MICROFILM DIVIDER

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

ROLL NUMBER

DESCRIPTION

2210

2003 SENATE JUDICIARY

SB 2210

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2210

Senate Judiciary Committee

❑ Conference Committee

Hearing Date 01/22/03

Tape Number	Side A	Side B	Meter #
1	X		44.9 - 46.8
1		X	33.0 - 48
2	X		0.0 - 14.0

Committee Clerk Signature Moira Solberg/dp

Minutes: **Senator John T. Traynor, Chairman,** called the meeting to order. This was a joint Session with Senate and House Representatives Roll call was taken and all committee members present. Sen. Traynor requested meeting starts with testimony on the bill.

Testimony in support of SB 2210

Wayne Stenehjem Introduced the Bill (Tape 1, Side 1, meter 17.8 to 40.1)

Senator Carolyn Nelson Introduce Bill (Tape 1, Side 1, meter 43.9) I served as a member of the ND Commission on Drug and Alcohol. This committee worked hard and traveled around ND. We heard from people of all ages. Story of SAD group. One constant concern was treatment and the lack of residential treatment.

Karen Romig Larson - Director of the Division of Mental Health and Substance Abuse. (Tape 1, Side 2, meter 33.0) Read Attachment # 1

Senator John T. Traynor, Chairman discussed the permeinant harm the drug causes and the dynamics of its withdrawel.

House Rep Klemin (meter 42.9) wanted to know what numbers would actually be effected by this bill. These numbers are unclear for they chanel some of it calling the recovery under another title. This will not affect insurance rates. This bill is designed for outpatient treatment.

Discussion of the difference of Residental Treatment vs. Out Patient treatmen (46.8 meter)

Senator Dick Dever asked for a list of present out patient facilities; Share House, Heritage Progect and two others . He wondered if they would be able to handle the additional patient if this bill were to go into effect.

(Tape 2, side 1)

George W. O'Neill - Blue Cross Blue Shield - read attachment #2

Rep Klemin wanted to know what is being done with Methamphetamine users without insurance. (meter 4.9) discussion was that at least we would have better facilities to accomadate them.

Wayne Stenehjem stated that drug addicts can be sons and daughters of insurance holders. (meter 7.9) Rep Klemin wondered why we were only addressing "group" health issues?

Mr. Stenehjem discussed the newness of meth comparied to other drugs that have been around for hundereds of years.

Testimony Neutral to SB 2210:

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Senator John T. Traynor, Chairman closed the hearing

Senator John T. Traynor, Chairman closed the hearing

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2210

Senate Judiciary Committee

☐ Conference Committee

Hearing Date 01/27/03

Tape Number	Side A	Side B	Meter #
1	X		33.0 - End
2	X		1.5 -54.0
4			14.50 - 17.0
Committee Clerk Signature			

Minutes: **Senator John T. Traynor, Chairman,** called the meeting to order. Roll call was taken and all committee members present. Sen. Traynor requested meeting starts with committee work on the bill.

Testimony in support of SB 2210

Sandi Taber opened (meter 38) Discussion of no Fiscal Note. Reviewed overview of Bill

Dan Ulmer - Lobbyist 172. (meter 39.5) Talked about his history in the health field and mandates. History of mandates and history of treatment.

Senator Dick Dever wanted to know how the Insurance companies will feel in regards to an Insurance "mandate" Discussion of this bill being the "floor" not the "top".

Karen Romig Larson Director of the Division of Mental Health (meter 51)

Heartview went from residential to Medically driven or outpatient. Not all health care is medical some are "social". This will help these issues and help mainstream the patient back into their lives. Research Study "Out patient Match" (meter 53.2)

Senator Dick Dever asked what the State Pen does for treatment. It is called day treatment in

intensive out treatment.

Testimony Neutral to SB 2210:

none

Testimony Neutral to SB 2210:

none

Senator John T. Traynor, Chairman closed the hearing

Senator John T. Traynor, Chairman Reopened the hearing p.m.

Sandi Tabre - Submitted amendment (tape 4, side 1 meter 16.3) attachement #1

Motion Made to move amendment on SB 2210 by Senator Thomas L. Trenbeath , seconded by Senator Dick Dever

Roll Call Vote: 6 Yes. 0 No. 0 Absent

Motion carried, amendment passed.

Motion Made to move SB 2210 as amended by Senator Thomas L. Trenbeath , seconded by Senator Dennis Bercier

Roll Call Vote: 6 Yes. 0 No. 0 Absent

Motion carried, amendment passed.

Floor Assignment Senator John T. Traynor, Chairman

#1

Proposed Amendments to Senate Bill 2210
January 27, 2003
Presented by the Office of Attorney General

Page 1, line 2, after "coverage" insert "; and to provide for application"

Page 3, after line 25, insert:

SECTION 2. APPLICATION. Recognizing that this Act represents a realignment of existing mandated coverage, notwithstanding any legislative measure approved by the fifty-eighth legislative assembly that could affect the application or expiration of this Act, the provisions of this Act apply as of August 1, 2003, and do not expire until specifically repealed by the legislative assembly.

38292.0101
Title.0200

Adopted by the Judiciary Committee
January 27, 2003

1-28-03

PROPOSED AMENDMENTS TO SENATE BILL NO. 2210

Page 1, line 2, after "coverage" insert "; and to provide for application"

Page 2, line 24, replace "A" with "An"

Page 3, after line 25, insert:

"**SECTION 2. APPLICATION.** Notwithstanding any legislative measure approved by the fifty-eighth legislative assembly which could affect the application or expiration of this Act, this Act applies as of August 1, 2003, and does not expire until specifically repealed by the legislative assembly."

