Prepared by the North Dakota Legislative Council staff for the Health and Human Services Committee
November 2009

UNMET HEALTH CARE NEEDS STUDY - BACKGROUND MEMORANDUM

The 2009 Legislative Assembly approved House Bill No. 1391 (Appendix A) providing for a Legislative Management study of the unmet health care needs in the state. The study must include an assessment of the needs of underinsured and uninsured individuals and families, consider federal health care initiatives, and include consultation with the State Department of Health, the Insurance Commissioner, and the Department of Human Services. Testimony regarding the bill indicated the study should identify the reasons individuals are uninsured or underinsured and how to make health insurance more accessible to North Dakota residents.

PREVIOUS STUDIES

The **1999-2000 Budget Committee on Health Care** studied the various challenges facing the delivery of health care in the state, including changes in hospital reimbursements, technological innovations, and the regionalization of services. The committee also studied health care access, quality, and cost to determine essential health care services, critical providers, and access sites and to identify geographic, demographic, and economic issues relating to health care. The committee also received a report from the Health Council on public input regarding health care needs and services. The committee received information regarding provider reimbursements, home health care, nurse practitioners, critical access hospitals, access and utilization of preventative care services, health insurance, and other health care issues.

The committee asked the Legislative Council chairman to request that the Department of Human Services discontinue the development of a prospective payment system for outpatient Medicaid services using ambulatory patient groups, that all changes to the current payment system for outpatient Medicaid services be delayed to allow the development and testing of ambulatory payment classifications by the Health Care Financing Administration, and that the department consider using ambulatory payment classifications in the development of a prospective payment system for outpatient Medicaid services in North Dakota. The chairman of the Legislative Council sent a letter to the Department of Human Services regarding the committee's request.

The **2001-02 Budget Committee on Health Care** studied the coordination of the medical assistance and children's health insurance programs, including the Department of Human Services' development of a single application form for both programs, whether the children's health insurance program should be administered by the state or the counties, the effects of eliminating the asset eligibility requirement for the medical assistance program, the standardization of the definition of "income" for all programs administered by the Department of Human Services, and the feasibility and desirability of seeking a federal waiver to allow the children's health insurance program to provide coverage for a family through an employer-based insurance policy if an employer-based insurance policy is more cost-effective than the traditional plan coverage for the children. The committee received information regarding enrollment statistics and costs of North Dakota's children's health insurance program. Authorized by the 1999 Legislative Assembly, the program, named Healthy Steps, provides health insurance coverage to low-income children not eligible for Medicaid.

The committee made no recommendation as a result of its study of the coordination of the Healthy Steps and Medicaid programs.

The **2005-06 Budget Committee on Health Care** studied the need for a comprehensive long-range study of the state's current and future health care needs in order to address issues, such as the aging population of the state, the phenomenon of health care cost-shifting to the private sector, the trend of uncompensated health care services, shortages in the number of health care professionals, duplication of technology and facilities, and any other factors that might affect the health care system in North Dakota in the year 2020. The committee received information regarding a Health Resources and Services Administration federal grant program to study health insurance coverage in North Dakota. Research related to the study, which was completed in August 2006, was conducted by the University of North Dakota School of Medicine and Health Sciences Center for Rural Health. Based on the study findings, approximately 8.2 percent of North Dakota's population did not have health insurance, compared to the national rate of 15.2 percent. The North Dakota percentage represented about 52,000 residents of the state, including approximately 11,000 children under age 18. American Indians were far more likely to be uninsured (31.7 percent) compared to Caucasians (6.9 percent). Residents living in a household with an annual income of less than $10,000 are twice as likely to be uninsured (16.6 percent), compared to the overall state rate of 8.2 percent.

The committee recommended that the 60th Legislative Assembly consider providing for a comprehensive Legislative Council study of health care and health insurance during the 2007-08 interim and that a consultant be hired, as necessary, to assist with the study. The committee did not propose

legislation to provide for the study and the 2007 Legislative Assembly did not approve a study.

The **2005-06 Budget Committee on Human Services** studied state programs providing services to children with special health care needs to determine whether the programs are effective in meeting these special health care needs, whether there are gaps in the state system for providing services for children with special needs, and whether there are significant unmet special health care needs of children which should be addressed. The committee also received a report from the Department of Human Services regarding the status of the Medicaid waiver to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care, the number of applications the department received for the in-home services, and the status of the program's appropriation. The committee received information regarding the annual budget for the children's special health services program and learned the program serves approximately 1,400 children per year. The committee received information on the various options under federal law for states to provide Medicaid services to children with special health care needs.

The committee made no recommendations regarding the children with special health care needs study.

