MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1512

2007 HOUSE HUMAN SERVICES

HB 1512

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1512

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 22, 2007

Recorder Job Number: 1501

Committee Clerk Signature Judy Schrock

Minutes:

Chairman Price: Opens the hearing on HB 1512.

Representative Al Carlson, District 41 Fargo, ND: See attached testimony, along with chart handouts. What is the best way to provide access and, doctor and professional care? I will go through the back ground with you, and the sections of the bill. You understand we have a State funded medical school. We make attempts to provide for training for doctors and hope they stay and to provide services to the people who are not insured or under insured by having access to this program to establish it.

Chairman Price: Do you expect 1 million to go to each quadrant?

Representative Carlson: that was our anticipation. We did not say that in the bill, but we assumed it would be divided equal amongst the regions. Obviously the more people they serve the more money they will request.

Representative Weisz: Where do you come up with the 4 million?

Rep. Carlson: there used to be 500,000 dollars if you go back for each facility. When we looked at how many people we were attempting to touch with this, we felt 500,000 dollars was a yearly fee. We are going back to something that used to be done. This is by no means anti

meds school. I use this as an enhancement for the med schools. If we have a shortage of 30 doctors, I would venture to say they are in the rural areas.

Representative Potter: Do you work with the Center of Rural Health for these suggestions or if they were consulted at all? I would hope we get their input; they have done all these studies on this. We are talking about 4 million dollars.

Rep Carlson: All I did was get their information from the information they put out I did not contact them. What we lack most times is the training facility and the money. We are offering both now, and hope they would view this as something they could work with the health department, local hospitals and med schools to provide a good program. This provides the money. You can study it to death, but if you don't put it into action you have nothing.

Representative Jeff Delzer, District 8 parts of McLean and Burleigh County: I think this bill is a good way to start a discussion about trying to get more doctors in the rural areas. One of the biggest missions is our school of medicine should have to provide doctors for ND, rural and urban. That is what the mission should say if it doesn't for what we invest in our medical school. It is a good medical school. This bill brings forward a chance to have that discussion. I would hope there is not a lot of duplication on it. I hope you could look at some aspect of this to promote them staying after their residency. How you do this in this bill? I have no idea.

Dr. Terry Dwelle, State Health Office of the ND Department of Health: I am here to supply information on HB 1512. See attached testimony.

Representative Porter: How do we get access to 44% that live in small rural areas? It doesn't do us good to have all the money sitting in the 4 major communities, when the access is always the issue. Would an incentive put out there to get primary care physicians to live in those more rural frontier areas? How would this tie in?

Dr. Dwelle: It will be a challenge, but let's go back to the last thing in details, in my testimony. I will let Gary Garland answer the latter part of your questions.

Gary Garland: The state loan repayment program for physicians is going through a transition at this time. Historically the loan payment program for physicians, gave 40,000 dollars to a physician who would work a period of 4 years. Obviously times have changed and they come out of school with a much larger bill, and they have less and less applying. 40,000 dollars is not sufficient coming out of medical school. Plus the 4 year period of time seemed quite long by a number of physicians who had just graduated from medical school. 90,000 dollars and add 2 years instead of 4 years would make it more attractive. This would compete more with neighboring states. We relied to much on the last legislative session on getting Federal money to help the state. What happened was the state appropriated the same amount of money for the 90,000 dollar program as it did the 14,000 dollar program. The federal dollars are in a state of uncertainty. They come out of school with around 100-150,000 dollars. We have had to negotiate with physicians.

Chairman Price: How much is in the budget and how much is in the option?

Mr. Garland: 75,000 continue to be in the budget, and an additional 75,000 dollars is being requested of the special funds for the Community Health Trust funds dollars. Additional money is anticipated for some federal money. This is a community state matching program.270,000 dollars is needed to run the program for each year.

Representative Conrad: This looks to me to be somewhat of a policy change for the state of ND. I am wondering if you could comment on that.

Dr. Dwelle: I think there is a linkage and always has been. There is a need for training residence to interact with patients. I think we have been engaged in this, but moving to

another level. It is an enhancement. I see it helping uninsured and under insured. I don't think it should be called a change.

Representative Potter: You referenced center rural health in your testimony. As we all know they have done all these studies. I am not particularly interested in the study, I am interested in if this bill fits in with what has already been done, and what might work for the state of ND.

Dr Dwelle: There is a lot of engagement not only research that has been done for rural health.

Chairman Price: Do you envision that all of these residents will be in the 4 major cities, or do you see the partnership as I have seen some develop where the Dr. is in New Town and the resident is in the smaller community for at least a part of their time.

Dr. Dwelle: I think it is probably premature to say what this program might look like.

Dr. Robert Beatty, Family Physician: I practiced 14 years in Hettinger. For about a year I have been at UND in Grand Forks as the chairman. I am in favor of more money for the program so that we can so that we can better fund the residency program. The Medical Schools mission does work. It is not as prestigious to be in family practice as in other medical areas. All of the residences try to do some out reach program.

Chairman Price: Obviously it takes time and an additional job for a physician to take a resident. Could we give them some reason for them to say I'll take a resident, and help them?