Renumber accordingly

Date: January 27, 2003
Roll Call Vote #: 1

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2210

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move Amendment - Sect 2

Motion Made By Senator Dick Dever Seconded By Sen. Trenbeath

Senators	Yes	No	Senators	Yes	No
Sen. John T. Traynor - Chairman	X		Sen. Dennis Bercier	X	
Sen. Stanley. Lyson - Vice Chair	X		Sen. Carolyn Nelson	X	
Sen. Dick Dever	X				
Sen. Thomas L. Trenbeath	X				

Total (Yes) SIX (6) No ZERO (0)

Absent Zero (0)

Floor Assignment

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

Date: January 27, 2003
Roll Call Vote #: 2

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2210

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DO PASS as Amended

Motion Made By Sen. Trenbeath Seconded By Sen. Bercier

Senators	Yes	No	Senators	Yes	No
Sen. John T. Traynor - Chairman	X		Sen. Dennis Bercier	X	
Sen. Stanley. Lyson - Vice Chair	X		Sen. Carolyn Nelson	X	
Sen. Dick Dever	X				
Sen. Thomas L. Trenbeath	X				

Total (Yes) SIX (6) No ZERO (0)

Absent Zero (0)

Floor Assignment Senator John T. Traynor, Chairman

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

REPORT OF STANDING COMMITTEE (410)
January 29, 2003 2:16 p.m.

Module No: SR-17-1299
Carrier: Traynor
Insert LC: 38292.0101 Title: .0200

REPORT OF STANDING COMMITTEE

SB 2210: Judiciary Committee (Sen. Traynor, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2210 was placed on the Sixth order on the calendar.

Page 1, line 2, after "coverage" insert "; and to provide for application"

Page 2, line 24, replace "A" with "An"

Page 3, after line 25, insert:

"**SECTION 2. APPLICATION.** Notwithstanding any legislative measure approved by the fifty-eighth legislative assembly which could affect the application or expiration of this Act, this Act applies as of August 1, 2003, and does not expire until specifically repealed by the legislative assembly."

Renumber accordingly

2003 HOUSE JUDICIARY

SB 2210

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2210

House Judiciary Committee

☐ Conference Committee

Hearing Date 3-5-03

Tape Number	Side A	Side B	Meter #
2	xx		13.6-14.9 / 40.9-41.0

Committee Clerk Signature APenrose

Minutes: 12 members present, 1 member absent (Rep. Wrangham)

The original hearing was held on January 22, 2003 in the Pioneer Room as a Joint Session with the Senate. The minutes are attached. Attachments can be found with the Senate minutes in the library.

Chairman DeKrey: We heard this bill so I would like to do committee work.

Sandi Tabor, Deputy AG: (See attached updated overview). This bill deals with residential treatment.

Chairman DeKrey: Is that the one we have to ask for a study on it. You said the law was passed before.

Ms. Tabor: What happened was that we had an opportunity this morning to talk to the chair of the Human Services Committee for the House and a couple of their members and SB 2210 takes the existing group insurance mandate for treatment and alters it a little bit to knock down the number of days that you are mandated for inpatient and gives those days to residential treatment.

It also provides the flexibility of residential treatment. In the discussion that were held this morning, it was brought up that this bill probably, in fact, needs to have a cost-benefit analysis, which is done through the Insurance Commissioner's department. The AG said that he would ask me to come to the committee today and ask this committee to make a motion to direct the chairman to ask for that study to be conducted, and then when the results come back, then you can finish your committee work.

Chairman DeKrey: Somebody want to make that motion.

Rep. Eckre: I so move.

Rep. Grande: Seconded.

Voice vote: Carried.

Chairman DeKrey: That will take care of that.

Ms. Tabor: So I think that takes SB 2210 off your plate for right now.

Chairman DeKrey: Thank you.

(Reopened later in the afternoon)

Chairman DeKrey: The mandate voted on this morning is being worked on by John Olsrud.

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2210

House Judiciary Committee

☐ Conference Committee

Hearing Date 3/25/03

Tape Number	Side A	Side B	Meter #
1	xx		0-12.8
Committee Clerk Signature	APenrose		

Minutes: 12 members present, 1 member absent (Rep. Onstad, but came later in the session).

Chairman DeKrey: We will take a look at SB 2210.

Rep. Weisz: Support (see attached amendments). Basically what this amendment does, it avoids an additional mandate on SB 2210 which is already an insurance mandate, and what this is going to do is allow insurance companies the option of, instead of 60 day inpatient, they would be able to drop down to 45 days of inpatient, and add 60 days of residential treatment to address the meth problem that we see that it takes more than 30 days residential treatment to treat these because they are definitely a harder case. All the amendments are doing is to allow insurance companies to take one of the two options. The current mandate that mandates a minimum 60 days inpatient, 30 days residential. With these amendments, if they so desire, they can cut that back down to 45 and have the option of the 2 for 1, for a max of 23 days, which could increase the days of residential treatment.

Chairman DeKrey: Thank you.

