages of 18 and 24, 15.9 percent are uninsured.

Age Group	Percentage of All Uninsured	Percentage of Age Group
0-17	22%	8.1%
18-24	19%	15.9%
25-34	17%	9.4%
35-44	15%	8.5%
45-54	17%	8.9%
55-64	8%	7.2%
> 64	2%	1.4%
	100%	

Employment of Uninsured

The majority of uninsured older than 17 were employed (71.7%), which compared with 82.3 percent of insured adults being employed. Of those who were employed, those in smaller-sized businesses were more likely to be uninsured. Self-employed individuals had the highest rate of uninsured at 21.3 percent. Businesses with two to 10 employees had a rate of 10.6 percent uninsured, and those with more than 500 employees had the lowest rate at 3.8 percent uninsured.

Rate of Underinsured

The 2004 study also estimated the rate of underinsured North Dakotans. The term underinsured is often defined as having some type of catastrophic health insurance coverage and spending more than 10 percent of a family's income on health care. A recent national study (*JAMA. 2006;296:2712-2719*) found that in 2003, 19.2 percent of Americans spent more than 10 percent of their tax-adjusted family income on health care, and 7.3 percent spent more than 20 percent of their family income on health care.

The 2004 study estimated that 8.5 percent of individuals in North Dakota were underinsured, defined as spending more than 10 percent of their family income on health care.

Healthcare Access Grants

As part of the efforts of the state planning grant to look at solutions for North Dakota, statewide summits were held in October 2005 and October 2006. These 100% Access Summits brought together hundreds of people from across the state to learn about and discuss programs that are successful in other local communities to improve access to health care. After the summits, several local coalitions have formed and are discussing possible programs they could implement in their communities.

Senate Bill 2384 provides an appropriation of $400,000, which would allow a catalyst fund of $320,000 to assist up to eight communities or regions to design and begin implementation of a demonstration project to increase health-care access for the uninsured and underinsured in their communities. The funding also would allow $41,500 to assess the design of programs and their impact on the uninsured and underinsured and $38,500 for administrative oversight and program evaluation.

Conclusion

The 2004 study estimated that about 17 percent of North Dakotans are either uninsured or underinsured. The consequences of being uninsured have been shown in a number of national studies. Without health insurance or access to affordable primary care, people are less likely to receive timely preventive care, more likely to be hospitalized for avoidable health problems, and have worse clinical outcomes for chronic diseases such as diabetes, cardiovascular disease and mental illness. They are less likely to receive preventive services, have a decreased life expectancy, and experience substantial financial impact from medical bills, often to the point of bankruptcy.

Senate Bill 2384 provides funding for a one-time mini-grant program to stimulate communities to develop local networks or partnerships to care for the uninsured and underinsured using models that have previously proven successful.

This concludes my testimony. I am happy to answer any questions you may have.

Attachment #4

Senate Bill No. 2384
Senate Human Services Committee, Senator Judy Lee, Chair
Testimony in Support
Timothy C. Cox
Northland Healthcare Alliance

Chairman Lee and members of the Senate Human Services Committee, my name is Tim Cox. I am President of Northland Healthcare Alliance. Northland is a member driven, provider based organization of 25 hospitals and long-term care facilities located throughout North Dakota. For more than 6 years Northland Healthcare Alliance has been an active participant, with many others in this state, working to increase access to health care services to North Dakotans. Northland wrote and received the first HCAP (Healthy Communities Access Program) grant in North Dakota and was extensively involved in the second one received by Dakota Healthcare Foundation. I am also a founding member of Communities Joined in Action (CJA) and serve as a board member of this national organization. This organization represents over 500 communities in the country that are working to have 100% access and 0 healthcare disparities. We have been involved in both North Dakota Healthcare Access Summits for the Uninsured and see the progress communities are making to give families and individuals unfettered access to primary care services.

Why is our organization of hospitals and long-term care facilities involved with this issue? You would think that providers do not care. Not so. Nobody is turned away from our facilities as they seek medical care. Research shows that families put off getting care because they do not have a coverage option. They cannot afford insurance even as they are working to make ends meet, some of them with two jobs or more, and sometimes running a farm as well. They resist coverage because they do have money to pay for it and they feel that they won't really need it. What is worse, they resist going for care when they need it because they know it is expensive and they hope that they will get better. Some do get better.

But many do not, and unfortunately, those that don't, end up going to the Emergency Room, the most expensive place to go for health care; often they

wait until the illness is chronic or serious when it could have been resolved much earlier at a much lower cost. In some ways this is a national problem. It then filters down to the state and frankly, **we all pay for the solution as the costs are shifted to everyone else that is covered by some form of insurance or program.** There is enough money in the health care system in this country, it is just spent incorrectly and this issue of misuse of services is one of the major problems.

What is exciting is that many communities have developed solutions to deal with this issue. They are close to the problem. Many have been creative and certainly they know what the issues are. With our HCAP work we were able to build some systems and services that have helped many individuals navigate the healthcare coverage issues. I personally have helped some families find programs that they did not know existed.

In other communities across the nation, community collaboratives have been able to have a significant impact.

With several health care collaboratives in place, Washington State has been able to:

- Reach a high percentage (65%) of uninsured and connect them to needed health care services
- Increase the safety-net provider capacity by 30%
- Significantly reduce inappropriate utilization for targeted populations
- Attract and efficiently deploy resources that otherwise wouldn't have come to the community (e.g., medications, donated care, revenue, etc.)

In Muskegon, Michigan they have developed a creative coverage program called Three-share. Over a period of five years they have enrolled more than 570 businesses in this program. These were businesses that previously had not offered any healthcare coverage for their employees. As a result of these efforts they estimate that they have reduced uncompensated care by more than $2,000,000 and covered more than 3500 employees in this program. Not only has it had a significant impact on the health of this targeted population, it has

also reduced the turnover for many small business because they can now offer a benefit that is important and essential to their employees.

We have given you some of the brightest examples of projects developed all over the country, in small and large communities. (See four-page handout of Best Practice Models) Many Individuals have received much-needed care that they would not have in any other way.

The two Healthcare Summits for the Uninsured we have held have explored many of these options and models that are available for communities to use. Senate Bill No. 2384 expands on the work of the two summits. We have organized communities and advised them to get creative. This is a partnership of all that are concerned. The money in this bill will be used by communities throughout North Dakota to work together to plan efforts that use local solutions and models to care for their neighbors. The intent is to bring together hospitals, clinic managers, physicians, public health workers, business people, community leaders and individuals in need to examine in depth the healthcare access issues in their community and come up with a plan that they can incubate: self-created plans and/or models that have already been created, that begin to solve access problems.

After participating in meetings nationally and seeing the evidence of community solutions, I know that this committee will not spend any dollars this Legislative session in a more worthwhile manner. It is a matter of choice of when to pay; later in the form of expensive medical services for those that did not access healthcare at the appropriate time or now when solutions can be developed locally that help people when they should have the services. It is a matter of timing. You have communities that are charged up and ready to find solutions to the problem now. All that they need to be effective is some resources to make it happen. The funding in this bill will provide exactly what they need.