Dr. Beatty: The way the residency programs are funded, part of the dollars that report the overall operation in the family practice center comes from the practice of medicine, seeing patients, taking care of etc.

Chairman Price: anyone else to testify in favor of HB 1512, any one in opposition? Hearing none we will close the hearing on HB 1512

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1512

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 31, 2007

Recorder Job Number: 2457

Committee Clerk Signature	Judy Bikoch

Minutes:

Chairman Price: Take out HB 1512. Should we put in incentives for the institutions? The medical schools, hospitals clinics, what ever is out there. Maybe we should have a motor home, put a resident r nurse practitioner in it and go to the small towns, and rural areas. We don't know what we could do creatively unless we try. We don't need to stop at the residency program, or it could be a partnership with another entity. We have proposed amendments attached.

Representative Conrad: Is this to provide services to uninsured people? That would be a dramatic change in the policy in ND. We have never had public medical programs.

Representative Potter: I voiced concern during the hearing as it originally was and I think that concern would continue with the amendments brought forth and my concern is that we have a center for rural health in ND. All sorts of study, and research done to try to figure out what will work better for ND, and rural area situations. I think we should go with what has been studied and looked at. By the professionals, and not come up with our own. I don't think I can support this.

Representative Kaldor: I have had a little experience with rural health. I can't speak for what they would think and know. The med schools are trying to convince their students to go out to rural areas, but it is not easy. I think we should embrace this if the state is willing to fund this.

Representative Porter: I think it is interesting that we are able to look at those populations that are under served in our state. The way the bill originally came in, I don't think anyone really supported the concept, other than the goal to have better access. I think the amendments do go after where a lot of our access problems are. We have a real access problem.

Representative Weisz: I am not necessarily endorsing this idea at this point. This language has potential to help many areas. Obviously you will have a price tag to deal with. I find it hard to disagree with anything in the bill and for its intentions. **Representative Uglem** makes a motion to move the amendments, seconded by **Representative Hatlestad.** The verbal vote was all yeas. **Representative Uglem** moves a do pads as amended RR/Appropriations, seconded by **Representative Hofstad.** The vote was 9 yeas, 3 nays and 0 absent.

Representative Price will carry the bill to the floor.

Date: 1/31
Roll Call Vote #: 1

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

House HUMAN SERVICES HB 1512 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken None Amendments

Motion Made By Rep Uglem Seconded By Rep Hatlestad

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) "Click here to type Yes Vote" 12 No "Click here to type No Vote" 0

Absent 0

Floor Assignment

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

Date: 4/3/
Roll Call Vote #: 2

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

House HUMAN SERVICES HB 1512 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do pass as amended DP/Cpp

Motion Made By Rep Uglem Seconded By Rep Hofstad

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. Price

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

REPORT OF STANDING COMMITTEE

HB 1512: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (9 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1512 was placed on the Sixth order on the calendar.

Page 1, line 1, replace "use of postgraduate residency training programs" with "a frontier and rural medical access grant program"

Page 1, line 2, replace "and to train and retain primary health" with "in rural areas of the state"

Page 1, line 3, remove "care providers"

Page 1, line 5, replace "Postgraduate" with "Frontier and rural" and replace "residency training programs in primary health" with "access grant program"

Page 1, line 6, remove "care"

Page 1, replace lines 7 through 23 with:

"1. The department of human services shall manage and administer a frontier and rural medical access grant program designed to improve access to health care in rural North Dakota.

2. The department of human services shall provide grants of no more than one million dollars each to providers that will provide health care in rural areas to ensure that individuals who reside in those areas have proper access to affordable health care. The department shall establish a quadrant system that provides for a single grant in each quadrant of the state.

3. The department of human services shall give preference to health care providers that will focus on providing primary health care in rural areas and on facilitating the access of underinsured and uninsured individuals to health care.

4. The grants awarded under this Act may be used to pay for services or assistance, including preventive health care services, case management services, health insurance premium assistance, and evaluation of the effectiveness of proposed grant programs."

Page 2, remove lines 1 through 24

Page 2, line 25, replace "6." with "5." and replace "state health officer" with "department of human services"

Page 2, line 31, after the comma insert "and from the special funds derived from federal funds, the sum of $7,100,000, or so much of the sum as may be necessary", remove "state", and replace "health" with "human services"

Page 3, line 2, remove "The state department of health's"

Page 3, remove line 3

Renumber accordingly

2007 HOUSE APPROPRIATIONS

HB 1512

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB1512

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 14, 2007

Recorder Job Number: 3482

Committee Clerk Signature Kelly N Stanley

Minutes:

Chairman Svedjan opened the hearing on HB 1512. HB 1512 was referred to us by the House Human Services Committee.