Sandi Tabor, Deputy AG: The Blues are here to answer the difficult questions. On the amendments, let me give you a little background just so that you know why we are here with these amendments. At the beginning of the session, we had talked to Rep. Price and Sen. Lee about whether this bill should be treated as a mandate bill or not and what process we should call them. After some discussion, they initially agreed with us that we could go ahead and present it as part of the meth package to the Judiciary Committees and go forward that way, because at that time were not convinced that it was a mandate. The Senate took care of this, it came here, several members of the Human Services Committee on the House side wondered about it, we had a meeting with the Attorney General and we said, look we will do whatever you want, we've never intended to not treat it however you wanted to", so consequently as you know, we had the report done for a cost-benefit analysis, and it presented a favorable showing that it should not have any significant or cost negligible impact on premiums and Rep. Weisz was kind enough to ask Legislative Council to prepare the amendments that you have before you, that should take care of the mandate question. So now I'm just here to say, could we please pass this bill.

Dan Ullmer, Blue Cross/Blue Shield: I think that one of the issues that we just discovered this morning, is that if you look at the Milliman report, pg 2, "one key consideration in determining the impact of this bill on costs is capacity. My understanding is that there are currently not many residential beds available in North Dakota. Until that changes, I would expect the provisions in this bill to have very little impact on utilization patterns." What they are basically saying, in reading on, it says that until the capacity is raised in North Dakota, we will be sending people out of state. The question before you, on page 2 of the amendments, I think what we'd like to get into the record, is an understanding that if you look at subsection d. line 3, this residential

treatment must be provided by an addiction treatment program, licensed under 50-31; which is a bill that you passed out earlier, which allowed the Department of Human Services to license adult residential facilities. Presently, they license childrens facilities. We would like to establish in the record as our intent would be that we only want this for instate residential. That way, this may spur on the development of residential facilities in the state. Our sense is that it will incur, in some of the gray areas, for instance Mercy Hospital in Williston is used as sort of a residential arrangement, if you will. Most folks come in for inpatient 3-5 days for detoxification and then are sent off to partial or outpatient. In particular, we think we are in agreement with the Attorney General, folks that a meth problem, need a little more secure environment to recover in, if you will, and rehabilitate themselves. This provides definitely an opportunity. I think one of the things that Milliman may have missed is that the average treatment program is 28 days of inpatient. It is a small number of people that go for inpatient treatment, but when they do go, it is a full 28 days. The expense is more, you are looking at $500-600/day, and residential should be anywhere from $200-300/day. So when you start doing the math, it makes imminent sense. We are in support of this bill.

Rep. Eckre: I don't know if you are aware of the situation in Wahpeton, but the hospital is over in Breckenridge, MN. They are building a brand new building. So will that effect us.

Mr. Ullmer: Sure. We understand that problem and will have to work something out, I guess. That is an interesting question. I would presume that we would have the latitude to do that, but what we're trying to do is focus it on instate and try and create residential programs in the state. It doesn't necessarily have to be connected with a hospital.

Rep. Eckre: I understand that.

Mr. Ullmer: The inpatient section remains the same. Do they have a psych facility?

Rep. Eckre: A very small one, but I don't know about the new hospital being built. I could find out that information.

Mr. Ullmer: I would presume that there is an inpatient detoxification program, that program doesn't change. When they move over to a residential facility, they will have to move back into the state.

Rep. Klemin: I'm not sure that I completely understand the difference between inpatient hospitalization and residential treatment in the hospital.

Mr. Ullmer: Cost. A big difference. The easiest way I can say it, is that hospitals usually cost us about $1,000/day. According to Milliman it is probably $600/day. In essence, the cost. If we just do the math, let's say that inpatient is $600/day x 28 days vs. $200/day in residential. The cost alone. It is the same treatment protocol. The distinction would be that the residential facilities would be from essentially a group home, if you will, open 24 hrs. a day, 3 hots and a cot and treatment within it. An inpatient facility being that you have all sorts of medical needs that need to be met. When particular medical needs arise, in the first few days of detoxification. You've got a pretty sick individual on your hands. Once the detoxification occurs, there is no need for a secure environment, or a hospital type environment. You can do probably much better in a home type environment.

Rep. Klemin: I understood from looking at the testimony of Karen Larson, that you were saying that detoxification typically, for meth. dependence, these types generally require sufficient time to recover from the effects of the drug. What is sufficient time.

Karen Larson, Dept. of Human Services: Sufficient time is just that. There is no predictor from one person to the other. The detoxification and withdrawal from meth. is more from a psychological and behavioral standpoint than it is from the intensity of withdrawal experience from things like heroin and alcohol. So you are going to have quite a wide variety of reactions to clear sufficiently, to get into actual rehabilitation or treatment programming.

Rep. Klemin: I thought I read somewhere hear, I can't put my finger on it, either you or someone else said something about 5 days for detoxification before you go into phase 2 basically. What does that mean.

Ms. Larson: I'm not recalling that I said that.

Mr. Ullmer: I think that I said that. Detox normally runs about 3-5 days for someone. It could run much longer. Take pot for instance, it takes 3 weeks at a minimum to get it out of your system, depending on how long you smoked it, etc. It is individually oriented. Normally, within the 3-5 days, the person has detoxified enough that you can go do something with them, other than watch them in a hospital.

Ms. Larson: One of the things about meth. withdrawal and detoxification, is that would lend itself to less of an intensive medical management. We really look at detoxification from all drugs of abuse, including alcohol, and to the depth and nature of that detoxification that we can deliver detoxification in what we call a social model detox, modified medical model detox, outpatient detox, and inpatient medical model detox. Again, all depending on the presentation and symptomology and the types of drugs that the person has been using.

Chairman DeKrey: If no further questions, we will close the hearing on SB 2210. What are the committee's wishes in regard to SB 2210.

Rep. Maragos: I would move the amendments, .0202.

Rep. Delmore: Seconded.