The **2007-08 Human Services Committee** received reports from the Department of Human Services regarding the statistics and costs associated with Healthy Steps and the status of medical assistance recipients' access to dental services. The committee learned the Legislative Assembly made a number of adjustments to the funding for Healthy Steps, including adding funding to allow income eligibility disregards similar to the Medicaid program. In addition, House Bill No. 1463 (2007) increased Medicaid eligibility for children under 19 years of age from 100 percent to 133 percent of poverty and the Healthy Steps net income eligibility from 140 percent to 150 percent of poverty. The Medicaid eligibility change was contingent on approval by the federal government. The federal government approved the expansion of the Healthy Steps eligibility level to 150 percent of poverty in June 2008 and the change become effective October 1, 2008. However, the federal government did not approve the increase in Medicaid eligibility. The committee learned through August 2008, 4,038 children were enrolled in the Healthy Steps program. As a result of the program eligibility expansion to include children up to 150 percent of the federal poverty level, an additional 800 children are expected to qualify for the program during the first 12 months under the new eligibility requirements.

2009 LEGISLATION

Critical access hospitals - Section 14 of House Bill No. 1012 provides $400,000 of one-time funding from the general fund to the Department of Human Services for a supplemental payment to eligible critical access hospitals. A critical access hospital is eligible for a payment under this section only if its percentage of medical payments exceeds 25 percent of its total annual revenue in its most recent audited financial statements and is located in a city with a population that does not exceed 1,450.

Children's health insurance program - Section 23 of House Bill No. 1012 amended North Dakota Century Code (NDCC) Section 50-29-04 to provide a net income eligibility limit of up to 160 percent of the federal poverty level, rather than 150 percent.

Comprehensive Health Association of North Dakota (CHAND) - Senate Bill No. 2214 amended NDCC Section 26.1-08-12 to provide CHAND coverage effective on the date the lifetime maximum occurred on previous coverage if eligible individuals apply for CHAND coverage within 90 days after the date the lifetime maximum occurred.

MEDICAID

Medicaid was authorized in 1966 for the purpose of strengthening and extending the provision of medical care and services to people whose resources are insufficient to meet their medical-related costs. Corrective, preventative, and rehabilitative medical services are provided with the objective of retaining or attaining capability for independence, self-care, and support. These services are extended to elderly, blind, or disabled individuals as well as to caretaker relatives and children to the age of 21. Funding is shared by federal, state, and county governments, with eligibility determined at the county level.

North Dakota currently receives a federal funding match of 67.49 percent. The state share of Medicaid costs is 32.51 percent. The federal medical assistance percentage changes annually on October 1 and is based on the relative relationship between each state's per capita personal income and the national average per capita personal income over the most recent three calendar years.

For those that qualify, Medicaid may provide aid to those without health insurance or for those whose health insurance does not cover all of their needs. Medicaid pays for health services for qualifying families with children and people who are pregnant, elderly, or disabled. According to the Department of Human Services, over 40,000 people in North Dakota are receiving this health coverage.

Medicaid pays for the following **services**, however, copayments may apply for certain recipients for the services with an asterisk (*).

- Doctor visits/services*.
- Hospital services (limits apply)*.
- Laboratory and x-ray.
- Dental care (limits apply)*.
- Eye care (limits apply)*.
- Prescribed drugs.

- Family planning services provided by a doctor or family planning center.
- Prosthetics (artificial limbs), braces, and related equipment.
- Home health care.
- Chiropractic services (limits apply)*.
- Out-of-state services if preapproved by North Dakota Medicaid.
- Physical and occupational therapy*.
- Podiatric services (foot specialist)*.
- Long-term care services (may range from home and community-based services, such as homemaker, personal care, adult day care, chore services, or respite care, to a nursing facility).
- Group home care for people with developmental disabilities.
- Transportation (within limits).
- Screening, diagnosis, and treatment for children younger than age 21 through the Health Tracks program (formerly early periodic screening, diagnosis, and treatment).
- Orthodontic services may be provided if referred by the Health Tracks program.
- Emergency room care is covered if the attending physician determines it is an emergency medical condition. Nonemergency conditions must be treated during physician or clinic office hours.
- Medicare Part A and Part B premiums, coinsurance, or deductibles.

Copayments do not apply if the recipient is:

- Younger than age 21;
- Living in a nursing facility, swing bed, intermediate care facility for the mentally retarded, the State Hospital, or the Anne Carlsen Center for Children;
- Pregnant;
- Needs emergency services; or
- Receives family planning services.

To **qualify for Medicaid coverage**, an individual must be a state resident and must qualify financially. The individual must also be:

- Pregnant;
- Blind, disabled, or age 65 or older;
- A member of a family with children;
- Age 21 or younger or age 65 or older and receiving services at the State Hospital;
- Younger than age 21 and living independently or in a licensed foster home;
- An adopted child younger than 21 who has special health needs or meets other criteria; or
- A woman screened through the State Department of Health's Women's Way program who needs treatment for breast or cervical cancer.