Rep Carlson distributed and reviewed amendment .0401 (Attachment A). This is the third attempt to accomplish what I introduced the original bill. The whole purpose of this bill is to have Primary Care Doctors and have Residency programs for Primary Care Doctors. There is a shortage of Primary Care Doctors. The rural situation of having those doctors is becoming rather severe in some cases. The issue that needs to be addressed is the training of our doctors in Primary care to service the rural, the non insured and under insured. So the amendments change things here as it says here the Department of Human Services shall establish and administer a program through which post graduate medical residency training programs in the state, contract with the department to provide Primary Care to low income, uninsured and under insured residents of this state. A Post Graduate Medical Residency Training Program but are not eligible to contract to the department under this section unless the residency training program meets the requirements established by the department. Not everyone is set up to train residents. It has to be programs to establish these doctors. The Department shall consult with University of ND School Medicine and Health Sciences in establishing minimum requirements for post graduate medical residency programs

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participating in this program. The Department of Human Services shall establish a quadrant system that provides for a single residency program in each quadrant to contract to serve as a head quarters for that quadrant for participation in the program established in this section. Awarding a contract the Department should give preference to a Family Practice or an Internal Medicine Post graduate Medical Residency Training Program.

Section 3 of the bill is the appropriations.

Section 2 talks about during the biennium the ND School of Medicine and Health Science shall seek the contract with private third parties to divest the University Ownerships Interest and the Family Practice Post Graduate Medical Residency Programs in Bismarck and Minot.

There is about $680,000 for each quadrant. We are looking at working with the assisting facilities, does it have an affect on the 4 million dollars building that they want to build in Bismarck; I would say it probably does.

Rep Skarphol: Why in each quadrant would it require single residency program such as Bismarck?

Rep Carlson: I can't give you a good answer. All I know is that you have to certify to provide the training.

Chairman Svedjan: The way things are right now, there would a single residency in each residency program in each of the quadrants now. Primary Care has 1 in Fargo and then there is one in Family Practice Residency in Bismarck, Minot and Grand Forks.

Rep Skarphol: Do they work with, for example with both hospitals?

Chairman Svedjan: Yes. They worked with facilities. What I am wondering here is does the single provide for a single program?

Rep Skarphol: Maybe there is a different between program and Medical Facility.

Chairman Svedjan: The way I read this is the Department shall establish a quadrant system that provides for single residency program. They are not talking about a provider. The intent is to establish a ling with the Medicaid program to help insure that the lower income people have access to these residency programs. Is that correct?

Rep Carlson: Most of the programs we have had have had financial problems because they have not been properly reimbursed.

Chairman Svedjan: It is intended to help the bottom line of these residency programs to become more financially viable. As I understand it when the Medical School was in testifying they did address the situations in especially Bismarck and Minot, where their uncollectible have grown to $700,000 in Minot and $400,000 in Bismarck. A big part of this is that they are serving Medical indigent patient. If that is true and there is a link established with the Medicaid Program to try and send Medicaid patience's to those facilities, it would seem to me it would help with their bottom line.

Rep Monson: I have a question on Section 2. University of North Dakota School of Medicine and Health Sciences shall seek to contract the private third parties to divest the Universities ownership interest and the Family Practice Post Graduate Medical Residency Training Programs. So they are going to get rid of the programs? They don't own the building in Bismarck, they rent the building. So are you saying they have to get rid of the program and them someone else is going to run the program? That is what the University of Medical School does is runs the program. So are you asking them to get rid of the building or are you asking them to get rid of the program and have someone else run the program?

Rep Carlson: What we want them to do is contract out, they do I believe in Grand Forks.

Chairman Svedjan: The way the situation is in Grand Forks right now is that the School of Medicine has virtually divested itself of that program. So Altru Health System is totally

responsible for that program. It is a community run residency program as apposed to a Medical School Based Program. When I read this, I understood it to say it would encourage other communities that have residency programs to look at moving them to a community based program. This is where providers would have an ownership interest in the Post Graduate Medical Education Program.

Rep Monson: I see that it works fine in Grand Forks because we have one facility in Grand Forks. In Bismarck you have two hospitals which neither one may be large enough to run the whole residency program on their own, so you are going to probably have the two facilities for the program. As I am reading, if you are going to limit it as being one program, I think you are going to run into problems in Bismarck with that wording. Fargo where you have 2 or 3 different facilities is you going to really survive very well there.

Chairman Svedjan: The language itself in section 2, the second line after the bold print says, that they shall seek to contract with private 3rd parties and doesn't limit to 1 party. Technically the language would allow for there to be multiple parties with whom you seek to contract.

Rep Monson: Inn sub section 2 of section 1 it says for single residency program in each quadrant.

Chairman Svedjan: But it doesn't say single residency program not single providers.

Rep Skarphol: Do they not have to be certified to be able to be a Post Graduate Residency Training Facility? Not every hospital has a program for training.

Chairman Svedjan: The Residency Programs have to be accredited.

Rep Skarphol: Referring to Sub section 1 Line 9 of section 1 it refers to the accredit council of graduation of medical education. Will they accredit more than one facility in a single community?

Chairman Svedjan: It is the program not the facility that gets accredited.

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Rep Skarphol: So would they accredit more than one?

Chairman Svedjan: More than one residency program.

Rep Skarphol: What you are saying the Department of Human Services would be required to set a residency program and they could intern contract with any provider.

Chairman Svedjan: That is not my interpretation, the way I understand this is the dept would contract with Residency Programs and that is where I see the link to the Medicaid program. Section 2 encourages the med school to contract with providers in quadrants where Residency Programs do exist to see if there is reason why they should move them to community based.

