**2025 HOUSE HUMAN SERVICES**

**HB 1339**

# 2025 HOUSE STANDING COMMITTEE MINUTES

**Human Services Committee**
Pioneer Room, State Capitol

HB 1339
1/20/2025

Relating to licensed ambulance services exempt from formation of rural ambulance service district requirements.

11:14 a.m. Chairman M. Ruby called the hearing to order.

Members present: Chairman M. Ruby, Vice Chairman Frelich, Representatives Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

**Discussion Topics:**

- Critical access hospitals
- Duplications from mandates
- Flexibility with districts

11:14 a.m. Representative Gretchen Dobervich, District 11, introduced the bill and submitted testimony, #30029, #30030.

11:23 a.m. Pete Antonson, CFO of Northwood Deaconess Health Center, testified in favor and submitted testimony, #29970.

11:37 a.m. Wayne Reid, CEO of Langdon Prairie Health, testified in favor and submitted testimony, #29919.

11:44 a.m. Adam Parker, on behalf of the North Dakota EMS Association testified in opposition.

**Additional written testimony:**
Lori Grommesh submitted testimony in opposition, #29938.
Jodi Hovdenes submitted testimony in favor, #30056.
Brock Sherva submitted testimony in favor, #30082.
Kristen Moos submitted testimony in opposition, #30106.

12:07 p.m. Chairman Ruby closed the hearing.

*Jackson Toman, Committee Clerk*

Wayne Reid
Written Testimony In Support of HB 1339
January 20, 2025

Honorable Chairman Ruby and Committee,

My name is Wayne Reid and I am the CEO of Langdon Prairie Health in Langdon, North Dakota.

I am testifying in support of HB 1339 that would exempt licensed ambulance services owned and operated by a hospital from the mandate to establish an ambulance district.

When I first assumed responsibility for the Hospital in Langdon, I was told by my Board Chair and my EMS director that the recently passed HB 1365 would require us to establish an ambulance district. Further, I was told that grant funding was available to hire a consultant who could assist in the establishment of the district.

A few of the things I was told by both my EMS director and the Consultant:

1. This was simply a formality
2. It would have little to no impact on current ambulance operations.
3. That the ambulance district would be required to contract with the existing licensed ambulance service.
4. The new district would not impact existing mill levy funds

After reading the legislation, I found that this was far from a benign exercise and that none of those items were actually in the century code.

I found that HB 1365 appeared to be enacting legislation that mandated certain ambulance services to establish ambulance districts. The districting regulations, which were first introduced in 1977, allow for the formation of Ambulance Districts and provide broad authority to the Ambulance District Board to operate ambulance services. There is nothing in either the enacting legislation mandating the formation of the district or the original legislation that defined ambulance district operations that requires them to contract with the existing licensed ambulance operator.

While the original legislation aimed to provide funding for community-based ambulances, it inadvertently imposed unnecessary administrative burdens on hospital-operated services that already function effectively under their existing oversight structures.

Currently, HB 1365 mandates that ambulance services serving populations under 6,500 establish a taxing district with its own board to request and manage levied funds. While this

approach may benefit stand-alone community-based services, it creates significant duplication and inefficiencies for hospital-owned services like ours.

Here are the primary reasons we believe the exemption proposed in HB 1339 is essential to preserve the efficiency and sustainability of hospital-owned ambulance services:

1. **Existing Oversight and Budgeting**: Hospital-owned ambulance services already operate under the direct oversight of the hospital's board of trustees, which manages and approves budgets for all hospital operations, including ambulance services. Requiring a separate taxing district creates redundant oversight structures, increasing administrative burdens without adding value.

2. **Challenges in Forming Taxing Boards**: Recruiting qualified and interested citizens to serve on additional boards is increasingly difficult, particularly in rural areas. Those who join taxing district boards may lack the expertise to make informed decisions about emergency services or could even have conflicting interests.

