HEALTH SERVICES COMMITTEE

The Health Services Committee was assigned the following studies:

- Senate Bill No. 2158 (2023) directed a study to determine the steps necessary for the dissolution of the Comprehensive Health Association of North Dakota (CHAND).
- Section 3 of Senate Bill No. 2085 (2023) directed a comprehensive study of the delivery of emergency medical services in the state.
- House Concurrent Resolution No. 3021 (2023) directed a study regarding whether the services provided in the state relating to the care and treatment of individuals with brain injury are adequate.

The Legislative Management delegated to the committee the responsibility to receive a report pursuant to North Dakota Century Code Section 19-03.1-23.5 from the Department of Health and Human Services (DHHS) by November 1 of each year summarizing the number of deaths that occurred in the state caused by or related to fentanyl consumption during the preceding calendar year, including the county in which the deaths occurred and the age and gender of the deceased individuals.

Committee members were Senators Kristin Roers (Chairman), Michelle Axtman, Jeff Barta, and Judy Lee and Representatives Gretchen Dobervich, Kathy Frelich, Dwight Kiefert, Carrie McLeod, Alisa Mitskog, Emily O'Brien, Todd Porter, and Robin Weisz.

STUDY OF THE COMPREHENSIVE HEALTH ASSOCIATION OF NORTH DAKOTA

In conducting the study to determine the steps necessary for the dissolution of CHAND, the committee was directed to consult with the Insurance Commissioner, DHHS, board of CHAND, and Public Employees Retirement System (PERS). In addition the study required was to include an analysis of the enrollees, transitioning of the current enrollees' plans to potential federal Affordable Care Act (ACA) plans, Medicaid programs, and PERS plans, and any other options determined by the study, and to review the process to discontinue any new enrollment into CHAND immediately and transition all major medical plans in effect as soon as plan year 2024.

Previous Studies

The 2011-12 Health Care Reform Review Committee studied the impact of the ACA on CHAND pursuant to Senate Concurrent Resolution No. 4005 (2011). The committee reviewed whether the CHAND program still was needed or could be discontinued. The Insurance Commissioner recommended no action be taken until lawsuits involving the ACA had been decided and more information could be obtained regarding how the ACA affected CHAND.

The 2013-14 Health Care Reform Review Committee received updates regarding the impact of the ACA on CHAND. The committee learned several states discontinued high-risk health insurance pools due to the ACA effectively eliminating any new enrollment in CHAND. However, committee discussion indicated it may be necessary to continue the CHAND program until the ACA became more established and additional information regarding the effect of the ACA on CHAND was known.

History

During the 1979-80 interim, the Legislative Management's interim Health Care Committee studied options for a remedy for providing accident and sickness insurance to uninsurable people in North Dakota. The committee recommended House Bill No. 1058 (1981) which was approved by the Legislative Assembly creating an intercarrier health insurance pool (now CHAND as codified in North Dakota Century Code Chapter 26.1-08). The CHAND program's participating membership consists of those insurers doing business in North Dakota with an annual premium volume of accident and sickness insurance contracts amounting to at least $100,000 for the previous calendar year. Each member pays an assessment based on their accident and health premium volume.

Board of Directors

The CHAND Board of Directors consist of:

1. The Insurance Commissioner;
2. The State Health Officer;
3. The Director of the Office of Management and Budget;
4. One senator appointed by the Senate Majority Leader;
5. One representative appointed by the Speaker of the House of Representatives; and

6. One individual from each of the three participating member insurance companies of the association with the highest annual premium volumes of health insurance coverage as provided by the Insurance Commissioner, verified by the lead carrier, and approved by the board.

Program

The CHAND program offers health insurance to North Dakota residents who are unable to find adequate health insurance coverage in the private market due to medical conditions or who have lost their employer-sponsored group health insurance. An insurance carrier licensed to do business in North Dakota must inform individuals denied health insurance coverage by their company about CHAND.

Subject to benefit plan limitations and exclusions, CHAND covers major medical and prescription drug expenses. An individual is eligible to receive up to $1 million in benefits from CHAND during that individual's lifetime. An individual who has received $1 million in CHAND benefits from enrollment in any combination of benefit plans is not eligible to obtain new coverage through CHAND.