Voice vote: Carried.

Rep. Delmore: I move a Do Pass as amended.

Rep. Maragos: Seconded.

12 YES 1 NO 0 ABSENT DO PASS AS AMENDED CARRIER: Rep. Maragos

Rep. Klemin: I think that it should be noted that, with this kind of thing, and the testimony that we received on this, that a relationship to the civil commitment statute, in other words the chemical dependence and the number of days for the hearing, as we heard from the court, it takes a while to detox these people, so that you can even talk to them rationally, and so they can help with their defense.

Rep. Kingsbury: On page 2 of this report, is where it says 6-7 days for detox.

Chairman DeKrey: Acute care stage, tends to be shorter than 6-7 days.

38292.0202
Title.

Prepared by the Legislative Council staff for
Representative Welsz
March 18, 2003

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2210

Page 1, line 1, after "to" insert "create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to alternative group health policy and health service contract substance abuse coverage; and to"

Page 1, line 2, replace "; and to" with a period

Page 1, remove line 3

Page 1, line 11, overstrike the second "or" and insert immediately thereafter an underscored comma, overstrike the third "or" and insert immediately thereafter an underscored comma, and after "franchise" insert an underscored comma

Page 1, line 14, overstrike "person" and insert immediately thereafter "individual"

Page 1, line 17, overstrike "and" and insert immediately thereafter an underscored comma

Page 1, line 18, remove "residential treatment,"

Page 1, line 20, remove the overstrike over "~~sixty~~" and remove "forty-five"

Page 1, line 21, overstrike "if provided by a hospital"

Page 1, overstrike line 22

Page 1, line 23, overstrike "department of health" and overstrike ", or as licensed under section"

Page 2, line 1, overstrike "23-17.1-01 offering treatment" and overstrike "of alcoholism, drug"

Page 2, line 2, overstrike "addiction, or other related illness" and after the period insert "Services provided under this subdivision must be provided by an addiction treatment program licensed under chapter 50-31."

Page 2, line 5, overstrike "If" and insert immediately thereafter ". Services provided under this subdivision must be"

Page 2, overstrike line 6

Page 2, line 7, overstrike "state department of health", remove the underscored comma, and overstrike "or as licensed under section"

Page 2, line 8, overstrike "23-17.1-01, or by"

Page 2, line 9, overstrike "section 50-06-05.2, offering treatment"

Page 2, line 10, overstrike "of alcoholism, drug addiction, or other related illness" and insert immediately thereafter "chapter 50-31"

Page 2, line 18, remove the overstrike over "~~forty-six~~" and remove "twenty-three"

Page 2, line 20, remove "In case of benefits provided for residential treatment, the benefits must be"

Page 2, remove lines 21 through 31

Page 3, remove lines 1 and 2

Page 3, line 3, remove "f."

Page 3, line 14, remove the overstrike over "e." and remove "g."

Page 3, after line 18, insert:

"f."

Page 3, line 19, overstrike ""Partial" and insert immediately thereafter "As used in this section and section 2 of this Act, partial" and after "hospitalization" overstrike the closing quotation marks

Page 3, replace line 28, with:

"**SECTION 2.** A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Alternative group health policy and health service contract substance abuse coverage.

1. As an alternative to the substance abuse coverage required under subsection 2 of section 26.1-36-08, an insurance company, a nonprofit health service corporation, or a health maintenance organization may provide substance abuse coverage under this section.

2. The provisions of section 26.1-36-08 apply to this alternative, except:

   a. In addition to the inpatient treatment, treatment by partial hospitalization, and outpatient treatment coverage required under section 26.1-36-08, the coverage must include residential treatment.

   b. In the case of coverage for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-09 in any calendar year.

   c. For the purpose of computing the period for which benefits are payable for a combination of inpatient and partial hospitalization, no more than twenty-three days of inpatient treatment benefits required under subdivision a may be traded for treatment by partial hospitalization.

   d. In the case of coverage for residential treatment, the benefits must be provided for a minimum of sixty days of services covered under this section in any calendar year. This residential treatment must be provided by an addiction treatment program licensed under chapter 50-31. If an individual receiving residential treatment services requires more than sixty days of residential treatment services, unused inpatient treatment benefits provided for under subdivision b may be traded for residential treatment benefits. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by a

residential treatment program, provided that no more than twenty-three days of inpatient treatment benefits required by this section may be traded for residential treatment benefits required under this section."

Page 3, remove lines 29 through 31

Renumber accordingly

Date: 3/25/03
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2210

House Judiciary Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 38292.0302 · 0300

Action Taken Do Pass as Amended

Motion Made By Rep. Delmore Seconded By Rep. Maragos

Representatives	Yes	No	Representatives	Yes	No
Chairman DeKrey	✓		Rep. Delmore	✓	
Vice Chairman Maragos	✓		Rep. Eckre		✓
Rep. Bernstein	✓		Rep. Onstad	✓	
Rep. Boehning	✓				
Rep. Galvin	✓				
Rep. Grande	✓				
Rep. Kingsbury	✓				
Rep. Klemin	✓				
Rep. Kretschmar	✓				
Rep. Wrangham	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Rep. Maragos

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

REPORT OF STANDING COMMITTEE

SB 2210, as engrossed: Judiciary Committee (Rep. DeKrey, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed SB 2210 was placed on the Sixth order on the calendar.