Medicaid eligibility is based on income and, in some cases, assets. Some assets are not counted when determining eligibility. Assets that do not affect eligibility include the individual's primary home, personal belongings and clothing, household goods and furniture, one car, certain burial plans, and property that produces earned income (such as a farm or business). There is no asset limit for children, families, or pregnant women in the children and families coverage group or women who apply under the Women's Way program. Generally, a person who is blind, disabled, or age 65 or older can have up to $3,000 in countable assets, such as savings accounts, checking accounts, stocks, bonds, or other types of assets, and up to $6,000 in funeral expense contracts, prepayments, or deposits to qualify for Medicaid. The asset limit for couples is $6,000. Giving property or income away or selling property for less than its value within five years of applying for Medicaid may affect a person's eligibility for long-term care services such as nursing care services, home and community-based services, or swing-bed care in a hospital.

Anyone applying for Medicaid coverage must, by law, provide that person's Social Security number or proof that the person has applied for a number. This applies for each person in the household who is seeking Medicaid coverage. Medicaid cannot cover a person until a Social Security number is provided or has been applied for with the exception of newborns who may be eligible for 60 days from birth. The Social Security number is used to verify income, assets, and eligibility.

If approved for Medicaid, the Medicaid program may pay for health services provided up to three months before the month the county social service office received the signed application. Medicaid may use the estate recovery process on estates of people who were age 55 or older when they received Medicaid coverage. When those individuals die, Medicaid may recover the cost of benefits paid out, but only if there is not a surviving spouse or a child who is younger than 21 or is blind or permanently and totally disabled.

HEALTHY STEPS

The state children's health insurance program, also known as Healthy Steps, provides premium-free health coverage to uninsured children in qualifying families. It is intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage, but not enough to afford private insurance.

There are no monthly premiums in the Healthy Steps program, but most families are required to pay copayments for emergency room visits, hospitalization, and prescriptions. Copayments are not required for American Indian children.

Healthy Steps-covered services include inpatient hospital stay, medical and surgical services, outpatient hospital and clinic services, mental health and substance abuse services, prescription medications, routine preventative services such as well baby checkups and immunizations, dental and vision services, and prenatal services.

The 2009 Legislative Assembly increased eligibility for the program from 150 percent to 160 percent of

the federal poverty level instead of an increase to 200 percent of the federal poverty level as provided for in the executive budget. To qualify, a family's **net income** (after deducting child care costs and payroll taxes such as Social Security tax, Medicare tax, and income tax) must be greater than the Medicaid level, but cannot exceed 160 percent of the federal poverty level. The following is a summary of the maximum net income allowed based on 160 percent of the federal poverty level:

Family Size	Net Income After Deducting Child Care Costs and Payroll Taxes	
	Annual	Monthly
1	$17,328	$1,444
2	$23,312	$1,943
3	$29,296	$2,442
4	$35,280	$2,940

When a child is enrolled in Healthy Steps, he or she is enrolled for a 12-month period or until the end of the month in which the child turns 19 years old. Household income is annually.

The 2009 Legislative Assembly provided funding of $21.6 million, of which $5.6 million is from the general fund, for the Healthy Steps program.

CARING FOR CHILDREN

Caring for Children is a benefit program for eligible North Dakota children up to age 19 who do not qualify for Medicaid or Healthy Steps and have no other insurance. Benefits include primary and preventative medical and dental care. Caring for Children is a program of the North Dakota Caring Foundation, Inc., a nonprofit 501(c)(3) foundation established by Blue Cross Blue Shield of North Dakota in 1989. Blue Cross Blue Shield provides Caring for Children administrative services as an in-kind donation. Primary and preventative care includes:

- Routine and primary medical care.
- Limited inpatient (hospital) care.
- Immunizations.
- Mental health and substance abuse.
- Primary and preventative dental care.

Children are eligible for Caring for Children if they are:

1. A resident of the state of North Dakota;
2. A United States citizen or legal permanent resident;
3. Under 19 years of age;
4. Unmarried and whose guardians have an annual income of between 151 percent and 200 percent of the federal poverty level;
5. Without comprehensive medical coverage through Medicaid, Healthy Steps, or a private insurance carrier; and
6. Within household income guidelines of the North Dakota Caring Foundation, Inc.