Under CHAND, premiums have funded approximately one-half to two-thirds of the program with most of the balance covered by assessments to companies that write at least $100,000 in annual premiums on behalf of residents of the state. The premium amount charged to individuals under CHAND may not exceed 135 percent of average premiums charged in the state for similar coverage.

Blue Cross Blue Shield of North Dakota is the insurance company the CHAND Board of Directors has selected to be the lead carrier to administer the CHAND benefit plans.

Enrollment History

The following schedule details the number of individuals enrolled in CHAND.

Year	Enrollment
2012	1,401
2013	1,383
2014	813
2015	617
2016	461
2017	359
2018	354
2019	335
2020	283
2021	242
2022	202

Eligibility and Coverage Options

Under Section 26.1-08-12(5), the four ways an applicant can qualify for CHAND are:

1. Traditional applicant (waiting period);
2. Health Insurance Portability and Accountability Act of 1996 (HIPAA) applicant (no waiting period);
3. Federal Trade Adjustment Assistance Reform Act of 2002 (TAARA) applicant (no waiting period); and
4. Age 65 and older applicant or disabled supplement applicant (waiting period).

An eligible traditional, HIPAA, or TAARA applicant has the option of choosing from the following coverage options:

	Deductible Amount Per Benefit Period	Coinsurance Maximum Per Benefit Period	Out-of-Pocket Maximum Per Benefit Period
Option 1	$1,000	$2,000	$3,000
Option 2	$500	$2,500	$3,000

These applicants are subject to a CHAND lifetime maximum of $1 million. An eligible supplement applicant has the option of choosing basic supplement coverage or standard supplement coverage.

Benefits

The Comprehensive Health Association of North Dakota program provides benefit allowances for the following items:

- Inpatient and outpatient hospital services;
- Physical, occupational, and speech therapy;

- Inpatient, outpatient, and surgical services;
- Home and office visits;
- Wellness services - well child care, immunizations, mammography, pap smear, fecal occult blood testing, and prostate cancer screening;
- Lab, x-ray, MRI, allergy testing;
- Radiation therapy, chemotherapy, and dialysis;
- Inpatient, outpatient, prenatal, and postnatal care maternity services;
- Inpatient, ambulatory behavioral health care (partial hospitalization), residential treatment, and outpatient services;
- Emergency services;
- Ambulance services;
- Skilled nursing facility services;
- Home health care services;
- Hospice services;
- Outpatient prescription drugs;
- Medical supplies and equipment;
- Hearing aids for subscriber under age 18;
- Bariatric surgery;
- Tobacco cessation services; and
- Optional chiropractic services endorsement.

Premium Rates

The following are the monthly premium rates for the traditional, HIPPA, and TAARA coverage options as of September 2024:

Subscriber Age	$500 Deductible without Chiropractic Benefits	$500 Deductible with Chiropractic Benefits	$1,000 Deductible without Chiropractic Benefits	$1,000 Deductible with Chiropractic Benefits
Under 18	$465.33	$469.33	$440.98	$443.98
18-29	$644.75	$652.75	$611.50	$617.50
30-39	$836.01	$844.01	$792.43	$798.43
40-44	$945.67	$953.67	$896.17	$902.17
45-49	$1,045.54	$1,053.54	$990.65	$996.65
50-54	$1,160.42	$1,168.42	$1,099.33	$1,105.33
55-59	$1,400.63	$1,408.63	$1,326.57	$1,332.57
60-64	$1,745.29	$1,753.29	$1,652.61	$1,658.61
Age 65 and over	$2,035.11	$2,043.11	$1,926.78	$1,932.78

The following are the monthly premium rates as of January 1, 2024, for supplemental coverage for individuals age 65 and older or individuals with disabilities who are eligible for Medicare.

Age	Basic Supplement	Standard Supplement
65-69	$149.00	$300.90
70-74	$175.80	$354.20
75-79	$194.30	$394.40
80-84	$198.80	$403.80
85 and older	$208.60	$421.30
Under 65 (disabled)	$215.10	$434.30

Testimony Received and Committee Considerations

The committee received the following testimony from the Insurance Department regarding CHAND:

- CHAND was created to provide health insurance coverage to individuals who were denied coverage through private health insurance.
- The ACA precludes health insurers from denying coverage due to pre-existing conditions.

