2021 HOUSE HUMAN SERVICES

HB 1465

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1465
2/3/2021

Relating to freedom of choice for healthcare services

Chairman Weisz opened the hearing at 10:54 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Provider selection freedom
- Willing provider laws
- Provider based billing

Rep. Greg Westlind, District 15 (10:54) introduced the bill.

Scott Meske, North Dakotans for Open Access Healthcare (10:56) testified in favor, submitted testimony #5119, and introduced Dr. Duncan Ackerman.

Dr. Duncan Ackerman, Bone & Joint Center/Bismarck Surgical Associates (10:58) testified in favor and submitted testimony #5134.

Courtney Koebele, Executive Director North Dakota Medical Association (11:13) testified in favor and submitted testimony #5217.

April Mettler, Owner CC's Physical Therapy (11:16) testified in favor and submitted testimony #5096.

Jack McDonald, Retained Counsel/Lobbyist America's Health Insurance Plans (11:23) testified in opposition and submitted testimony #4428.

Matt Schafer, Director Government Relations Medica (11:30) testified in opposition.

Chrystal Bartuska, North Dakota Insurance Department (11:36) testified neutral with opposition to a paragraph in the bill.

Marnie Walth, Sanford Health Plan (11:38) introduced Dylan Wheeler, Senior Legislative Affairs Specialist Sanford Health.

Dylan Wheeler, Senior Legislative Affairs Specialist Sanford Health (11:39) testified in opposition and submitted testimony #5072.

Additional written testimony: #5080, #5088, #5094, #5117, #5171

Chairman Weisz adjourned at 11:45 a.m.

Tamara Krause, Committee Clerk

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Giving Patients Freedom of Choice in Health Care

HOUSE BILL NO. 1465 – 67TH LEGISLATIVE ASSEMBLY OF NORTH DAKOTA

HB1465 gives patients new freedoms to choose their health care provider by guaranteeing medical providers have the right to negotiate inclusion in health care networks with insurers.

As healthcare networks have consolidated across the country, some insurance plans provide patients with fewer choices to see local medical experts. The bill requires good faith negotiation between medical providers and insurers, giving patients the benefit of expanded options to choose their medical providers. Importantly medical providers only if they are willing, qualified, and meet the conditions for participation established by the insurer.

MORE THAN JUST DOCTORS: HB 1465 expands patient choice for many types of health care providers including family physicians, surgeons, specialty physicians, physical and occupational therapists, chiropractors, nurse practitioners, dieticians, mental heath providers and more.

INCREASED PATIENT CHOICE: House Bill 1465 makes it more likely that patients can see the doctor of their choice. Insurance companies must admit to their networks providers who meet their standards and agree to the insurance companies' terms. This will increase competition and help to control spiraling medical costs.

PATIENT COSTS: This simple bill would allow any North Dakotan/patient to visit their chosen provider without paying more. HB1465 virtually eliminates out-of-network personal medical fees and will help control out-of-pocket costs and co-pays while improving medical outcomes. There is no credible research which shows upward pressure on costs will go up. With out-of-pocket fees reduced or eliminated, North Dakotans will spend less out-of-pocket.

EXPANDED ACCESS TO LOCAL SPECIALISTS: Many providers have extra training including residencies and fellowships in very specific sub-specialties. HB 1465 opens new options for patients to access local sub-specialists rather than travel hundreds of miles for the same care.

BETTER PATIENT OUTCOMES: HB1465 will allow families to see doctors and other medical providers they know and trust. This will cut unnecessary re-testing by providers and reduces the probability of diagnostic prescription errors.

HEALTH CARE SYSTEM PLANS: HB 1465 allows patients to utilize medical providers outside major health care systems without suffering additional expenses. Many patients are forced to use providers in insurance company networks or pay extra, and some are even required to undergo unnecessary travel at their own expense.

ONLY PRIVATE MEDICAL INSURANCE: The bill does not apply to all health insurers, nor to certain kinds of insurance and plans including those involving specific disease, indemnity, accident only, dental, vision, Medicare supplement, long-term care or disability income, and workers' compensation.

PHARMACISTS HAVE HELD THIS ACCESS FOR DECADES: Since 1989, North Dakota pharmacists have had essentially the same guarantee for more than three decades.

OVERWHELMING SUPPORT IN SOUTH DAKOTA: In 2014 South Dakota voters overwhelmingly adopted patient choice at the ballot box by 62 percent to 38 percent. This has caused a positive impact on the state's health care industry and allowed for increased competition amongst providers reducing costs to patients and insurers.

WHY NORTH DAKOTA: In a State where many patients are forced to travel long distances to use in-network providers, HB 1465 will give them the ability to use a local provider with the same specialties. North Dakotans will experience fewer constraints on choosing healthcare providers due to factors such as changes in employment and insurance plans.

North Dakotans for Open Access Healthcare supports House Bill No. 1465 because patients should have more options and having a consistent, ongoing relationship with a provider is in the best interest of quality care.

Supported by North Dakotans for Open Access Healthcare
Contact: Duncan Ackerman, M.D. | dackerman@bone-joint.com

Testimony

House Bill 1465

Human Services Committee

Representative Robin Weisz, Chairman

Representative Karen M. Rohr, Vice Chairman

2/3/2021

Chairman Weisz, Madam Vice Chairman Rohr, 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.

I am also an owner / partner of Bismarck Surgical Associates (BSA). BSA is an outpatient ambulatory surgery center (ASC). My partners are Orthopedic Surgeons, Anesthesiologists, and an Ophthalmologist. We perform a full array of outpatient procedures from cataract surgery to total joint replacement. ASCs, which were established in 1970, have proven to provide lower cost, high quality care. We employ 45 full time employees at the BSA.

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, and numerous medical specialties such as pediatrics, family practice, internal medicine, ophthalmologists, general surgery, orthopedic surgery, neurosurgery, and retinal specialist. 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. 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 times 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'll 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 swirls down the walls of the funnel to the door of the hospital.

We have recently seen the rise of less expensive plans. These plans offer a limited network of providers, not based on only a few 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, access is denied. 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, aka 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 that has limited economic means to get basic care 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 from 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. 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.”

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 concerns. The main point was that South Dakota Measure 17 would increase cost. I’m 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 has the ability to exercise that choice.

In addition, HB 1465 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 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 affiliate's benefits.

