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DESCRIPTION

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2001 HOUSE HUMAN SERVICES

HB 1314

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1314

House Human Services Committee

☐ Conference Committee

Hearing Date January 24, 2001

Tape Number	Side A	Side B	Meter #
Tape 2	X		0 to 2070
Committee Clerk Signature	Connie Easton		

Minutes:

Chairman Price, Vice Chairman Devlin, Rep. Dosch, Rep. Galvin, Rep. Klein, Rep. Pollert, Rep. Porter, Rep. Tieman, Rep. Weiler, Rep. Weisz, Rep. Cleary, Rep. Metcalf, Rep. Niemeier, Rep. Sandvig.

Chairman Price: Open hearing on HB 1314.

Rep. Porter: Presented Bill. (See written testimony.) I am going to testify as a nonparticipating provider and as a consumer of Blue Cross/Blue Shield. We cannot accept what BCBS is paying for ambulance transport. Poor reimbursements is why ambulance services fail in North Dakota. The Bill would protect every insurance and health care consumer in North Dakota. This bill provides the basic protection that every consumer of health insurance deserves.

Chairman Price: Did you say that the constituents are asking you why they pay nonparticipating providers less?

Rep. Porter: Yes.

Chairman Price: But yet on page 2 you said "in a non emergency run. Is that what you said?

Rep. Porter: Yes.

Chairman Price: But yet you're saying that they only have one rate on page 2. I'm confused.

Rep. Porter: In an emergency situation - I'm not sure what it is right now. Last year it was $400, was the advanced life support emergency reimbursement. It was the advanced life support non-emergency reimbursement - it was every advanced life support reimbursement. In those situations if you are a participating provider, then you are allowed to bill the patient 20% co-pay and the insurance company would pay 80% of that $400. As a nonparticipating provider emergency situation, the patient would be mailed a check. Non-emergency situation there is a penalty imposed because the consumer used a nonparticipating provider.

Chairman Price: Just to get an idea, do you know how many runs Metro made in the year 2000?

Rep. Porter: I do, but I don't have them right now. We do all of the funeral home removals, MRI transfers - that is all grouped into the category. It would have been somewhere around 5,300.

Chairman Price: How about the year 1999?

Rep. Porter: That one I don't know.

Mike Hall: Executive Director of Fargo Ambulance Service. I concur with Rep. Porter, however, we are a participating provider of BCBS. The reason we are is that we try to meet the needs of our customers. A year and a half ago BCBS changed their policy on how they dealt with nonparticipating providers. If we were not participating, they would send a check to the consumer, and since we filed the claim they would reimburse the consumer for the cost of the ambulance service. Another service we provide to our consumer, if they would have a

supplemental insurance, we actually went through and filed that for the consumer to help them out so that they could get reimbursed. What we encountered was that the consumer was getting the checks and they didn't understand what the checks were for, and they would spend it on something else. We had no idea whether they got the checks or whether the claim was accepted or denied by BCBS, and hence we would ask them for money and they wouldn't have it and we would expect the money. We got a lot of negative feedback from our customers. How can we do it better. We discussed with BCBS and they had no alternatives for us, so we discussed with our board and we decided that to meet the needs of our customer and help them with the claim process we would become Participating. We discounted those rates and we were able to absorb that in our operations, but what is happening now is the reimbursement with Medicare is going to be dramatically reduced and it is going to be hard for any ambulance service in the country to survive. We need to figure out ways we can work with the providers.

Chairman Price: Are you a community ambulance service or privately owned?

Mike Hall: We're privately owned.

Chairman Price: Has the ambulance group across the state gotten together and talked to the Congressional Delegation about the Medicare reimbursement?

Mike Hall: Yes. We belong to a national association and lobbied pretty heavily for it.

Chairman Price: What has your response been?

Mike Hall: There was some legislation in the last Congress that didn't make it through, and so far we don't have any hope right now. There is nothing pending on it. There has been a little bit of relief for the very rural providers.

Rep. Niemeier: What is involved in being a participating provider? Are there fees, regulations, restrictions?