3. **Funding Uncertainty**: The current legislation does not guarantee that taxing districts will contract with hospital-owned services or provide sufficient funding to cover costs like staffing, capital improvements, and liability insurance. This creates financial uncertainty for hospitals that are already bearing the risks associated with these services.

4. **Existing Funding Mechanisms**: Many counties, including ours, already have effective mill levy funding in place to support emergency medical services. The introduction of a mandated taxing district risks destabilizing these established funding mechanisms, creating confusion and potential funding gaps.

In North Dakota, there are only nine hospital-owned ambulance services that would be subject to this mandate. By exempting these services from the taxing district requirement, rural North Dakota would maintain the streamlined and efficient delivery of emergency medical care, ensuring that hospitals can continue to focus on providing high-quality services to rural communities.

We understand and appreciate the intent of HB 1365 to support emergency services in underserved areas. However, we believe that an exemption provides a practical solution that respects the unique structure and oversight of hospital-owned ambulance services while allowing counties without current mill levies to create taxing districts if needed.

Thank you for your consideration of this important legislation. If you have any questions or would like additional information, I would be happy to discuss this further.

01/19/2025

House Human Services Committee
600 East Boulevard Avenue
Bismarck, ND 58505

RE: Opposition of House Bill 1339

Dear Chairman Rudy and Members of the Committee,

As a current board member of a rural ambulance service district, I am writing to express my strong opposition to House Bill 1339, which seeks to amend subsection 2 of section 23-27-07 of the North Dakota Century Code to exempt hospital-owned ambulance services from the requirements for forming rural ambulance service districts.

The formation of rural ambulance service districts is a vital process that empowers communities to have a voice in the sustainability and oversight of their local emergency medical services. These districts ensure that decisions regarding funding, governance, and operations are made with direct community input, reflecting the unique needs of the people they serve. Exempting hospital-owned ambulance services from these requirements undermines this critical framework and removes an essential layer of accountability.

From my experience, hospital-owned ambulance services are no different from private providers, whether for-profit or non-profit, in their operational and governance structures. The majority of rural ambulance services, regardless of ownership, are governed by boards responsible for overseeing policies, finances, and service quality. When taxpayers are aiding in a public safety entity, such as EMS, they should be assured that their tax dollars are spent on the intended goal. The taxing districts and their board assure this result. It is only fair that they all adhere to the same regulatory requirements, ensuring consistency and equity in how emergency medical services are managed.

By granting an exemption to hospital-owned services, HB 1339 creates an uneven playing field that could have far-reaching consequences. In rural areas, where emergency medical services are already stretched thin, this legislation risks creating disparities in service provision and potentially undermining community confidence in the system. Such an exemption could also lead to unfair competition, eroding the collaborative efforts that are often necessary to sustain rural EMS providers.

I urge you and your colleagues to reject HB 1339 in its current form and instead focus on policies that maintain fair and consistent regulations for all ambulance service providers. Ensuring equitable oversight is critical to preserving high-quality emergency care and empowering communities to shape the services they depend on.

Thank you for your time and thoughtful consideration. I am happy to discuss my concerns further and share additional insights from my perspective as a rural ambulance district board member.

Sincerely

Lori Grommesh
Treasurer/Board Member
Casselton Rural Ambulance District

NDHC
NORTHWOOD DEACONESS HEALTH CENTER

January 20, 2025

Testimony of HB 1339

By: Pete Antonson, CFO at Northwood Deaconess Health Center

Chairman Ruby and Members of House Human Services:

Good morning. Thank you for the opportunity to provide testimony on HB1339. My name is Pete Antonson. I was born and raised in Northwood, ND and have spent the last 60 years as a resident of Northwood.

My career began at NDHC in 1983 where I served as CFO until May 2000. At that time, I was hired as the CEO of NDHC and served a dual role as CEO/ CFO for the organization. As I got closer to the end of my career, I stepped down from the CEO role, but retained the role of CFO. With me today is Brock Sherva, current CEO of NDHC.