- An October 2022 review of the CHAND program by the Insurance Department recommended the program be dissolved and enrollees be transitioned to private health plans.

The committee received the following information from PERS regarding options to transition CHAND enrollees to state employee health insurance plans:

- The current Dakota Retiree Plan is fully funded through premiums and adding high-risk individuals to the plan could cause significant increases in premium amounts.
- Adding nongovernmental employees to a government plan could result in the plan losing government plan status.

A representative of Blue Cross Blue Shield of North Dakota suggested assessments for the CHAND program be charged based on actual claims rather than projected claims until the program is discontinued.

Committee Discussion

Committee members discussed options to either discontinue CHAND or to continue the program and use state funding for program costs. Committee members noted enrollment in CHAND will likely continue to decrease and program costs will become unstable. The Insurance Department reported all current CHAND enrollees are able to be transitioned to a comparable benefit plan or Medicaid supplement policy. Committee members supported the option to discontinue CHAND if enrollees could be successfully transitioned into comparable benefit plans and supplemental policies. No opposition was noted for discontinuing CHAND.

Committee Recommendations

The committee recommends a bill to cease enrollment in the CHAND program effective May 1, 2025, and to terminate all existing CHAND benefit plans effective December 31, 2025. The bill requires current CHAND enrollees to be transitioned a comparable benefit plan or Medicare supplement policy.

STUDY OF THE DELIVERY OF EMERGENCY MEDICAL SERVICES

The committee was directed to undertake a comprehensive study of the delivery of emergency medical services (EMS) in the state, including consideration of funding, taxation, access critical areas, demographics, volunteer training, volunteer retention, systems approach to rural areas, employment options, including access to a public safety pension, and educational reimbursements. In addition the study required was also to include consideration of distressed ambulance services, which are ambulance services that have indicated an intention to close or change their license level, or an ambulance service that fails to meet performance standards as established by the DHHS.

Previous Studies

The 2007-08 interim Public Safety Committee studied the state's EMS system, including the funding, demographics, and impact on rural areas.

The 2011-12 interim Health Services Committee received information regarding the EMS improvement grant to study rural EMS issues awarded to SafeTech Solutions, LLP, from the Emergency Medical Services Advisory Council.

The 2013-14 interim Health Services Committee studied the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state, including the ability to receive third-party reimbursement for the cost of these services and the effect of these services on the operations and sustainability of the EMS system.

The 2017-18 interim Government Administration Committee studied EMS funding in the state. The committee reviewed the amount of funding provided for EMS programs. The committee also reviewed the criteria used by the State Department of Health to distribute grants to ambulance services. The committee did not make any recommendations.

Background

Chapter 23-27 provides DHHS is the licensing authority for EMS operations and may designate their service areas.

Definition

Section 23-27-02 defines EMS as "the prehospital medical stabilization or transportation, including interfacility transportation, of an individual who is sick, injured, wounded, or otherwise incapacitated or helpless, or in a real or perceived acute medical condition, by a person that holds oneself out to the public as being in that service or that regularly provides that service. The term includes:

a. Assessing, stabilizing, and treating life-threatening and non-life-threatening medical conditions; or

b. Transporting a patient who is in a real or perceived acute medical condition to a hospital emergency room or other appropriate medical destination."

Licensing

Section 23-27-03 provides the fee for a license to operate an EMS operation, or a substation ambulance services operation may not exceed $25 annually. The fee, currently set at $25, is to defray the costs of administration of the licensing program. All operation license fees must be paid to DHHS, deposited with the State Treasurer, and credited to the state general fund. Emergency medical service personnel are not subject to the operation license fee.

Emergency Medical Services Training and Certification

Section 23-27-04.2 requires DHHS to assist in the training of EMS personnel of certain EMS operations and financially assist certain EMS operations in obtaining equipment. In addition, Section 23-27-04.3 requires DHHS to adopt rules prescribing minimum training, testing, certification, licensure, and quality review standards for EMS personnel, including community EMS personnel, instructors, and training institutions.

Section 23-27-04.6 provides for the licensure of quick response units and provides 24-hour availability is not required for licensure of a quick response unit.

