INSURANCE AND HEALTH CARE COMMITTEE

The Insurance and Health Care Committee was assigned six studies. Section 27 of Senate Bill No. 2004 directed a study of emergency medical services. House Concurrent Resolution No. 3030 directed a study of the development of a strategic planning process for the future of public health in this state. House Concurrent Resolution No. 3033 directed a study of the effects of managed health care on the future viability of the health care delivery system in rural North Dakota. House Concurrent Resolution No. 3043 directed a study of the feasibility and desirability of implementing hail suppression programs for the reduction of property damage in urban and rural areas and funding the programs through property and casualty line insurance premium taxes. The Legislative Council also assigned the committee the responsibility to receive annual reports from the Commissioner of Insurance relating to the progress of the partnership for long-term care program. The Legislative Council chairman directed the committee to receive reports from the Governor and the Department of Human Services on the children's health insurance program (CHIP).

Committee members were Senators Karen K. Krebsbach (Chairman), Judy L. DeMers, and Jerry Klein and Representatives Michael Brandenburg, Thomas T. Brusegaard, Mike Callahan, Ron Carlisle, Al Carlson, David Drovdal, Pam Gulleson, Kenneth Kroeplin, Alice Olson, Clara Sue Price, Wanda Rose, and John M. Warner.

The committee submitted this report to the Legislative Council at the biennial meeting of the Council in November 1998. The Council accepted the report for submission to the 56th Legislative Assembly.

EMERGENCY MEDICAL SERVICES STUDY

The committee was charged with studying emergency medical services and encouraged to review the emergency medical services system, the training and equipment funding needs of emergency medical providers, and the role of emergency medical services in trauma care coordination.

Legislative Background

House Bill No. 1257 (1997) required the State Health Council to adopt rules prescribing minimum quality review standards for emergency medical services personnel. The bill also provided that a certified emergency medical technician-intermediate or paramedic employed by a hospital and working in a nonemergency setting is under the supervision of the hospital's patient services management. House Bill No. 1474 (1997), which was withdrawn, would have provided for a volunteer emergency medical technician award program.

Recent Studies

During the 1987-88 interim, the Budget Committee on Institutional Services studied the problems faced by and the funding of the North Dakota emergency medical services system and, in particular, volunteer ambulance services and the State Department of Health's Division of Emergency Health Services. The committee recommended two bills relating to emergency medical services which were enacted in 1989. One bill, as recommended, would have imposed a 25 cent per month excise tax on telephone access lines to provide financial assistance to licensed ambulance services, training, and equipment. As passed, only the portion of the bill creating North Dakota Century Code (NDCC) Section 23-27-04.2, relating to the distribution of training and equipment grants to licensed ambulance services prehospital emergency medical services, was enacted.

Statutory Background

North Dakota Century Code Section 23-27-04.1 requires the State Department of Health to assist in the training of certain licensed ambulance service prehospital emergency medical services personnel and to financially assist certain licensed ambulance service prehospital emergency medical services units in obtaining equipment. The legislative history indicates personnel training services must be met before the department may financially assist ambulance units in obtaining equipment. Since the enactment of NDCC Section 23-27-04.2, appropriations have been insufficient to provide financial assistance in obtaining emergency medical services equipment.

Testimony and Committee Considerations

The emergency medical services system is a free enterprise system. Ambulance service ownership varies across the state, including city, private, and volunteer services. Representatives of the North Dakota Emergency Medical Services Association testified the funding and health of emergency medical services is not a local issue because emergency medical services providers treat individuals from all over the state and country.

Volunteerism

Representatives of the North Dakota Emergency Medical Services Association and representatives of volunteer ambulance services testified the issue of volunteerism is a major concern in rural areas. The threat to volunteerism is a result of a variety of factors that ultimately result in the job descriptions of emergency medical services volunteers becoming more and more demanding. Additionally, although the number of continuing education credits required of an emergency medical services provider has not increased over the last 20 years, new medical innovations result in the content of the training hours becoming more complex.

Funding Sources

The committee received information regarding possible emergency medical services funding sources, including funds from a telecommunications relay service surcharge, a wholesale or retail liquor tax, a cigarette or tobacco tax, a motor vehicle excise tax, a surtax on health and accident insurance policies, and a gasoline tax. The committee also reviewed information regarding how other states fund emergency medical services. Unique funding sources used by other states include special education trust funds, revenue from emergency medical services publications, ordinance violations, preventative health services block grants, vehicle registration fees, drivers' license fees, seatbelt violation fines, tax levies, sales tax, and emergency medical services licensure fees. While reviewing possible funding sources, the committee recognized that the Constitution of North Dakota, Article X, Section 11 provides that revenue from gasoline and other fuel excise and license taxation, motor vehicle registration, and license taxes may only be used for construction, reconstruction, repair, and maintenance of public highways and the Constitution of North Dakota, Article IX, Section 2 limits how fines for violation of state laws may be used.

Ambulance services may impose a mill levy up to five mills; however, use of the ambulance service mill levy varies because tax bases vary considerably across the state and some counties hesitate to increase mill levies because the amount of the increased funding might be less than the amount of voluntary funding lost due to the decreased giving to voluntary fundraising activities. The committee considered whether raising the mill levy limit from 5 to 10 mills would help emergency medical services providers, but recognized local communities might oppose an increase in mill levies because it would be perceived as a tax increase.