In addition, the Centers for Medicare and Medicaid Services (CMS) has developed an online tool 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. Why wouldn't the health plan allow that 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. Remember that funnel, lets label it HB 1465, turn it around and use it as a megaphone, use your voice to tell our patients, your constituents, that you support their choice and passed HB 1465. Mr. Chairman, Madam Vice Chairman, and distinguished members of the Health Services Committee, I ask you to please pass HB 1465. I would be happy to take any questions at this time.

Duncan B. Ackerman, MD

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

House Human Services Committee
HB 1465
February 3, 2021

Chairman Weisz and Committee Members, I am Courtney Koebele, the Executive Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

NDMA supports HB 1465 which provides that an insurer may not deliver, issue, execute, or renew a policy if that policy denies a health care provider the right to participate as a participating provider for any policy on the same terms and conditions as are offered to any other provider of health care services under the policy.

As others have discussed, similar legislation has been enacted in several states. This legislation supports the idea that any provider willing to meet reasonable standards of care and quality set by the insurance plan should be able to care for the plan's beneficiaries. We are aware of health insurer's claims that this would increase health care costs. However, we would argue that the increased competition should provide for lower costs for patients and health care insurers.

The policies in this bill are helpful because it means providers can't be "locked out" of products that are "narrow network" and means patients have the broadest possible choice of products that can include their preferred healthcare provider. Patients deserve the freedom to choose their own doctor. This bill allows families to see doctors and other medical providers they know and trust.

HB 1465 supports having a consistent and on-going relationship with a provider that is in the best interest of patient/physician relationship. We

urge a DO PASS. Thank you for the opportunity to testify today. I would be happy to answer any questions.

In support of House Bill 1465

Good morning Chairman and Committee Members. My name is April Mettler. I received my Doctor of Physical Therapy degree from the University of Mary in 2008 and have been a private practice owner in Bismarck for the last 10 years. We employ 6 physical therapists and serve nearly 750 new patients every year.

In the start of my entrepreneurial career, I was a one woman show; I did patient care, answered phones, verified insurance, and manually billed for every service rendered within my facility. I have a thorough understanding and have studied the ins and outs of billing, coding, and reimbursement and have witnessed the changes and increased borders placed on private practices or "out of network" health care businesses in the 10-year progression. With each year, we have increased restrictions, increased rules, and increased limitations or "hoops to jump through" in an attempt to provider our patients with covered health services.

What is the importance of "patient choice" or ability to transcend networks for multiple healthcare options? In my 10 years as a private practice owner, I can tell you that patient choice is not only important, but also crucial in the reception of optimal care for many of our patients. A vast majority of the patients seen in my clinic that come with insurance that does not allow "out of network" benefits simply do not receive care. The cost associated with coming to see us out of network is far too large and many come in in hopes that a couple of visits will give them enough treatment and know-how to manage things independently. As in any rehab, a couple visits does not treat the problem. These patients do not leave us to go someplace else; they simply do not find alternative care or get lost in the healthcare shuffle. A commonality we see with these patients like most, is most of them do not fully comprehend their insurance benefits or limitations. Employees take the least expensive plan without understanding what it means in its entirety; we are all guilty of that on some level. It's insurance. It's complicated. It is not until the patient experiences a severe pain exacerbation, injury, or pregnancy induced pain they discover there is no way for them to receive benefits outside of a large network to utilize their insurance benefits. At this point, it is too late. As we know, changes to the plan cannot be made until the next calendar year and the patient is left with the choice to simply pay out of pocket or leave their symptoms unaddressed. Often, these small issues then develop into greater disability and a higher risk of continued re-injury or possibly pharmaceutical intervention with the known risk of pain med addictions.

Logistically, our out of network clinic offers extended hours of service seeing patients from 7:00 AM-6:30 PM most days of the week; a large benefit to working patients when compared to larger entities. Time out of work is money out of the pocket and creates another barrier for patients to access needed healthcare. The number of clinicians such as myself with board certifications in specialized forms of PT are found predominantly in independent practices across the state, not larger institutions. To say all practices and practitioners are the same is not an accurate statement when comparing the impressive credentials of practice owners and their employees across this great state along with their patient centric benefits in providing care. It is not something that should be denies to anyone that wants to explore it.

In summary, if a patient needs a pelvic health expert at 7 am on a Tuesday for physical therapy, insurance should not be the deciding factor on whether care is rendered, and benefits are received.

Dr. April Mettler, PT, WCS

February 3, 2021

House Human Services Committee
HB 1465

CHAIRMAN WEISZ AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing 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 like a straightforward approach, 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.

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. I’d be happy to answer any questions.

SANFORD HEALTH PLAN

February 3, 2021

Chairman Weisz and members of the House Human Services Committee –

Good Morning – my name is Dylan Wheeler, Senior Legislative Affairs Specialist for Sanford Health. I address the committee this morning regarding HB1465 – thank you for the time and ability to speak this morning. As an integrated system and health insurance plan, Sanford Health strives to provide access to high-quality healthcare through competitive and cost-concious options for it patients and members. Moreover, in a time where healthcare costs are a primary focus at both the Federal and State levels, markets should continue to offer significant choice for members, including both employer groups and individuals, to select a product that fits their unique health care needs and fits their budget.

Sanford Health respectfully opposes HB1465 at this time because it limits those member choices.

With that in mind, health plans may seek to offer an array of product offerings to its members with different networks, providers and benefits – each with different associated costs. Recently, and in an effort to address the needs of its members, health plans have taken the intiative to narrow its provider networks on some plans. By narrowing a network on one of its numerous products, health plans are able to significantly lower the premium cost to the member because narrower networks allow health plans to negotiate discounts with a limited set of providers in exchange for the volume of members that will seek care from those providers. This is all done while continuing to meet network adequacy regulations to ensure that the narrow network provides for the member's healthcare needs. Albeit, the network may be more localized and more streamlined, this lower cost option empowers the member to make the best decision in terms of both choice of provider and cost for them, their family, or their employees.

As payment or reimbursement models transition from fee for service to a more value based or outcome based model – mandating health plans contract with any willing provider would be counter productive to that effort. Notably, within a free market, when providers maintain competitive rates for services, health plans would be more likely to contract them into a narrow network. By driving down costs across broad and narrow networks alike, providers are incentivized to improve quality and innovate pricing to be included in different networks.