Integrated Emergency Medical Services Plan

The 2011 Legislative Assembly, in House Bill No. 1044, created Chapter 23-46 related to EMS. Section 23-46-03 requires DHHS to establish and update biennially a plan for integrated EMS in the state. The plan must identify ambulance operations areas, EMS funding areas that require state financial assistance to operate a minimally reasonable level of EMS, and a minimum reasonable cost for an EMS operation.

Section 23-46-02 requires DHHS to establish an EMS advisory council to provide recommendations regarding:

- The plan for integrated EMS in the state;
- Development of EMS funding areas;
- The development of EMS funding areas application process and budget criteria; and
- Other issues relating to EMS.

Membership of the EMS advisory council must include:

- At least three members appointed by an EMS organization;
- One member appointed by the Commissioner of DHHS to represent basic life support;
- One member appointed by the Commissioner of DHHS to represent advanced life support; and
- Any additional members appointed by the Commissioner of DHHS to provide for a maximum of 14 members on the council.

Funding for EMS

State Appropriations

The 2023 Legislative Assembly appropriated a total of $14,721,000 for EMS purposes during the 2023-25 biennium. Of this amount, $6,596,000 is from the general fund, $1,125,000 is from the insurance tax distribution fund, and $7,000,000 is from the community health trust fund. Of this amount, $846,000 is for training grants and $13,875,000 is for rural EMS grants and assistance.

The following schedule details state appropriations for EMS since the 2015-17 biennium:

Biennium	General Fund	Insurance Tax Distribution Fund	Community Health Trust Fund	Total
2015-17	$7,190,000	$1,250,000		$8,440,000
2017-19	$6,596,000	$1,125,000		$7,721,000
2019-21	$6,596,000	$1,125,000		$7,721,000
2021-23	$6,596,000	$1,125,000		$7,721,000
2023-25	$6,596,000	$1,125,000	$7,000,000	$14,721,000

Section 23-46-04 requires EMS organizations requesting state assistance to submit fiscal information to DHHS for use in financial assistance allocations. The Department of Health and Human Services is to determine annual allocations for each medical services funding area based on the department's determination of the minimum annual funding necessary to operate in the funding area.

Rural Ambulance District Levy

Chapter 11-28.3 provides a rural territory may elect to form and maintain a rural ambulance service district upon approval of a majority of electors of the district. The chapter authorizes a levy of up to 15 mills as part of the creation of the district.

County Tax Levy

Section 57-15-50 authorizes a county to levy a tax for EMS subject to majority approval of the electors in the county. A tax levied under this section may not exceed 15 mills.

Testimony Received and Committee Considerations

The committee received the following information from DHHS regarding EMS in the state:

- The current EMS services in the state include 96 basic life support ground ambulance services, 15 advanced life support ground ambulance services, 5 industrial ambulance services, 106 quick response units, and 5 air medical service providers.
- The average ambulance response time in the state is 8 minutes and 36 seconds, with quicker response times in metropolitan areas and slower response times in rural areas.
- Challenges facing ambulance services include workforce shortages and financial sustainability.
- DHHS began a law enforcement behavioral health trial program in March 2022. As of December 31, 2023, the program was serving six state agencies and 27 individuals have received services through the program.
- The following schedule compares licensed EMS personnel in the state in August 2023, August 2022, and April 2020:

	August 2023	August 2022	April 2020
Paramedics	688	648	661
Advanced emergency medical technicians	109	95	97
Emergency medical technicians	1,703	1,818	2,003
Emergency medical responders	1,547	1,743	2,073

The committee received the following information from the North Dakota EMS Association regarding rural EMS services:

- A survey of ambulance services identified major challenges for EMS include staffing shortages, the inability to recruit new members, and training expenses.
- The main sources of revenue for rural ambulance services include service reimbursement, local property taxes, and rural EMS assistance grants.
- The median cost per ambulance call is $1,893.
- Based on the current funding model only 45 percent of ambulance services can generate enough revenue to hire a partially paid crew.
- Rural ambulance services have increased compensation to improve retention.
- Staffing costs account for an average of 57 percent of total expenses of an ambulance operation.
- Approximately 70 percent of rural ambulance operations have at least one full-time person on staff.
- Allowing EMS personnel to participate in the state public safety retirement plan may improve personnel retention.
- Approximately two ambulance services close each biennium.
- The main indicator that an ambulance service is in distress is the failure to respond to requests for service.