A representative of the North Dakota Emergency Medical Services Association proposed that emergency medical services funding shortfalls be met by imposing an excise tax on nongovernmental access telephone lines. The representative testified that a charge on cellular telephone users is especially appropriate considering the use of cellular telephones to report roadside accidents.

Department of Health Initiatives

The State Health Officer described emergency medical services initiatives of the Department of Health. These include assisting ambulance services with billing; establishing a "center of excellence" within the department; assisting ambulance services partnering with regional hospitals; helping to improve the accuracy and quality of ambulance service billing of the federal government and increasing the recovery from the federal government; and providing a more accurate state emergency medical services data base.

The department plans to reduce the redundancy of multiple emergency medical services forms and to provide training to ambulance services regarding proper completion of data collection forms and reimbursement forms. Additionally, because emergency medical services forms are often improperly completed, the department has initiated a pilot program that will provide for electronic forms at hospitals.

A representative of the North Dakota Health Care Association testified that although hospitals are strong supporters of ambulance units, the 46 hospitals in the state are unable to provide, by themselves, emergency medical services to the entire state.

Funding Needs

The committee received testimony that specific emergency medical services areas in need of funding include retention and training of emergency medical services providers, transportation funding, equipment funding, and the state trauma plan. Representatives of the North Dakota Emergency Medical Services Association testified emergency medical services programs need to be removed from federal funding because federal funding comes with obligations, and when the federal money dries up, the Emergency Health Services Division must use state funds to continue programs.

The current emergency medical services grants appropriation is not meeting the educational needs within the state; therefore, the Department of Health is not making equipment grants. Testimony of a representative of an ambulance service indicated that most ambulance services have certain fixed costs regardless of the number of runs made; therefore, in order to provide equitable funding, instead of basing grants on run volume, grants should be based on the fixed costs of an ambulance service.

The committee received copies of the 1997-2001 North Dakota EMS Plan (five-year plan). The plan was created through a group process involving 19 representatives from medical stakeholder organizations and addresses each of the nine emergency medical services components. The nine components are: regulation and policy, resource management, human resources and training, transportation, hospital facilities, communications, medical direction, public information and education, and evaluation. Under the plan, attainable goals of each of the nine emergency medical services components are established, with three objectives created and prioritized for each of the nine components. The plan includes implementation strategies for each of the 27 objectives.

The committee received requests from representatives of ambulance services, representatives of the North Dakota Emergency Medical Services Association, and representatives of the Division of Emergency Health Services for funding for emergency medical services training grants, emergency medical services equipment grants, and for implementing the five-year plan. Testimony indicated ambulance service emergency medical services training grants are underfunded in the amount of $2 million, ambulance service equipment grants are underfunded $1 million, and the estimated costs of initiating the first steps of the five-year plan would be $.8 million.

Reimbursement

Representatives of the North Dakota Emergency Medical Services Association testified emergency medical services providers face a significant problem with reimbursement for services. The 1997 Balanced Budget Act Medicare reimbursement provisions make it very difficult for emergency medical services to be reimbursed. New federal Medicare legislation allows retrospective reviews of emergency medical services for reimbursement purposes. Although Medicare and Medicaid use the same billing codes, the rates established by the state for Medicaid are different from the rates established by the federal government for Medicare. The new Medicare rate structure may impact ambulance transportation reimbursement.

Testimony from an ambulance service volunteer was that information regarding how to bill Medicare and Medicaid for services is available from Blue Cross Blue Shield of North Dakota, but Medicare and Medicaid rules change so rapidly the ambulance services have a hard time keeping up to date with the changes. The committee also received testimony that bad debt is high in the ambulance industry. Nationally, 20 to 40 percent of bad debt is written off by ambulance services.

Recommendations

The committee recommends House Bill No. 1038 to appropriate from the general fund $3,800,000 to the State Department of Health for the purpose of defraying expenses of prehospital emergency medical services. This bill also amends the law relating to distribution by the State Department of Health of grant moneys for prehospital emergency medical services, specifically requiring the equipment grant distribution formula to consider ambulance unit fixed costs and not rely entirely on run volume in the formula.

The committee recommends House Bill No. 1039 to require that determination of insurance coverage of ambulance services for prehospital emergency medical services be based on a prudent layperson standard. The bill addresses the problem of insurers failing to reimburse ambulance services for prehospital emergency medical services when a retrospective review indicates the

client did not require emergency medical services.

PUBLIC HEALTH STRATEGIC PLANNING STUDY

The committee was charged with studying the development of a strategic planning process for the future of public health in the state.

Background Turning Point Grant

In March 1997 the State Department of Health applied for the Turning Point Grant from the Robert Wood Johnson and W. K. Kellogg Foundations to assist in creating a strategic plan for public health. The application proposed a complete examination of the public health system in North Dakota. Although the department did not receive the grant, the application indicates the direction strategic planning for public health is going in the state.

Public Health System Framework

The State Department of Health and several local public health departments make up the state's public health system. Additional federal public health services are provided within the state by Indian Health Service and a federal public health clinic in Fargo. The state's public health system is made up of a variety of players across the state, including county public health departments, city public health departments, multicounty public health districts, single county public health districts, and city-county public health districts. Twenty-four public health units provide public health services to 49 of the state's 53 counties. Four counties in the state are not included in a public health unit.