Rep Wald: Sub section 1 of Section 1. The Department of Human service, what is there roll currently in Residency Training Programs?

Chairman Svedjan: I don't believe there is any roll what so ever.

Rep Wald: Why are we dragging the Department of Human Services into this then? We are creating more bureaucracy when we already have a problem and have another layer of government. There is a performance audit going on at the Medical School and while agree of some of the divesture of these family practice centers because they are provide a service to the uninsured and underinsured. But this is a quantum leap into solving this problem.

Chairman Svedjan: Department of Human Service involvement here would be to try and create a means by which Medicaid patients would utilize the Residency Facilities to help with their bottom line.

Rep Aarsvold: Could they not do that now? Could they not direct those folks to the Family Practice Center?

Chairman Svedjan: I don't think that is happening now. With the flexibility in Medicaid now that has been granted through the deficit reduction act, there can be more requirements to place on Medicaid patience.

Rep Aarsvold: Regarding the uncollectible, I suspect that the traditional providers have significant uncollectible also. I am not sure that is not a strong argument in favor of making a change.

Chairman Svedjan: And here to I can only speak of Altru experience, that we have been able to improve the collection of outstanding debts because we do it.

Rep Kerzman: You have been referring to the larger institutions and when we talk rural access and rural delivery, Hettinger has is doing a tremendous job down there, are we going to put them at a disadvantage when they have to have community help?

Chairman Svedjan: I would say no because there is no residency program in Hettinger. But there is a link that would have residents spend time in smaller facilities. Based on my interpretation there would not be a negative impact. The ROAM program places residents in rural communities.

Rep Carlson: The purpose to the residency program is to train doctors. If we train them here, hope they will stay here. We want to get them involved in part of the cities and let them contract with the existing facilities. This is what the focus in the bill.

Rep Martinson: I don't think we want the Department of Human Services to set the minimum requirements of a residency program at the University of ND Medical School. What ownership interest does the UND Medical School have to invest in Bismarck?

Rep Carlson: If they don't own a building they don't have any.

Rep Martinson: What is the purpose of this?

Chairman Svedjan: University of Medical School has an ownership interest in the Residency Program. In case of Bismarck they do not have ownership in the building because they lease the building.

Rep Martinson: So what you are asking UND Medical School is to go to a hospital and ask them to run the Family Practise Program for them. There are huge hospital wars in Bismarck and if that is your intent to get one of them to get involved in running them, I would be interested in sitting in on some of those meetings. That program competes with those hospitals and the clinics in town. They would just as soon see it go away. I do think we the hidden agenda is to see the Family Practice go away at UND.

Rep Carlson: Couldn't disagree with that more.

Rep Skarphol: I do agree that there needs to something looked at with regards to how our physicians are trained and retained in ND. I do not agree with the language in this amendment. I think we need a lot of questions we need answers for. We can either pass this bill or amended into a study.

Rep Skarphol motioned to adopt amendment .0401. Rep Thoreson seconded the motion.

Rep Monson: I do agree with Rep Skarphol that a study is needed and am unsure if the amendment is workable. I also know that there is a performance audit done of the Medical School and I think that this would be a study if you will.

Rep Wald: The language that bothers me most is Section 1 of sub section 1 the first 2 lines where the Department of Human Services shall establish and administer. You are really short circuiting the Medical and the Dean and their whole education in training doctors. You bring in another agency and simply duplicate the bureaucracy it just does not make sense.

Rep Skarphol: I agree with what Rep Wald just said. I think it is a topic worthy of discussion.

Rep Glassheim: I really object to this whole process, there is no hearing on this. We are asked to make decisions we have no information. The Med School is not here to testify on the implications. It has very little to do with the original bill. The original bill was to promote interns in rural areas. Now we are taking over programs in Bismarck and Minot. It really needs more thought than the amendments.

The motion to adopt amendment .0401 failed by voice vote.

Rep Monson motioned for a Do Not Pass to HB 1512. Rep Gulleson seconded the motion. The motion carried by a roll call vote of 17 ayes, 6 nays and 1 absent and not voting. Rep Monson was designated to carry the bill.

Attach A
2/14/07

70576.0401
Title.

Prepared by the Legislative Council staff for
Representative Carlson
February 13, 2007

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1512

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for use of postgraduate residency training programs to provide primary health care to the uninsured and underinsured and to train and retain primary health care providers; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Postgraduate medical residency training programs in primary health care - Services to the uninsured and underinsured.

1. The department of human services shall establish and administer a program through which postgraduate medical residency training programs in the state contract with the department to provide primary health care to low-income, uninsured, and underinsured residents of the state. A postgraduate medical residency training program is not eligible to contract with the department under this section unless the residency training program meets minimum requirements established by the department of human services which must include the requirement the residency training program be accredited by the accreditation council on graduate medical education and the requirement the residency training program provide primary health care. The department shall consult with the university of North Dakota school of medicine and health sciences in establishing minimum requirements for postgraduate medical residency programs participating in this program.