Best Practice Model	Collaborative Communities	Problem/ Catalyzing Event	Description/Overview	Financing	Lead Agency	Outcomes/ Impacts	Contact
3-Share Employer Program	Access Health Muskegon County, MI	Uninsured, low income employees of small businesses unable to access affordable health care	Access Health provides health coverage to the working uninsured through their employers. Not an HMO or an insurance product. Designed to fill gap between no insurance and commercial products. Targets small to mid-sized businesses unable to provide coverage through community sources.	Three-way "shared buy-in" among the employer (30%), employee (30%), and community match pays remainder.	Private, non-profit coalition	▪ Employers self-report reduced absenteeism, productivity increased, high satisfaction with program, improvements in health status ▪ Enhanced provider productivity ▪ Improved efficiencies in coordination of care for local providers & clients ▪ Increased capacity for the uninsured & indigent clients	Vondie Moore-Woodbury, Director Muskegon Community Health Project 231-728-3201 vwoodbury@mchp.org www.mchp.org
	HealthforAll Buffalo, NY	Uninsured employees of small businesses unable to access affordable health care	HealthforAll provides financial assistance to small businesses (2-10 employees) to offer health insurance to their employees. Comprehensive benefit package is offered by every HMO in New York State.	HealthforAll pays a portion of the premium to the health plan. Employers pay the premium balance, which must be at least 50% of the reduced individual premium. Employees are responsible for the remaining premium.	Private, non-profit organization	▪ Increased access to health care by previously uninsured clients ▪ Improved business productivity ▪ Reduced costs incurred by health care organizations and their support systems	Amber Slichta, Executive Director HealthforAll of Western NY 888-527-9200 info@healthforall.org www.healthforall.org
Project Access	Project Access Buncombe County, Asheville, NC	15,000 low-income, uninsured county residents in 1996 resulting in unstable safety net, poor health status, and high healthcare costs	A program spearheaded by the Buncombe County Medical Society which organizes voluntary and charitable contributions of physicians to provide a system of health care for uninsured and low-income county residents. Mountain Health Care processes claims and provides data on the value of physician services donated and the reduction in utilization costs (PMPM) due to a coordinated approach.	Physicians and other contributing health care workers and hospitals absorb the costs.	Buncombe County Medical Society	▪ Improved health care outcomes of target population ▪ Reduced ER utilization ▪ Increased collaboration among the health care community and with other human and social services agencies. ▪ No show rate reduced to less than 5% ▪ Reduced per capita monthly health care costs ▪ Elimination of Minority Health Disparity for pre-term delivery rates ▪ Hospital charity care reduced ▪ Employers' self report reduced absenteeism and productivity increases	Alan McKenzie American Project Access Network 828-274-9820 info@apanonline.org www.apanoline.org
	Project Access Sedgwick County, Wichita, KS	Increasing % of low-income, uninsured residents of Sedgwick County resulting in unstable safety net	A community-based, physician-led initiative that coordinates donated medical care and services provided by physicians, hospitals, pharmacies and others for low-income, uninsured residents of the county.	Primarily financed through donated medical service contributions, county, funds, and limited patient cost-sharing	Sedgwick County Medical Society in partnership with the Central Plains Regional Health Care Foundation.	▪ Coordination of patient enrollment and referrals make a broader range of donated services available for uninsured people ▪ Frees physicians and office staff from tracking down additional donated services, allowing more time for direct patient care ▪ Improved health status of target population	Anne Nelson, Program Director Project Access 316-688-0600 annenelson@projectaccess.net www.projectaccess.net

Best Practice Model	Effective Communities	Problem/ Catalyzing Event	Description/Overview	Fin	Lead Agency	Outcomes/Impacts	Contact
Portfolio of Best Practices	CHOICE Regional Health Network Olympia, WA	Barriers to accessing services for low income, uninsured residents of 5 mostly rural counties	CHOICE Regional Health Network is an organization that supports 6 interdependent principles through innovative health initiatives in their goal of achieving 100% access. ▪ Stabilize the safety net ▪ Get small employers participating ▪ Enroll people with limited incomes in a medical home ▪ Reduce costs and redirect savings to cover more people ▪ Deliver evidence-based and patient-focused care through health teams ▪ Purchase services of greater value to the community	Hospitals membership dues, HCAP Grant	Non-profit regional community organization	▪ Sustained Return on Investment for hospitals of 5:1 ▪ Found 17,000 people a medical home ▪ Connected ethnic minorities, children, pregnant women, and homeless to needed services ▪ Each month connect 114 adults and kids to dental services ▪ Assisting in implementation of Project Access ▪ Assisting in implementation of a 3-share product for small business owners	Kristen West, Executive Director CHOICE Regional Health Network 800-981-2123 westk@crhn.org www.choicenet.org
Faith-Based Initiatives	Jesse Tree Galveston, TX	Barriers to accessing medical services, fragmentation of the existing social service delivery system for low income uninsured county residents (28% of county residents uninsured)	At the request of a group of local ministers, a grassroots organization was established and charged with creating an ecumenical network of support that promotes a system that integrates social services, ministry and healthcare networks in Galveston. A web-based information, referral system and universal application was developed for the local ministries, churches and faith-based providers. Established a Health Equipment Loan Program of durable medical equipment to be loaned at no cost to those in need.	Funded through donations and grants from Salvation Army, HRDS and a Telecommunications Infrastructure (TIF) grant	Non-profit, faith-based community organization	▪ Promotes 100% Access – 0% Disparity ▪ Established medical homes ▪ Increased patient adherence resulting in improved health status of target population ▪ Promotes holistic referrals ▪ Reduced ER visits ▪ Reduced hospitalizations ▪ Improved quality of life ▪ Increase social service and medical dollars brought to local level – maximizing existing resources ▪ In 24 months loaned equivalent of $340,000 worth of DME equipment at no cost to uninsured	Ted Hanley, Director The Jesse Tree 866-762-2233 JesseTree@aol.com www.jessetree.net http://www2.utmb.edu/jessetree/Information/about.htm
Lay Health Worker Navigation/ Case Management & ER Diversion	SkyCap Hazard, KY	Highest rates of asthma, diabetes, heart disease, hypertension and severe mental illness in the state	SkyCap employs people from the community as Family Health Navigators who conduct home visits and provide education and extensive chronic disease case management. They are trained to link uninsured or underinsured residents of 2 counties to health services, mental health services, housing and environmental assistance, medications, and other necessary services.	HCAP Grant, Hospital & providers donate their time	Joint endeavor of the University of Kentucky Center of Excellence in Rural Health, Harlan Countians for a Healthier Community, Hazard Perry County Community Ministries, and Data Futures, Inc	▪ Reduced unnecessary use of ER ▪ Reduced hospital charity care ▪ Increased access to medications ▪ Increased the number of providers in the network ▪ SkyCap intends to measure diabetes disease management outcomes	Fran Feltner, Director UK Center of Excellence in Rural Health 800-851-7512 606-439-3557 x257 ffeltn@pop.uky.edu www.mc.uky.edu/ruralhealth/LayHealth/SkyCap.htm

Best Practice Model	Active Communities	Problem/ Catalyzing Event	Description/Overview	Funding	Lead Agency	Outcomes/Impacts	Contact
	CHAP Community Health Access Project Mansfield, OH	Poor social and health statistics in the state of Ohio, including low birth weights and teen pregnancies	The Community Health Access Project (CHAP) provides a model of community-based care coordination as a means of improving the basic health and social outcomes of individuals in neighborhoods with the greatest needs. Community Care Coordinators, identified, hired and trained directly within the community, serve as the foundation. Through home visits, the Care Coordinator serves as an ongoing resource to neighborhood families, identifying individual needs and providing connections to appropriate services.	Majority of funding through the Osteopathic Heritage Foundations. In addition, funding comes from local Department of Job & Family Services, other Foundation grants, and the Ohio Commission on Minority Health.	Non-profit Community organization	▪ Over 3000 people have been served since the program's inception ▪ 89% of CHAP's Community Care Coordinators are enrolled in post-secondary courses ▪ With over ½ of the Knox CHAP client pregnancies identified as at risk, only one of 22 babies was born pre-term ▪ More than 100 people in Richland County have been employed as a direct result of CHAP services	Mark M. Redding, MD Executive Director Community Health Access Project 419-525-2555 info@chap-ohio.net www.chap-ohio.org
Coordination of Services & Fees Based on Sliding Scale for the Uninsured	M-CAP Middlesex County, CT	Barriers to access affordable health care in county	M-CAP helps people in Middlesex County who lack adequate health insurance gain access to appropriate health care through a common M-CAP card. The core services provided to members are as follows: ▪ Identify eligibility for financial aid programs ▪ Sliding scale discount with private specialists and primary care practices ▪ Access to reduced-cost medications at local pharmacies	Funded primarily through a HRSA CAP grant. Co-funded with Middlesex Hospital a Nurse Care Managers program concentrating on diabetes, asthma and complex disease.	Non-profit community organization	▪ Documented positive clinical outcomes on more than 100 patients ▪ Eligibility Specialists assisted more than 1000 clients access public insurance programs ▪ Increased dental services ▪ Increased capacity of mental health services ▪ 12 private practices are participating in the Sliding Scale Program ▪ M-CAP's Compassionate Care Program helps eligible clients apply for free medication offered by pharmaceutical companies	Paul Freundlich, Director Middlesex Community Access Program 860-358-4856 Paul_Freundlich@midhosp.org www.m-cap.org
	PCAP Pima Community Access Program, Tucson, AZ	140,000 uninsured adults and children in Pima County	PCAP links low-income, uninsured residents with access to an affordable, comprehensive and coordinated network of health care providers.	Funded by a St. Lukes grant, matching local funds and HCAP grants. Membership fees from participants also subsidize the program.	Non-profit community organization	▪ Successful implementation of Healthy Arizona, a program only offered through California and Arizona ▪ Increased medical care capacity for uninsured adults ▪ Improved efficiencies in coordination among participants, providers and state agencies	Tammy Stoltz, Executive Director Pima Community Access Program 520-694-2755 tammy@pcap.cc www.pcap.cc
Pharmacy Coverage Initiatives	Coordinated Care Network, Pittsburgh,PA	RXs written for underserved patients, but 40-50% were not being filled because of the cost. Identified need to fill RX at the doctor's office.	Coordinated Care Network seeks to provide non-fragmented whole person preventive care across medical, social and behavioral health disciplines. Serves 57,000 patients annually. Developed a prescription discount program that utilizes 340B Drug Pricing Program. Centralized pharmacy and mail order facility that pre-packages drugs, sends to physician's offices at FQHC for dispensing or can be mailed to patient's home. Fair market fee for pharmacy services.	Infrastructure setup funded by a HRSA CAP grant. Developed case management product marketed to 2 HMOs to be self-sustaining. Drug Pricing Program utilizes 340B Drug Pricing Program.	Non-profit community organization	▪ Patient RX compliance improved resulting in improved health care outcomes ▪ Patients and Insurers receive prescription discounts ▪ Convenient for patients ▪ Health Centers generate revenue	Jeffrey S. Palmer, President & CEO Coordinated Care Network 412-349-6300 jspalmer@nb.net www.coordinatedcarenetwork.org