Mike Hall: What the participation agreement says is: we will bill for certain rates for certain codes and accept on 80% of that, and then we'll bill a co-pay to that customer of 20%, we will submit the claims to them and in turn they will provide the information to us. Meaning whether the claim was paid, how much they paid on the claim so we're sharing information.

Rep. Porter: When you first became a participating provider, did you have non-emergency rates that were less than the fee schedule so that you moved up to cost shift the difference between emergency and non-emergency transportation?

Mike Hall: No we didn't.

Chairman Price: When new Medicare rates come out you're going to go non-par, are you talking with the Blues?

Mike Hall: Yes, with the Blues. We're not participating with Medicare right now. It is mandatory with the new fee schedule for Medicare.

Mike Hamerlik: Blue Cross/Blue Shield of North Dakota. (See written testimony.) This bill changes only a few words in North Dakota's Preferred Provider Organization (PPO) statute, but the changes are significant. This bill virtually eliminates all incentives to control costs through enrollment in a PPO. This bill will raise health care costs for North Dakota through increased out-of-pocket costs and increased health insurance premiums. We ask that you help try to contain the increases in medical costs by giving a DO NOT PASS recommendation to HB 1314.

Rep. Porter: On the last two areas on page 3 - on the top one you say the incentive is to join because of additional payments and direct reimbursement, yet on the bottom one you say that having more nonparticipating providers you'll end up paying more for the service. Wouldn't it be the reverse if you have more participating providers - Blue Cross/Blue Shield actually pays more than if you have less. The increase would come from the out-of-pocket, not from BCBS.

Mike Hamerlik: The 20% deduction wouldn't be taken, we would pay it back. I am stressed by Medicare squeezing out North Dakota providers. It is a horrible problem and we have to fix it, but having Blue Cross pay it is not the solution.

Chairman Price: Close hearing on HB 1314.

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1314 b

House Human Services Committee

☐ Conference Committee

Hearing Date 1-24-01

Tape Number	Side A	Side B	Meter #
3	xx		4300--4450.
Committee Clerk Signature	Connie Easton		

Minutes:Chair Price : Take up HB1314.

Rep. Porter : After the hearing on this, Mr. St.Aubourn and I got together and have come together to say we don't think this bill is necessary at this time. **I move a DO NOT PASS.**

Rep. Pollert **: I second.**

VOTE: 12 YES and 0 NO with 2 absent. PASSED. Rep. Weiler will carry the bill.

Date: 1-24-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1314

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass

Motion Made By Rep. Porter Seconded By Rep. Pollert

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairman	✓		Audrey Cleary	✓	
William Devlin - V. Chairman	✓		Ralph Metcalf	✓	
Mark Dosch	✓		Carol Niemeier	✓	
Pat Galvin	✓		Sally Sandvig	✓	
Frank Klein					
Chet Pollert	✓				
Todd Porter	✓				
Wayne Tieman	✓				
Dave Weiler	✓				
Robin Weisz					

Total (Yes) 12 No 0

Absent Two

Floor Assignment Rep. Weiler

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
January 31, 2001 7:29 a.m.

Module No: HR-17-1968
Carrier: Weiler
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1314: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (12 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). HB 1314 was placed on the Eleventh order on the calendar.

2001 TESTIMONY

HB 1314

TESTIMONY ON HB 1314

TODD PORTER, STATE REPRESENTATIVE

DISTRICT 34 MANDAN

Good morning, Madam Chair and members of the House Human Services Committee. For the record, my name is Todd Porter, State Representative from Mandan.

As you can see by the individuals present in the room, HB 1314 is a controversial piece of legislation. I am going to testify first as a non-participating provider of Blue Cross/ Blue Shield of North Dakota, and secondly as a consumer of Blue Cross/Blue Shield of North Dakota.

As a non-participating provider we have determined over the years that we cannot afford to accept the amounts that BC/BS is willing to pay for an ambulance transport. Our premiums for our group plan of 25 employees went up 16% this year year with a known utilization of 27%, yet their reimbursement back to providers moved a mere 4% in the ambulance industry.