The committee received the following information from representatives of the North Dakota University System regarding EMS training programs:

- The duration of an EMS education program is determined by several factors, including national and state standards and the ability for a student to complete lab, clinical, and ride time.
- EMS education program instruction time requirements range from 40 to 48 hours for emergency medical responders, and up to 1,500 to 1,800 hours for paramedics.
- Bismarck State College offers emergency medical technician and paramedic technology programs. The number of annual graduates from each program has ranged from 8 to 24 since 2018.

- Four community colleges in the state participate in the Dakota Nursing Program. Education is provided at the campuses and at satellite locations across the state. The four colleges collaborate on curriculum and graduation requirements.
- North Dakota University System 2-year institutions offer various credit and noncredit emergency medical responder, emergency medical technician, and paramedic programs.
- Coordinating programs among institutions would provide a greater variety of expertise, coordinated curriculum, and reduced administrative burden.

The committee received testimony from the North Dakota Association of Counties regarding public safety answering points:

- EMS in the state are dispatched through 21 primary public safety answering points (PSAPs), 1 secondary PSAP, and 1 military PSAP.
- Some answering points gather data regarding dispatches, including response times and failure to respond to service.
- Answering points are reviewing options to transfer certain calls to the 988 response system.
- There is no requirement for PSAPs to report ambulance response times or failure to respond for service to DHHS.
- Liability protection is needed for 988 and 211 hotline operators, 911 dispatchers, and mobile crisis responders.
- Other states have enacted legislation to provide liability protection for operators, dispatchers, and responders.

The committee reviewed options to allow EMS personnel to participate in the state public safety retirement and received the following information:

- Law enforcement and fire department personnel may enroll in the plan while EMS providers may not.
- There would be no cost to the state to allow EMS providers to enroll in the plan because costs would be paid by participating EMS providers.
- The contribution rate for the public safety retirement plan with prior service is 18.04 percent which consists of a 5.50 percent employee contribution, 11.40 employer contribution, and a 1.14 percent retiree health credit.
- The contribution rate for the public safety retirement plan without prior service is 15.80 percent which consists of a 5.50 percent employee contribution, 9.16 employer contribution, and a 1.14 percent employer contribution relating to the retiree health credit.
- The PERS Board has the authority to adjust the employer contribution rate based on actuarial estimates.

The committee discussed distressed ambulance services and received the following testimony:

- A process is needed to determine when an ambulance service is distressed.
- Clear guidelines should be provided regarding the process to notify an ambulance service that it is not meeting state or federal guidelines.
- Ambulance services should have the ability to respond to service deficiencies before being declared a distressed ambulance service.

The committee also received information regarding:

- EMS training provided for law enforcement at the Highway Patrol Law Enforcement Training Academy. The Law Enforcement Training Academy requires basic law enforcement academy students to be trained in basic first aid and CPR.
- The North Dakota Critical Incident Stress Management program. Critical Incident Stress Management team members provide stress management services for EMS personnel to minimize the harmful effects of stress, particularly in crisis or emergency situations.
- Emergency medical telemedicine can be used to assist EMS crews and hospital emergency rooms.

Committee Discussion

Committee members reviewed a bill draft to create a distressed ambulance program in DHHS. Committee members supported the bill draft and also reviewed other options to enhance EMS in the state. No opposition to the bill draft was noted. The committee also reviewed bill drafts relating to liability protection for 988 and 211 hotline operators and to

allow EMS personnel to participate in PERS retirement plans. However, some committee members indicated the drafts needed further refinement and will be sponsored by individual legislators during the 2025 legislative session.

Committee Recommendations

The committee recommends a bill to create a distressed ambulance program in DHHS to administer a process to address ambulance services that are not complying with state or federal law or are likely to fail to respond to requests for service.

STUDY OF BRAIN INJURY SERVICES

The study of whether the services provided in the state relating to the care and treatment of individuals with brain injury are adequate was required to include a review of the state's existing programs to identify potential pathways and treatment options for individuals with brain injury, gap identification with programmatic recommendations identifying potential strategies to address the gaps, potential federal and state funding sources for services, and developing a method to evaluate the efficacy of new programs.