2. The department of human services shall establish a quadrant system that provides for a single residency program in each quadrant to contract to serve as the headquarters for that quadrant for participation in the program established under this section. In awarding a contract under this section, the department shall give preference to a family practice or internal medicine postgraduate medical residency training program of an organization exempt from federal taxation under section 501(c)(3) of the Internal Revenue Code.

SECTION 2. UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES - POSTGRADUATE RESIDENCY TRAINING PROGRAMS. During the 2007-09 biennium, the university of North Dakota school of medicine and health sciences shall seek to contract with private third parties to divest the university of the university's ownership interests in the family practice postgraduate medical residency training programs in Bismarck and Minot. A transfer of ownership of a postgraduate medical residency training program under this section must be contingent upon the third party being awarded a quadrant contract under section 1 of this Act.

SECTION 3. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $2,300,000, or so much of the sum as may be necessary, to the department of human services for the purpose of administering and funding the health care service program under section 1 of this Act, for the biennium beginning July 1, 2007, and ending June 30, 2009. The department of human services' administrative expenses under this program may not exceed $50,000 for the biennium."

Renumber accordingly

Date: 2/14/07
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1512

House Appropriations Full Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70576.0401

Action Taken Adopt amend. 0401

Motion Made By ~~Gulleson~~ Skarphol Seconded By Thoreson

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan					
Vice Chairman Kempenich					
Representative Wald			Representative Aarsvold		
Representative Monson			Representative Gulleson		
Representative Hawken					
Representative Klein					
Representative Martinson					
Representative Carlson			Representative Glassheim		
Representative Carlisle			Representative Kroeber		
Representative Skarphol			Representative Williams		
Representative Thoreson					
Representative Pollert			Representative Ekstrom		
Representative Bellew			Representative Kerzman		
Representative Kreidt			Representative Metcalf		
Representative Nelson					
Representative Wieland					

start here →

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Voice Vote — Carried

Date: 2/14/07
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1512

House Appropriations Full Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number —

Action Taken Do Not Pass

Motion Made By Monson Seconded By Gulleson

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan		✓			
Vice Chairman Kempenich	✓				
Representative Wald	✓		Representative Aarsvold	✓	
Representative Monson	✓		Representative Gulleson	✓	
Representative Hawken	✓				
Representative Klein	✓				
Representative Martinson	✓				
Representative Carlson		✓	Representative Glassheim	✓	
Representative Carlisle	✓		Representative Kroeber	✓	
Representative Skarphol	✓		Representative Williams	✓	
Representative Thoreson		✓			
Representative Pollert	✓		Representative Ekstrom	✓	
Representative Bellew	—		Representative Kerzman	✓	
Representative Kreidt		✓	Representative Metcalf	✓	
Representative Nelson		✓			
Representative Wieland		✓			

Total (Yes) 17 No 6

Absent 1

Floor Assignment Monson

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

REPORT OF STANDING COMMITTEE

HB 1512, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **DO NOT PASS** (17 YEAS, 6 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1512 was placed on the Eleventh order on the calendar.

2007 TESTIMONY

HB 1512

Rep. Carlson

HB1512 PRIMARY GOALS:

1. **Bolster primary care medical residency training programs to ensure a long-term supply of highly skilled doctors to provide healthcare for both rural and urban citizens of North Dakota.**

2. **Utilize existing state-funded and other primary care residency training programs and other clinics to ensure a "medical home" to serve the primary healthcare needs of North Dakota's uninsured, underinsured, low-income population.**

Background:

Since the mid-70's, North Dakota has maintained state funded and owned Family Practice Residency training programs in Fargo (closed 2002), Grand Forks (transferred to Altru in 2004), Bismarck and Minot. The remaining training programs operate primary care clinics staffed by outstanding medical doctors and associated clinical staffs which serve as mentors in preparing our state's future family doctors to properly care for our state's citizens. All North Dakota medical residency training programs have produced many outstanding primary care doctors that choose to practice in both rural and urban areas of North Dakota. All of the remaining family practice training programs in Grand Forks, Minot, and Bismarck operate primary care clinics which serve both insured and uninsured North Dakotans.

In 2002, the state School of Medicine discontinued the Fargo program. In 2004, the school transferred ownership and responsibility for the Grand Forks program to Altru Health System. During the Grand Forks program transition, the School of Medicine assumed the program's accounts receivable and absorbed some of the costs associated with the transfer of operations. I am uncertain as to the School of Medicine's current financial support of this program.

All programs used to receive about $500,000 per year in direct state funding through the medical school's budget. The only state owned and funded programs as of 2006 are the remaining Family Practice Residencies in Minot and Bismarck. I will request the Dean of the Medical School to provide the exact amount of state funding currently provided for family practice as well as all other residency programs in the state. The Dean of our state's medical school has indicated in an email message to me that he supports this bill.

It is clear that North Dakotan's demand for primary care health services will only increase in the future due to the state's aging population. In fact, as of late 2006, a shortage of about 30 family practice physicians exists - demonstrating a current serious healthcare access problem for our state. Our state medical school data indicates that about one-half of the family practice doctors trained in North Dakota choose to practice near their training residency locations. Therefore, it is critical that we look for innovative ways to strengthen these training programs so they continue to serve as a steady pipeline for our future physician workforce.