The duties and qualifications of public health board members and funding sources vary for each of the different types of public health units. Services provided by public health units are not consistent across the state. Services vary based on the combination of local need as determined by community assessments, emergency response, and state and federal funding priorities.

State Department of Health

The duties of the State Health Council include establishing standards and regulations necessary for the maintenance of public health. The duties of the State Health Officer include establishing and enforcing minimum standards of performance of the work of local departments of health, promoting the development of local health services, and recommending the allocation of health funds to local jurisdictions. Community, county, regional, and tribal assessments are made by the State Department of Health for many public health units.

Testimony and Committee Considerations Turning Point Grant

The Turning Point Grant would have awarded $300,000 over two years to hire a strategic planning consultant. The State Health Officer testified that regardless of receipt of grant moneys or additional appropriations, public health strategic planning will be implemented at the state level because strategic planning is an expense of doing business. However, the committee received testimony that in order to be effective, a grassroots approach to public health strategic planning is necessary instead of a plan created at the state level.

A representative of the North Dakota Health Care Association testified that if statewide public health strategic planning occurs, although it is not reasonable to merge public and private health, it would be beneficial to clarify the public health roles and services in order to provide a seamless health system. The State Health Officer testified existing law regarding public health is spread out over four North Dakota Century Code chapters and the law is antiquated; therefore, it would be very helpful to consolidate the law in one chapter.

Public health has undergone significant changes over the last 10 to 15 years. Testimony indicated that in performing strategic planning, public health should focus on the core services and not let economic incentives dictate policy. Generally, a problem with public health systems is "following the money" as a result of dedicated funding for special interest programs. The committee

received testimony that North Dakota is fortunate in this respect because it does not rely heavily on federal moneys within the public health system.

Local Public Health Unit Strategic Planning

Some local public health units perform their own strategic planning. A representative of First District Health Unit testified the local public health administrators identified the following three issues as priorities for all local public health units in the state: the development of a shared vision for public health by the local public health units and the Department of Health, the development of an effective communication system between the local public health units and the Department of Health, and the development of a continuing education and training program that includes training on essential population-based functions of public health and training on emerging trends.

The committee considered changing the minimum qualifications of public health unit local health officers. Current law requires a local health officer to be a licensed physician. The committee considered allowing a local health officer to be a nonphysician medical provider, or to be a nonphysician if a three-physician advisory committee is formed. The committee received mixed responses to the proposed changes in local health officer qualifications.

Recommendations

The committee recommends Senate Bill No. 2045 to repeal four chapters of the North Dakota Century Code regarding public health and to create a chapter that consolidates existing public health law, unifies the powers and duties of local public health units, and requires statewide participation in some type of public health unit. Most of the substantive changes are intended to unify the law that applies to public health units; however, one substantive change would require statewide participation in some type of public health unit. The committee worked closely with the Department of Health in consolidating and unifying the public health law, and the Department of Health worked closely with the local public health unit administrators in reviewing and making suggestions relating to the committee's bill drafts. The State Health Officer and representatives of public health administrators testified in support of the bill draft the committee recommended, but a representative of the North Dakota Association of Counties testified in opposition to the statewide public health unit requirement.

MANAGED HEALTH CARE STUDY

The committee was charged with studying the impact managed care may have on the rural North Dakota health care delivery system.

Legislative Background 1997 Legislation

House Bill No. 1168 implements the requirements of the federal Health Insurance Portability and Accountability Act of 1996. House Bill No. 1418 prohibits insurers from interfering with certain medical communications or taking certain retaliatory actions solely on the basis of a medical communication. The bill also prohibits certain indemnity provisions in contracts between health care providers and third-party administrators.

Recent Studies

During the 1995-96 interim, the Legislative Council's Insurance and Health Care Committee studied the feasibility and desirability of implementing recommendations of the North Dakota Health Task Force for improving the health status of North Dakotans, monitoring the rate of health care cost increases, reviewing the impact of newly enacted programs to improve the health status of North Dakotans, and addressing unmet medical needs in rural areas. The committee did not recommend any legislation as a result of this study.

Managed Care Health Care System

Managed care is a health care system that integrates the financing and delivery of a comprehensive set of health care services to covered individuals through an agreement with a service provider. Managed care combines the traditional roles of insurance companies--paying for health care--and traditional roles of health care providers--overseeing and delivering care. Additional features common to managed care include contractual arrangements with selected providers to provide care to a specified group, organized arrangements for quality assurance and utilization review, and payment arrangements that typically include some degree of risk-sharing by providers. In addition to managed care, there are a variety of hybrid systems, such as systems that integrate providers without assuming direct financial risk for the delivery of medical services.

Goals of Managed Care

The primary reason organizations change from fee-for-service models to managed care is managed care's potential to control the cost of health care. The goal of managed care is to reduce costs by contracting with providers for a comprehensive set of services at a fixed amount. As a result, providers are encouraged to avoid waste and unnecessary tests because this would result in reduced net income to the providers.

Methods used in the managed care system to control costs while maintaining service quality include**:**

1. Formal quality assurance, which is a process used by an organization to measure the extent to which providers conform to defined standards, and the process is based on the information, improved care, and outcome.
2. Utilization review, which is a process involving medical professionals outside the managed care organization who review the activities of medical professionals within the managed care organization. The review evaluates the medical necessity of various tests, treatments, and procedures based on guidelines for various diagnoses.
3. Standards for selection of health care providers within the managed care organization.
4. Mandates that members use providers and procedures within the managed care organization or significant financial incentives for members to use providers and procedures within the managed care organization.
5. Gatekeeping, which is a process to help ensure that members seek and receive only the necessary treatment and that the treatment a patient receives from different specialists is coordinated.

