March 9, 2021

Senate Human Services Committee HB 1465

CHAIRMAN LEE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm submitting testimony on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP. AHIP opposes this bill and asks for a no vote.

While the intent of this bill may seem straightforward, these mandates end up having the opposite effect. They actually impede the quality-of-care patients receive, increase costs, and harm market competition.

By forcing health plans to accept any provider who states willingness to meet contract terms, these "any willing provider (AWP) " requirements undermine efforts to provide access to doctors and hospitals with a track record of providing the highest quality and most cost-efficient care to patients.

Requiring health plans to contract with any willing provider reduces their ability to obtain price discounts and conduct effective utilization review due to interference with standard contracting principles. In the past, the Federal Trade Commission (FTC) has expressed concerns about AWP laws because they make it more difficult for health plans to negotiate discounts from providers, which can lead to higher premiums for consumers. The provision of high quality care that is also cost-effective should be everyone's focus.

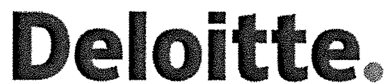
In other words, **it just plain will cost more**. The national DeLoitte Consulting Firm, which prepared the Feb. 3, 2021, Actuarial Review for this bill (attached to my testimony) makes this clear. "The discounts agreed to

by health systems (e.g. average discount is usually 30-40% for hospital care) would likely be lost almost **immediately causing a significant increase in health insurance premium for all covered people in North Dakota."** (emphasis supplied)

AWP mandates destroy incentives for improved competition, giving health care providers rights not given to other service providers. For example: schools are not required to hire "any willing teacher;" airlines are not required to hire "any willing pilot;" physician group practices are not required to admit "any willing doctor;" and hospitals are not obliged to accept any willing physician, nurse, or other health care professional. This creates a presumed "right to employment or contract" -- a right that does not exist in any other industry or even elsewhere within the health care sector.

Health plans are motivated to assure that they have enough qualified providers in their networks so patients have adequate access to a broad array of providers. Given the market forces already in place as well as the cost and quality implications to consumers and the adverse effect on market competition of this proposal, we respectfully request a no vote on HB 1465.

Thank you for your time and consideration. The DeLoitte actuarial review follows on the next two pages.



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Memo

Date: February 3, 2021

To: Rep. Mike Lefor, Chairman
Employee Benefits Programs Committee

From: Josh Johnson and Jon Herschbach, Deloitte Consulting LLP

Subject: **ACTUARIAL REVIEW OF PROPOSED BILL 21.00988.01000 (HB1465)**

The following summarizes our review of the proposed legislation as it relates to actuarial impact to the uniform group insurance program administered by NDPERS.

OVERVIEW OF PROPOSED BILL

The proposed bill would create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

The bill would require all health insurance policies within the state to include all licensed health care providers as participating providers (or in-network providers). The bill goes on to restrict all health insurance policies from preventing an individual covered under an insurance policy from selecting a health care provider of the individual's choice to furnish the health care services offered under any policy, provided that the health care provider is a participating provider.

The bill specifically cites the following provider types as included under the legislation: Podiatrists, Chiropractors, Registered Nurses, Advanced Practice Registered Nurses, Optometrists, Pharmacists, Physicians and Surgeons, Physical Therapists, Dentists, Psychologists, Audiologists and Speech-Language Pathologists, Occupational Therapists, Social Workers, Respiratory Care Practitioners, Dieticians and Nutritionists, Addiction Counselors, Counselors, Naturopaths, and Genetic Counselors.

ESTIMATED ACTUARIAL IMPACTS

Most health plans in today's market create provider networks for various reasons. Members participating in health insurance policies and programs are incented or sometimes required to utilize in-network providers for services depending on the specifics of the policy elected by the individual for coverage.

One of the primary reasons that health plans and administrators develop provider networks is to reduce the cost of care. The plans negotiate with providers, provider groups and health systems to lower the scheduled reimbursements for care in exchange

for being included in the health plan's network. The health plan, and subsequently those that purchase coverage from the plan, pay lower premium and/or lower cost-sharing at the point of care as a result. The providers agree to lower reimbursements in order to gain additional patients.

Removing the ability for health plans to exclude any providers from their networks removes all incentives and reasons for any providers to agree to any reduction in reimbursements. The discounts agreed to by health systems (e.g. average discount is usually 30-40% for hospital care) would likely be lost almost immediately causing a significant increase in health insurance premium for all covered people in North Dakota.

TECHNICAL COMMENTS

There are other requirements that providers must meet in order to be included in the networks managed by health plans that are beneficial to covered individuals.

Health plans conduct detailed provider credentialing on an ongoing basis to ensure providers haven't had their licenses suspended, have no substance abuse issues, will agree to have their financial practices audited, maintain adequate malpractice insurance, are not currently restricted from receiving payments from any state or Federal program, including, but not limited to Medicare or Medicaid, don't have mental health issues that would impact adequacy of care, etc.

Providers are also typically required to agree to not balance-bill any patients for any amounts above the agreed to in-network reimbursements. Without this provision, people can receive unexpected bills from their providers for amounts not covered by insurance.

People can ensure freedom of choice in health care services by electing health insurance programs that include coverage from out-of-network providers. Most PPO programs allow members to decide whether to elect in-network or out-of-network providers for their care with different cost-sharing requirements based on the type of providers they elect.