NDHC was founded in 1902. It is a 501-c-3 non profit organization, governed by a board of directors elected at its annual meeting. A majority of the board members must be members of the owner Lutheran churches. We have board members representing not only Northwood, but other area communities including Larimore, Niagara, and Sharon, ND. The annual meeting is held each March with delegates from the owner churches serving as voting members. The meeting is advertised and open to the public as well.

The bill I am testifying for is related to hospital owned ambulance services. Let me take a minute to talk about how the service is completely integrated part of the hospital operations. The hospital has owned and operated the ambulance as part of its facility going back to and maybe even prior to the 1970's.

The department is largely staffed by community volunteers that get paid for call, runs, and education. Due to difficulty in daytime staffing, a full time EMS manager was brought on board approximately 15 years ago to help stabilize daytime coverage.

In addition, staff throughout the facility have regularly been a part of the department. Here are just a few examples. Our clinic manager and ward clerk are on the EMS roster. As a matter of fact, our ward clerk has chosen to further her education and is set to take her examination to become a paramedic. We currently have no paramedics and hope she will remain on the squad once she is fully certified.

Members of our nursing staff have been involved as well. Some have actually joined the roster and participate fully in call rotations. Other nurses go on the ambulance when the medical nature of the transport requires an RN or paramedic.

Our facility provides the vehicles, equipment, and garage services for the rigs. Additionally, our staff do the billing for services provided. Our ambulance department participates in our safety department, does staff CPR training, and attends Medical Staff and other facility meetings. The department leads an annual community blood drive. The manager of EMS installs and maintains the emergency response units in family homes. You have likely seen the commercial, "I have fallen and I can't get up". It is those units. As you can see, the service is not just physically, but clinically integrated in our facility.

Grand Forks County is served by 3 services, 2 being hospital based. Altru of Grand Forks and Northwood are hospital based with Larimore being an independent service. The 3 services have worked together for decades for training, emergency drills, and joint purchases for mass casualty events.

We feel blessed that voters of the county not only passed a dedicated mill for emergency services once, but actually voted to increase it in the early 2000's. The combined advocacy efforts of Larimore, Northwood, and Altru Grand Forks helped this pass. The mills go into a fund, then are distributed based on townships served. We certainly benefit from the tax base of the city of Grand Forks being included in the overall fund. Though we don't have the means to calculate this, it seems highly likely that the mills levied in our service area district properties alone would be far less than our share of the entire county, then distributed back based on service area.

Additionally, NDHC has stretched itself to the west. A few years ago now, the Aneta Ambulance service was no longer able to sustain coverage and became a rescue squad only. Northwood picked some of their service territory as well as sitting in with the Aneta squad discussing options for their future. Just last week, the Nelson County service had both units out on calls, and Northwood had to pick up the slack when additional transportation was needed. Now that I have given some background, let me talk about the reasons we would like this bill to pass.

HB 1365 passed in 2023 was a much needed and important bill. In such a large state with relatively low population density, the need for EMS services goes across the state and not just in the populated areas. The bill provides a funding mechanism to support these services. The bill also provides an exemption for a number of different entities including hospitals based in communities over 6,500. Our request is to extend it to all hospital based services.

If required to abide, our service area would be required to form a taxing district with a unique set of board of directors. This board would receive the funding and contract with us to provide the services. Why is this problematic?

It creates another board of directors isolated from the facilities operations. Our current board of directors manages the entire facility. This creates a second entity that controls a significant and important source of funding.

Secondly, coming up with volunteer board members in small town is increasingly difficult. My church council recently reduced its size by 2 and still is unable to fill all its positions. The city

council has relied on appointments (coercion) when no one ran for open positions. Most elected positions run unopposed if there is anyone at all on the ballot.

There is some risk that the only ones to serve on this board may potentially not have the knowledge nor expertise, understand the clinical integration of the department within NDHC, or just plain have an axe to grind with the current CEO or hospital staff. None of these would be a benefit to our community, the taxpayers, or the health services provided.