Proposal:

Utilize our existing state funded primary care residency program clinics to provide comprehensive primary care to the low-income, uninsured in the state. By providing access to primary care services throughout the state, we can ensure a "medical home" for all North Dakotans, especially the uninsured estimated at about 51,920 in the state as of 2004.

Section 1.

Subsection 1.

Subsection 1 authorizes the state Department of Health to establish a program for accredited primary care residency physician training programs to provide healthcare services to low-income, uninsured and underinsured state residents.

Subsection 2.

Subsection 2 directs the Health Department to establish quadrants in the state which contain primary care residency program clinics which will serve as a "headquarters" for such quadrants to serve the primary care health needs of low-income, uninsured, and underinsured citizens. Family Medicine residencies operated by UND are given preference under the Health Department's grant program. If UND does not operate a residency in a quadrant, preference shall be given to another family practice residency program operated by a 501(c)(3) tax exempt entity.

Subsection 3.

Subsection 3 requires the primary care residencies of the state School of Medicine to participate, since we are already providing significant state funding to UND's training programs. The appropriation under this bill will bolster their programs to continue to train and serve as a consistent source for our state's primary care doctors while also addressing the health care needs of the low-income population served through this initiative.

Subsection 4.

Subsection 4 allows the Health Department to contract with these primary care residency programs which include family medicine and internal medicine and other clinics operating in the state to effectively address the healthcare needs of low-income persons in each quadrant throughout the entire state, as designed by the Health Department.

Subsection 5.

Subsection 5 gives specific authority to the Health Department to manage and issue grants under the program. Recipients of grants may only use these funds for costs directly associated with uncompensated care. The grants under this initiative are not to be used to replace existing funds within these residency training program or for construction, training, or regular costs associated with operating a clinic.

Subsection 6.

Subsection 6 requires the state health officer to report every even numbered year to Legislative Council on the effectiveness of the program.

Section 2.

Section 2 includes up to $4,000,000 for the Health Department to implement and administer the program with an administrative expense limit of $50,000 for the biennium.

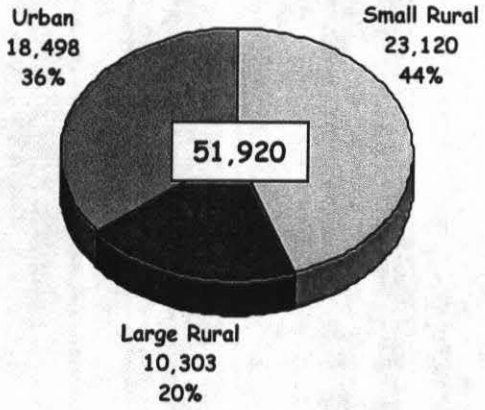
Uninsured in North Dakota - How do we best approach 100% Access?

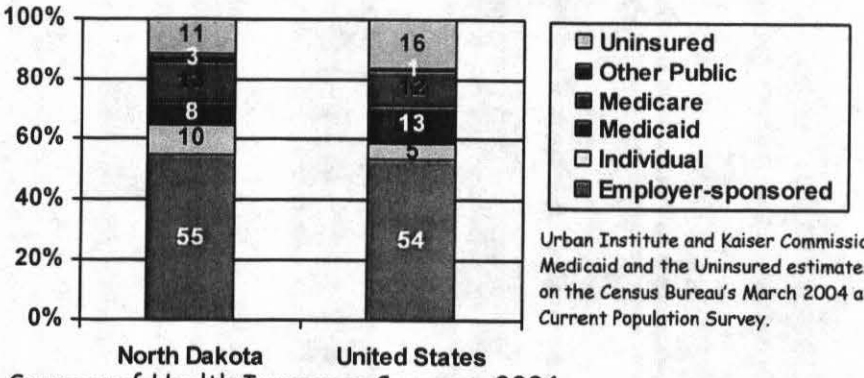
13.2% of North Dakotans are uninsured (51,920 people)

North Dakota Household Survey - Feb-Mar 2004, UND Center for Rural Health
(1994 RWJF State Initiatives Project survey - 9.9% uninsured)

NORTH DAKOTA DEPARTMENT of HEALTH

funded by HRSA State Planning Grant





Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey.

Sources of Health Insurance Coverage 2004

Demographics of Uninsured -

Age - 22 percent of uinsured are children (11,311)
- younger adults high rates of uninsured