Types of Managed Care

Under the managed care system, providers generally do not receive compensation for each service provided as is done in the traditional fee-for-service system; instead, providers receive a predetermined amount per individual enrolled in the managed care plan. Managed care covers a broad variety of models, with differing degrees of provider choice accorded participants and provider reimbursement techniques. The major types of managed care organizations include:

1. Health maintenance organizations (HMOs) are groups of providers that provide prepaid health care. Health maintenance organization providers make available a prearranged set of basic and supplemental health maintenance and medical services to the individuals covered by the plan. The individual's choice of providers is limited to those participating in the health maintenance organization. In a health maintenance organization, the individual member pays a fixed annual premium for comprehensive care rather than paying for each service received. The health maintenance organization assumes the risk the expenses in providing care will not exceed the premiums charged.
2. Preferred provider organizations (PPOs) are systems in which a third party negotiates discounted rates for services directly with selected providers. Individuals covered by a preferred provider organization plan may use providers outside the member group; however, financial incentives encourage the use of the preferred providers.
3. Exclusive provider organizations (EPOs) are similar to preferred provider organizations except that exclusive provider organization providers can be prohibited from treating any patient who is not enrolled in the organization, and individuals covered by the plan are reimbursed for services received only from participating providers. The costs of services rendered by a nonparticipating provider are not reimbursed.
4. Point of service (POS) plans cover individuals by providing care from providers designated by the network. Care received from other providers are reimbursed at significantly reduced levels.
5. Independent practice associations (IPAs) often are not exclusive for the provider. Under this model, providers have service agreements to provide health care to enrollees, and the providers also have other managed care or fee-for-service patients.

The main characteristic of all managed care models is the integration of the delivery of medical care and the financing of medical care into one system.

Advantages of and Concerns Related to Managed Care

Potential advantages of managed care include:

1. Improvement in coordination of care because in many managed care systems each enrollee is assigned to a single primary care physician who coordinates the delivery of comprehensive services designed to meet the enrollee's special needs.
2. Improvement in access to care when states contract with managed care organizations for services designed to overcome access barriers such as lack of transportation, language differences, multiple-social problems, and the unavailability of providers willing to accept Medicaid patients.
3. Emphasis on preventive health care because managed care organizations have financial incentives to prevent illnesses and maintain health.

Concerns related to managed care include:

1. Managed care is more costly to establish, administer, and monitor than fee-for-service programs because significant startup costs are necessary for the acquisition of computer systems for the processing of utilization and quality data, and costs may also include expenses of contracting with an actuarial firm for the development of capitation rates.
2. Managed care organizations may increase their profits by limiting access to care or providing poor quality services.
3. Managed care organizations have little incentive to provide Medicaid recipients (who may be in the system for only a few months at a time) the kind of preventive care that produces cost savings only on a long-term basis.

Testimony and Committee Considerations

The committee received testimony from the State Health Officer encouraging the committee to focus its study on the continuing outmigration of North Dakotans from rural areas, the redesignation of small rural hospitals as critical access hospitals, the continuation of emergency medical services in rural areas, and the provision of reasonable access to primary care providers in rural areas.

North Dakota Managed Care

The committee received data indicating most people who belong to managed care plans in the United States live in urban areas and learned that this trend is true in North Dakota as well. A representative of the Insurance Department provided the committee with a list of health maintenance organization providers in the state and testified that most insurance products include some elements of managed care.

North Dakota insurance law includes some statutory managed care safeguards. State law addressing health maintenance organizations provides grievance and appeal procedures and requires health maintenance organizations to provide that quality assurances exist within the programs. Existing safeguards for preferred provider organization plans include requirements that emergency services must be reimbursed, unavailable services must be reimbursed, there must be a reasonable differential between reimbursement of services provided by preferred provider network providers and nonpreferred provider network providers, and services must be available within a 50-mile radius.

Testimony indicated that managed care is not currently problematic in rural North Dakota. The committee also received testimony from a representative of Blue Cross Blue Shield of North Dakota that the Legislative Assembly should not rush to enact legislation because managed care is in such a state of change on the state and federal levels. The representative testified that at this point, any new state legislation would apply to "things that could be," versus "things that are" which would likely slow the development and lessen the flexibility of the development of health care in the state.

Although the committee received reports of the success of managed care in rural portions of the state, the committee also received testimony that a possible drawback to managed care in rural North Dakota is that any rural providers who do not use networks will not have the benefits of managed care. Additionally, the committee received testimony that managed care is generally not appropriate in rural North Dakota, in part because managed care encourages physicians to limit care.

Other States

The committee received information regarding managed care legislative actions taken in other states, including comprehensive consumer bills of rights, willing providers, point of service, bans on "gag" clauses, emergency care services, and mandated benefits. The committee received information regarding managed care consumer protections the state of Minnesota has implemented, including the requirement that all health maintenance organizations in Minnesota must be nonprofit and the state-

sponsored incentives for health maintenance organizations in smaller Minnesota communities. Additional information was provided regarding the similarities and differences of nonprofit and for-profit managed care entities.