There is nothing requiring the district to contract with the hospital, while the hospital assumes all the risk and expense of the operation. The elected governing board overseas all operations and to potentially pull a funding source or even the operation away from NDHC would be a detriment to healthcare in our community.

In conclusion, our opinion is that HB 1365 as passed in 2023 was really good bill that can be made even better by passing HB 1339. HB 1339 would mitigate the administrative and financial risk that we have identified. We respectfully ask a do pass on HB 1339.

I want to thank you for your time and service to the state of North Dakota. In my spare time, I have worked with Representative Beltz in District 20. Learning from him and others elected from our district, it has made me even more interested in the work that you do. Who knows, maybe I will try join you one day if I was fortunate enough to be elected.

I would be happy to answer any questions you may have. Brock Sherva, the current CEO of Northwood Deaconess Health Center is with me today as well and with your okay, I may deflect a question his way. Again thank you!

Pete Antonson, CFO

Northwood Deaconess Health Center

Pete.antonson@ndhc.net / 218-230-8471

North Dakota
House of
Representatives

State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505-0360

Representative
Gretchen Dobervich
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1625 23rd Street South
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Committees:
Agriculture
Human Services

House Bill 1339
House Human Services Committee
Testimony of Rep. Gretchen Dobervich, Bill Sponsor
January 20, 2025

Good Morning Mr. Chairman and Members of the House Human Services Committee. For the record my name is Representative Gretchen Dobervich. I work for the people of District 11 in Fargo. I come before you today with a bill to exempt critical access hospitals which own and operate ambulance services from being mandated to form a rural ambulance service district, if they so choose, under NDCC 23-27-07. NDCC 23-27-07 currently exempts ambulance services owned by a county, a city, under joint ownership between a city and a county, a Tribal Nation, the Federal government, and for ambulance services in cities with a population of 6,500 or more citizens in the 2020 US Census from forming a rural ambulance service district. This includes Fargo, Bismarck, Grand Forks, Minot, West Fargo, Williston, Dickinson, Mandan, Jamestown, Wahpeton, Devils Lake, and Valley City. Currently 9 of the 36 critical access hospitals in North Dakota operate an ambulance service: Bowman, Carrington, Hettinger, Hillsboro, Langdon, Linton, Northwood, Rugby, and Wishek.

Under NDCC 23-27-04.7 taxing districts which levy Emergency Medical Services (EMS) or ambulance service mill levy must allocate all the levy revenue per township to the ambulance service with the largest service area. There are some counties which have a mechanism for allocating county tax revenue to more than one ambulance provider in addition to the specific ambulance tax district funds going to the service with the largest service area.

As the service areas of rural ambulances grow, the tax base for revenue to fund public ambulance service declines in rural areas, and the overall decline in volunteerism impacts the number of volunteer staffed ambulance services, the creation of ambulance service districts in taxing districts is a lifeline for rural

North Dakotans in towns and counties not currently under exemptions. However, if a critical access hospital provides ambulance service in the same county/counties as a non-exempted ambulance service in the same taxing district and ambulance service area, current law dictates the tax revenue goes to the ambulance provider with the largest service area. Therefore, there is no guarantee the funds will go to the non-hospital run ambulance service.

In addition to the winner/loser funding. both are required to be reviewed annually by their county's Board of County Commissioners and the Commission required to write and submit a report to the North Dakota Department of Health Human Services regarding the service over the past year. This is a duplication of oversight for critical access hospitals operating ambulance services who may or may not be receiving tax dollars for providing ambulance services in the ambulance service district they fall under. The critical access hospital may pull ambulance tax district funds from a volunteer operated rural ambulance with more limited funding than the critical access hospital's ambulance service has.

At least one of the ambulance services operated by a critical access hospital is the result of a community-based ambulance service closing related to funding and staffing struggles. To assure the community and surrounding areas have access to ambulance services they assumed the management and operation of ambulance service. I mention this as one of the push backs on an exemption for critical access hospital ambulance services is that the ones who would like the option for exemption do not want to do their part in assuring vital ambulance services are available everywhere in North Dakota.