We are not like hospitals and other medical providers we provide one service, transportation of the sick and injured. Ambulance provider's staff 24/7 without any idea of utilization or schedules. Some days were busy, some days were not. The ambulance industry also has to deal with some of the highest collections in the nation with bad debt ratios of 20%. This coupled with low reimbursements from government programs like Medicaid and Medicare make it impossible to survive based upon participating schedules like the one offered from BC/BS of ND.

I have been in this career for 22 years now, 17 of those as a part owner of the local ambulance service. Over ten years ago we told the local governments that we contract with that local taxpayer subsidies were not necessary anymore. In exchange for the freedom to operate as a small business we agreed to a rate structure approved by the government entities with built in increases each year (maximum 5%).

When BC/BS of ND first approached us and wanted to sign up all ambulance providers in the state they used the previous years rates as the base for the plan. They also group all rates together and reimbursed the same rate for all Advanced Life Support base rates. We explained our rate structure and told BC/BS that we couldn't justify raising one of our existing rates over $100.00 just to meet their contract. We asked that they adjust their emergency rates higher and bring down the reimbursement in the non-emergency area to fit our local government imposed fee schedule. We were told that they would only have one set of rates for the entire state. This point brought up another question, if you only have one rate structure then you pay us the same reimbursement as you would a service that receives local taxpayer subsidies, even though our costs to operate are higher? Their answer was we don't get involved in local government agreements. In Grand Forks the ambulance service serves an area about the same size as ours and receives in excess of $250,000.00 in local taxpayer subsidies to operate and still receives the same reimbursement from BC/BS of ND as we would. This means that I have to make up $250,000.00 worth of non-BC/BS business in the course of each year in a state where BC/BS writes 80% of the health premiums. I can't do it.

Recently we transported a patient by fixed wing air ambulance to Rochester Minnesota. We provided the ground transportation in Bismarck and the fixed wing air ambulance. Typically we charge around $2000.00 less than a service out of Minnesota to provide the

same fixed wing transports. The patient called me and complained that since we are not participating providers with BC/BS reimbursement were less than if a service in Minnesota was used. He went on to tell me he was reimbursed more for the ground ambulance in Rochester than in Bismarck. I called my good friend and classmate who works for Rochester and asked him if they were participating providers for BC/BS of North Dakota and his response was "we are not participating providers with any insurance company". I then asked him how they bill BC/Bs of ND and his response was alarming. He told me they were told by BC/BS of ND to code everything as emergencies so they wouldn't be discounted as non-participating.

So this patient was reimbursed more for using an out of state provider (non income tax paying, non use tax paying, non employing service) than we were even though our rates were less than they would have charged to come from Minnesota and get the patient. You my wonder why services such as helicopter ambulance services fail in North Dakota. The answer was in the news POOR REIMBURSEMENTS.

There is not a single community in North Dakota with more than 1 ambulance service. The population and utilization is not large enough to keep additional ambulance services busy enough to operate successfully. Recently the CEO of BC/BS stated at a Health Care Interim Meeting "one of the reasons that health care costs continue to rise is too many providers in the same community drives up utilization and insurance costs". Well ambulance services certainly cannot be one of the contributors to higher insurance premiums since most are run by volunteers and charge less than the fee schedule imposed by BC/BS. One last point about reimbursements. BC/BS has announced a study that will cost over $300,000.00 to look at the impact in rural communities. Why not take that money and put it towards your fee schedules so there might be a provider left in North Dakota after the study is concluded.

That's enough as a frustrated provider. Now lets switch hats to the frustrated consumer of BC/BS of North Dakota.

This bill the way it is written would protect every insurance and health care consumer in North Dakota. As costs increase and providers come to grip with fee schedules fewer and fewer providers will be participating. This means that insurance companies will reimburse the patient at a lesser fee than they would a participating provider in another community. The provider will still bill the patient what the provider feels is necessary to operate their small business. The patient gets less. The patient gets more out of pocket expenses and yet their premiums continue to rise. The patient gets less.