Previous Studies

The 2009-10 interim Long-Term Care Committee studied the impact of individuals with a traumatic brain injury (TBI) on the state's human services system. The committee specifically received information from the National Guard regarding services available to veterans with TBI. Information also was received from the Department of Public Instruction regarding services available to students with TBI.

The 2013-14 interim Human Services Committee conducted a study of the need for a comprehensive system of care for individuals with a brain injury. The committee reviewed options to allow access to Medicaid for individuals with brain injury who are working. The committee also reviewed requirements for providers of employment-related services to register with the Department of Labor and Human Rights.

Statutory Provisions

Definition of Brain Injury

Section 50-06.4-01 provides "brain injury" means damage to the brain or the coverings of the brain which produces an altered mental state and results in a decrease in cognitive, behavioral, emotional, or physical functioning. The term does not include an insult of a degenerative or congenital nature.

Lead Agency to Provide Services

Section 50-06.4-02 provides DHHS "shall act as lead agency in the state for the purpose of coordinating services to individuals with brain injury. At least annually the department shall call a joint meeting of the adjutant general, the department of veterans' affairs, and the superintendent of public instruction to discuss the provision of services to individuals with brain injury. State agencies and political subdivisions shall cooperate with the department to permit the department to efficiently coordinate services to individuals with brain injury while avoiding duplication of services."

Prevention and Identification

Section 50-06.4-05 directs DHHS to "provide outreach services and conduct public awareness efforts regarding the prevention and identification of brain injury."

Services and Support

Section 50-06.4-07 provides DHHS "shall contract with public or private entities for the provision of informal supports to individuals with brain injury. As used in this section, 'informal supports' includes information sharing and referral services, peer mentoring, training, facilitation of support groups, public awareness efforts, and individual and programmatic advocacy efforts."

Section 50-06.4-08 provides DHHS "shall provide or contract for the provision of social and recreational services, including day supports, to individuals with brain injury, if the department determines that available vocational rehabilitative services do not meet the individuals' needs."

Section 50-06.4-09 provides DHHS "shall provide or contract for the provision of increased and specialized vocational rehabilitation and consultation to individuals with brain injury who receive case management for personal care services. Services under this section include extended support for individuals at risk of losing their employment upon exhausting their vocational services."

Brain Injury Advisory Council

Membership

Section 50-06.4-10, which was most recently amended by House Bill No. 1418 (2023), establishes the membership of the Brain Injury Advisory Council. The section provides:

"1. The governor is to appoint at least eight, but no more than thirteen, voting members which include:
   a. At least two brain injury survivors, nominated by the council;
   b. At least two family members of a brain injury survivor, nominated by the council;
   c. At least one service provider who provides services to brain injury survivors, nominated by the council, who may be a brain injury survivor or a family member of a brain injury survivor;
   d. An individual representing the Indian affairs commission, nominated by the Indian affairs commission, who may be a brain injury survivor or a family member of a brain injury survivor; and
   e. At least one individual representing a religious, charitable, fraternal, civic, educational, legal, veteran, welfare, or professional group or organization, who may be a brain injury survivor or a family member of a brain injury survivor.
2. The speaker of the house of representatives shall appoint one member of the house of representatives and the president pro tempore of the senate shall appoint one member of the senate to serve as members of the council.
3. Each of the following entities shall appoint a representative to serve as a nonvoting member of the council who serves at the pleasure of the appointing entity:
   a. The protection and advocacy project, one representative;
   b. Department, one individual representing injury prevention, one representative representing emergency medical services and trauma, one individual representing behavioral health, one individual representing Medicaid, one individual representing the adult and aging population, and one individual representing vocational rehabilitation; and
   c. Department of public instruction, one representative.
4. The governor may appoint an individual representing stroke health and an individual representing a brain injury advocacy organization to serve as nonvoting members of the council who serve at the pleasure of the governor."

Duties

The Brain Injury Advisory Council is to advise DHHS and participate in activities to improve the quality of life for an individual with brain injury and the individual's family through brain injury awareness, prevention, research, education, collaboration, support services, and advocacy. DHHS is to contract with a private, nonprofit agency that does not provide brain injury services, to facilitate and provide support services to the council.