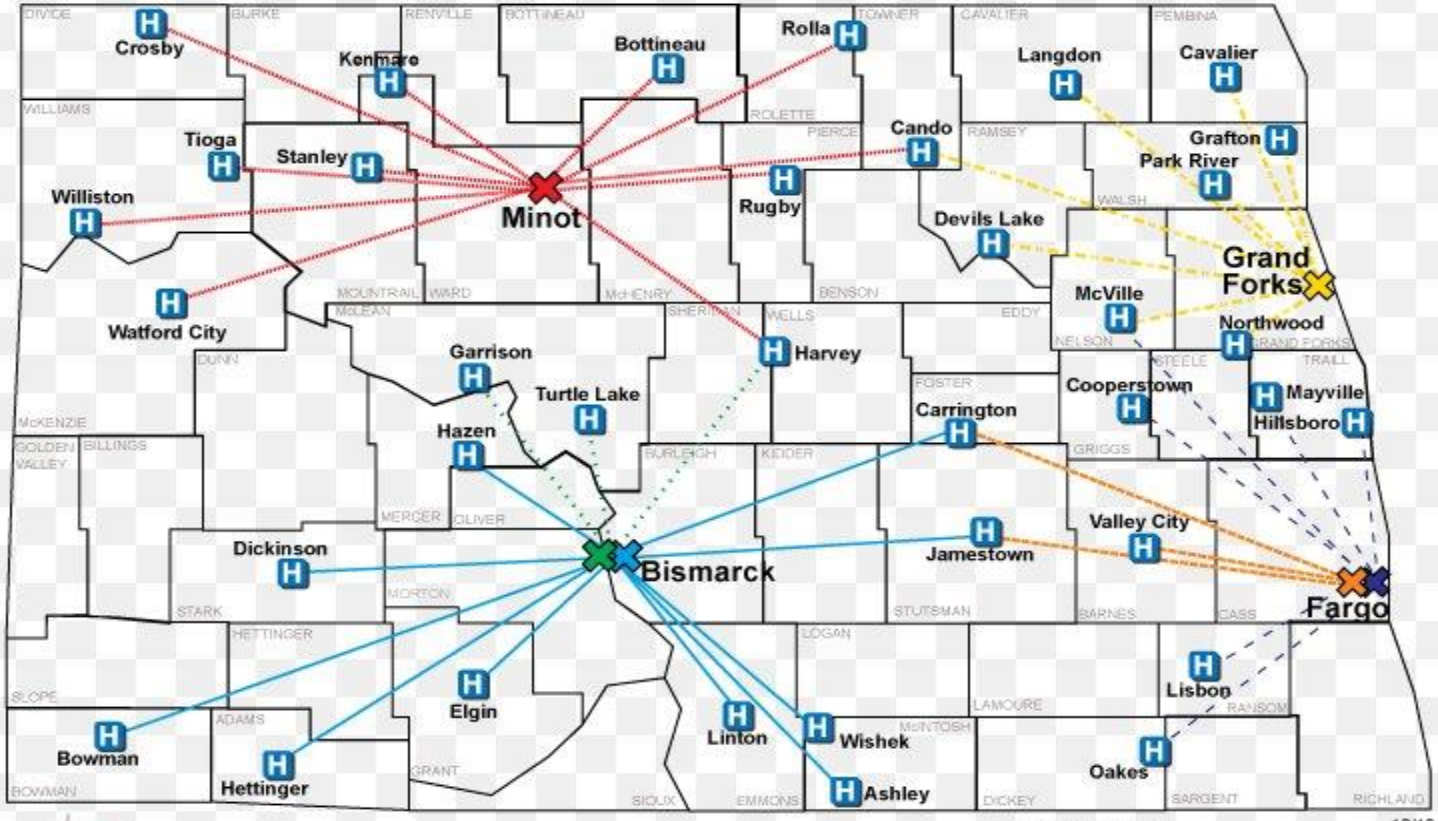
Last week a critical access hospital managed and operated ambulance service assisted a volunteer rural ambulance service near them who had received more calls than they had vehicles and crews to respond to in the period of time the calls came in. This is not uncommon as success and survival in rural North

Dakota has always required partnerships and leveraging resources. Critical access hospitals who reached out to me regarding the issue of taxing district exemptions all expressed interest, willingness, and commitment to sign memorandums of agreement or other legally binding documents with non-exempt ambulance services to assure back up and support was always available for crews and emergency services were always a 911 call away for citizens.