This bill provides the basic protection that every consumer of health insurance deserves. It provides that in communities where no one can afford to succumb to the fee schedule of the insurance industry the patient of all people, the consumer of the insurance industry, the payor of insurance premiums does not become the victim of the insurance companies policies.

Thank you Madam Chair. I will be happy to answer any questions of the committee.

Testimony in Opposition to HB 1314
House Human Services Committee
January 24, 2001
Mike Hamerlik
Blue Cross Blue Shield of North Dakota

Madam Chairman, Members of the Committee:

My name is Mike Hamerlik, appearing in opposition to House Bill 1314 on behalf of Blue Cross Blue Shield of North Dakota.

This bill changes only a few words in North Dakota's Preferred Provider Organization ("PPO") statute, but the changes are significant. This bill virtually eliminates all incentives to control costs through enrollment in a PPO. This bill will raise health care costs for North Dakota through increased out-of-pocket costs and increased health insurance premiums.

Attached to my testimony is Chapter 26.1-47 of the North Dakota Century Code in its entirety. If you read the sections not printed in HB 1314, you will see that there is a statutory requirement that PPO's include mechanisms to "review and control the utilization of health care services." NDCC §26.1-47-02(1)(b). Similarly, these statutes require mechanisms to "preserve the quality of health care." NDCC §26.1-47-02(1)(c).

These mechanisms are used in PPO's to help control health care costs by providing an incentive to use providers who agree with the goals and objectives of PPO's, yet PPO's still allow patients to choose his or her provider. There is a financial incentive to use network PPO providers by having a lower co-insurance (usually 10% instead of 20%).

But, the most financially significant feature of using a PPO provider is the contractual prohibition of balance billing. "Balance billing" is when a provider requires a patient to pay directly the difference between the allowed charge and the providers billed amount. In other words, there is no discount. The PPO providers' agreement to not balance bill a patient helps control medical costs, protects the consumer from unusually high medical bills, and adds a measure of certainty to the patient's out-of-pocket expenses for a health care episode.

Here are some examples of claims under these arrangements:

PREFERRED PROVIDER ARRANGEMENT:

$300 Billing from provider
-100 Agreed discount
$200 Total payment to provider

$ 20 Coinsurance paid by patient
$180 Paid by insurer or employer

USE OF NON-PARTICIPATING PROVIDER:

$300 Billing from provider
____ NO DISCOUNT
$300 Total payment to provider

$ 20 Coinsurance paid by patient
$144 Paid by insurer or employer
$136 Balance billed to patient

Some of you may be familiar with or participate in the North Dakota PERS PPO product. In fact, many of you may participate in it. That is the type of insurance products affected by this bill, and they generally work quite well. The PERS plan has two levels of savings for participants: a Preferred Provider Organization ("PPO") and an Exclusive Provider Organization ("EPO"). The EPO provides even more savings for using a network provider.

Here are some specific objections to HB 1314:

1. The new language is vague. It adds "in that community" to subsections 1(a) and 1(b). What does "in that community" mean?

There are no hospitals in West Fargo. Is Fargo in the West Fargo community? There are no hospitals or other medical providers in Horace (about 5 miles southwest of Fargo). Is Horace in the Fargo "community"? Is Mandan in the Bismarck "community"?

Although a "common sense" definition may be implied, insurance laws require specificity. A person covered under a PPO arrangement needs to be informed about the benefits of his or her contract so there are no surprises when the medical bills arrive. "Community" is not defined in section 1(a) or 1(b), but section 1(d) does contain some specificity regarding distance from medical facilities.

2. As noted above, there are no protections for consumers that place a limit on the patient's financial liability. There are incentives built into a PPO provider contract so providers want to join, including additional payment and direct reimbursement. House Bill 1314 would allow providers to charge whatever they want, and would remove any incentive to participate in a PPO arrangement.

3. The changes to subsection 1(b) are the most problematic. Unlike subsection 1(a), which relates only to emergency services, this section affects ALL services under a health insurance policy. If this bill passes, there would be no reason for a provider to join a network, because the providers will get paid MORE for not being in the network. When providers are paid more, premiums and out-of-pocket costs rise.