Page 1, line 1, after "to" insert "create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to alternative group health policy and health service contract substance abuse coverage; and to"

Page 1, line 2, replace "; and to" with a period

Page 1, remove line 3

Page 1, line 11, overstrike the second "or" and insert immediately thereafter an underscored comma, overstrike the third "or" and insert immediately thereafter an underscored comma, and after "franchise" insert an underscored comma

Page 1, line 14, overstrike "person" and insert immediately thereafter "individual"

Page 1, line 17, overstrike "and" and insert immediately thereafter an underscored comma

Page 1, line 18, remove "residential treatment."

Page 1, line 20, remove the overstrike over "~~sixty~~" and remove "forty-five"

Page 1, line 21, overstrike "if provided by a hospital"

Page 1, overstrike line 22

Page 1, line 23, overstrike "department of health" and overstrike ", or as licensed under section"

Page 2, line 1, overstrike "23-17.1-01 offering treatment" and overstrike "of alcoholism, drug"

Page 2, line 2, overstrike "addiction, or other related illness" and after the period insert "Services provided under this subdivision must be provided by an addiction treatment program licensed under chapter 50-31."

Page 2, line 5, overstrike "if" and insert immediately thereafter ". Services provided under this subdivision must be"

Page 2, overstrike line 6

Page 2, line 7, overstrike "state department of health", remove the underscored comma, and overstrike "or as licensed under section"

Page 2, line 8, overstrike "23-17.1-01, or by"

Page 2, line 9, overstrike "section 50-06-05.2, offering treatment"

Page 2, line 10, overstrike "of alcoholism, drug addiction, or other related illness" and insert immediately thereafter "chapter 50-31"

Page 2, line 18, remove the overstrike over "~~forty-six~~" and remove "twenty-three"

Page 2, line 20, remove "In case of benefits provided for residential treatment, the benefits must be"

Page 2, remove lines 21 through 31

Page 3, remove lines 1 and 2

Page 3, line 3, remove "f."

Page 3, line 14, remove the overstrike over "e." and remove "g."

Page 3, after line 18, insert:

"f."

Page 3, line 19, overstrike ""Partial hospitalization"" and insert immediately thereafter "As used in this section and section 2 of this Act, partial hospitalization"

Page 3, replace lines 28 through 31 with:

"**SECTION 2.** A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Alternative group health policy and health service contract substance abuse coverage.

1. As an alternative to the substance abuse coverage required under subsection 2 of section 26.1-36-08, an insurance company, a nonprofit health service corporation, or a health maintenance organization may provide substance abuse coverage under this section.

2. The provisions of section 26.1-36-08 apply to this alternative, except:

   a. In addition to the inpatient treatment, treatment by partial hospitalization, and outpatient treatment coverage required under section 26.1-36-08, the coverage must include residential treatment.

   b. In the case of coverage for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-09 in any calendar year.

   c. For the purpose of computing the period for which benefits are payable for a combination of inpatient and partial hospitalization, no more than twenty-three days of inpatient treatment benefits required under subdivision a may be traded for treatment by partial hospitalization.

   d. In the case of coverage for residential treatment, the benefits must be provided for a minimum of sixty days of services covered under this section in any calendar year. This residential treatment must be provided by an addiction treatment program licensed under chapter 50-31. If an individual receiving residential treatment services requires more than sixty days of residential treatment services, unused inpatient treatment benefits provided for under subdivision b may be traded for residential treatment benefits. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by a

residential treatment program, provided that no more than twenty-three days of inpatient treatment benefits required by this section may be traded for residential treatment benefits required under this section."

Renumber accordingly

2003 TESTIMONY

SB 2210

AH #1

TESTIMONY

SB 2210

JOINT JUDICIARY COMMITTEES

SENATOR JOHN TRAYNOR AND REPRESENTATIVE DUANE DEKREY, CHAIRS

JANUARY 22, 2003

Chairman Traynor and Chairman DeKrey; members of the Senate and House Judiciary Committees: I am Karen Romig Larson, Director of the Division of Mental Health and Substance Abuse in the Department of Human Services. I appear before you today to speak about SB 2210.

It has been my pleasure to serve as Carol Olson's designee on the North Dakota Commission on Drug and Alcohol Abuse since it was formed in 2002. As part of the Commission's activities, I was able to attend all but one of the regional forums held this past summer. Among the excellent observations and concerns raised by many North Dakotans, was the consistently expressed concern about access to adequate treatment.

As a result of these concerns, SB 2210 is offered as just one way we might address reimbursement for all effective modes of treatment, so persons with alcohol and drug abuse problems may access the most appropriate form of treatment for their illnesses.

Specifically, the changes proposed to Section 26.1-36-08 of the North Dakota Century Code relating to group health policy and health service contract substance abuse coverage are as follows:

1. **The addition of residential treatment as a covered benefit of sixty days in any calendar year.**
2. **The reduction of required inpatient benefits from sixty to forty-five days in any calendar year.**
3. **The ability to trade unused inpatient treatment benefit up to twenty-three days to be applied on a two day residential benefit for each**

traded inpatient day in any calendar year. This will allow additional residential coverage if the individual needs longer residential treatment services.

4. The ability to trade unused inpatient treatment benefits for additional partial hospitalization has been decreased to twenty-three days from the current forty-six days in any calendar year.
5. Removal of repeated references to the "prevention and cure" since we do not treat prevention, nor do we cure a chronic illness, in this instance, alcoholism and drug addiction.

There is one remaining component of the current law which requires additional clarification. This will be presented as an amendment to the Senate Judiciary Committee during its work on SB 2210 next week.