Federal Legislation

The committee received reports on federal legislation that might affect managed care in rural North Dakota. "Patient's Bill of Rights" legislation being considered in Congress; a portion of the Balanced Budget Act of 1997 sets a floor for Medicaid fee for service, and this floor might result in increasing managed care in rural North Dakota because the floor is perceived by health care providers as a chance to make more money; and a portion of the Balanced Budget Act of 1997 establishes the Medicare rural hospital flexibility program and allows for critical access hospitals.

The committee received testimony that the federal critical access hospital legislation provides flexibility and allows North Dakota to create a plan that fits the state's needs. Although the federal legislation does not set a timeline for completion of a state's critical access plan, parties interested in the critical access hospital plan are holding information gathering and planning meetings. A representative of the University of North Dakota Center for Rural Health testified the federal legislation regarding critical access hospitals is in response to an ongoing evolution of rural hospitals. Critical access hospitals are closely related to managed care and the rural health care delivery system. Proponents of the federal critical access hospital legislation hope that critical access hospitals will help stabilize the rural health care delivery system, and a stable delivery system is required for successful implementation of managed care. The committee also received testimony that emergency medical services are integral to a critical access hospital plan.

The committee was informed that the flexibility the federal legislation gives the state will not necessarily result in decreasing the level of patient care, but may allow critical access hospitals to forego providing patients unneeded services. One problem faced by rural hospitals is that individuals are not using the small hospitals and are going straight to the larger community hospitals. The use of the small rural hospitals is primarily for low-intensity emergencies, and a critical access hospital would be ideal for this type of situation, thereby making care more readily accessible to individuals living in small communities. Additionally, critical access hospitals might result in increasing reimbursements to hospitals. The committee learned that a possible drawback critical access hospitals may face is the public perception that the facility is less-qualified to deal with emergency situations; however, this public perception may already exist for small, rural hospitals.

Medicaid Managed Care Pilot Project

A representative of the Department of Human Services provided the committee with information regarding the Medicaid managed care pilot project being implemented in Grand Forks. In addition to quality, access, and cost measures, the pilot project will monitor specific diseases that will be targeted for management and review.

Health Care Quality Reviews and Health Care Data Collection

The committee received information on the statutory creation of the Health Care Data Collection Committee in 1987 and the statutory duty--created in 1995--of the Department of Health to collect health care data. A representative of the Department of Health testified the State Health Council's Health Care Data Collection Committee collects data on the average charges made by physicians in the state, and this data base is in the process of being updated. The data base is being designed to track the charges made by the state's larger third-party payers. This information is available to consumers and will be available on the Department of Health's web page.

Conclusion

The committee makes no recommendation regarding managed health care legislation; however, the committee recognizes the importance of the Legislative Assembly staying abreast of the effects managed health care might have on rural North Dakota.

HAIL SUPPRESSION STUDY

The committee was charged with studying whether the state should implement hail suppression programs for the reduction of property damage in urban and rural areas, and the possible funding of such a hail suppression program through property and casualty line insurance premium taxes.

Background Neighboring States and Provinces

Neighboring states and a Canadian province have addressed hail suppression. In Alberta, Canada, insurance companies and brokers established the Alberta Severe Weather Management Society to administer a cloud seeding program that serves rural and urban areas. The Alberta Severe Weather Management Society is private and not for profit. South Dakota Codified Laws Chapter 46-3A provides for the South Dakota Water Management Board, which may perform hail suppression operations, and Montana Statutes Chapter 85-3 authorizes the Montana Department of Natural Resources and Conservation to perform hail suppression operations. Although the Montana and South Dakota weather modification laws were patterned on North Dakota weather modification law, neither state is active in weather modification.

North Dakota Atmospheric Resource Board

North Dakota Century Code Chapter 61-04.1 pertains to weather modification, and hail suppression falls within the definition of weather modification. Section 61-04.1-08 creates the North Dakota Atmospheric Resource Board as a division of the State Water Commission. The board may contract with any person, the federal government, or any county or group of counties to provide weather modification operations. Additionally, Section 58-03-07 authorizes township electors to use township funds for weather modification activities. Although the board has discretion in what to charge counties for providing weather modification services, the mill levy tax funds appropriated to the state weather modification fund by a county may not exceed seven mills upon the taxable valuation of property in the county. This mill levy may be levied in excess of the mill levy limit fixed by law for taxes for general county purposes.

Operational cloud seeding in North Dakota began in the 1950s when ground-based seeding began in the western portion of the state. In 1975 the North Dakota Weather Modification Board was created as a division of the Aeronautics Commission, and state cost-sharing was made available in 1976. Six counties--Ward, Mountrail, McKenzie, Hettinger, Slope, and Bowman--conduct weather modification activities for the purposes of suppressing hail and enhancing rainfall.

Insurance Premium Taxes

North Dakota Century Code Section 26.1-03-17 provides a premium tax of two percent must be paid for life insurance, 1.75 percent for accident and health insurance, and 1.75 percent for all other lines of insurance. This money is deposited in the insurance tax distribution fund. North Dakota Century Code Chapter 18-04 provides for the distribution of a portion of the insurance premium tax to fire departments and fire districts, as appropriated by the Legislative Assembly. The amount appropriated to the insurance tax distribution fund for insurance tax payments to fire departments for the 1997-99 biennium was $5.2 million, the same amount as was appropriated for the 1995-97 biennium. The tax premium for fire departments has been a topic of discussion over the years. Section 8 of House Bill No. 1010 (1997) requires the Commissioner of Insurance to analyze fire district payments distributed during 1996, 1997, and 1998 and report to the Budget Section in December 1998.