Best Practice Model	Innovative Communities	Problem/ Catalyzing Event	Description/Overview	Financing	Lead Agency	Outcomes/Impacts	Contact
	MedConnex Pharmacy Program, River Cities Community Health Coalition (RCCHC) Ashland, KY	RXs written for patients (90% identified as Medicare) not being filled, resulting in poor health outcomes.	MedConnex is an indigent pharmacy program operated by RCCHC to assist in finding resources for qualified individuals to help with maintenance medication program. Four client Advocates each assigned go a geographic area, travel to client's community to assist in filling out the forms for pharmacy assistance programs. Clients are then required to contact MedConnex when they need refills. Advocates also identify clients who qualify for Medicaid and assist in completing application.	HRSA Cap grant funded infrastructure. Through collaboration with a local Community Action agency, the agency pays ½ of salary plus benefits and the coalition pays the other half of the salary.	Non-profit community coalition	▪ Able to document in one month (February 2003) $41,868.00 in "free medications" ▪ By linking eligible clients to Medicaid, were able to document $500,000 in Medicaid payments within their service area as a result of referrals made ▪ Patient health outcomes improved as a result of patients being able to access their maintenance medications on a routine basis	Rose Rousou MedConnex 740-574-MEDS Ext 5 rosier@somc.org www.rivercities.org
Health Care Initiatives Funded Through Local Taxation	Hillsborough HealthCare Plan Hillsborough County, FL	Cost of providing state-mandated charity care was increasing at 17% a year	Hillsborough HealthCare Plan is a comprehensive managed program specifically designed for working people whose income is at or below the federal poverty level who have no medical coverage. The plan has four networks providing primary care at several clinics. In addition there are referral specialists, diagnostic and hospital services, prescription coverage, vision, dental, home health and other medically necessary services. County residents with income over 100% of the poverty level and no insurance coverage can qualify for a Medical Crisis Intervention (MCI) Program with sliding scale co-payments. Medicare citizens, who are within the poverty guidelines, may qualify for limited assistance.	Funded by a special county sales tax, along with property taxes as mandated by the State of Florida.	Administered by the Hillsborough County Department of Health & Social Services	▪ Health care plan members increased from 15,000 to 28,000 per year while per-patient cost went down by more than 65% ▪ Reduced average hospital length of stay from 10.2 days to 5.1 days ▪ Reduced the average # of hospital admissions per 1000 patients from 126.5 to 12.4 ▪ Reduced more that $10 million in emergency room care. ▪ Saved more than $90 million in medical expenses ▪ Savings for the County are now approximately $50 million per year	Phyllis Busansky 813-221-9072 phyllisb@chln.org Dave Rogoff 813-301-7344 jrogoff426@aol.com Health & Social Services Hillsborough County, FL www.hillsboroughcounty.org/health_ss/dhc.html
	GAMP General Assistance Medical Program, Milwaukee County, WI	10% of County residents uninsured	General Assistance Medical Program (GAMP) purchases health care for qualified uninsured Milwaukee County residents who qualifies for services which include hospitalizations, diagnostics, prescriptions, labs, & specialty care. A network of providers, including 13 community-based clinics, has been established to act as the gatekeeper for all services provided to eligible clients.	Funded by Milwaukee County and State of Wisconsin funds, including Federal disproportionate share and supplemental funding.	Administered by the Milwaukee County Department of Health & Human Services	▪ Increased access to health care for the uninsured ▪ Survey research indicated statistically significant increases in patient confidence in self-management of disease as a result of contacting the Nurse Line ▪ 77% decrease in patients going to ER after contacting Nurse Line ▪ Greater collaboration between & linkages among community based organizations	Paula Lucey, RN, MSN, CNAA Director of Health & Human Services Milwaukee County 414-257-5949 plucey@milwcnty.com www.milwaukeecounty.org/Service/organizationDetail.asp?org=7251&audience=5

Attachment #5

St. Aloisius Medical Center

325 Brewster St. East
Harvey, ND 58341
Phone & Fax 701-324-4651
www.staloisius.com

SMP Health System

January 29, 2007

To: Chairman Lee and members of the Senate Human Services Committee

From: Ronald J Volk
President

Subject: Senate Bill No. 2384

Chairman Lee,

I would like to go on record of supporting Senate Bill 2384.

I feel that the work already done in North Dakota Healthcare Access Summits is just the tip of the iceberg of what the can be done in providing a healthcare home for every person in North Dakota. There has been a great interest in providing this from every corner of the state.

Hospitals in all of North Dakota do not turn anyone away, but many do not come because they do not have coverage, and when they must come it is very serious and very costly and most likely could have been prevented with intervention at the onset of what ever brought them to the hospital.

I feel this bill would be another avenue for the citizens of North Dakota to have access.

Sincerely,

Ronald J Volk
President

Attachment #6

SB 2384 - TESTIMONY
SENATE HUMAN SERVICES COMMITTEE
Senator Judy Lee, Chair
January 30, 2007

Senator Lee and members of the Committee, my name is Rodger Wetzel. I am the Director of the Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center here in Bismarck. We serve much of western North Dakota.
I am here today as Director of the St. Alexius Community Health Program, and as chair of our Burleigh-Morton Task Force on Uninsured. I have chaired that Task Force for the past two years. I also am a member of the state 100% Health Access Coalition, chaired by Dr. Baird, and I have attended both state summits on uninsured/ underinsured issues. In addition I am a past board member of our United Way Board,

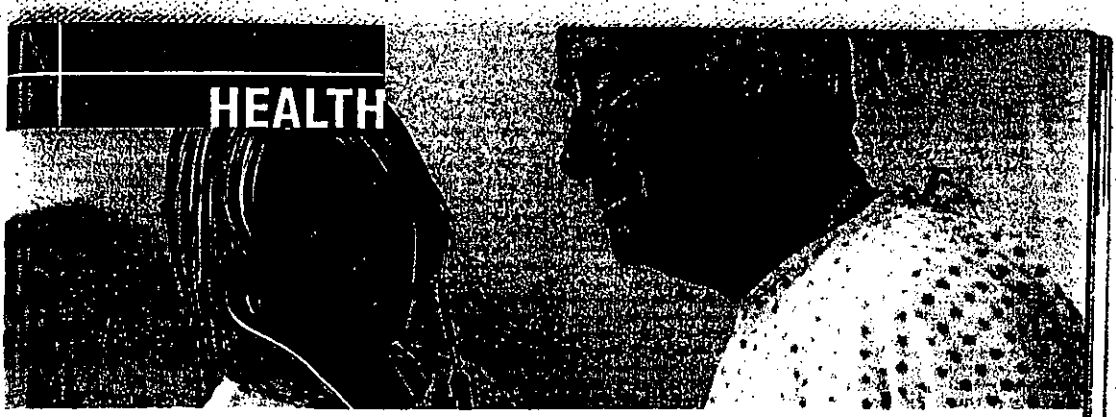
I support SB 2384 with the proposed amendments. St. Alexius is committed to working with other community organizations to address community health issues. Our area United Way Community Impact Committee also has developed 5 "community impact vision councils," including one which is addressing unmet "Basic Needs" (food, clothing, shelter, healthcare). The United Way community surveys and forums have identified healthcare for the uninsured to be one of our top human service needs in our area.