Testimony Received and Committee Considerations

Members of the North Dakota Brain Injury Network provided the following information:

- Brain injuries can be caused by external events including a fall or vehicle accident or by an internal event such as a stroke or aneurysm.
- Each year an estimated 5,500 individuals in the state sustain traumatic brain injury.
- More than 13,000 individuals in the state have a long-term disability from a traumatic brain injury.

Members of the North Dakota Brain Injury Network provided updates regarding a study of brain injury services being conducted by the National Association of State Head Injury Administrators. They reported the following findings:

Area	Findings
Care and treatment	• Gaps exist in the continuum of care from acute care to community-based services and within other settings such as substance use programs and criminal legal systems. • While there is infrastructure for brain injury resource facilitation, expansion of this support is needed. • Specifically identified underserved areas include the American Indian population, those engaged in the criminal legal system, and individuals from rural areas of the state.
Providers	• North Dakota has a lack of brain injury informed providers as well as a lack of providers.
Education	• There is a lack of awareness of brain injury and eligibility requirements for special education services. • Supports are lacking for people with brain injury transitioning from high school to work or a different educational setting.

Area	Findings
Behavioral health	• Options for behavioral health supports are lacking for people with brain injury. • Housing issues exist, including availability of and affordability of housing.
Advocacy	• Gaps exist in self-advocacy and caregiver advocacy skill training.

Committee Recommendations

The committee makes no recommendations regarding the study of brain injury services.

FENTANYL AWARENESS CAMPAIGN REPORT

Section 19-03.1-23.5 provides reporting requirements related to fentanyl awareness. The section requires DHHS to provide a report to the Legislative Management and the Governor by November 1 of each year summarizing the number of deaths that occurred in the state caused by or related to fentanyl consumption during the preceding calendar year, including the county in which the deaths occurred and the age and gender of the deceased individuals. The department also is to make the data reported available to the public by:

- Making the information easily accessible on the department's government website;
- Publishing easily comprehensible printed materials on fentanyl awareness, information, and resources;
- Placing visible billboards in high-traffic areas to inform the public of the dangers of fentanyl; and
- Developing a media and social media campaign to expand statewide awareness of fentanyl drug deaths and the fentanyl overdose epidemic occurring within the state.

Opioid Settlement Fund

The opioid settlement fund was created in House Bill No. 1447 (2023). Money recovered by the state as a result of opioid litigation must be deposited in the fund. The State Investment Board is to invest money in the fund, and income earned on the money in the fund must be credited to the fund. Money in the fund may be used in compliance with any court-ordered restrictions and as authorized by legislative appropriation; however, legislative appropriations from the fund may not exceed $8 million in a biennium.

Opioid Settlement Advisory Committee

The Opioid Settlement Advisory Committee, which also was created in House Bill No. 1447 (2023), is composed of the following members:

- One member of the North Dakota Association of Counties appointed by the Chairman of the Legislative Management, who shall serve a term of 2 years.
- One member of the North Dakota League of Cities appointed by the Chairman of the Legislative Management, who shall serve a term of 2 years.
- One member of the North Dakota State Association of City and County Health Officials appointed by the Chairman of the Legislative Management, who shall serve a term of 2 years.
- One member who represents the Highway Patrol appointed by the Highway Patrol Superintendent, who shall serve a term of 2 years.
- The Executive Director of the Department of Health and Human Services Division of Behavioral Health.
- The managing Director of the Office of Recovery Reinvented.
- One member appointed by the Governor who shall serve as a nonvoting member and as the presiding officer of the committee, who shall serve a term of 2 years.

The committee is to make recommendations to DHHS regarding the spending of legislative appropriations for remediation or abatement of the state opioid crisis. In developing the recommendations, the committee is to receive input from political subdivisions and the public.

Report

Representatives of DHHS reported:

- The drug overdose death rate has increased from 0.98 per 10,000 individuals in 2019 to 1.44 per 10,000 individuals in 2022.
- On average, two residents of the state die each week from an unintentional drug overdose.
- Most individuals who have an unintentional overdose are under the age of 39.

- The Opioid Settlement Advisory Committee has hosted listening sessions to gather public input regarding efforts to reduce opioid misuse.
- There are four licensed opioid treatment programs in the state with 1,125 active participants.
- From October 2023 through July 2024 a total of 25,800 naloxone kits were distributed with 707 known successful overdose reversals using naloxone.