Testimony and Committee Considerations Hail Suppression Technology

The committee learned that the materials used in hail suppression cloud seeding are silver oxide, dry ice, and salt. Delivery systems used in hail suppression are either ground based or airborne, and for a variety of reasons, airborne delivery systems are more accurate than ground-based delivery systems. Cloud seeding opportunity recognition technology includes radar, satellite imagery, National Weather Service observations, forecast products, airborne instrumentation, and visual observations. The testimony received indicated the effects of hail suppression cloud seeding is decreased hail and increased rain. A representative of the University of North Dakota Department of Atmospheric Science, however, testified not all weather scientists believe weather modification works. Weather modification opponents want to evaluate hail suppression by studying random cloud seeding projects, but cloud seeding programs are seldom willing to seed only half of the time and for that reason such studies do not exist.

A representative of the Atmospheric Resource Board explained the dynamics of hail producing thunderstorms and the three hail

suppression cloud seeding methods. Although each storm behaves differently, a storm eventually decays without hail seeding, and it is difficult to determine on a case-by-case basis whether hail suppression cloud seeding made a difference in a particular storm. A representative of the Atmospheric Resource Board testified it is because each storm behaves differently that it is most appropriate to evaluate hail suppression using large data bases over long periods of time, and these statistics show that hail suppression cloud seeding has a positive effect overall, and this supports case-by-case interpretations that hail seeding helps in a particular storm.

A representative of the Atmospheric Resource Board testified hail suppression is generally effective in a matter of minutes and stops being effective in a matter of minutes. Generally, South Dakota does not allow hail suppression to take place in South Dakota to affect North Dakota storms and Montana does not allow hail suppression to take place in Montana to affect North Dakota storms.

North Dakota Hail Suppression and Hail Suppression Studies

The North Dakota cloud modification project is funded 80 percent from county funds that are from mill levies and 20 percent from state funds. The six participating counties use a 10-mile buffer zone, and there are slight downwind effects. The participating counties do not distinguish between rural and urban areas within the county in providing hail suppression services. Organizations that have evaluated the North Dakota cloud modification project evaluate primary factors, secondary factors, and economic factors.

Studies of the North Dakota project indicate rainfall increases in a near downwind area from 7 to 14 percent. The article "An Exploratory Analysis of Crop Hail Insurance Data for Evidence of Cloud Seeding Effects in North Dakota" in the May 1997 issue of the *Journal of Applied Meteorology* refers to studies of the climatology of hail damage to crops which show North Dakota experiences the highest insurance dollar loss of any state in the United States, and southwestern North Dakota has the highest ratio of damage claims paid to insured crop liability. The reduction in hail crop insurance loss ratios in the six program counties is estimated to be 45 percent. Specific statistics are not available for hail damage to property other than crops because most insurance companies do not classify property and casualty claims for hail-only damage. North Dakota State University performed three studies for the North Dakota Atmospheric Resource Board.

North Dakota State University study "Economic Effects of Added Growing Season Rainfall on North Dakota Agriculture" (Ag Econ Report No. 172) indicates the total statewide value of one inch of rainfall is projected to average over $600 million annually for the state's most common crops.

North Dakota State University study "Economic Benefits of Crop-Hail Reduction Efforts in North Dakota" (Ag Econ Report No. 247) indicates total benefits recognized by participants of the North Dakota Cloud Modification Project are approximately $10 million annually, exclusive of possible decreased property damage benefits. The study is based on the study of crop-hail loss-cost ratios for the 1976-85 period.

North Dakota State University study "A Target-Control Analysis of Wheat Yield Data for North Dakota Cloud Modification Project Region" is based on crop data for five classes of wheat for the years 1976-88. The study indicates an increase of wheat yield in hail suppression target areas of almost six percent, which translates to $16 million per year in present hail suppression target areas, exclusive of any positive downwind effect in nontarget areas.

Alberta Hail Suppression Program

A representative of the Alberta Severe Weather Management Society testified the Alberta hail suppression program was established due to a series of severe storms in the early 1990s, after which the insurance companies worked together to try to mitigate damages resulting from hail. Because the provincial budget did not include funding the program, the insurance companies looked to funding the program through private enterprise. The Alberta hail suppression program is funded by voluntary contributions from insurance companies, and the amount of money contributed is determined by the percentage of each company's property and automobile insurance gross written premiums. The Alberta hail suppression program took bids from private enterprise and ultimately contracted with Weather Modification, Inc., Fargo. The representative of the Alberta Severe Weather Management Society testified that although the program has been very successful at addressing hail damage in urban areas, the decrease in property damage has not been reflected in the cost of insurance because the program is only two years old and the actuarial process does not work that quickly. Because of the success the Alberta program has achieved, Manitoba and Saskatchewan are considering similar programs.

Insured Property

A representative of Nodak Mutual Insurance Company testified that in an average year there are 25 hailstorms in the United States which cause significant property damage. The three largest hailstorm losses in the United States were the 1990 hailstorm in Denver, causing $625 million of insured property damage; the 1992 Orlando hailstorm, which caused $575 million of insured property damage; and the 1992 Wichita hailstorm, which caused $420 million of insured property damage. The representative testified hail is the largest classification of insured property damage. Nodak Mutual Insurance insured property damage from the 1995 Minot hailstorm was in excess of $2 million, an amount larger than the Nodak insured property damage caused by the 1997 Grand Forks flood.