HB1465 as currently written may lead to an increase in health insurance premium and inhibit financial innovation by health plans. The plain reading of HB1465 would mandate health plans contract with any provider if that provider would otherwise accept the same terms of a participating provider. To this concept, we need to pause and consider - is that a concept that furthers market competition in North Dakota? Maintaining and creating competition through narrow network products is pivotal to reducing costs to North Dakotans. Moreover, the idea of compelling parties to contract – as well as presumably being forced to disclose competitively sensitive pricing in order to meet terms of

participation – is questionable and debatable from a legal standpoint and must be understood further if that is the intent of this legislation.

Additionally, members, including individuals and small/large groups, decide which health insurance plan is best for them, their family, or their employees. Different networks and different plan options may have increased – or decreased costs based on the plan offering selected. If a member selects a plan with a broader network and rich benefits – that plan is likely more expensive. Conversely, a member that selects a narrow network would likely have a limited set of providers but also a lower premium. Importantly, prior to selecting the plan, a member or group would have access to a list of the in network or participating providers – again reinforcing the consumer choice in this process.

This bill is really a question of whether we want to continue to empower consumers and citizens to choose the unique health plan that meets their needs – or whether we want providers to be able to choose what plans they participate in.

Respectfully Submitted,

Dylan C. Wheeler, JD
Senior Legislative Affairs Specialist
Sanford Health Plan

Talking Points for Mike Lillestol, MD,

Practicing Internal Medicine in Fargo, ND since 1983, prior to that in Mpls/St Paul since 1977

Graduated NDSU Pharmacy, UND school of Medicine, and University of Minnesota

Residency at Abbott Northwestern Hospital/University of Minnesota

I have been a patient advocate for the last 44 years and have first hand seen the value of continuity of care in people lives

I oppose anything that is disruptive to that continuity of care such as restrictive access

I have personally experienced it all from my time in Minneapolis, with the birth of the HMO's, PPO's and all their variations, and I have not seen any of them that enhanced patient care, and many times to the contrary

What is the rationale for restricting patient access? Is it to improve healthcare? I say no. It is all about control of the patient, so that referrals from the primary care group can be controlled, so the patients are referred within the system to the high reimbursement areas, cardiology, CV surgery, general surgery, interventional radiology, and the hospital itself. Why, because those are the high profit areas.

As an independent physician I am not bound to refer to a particular system. I can chose the best provider for my patient, regardless of the system, and after 44 years I know who they are, the same physicians I or my family would see. Why is that important, good doctors have good outcomes, and deliver by far the most cost effective care.

I support this bill because, I think it will help maintain continuity, and provide good care for my and other primary care patients

Aa a former pharmacist, I am familiar with the attempts by the State of North Dakota be keep pharmacists in charge of the pharmacies, and not the store manager for a large chain, I think this is a good thing because I know they also care about their patients.

I think large institutions in the state do deliver good medical care, and I think working in collaboration with the independent providers in the state would only make that care better. I see no good medical reason why patients should be restricted from the provider of their choice. Having independent practices creates more competition, I am happy to compete for patients on the basis of service and good care, and that should be everyone's goal, without barriers.

Testimony in support of HB 1465 – Giving Patients Freedom of Choice in Health Care
February 3, 2021

Good morning Chairman Weisz and Members of the Committee:

For the record my name is Michael Greenwood, I am a Cataract, Refractive, Cornea, and Glaucoma surgeon at Vance Thompson Vision in West Fargo, ND. I grew up in Jamestown, ND and attended the University of North Dakota for undergraduate and medical school. My residency training was at Case Western Reserve University, and my fellowship at Vance Thompson Vision in Sioux Falls, SD. My goal was to come back to North Dakota, and provide specialty care to the people who raised me and offer services that weren't readily available in the region, so that they could avoid long trips to access specialty care. I have been in practice here in West Fargo since 2016. I am writing to testify in support of House Bill 1465, which will give patients freedom in choosing their provider for health care.

The Importance of Patient Choice

Patients have the freedom to choose the date and time of their appointment and also get to choose whether or not to undergo certain treatments, but they DO NOT always have the freedom to choose WHO they will be seeing for these appointments and treatments. Currently, many patients are forced to use providers in insurance company networks or pay extra, and some are required to undergo unnecessary travel at their own expense.

Giving patients freedom of choice will allow families to see doctors and other medical providers they know and trust. Patients will be able to be cared for by providers who fit their personal goals and values. In fact, just this morning our office saw a patient who needed cataract surgery although they had no benefits with us since someone in his network could perform cataract surgery. This patient, however, wanted to come to us as we are able to offer special intraocular lenses that can reduce or eliminate the need for glasses following cataract surgery. By coming to us, that patient will have to pay for all of his visits and care out of pocket, but he was able to choose the type of surgery and outcomes that fit his goals. An expense he could afford, but many cannot.

Freedom of choice allows patients to see specialists who are more familiar with certain disease processes. This reduces diagnostic errors which in turn reduces unnecessary re-testing by providers not familiar with these cases. This saves time and money for the patient, and obviously provides better care. A patient was recently denied seeing me for a specific corneal disease (I am 1 of 3 fellowship trained cornea specialists in the state), stating an in-network provider could see the patient, and listed a couple of options. The ophthalmologists listed are great people and doctors, but one was a retina specialist, and the other a glaucoma specialist. These doctors are very skilled, but not for what this patient needs. And it is also very likely that these doctors don't want to see this kind of patient. That is why they specialize in something else! This is not what is best for the patient and certainly not standard of care.

There are also cost savings for the patient. Freedom of choice will ease travel burdens and would increase competition, helping control spiraling medical costs. It may also work to eliminate out-of-network expenses to patients. My colleagues and I have countless stories of hearing of patients who have travelled out of state to receive equivalent care that they could have received locally and without all of the extra time off work and cost of travel including overnight stays. And unfortunately, we learn of these cases after the fact and are unable to help these patients and support the local community. Additionally, our neighbors Minnesota and South Dakota, have similar laws in place which allows their patients to seek care locally and not leave the state.

The above are just a few examples from 1 surgeon at 1 practice, but this happens to patients every single day across the state. Giving patients the freedom of choice allows them to have a voice. Patients should be able to choose who they want to see based on relationships, comfort, and qualifications. It should not be dictated by what insurance you have.