Speakers after me will clarify in greater detail why this exemption should be granted, the dollars and cent impacts, and most importantly any impacts to ambulance service area coverage in rural North Dakota. A copy of my testimony and a map of the locations of the critical access hospitals has been uploaded in LAWS. Searches for publicly available maps of ambulance services was not found.

This concludes my testimony, and I stand for any questions. Thank you Chairman Ruby and members of the Committee.

# North Dakota Critical Access Hospitals & Referral Centers




12/10

Center for Rural Health
The University of North Dakota School of Medicine & Health Sciences

**Referral Centers**

Trinity Hospital
Altru Hospital
St. Alexius Medical Center
Sanford Health
MedCenter One & St. Alexius
Sanford & Essentia Health
**Critical Access Hospitals** H

CHI St. Alexius Health
Imagine better health.℠

Carrington Medical Center
800 North Fourth Street
PO Box 461
Carrington, ND 58421-0461

North Dakota House of Representatives
Human Service Committee
January 20, 2025

RE: Testimony in Support of HB 1339

Dear Chairman Ruby and members of the Human Services Committee,

My name is Jodi Hovdenes, and I am the CEO of CHI St. Alexius Health Carrington. I have had direct oversight of our ambulance service for over 10 years. We are a BLS licensed ambulance service with ALS capabilities.

I am testifying in support of HB 1339, which would exempt Critical Access Hospitals from having to be part of a rural ambulance service taxing district.

While HB 1365 aimed to provide funding for ambulance services, it inadvertently imposed unnecessary administrative burdens on hospital-owned services. HB 1365 creates significant duplication and inefficiencies for hospital-owned ambulance services like Carrington.

The development of an ambulance taxing district board creates unnecessary duplication in budgeting and oversight of the ambulance service. CHI St. Alexius Health Carrington's ambulance service is already governed by a board of directors. This board is responsible for the budget and oversight of the ambulance service. Additionally, monthly updates regarding the operational activities of the ambulance service are presented to the Mayor of Carrington, and a representative of the Foster County Commission.

Currently, Carrington Ambulance receives 7 mills for overall support of the Carrington Health Center Ambulance. In addition, we share another 3 mills with McHenry ambulance that are restricted for vehicle replacement. The current mills were voted on and approved by the taxpayers of Foster County. HB 1365 lacks clarity around whether or not these mill funds will remain in place, and poses a threat of possible cuts or changes to the current funding.

Carrington Ambulance Service was a county owned service when it was first formed. In the early 90's, the county approached the hospital, and asked that the hospital assume full responsibility for the ambulance service. The county did not feel they were equipped in a manner to be in charge of an ambulance service. Carrington Health Center agreed to take over ownership of the Carrington Ambulance service because it was the right thing to do for the communities and people we serve. According to HB 1365,Carrington Ambulance would be exempt from creating an ambulance district if we were county owned. Because Carrington Health Center did what was right for our taxpayers, it now feels like we are being penalized because we are hospital owned.

Carrington Ambulance takes pride in the care and services we are able to provide our communities and people. We like other Critical Access Hospital owned ambulance services consistently step up to provide additional coverage when needed. Creating an ambulance taxing district would not enhance the care or coverage our service provides.

CHI St. Alexius Health
Imagine better health.℠

**Carrington Medical Center**
800 North Fourth Street
PO Box 461
Carrington, ND 58421-0461

I understand and appreciate the intent of HB 1365 to support emergency services in underserved areas. However, I believe that an exemption for Critical Access Hospital owned ambulance servicers provides a practical solution that respects the unique structure and oversight of hospital-owned ambulance services while allowing counties without current mill levies to create taxing districts if needed.