Caring For Children Income Guidelines Effective Through March 31, 2010		
Eligible Individuals	Children (Birth up to Age 19)	Children (Birth up to Age 19)
April 1, 2009, to March 31, 2010, Household Size	Minimum - 151% of the Federal Poverty Level Monthly Net Income[1]	Maximum - 200% of the Federal Poverty Level Monthly Net Income[1]
1	$1,355	$1,805
2	$1,823	$2,429
3	$2,290	$3,052
4	$2,758	$3,675
5	$3,225	$4,299
6	$3,693	$4,922
7	$4,160	$5,545
8	$4,628	$6,169
9	$5,095	$6,792
10	$5,563	$7,415

[1]Deductions may apply for payments made out of the household such as child support, child care, and health care.

Individuals who have voluntarily cancelled medical insurance are not eligible to participate in Caring for Children for six months after the date the coverage was canceled.

HEALTH TRACKS

North Dakota Health Tracks (formerly early periodic screening diagnosis and treatment) is a preventative health program that is free for children aged 0 to 21 who are eligible for Medicaid. Health Tracks pays for screenings, diagnosis, and treatment services to help prevent health problems from occurring or help keep health problems from becoming worse. Health Tracks also pays for orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling, and other important health services.

COMPREHENSIVE HEALTH ASSOCIATION OF NORTH DAKOTA

The Comprehensive Health Association of North Dakota was created by the North Dakota Legislative Assembly in 1981 and became operational in 1982. Its initial purpose was to provide comprehensive health insurance benefits to residents of the state who have been denied health insurance or have been given restricted coverage or excessive health premiums because of high-risk health problems.

The 1997 Legislative Assembly modified CHAND to comply with federal law--the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Now, in addition to its traditional role of insuring the uninsurable population of North Dakota, CHAND issues, on a guaranteed basis, its major medical contracts to certain people eligible under HIPAA.

To be eligible for coverage under HIPAA, an applicant must:

1. Be a resident of North Dakota.
2. Meet the federally defined eligibility guidelines that require the applicant to:
   a. Have had 18 months of qualifying previous coverage, the most recent of which is coverage under a group health benefit plan, government plan, Medicaid, church plan, or health insurance coverage offered

in connection with any of these plans (verification of previous health insurance is required);
   b. Have applied for coverage within 63 days of the termination of the qualifying previous coverage;
   c. Not be eligible for coverage under Medicare or a group health benefit plan;
   d. Not have any other health insurance coverage;
   e. Not have the most recent qualifying previous coverage terminated for nonpayment of premiums or fraud; and
   f. Have declined continuation coverage offered by the employer or have elected continuation coverage through the employer and have exhausted the coverage extension (verification of previous health insurance is required).
3. Not be enrolled in health benefits with the state of North Dakota's medical assistance program (Medicaid).
4. Not have health insurance premiums paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or employer.

The Health Care Financing Administration has certified that CHAND meets the federal requirement of HIPAA.

The 2003 Legislative Assembly added language that allows CHAND to be utilized as an insurance vehicle for North Dakota residents that are eligible for assistance with health premiums through the federal Trade Adjustment Assistance Reform Act of 2002 (TAARA) or Pension Benefit Guaranty Corporation assistance. These individuals are able to receive reimbursement of 65 percent of their health premiums on a monthly pretax basis or through a special federal income tax credit at yearend.

To be eligible for coverage under TAARA, an applicant must:

1. Be a resident of North Dakota.
2. Be eligible for federal trade adjustment assistance and a health insurance tax credit or for Pension Benefit Guaranty Corporation assistance as provided by TAARA.
3. Have had three or more months of previous health insurance coverage.
4. Have applied for coverage within 63 days of termination of previous coverage.
5. Not be imprisoned under federal, state, or local authority.
6. Not be enrolled in health benefits with the state of North Dakota's medical assistance program (Medicaid).
7. Not have been insured through CHAND during the last 12 months.
8. Not have health insurance coverage through any of the following:
   a. The applicant's or the applicant's spouse's employer plan that provides for employer contribution of 50 percent or more of the cost of coverage for the applicant, the applicant's spouse, and eligible dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan;
   b. Healthy Steps;
   c. A government plan;
   d. Chapter 55 of the United States Code Title 10 relating to armed forces medical and dental care; or
   e. Medicare.
9. Be eligible for health insurance coverage through one of the following but electing to obtain coverage as a trade adjustment assistance/Pension Benefit Guaranty Corporation-qualified individual:
   a. Continuation coverage;
   b. An employer plan in which the employer contribution is less than 50 percent; or
   c. An individual marketplace plan, including continuation or guaranteed issue.