Thank you, Mr. Chairman and committee, for your time and consideration this morning and I ask the Committee for a DO PASS recommendation on House Bill 1465

February 3, 2021

House Human Services Committee
Re: HB 1465

Chairman Weisz and Committee Members:

I am providing written testimony in favor of HB 1465 and am requesting a recommendation of "do pass."

This is a bill that would require insurance companies to allow for coverage of services to "any willing provider"and does allow for increased access to health care services to the members they serve.

I own a private practice physical therapy clinic in Minot. I have developed relationships with many families and clients throughout the area. These families and clients often seek physical therapy care at my clinic because of relationships and care received at my clinic in the past. However, at times because of the insurances that they have and networks within those insurance companies they are not able to receive care in my physical therapy clinic even though I am willing to provide the physical therapy care they are seeking under the terms of their insurer.

When a physician writes an order for a medication their clients can take that prescription to any pharmacy of their choosing and have that prescription filled. I believe that my clients should have the right to choose physical therapy services at any clinic of their choosing as long as that clinic is willing to provide that service.

HB 1465 will allow residents of North Dakota to seek health care services at the willing provider that they choose. Therefore, I am recommending that you vote in favor of this bill and recommend a "do pass" out of this committee.

Thank you for consideration of my written comments.

Reed Argent, MPT
First Choice Physical Therapy, Inc.
2111 Landmarks Cir. Suite B
Minot, ND 58703

Testimony in support of House Bill 1465 – Any Willing Provider

February 3, 2021

Good morning Mr. Chairman and Members of the Committee:

For the record my name is Dr. Steven Jared Broadway and I am a board-certified Neurosurgeon who founded Northern Neurosurgery and Spine in Fargo in January 2020. I graduated from the University of Arkansas for Medical Sciences in 2005, then went on to Neurosurgical residency at the University of Tennessee in Memphis which I completed in 2011. One of my coresidents decided to move to Duluth and recruited me to join the Duluth Clinic which, as you may know, was a physician led practice that was incorporated into Essentia Health just before I started my practice in 2011. I was the third neurosurgeon in the practice, but my senior partner retired about a year after my arrival. My friend and partner decided to leave Essentia in early 2014, leaving me as the sole neurosurgeon. It took me almost 2 years to recruit a partner, and when I resigned in November 2019, I had hired 3 neurosurgeons and had 6 NP and or PAs. Although I had a very robust practice and had sacrificed a lot for the betterment of the organization, I could never find a balance between patient care and administrative pressures. Through fate I was able to learn about the independent medical community in Fargo, and I saw a need and opportunity to establish an independent Neurosurgical Spine practice.

Access is key:

Starting my own practice has been a breath of fresh air and has allowed me to reflect on why I truly became a physician and surgeon. I have been able to provide robust access for patients with spinal pathology. Patients and referring providers have direct access to me and my clinic, which does not happen in large systems. This allows for timely consultation and surgical intervention which are paramount for good surgical outcomes.

Cost effective care and patient outcomes:

I am the only surgeon in the Fargo area performing spinal surgery in an ambulatory center. Healthcare is moving more and more toward the outpatient setting as surgical techniques and anesthesia delivery advance. Despite having performed over 3000 operations in the hospital setting in Duluth, I can say with absolute confidence that quality and outcomes are not sacrificed while delivering lower cost of care. This not only benefits the patient, but also the insurers and society as a whole. We have had absolutely no complaints, and many accolades. Patient experience results in better outcomes; all with decreased costs to our healthcare community. Not allowing patients to choose their provider based on their insurer contradicts our collective goal as a society to decrease healthcare spending.

Retention:

Though all of us involved in this discussion clearly have a commitment to our North Dakota communities, they are difficult to recruit new practitioners to. This results in a revolving door of providers, except in the independent community. Patients want to receive care at home but become disenfranchised when their provider leaves and/or they have to be referred out due to access constraints. This is an unfortunate reality, and I truly believe having a rich and robust network of independent practitioners allows for hospitals and healthcare systems to benefit by providing a choice

for patients and allowing them to be served within their community. In order to ensure viability of these practices, we must come together to support and pass house bill 1465.

Thank you, Chairman and committee, for your time and consideration.

Testimony in Support of Bill #1465
(Freedom of Patient Choice)

We are two practicing orthopedic surgeons from Grand Forks. We are both originally from Grand Forks, and practice a Valley Bone & Joint Clinic, an independent musculoskeletal clinic in Grand Forks with nine providers. Eight of us are originally from North Dakota and six of us originally from Grand Forks. As such, we represent physicians returning to their home state and currently successfully practicing independently from any large health systems, which are so very dominant and pervasive in our state. We have honed our surgical and medical skills in practice, but find it paramount to be adroit with the business of medicine and the politics of practicing in the Red River Valley with large health care systems.

We practice in the very dark shadow of two large monopolistic health systems, which control the flow and referrals of many patients in the Red River Valley. We are successful in our practices not only because of our reputations, but very importantly in the ability of patients to schedule their own appointments and see us directly through request and self-referral. That "patient choice" environment is becoming increasingly eroded via insurance and other payment methods which form networks of exclusive providers and the *de facto* exclusion of other practitioners. This exclusion is not merit based, but solely based on business or insurance contracts. Worse yet, many patients enrolled in such insurance products, are unaware of the existence of these networks, and their lack of freedom to choose their preferred doctor, and never consider these issues, until they are sick or injured.

We have many examples of situations pertaining to friends and acquaintances who desire to see us for care but are denied due to insurance constraints. They are frequently surprised when we inform them of this when they try to schedule an appointment.

Bill 1465 seeks to "level the playing field" and address a person's ability to choose whom they see for their medical care. We recognize the legitimate right of providers, hospitals, and health systems to refer patients where and to whom they desire, but categorically object to the denial of a patient's request to see anyone else of their choice. More strongly, we would like to eliminate the "systemic legitimization" of this practice via insurance and other business contracts. We contend that if a medical practitioner has proper credentials, training, and licensure in the State of North Dakota, then a patient should have the freedom to see their professional of choice.

We also acknowledge some exceptions to this proposed policy, namely the right of employers to control health care decisions of their employees covered under private employer financed insurance plans.