Gender - Males more often uninsured

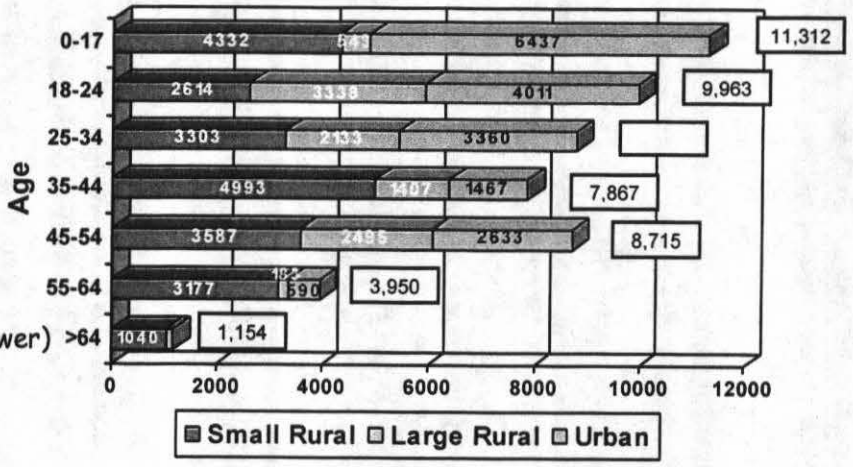
Race - Native Americans 31.7% uninsured
- Whites - 6.9% uninsured

Marital status - unmarried more uninsured

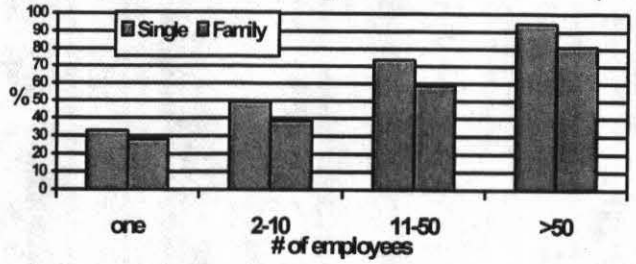
Income - lower income are more uninsured

Employment - 71.7% of uninsured are employed

Small-businesses - higher uninsured rates (10 or fewer)



ND Employers offering Insurance to Employees



Reasons employers not offering insurance

Premiums too high (46%)
Employees covered elsewhere (34%)
High turnover (7%)
Too many low wage employees (6%)