St. Alexius, as part of its community health and mission focus, surveyed community leaders about two years ago and asked for most significant unmet health-related needs. One of the top needs identified was healthcare for uninsured persons. So we recruited a variety of area health-related staff to serve on our local task force. We have studied demographic data in North Dakota and in our region, publicized this issue in local media, surveyed a sample of uninsured persons, learned about services that might help some uninsured, and developed a brochure on these services. But we soon realized that only between 10-20% of uninsured may be eligible for any current medical programs. The large majority fall between the cracks and are not eligible for medical programs or reimbursement sources. We need additional resources to expand our efforts, work with additional community leaders, and look at as many options as possible.

St. Alexius itself is significantly impacted by uninsured and underinsured patients. In our last fiscal year we provided $1.8 million in "charity care," where patients formally applied to have all or some of their medical bills forgiven. In addition, $4.2 million in bills were simply not paid by the patients, and are "bad debt." But we turn no one away.

I appreciate the opportunity to speak to you today in support of this proposed legislation. I would be happy to answer any questions you might have. Thank you.

(Two-part article appearing in the Bismarck "City" magazine raising awareness of the issue of healthcare for the un/underinsured; and listing some available healthcare programs.)



A Hidden Health Crisis in Our Community

By Rodger Wetzel

There is a hidden health crisis in our community. The crisis is the reality that about 10,000 people in Burleigh and Morton counties have no health insurance.

Most of us work for employers who provide health insurance as a benefit. But thousands of people either are self-employed and indicate they cannot afford to pay health insurance premiums, or they work for employers who do not provide health insurance as a fringe benefit.

The uninsured represent about 10 percent of our population. Of the estimated 10,000 who have no health insurance in the two counties, it is estimated that about 2,000 are children. Age groups with the highest percent of uninsured are the 18-24 young adult age group, and the 45-54 middle age group.

The percent of uninsured generally is even higher in more rural areas, where there are more small employers, a higher percent who are self-employed, and many farmers/ranchers. Small employers and self-employed people often pay higher insurance premiums than those who are part of a larger group plan.

Many people assume that the majority of the uninsured are unemployed or homeless. The reality is that the majority work full time or part time, and many hold down two jobs. Actually, about 72 percent of uninsured persons are employed.

Unfortunately, many employers, especially smaller ones, do not offer health insurance, often due to the cost, or the employee does not work enough hours at one or more jobs to quality for health benefits. For example, someone working 20 hours each at two jobs is actually working equivalent to full time, but may not get health insurance as a benefit at either job.

Less than half of employers in North Dakota who have 10 or fewer employees offer health insurance as a benefit. This compares with about 90 percent of employers with 50 or more employees. North Dakota has a high number of smaller employers.

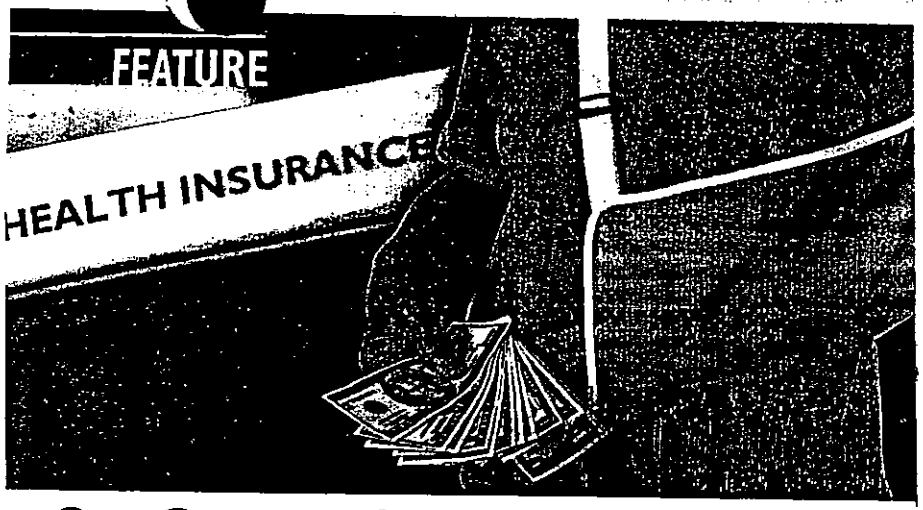
The reasons that employers give for not providing health insurance are: the premiums are high; employees already are covered by other plans; they have high employee turnover; and they have too many low wage employees who can't afford to share in the premium costs.

Having no health insurance affects uninsured people, those with insurance, and the health-care providers. Uninsured people are personally affected in that they are less likely to receive preventive care, are more likely to be hospitalized for health problems, have worse outcomes for chronic diseases, and have a decreased life expectancy.

Consequences to health-care providers include needing to offer more charity care, being required to provide more uncompensated care, and needing to spread costs to those with insurance. People without insurance also cause premiums of those with insurance to be higher. It is estimated that each person with insurance pays about $1,000 annually toward health-care costs for those without insurance.

Making health services available to as many of our citizens as possible improves their health, supports our many health-care providers, and reduces health-care costs to those of us with insurance.

In the next issue, Part 2, "Resources for People With No Health Insurance"



Our Community Spends Millions Providing for Those Without Health Insurance

(This is the second story in our series on "The Uninsured.")

By Pam Berreth

For an estimated 10,000 people living among us in Burleigh and Morton counties, accessing health care isn't as simple as deciding which clinic or hospital to use. For them, the choice has deep financial ramifications, which may delay or prevent receiving needed care. This is the reality for those without health insurance.

There are faces to these numbers. About 72 percent of the uninsured are employed, often working one or more jobs. Some are self-employed and unable to afford premiums. Others may work for small businesses unable to offer health insurance benefits. Part-time workers may not qualify for benefits.

The insured population, as well as health-care providers, are impacted by this crisis. The insured pay higher insurance premiums. Health-care providers are providing millions in charity care to those who formally apply to have all or part of their bill written off.

For the fiscal year July 1, 2005, to June 30, 2006, St. Alexius Medical Center provided $1.8 million dollars in formal "charity care" (patients requested free care). In addition, $4.2 million in services was "bad debt" (patients simply did not pay their bills).

For the 2005 fiscal year (Jan. 1 to Dec. 31, 2005), Medcenter One Health Systems' "charity care," which includes care at Medcenter One Hospital and Q & R Clinic's main offices and satellite clinics, totaled $5.54 million. The amount of bad dept incurred at Medcenter One in 2005 was $4.3 million.

Patients are not able to pay for about five percent of health-care services provided by Mid Dakota Clinic.

There are a number of programs to provide financial assistance or health-care services for people who have no insurance or who are underinsured, meaning their high deductibles and co-payments are barriers to their seeking health care. Those who have difficulty paying or cannot pay their bills are also encouraged to visit the health-provider business office. There are often payment options available, including charity-care programs and monthly payment options.

"Resources are being underutilized because those qualified are unaware of available programs," explained Rodger Wetzel, chair of the Burleigh-Morton Uninsured Task Force. "A significant number of the 10,000 people in our counties who are uninsured may be eligible for assistance programs, especially if they have children in the family."

The Task Force is taking steps to help agencies with limited marketing and public-information budgets to increase awareness and, ultimately, utilization of their programs. A comprehensive services brochure is now available at Burleigh or Morton County Social Services, Bismarck-Burleigh Public Health, Custer District Public Health, Bismarck and Mandan public libraries, and online at www.st.alexius.org.

Bismarck-Burleigh Public Health, Custer District Public Health, and both Burleigh and Morton County Social Services also serve as main contacts for referral and further information on all programs.

Resources for Those Without Health Insurance

Bismarck-Burleigh Public Health
222-6525
Custer District Public Health (Morton County)
667-3370
Bismarck-Burleigh Public Health and Custer District Public Health offer a wide variety of services, from home visits to new mothers and babies, in-home health services, immunizations and screenings, and "Women's Way."

Women's Way
Women's Way is a program to promote early detection of breast and cervical cancer through screening services to income-eligible North Dakota women ages 40 through 64.