North Dakota led the nation in the 1960's, '70's and '80's with its development of inpatient addiction treatment. But, as with many other illnesses, research and other proven effective methods of treatment have certainly evolved. Depending on a number of variables such as the severity and chronicity of the addiction; the need for medical interventions for withdrawal or related physical problems; the presence of co-occurring psychiatric problems; relapse potential; home environment; and a host of other items, there is excellent evidence that good outcome for addiction treatment is dependent upon appropriately matching the client with the appropriate array of services.

The inpatient model of treatment with which many of us are familiar remains appropriate for some. Clients with shorter histories of substance abuse and stable living and work/school environments, and no accompanying medical problems will likely do quite well in an outpatient treatment setting.

One significant gap in our treatment system in North Dakota has been residential treatment. It is a level of care that does not rely on daily medical interventions, but does provide a therapeutic environment for certain clients who need to have more structure and consistent intervention as they begin their recoveries. According to

the ASAM (American Society of Addiction Medicine) Patient Placement Criteria for the Treatment of Substance-Related Disorders: Residential treatment programs are appropriate for individuals "who have minimal problems with intoxication and withdrawal and few biomedical complications....Such individuals may have relatively stable problems.....Many also have significant deficits in the areas of readiness to change, relapse, continued use or a recovery environment....Therefore, they are in need of interventions directed by appropriately trained and credentialed addiction treatment staff. Such individuals also need case management services to facilitate their reintegration into the community."

Examples of residential treatment include Therapeutic Community or Residential Treatment Centers. They provide 24-hour per day service, include room, board, group and individual therapy, case management, and transition to less restrictive care, when the client is ready to transition to that. Residential treatment does not require physician and nursing care on site, but may rely on referral arrangements for medical care if necessary. The 24-hour staffing is generally provided by trained paraprofessionals, with the therapeutic interventions led by licensed addiction counselors.

As all of you know only too well, the increase in the numbers of clients who have methamphetamine dependence as their primary diagnoses, has raised the issue of appropriate levels of treatment services. These clients generally require sufficient time to clear from the effects of the drug, and they often need a therapeutic environment in which to begin the recovery process.

It is in this light that I support the proposed addition of residential treatment to the current modes of care required to be reimbursed for certain group health policies. It will allow for a broader, more appropriate, and effective array of services to meet the needs of clients. It will also allow for the transfer of some of the allowed inpatient days to residential treatment if that is the more appropriate level of care for some clients.

I began working in this field in 1979. We have so much more information and research at our disposal today than at that time. The one thing I do know is that in addressing the chronic, progressive, and often fatal disease of alcoholism/drug addiction, we must respond with the best practices known to treat persons who are suffering.

Thank you for the opportunity to speak to you about SB 2210. I would be pleased to respond to any questions you may have.

SB 2210

Adds Residential Treatment to Substance Abuse Coverage in Group Health Service Contracts

The bill amends the group health policy and health service contract substance abuse coverage section of the Century Code by adding residential treatment as a covered service. It provides a minimum of 60 days of coverage for residential treatment services. In addition it provides flexibility for individuals requiring more days by allowing the individual to use unused inpatient treatment days at a rate of two days of residential treatment for every one day of inpatient treatment.

AH #2

Testimony Before The

SENATE JUDICIARY COMMITTEE

regarding

Senate Bill 2210

provided on January 22, 2003

by

George W. O'Neill, Ph.D.
Clinical Director of Mental Health
Blue Cross Blue Shield of North Dakota

Chairman Traynor, Vice Chair Lyson, and Members of the Senate Judiciary Committee, good morning. I am Dr. George O'Neill, Clinical Director of Mental Health for Blue Cross Blue Shield of North Dakota, and a psychologist by profession. I am here today in support of Senate Bill 2210. In 1997 the legislature passed a bill adding psychiatric residential treatment for children and adolescents to the list of mandated benefits for North Dakota residents. The current bill, SB2210, extends residential treatment to substance abuse. We at Blue Cross Blue Shield of North Dakota see this as an appropriate extension of services for persons with substance abuse disorders and expect improved outcomes with the addition of residential treatment.

The mandated benefit parameters indicated in SB2210 are as follows: forty-five days for inpatient treatment, one-hundred and twenty days of partial hospitalization treatment and sixty days of residential treatment. In parallel with the psychiatric benefit mandate, this bill includes a provision for trading unused inpatient days for residential days. As with the psychiatric benefit mandate, up to twenty-three inpatient days may be traded on a two-for-one basis with one inpatient day traded for two residential treatment days. Residential treatment services must be provided by hospitals or by residential treatment programs licensed by the State of North Dakota pursuant to rules adopted by the Department of Human Services.

With the passage of this bill, residential treatment for substance abuse would be payable for people of all ages. Most treatment for substance abuse disorders is currently conducted on an outpatient basis. This is appropriate. Inpatient treatment is not required unless there is a comorbid psychiatric disorder or risk of harm. However, in cases of failure of outpatient treatment or the inability to maintain abstinence while in outpatient treatment, residential treatment would be an appropriate and cost-effective option. Twenty-four hour nursing care and immediate access to physician care is not needed in the treatment of substance abuse, unless there is a comorbid disease requiring such treatment. Residential treatment for

substance abuse would provide an alternative between outpatient and costly inpatient treatment.

I would like to note that SB2210 would not affect the management of detoxification. Currently, detoxification is carried out either in the hospital (typically five days or less), on an outpatient basis (referred to as "social detox"), or in partial hospital.

This bill represents a win-win for the insurance industry and for persons in need of treatment for substance abuse. I urge the Committee to recommend passage of SB2210.