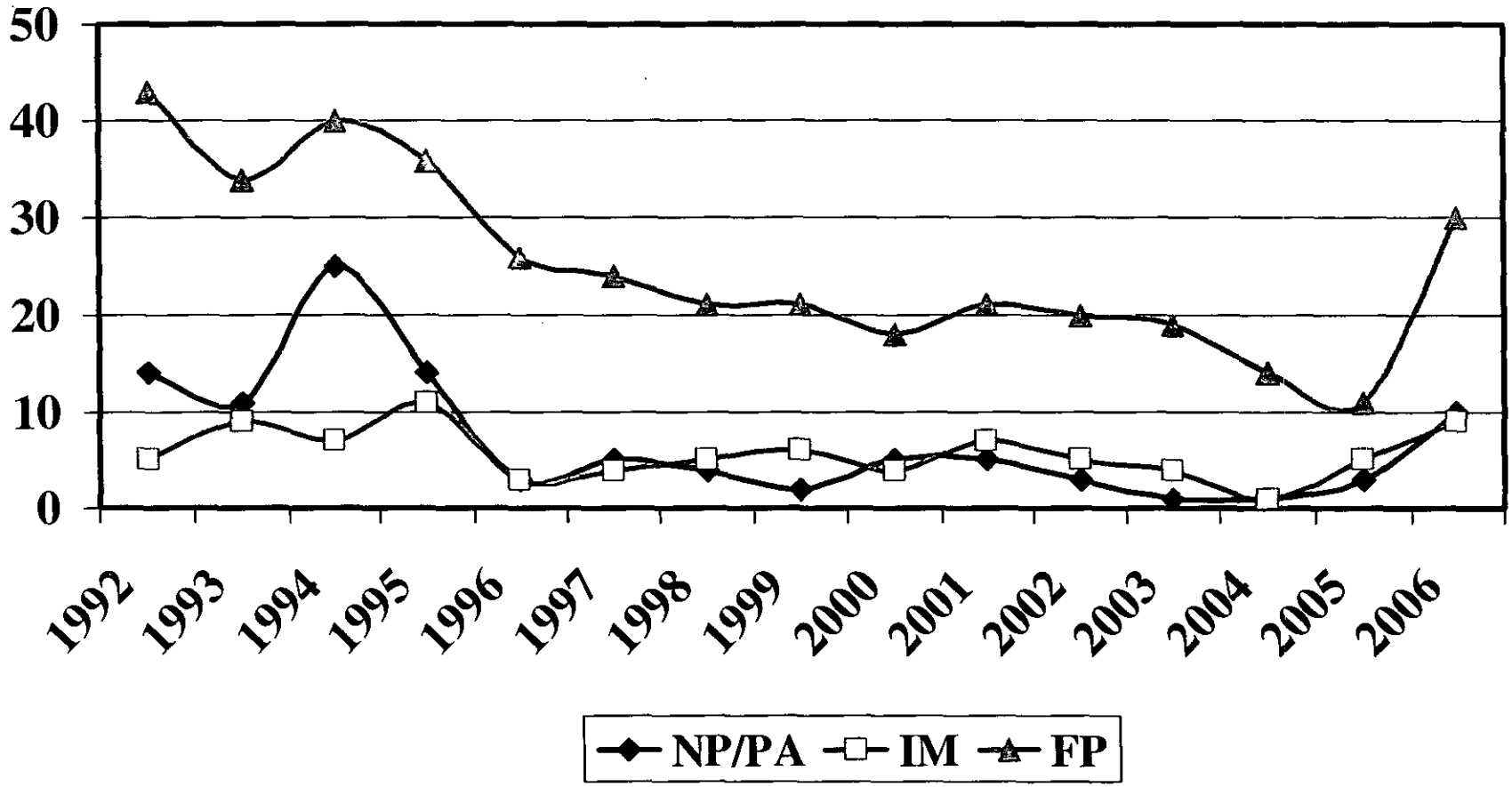
Consequences

Uninsured
- Less likely to receive timely preventive care
- More likely to be hospitalized for avoidable health problems
- Worse clinical outcomes for chronic diseases (Diabetes, CV disease, Mental illness)
- Less likely to receive preventive services
- Substantial financial impact, Medical bills - factor in half of bankruptcies
- Decreased life expectancy

Health Care providers - Uncompensated/Charity Care
- ND Hospitals estimated annual uncompensated care - $32.5 Million (AHA Annual Survey 2000)

JRB - September 2006

Primary Care Vacancies in Rural North Dakota
1992 – 2006



NP: Nurse Practitioner PA: Physician Assistant IM: Internal Medicine FP: Family Practice

Employer Recruitment

What do we know about the state's physician workforce?

1,461 licensed physicians 2004-05

National

- average age is 51
- 26% are female
- 11% practice in rural areas

State

- average age is 49
- 21% are female
- 32% practice in rural areas

25% will retire by 2015 - 42% by 2020

Source: Physician Characteristics & Distribution in the US; State Health Workforce Profiles 2004; Amundson, M., Moulton, P., Kruger, G., Speaker, K., Zavalney, B. & Monley, K. A Survey of North Dakota Physicians. Center for Rural Health, School of Medicine and Health Sciences Health Professions Tracking Program.

Heard 1/22

Testimony

House Bill 1512

House Human Services Committee

Monday, January 22, 2007; 10 a.m.

North Dakota Department of Health

Good morning, Chairman Price and members of the House Human Services Committee. My name is Dr. Terry Dwelle, and I am the State Health Officer of the North Dakota Department of Health. I am here to provide information about House Bill 1512.

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. Dr. John Baird, a field medical officer for the Department of Health, 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, 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.

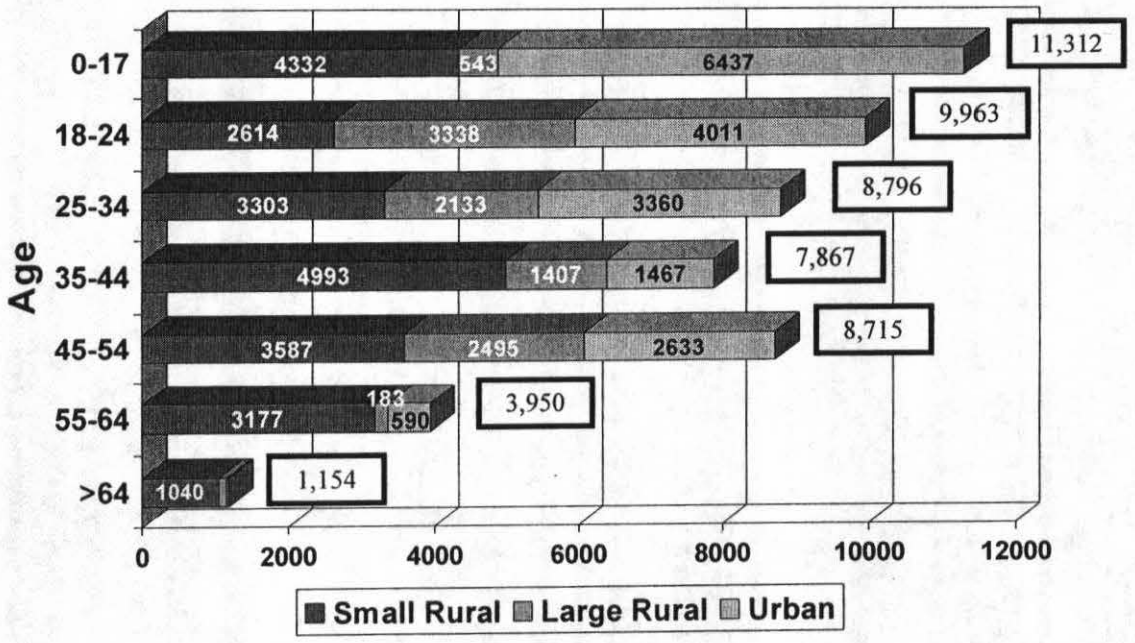
Areas of Residence of Uninsured

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 also looked at the number of uninsured individuals by age groups and areas of residence. As the following chart shows, a larger portion of uninsured young adults and children live in the four major urban areas of the state.



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.

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.

House Bill 1512 outlines a mechanism to provide primary health care to this uninsured and underinsured population. If the North Dakota Department of Health were to establish and monitor this program, it may be possible to draw on the recordkeeping and reporting systems of the state's federally funded community health centers that have experience and systems in place to care for the uninsured.

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