With passage of the 1997 and 2003 legislation, the program now offers coverage to four types of eligible residents: standard, HIPAA, TAARA, and age 65 and over or disabled. The standard, HIPAA, and TAARA comprehensive major medical policies offer $500 and $1,000 deductibles with or without a chiropractic endorsement, each with a $3,000 out-of-pocket maximum. The age 65 and over or disabled policy offers a basic or standard supplemental plan. The maximum lifetime benefit of a CHAND comprehensive plan is $1 million which closely resembles major medical contracts sold by commercial health insurance carriers doing business in North Dakota. An individual is not eligible for CHAND if:

- Eligible for the state's medical assistance program;
- CHAND has paid $1 million in benefits on behalf of the individual;
- The individual previously terminated CHAND coverage within the last 12 months (not applicable to HIPAA individuals);
- The individual is an inmate or a resident of a public institution (not applicable to HIPAA individuals); or
- The individual's premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or the individual's employer (not applicable to TAARA individuals).

The program has a 180-day waiting period for preexisting conditions, which is waived if the applicant is:

- Receiving nonelective treatment or procedures and has lost dependent status under a parent's or guardian's policy that has been in effect for

the 12-month period immediately preceding application;

- Receiving nonelective procedures for a congenital or genetic disease;
- A HIPAA enrollee;
- A standard enrollee eligible for a reduction in waiting period days by the aggregate period of qualifying previous coverage provided application has been made within 63 days of termination of the qualifying coverage; or
- A TAARA enrollee.

The Comprehensive Health Association of North Dakota is composed of those accident and health insurance companies selling a minimum of $100,000 of health insurance annually in North Dakota. The original legislation was intended to create a self-supporting pool funded by participants' premiums. In 1983, however, the original legislation was amended to limit the premiums charged by CHAND to 135 percent of the average amount charged for standard coverage in the state. Rates for the CHAND program are reviewed annually. Losses in excess of the premium are paid by participating companies in the form of assessments. Companies are allowed a credit against the premium tax they would otherwise pay to the state in an amount equal to the assessment paid to CHAND. The CHAND Board of Directors consists of eight members, including the Insurance Commissioner, the State Health Officer, the director of the Office of Management and Budget, one senator (Senator Judy Lee), one representative (Representative Nancy Johnson), and one representative from each of the three insurers with the highest premium volumes, (currently, Blue Cross Blue Shield of North Dakota, Medica Health Plans, and Assurant). North Dakota is one of 32 states with traditional risk pools such as CHAND and was one of the first three in the country. Other states have opted for special alternative health insurance programs or require guaranteed issue in the individual market. Blue Cross Blue Shield of North Dakota is currently under contract with the state of North Dakota to administer the day-to-day business of CHAND. Premiums are collected and claims are paid through the Blue Cross Blue Shield Fargo office. The Comprehensive Health Association of North Dakota has grown from 78 insured in December 1982 to about 1,678 insured as of June 30, 2006. Of these, 411 individuals were covered under an age 65 and over or disabled supplement contract. Enrollment in the program has leveled off and the expectation is that it will remain between 1,200 and 1,800 participants.

ASSESSMENT OF HEALTH CARE IN NORTH DAKOTA

In November 2008, the Dakota Medical Foundation and the University of North Dakota School of Medicine and Health Sciences Center for Rural Health formed a partnership to conduct an assessment of health and health care in North Dakota. The study was conducted from December 2008 to February 2009. Issued in May 2009, the report, entitled *An Environmental Scan of Health and Health Care in North Dakota*: *Establishing the Baselines for Positive Health Transformation*, provides an overview of selected health and health care issues in North Dakota The report addresses environment, health-related behaviors, and chronic diseases. In addition, the report provides information regarding health care infrastructure, quality, access, and financing of health services. A copy of the executive summary of the report is provided as Appendix B.

STUDY PLAN

The committee may wish to proceed with this study as follows:

1. Gather and review information on programs available to individuals unable to acquire private health care coverage and the current status of those programs and unmet health care needs in the state.
2. Gather and review information on the number of uninsured and underinsured individuals in North Dakota.
3. Gather and review information on the needs of underinsured and uninsured individuals and families.
4. Gather and review information on federal health care initiatives, including how they will affect current programs.
5. Receive information from interested persons, including AARP, the North Dakota Healthcare Association, the North Dakota Medical Association, the North Dakota County Social Service Directors Association, the North Dakota Health Information Technology Office and advisory committee, the University of North Dakota School of Medicine and Health Sciences Rural Opportunities in Medicine, and Blue Cross Blue Shield of North Dakota, regarding the availability and affordability of health care services in the state, the role of telemedicine in providing health care services in the state, and efforts to bring health care to rural North Dakota.
6. Receive information from the Department of Human Services, the State Department of Health, and the Insurance Commissioner regarding programs and services available to underinsured and uninsured individuals and families in the state.
7. Receive information from the University of North Dakota School of Medicine and Health Sciences Center for Rural Health regarding its recent report on health and health care in North Dakota as it relates to the needs of underinsured and uninsured individuals and families in the state.

8. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
9. Prepare a final report for submission to the Legislative Management.

ATTACH:2

Sixty-first Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 6, 2009

HOUSE BILL NO. 1391
(Representatives Kasper, Dosch, Headland, Ruby)
(Senator Klein)

AN ACT to provide for a legislative council study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE COUNCIL STUDY - HEALTH INSURANCE NEEDS - REPORT. During the 2009-10 interim, the legislative council shall conduct a comprehensive study of unmet health care needs in the state. The study must include an assessment of the needs of underinsured and uninsured individuals and families. In addition to considering the federal health care initiatives, the study must include consultation with the state department of health, the insurance commissioner, and the department of human services. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

Executive Summary

This report provides an overview of selected health and health care issues in North Dakota. Where available, measures specific to these issues are identified and North Dakota's performance on the measures is presented. Performance measures are important because they can be used to track trends in health and health care and to evaluate the effect of programs and initiatives. Additionally, examples of programs designed to address the selected health and health care issues are briefly summarized. This summary can serve as a resource for individuals and organizations interested in capitalizing on current health care activities in the state.

Information presented in this report is drawn from a range of sources including reports, websites, data sources, queries of agencies and organizations, and perspectives of a small set of key stakeholders. The Environmental Scan was conducted from December 2008 to mid-February 2009. The following is a synopsis of the information and perspectives presented in the report.

Health and Health Care in North Dakota: The Environmental Context

North Dakota's health and health care are affected by demographic, social, and economic factors. Population characteristics, including age composition, income levels, educational achievement, and changes in the number and distribution of people, affect health status. North Dakota, with urban clusters and a small, geographically rural and frontier population, faces a unique set of challenges and opportunities that confront the population's health, the types of health care services needed, and the financial viability of health care systems. The state's growing elderly population (46 of the state's 53 counties will have 22% or more of their population age 65 or older by 2020), expanding minority population (13.8% increase from 2000 to 2006; primarily occurring on Indian reservations), and the significant decline in the number of youth, aged 19 and younger (a 15% decline from 2000 to 2005), have direct implications for health care services. Around 12% of the state's population lives in poverty. Rural poverty is greater than urban, and rural income is, on average, lower than urban income levels. Poverty and income levels have direct implications for public programs, such as Medicaid, and the financial status of providers. Related to these are the higher levels of unemployment on the state's reservations. The health system is also affected when patient volumes change, causing financial concerns for many types of providers (e.g., decreases in elective procedures due to economic concerns, depopulation of some rural communities). Dynamics external to the state, including a deepening recession and a compromised national economy, have implications for both the health of the state's population and the economic health of providers that serve the state's population. As strategies to strengthen both health and health care in North Dakota are contemplated, meaningful efforts by stakeholders need to consider these broader characteristics. Additionally, efforts directed toward improving health and health care should be accompanied by close attention to performance on key measures in order to ascertain effectiveness of strategies and programs.

The Health Status of North Dakota

Health-related behaviors and other selected topic areas. North Dakota has achieved improvement in many health related behaviors, particularly the 19.5% decrease in youth smoking since 1999 and seat belt use at an all time high at 82% in 2007. Still, serious behavioral health challenges exist in the state, including a large overweight and obese adult population (64.9%), 21% of the adult population that smokes, and the second-highest rate (23.2%) in the nation in binge drinking. Decreases in these and other health-compromising behaviors are important as they have significant consequences for individual health, morbidity, mortality, and health care service utilization and related costs.

Experience shows that improving the health of communities through behavioral change is possible. However, change is often slow and involves commitment of human and other resources and community engagement. In order to reduce the future burden caused by negative health behaviors, where they exist, proven strategies should be considered and supported and, where such evidence is lacking, pilot projects should be developed and evaluated related to selected priorities. As with all areas selected for action, measures need to be adopted and applied in order to track progress at individual, community, and state levels, with adjustments made as needed. A set of health-related measures, rankings, rates, and comparisons associated with the state of North Dakota can be found in Volume II of the report.

Chronic diseases. Cardiovascular disease and cancer are clearly the leading causes of death in North Dakota, comprising 49% of all mortality. Regarding morbidity, there are several chronic conditions that adversely affect the health, well-being, and quality of life among North Dakotans: arthritis (26.9% prevalence among ND adults), disability (15.0%), asthma (7.7%), and diabetes (6.3%). North Dakota's performance on measures of chronic disease-related conditions tends to be better than national averages and most states, with the following exceptions: prostate cancer (9th highest of 46); colorectal cancer in men (15th highest of 46); stroke mortality (16th highest of 51); and prostate cancer mortality (17th highest of 46).