Burleigh County Social Services
222-6622
Morton County Social Services
667-3395
County social services offices serve as contacts for the following financial assistance programs:

Medicaid
Medicaid is available to eligible adults and children and offers comprehensive medical coverage. Coverage includes prescription medications, routine preventive services, inpatient hospital medical and surgical services, and outpatient hospital and clinic services, among others.

Healthy Steps
Healthy Steps is a benefit program for eligible North Dakota children up to age 19 who do not qualify for Medicaid. Benefits include doctor or nurse practitioner care, hospital care, immunizations, mental-health services, drug/alcohol-abuse services, prescription medicines, eye care, and dental care.

Caring for Children Program
This program is for eligible North Dakota children up to age 19 who do not qualify for Medicaid or Healthy Steps. Services include doctor or nurse-practitioner care, limited hospital care, immunizations/shots, mental-health services, drug/alcohol-abuse services, and dental care.

Other programs available:

Joanne's Clinic
222-2108
Joanne's Clinic, located at Ruth Meiers Hospitality House, provides free nursing care to anyone who is homeless, uninsured, or underinsured.

Prescription Connection
328-2440 or 1-888-575-6611 (toll free)
This program of the North Dakota Insurance Dept. connects qualified, low-income people with free or discount prescription drugs directly from the prescription-drug company.

Bridging the Dental Gap
221-0518
This non-profit dental clinic accepts all forms of dental coverage, including Medicaid, and has a sliding-fee scale for those who qualify. Payment plans can also be arranged.

Attachment # 7

Testimony

Senate 2384

Senate Human Services Committee

Same given to House Human Services

Tuesday, January 30, 2007

Presented by: Mary Kay Herrmann

Senator Lee and members of the committee, thank you for this opportunity to share with you information on the South Valley Health Access Coalition and the work that has been done to address the issue of uninsured and underinsured in the south east region of the state.

Last June we held an Access to Health Care Summit in Fargo with about 70 people in attendance. Individuals from small business to health care providers were in attendance. This summit was sponsored in part by the Fargo Moorhead Chamber of Commerce and had a focus on the impact of uninsured in our community as well as the impact it plays on businesses and their ability to provide health insurance. We looked at several models that could be used at the community level. There were three issues that came from that summit for us to work on: 1) Alternative models of health insurance that could be provided to small businesses, 2) Securing the safety net which is services provided on a sliding fee schedule by the providers, 3) Pubic Education about the problem.

Most recently we have received support through the Dakota Medical Foundation to do community planning around the issue of Access to Health Care. A community meeting is being planned to gain more community input and develop a plan to move forward. SB2384 would provide seed money to assist local communities in developing a community plan and move forward.

Our long term goal is to have a self sustaining program that would address small business need to provide health insurance and at the same time secure the safety net for those individuals in our community that have no insurance.

Thank You.

Attachment #8

North Dakota
1003 East Interstate Avenue, Ste 6
Bismarck, ND 58503
Phone: (701) 221-9824
Fax: (701) 221-0615

CHAD
Community HealthCare
Association of the Dakotas

South Dakota
1400 West 22nd Street
Sioux Falls, SD 57105-1570
Phone: (605) 357-1515
Fax: (605) 357-1510

TESTIMONY
SB 2384
SENATE HUMAN SERVICES COMMITTEE
Senator Judy Lee, Chair
January 30, 2007

Senator Lee and members of the Committee, my name is Karen Larson, Deputy Director of the Community HealthCare Association of the Dakotas. Our organization serves as the Primary Care Association for North and South Dakota, and supports the work and efforts of the Community Health Centers, also known as Federally Qualified Health Centers, throughout North and South Dakota.

I appear before you today in support of SB 2384 as proposed to be amended. Our organization is committed to working with others to increase both geographic and financial access to primary health care, and to create a medical home for all North Dakotans. In that light, our office has been privileged to work with others through the efforts of the 100% Access Coalition for the past year and a half.

As a result of the two Access Summits, and because we know that addressing the dilemma of those who are uninsured and underinsured is complex and demanding, we support the action of this bill to create capacity at the local level to find, develop and test solutions to make health insurance and/or health care more accessible and affordable to a community's residents. This bill provides funding for one biennium to challenge and assist communities who are interested in taking on such an effort.

The 100% Access Coalition has as its goal to assist in the development of the criteria and application for these grants, and, most importantly to develop rigorous evaluation criteria by which the results of these efforts will be reported back to the Legislature.

I appreciate the opportunity to appear before you today in support of this exciting opportunity. I will attempt to answer any questions you might have.

SB 2384 - TESTIMONY - March 5, 2007
HOUSE HUMAN SERVICES COMMITTEE
Rep. Clare Sue Price, Chair

Senator Price and members of the House Human Services Committee, my name is Rodger Wetzel. I am the Director of the Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center here in Bismarck, which serves much of southwestern North Dakota.

I am supporting this legislation as Director of the St. Alexius Community Health Program, and as Chair of our Burleigh-Morton Task Force on the Uninsured. I have chaired this Task Force for the past two years.

I also am a member of the state 100% Health Access Coalition, chaired by Dr. Baird, and I have attended both state summits on uninsured/underinsured issues.

St. Alexius is committed to working with other community organizations to address community health issues, especially access to essential healthcare services.

I also am a past board member of our United Way Board. Our United Way Community Impact Committee has developed 5 "community impact vision councils," including one which is addressing unmet "Basic Needs" (food, clothing, shelter, healthcare). Our United Way's community surveys and community forums have identified healthcare for the uninsured to be one of our top human service needs in our area. But that issue is much larger than the United Way can address with its limited financial resources and increasing human service needs.

St. Alexius, as part of its community health and mission focus, surveyed community leaders about two years ago and asked for the most significant unmet health-related needs. One of the top needs identified was healthcare for uninsured persons. So we recruited a variety of area health-related staff to serve on our local task force. We have studied demographic data in North Dakota and in our region, publicized this issue in local media, surveyed a sample of uninsured persons, learned about services that might help some uninsured, and developed a brochure on these services.

But we soon realized that only about 10% of uninsured may be eligible for any current medical programs (brochure attached). The large majority fall between the cracks and are not eligible for medical programs or reimbursement sources. We need additional resources to expand our efforts, work with additional community leaders, and look at as many options as possible to address this need.

St. Alexius itself is significantly impacted by uninsured and underinsured patients. In our last fiscal year we provided $1.8 million in "charity care," where patients formally applied to have all or part of their medical bills forgiven. In addition, $4.2 million in bills were simply not paid by the patients, and are "bad debt." For example, in that same fiscal year 2499 people with no health insurance came to our Emergency Room. But we turn no one away because of our mission, values and charitable status.

I appreciate the opportunity to speak with you today in support of this proposed legislation. I would be happy to answer any questions you might have. Thank you!

Bismarck-Burleigh Public Health

Primary and Preventive Care includes:

- BAMBBE Program (home visit by nurse to new mother and baby within 1-2 weeks of birth)
- Breastfeeding Resources
- Car Seat Program
- Dietician Services (counseling/education)
- Ear Wash
- Health Maintenance
- Health Tracks (well child health services)
- HIV/AIDS Testing/Counseling
- Home Health (licensed in-home health services)
- Immunizations (children, adult)
- Nursing Services
- Pedicures
- School Nursing
- Screenings:
  Blood Glucose (blood sugar), Hearing, Blood Pressure, Vision, Urine, Cholesterol, Depression, other
- Sexually Transmitted Diseases (STD's)
- Tobacco Prevention & Control
- Smoking Cessation Classes
- "Women's Way" (see this section of brochure)

Contact:
Bismarck-Burleigh Public Health
500 E Front Ave.
Bismarck, ND
Phone: 222-6525

Custer Health (Morton County)

Services and Programs:

- BAMBBE Program (home visit by nurse to new mother and baby within 1-2 weeks of birth)
- Breastfeeding Resources
- Car Seat Program
- Child Health Screening
- Environmental Health Services
- Health Maintenance
- Health Tracks (well child health services)
- HIV/AIDS
- Home Health (home visits by RN)
- Immunizations
- Men's Health
- Nursing Services and Hours
- Babysitting Classes
- Bike Helmets
- Cholesterol Screening
- TB Testing
- Prenatal Home Visit Program
- School Health Services
- Tobacco Prevention and Control
- WIC (women, infants, children)
- "Women's Way" (see this section of brochure)
- Women's Health Services (separate office)

Contact:
Custer Health
210 2nd Ave. NW
Mandan, ND
Phone: 667-3370, or
- Women's Health Services Offices
  549 Airport Rd.
  Bismarck, ND
  Phone: 255-3535

Women's Way

Women's Way is a program to promote early detection of breast and cervical cancer for women through screening services to eligible women. Mammograms and pap smears are safe and effective. Low-income, minority and older women are less likely to have these life-saving tests. One barrier to obtaining screening is cost.