I want to thank you for your time and consideration in supporting HB 1339. If you have any questions, please feel free to contact me.

Respectfully submitted,

Jodi Hovdenes

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NDHC
NORTHWOOD DEACONESS HEALTH CENTER

North Dakota House of Representatives
Human Services Committee- January 20, 2025

RE: Testimony in Support of HB 1339

Dear Chairman Ruby and members of the Human Services Committee,

My name is Brock Sherva, and it is my honor and privilege to serve as CEO of Northwood Deaconess Health Center (NDHC) in Northwood, ND. NDHC strives to provide full service, high quality health care to the communities we serve. I am a lifelong user of the amazing services provided by NDHC, being a 5th generation resident of Northwood myself.

I am testifying in support of HB 1339, which adds hospital owned ambulance services to the list of exempt entities from having to be a part of a rural ambulance service taxing district.

Rural ambulance service taxing districts fail to consider the complexity of how the ambulance service operates when it's a part of a health system. Hospital-owned ambulance services operate under the direct oversight of the hospital's board of directors. The board is responsible for creating and approving budgets for all areas of the hospital, including its ambulance service. Creating a separate rural taxing district creates unnecessary duplication of budgeting and oversight, without any apparent benefit increase for the taxpayers.

One argument I have heard against an exemption for hospital owned services is that hospital boards are not elected by the taxpayers, but are receiving taxpayer funding. I can only speak from NDHC's unique situation, but the opposition is correct that our hospital board is not elected by the citizens in our county. That being said, the citizens of our county did vote on the current levied amount that supports EMS services in Grand Forks county. Our finances are audited annually and are available for any taxpayer, commissioner, or county auditor to request as required by our 501c3 nonprofit status. I question why hospitals would need to be treated any differently than other non-profit organizations that receive levied dollars. For example, in Grand Forks county, the Community Violence Intervention Center and Grand Forks Regional Economic Development both receive levied dollars but have boards that are not appointed by the taxpayers. Their levied funds flow from the state to the county commission, then to the organization, just like ours do today. Locally, our Northwood Economic Foundation and Northwood Cemetery Association have levied dollars that go to the city and are then distributed to the organizations. Both of those non-profit corporations also have boards that are not elected by the taxpayers. I feel strongly that there are adequate checks and balances already in place- the taxpayers voted to approve the levy, the county receives and distributes the levy with the ability to request financials from the organizations, and the hospitals utilize the funds to help offset the loss of operating an ambulance service while providing a service to the taxpayers.

In addition to the duplication of oversight, more concerning is the lack of clarity around how the district will contract with the hospital-owned ambulance service. Hospitals will continue to take on all the risk of staffing, capital improvements, and liability insurance without any assurances that the district would provide adequate funding to cover the expenses. Many counties, like Grand Forks county, already have funding mechanisms in

place for emergency medical services. By creating a taxing district, current funding is put into limbo and will be subject to annual changes and potential cuts.

As stated above, rural ambulance service districts fail to take into consideration the complexity of the overall emergency services of the hospital. NDHC's ambulance service transferred me when I was 8 years old to receive additional care for an exacerbated case of croup, they responded to my father's fatal car accident, and they saved my grandfather's life when he was suffering a stroke. In all three of these instances, a nurse from NDHC's emergency department was onboard the ambulance to provide additional assistance and support to EMS staff. How can we begin to calculate the cost of that in a contract with the service district?

I fail to see how the rural ambulance service districts enhance NDHC's ability to provide ambulance services, and more importantly, enhance patient experience and care received. Hospital owned ambulance services have consistently stepped up to take on additional coverage when needed, and being exempt from rural ambulance taxing districts would not change this. This exemption would still allow a hospital to be a part of a district if that is best for patient care, it simply removes the mandate of having be a part of one.