We strongly urge consideration for and a "yes" passage vote for bill 1465 to help maintain a healthy independent medical practice environment in North Dakota.

PATIENTS SHOULD HAVE THE RIGHT TO CHOOSE!
It is no more complicated than that.

Robert Clayburgh, MD
David Schall, MD
Valley Bone & Joint Clinic
Grand Forks, North Dakota

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1465
2/16/2021

Relating to freedom of choice for healthcare services

Chairman Weisz opened the committee meeting at 11:17 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Geographic area
- Health Benefit Plan
- Narrow network

Rep. Robin Weisz (11:18) presented **Amendment 21.0988.01000** - #7042

Rep. Matthew Ruby (11:19) moved to adopt amendment

Rep. Bill Tveit (11:19) second

Voice Vote – Motion Carried

Rep. Todd Porter (11:23) moved **Do Pass As Amended**

Rep. Karen Rohr (11:23) second

Representatives	Vote
Representative Robin Weisz	Y
Representative Karen M. Rohr	Y
Representative Mike Beltz	Y
Representative Chuck Damschen	Y

Representative Bill Devlin	N
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y
Representative Dwight Kiefert	Y
Representative Todd Porter	Y
Representative Matthew Ruby	Y
Representative Mary Schneider	Y
Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion Carried Do Pass As Amended 13-1-0

Bill Carrier: Rep. Todd Porter

Chairman Weisz adjourned at 11:29 a.m.

Tamara Krause, Committee Clerk

DO 2/16/21
1 of 1

21.0988.01001
Title.02000

Adopted by the Human Services Committee

February 16, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1465

Page 1, line 12, replace "an accident and" with "a"

Page 1, line 14, remove "An insurer may not deliver, issue, execute, or renew a policy if that policy:"

Page 1, replace lines 15 through 22 with "A health insurer, including the North Dakota Medicaid program, may not obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation, as established by the health insurer."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1465: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). HB 1465 was placed on the Sixth order on the calendar.

Page 1, line 12, replace "an accident and" with "a"

Page 1, line 14, remove "An insurer may not deliver, issue, execute, or renew a policy if that policy:"

Page 1, replace lines 15 through 22 with "A health insurer, including the North Dakota Medicaid program, may not obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation, as established by the health insurer."

Renumber accordingly

21.0988.01000

Sixty-seventh
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1465

Introduced by

Representatives Westlind, Tveit, Weisz

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-36-12.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36-12.7. Freedom of choice for health care services.

1. As used in this section:
   a. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
   b. "Policy" means an ~~accident and~~ health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
2. No health insurer, including the North Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer, ~~as established by the health insurer. An insurer may not deliver, issue, execute, or renew a policy if that policy:~~
   ~~a. Denies a health care provider the right to participate as a participating provider for any policy on the same terms and conditions as are offered to any other provider of health care services under the policy; or~~
   ~~b. Prevents an individual who is a party to or beneficiary of a policy from selecting a health care provider of the individual's choice to furnish the health care services~~

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~~offered under any policy, provided that the health care provider is a participating provider under the same terms and conditions of the policy as those offered to any other health care provider.~~

2021 SENATE HUMAN SERVICES

HB 1465

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
3/9/2021

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the hearing on HB 1465 at 3:00 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Charity care and independent clinics
- Facility fees
- Insurer/provider requirements
- Employee insurance plans (ERISA)
- Constitutionality

[3:00] Representative Greg Westlind, District 15. Introduced HB 1465.

[3:01] Scott Meske, North Dakotans for Open Access Healthcare. Introduced Dr. Duncan Ackerman to the committee.

[3:02] Dr. Duncan Ackerman, Orthopedic Surgeon, North Dakotans for Open Access Healthcare. Provided testimony #8269 in favor.

[3:23] Dr. Michael Greenwood, Ophthalmologist, Vance Thompson Vision. Provided testimony #7734 in favor.

[3:33] Dr. Steven Jared Broadway, Neurosurgeon, Founder, Northern Neurosurgery and Spine, Fargo. Provided testimony #7983 in favor.

[3:48] Dr. Michael Lillestol, President, Heartland Healthcare. Provided testimony #8149 in favor.

[3:56] Dr. April Mettler, Owner, CC's Physical Therapy. Provided testimony #8055 in favor.

[4:08] Dylan Wheeler, Senior Legislative Affairs, Sanford Health Plan. Provided testimony #8248 in opposition and provided the committee with Sanford Health Plan True document (testimony #8381) and Deloitee study (testimony #8382).

[4:18] Scott Miller, Executive Director, NDPERS. Provided testimony #8033 in opposition.

[4:29] Jon Godfread, ND Insurance Commissioner. Provided neutral oral testimony.

[4:36] Megan Houn, Director, Government Relations, Blue Cross and Blue Shield. Provided testimony #8278 in opposition.

Additional written testimony:

Dr. Fadel Nammour, Owner, Ambulatory Surgery Center. Written testimony #8519 in favor.

Dr. Kurt Kooyer, Internal Medicine/Pediatrics, Urgent Medicine Associates, LLC. Written testimony #8370 in favor.

Laurie Holte, Physical Therapist. Written testimony #8239 in favor.

Jed LaPlante, MHA, Administrator, Center for Special Surgery. Written testimony #7957 in favor.

Dr. Joe Carlson, Orthopedic Surgeon, Bone & Joint Center. Written testimony #7917 in favor.

Stephen Churchill, PT/ATC, AIM Physical Therapy Clinic, LLC. Written testimony #7817 in favor.

Paula Moch, BSN, MSN, FNP-BC, Legislative Liaison, ND Nurse Practitioner Association. Written testimony #7696 in favor.

Jack McDonald, Lobbyist, America's Health Insurance Plans (AHIP). Written testimony #8165 in opposition.

Matt Schafer, Medica. Written testimony #8021 in opposition.

Madam Chair Lee closed the hearing on HB 1465 at 4:41 p.m.

Justin Velez, Committee Clerk

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.