What services are available?

Eligible women ages 40 through 49 can receive:
- Clinical Breast Exams
- Pap Tests
- Pelvic Exams

Eligible women ages 50 through 64 can receive:
- Mammograms
- Clinical Breast Exams
- Pap Tests
- Pelvic Exams

You qualify if you are a woman who:
- lives in North Dakota
- is between ages 40 through 64
- meets income guidelines
- has insurance that doesn't cover pap tests and/or mammograms, or
- can't afford to pay her deductible/co-payments or doesn't have insurance

Contact: Bismarck-Burleigh Public Health or Custer Health (above).

West Central Human Service Center

Community Services:

- Crisis and outreach services
- Developmental disability case management and related services such as day supports, residential supports, and extended supports such as job coaches
- Mental health treatment services, care coordination, medication management, and residential and crisis services
- State Hospital admission screening and referral
- Substance abuse treatment services including care coordination, case aide, evaluations, treatment, and residential services
- Vocational rehabilitation and vision services
- Vulnerable adult protective services
- Other services

Contact:
West Central Human Service Center
1237 W Divide Ave., Suite 5
Bismarck, ND
Phone: 328-8888
Toll Free: 1-888-328-2662
TTY: 1-800-366-6888 (Relay ND)
Crisis Line: 328-8899 or
Toll Free: 1-888-328-2112
Counties served: Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux.

Mental Health Association in ND

- Information on many mental health issues
  Phone: 255-3692
- Helpline (crisis line), Toll Free: 1-800-472-2911

Vision Assistance Programs

- Vision USA, Phone: 258-6766
- VSP Sight for Students, Toll Free: 1-888-290-4964

2-1-1 Service (service information)

Dial 2-1-1 on your telephone

Senior Info-line (services for 60+)

Toll Free: 1-800-451-8693
website: *ndseniorinfoline.com*

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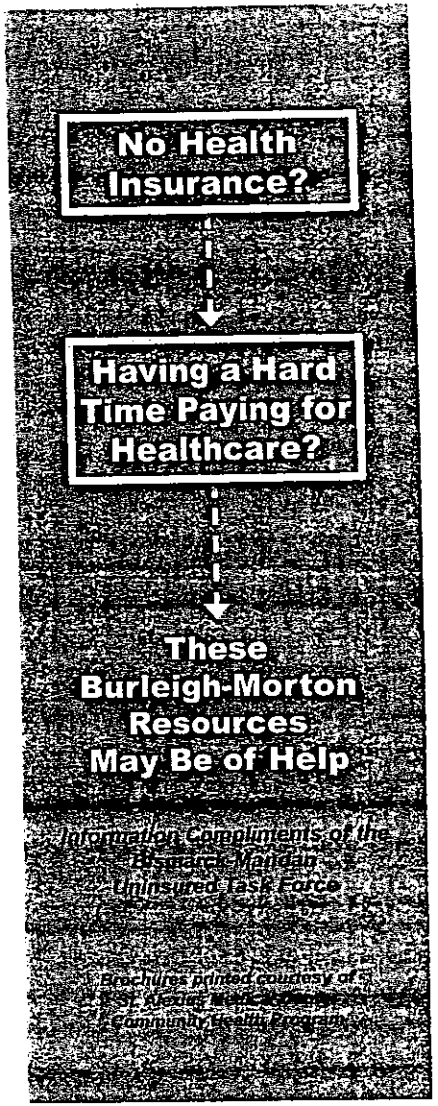

Medicaid

The Medicaid Program is available to eligible adults and children. Medicaid offers comprehensive medical coverage and encourages each member to have a primary care provider. It is administered by local county social service offices.

You may be eligible if:

- You qualify for other county-based federal assistance programs.
- Your **adjusted** net income is less that 133% of the federal poverty level.
  For example, if you have four people in your family and your adjusted net income is *$2217 a month or less, some/all family members (dependent on age) may be eligible for health-care coverage through Medicaid.
  **effective through 03/31/07*

Medicaid covers:

- Inpatient Hospital - Medical and Surgical Services
- Outpatient Hospital and Clinic Services
- Psychiatric and Substance Abuse Services
- Prescription Medications
- Routine Preventive Services:
  Well Child Checkups and Immunizations
  Preventive Dental and Vision Services
  Prenatal Services

Medicaid Also Covers:

- Certain Mental Health Services
- Prenatal Services

Have questions, or want to apply?
Contact:
www.state.nd.us/humanservices/services/medical serv/index.html **or**

Your local County Social Service Office:
Burleigh County Social Services
415 E Rosser Ave., Suite 113
Bismarck, ND
Phone: 222-6622

Morton County Social Services
200 2nd Ave. NW
Mandan, ND
Phone: 667-3395

Healthy Steps
(or State Children's Health Insurance Plan/SCHIP)

Healthy Steps is health insurance for eligible North Dakota children age 19 and younger who do not qualify for Medicaid, and do not have health insurance coverage. The program offers comprehensive medical, dental, and vision coverage and is administered by the ND Department of Human Services.

Children with Indian Health Services may participate in Healthy Steps.

Benefits include:

- Routine and primary medical care
- Inpatient (hospital) care
- Immunizations
- Mental health and substance abuse
- Prescriptions
- Vision care
- Primary and preventative dental care

Family Size	*Monthly Net Income
2	$1,540 or less
3	$1,937 or less
4	$2,334 or less

**effective through 03/31/07*

Have questions, or want to apply?
Contact:
1-877 KIDS NOW (1-877-543-7669), **or**
Your local County Social Service Office:
Burleigh County Social Services
415 E Rosser Ave., Suite 113
Bismarck, ND
Phone: 222-6622

Morton County Social Services
200 2nd Ave. NW
Mandan, ND
Phone: 667-3395

Caring for Children Program

Caring for Children is a benefit program for eligible North Dakota children up to 19 years old who do not qualify for Medicaid or Healthy Steps. Blue Cross Blue Shield of North Dakota administers this coverage, which includes primary medical and dental care, as well as mental health and chemical dependency treatment.

Benefits include:

- Routine and primary medical care
- Limited inpatient (hospital) care
- Immunizations
- Mental health and substance abuse
- Primary and preventive dental care

Family Size	*Monthly Net Income
2	$1,870 or less
3	$2,530 or less
4	$2,834 or less

**effective through 03/31/07*

Have questions, or want to apply?
Contact:
1-877 KIDS NOW (1-877-543-7669), or
Your local County Social Service Office:
Burleigh County Social Services
415 E Rosser Ave., Suite 113
Bismarck, ND
Phone: 222-6622

Morton County Social Services
200 2nd Ave. NW
Mandan, ND
Phone: 667-3395

Prescription Connection

This program of the North Dakota Insurance Department connects qualified, low-income people with discount prescription drugs direct from the prescription drug company.

Help for Those in Need
Patient assistance programs provide help to patients who lack prescription drug coverage and earn less than 200% of the federal poverty level (approximately $19,000 for an individual or $31,000 for a family of three).

Free or Low Cost Medicines
Patients will be directed to the public or private programs most likely to meet their needs.

Contact:
ND Insurance Department
Prescription Connection
600 E Boulevard Ave.
State Capitol, Fifth Floor
Bismarck, ND
Phone: 328-2440 or Toll Free: 1-888-575-6611
website: *http://rxconnectnd.org*

Bridging the Dental Gap

Bridging the Dental Gap is a non-profit dental clinic. The clinic serves people living within 50 miles of the Bismarck-Mandan area. The clinic accepts all forms of dental coverage, including Medicaid, and has a sliding fee scale for those who qualify according to the Federal Poverty Guidelines.

Contact:
Bridging the Dental Gap Clinic
1223 S 12th St.
Bismarck, ND
Phone: 221-0518

Joanne's Clinic
Ruth Meiers Hospitality House

Joanne's Clinic, located at the Ruth Meiers Hospitality House, is open to anyone in the community who is homeless, uninsured, or underinsured.

