

Response to 1416 Amendment

We respect the insurance department and the healthcare providers on the committee. Unfortunately, their positive experiences with their own vertically integrated networks are not always the norm. This amendment, while well-intentioned, changes nothing. An out-of-network request process is already implemented and delays care. Putting it into code will do nothing for patients who want to receive out-of-network care for availability, treatment paths, or specialties. Companies that provide both healthcare and insurance will continue to steer patients to their doctors, and narrow-network insured patients will continue to be forced to have these paths decided for them.

Upon receiving the amendment, we realized that it does nothing to solve the issue at hand. Patients are already able to request to see out-of-network providers. Putting this into code does not change the fact that narrow-network healthcare and insurance providers will be able to deny patients the ability to see an out-of-network provider, steering patients to the doctors that they employ, forcing profits into their own pockets. This amendment takes away any ability to get a second opinion for treatment, as narrow-network reviewers will say that they already provide the treatment, and deny any second opinion. For example, there is a 15-year-old in Bismarck who got a concussion. They saw healthcare providers in their narrow network with no positive results on treatment. They found a physician with a different subspecialty in neurology on the East Coast, who undid everything healthcare providers did here. Two weeks later, he is already showing signs of improvement. His family paid cash for the treatment.

The narrative surrounding this bill has been confused. This bill does not impact Medica or Blue Cross Blue Shield as they do not provide healthcare services in addition to their insurance services. They do not force patients to their employed doctors, because they do not provide healthcare. They are simply insurers. The intent of this bill is to stop this steering for companies that provide both healthcare and narrow-network insurance plans.

In our experience, narrow-network reviewers have denied every request as long as they are able to provide the same medical specialty. The companies that steer patients to their own doctors do not consider availability of doctors, treatment paths, and sub-specialties. They simply check the box that says they “have a medical specialty of ‘x’” without taking into account what the individual patient needs or potential sub-specialties in the field of medicine. If we had a special treatment with a 95% cure rate of cancer in our clinics, narrow-network reviewers would deny patients coverage because they “provide oncology treatment.” Fulfillment of medical needs extends beyond healthcare provider type. It is known throughout the profession that doctors in narrow-network plans are reprimanded for even referring patients to out-of-network providers. We will be the first to tell you that our care may not be for everybody, but it is our duty to send the patient to the best care possible. This does not happen with companies that provide healthcare and narrow-network insurance plans.

The word “disingenuous” was used in this morning’s committee work. To say that this amendment was “facilitated” is disingenuous. We received word that there was an amendment to the bill in a meeting at 2 PM yesterday. The amendment was not given to us until this morning’s committee work. We were not a part of the conversation in drafting the amendment. This is not facilitating a compromise.

-ND for Open Access Healthcare