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Title.02000

Prepared by the Legislative Council staff for Representative Hendrix
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Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1594

Introduced by

Representatives Hendrix, Conmy, Frelich, Kasper, Koppelman, Rohr, Nelson, D. Johnston

Senators Mathern, Weston, Magrum

A BILL for an Act to create and enact a new section to chapter 23-12 ~~and~~of the North Dakota Century Code, relating to medical costs transparency for health care facilities; to amend and reenact section 26.1-47-02 of the North Dakota Century Code, relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 23-12 of the North Dakota Century Code is created and enacted as follows:

Medical costs transparency for health care facilities - Penalty.

1. For purposes of this section:
   a. "Health care facility" means those facilities licensed under chapter 23-16, except for nursing facilities and basic care facilities.
   b. "Items and services" means any item or service, including individual items or service packages, which could be provided by a health care facility to a patient in connection with an inpatient admission or an outpatient visit for which the health care facility has established a standard charge, including supplies and procedures, room and board, use of facility, and services performed by health care facility staff.
2. Health care facilities shall:
   a. Make available to the public a list of standard charges for:

(1) Items and services; and

(2) Shoppable services, as outlined in title 45, Code of Federal Regulations, part 180, subpart B.

b. Produce the list in a format consistent with rules adopted by the centers for Medicare and Medicaid services.

3. ~~The department of health and human services may refuse to issue, refuse to renew, revoke, or suspend the license of a health care facility that violates this section.~~

~~4.~~ A health care facility that violates a provision of this section may be assessed a civil penalty ~~not to exceed one thousand dollars for each violation and for each day the~~by the insurance commissioner. A penalty for a violation by a health care facility with more than twenty-five beds must be ten dollars per bed per day, not to exceed five thousand five hundred dollars per day, for each day the violation continues. A penalty for a violation by any other health care facility may be up to one hundred dollars per day for each day the violation continues, plus interest and any costs incurred by the ~~department~~insurance commissioner to enforce this penalty. The civil penalty may be imposed by a court in a civil proceeding or by the ~~department~~insurance commissioner through an administrative hearing under chapter 28-32. The assessment of a civil penalty does not preclude the imposition of other sanctions authorized by rules adopted under this ~~chapter~~title.

SECTION 2. AMENDMENT. Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-02. Preferred provider arrangements.

Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:

a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to review and control the utilization of health care

services and establish a procedure for determining whether health care services rendered are medically necessary.

c. Include mechanisms which are designed to preserve the quality of health care.

d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

e. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.

f. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.

g. Provide that either party terminating the contract without cause provide the other party at least sixty days' advance written notice of the termination.

h. Provide that if a preferred provider has failed to comply with federal transparency rules and regulations, the health care insurer may terminate the contract without consent.

2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

3. Preferred provider arrangements may not restrict a health care provider from entering into preferred provider arrangements or other arrangements with other health care insurers.

4. A health care insurer must file all its preferred provider arrangements with the commissioner within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the

commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.

5. A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.

6. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health care insurer which jeopardizes patient health or welfare.

7. A preferred provider arrangement must include an attestation from the preferred provider that the preferred provider is in compliance with federal transparency rules and regulations.