To address the state's health issues related to chronic disease, private and public sector investments in prevention-related activity can be instituted or strengthened or both, from education (e.g., proper diet and exercise) to wellness activities to providing incentives for healthful decisions. For example, some evidence-based strategies to improve health and prevent disease in communities can be found at http://www.thecommunityguide.org/index.html. To ensure data-driven decision-making, rather than just anecdotally driven decisions, and to maximize the efficient use of resources directed to high need health care problems, it is also important to close information gaps regarding chronic diseases and other common health problems in North Dakota.

The Status of North Dakota Health Care

Both strengths and challenges are associated with health care infrastructure in North Dakota. Public and private insurers tend to obtain health care services at low cost compared to other states. However, an imbalance between reimbursement levels and cost of providing care is driving some health care facilities to decrease services (e.g., home health, public health, Emergency Medical Services [EMS]) or at least consider cut-backs in infrastructure, salaries, and staffing. Negative operating margins are increasing the financial fragility of health care in the state. Additionally, limited access to health services is a challenge due to geographic distances, health professions shortage areas, and, for uninsured and underinsured, lack of adequate insurance coverage. In terms of quality, the state does very well in the aggregate on a number of quality measures. However, performance of small rural hospitals is frequently not reflected in quality data, and consequently, significantly less is known about quality in some of these facilities (i.e., whether it is better, worse, or the same as urban North Dakota hospitals). Regarding quality, while there are clear areas in need of quality improvement, performance measurement indicates that hospitals and nursing homes frequently meet and exceed national averages in both individual rural and urban facilities. A challenge is to eliminate the variation in quality and aim for performance that is consistently high on quality measures, regardless of where in North Dakota health care consumers seek care.

Infrastructure. North Dakota hospitals (6 urban and 39 in rural areas) tend to be highly integrated with other services (e.g., medical clinics). This integration can help position North Dakota to respond to new emerging care models such as medical homes and new payment strategies (e.g., episodic payment) currently being contemplated by both national-level public and private payers. Supply of health workforce, aging physical plants, reimbursement levels, demographic changes, and the prospect of increasing numbers of uninsured associated with deteriorating economic conditions are systemic issues facing health care facilities, both urban and rural alike. Public health (28 single and multi-county local public health units), home health (35 entities), and EMS (at least one ambulance service in each county) are, in many cases, challenged to continue their current activities across their current service areas. Decreasing or delaying access to these services can have direct implications for patient outcomes. Regionalization of more health care infrastructure, network building, and use of telemedicine can help to strengthen health care services and extend these services to hard-to-reach populations. For example, the state's trauma system needs further development of a system-wide approach to performance improvement, development of a formal critical care transportation network (with combined ground and air medical resources), and improved access to data to better inform and respond to injuries.

Slightly different problems affect special services, including oral health care and pharmacy services. Access to dental services is hampered by both workforce shortages and payment systems such as Medicaid. Financial vulnerability is illustrated by the fact that less than one-fourth of North Dakota dentists in 2005 accepted all Medicaid patients and one-third limited the number of Medicaid patients. Access to dental health services for patients on Medicaid and those unable to pay out-of-pocket for services is essential. The availability of oral health education and preventive services delivered using new approaches merits consideration. The transformation of a number of rural pharmacies to "telepharmacies" utilizing pharmacists and pharmacy technicians as well as technology is a successful example of addressing some workforce shortage dimensions. Harnessing technology, developing networks, and deploying different levels of health care providers can ensure access to high quality services ranging from home health to mental health.

Quality. Based on available data, the state's health care systems perform better than many others in providing consumers with relatively high-quality and efficient health care services (the 13th highest performance average in the country, according to the Commonwealth Fund, 2007). Nevertheless, within the state, there are clear opportunities for quality improvement. Enhanced networking and communication, and sustaining and strengthening primary care are pivotal to quality health care. Additionally, encouraging consumers to access publicly available information about care quality can assist them in making informed decisions when choosing health care facilities.

From the vast number of measures that currently exist to monitor quality, a subset could be selected that is most relevant for North Dakota. As with most topics discussed in this report, there are improvement opportunities and relevant measures. A multi-stakeholder approach (private and public entities) can be important to selecting priorities and related measures that can track progress in specific areas. In terms of quality, annual reviews could be conducted to track how well the state's facilities do compared to each other and to other states in order to identify areas and approaches to improve care. Some collaborative efforts are currently underway in the state, but they are fragmented.

