Engrossed Senate Bill No. 2179

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Before: House Human Services Committee
Representative Robin Weisz, Chairman

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Chairman Weisz and members of the House Human Services Committee, my name is Jon Godfread and I am North Dakota's Insurance Commissioner. I appear before you today in support of the study that currently makes up Engrossed SB 2179.

I was opposed to the original intent of the bill and I remain opposed to telehealth payment parity. As this has been amended into a study, we are supportive of the study but would offer the committee one thought to add to the study. Payment parity essentially sets a floor for payment schedules, it would effectively increase the reimbursements from our carriers to our providers based on this law and remove the inherent efficiencies that can be found using technology. This legislature has discussed the issue of caps, reimbursement caps, perhaps setting a reimbursement cap of 200% of Medicare for all medical services, that is a ceiling and our providers are adamantly opposed to those price ceilings. So if we are going to study the impact of a payment floor, I think it's only fair to study the impact of a payment ceiling. I think through the study, neither option will be shown to be a good idea. But, if we are going to look, let's make sure we are not just looking at increasing reimbursements, perhaps the increase in reimbursements can be made up by instituting a payment cap in other areas.

For those of you who are unaware, we recently completed a study at the direction of the 66th Legislative Assembly to look at health care cost within the state of North Dakota. If you have not had a chance to review that study, I would encourage you to look at this comprehensive study.

The study highlighted a number of important issues in the North Dakota Hospital market including:

- **Hospital Utilization.** North Dakota has seen an increase in hospital usage. North Dakota Hospitals are seeing longer hospital stays than the national average, and utilization is growing faster in North Dakota than most of the rest of the country.
- **Hospital Expenses.** Hospital Expenses are ranking higher than the national average (usually top 5) and continuing to grow at higher than national average rates (also top 5 rankings)
- **Hospital Operating Revenue.** North Dakota hospitals are seeing high revenue and high revenue growth.
- **Medicare Revenue.** Medicare revenue is also very high and growing for North Dakota Hospitals

- **Hospital Reimbursement.** Private hospital reimbursement based on Medicare rates grew from 170 percent of Medicare in 2010 to over 200 percent of Medicare in 2018.
- **Acute Care vs. Critical Access Hospitals.** Critical access hospitals appear to be reimbursed at a much lower rate (149% of Medicare) than acute care hospital (211% of Medicare)
- **Premiums.** North Dakota premiums are largely average as compared to national average.
- **Claims.** Insurer claims are averaging slightly higher than the national average and are growing at higher than the national average.
- **Administrative costs.** Insurer administrative expenses remain low, but the administrative expenses are growing at a very fast rate.

The data clearly shows a number of warning signs in the North Dakota market. For the Hospitals, Commercial, Medicare, and Medicaid revue appears to be showing sizable growth. Hospitals appear to be offering more services and longer stays. In health insurance, administrative costs have grown substantially – though still generally at or below the national average. These trends bear watching.

I stand before you in opposition to the original intent of Senate Bill 2179 because it would utilize telehealth to perpetuate many of these issues, despite the potential role that telehealth could play in addressing these issues.

Telemedicine depends on technological innovation that should reduce the cost structure of providing care. If so, those providers should compete on price. Markets can adapt to serve customers' needs under a certain burden of regulation of safety and standardization, but it is very hard for markets to adapt efficiently to regulated prices. If providers are not competing on price, they are not properly competing at all.

We will be unable to realize the cost-cutting and health care delivery modernization with a regulated price floor, the key to successful adoption of telemedicine is to restore a greater share of patient's health spending to their direct control, not impose price regulation.

Imposing payment parity removes any incentive for the health care system to innovate and examine their health care delivery model. I understand the desire for payment parity, but given our most recent and exhaustive health care cost study, it has never been more clear to me that it's our delivery model that needs modernizing and mandating price parity for services that are inherently different does not seem logical and would only further kick the health care delivery discussion down the road.

Some innovator is going to figure this out, some hospital system will figure this out, with payment parity in place it removes the incentive from solving this delivery model problem and only further exacerbates the issues we have with the cost of health care. Telemedicine should lead to a reduction of health care costs for our consumers. For those reason we oppose the original intent of this bill.

If structured properly, telehealth services may increase access to needed care while also controlling costs. In a rural state like North Dakota, telehealth can provide the opportunity to access medical specialists without time consuming travel. For those with mental health issues, telehealth can be an important lifeline. With more frequent visits and early interventions available, telehealth can help avoid costly delays in care (such as undiagnosed conditions that become worse with time) and, in situations where an in-person visit may not be required, virtual encounters may be priced at a lower rate than in-person care (if there is no state mandate requiring payment parity).

For North Dakota, proper utilization of telehealth could have an overwhelming impact considering the 6,000+ percent increase in telehealth visits in the midwestern U.S. between April 2019 and April 2020.Consumers are increasingly becoming accustomed to telehealth.

There are several issues that states should examine to create a permanent infrastructure that supports widespread adoption and utilization of telehealth:

Licensure: Many states have significant licensing barriers that control providers' ability to use telehealth. Provider licensing boards should be encouraged to embrace telehealth, allowing providers to establish relationships remotely as long as necessary conditions are met and the standard of care is upheld. State boards should consider the interstate compacts available, as well as other flexibilities that may enhance providers ability to practice telemedicine.

Payment: Rather than considering legislation that would stifle competition, establish guidance through which insurers and providers set appropriate rates based on the delivery of service. Perhaps looking at payments based on access to care, or the needs of community. Rural parity would be an area we would be interested in further study, but blanket parity does not seem to make logical sense.

Software: Consumers and medical providers should be allowed to agree on the use of any software service. States shouldn't pick winner and losers.

Scope of practice: The pandemic has allowed many new types of service to be delivered by telehealth. States should look closely at their telehealth practice requirements and permanently modernize the statutes.

Lastly, I have proposed an amendment for the committee's consideration, which addresses some of the areas I outlined above. On March 20th, 2020, we worked with the Governor's Office on Executive Order 2020-05.1, primarily on the telehealth services portion. The goal of this executive order was meant to relax some of the requirements around telehealth to ensure our consumers would have access to their health care providers during the pandemic without having to go into the hospital. This was critically important for those seeking and providing mental and behavioral health services. This has been a very successful expansion of telehealth and our consumers and providers have all adapted to the utilization of telehealth. Essentially, this executive order was a success and it did what we thought it would do.

The amendment you have before would essentially update the law to reflect some of the changes that were made through the executive order. Without this amendment, when the executive order

is taken down or the emergency is declared over, these relaxations of current law will end. This would have an impact on our providers.

We did not bring this amendment to the Senate Committee, as I was surprised that it was not offered by the provider community. Rather than seeking the meaningful regulatory relief that was offered in the executive order and also offered in this amendment, SB 2179 as introduced was primarily a payment reimbursement bill. The amendment we are offering, I think, is a reasonable compromise to ensure our consumers still have access, our providers are able to utilize the new technology deployed during the pandemic and the market can respond in terms of payment schedules.

Thank you, Chairman Weisz and members of the committee, as I mentioned we support the study language currently contained in the bill and would offer the inclusion of studying the payment caps for health services, as well as the amendment we have just offered that would essentially update our current laws, to reflect what happened during the pandemic. We, however, remain opposed to blanket payment parity for telehealth services. Happy to answer any questions you might have.