Testimony

House Bill 1465

Human Services Committee

Senator Judy Lee, Chairman

Senator Kristin Roers, Vice Chairman

3/9/2021

Madam Chairman Lee, Madam Vice Chairman Roers, and distinguished members of the Human Services Committee, my name is Duncan Ackerman. I am native to North Dakota, born and raised in Minot, and I am an Orthopedic Surgeon who has practiced in North Dakota since completing my residency and fellowship training at The Mayo Clinic in 2009. My family proudly chose to return to our great state to practice medicine and have had the distinct opportunity to care for our friends and neighbors over the past 12 years.

I am also an owner / partner of The Bone & Joint Center, established in 1973, which is an Orthopedic Surgery clinic that provides a broad scope of musculoskeletal care. There are nine partners in the practice with eight of the partners hailing from North Dakota. The places we grew up include Hillsboro, Bowman, Kenmare, Lansford, Minot, Turtle Lake, and Bismarck. We employ Fourteen Advanced Practice Providers, Five physical therapists, and three certified hand therapists. We employ a total of 107 people including our providers. We have permanent offices in Bismarck, Dickinson, and Minot along with outreach locations in Garrison, Turtle Lake, Hazen, Beulah, Williston, Hettinger, Linton, and Wishek.

Today I represent North Dakotans for Open Access Healthcare because HB 1465 expands patients' abilities to choose their own health care provider.

Several years ago, a Vertically Integrated Health System moved into our state. Since that time, we have noticed an increasing number of patients that are voicing their concerns about their health plan. Our

independent colleagues in other parts of the state have heard similar concerns. We have heard from a broad spectrum of providers, including physical therapists, occupational therapists, and numerous medical specialties including pediatrics, family practice, internal medicine, ophthalmologists, general surgery, orthopedic surgery, neurosurgery, and retinal specialists. The message is patients are losing their choice to see the providers they want to see due to specific narrow network health plans. These plans continue to be more common.

So how does this look in real life? My family is a hockey and dance family. Four hockey players and one dancer with kids ranging from 12 – 20 years old. These communities are relatively small knit personal communities. So, after being in Bismarck over the past 12 years phone calls for injured kids, parents, family members are a common occurrence. It used to be a player or family member would get hurt, they would call, and I would see them often the next day. Twelve years ago, this was not a problem, it was easy to get the patient to the office, evaluated, and treated in a seamless fashion. Now, its more frequent that I must call the patient back and tell them I cannot see them because their health plan does not allow them to see me at The Bone & Joint Center. Loss of choice due to the health plan. We might blame the patient but often they have not even been educated on what services are provided and what providers they can see.

It is also not uncommon to hear from, friends or family, that they recently had to travel longer distances than needed to receive specialty care. Specifically, for me, I hear about upper extremity injuries, as I specialize in hand, elbow, and shoulder conditions. In passing, a I hear a person had a particular problem that could have been treated locally but the health system either passed on that option to avoid sending the patient to a competitor or that person's health plan handcuffed them to travel to distant health care facility to receive the care needed.

Think about this, we are a rural state, our specialists typically reside and practice in our population centers. Think about the inconvenience to a family with limited resources; the time off work, the travel, the risk of winter weather this time of year, the food and lodging, and personal inconvenience for any other family member that may need to make that trip with the patient. This could all potentially be avoided if the patient had a choice.

Let us discuss Vertically Integrated Health Systems or I will call it a Vertically Integrated Network (VIN). What does this mean, and I do apologize if you are versed in VINs but allow me to offer you a different perspective. The local VIN owns the health care plan (insurance), owns the physicians, the hospital and the entire support system of supporting providers such as physical and occupational therapists. This structure creates a funnel for capturing patients. The purpose of this funnel is to get people to buy a health plan that funnels the insured (patient), to the physicians it owns, who then perform tests, procedures, and admit patients to the health care system (hospital). In this funnel, the patient's choice, and voice are limited as it is trapped inside the walls of the funnel.

We have recently seen the rise of less expensive plans. These plans offer a limited network of providers, not based on a providers' willingness to participate, but because of the insurer's limited selection of providers, most often those affiliated with their organization. Even if an outside provider is willing meet the terms of the plan, access is denied. In this model, the actual patient has very little choice. Most often, the health care plan was selected by an employer based on cost or by the patient's family income. The employee had little input into the decision, nor did the plan holder's spouse or child. As a result, competition in these healthcare plans is based purely on cost. There is little incentive to compete on quality of care, or even the experience of the patient's interaction with the health care system.

Why is it that the cheaper health plans trap patients within confines of the funnel? Why is it some patients can leave the confines of the funnel, but they are penalized for doing so, as an out-of-network cost? Why

is it that patients who pay for more expensive plans do not have to reside within the funnel, and have a voice and the choice to choose their health care provider? Does this seem fair? Why should a patient who has limited economic means, or is simply locked into their employer's plan, have any different choice than a patient who is well to do and can afford the best plan available? In 2014, a similar billed was introduced in South Dakota, Dave Hewett, president of the South Dakota Association of Healthcare Organizations spoke in opposition and was quoted, "Those who want more choice and are willing to pay more for it have that option." That comment should resonate….and so should the following question……what if you are unable afford to pay more for that choice? HB 1465 answers that question for you.