4. If you favorably consider this bill, we urge that this Committee attach an amendment to both subsections 1(a) and 1(b), as follows:

"A non-preferred provider who accepts a preferred provider level of payment under this subsection shall accept the payment as payment in full, and shall not collect charges in excess of the insurer's allowed charge from either the insurer or the covered person."

This proposed amendment accomplishes the same goal as the last sentence in subsection 1(d) of NDCC §26.1-47-03.

5. Passage of this bill will increase costs: to the patients, to the premium payers, and to the employers. Continued erosion of affordable

insurance options will cause more employers to choose the self-funded option, which erodes the State of North Dakota's legal jurisdiction of health plans. Self-funded plans also reduce the State's premium tax collections because there is no premium tax paid on health payments to providers.

Madame Chairman and Members of the Committee, we ask that you help try to contain the increases in medical costs by giving a "Do Not Pass" recommendation to House Bill 1314.

Respectfully submitted,

Mike Hamerlik
Blue Cross Blue Shield of North Dakota

CHAPTER 26.1-47
PREFERRED PROVIDER ORGANIZATIONS

26.1-47-01. Definitions. As used in this chapter, unless the context indicates otherwise:

1. "Commissioner" means the insurance commissioner of the state of North Dakota.

2. "Covered person" means any person on whose behalf the health care insurer is obligated to pay for or provide health care services.

3. "Health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the services covered.

4. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

5. "Health care provider" means licensed providers of health care services in this state.

6. "Health care services" means services rendered or products sold by a health care provider within the scope of the provider's license. The term includes hospital, medical, surgical, dental, vision, chiropractic, and pharmaceutical services or products.

7. "Preferred provider" means a duly licensed health care provider or group of providers who have contracted with the health care insurer, under this chapter, to provide health care services to covered persons under a health benefit plan.

8. "Preferred provider arrangement" means a contract between the health care insurer and one or more health care providers which complies with all the requirements of this chapter.

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.

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 carrier that jeopardizes patient health or welfare.

26.1-47-03. Health benefits plans.

1. Health care insurers may issue policies or subscriber agreements which provide for incentives for covered persons to use the health care services of preferred providers. These policies or subscriber agreements must contain all of the following provisions:

a. A provision that if a covered person receives emergency care and cannot reasonably reach a preferred provider that care will be reimbursed as though the covered person had been treated by a preferred provider.

b. A provision that if covered services are not available through a preferred provider, reimbursement for those services will be made as though the covered person had been treated by a preferred provider.

c. A provision which clearly discloses differentials between benefit levels for health care services of preferred providers and benefit levels for health care services of other providers.

d. A provision that entitles the covered person, if any health care services covered under the health benefit plan are not available through a preferred provider

within fifty miles [80.47 kilometers] of the policyholder's legal residence, to the provision of those covered services under the health benefit plan by a health care provider not under contract with the health care insurer and located within fifty miles [80.47 kilometers] of the policyholder's legal residence. For the covered person to be eligible for benefits under this subdivision, the health care provider not under contract with the health care insurer must furnish the health care services at the same cost or less that would have been incurred had the covered person secured the health care services through a preferred provider.

2. If the policy or subscriber agreement provides differences in benefit levels payable to preferred providers compared to other providers, the differences may not unfairly deny payment for covered services and may be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

26.1-47-04. Preferred provider participation requirements. Health care insurers may place reasonable limits on the number of classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against any providers on the basis of religion, race, color, national origin, age, sex, or marital status, and further provided that selection of preferred providers is made on the combined basis of least cost and highest quality of service.

26.1-47-05. General requirements. Health care insurers complying with this chapter are subject to all other applicable laws, rules, and regulations of this state.

26.1-47-06. Rules. The commissioner may adopt rules necessary to enforce and administer this chapter.

26.1-47-07. Penalty. The commissioner may levy an administrative penalty not to exceed ten thousand dollars for a violation of this chapter. Any person who violates this chapter is guilty of a class A misdemeanor.