Fifteen percent of the Nodak Mutual Insurance Company's business is crop hail insurance. In the years 1988 through 1994, Nodak Mutual Insurance experienced a 77 percent loss, with 33 percent less loss in the counties with hail suppression programs. The representative of Nodak Mutual Insurance Company testified that in some areas of the state, crop insurance has become unaffordable for farmers. PIA member companies in North Dakota reported a crop insurance loss ratio of 85 percent in 1997, and the concentration of casualty loss in North Dakota is in the four major population centers.

A representative of the Consumer Protection Division, Insurance Department, testified one of the problems the department faces in gathering hail damage data for urban and noncrop hail losses is that most insurance companies do not specifically categorize losses for hail; therefore, any of the statistics used by the department are based on informal information. The representative testified there is a need for standardized hail information, and this information could be acquired through legislation; however, the attitude of insurance companies regarding collection of hail damage data is mixed.

Insurance Availability

Insurance companies in North Dakota expressed concern about the affordability and availability of property casualty insurance. However, their representatives testified that in North Dakota there is not an availability crisis but there is an availability problem. A representative of the Atmospheric Resource Board testified hail suppression programs may result in insurance premiums decreasing or insurance premiums remaining constant instead of increasing, and hail suppression may also increase the number of people able to afford insurance for hail damage.

An Insurance Department representative reported in the last five years there has been a trend in homeowners' insurance premiums dramatically increasing, and insurance companies tightening the restrictions on whom the companies are willing to underwrite; therefore, there is value to insurance companies in mitigating hail damage. The committee was reminded that hail damage is only one element of loss that goes into determining the amount of homeowners' insurance premiums. Other elements of loss include fire and crime.

Funding Sources

Increasing the current insurance premium tax of 1.75 to 2 percent on specific lines of property and casualty insurance might negatively impact domestic insurance companies and not affect foreign insurance companies. Because of premium tax retaliatory statutes, an insurance premium tax increase to two percent would likely only affect the six North Dakota domestic insurance companies and not foreign insurance companies because most states have insurance premium taxes in excess of two percent.

A representative of the Insurance Department testified an alternative funding source for hail suppression might include charging insurance companies a hail mitigation fee, which would be charged directly to the insurance companies instead of the consumers; however, to the extent a company incorporates the fee into its premium to the consumer, the fee might show up in the gross premium and indirectly be subject to the premium tax. Additional funding alternatives for a hail suppression program include:

- Legislation that would require a specific "hail mitigation fund fee" be charged directly against each consumer's premium in designated lines of insurance and designate the insurance company as the collector of the fee;
- Legislation that would require a specific "hail mitigation fund fee" be charged against insurance companies for designated lines of insurance and be exempt from the application of premium tax;
- Legislation that would require a specific "hail mitigation fund fee" be charged against the company--tax or fee--to be collected and reported as premium; or
- Legislation to establish a special "hail mitigation fund" with funding coming directly out of the general fund.

The total premium for the designated lines of insurance in 1996 was $295,426,000; therefore, a one-half percent of premium "hail mitigation fund fee" would generate an annual revenue of $1,474,125. A representative of the Insurance Department testified if a hail suppression program is set up on a voluntary basis similar to Alberta's, it is likely a majority of the North Dakota companies will not participate because there seems to be a fear that hail suppression will result in the writing of fewer insurance policies.

The PIA representative testified the insurance industry should not be the only entity responsible for funding a hail suppression program, but instead a simple funding mechanism that does not burden the insurance industry, such as funding hail suppression through the general fund using money that is generated via the existing insurance premium taxes, should be implemented.

Although the PIA representative was unable to determine how much of the PIA members' premiums go to paying for hail loss because insurance companies treat this information as proprietary, fire is probably the number one loss for homeowners, and hail is probably the number one loss for crops. The representative of Nodak Mutual Insurance Company testified in support of hail suppression programs because one of the positive aspects of hail suppression includes more affordable insurance. The PIA representative opposed funding a hail suppression program via premium taxes, in part because not everyone insures property and not everyone insures property to value.

Hail Suppression Program Considerations

A representative of the University of North Dakota Department of Atmospheric Science testified if a region participates in hail suppression activities, the region needs to make policy decisions regarding the impact of increasing rainfall versus the impact of receiving hail, and it is important that hail suppression programs be flexible to take these regional considerations into account. The representative testified it may be helpful to have some universal guidelines, and it may also be helpful to have a board made up of local representatives who look out for local interests to assist in decisions being made from the ground up.

Proposals Considered

The committee considered three alternative bill drafts for a hail suppression pilot program. One pilot program would provide hail suppression services to the western portion of the state, one pilot program would provide hail suppression services to the western and central portions of the state, and one pilot program would provide hail suppression services statewide. Each of the three bill drafts provided for a one-year organizational period and a five-year implementation period, with the pilot program running through June 30, 2005. The six-year cost of a pilot program servicing the western portion of the state would be $7.7 million, the program servicing the western and central portions of the state would be $10.7 million, and the pilot program servicing the entire state would be $15 million.