Clinic hours are Monday - Thursday
8:00 am - 5:00 pm
No appointments are needed
There is no fee for services provided

A nurse will provide the following services:

- Assessment of health problem
- Health screenings
- Referrals to other healthcare providers
- Follow-up visits after all appointments

Contact:
Joanne's Clinic
Ruth Meiers Hospitality House
1800 E Broadway Ave.
Bismarck, ND
Phone: 222-2108

Working with your hospital, clinic, doctor, or other healthcare provider

You are encouraged to visit with the business office at your hospital, clinic, or doctor's office if you will have difficulty paying for your healthcare services. There often are monthly or other small payment options available. Charity care programs sometimes are offered.

Contact:
The business office or insurance office of your hospital, clinic or doctor's office.

Senate Bill No. 2384
Testimony in Support
Timothy C. Cox
Northland Healthcare Alliance

Chairman Price and members of the House Human Services Committee, my name is Tim Cox. I am President of Northland Healthcare Alliance. Northland is a member driven, provider based organization of 25 hospitals and long-term care facilities located throughout North Dakota. For more than 6 years Northland Healthcare Alliance has been an active participant, with many others in this state, working to increase access to health care services to North Dakotans. Northland wrote and received the first HCAP (Healthy Communities Access Program) grant in North Dakota and was extensively involved in the second one received by Dakota Healthcare Foundation. I am also a founding member of Communities Joined in Action (CJA) and serve as a board member of this national organization. This organization represents over 500 communities in the country that are working to have 100% access and 0 healthcare disparities. We have been involved in both North Dakota Healthcare Access Summits for the Uninsured and see the progress communities are making to give families and individuals unfettered access to primary care services.

What is the problem that this projects would correct?

Why is our organization of hospitals and long-term care facilities involved with this issue? You would think that providers do not care. Not so. Nobody is turned away from our facilities as they seek medical care. Research shows that families put off getting care because they do not have a coverage option. They cannot afford insurance even as they are working to make ends meet, some of them with two jobs or more, and sometimes running a farm as well. They resist coverage because they do have money to pay for it and they feel that they won't really need it. What is worse, they resist going for care when they need it because they know it is expensive and they hope that they will get better. Some do get better.

But many do not, and unfortunately, those that don't, end up going to the Emergency Room, the most expensive place to go for health care; often they

wait until the illness is chronic or serious when it could have been resolved much earlier at a much lower cost. In some ways this is a national problem. It then filters down to the state and frankly, **we all pay for the solution as the costs are shifted to everyone else that is covered by some form of insurance or program**. There is enough money in the health care system in this country, it is just spent incorrectly and this issue of misuse of services is one of the major problems.

What will be accomplished with these funds?

What is exciting is that many communities have developed solutions to deal with this issue. They are close to the problem. Many have been creative and certainly they know what the issues are. With our HCAP work we were able to build some systems and services that have helped many individuals navigate the healthcare coverage issues. I personally have helped some families find programs that they did not know existed.

I would like to briefly summarize the vision of what can happen to expand healthcare services to more of the uninsured population and how it can happen with a bit of seed money to serve as a potent catalyst in this process.

In other communities across the nation, community collaboratives have been able to have a significant impact.

With several health care collaboratives in place, Washington State has been able to:

- Reach a high percentage (65%) of uninsured and connect them to needed health care services
- Increase the safety-net provider capacity by 30%
- Significantly reduce inappropriate utilization for targeted populations
- Attract and efficiently deploy resources that otherwise wouldn't have come to the community (e.g., medications, donated care, revenue, etc.)

In Muskegon, Michigan they have developed a creative coverage program called Three-share. Over a period of five years they have enrolled more than 570 businesses in this program. These were businesses that previously had not offered any healthcare coverage for their employees. As a result of these efforts

they estimate that they have reduced uncompensated care by more than $2,000,000 and covered more than 3500 employees in this program. Not only has it had a significant impact on the health of this targeted population, it has also reduced the turnover for many small business because they can now offer a benefit that is important and essential to their employees.

Other efforts in the country include programs that encourage and assist physicians to donate medical care by building mechanisms that protect them from malpractice for delivering that care and providing them an organized program in which to offer their services. Many would like to provide some pro bono coverage, but it needs to be organized and offer protection to them. Project Access is helping communities throughout the country to build programs around these principles with physicians and providers willingly donating their time to meet these needs. Many of them indicate that they enjoy doing it. It is fulfilling and it reaches the most needy. Project Access has assisted programs in 50 communities and they have received more than $30,000,000 in donated physician care in those communities. It's impressive.

These are some of the brightest examples of projects developed all over the country, in small and large communities. Many Individuals have received much-needed care that they would not have in any other way.

The two Healthcare Summits for the Uninsured we have held have explored many of these options and models. Senate Bill No. 2384 expands on the work of the two summits. We have organized communities and advised them to get creative. This is a partnership of all that are concerned. The money in this bill will be used by communities throughout North Dakota to work together to plan efforts that use local solutions and models to care for their neighbors. The intent is to bring together hospitals, clinic managers, physicians, public health workers, business people, community leaders and individuals in need to examine in depth the healthcare access issues in their community and come up with a plan that they can incubate: self-created plans and/or models that have already been created, that begin to solve access problems.

After participating in meetings nationally and seeing the evidence of community solutions, I know that this committee will not spend any dollars this Legislative session in a more worthwhile manner. It is a matter of choice of when to pay; later in the form of expensive medical services for those that did not access healthcare at the appropriate time or now when solutions can be developed locally that help people when they should have the services. It is a matter of timing. You have communities that are charged up and ready to find solutions to the problem now. All that they need to be effective is some resources to make it happen. The funding in this bill will provide exactly what they need.

SB 2384

- ✓ **DOES** provide "seed money" grants to large, medium, and small communities who are interested in applying, to bring key local stakeholders (*i.e.* employers, businesses, churches, health care providers, and health care consumers) together to identify needs and to develop possible solutions to assist uninsured individuals and families in creative new ways.

- ✓ **DOES** allow local communities to become part of finding solutions to the issues of the uninsured in their own communities.

- ✓ **DOES** give local communities an opportunity to test innovative methods at a local level.

- ✓ **DOES** provide funding to do a rigorous evaluation of community efforts, which will be shared with the ND Legislature in 2009

- ✓ **DOES NOT** mandate any community to take part in the grant opportunity.

- ✓ **DOES NOT** dictate to any community what program or specific solution they must implement. Communities applying for a grant will be given information about what other communities have done as examples of what has been tried and found to be successful, but they may develop their own innovative programs as well.

North Dakota

3 East Interstate Avenue, Ste 6
marck, ND 58503

Phone: (701) 221-9824
Fax: (701) 221-0615

CHAD
Community HealthCare
Association of the Dakotas

South Dakota

1400 West 22nd Street
Sioux Falls, SD 57105-1570

Phone: (605) 357-1515
Fax: (605) 357-1510

Same given to House Human Services

TESTIMONY
SB 2384
SENATE APPROPRIATIONS COMMITTEE
Senator Ray Holmberg, Chair
February 9, 2007

Senator Holmberg and members of the Committee, my name is Karen Larson, Deputy Director of the Community HealthCare Association of the Dakotas. Our organization serves as the Primary Care Association for North and South Dakota, and supports the work and efforts of the Community Health Centers, also known as Federally Qualified Health Centers, throughout North and South Dakota.

I appear before you today in support of SB 2384 as amended. Our organization is committed to working with others to increase both geographic and financial access to primary health care, and to create a medical home for all North Dakotans. In that light, our office has been privileged to work with others through the efforts of the 100% Access Coalition for the past year and a half.

As a result of the two Access Summits, and because we know that addressing the dilemma of those who are uninsured and underinsured is complex and demanding, we support the action of this bill to create capacity at the local level to find, develop and test solutions to make health insurance and/or health care more accessible and affordable to a community's residents. This bill provides funding for one biennium to challenge and assist communities who are interested in taking on such an effort.

The 100% Access Coalition has as its goal to assist in the development of the criteria and application for these grants, and, most importantly to develop rigorous evaluation criteria by which the results of these efforts will be reported back to the Legislature.

I appreciate the opportunity to appear before you today in support of this exciting opportunity. I will attempt to answer any questions you might have.