Thank you for your consideration in supporting this legislation and thank you for all that you do for our great state. If you have any questions, please don't hesitate to contact me.

Respectfully,

Brock Sherva, Administrator/CEO
brock.sherva@ndhc.net
(701) 587-6955/ (218) 779-3755

Chairman Ruby and Members of the Committee,

Thank you for the opportunity to provide testimony in opposition to HB 1339. My name is Kristen Moos, and I am the manager of a rural ambulance service district, I write to express my strong concerns regarding this bill, which seeks to exclude hospital-owned ambulance services from the rural ambulance district mandate.

HB 1339, if enacted, will undermine the flexibility, transparency, and accountability that are essential to ensuring the continued provision of high-quality emergency medical services (EMS) across North Dakota. By including hospital-owned ambulance services within the rural ambulance district mandate, we can preserve and strengthen the foundation of EMS delivery in rural communities, both now and in the future.

One of the primary advantages of including hospital-owned ambulance services in the district mandate is the flexibility it offers. The EMS system is continuously evolving to meet the demands of changing demographics, economic pressures, and potential service closures. Hospital-owned ambulance services play a role within the larger EMS framework. Their inclusion in the district mandate ensures the greatest amount of adaptability to address current and future challenges and minimize potential service gaps in the future.

Additionally, incorporating hospital-owned ambulance services into the mandate enhances transparency and accountability. The mandate requires uniform standards and oversight with public funds, ensuring that all ambulance services—regardless of ownership—operate under the same expectations with the same amount of transparency. This level playing field fosters trust and confidence among residents, knowing that every ambulance service is held to the same high standard.

Furthermore, as we look to the future, the EMS landscape will likely continue to evolve due to advances in medical technology, changes in healthcare policy, and shifting population trends. By ensuring that hospital-owned ambulance services remain part of the district mandate, we establish a framework that is better equipped to adapt to these changes while maintaining equitable and effective care for all North Dakotans.

For these reasons, I respectfully urge the committee to oppose HB 1339 and preserve the inclusion of hospital-owned ambulance services within the rural ambulance district mandate. Doing so will ensure that our EMS system remains flexible, transparent, and accountable, while providing equitable access to lifesaving services for all residents of our state.

Thank you for your time and consideration.  Please feel free to contact me should you have any questions I may answer.

Kristen Moos
701-321-1481

# 2025 HOUSE STANDING COMMITTEE MINUTES

**Human Services Committee**
Pioneer Room, State Capitol

HB 1339
2/18/2025

Relating to licensed ambulance services exempt from formation of rural ambulance service district requirements.

10:30 a.m. Chairman M. Ruby opened the meeting.

Members present: Chairman M. Ruby, Vice Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Members absent: Representative Davis

**Discussion Topics:**

- Committee action

10:36 a.m. Representative K. Anderson moved a Do Not Pass.

10:36 a.m. Vice-Chairman Frelich seconded the motion.

| Representatives | Vote |
|---|---|
| Representative Matthew Ruby | Y |
| Representative Kathy Frelich | Y |
| Representative Karen Anderson | Y |
| Representative Mike Beltz | N |
| Representative Macy Bolinske | Y |
| Representative Jayme Davis | AB |
| Representative Gretchen Dobervich | N |
| Representative Cleyton Fegley | N |
| Representative Jared Hendrix | Y |
| Representative Dawson Holle | Y |
| Representative Dwight Kiefert | N |
| Representative Nico Rios | Y |
| Representative Karen Rohr | N |

10:37 a.m. Motion passed 7-5-1.

Vice-Chairman Frelich will carry the bill.

10:38 a.m. Chairman Ruby closed the meeting.

*Jackson Toman, Committee Clerk*

# REPORT OF STANDING COMMITTEE
## HB 1339 (25.1053.01000)

**Human Services Committee (Rep. M. Ruby, Chairman)** recommends **DO NOT PASS** (7 YEAS, 5 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). HB 1339 was placed on the Eleventh order on the calendar.