Thank you.

Library

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March 24, 2003

Mr. John D. Olsrud
Director
North Dakota Legislative Council
600 E Boulevard
Bismarck, ND 58505-0360

Re: Analysis of Senate Bill No. 2210

Dear Mr. Olsrud:

Thank you for your letter of March 5 requesting a cost-benefit analysis of the mandates included in Senate Bill No. 2210. In accordance with NDCC 54-03-28, you asked that we provide information to help determine the following:

a. the extent to which the proposed mandate would increase or decrease the cost of the service;
b. the extent to which the proposed mandate would increase the appropriate use of the service;
c. the extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and
d. the impact of the proposed mandate on the total cost of health care.

This letter is intended for use by North Dakota legislators and officials for the purpose of considering this proposed legislation. It should not be used for other purposes and was not prepared for the benefit of any third party. In doing our work, we have relied on the data and information cited in this letter. This information includes the House Bills attached to your letter. If there are changes to these bills, the comments here may no longer be appropriate.

Senate Bill No. 2210

This bill amends Section 26.1-36-08 of North Dakota's Statutes, which mandates coverage for substance abuse treatment. The substantive changes to benefits include:

- reducing coverage for inpatient treatment for substance abuse and/or mental health conditions (provided by NDCC 26.1-36-09) from 60 to 45 days per calendar year and reducing the inpatient-partial hospitalization day trading limit from 46 to 23 inpatient days.

- adding coverage for residential treatment to the other named options—inpatient, partial hospitalization, and outpatient.

Cost Analysis

I estimate that benefits for inpatient alcohol and drug abuse treatment typically account for less than 0.5% of health insurance premiums for a comprehensive plan covering a standard commercial (under age 65) population. Therefore, in general, I would not expect that making the changes included in this bill to North Dakota's existing substance abuse coverage would have a significant impact on overall premium levels.

That being said, I can comment on the potential impact of this bill on insurance costs and utilization patterns in North Dakota.

Reducing Treatment for Inpatient Treatment

First, I don't expect the reduction from 60 to 45 days of inpatient coverage per calendar year to have a significant impact on cost. Based on our Milliman *Health Cost Guidelines (HCGs)*, I would only expect this to impact insurance costs for inpatient substance abuse treatment by about 1%. Applied to the 0.5% mentioned above, this amounts to only about five 1000ths of a percent. Likewise, I expect that cutting the inpatient-partial hospitalization day trading limit from 46 to 23 inpatient days will have relatively little impact on cost, especially since the residential treatment center option is being added.

Adding Coverage for Residential Center Treatment

According to the Milliman *Health Cost Guidelines*, the average charge per day for inpatient alcohol and drug abuse treatment in North Dakota will be about $550 to $575 in 2003. This figure recognizes that inpatient treatment may include both detoxification and rehabilitative services. Acute care stays (mainly for detoxification) tend to be short—about 6 or 7 days and somewhat more expensive on a per day basis—something more in the range of $650 - $700 per day.

Rehabilitative services are sometimes provided on an inpatient basis. Rehabilitative inpatient stays tend to be longer than acute care stays—averaging something like 15 – 20 days, and slightly less expensive on a per day basis—based on the HCGs, about $325 to $375 per day in North Dakota. However, it is common for hospitals to admit patients to provide detoxification services and then discharge them with the understanding that rehabilitation will be provided through partial hospitalization or intensive outpatient treatment.

One key consideration in determining the impact of this bill on costs is capacity. My understanding is that there are currently not many residential beds available in North Dakota. Until that changes, I would expect the provisions in this bill to have very little impact on utilization patterns.

If and when more residential treatment beds do become available, it is likely that at least some insureds will be redirected from the acute inpatient/rehabilitative outpatient combination to a residential treatment center. These treatment centers typically charge less

per day than hospitals. Although the average cost per day ranges widely—from $20 or $30 per day to over $400 per day, most charge something in the range of $50 to $200 per day. However, residential treatment centers also tend to keep people longer than acute care hospitals. Lengths of stay in a residential center also vary widely, but stays in the range of 3 to 6 months are typical. It is worth keeping in mind that Senate Bill No 2210 limits benefits to 106 days per calendar year (60 plus 2 times 23).

While inpatient days and partial hospitalization visits may drop as patients are redirected to residential treatment facilities, we would not necessarily expect to see a reduction in outpatient professional visits. This is because it is likely that patients who come out of a residential treatment setting will likely continue to receive care on an outpatient basis.

To further explore the potential impact of this bill on insurance costs, we built a simple model that we could use for scenario testing. The key assumptions in this model include:

- the percentage of patients that are redirected from inpatient to residential care
- the average length of stay in residential treatment centers, and
- the average per diem charged by the residential treatment centers.

Given the limited scope of this analysis and the short time frame, we ignored the impact of partial hospitalization.

By testing a variety of scenarios, we found that savings in inpatient hospital costs for substance abuse coverage could easily swing between -30% and + 30%. However, since these costs only account for about 0.5% of premium, this is a small percentage of total health care cost. Lower average lengths of stay and/or per diems increase savings, while higher average lengths of stay and/or per diems decrease savings. A higher percentage of patients redirected to residential care will magnify the impact of changes in length of stay and/or per diems. Given the lack of residential beds in North Dakota at this time, I would expect that the real impact would be very small.