2384

North Dakota's 100% Health Care Access Coalitions - Leadership Team

Last	First	Title	Organization	Street Address	City	St	ZIP	Phone	Fax	Email Address
Northwest ND Coalition										
Funk	Annette	Community Resource Coordinator	Trinity Health	400 Burdick Expressway E	Minot	ND	58701	701-857-7491	701-857-7342	annette.funk@trinityhealth.org
Andrist	Barbara	Prevention Team Leader	Upper Missouri District Health Unit	PO Box 69	Crosby	ND	58730	701-965-6813	701-965-6814	bandrist@umdhu.org
Weppler	Shelly C.	Executive Director	St. Joseph's Community Health Foundation	308 2nd Ave SW	Minot	ND	58701	701-837-1726		sjchf@minot.com
Lumley	Gerald	Executive Director	Souris Valley United Way	15 2nd Ave. SW	Minot	ND	58701	701-839-2994	701-852-0873	svuw@srt.com
North Central ND Coalition										
Volk	Ronald	President	St. Aloisius Medical Center	325 Brewster St E	Harvey	ND	58341	701-324-4651	701-324-4651	rvolk@staloisius.com
East Central ND Coalition										
Ericson	Sharon	Executive Director	Valley Community Health Centers	PO Box 160	Northwood	ND	58267	701-587-6000		sharon.ericson@valleychc.org
Drengson	Gayla	SW/CM Manager	Altru Health Systems	PO Box 6002	Grand Forks	ND	58201	701-780-1942		gdrengson@altru.org
Gerloff	Chad	CRC	Altru Health Systems	1000 S. Columbia Road	Grand Forks	ND	58201	701-780-6261		cgerloff@altru.org
Rude	Sheryl	CRC	Nelson County Health System	200 N Main	McVille	ND	58254	701-322-4328, Ext.		slrude@gondtc.com
Southwest ND Coalition										
Andress	Denise	Wellness Center Coordinator	West River Health Services	401 7th St. South	Hettinger	ND	58639	701-567-6177		denisea@wrhs.com
Hilfer	Karen	CSBG Coordinator	Community Action Partnership	202 East Villard	Dickinson	ND	58601	701-227-0131		karenh@dickinsoncap.org
Burleigh-Morton Counties Coalition										
Wetzel	Rodger	Director, Community Health Program	St. Alexius Medical Center	PO Box 5510	Bismarck	ND	58506	701-530-7389		rwetzel@primecare.org

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South Central ND Coalition

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South Valley Healthcare Coalition

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Tribal Region Coalition

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Statewide Coalition

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SB 2384 - TESTIMONY - February 9, 2007
SENATE APPROPRIATIONS COMMITTEE
Sen. Ray Holmberg, Chair

Senator Holmberg and members of the Senate Appropriations Committee, my name is Rodger Wetzel. I am the Director of the Eldercare, Community Health, and Foundation Programs at St. Alexius Medical Center here in Bismarck, which serves much of southwestern North Dakota.

I am supporting this legislation as Director of the St. Alexius Community Health Program, and as Chair of our Burleigh-Morton Task Force on the Uninsured. I have chaired this Task Force for the past two years.

I also am a member of the state 100% Health Access Coalition, chaired by Dr. Baird, and I have attended both state summits on uninsured/underinsured issues.

I support SB 2384, and St. Alexius is committed to working with other community organizations to address community health issues.

I also am a past board member of our United Way Board. Our United Way Community Impact Committee has developed 5 "community impact vision councils," including one which is addressing unmet "Basic Needs" (food, clothing, shelter, healthcare). Our United Way's community surveys and community forums have identified healthcare for the uninsured to be one of our top human service needs in our area. But that issue is much larger than the United Way can address with its limited financial resources and increasing needs.

St. Alexius, as part of its community health and mission focus, surveyed community leaders about two years ago and asked for the most significant unmet health-related needs. One of the top needs identified was healthcare for uninsured persons. So we recruited a variety of area health-related staff to serve on our local task force. We have studied demographic data in North Dakota and in our region, publicized this issue in local media, surveyed a sample of uninsured persons, learned about services that might help some uninsured, and developed a brochure on these services.

But we soon realized that only about 10% of the 10,000 uninsured in our region may be eligible for any current medical programs. The large majority fall between the cracks and are not eligible for medical programs or reimbursement sources. We need additional resources to expand our efforts, work with additional community leaders, and look at as many options as possible to address this need.

St. Alexius itself is significantly impacted by uninsured and underinsured patients. In our last fiscal year we provided $1.8 million in "charity care," where patients formally applied to have all or part of their medical bills forgiven. In addition, $4.2 million in bills were simply not paid by the patients, and are "bad debt." In that same fiscal year 2499 people with no health insurance came to our Emergency Room. But we turn no one away because of our mission and charitable status.

I appreciate the opportunity to communicate with you today in support of this proposed legislation. I would be happy to answer any questions you might have. Thank you.

Senate Bill 2384

Appropriations Committee

Good Morning, Chairman Holmberg and members of the Appropriations Committee, my name is Tim Cox, President of Northland Healthcare Alliance. Northland is a group of hospitals and long-term care facilities (25) that collaborate on projects, services and programs to improve healthcare in North Dakota. You have the testimonies that we delivered before the Senate Human Services Committee, so today I would like to briefly summarize the vision of what can happen to expand healthcare services to more of the uninsured population and how it can happen with a bit of seed money to serve as a potent catalyst in this process.

I have attached to my written testimony a spread sheet that describes some of the most successful efforts to provide healthcare access in communities all over the country.

Let me describe briefly how two of them work to show what is possible and then I would like to explain what the grant money would be used for in North Dakota to move this process along.

The Three Share Model

The Three Share Program started in Muskegon, Michigan more the five years ago as an experiment to expand healthcare coverage for small business that previously did not offer any form of insurance or healthcare coverage as a benefit for their employees. They created a scaled down coverage plan that would offer basic primary care health benefits to employees. This basic coverage costs about $160 per employee per month. The cost is shared three ways, $50 from the employer, $50 by the employee and the remaining share is taken from Disproportionate Share Funds that the state receives. They estimated that they have generated more that $2,000,000 in additional dollars using this model. It is a fairly significant number. Our group has examined this program and has developed an alternate plan. We do not have Disproportionate Share Funds like Michigan. Each year our hospitals and medical facilities dedicate a percentage of their funds as charity care dollars that they use to help qualified individuals that cannot afford to pay for healthcare services that have been provided. They work with applicants to write off or reduce the costs of medical services at their facilities. Our facility administrators have determined

that they could allocate a portion of those funds as a part of this three share program. To them this is a win-win situation. It is a proactive way to use the charity care dollars in a planned way. The investment of those dollars expands the dollars that are generated because now employers and employees are contributing where they did not have any coverage in the past. The dollars they put in the program are new dollars. What happens is because the hospitals do not pay for 100% or write off the total amount they actually have expanded their ability to care for more in the community because their charity care dollars go farther. .

Project Access

Other efforts in the country include programs that encourage and assist physicians to donate medical care by building mechanisms that protect them from malpractice for delivering that care and providing them an organized program in which to offer their services. Many would like to provide some pro bono coverage, but it needs to be organized and offer protection to them. Project Access is helping communities throughout the country to build programs around these principles with physicians and providers willingly donating their time to meet these needs. Many of them indicate that they enjoy doing it. It is fulfilling and it reaches the most needy. Project Access has assisted programs in 50 communities. In an October 2006 the various programs that reported indicated that they had received more than $30,000,000 in donated physician care in those communities. It's impressive.

There are many other interesting and creative programs that have been developed and are being developed to increase access and eliminate disparities. One in Ohio has assisted communities to better manage Medicaid resources that use a Care Coordination Model. They have lowered the number of low weight births by 80% using this model and are now involved in a successful Medicaid Managed Care initiative.

The Grant Program

We envision that the communities or regional coalitions will use the seed funding to complete planning of their efforts. Funds would be used to pay someone to coordinate the work, to hire consultants or staff from other national coalitions to come to the communities to help them launch similar efforts in their towns. Funds could be used to pay for actuarial analysis for any coverage plans and to provide some start up funding to

get a project rolling. Currently the regional coalitions have met and have some projects in mind. They just need a catalyst to move them to the next level. The funding would take them to the next level.

Benefits to the State

Communities are interested in this issue because healthcare systems are the lifeblood of many communities. There is a tremendous strain on the healthcare safety net. The hospital and clinic resources are limited and it is difficult to continue to provide services for those that cannot pay. This funding is in part grassroots economic development. It prioritizes resources to take care of the uninsured up front rather than waiting and getting assistance to them when they are chronically ill and using extensive resources. It is a valuable use of funding because it will magnify the dollars or assistance that is provided as described in the two examples I discussed previously.

Everyone wins because no one is turned away that needs medical care. We just improve the local mechanisms so that the care is provided in the most timely, efficient way.