Duncan B. Ackerman, MD

Testimony in support of HB 1465 – Giving Patients Freedom of Choice in Health Care
March 9, 2021

Good morning Madam Chairman and Members of the Committee:

For the record my name is Michael Greenwood, I am a Cataract, Refractive, Cornea, and Glaucoma surgeon at Vance Thompson Vision in West Fargo, ND. I grew up in Jamestown, ND and attended the University of North Dakota for undergraduate and medical school. My residency training was at Case Western Reserve University, and my fellowship at Vance Thompson Vision in Sioux Falls, SD. My goal was to come back to North Dakota, and provide specialty care to the people who raised me and offer services that weren't readily available in the region, so that they could avoid long trips to access specialty care. I have been in practice here in West Fargo since 2016. I am writing to testify in support of House Bill 1465, which will give patients freedom in choosing their provider for health care.

The Importance of Patient Choice

Patients have the freedom to choose the date and time of their appointment and also get to choose whether or not to undergo certain treatments, but they DO NOT always have the freedom to choose WHO they will be seeing for these appointments and treatments. Currently, many patients are forced to use providers in insurance company networks or pay extra, and some are required to undergo unnecessary travel at their own expense.

Giving patients freedom of choice will allow families to see doctors and other medical providers they know and trust. Patients will be able to be cared for by providers who fit their personal goals and values. In fact, just this morning our office saw a patient who needed cataract surgery although they had no benefits with us since someone in his network could perform cataract surgery. This patient, however, wanted to come to us as we are able to offer special intraocular lenses that can reduce or eliminate the need for glasses following cataract surgery. By coming to us, that patient will have to pay for all of his visits and care out of pocket, but he was able to choose the type of surgery and outcomes that fit his goals. An expense he could afford, but many cannot.

Freedom of choice allows patients to see specialists who are more familiar with certain disease processes. This reduces diagnostic errors which in turn reduces unnecessary re-testing by providers not familiar with these cases. This saves time and money for the patient, and obviously provides better care. A patient was recently denied seeing me for a specific corneal disease (I am 1 of 3 fellowship trained cornea specialists in the state), stating an in-network provider could see the patient, and listed a couple of options. The ophthalmologists listed are great people and doctors, but one was a retina specialist, and the other a glaucoma specialist. These doctors are very skilled, but not for what this patient needs. And it is also very likely that these doctors don't want to see this kind of patient. That is why they specialize in something else! This is not what is best for the patient and certainly not standard of care.

There are also cost savings for the patient. Freedom of choice will ease travel burdens and would increase competition, helping control spiraling medical costs. It may also work to eliminate out-of-network expenses to patients. My colleagues and I have countless stories of hearing of patients who have travelled out of state to receive equivalent care that they could have received locally and without all of the extra time off work and cost of travel including overnight stays. And unfortunately, we learn of these cases after the fact and are unable to help these patients and support the local community. Additionally, our neighbors Minnesota and South Dakota, have similar laws in place which allows their patients to seek care locally and not leave the state.

The above are just a few examples from 1 surgeon at 1 practice, but this happens to patients every single day across the state. Giving patients the freedom of choice allows them to have a voice. Patients should be able to choose who they want to see based on relationships, comfort, and qualifications. It should not be dictated by what insurance you have.

Thank you, Madam Chairman and committee, for your time and consideration this morning and I ask the Committee for a DO PASS recommendation on House Bill 1465

March 8, 2021

Dear Madam Chairman and Members of the Human Services Committee,

My name is Jared Broadway and I am a board certified neurosurgeon practicing in Fargo. As I stated in my email this weekend, I founded Northern Neurosurgery and Spine in Fargo in January 2020 which is a spine-focused surgical practice.

I would ask for your support for HB 1465 as I believe that patients should be able to choose the provider that best suits their needs based on factors that fall outside of their insurance network, including skill set, reputation, cost of care and geographic location.

HB 1465 allows patients and their families to choose their preferred health care provider, gain access to additional local options for care and will ensure opportunities for patients to get around healthcare bottlenecks and doctor shortages.

Timely access to a spinal surgeon is critical to prevent neurological decline and unnecessary suffering. This is even true of a (now) spinal surgeon. When I was 20 years old, I suffered a herniated disc in my lumbar spine resulting in severe and limiting left leg pain. I'm from a medium size town in Arkansas which, at the time, had four neurosurgeons in active practice. The wait to see a surgeon was over 3 months which prompted me to seek care over an hour away in Memphis, Tennessee. I happened to be lucky enough from an insurance and demographic perspective to have that option, but many patients are not so fortunate.

North Dakota is similar to Arkansas in that there is not an abundance of Neurosurgeons given the rural nature of the state. Allowing patients to choose their provider will allow for better access and, ultimately, better care.

I ask the committee for a DO PASS vote on House Bill 1465.

Respectfully,

S. Jared Broadway, MD, FAANS

Dear Madam Chairman and Members of the Human Services Committee:

I have been practicing Internal Medicine in Fargo, ND since 1983, prior to that in Mpls/St Paul since 1977

I Graduated from the NDSU of Pharmacy, UND school of Medicine, and University of Minnesota

I performed a Residency at Abbott Northwestern Hospital/University of Minnesota in internal medicine

I have been a patient advocate for the last 44 years and have first hand seen the value of continuity of care in peoples lives and I support HB 1465,s efforts to ensure patients can chose their health care provider.

I have personally experienced different health care structures from my time in Minneapolis, with the birth of the HMO's, PPO's and all their variations, and each struggle to enhance patient care, and many times they work to the contrary

What is the rationale for restricting patient access? Is it to improve healthcare? No. These platforms are designed to restrict patient choice, so that patients are unable to change from a health care system so the patients are referred within the system to the high reimbursement areas, e.g. cardiology, CV surgery, general surgery, interventional radiology, and the hospital itself.

Patients deserve to choose their health care provider, as long as the provider meet the terms and prices of the insurance plan. As an independent physician I am not bound to refer to a particular system. I can chose the best provider for my patient, regardless of the system, and after 44 years I know who they are, the same physicians I or my family would see. Why is that important, good doctors have good outcomes, and deliver by far the most cost effective care.

I support this bill because, I think it will help maintain continuity, and provide good care for my and other primary care patients

Aa a former pharmacist, I am familiar with the attempts by the State of North Dakota be keep pharmacists in charge of the pharmacies, and not the store manager for a large chain, I think this is a good thing because I know they also care about their patients.

I think large institutions in the state do deliver good medical care, and I think working in collaboration with the independent providers in the state would only make that care better. I see no good medical reason why patients should be restricted from the provider of their choice. Having independent practices creates more competition, I am happy to compete for patients on the basis of service and good care, and that should be everyone's goal, without barriers.