There are some risks to insurers associated with adding coverage for residential treatment. First, because North Dakota does not currently have many residential treatment beds, insureds may be more likely to choose to go out-of-state for this treatment. The current legislation does not conclusively exclude the use of out-of-state facilities. There are some well-known residential treatment centers around the country, which can be very expensive. I am attaching a list I found on the internet to this letter, by way of example. A second, and related concern, is that North Dakota based insurers are much less likely to be able to negotiate discounts with out-of-state centers than they are with in-state facilities.

Adding residential treatment facility coverage can provide an important treatment alternative which lies between acute inpatient services and partial hospital/intensive outpatient services along the continuum of care for alcoholism and chemical dependency. Many that suffer from these conditions find that these types of facilities provide a more balanced environment for care than do acute inpatient facilities, especially for adolescents. Residential treatment facilities provide medically supervised 24 hour care, but also provide a more home-like environment, which can be more effective in obtaining successful outcomes.

According to our Milliman *Care Guidelines*, the continuum of care for substance abuse treatment outside of an inpatient setting includes:

- Residential Treatment
- Partial hospitalization
- Intensive outpatient treatment or day treatment
- Outpatient treatment, or individual or group treatment
- Intensive case management or assertive community treatment and
- Home healthcare.

The *Care Guidelines* includes criteria for placement into each level of care. According to the *Care Guidelines*, residential treatment may be indicated if a patient has few or stable medical comorbidities and all of the following:

- Serious and persistent impairment in functioning in 1 or more area, including vocation, education, family, or social relations;
- High risk of harm, high likelihood of relapse, or other behavior that requires 24-hour, continuous, therapeutic environment for effective treatment;
- Medication monitoring, although medication may or may not be self-administered; and
- A safe, stable living environment is not otherwise available.

The *Care Guidelines* also indicates that a patient should be admitted to the least restrictive and most cost-effective level of care that meets his/her needs. Also, an individual may need more than one type of treatment (for example—both residential treatment and group therapy.)

In general, these mandates will introduce some added administrative costs. These include updating contracts and other policyholder communications, changes in claims processing systems to allow payment of these claims, and additional agent or broker commissions where they apply. As a percentage of total health insurance premium, we would expect these additional costs to be very minor. Adding coverage in residential treatment centers may also introduce other costs to carriers related to establishing relationships and contracting with these providers.

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This letter contains estimates of future experience, based on the assumptions described here. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. If actual experience is different from the assumptions used in the calculations, the actual amounts will also deviate from the projected amounts.

I hope this letter is helpful to you as you consider this bill. If you have questions regarding this letter, or would like us to do additional analysis, please feel free to contact me at (952) 820-2481 or leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal

cc: Jim Poolman, Insurance Commissioner

THE Addiction Recovery GUIDE

RESIDENTIAL TREATMENT

NAME	LOCATION	COST	INSURANCE	BEDS	GYM	DETOX
Arrut Acres	Carmel NY	$9,505/28 days	Private & Medicaid	129	Y	Y
Ashley	Havre de Grace MD	$10,000/28 days Financial Aid Available	Private Only	80	Y	Y
Betty Ford	Rancho Mirage CA	$16,500/30 days Financial Aid Available	Private Only	100	Y	Y
Caron Foundation	Wernersville PA	$17,100/28 days Financial Aid Available	Private Only	112	N	Y
Cri-Help	Los Angeles CA	$4,200/ 30 days Financial Aid Available	Private Only	120	Y	Y
Dav-Ton	26 centers	$60/day	Private & Public	Varies	Y	Y
Fairview Recovery	Minneapolis MN	$84/3-5 days $387 next 20 days	Private & Medicare	50	N	Y
Hazelden	FL, MN, IL, NY, OR	$20,000/30 days Financial Aid Available	Not Accepted	Varies	Y	Y
Mainwadh	Waverly PA	$2,760/week Full scholarships	Not Accepted	60	N	Y
Odyssey House	LA, MI, NH, NY, TX, UT	Utah $1,360/month Others $845/month	All	Varies	N	N
Phoenix House	CA, FL, MA, NH, NY, RI, TX, VT	Approx.$17,000 per patient	Full Coverage	Varies	Y	N
Samaritan	Briarwood NY	Sliding Scale	Medical	763	Y	N
Sierra Tucson	Tucson AZ	$23,270/28 days	Not Accepted	79	Y	Y
Silver Hill	New Canaan CT	$1,000/day	Private & Medicare	84	Y	Y
Smithers Center	New York NY	$500/day	Private, Medicaid, Medicare	44	Y	Y
Spencer Recovery	Laguna Beach CA Boulder CO Clearwater FL	$12,000 & up 28 days	Private Only	Varies	Y	Y
Turning Point	Tampa FL	$695/day insured $8,000/30 days w/out	Private Only	60	N	N
Valley Hope	AZ, CO, KS, MI, NE, OK, TX	$9,000/30 days Scholarships Available	Private Only	30	Y	Y

Accessibility information for people with disabilities is included with each center description.

ENGROSSED SB 2210

Adds Residential Treatment to Substance Abuse
Coverage in Group Health Service Contracts

The bill amends the group health policy and health service contract substance abuse coverage section of the Century Code by realigning existing treatment coverage to include residential treatment as a covered service.

To accommodate the residential treatment component, the bill provides:

- a minimum of 60 days of coverage for residential treatment services.
- reduces the number of inpatient days from 60 to 45.
- allows an individual requiring more than 60 residential days to trade unused inpatient days at a ratio of 2 residential days for each day of unused inpatient treatment

The Senate added Section 2 clarifying that since the bill is a realignment of treatment coverage it will be effective August 1, 2003, and is not to any other legislation passed during this legislative session.