Now let us add some data on VINs. On June 21, 2019 The California Health Care Foundation published an article entitled "Is Vertical Integration Bad for Health Care Consumers?" it was stated "vertical integration can easily enable market power to use in an anticompetitive manner, allowing the merged firm to use its new structure to the disadvantage of others, and in some cases, to the harm of consumers. In that article it also noted a Study from Stanford University that reported "hospital ownership of physician practices leads to higher prices and higher levels of hospital spending." It also noted that vertical integration increased hospital's bargaining power with the insurers, meaning the dominant hospitals can demand higher costs and limit competition. Other studies in the same article noted that physician groups owned by large hospital systems were more than 50% more expensive than those owned exclusively by physicians. The Health Affairs study concluded that recent increases in vertical integration in California were associated with higher prices for primary care, more expensive specialty care, and higher health insurance premiums. Not to belabor the negative but "Physician-Hospital integration did not improve the quality of care for the overwhelming majority of quality measures." The data from the North Dakota Legislative Management Interim Healthcare Study confirms much of the above information.

In South Dakota, Measure 17 guaranteed the same provider choice to patients as HB 1465 and it passed 62 percent to 38 percent. Those who opposed Measure 17 in South Dakota had several claims. The main point was that South Dakota Measure 17 would increase cost. I am a bit confused by the claim, because I believe the insurance companies control the fee schedule for services, the cost. If the insurers and providers cannot come to agreeable terms, then there is no change in service. The provider can exercise that choice. HB 1465 is not "any willing provider" at "any willing price," just because a provider can see a patient covered under a particular plan does not mean that provider can charge whatever price he/she wants to charge. Again, the fee schedule is ultimately set by the insurance carrier.

If we review the Kaiser Family Foundation information for 2019, the data shows NO correlation between increased premium cost and states with any willing provider legislation. There are 27 states with some form of any willing provider law. Twelve states have similar language to HB 1465 that gives patients the freedom of choice to choose their health care provider. If we assume any willing provider laws increase cost, including premiums, then we should see any willing provider laws in states that have the highest premiums. This is not the case at all. Among the states with the highest premium costs, there are ZERO states that have any willing provider laws. If anything, any willing provider laws seem to enhance price competition. In fact, 50% of states with the lowest premiums have any willing provider laws similar to HB 1465.

*Kaiser Family Foundation - Average Annual Single Premium Per Enrolled Employee for Employer Based Health Insurance https://www.kff.org/other/state-indicator/single-coverage

HB 1465 not only gives patients a choice but also provides opportunities for financial savings to both insurers and patients. Most clinics attached to hospitals can bill patients more with what is called Provider-Based billing. If a patient is seen in a clinic attached to the hospital, the health system can charge the patient a facility fee AND a professional fee for seeing a provider. Simply put, the cost goes up. Now,

if that same patient is seen in an independent clinic, such as my own, my practice can only charge for the professional fee. The independent clinic needs to cover that over head with just that professional fee. We need to be more cost effective, more cost conscious, just to keep our doors open. Those stuck in the funnel would save money for the health plan just by being able to see someone in an independent clinic. This cost structure is better for the patient and for an insurer looking at only its costs, and not its affiliated health system benefits.

In addition, the Centers for Medicare and Medicaid Services (CMS) has developed an online tool (https://www.medicare.gov/procedure-price-lookup/cost) for patients to research the difference in cost when comparing surgery at an Ambulatory Surgery Center (ASC) versus a Hospital Outpatient Department (HOPD), the funnel. Using national data, an ASC is paid about 56.39% of the HOPD rate for the exact same procedure, saving the Medicare and Medicaid systems more than 43 percent on average. I am an upper extremity specialist, so rotator cuff shoulder surgery is a common procedure in my practice. Utilizing CMS's tool, we can look at and compare the cost difference for arthroscopic rotator cuff repair in an ASC vs. HOPD. In an ASC, the total cost for arthroscopic rotator cuff repair is $3,918, Medicare pays $3,134, the patients responsibility is $783. In comparison, the total cost for the same procedure at a HOPD is $7,096, Medicare pays $5,677, the patient's responsibility is $1,419. The savings are clear, procedures performed in an ASC cost the payor and consumer less than if performed in a HOPD, whether insured by Medicare or private health plans, often with substantial deductibles and co-pays. With demonstrable savings to patients and employers, why not allow provider choice?

The national trend for payment to providers is contracting through value. Value is defined as quality divided by cost. I personally encourage this model. The Bone & Joint Center and our affiliated hospital system have been tracking quality for the better part of a decade. We participated in CMS's Comprehensive Care for Joint Replacement (CJR). We developed a gain-sharing agreement with our affiliate to share savings on total knee replacements. The agreement was based on defined quality metrics

and cost savings. Collaboration with willing partners (choice) led to continued improvement in quality and significant cost saving (value). This same improvement was seen with the privately insured patients. Value comes with innovation, collaboration, independent thinking, and patient choice which creates inherent competition. I believe most of us would agree healthy competition is beneficial for patients. Let the patient choose who they feel is the best.

Freedom of choice for health care services, HB 1465 does not stand alone. According to The National Conference of State Legislatures there are 27 states that have similar "any willing provider" laws, including North Dakota. NDCC, 26.1-36-12.2 (1989) which applies to pharmacies and pharmacists. Again, our neighbors in South Dakota passed Initiated Measure 17 in 2014 with a healthy yes vote of 61.81%, which accomplished the same goal and intent of HB 1465.

The primary goal of HB 1465 is to provide patients with the freedom to select and access their health care provider of choice, providing equality of access without penalty or additional cost. There is no data to suggest this bill will drive up health care costs. This bill is not "any willing provider" at "any willing price," and the insurance providers still control the provider fee schedule. It is not a mandate and HB 1465 increases competition for patient costs and quality of care. HB 1465 was given a 13-1 DO PASS vote in the House Human Services Committee and passed the full House 70-22. I ask this committee to use your voice to tell your constituents, our patients, that you support their choice and pass HB 1465. Madam Chairman Lee, Madam Vice Chairman Roers, and distinguished members of the Health Services Committee, I ask you to vote your conscience and vote DO PASS on HB 1465. I would be happy to take any questions at this time.

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