Recommendation

The committee recommends House Bill No. 1040 to require a statewide urban and rural hail suppression pilot program that will run from August 1, 1999, through June 30, 2005. The bill provides for a general fund appropriation of $3,100,000 to the State Water Commission for the purpose of funding the first two years of the hail suppression pilot program.

PARTNERSHIP FOR LONG-TERM CARE PROGRAM ANNUAL REPORTS

The committee was charged with receiving annual reports from the Commissioner of Insurance regarding the status of the partnership for long-term care program. A representative of the Commissioner of Insurance reported that the program was never put into effect because Congress passed the Omnibus Budget Reconciliation Act of 1993, which contained provisions precluding the pursuit of the program. Because of this change in federal law, the state does not have authority to pursue the partnership for long-term care program.

Recommendation

The committee recommends Senate Bill No. 2046 to repeal North Dakota Century Code Chapter 26.1-45.1, relating to the partnership for long-term care program.

CHILDREN'S HEALTH INSURANCE PROGRAM STATUS REPORTS

The committee was charged with receiving executive reports regarding the status of the children's health insurance program (CHIP) state plan. The children's health insurance program was enacted by Congress as part of the Budget Reconciliation Act of 1997. Under the children's health insurance program, with an approved state plan and a partial fund match, each state may be eligible to receive an allotment of money based on the estimated number of uninsured children in the state and based on a regional cost factor. North Dakota has been allotted over $5 million in federal children's health insurance program funds for the current federal fiscal year and a portion of the state's unused funds may be carried over to future years. The federal government has budgeted the children's health insurance program for 10 years, with funding decreasing in the fifth through seventh years. Under the children's health insurance program, a state's plan may expand Medicaid coverage, create a separate health insurance plan, or may include both methods by expanding Medicaid and creating a separate health insurance plan.

The Budget Reconciliation Act of 1997 required approval of a state children's health insurance program plan by September 30, 1998, in order to qualify for the first year federal allotment. Later, federal legislation changed the children's health insurance program submission requirements to allow states an additional year to have a state plan approved while preserving the entire amount of the first year federal allotment. A representative of the Department of Human Services testified the state's initial children's health insurance program plan would have expanded Medicaid coverage and created a separate health insurance plan. The initial plan would have:

1. Added Medicaid coverage for all 18-year-old children whose family income is below 100 percent of the poverty level.
2. Provided insurance coverage for uninsured children who are not Medicaid-eligible up to 150 percent of the poverty level.
3. Provided the same coverage provided through the Public Employees Retirement System, plus basic preventive dental and vision coverage and well-baby, well-child, and well-adolescent preventive health care services.
4. Subjected families to the same asset test used for the Medicaid program.
5. Not charged families any premiums for insurance coverage and not required payment of any coinsurance or deductible amounts.
6. Determined eligibility by personnel of the local county social service offices.
7. Redetermined eligibility at six-month intervals.
8. Provided a six-month waiting period between the time insurance is dropped and eligibility for North Dakota Healthy Steps begins.

The representative testified that as a result of the extension of the children's health insurance program state plan approval deadline, the plan is to implement the state plan in two phases, with the first phase expanding Medicaid coverage to children 18 years of age residing in families with income at or below the current federal poverty level, and with the second phase creating a separate health insurance plan. The representative testified the first phase of the children's health insurance program state plan would cost approximately $800,000 for two years and would be funded by Medicaid savings, and the second phase would be included in the 1999-2001 executive budget.

MISCELLANEOUS ISSUES

The committee obtained information regarding telemedicine in the state and the impact telemedicine may have on critical access hospitals, emergency medical services, and managed care in rural areas. The term telemedicine encompasses a wide variety of services and technology, ranging from medical use of store-and-forward technology to the medical use of real-time technology. Nationwide, telemedicine concerns include funding and reimbursement, infrastructure planning and development, professional licensing, and confidentiality. These same telemedicine concerns have been raised in North Dakota as well. In 1995 the Governor established the Task Force on Telemedicine and organized the *Governor's Conference on Telemedicine: Exploring an Emerging Technology*. The committee reviewed the basic concepts of telemedicine. Additionally, the committee received testimony from several North Dakota telemedicine providers. The committee learned a variety of different technologies are used across the state to provide medical education, physical and mental health consultations, preventive medical services, virtual house calls, medical appointments with nonlocal specialists, and administrative services for health service providers.

The committee learned that different types of telemedicine technology have different purposes. Some technology is better suited for routine medical services, while other technology might be more appropriate for emergency medical services. Additionally, the issue of professional licensing across state lines is not unique to medicine, but is becoming a common issue for all types of professionals.

A representative of U S West reported on the status of the federal universal service fund, informing the committee that telemedicine providers can apply to access federal money to assist in implementing telemedicine services. The representative acknowledged telemedicine technology can be very expensive and smaller medical providers may find telemedicine cost-prohibitive; however, cooperation between telemedicine providers resulting in bulk purchasing can lessen some of the financial barriers to telemedicine.

The committee was informed some of the concerns of North Dakota telemedicine providers include high equipment prices, duplication of services between competing or noncompeting telemedicine providers, licensure across state lines, lack of reimbursement for telemedicine services, malpractice, acceptance of new technology, and the complicated network of telephone services providers. Additionally, some North Dakota licensed medical professionals are concerned about out-of-state medical providers entering the state.