Thank you for your consideration of this bill

Mike Lillestol, MD

In support of House Bill 1465

Good morning Chairman and Committee Members. My name is April Mettler. I received my Doctor of Physical Therapy degree from the University of Mary in 2008 and have been a private practice owner in Bismarck for the last 10 years. We employ 6 physical therapists and serve nearly 750 new patients every year.

In the start of my entrepreneurial career, I was a one woman show; I did patient care, answered phones, verified insurance, and manually billed for every service rendered within my facility. I have a thorough understanding and have studied the ins and outs of billing, coding, and reimbursement and have witnessed the changes and increased borders placed on private practices or "out of network" health care businesses in the 10-year progression. With each year, we have increased restrictions, increased rules, and increased limitations or "hoops to jump through" in an attempt to provider our patients with covered health services.

What is the importance of "patient choice" or ability to transcend networks for multiple healthcare options? In my 10 years as a private practice owner, I can tell you that patient choice is not only important, but also crucial in the reception of optimal care for many of our patients. A vast majority of the patients seen in my clinic that come with insurance that does not allow "out of network" benefits simply do not receive care. The cost associated with coming to see us out of network is far too large and many come in in hopes that a couple of visits will give them enough treatment and know-how to manage things independently. As in any rehab, a couple visits does not treat the problem. These patients do not leave us to go someplace else; they simply do not find alternative care or get lost in the healthcare shuffle. A commonality we see with these patients like most, is most of them do not fully comprehend their insurance benefits or limitations. Employees take the least expensive plan without understanding what it means in its entirety; we are all guilty of that on some level. It's insurance. It's complicated. It is not until the patient experiences a severe pain exacerbation, injury, or pregnancy induced pain they discover there is no way for them to receive benefits outside of a large network to utilize their insurance benefits. At this point, it is too late. As we know, changes to the plan cannot be made until the next calendar year and the patient is left with the choice to simply pay out of pocket or leave their symptoms unaddressed. Often, these small issues then develop into greater disability and a higher risk of continued re-injury or possibly pharmaceutical intervention with the known risk of pain med addictions.

Logistically, our out of network clinic offers extended hours of service seeing patients from 7:00 AM-6:30 PM most days of the week; a large benefit to working patients when compared to larger entities. Time out of work is money out of the pocket and creates another barrier for patients to access needed healthcare. The number of clinicians such as myself with board certifications in specialized forms of PT are found predominantly in independent practices across the state, not larger institutions. To say all practices and practitioners are the same is not an accurate statement when comparing the impressive credentials of practice owners and their employees across this great state along with their patient centric benefits in providing care. It is not something that should be denies to anyone that wants to explore it.

In summary, if a patient needs a pelvic health expert at 7 am on a Tuesday for physical therapy, insurance should not be the deciding factor on whether care is rendered, and benefits are received.

Dr. April Mettler, PT, WCS

SANFORD HEALTH PLAN

March 9, 2021

Madam Chair and members of the Senate Human Services Committee –

Good Afternoon, my name is Dylan Wheeler, Senior Legislative Affairs Specialist for Sanford Health. I am here today to respectfully oppose HB1465 as amended, better known as Any Willing Provider legislation. Unfortunately, what has been construed as a bill premised as a substitute for "consumer choice" or "member choice" actually would inhibit future innovation, eliminate that same consumer or member choice for lower cost health insurance options, and run contrary to quality and value based payment models. An independent review of the legislation by Deloitte during this legislative session for the Employee Benefits Committee indicated it will lead to an increase in health insurance premiums and healthcare spending.

Sanford Health, as an integrated system, continually offers access to high quality health care – including primary, speciality and many others. Today, many affordable health insurance options are available in North Dakota. An individual or group may get a policy on the ACA exchange, through their employer, or through an local agent. At this point, it is important to emphasize that this bill possibly will not apply to ERISA governed or self-funded group health insurance plans, such as plans offered by employers, which make up a large portion of the market in North Dakota.

Health plans offer numerous product offerings to its members with different networks, providers and benefit structures – each with different associated costs. For correlation, think of other insurance products (or other services generally) where you may upgrade or broaden coverage or select certain add-on coverage to suit your needs. Sanford Health Plan offers a narrow network along with many other plan offerings. This plan, called Sanford TRUE, is not sold statewide and members must be eligible, that is, have a home residence within a specified distance of certain providers – this is done to ensure that the plan meets access and availability requirements, and to esnure that the member does not have to travel a long distance to receive care.

By narrowing a network on one of its numerous products, health plans are able to significantly lower the premium cost to the member - estimated at 20%. These savings are achieved because narrower networks allow health plans to negotiate discounts with a limited set of providers in exchange for the volume of members that will seek care from those providers. This lower cost option empowers the member to make the best choice in terms of panel of providers and cost which best meets the needs and budget for them, their family, or their employees. This is all done while continuing to meet stringent network adequacy and access regulations (State and Federal) to ensure that the network provides for the member's healthcare needs – including access to primary and specialist care.

Any Willing Provider laws raise several concerns - first, in addition to the cost considerations by individuals, families, and businesses, the market is currently trending to implement quality based and value based payment models for reimbursement. By permitting any provider to ad hoc admit into a

network with this payment mechanism, the entire framework for the pre-existing network and cost structure could be cast into doubt. To be clear, this is not to suggest that any North Dakota provider would not deliver high-quality care – however, that concern must be raised. Moreover, as written, this law would permit providers to test-drive a particular network to see if the volume and influx of patients within the network is worth the risk of remaining within the plan.

Furthermore, the plain reading of HB1465 would require health plans to contract with any provider if that provider would "willing and qualified" to accept the same terms of a participating provider. To this concept, we need to also consider its legality. Meaning whether by state statute, can two parites be compelled to contract – as well as presumably being forced to disclose competitively sensitive pricing in order to meet terms and conditions of participation.