Access. Access to health services in North Dakota is influenced by geographic, economic, and other factors. Payment methods, workforce supply, and even area population fluctuations influence the availability of services. In rural states, the availability and location of services are important considerations, and potential and actual decreases in service areas or closures of health facilities (e.g., dental clinics and home health agencies) should be carefully evaluated to determine their effect on local communities. While community leaders engage in discussions about facility closures, no mechanism is used to engage a larger group of experts to consider, along with the community, potential strategies to continue obtaining services using new approaches.

Health Insurance: With an uninsured prevalence of 8.2% (approximately 51,900 people), North Dakota has variability across geography, race, income, and other factors in rates of insurance. Particularly with current economic conditions, ongoing assessment of insurance coverage across vulnerable groups is important, in addition to ensuring comprehensive dissemination of information regarding the availability of public programs. The lack of health insurance has a profound impact on individuals and families as it seriously limits access to health care, contributes to poorer health outcomes, increases inefficiencies within the health care system (e.g., seeking care in more expensive service centers such as the emergency room), and reallocates financial responsibility for the payment of care in inequitable ways. Public policy can be used as a means to strategically address specific problem areas, targeting resources to better meet standards of efficiency and equity. In North Dakota, specific groups that are more likely to be uninsured include the following: rural residents, young adults, American Indians, and workers of small employers.

Workforce: Given the demographic trajectory of North Dakota as well as anecdotal and quantifiable information about the health care workforce, the state clearly faces emerging challenges to ensure access to an adequate workforce, ranging from primary care shortages to shortages of dentists. Total reported health care provider vacancies in North Dakota indicate a need for 271 physicians, nurses, clinical laboratory science practioners, mental health professionals, and X-ray technicians. A comprehensive approach to generate interest and support for greater production, recruitment, and retention of health care providers require assessing successful strategies targeting all components of the workforce pipeline and replicating them where possible. This effort could involve a range of stakeholders from high school teachers to health care employers to policymakers.

Utilization of Services: Health care costs are directly tied to utilization of health services. Data indicate that the state has higher admission rates (9th highest in the nation; 137 admissions per 1,000 population in 2005) and longer lengths of stay than the national average (8.8 days compared to the U.S. average of 5.7 days in 2005). Research that explores the reasons behind utilization patterns can inform strategies to further decrease health care spending in the state.

Financing health services. Health expenditures in North Dakota increased annually by 6% from 1991 to 2004. In 2004, the most recent year for state–national comparisons, the per capita health spending level in North Dakota was $5,808, whereas the U.S. per capita rate was $5,283. North Dakotans spend more on hospital care, drugs, other medical nondurables, and nursing home care than found for the overall United States. However, North Dakotans spend less on physician and other professional services, home health care, and other personal health care compared to the U.S. population.

The current economic recession is likely to affect public and private payers of health services as well as health care systems, businesses, and families. Projections for a growing population of older citizens in North Dakota indicate that Medicare will remain a dominant payer, and consequently, the state's health care providers will be particularly sensitive to the adequacy of the program's reimbursement rates. With very low or negative margins across many North Dakota hospitals and other signs of health system vulnerability, such as contraction of home health services, measures of viability and access are important to monitor. Data that tracks access measures at local and regional levels as well as factors influencing the viability of the local health care sector (e.g., local and regional population characteristics) can facilitate planning for strengthening or redeploying health care services to minimize access-to-care problems. Local communities and health facility leaders can embark on community assessments to ensure an alignment between what community members want in terms of health care and what providers offer.

Improving the Health Status of North Dakota: Key Stakeholder Perspectives

In their interviews, key stakeholders recommend investment in prevention-related activity. Similarly, a majority of recently surveyed North Dakotans indicate strong interest in wellness programs. The sensitivity of chronic illness to healthful behaviors and the interest on the part of the public and opinion leaders in addressing health promotion and disease prevention strategies speak to the importance of and opportunity for offering related programs, education, and services, including fitness activity, encouraging more work and community-based wellness programs and incentives, and encouraging businesses and insurers to leverage health coverage and activities that include wellness benefits.

Summary

Health and health care in North Dakota present an array of challenges and opportunities. To achieve improvement in both areas, collaborative efforts are important and there is significant potential to extend their reach and expand their focus. Collaboration and broad-based approaches to addressing health care cost, access, and quality issues are supported by key stakeholders. Networking can offer opportunities to build new linkages and capitalize on sharing resources and expertise.

Improving the health status of the population includes engaging communities in the process of enacting new policies (e.g., school-based) and programs that are, when possible, evidence based and transportable to other communities. Involvement of representatives from a wide range of public and private (health and non-health), local to statewide entities that are open to new ideas is essential. When instituting new initiatives, the most effective initiatives (from either within or external to the state) should be selected, promoted, and replicated, and related progress tracked. Current and future health and health care plans should be assessed against clearly defined and North Dakota relevant performance measures.