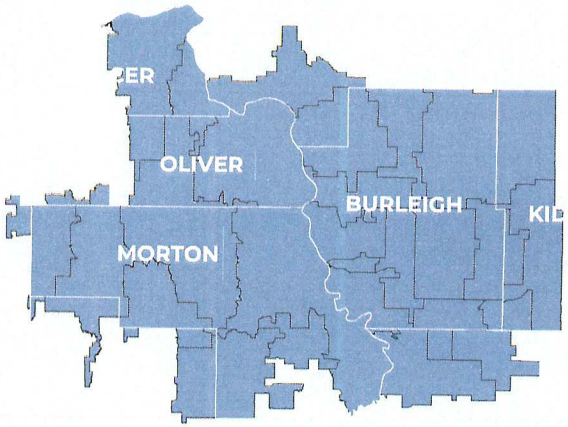
Nationwide, and also in North Dakota, there is interest in the narrow networks and lower cost health insurance products. Our competitors, within and in other states are also offering these products. Current efforts are looking to bend the cost curve of healthcare and perhaps now more than ever, we need to consider this legislative proposal within the the economic and health landscape in which we find ourselves. Prior to COVID-19, healthcare costs and access was and continues to be an ongoing dialogue – engaging all aspects of the healthcare economic spectrum – not just the limited engaged in debtate here today. COVID-19 has elevated those discussions as individuals and businesses look at ways to minimize the financial impact of COVID-19.

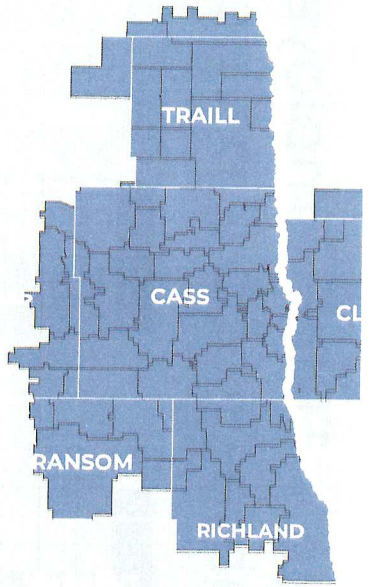
This bill is really a question of whether we want to continue to empower consumers and citizens to choose the unique health plan that meets their needs.

I thank you for your diligent consideration and will try to answer any questions you may have.

Respectfully Submitted,

Dylan C. Wheeler, JD
Senior Legislative Affairs Specialist
Sanford Health Plan





Sanford TRUE Employee Eligibility Zip Codes - North Dakota

SANFORD HEALTH PLAN

#8381

North Dakota - TRUE Employee Eligibility Large Group Zip Codes

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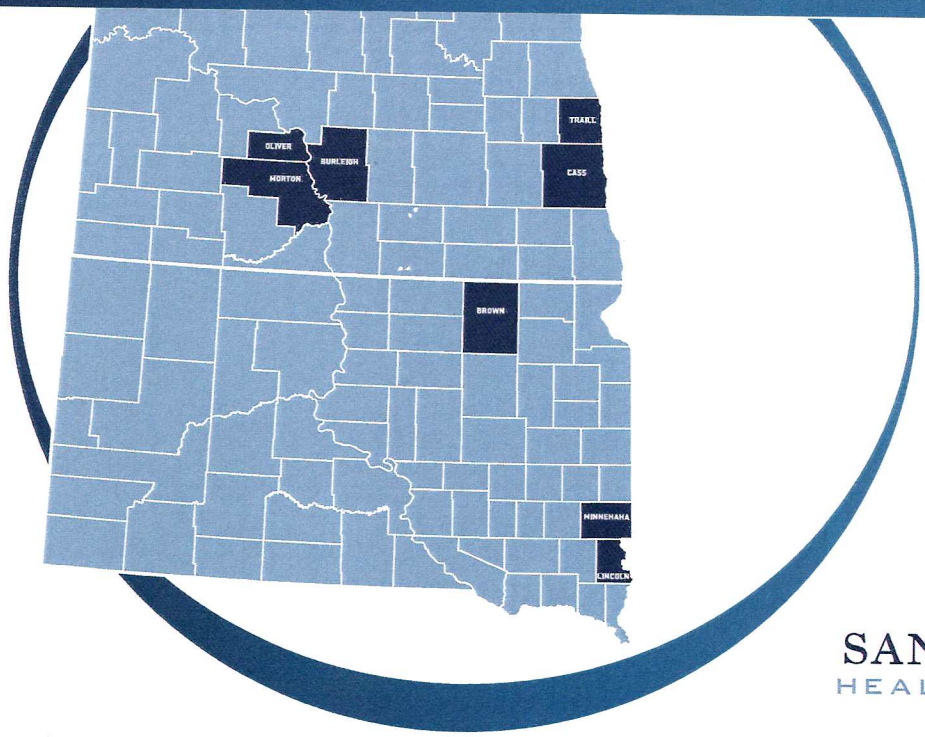
SANFORD TRUE INDIVIDUAL
NORTH DAKOTA AND SOUTH DAKOTA



SANFORD HEALTH PLAN

Plan Profile: Sanford TRUE plans are offered to individuals in approved counties of the Dakotas. These plans are a great option for the self-employed, those between jobs, early-retired, families or those no longer eligible for health insurance coverage under their parent's plan. The Sanford TRUE plans are qualified health plans that offer a variety of cost-sharing options.

Provider Network: Consists of 2,200 providers, including access to our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa. You can choose to see any licensed Sanford Health provider for covered services without a referral for in-network coverage. This plan does not have out-of-network coverage, except for urgent and emergent situations.

- **9 plan options** available – also available on the Exchange at healthcare.gov
- Focused Network
- Video visit and e-visit services offered at a **$0 copay** with Sanford Health providers. Exclusions apply.
- **Fitness Center Reimbursement** and Wellness Services
- **Pediatric Dental** and **Vision** benefits built into all plan options
- No out-of-network coverage, except urgent and emergent services
- Approximately **20% in premium savings** compared to *Simplicity* plans

Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000
Fax: 612 397 4450
www.deloitte.com

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.

TESTIMONY OF SCOTT MILLER

Engrossed House Bill 1465 – "Freedom of Choice" for Healthcare Services

Good afternoon, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in opposition to House Bill 1465.

NDPERS maintains a broad network product and the immediate impact of HB 1465 is lessened due to openness of our plan – we currently have over 97% of the state's providers in our network. However, we are concerned about the indirect impact the legislation may have.

First, HB 1465 would restrict NDPERS' ability to evaluate future innovations with different plan designs or network offerings that narrow the provider network in exchange for deeper provider discounts. We do not have current plans to do so, but if NDPERS finds itself in a position to need to further reduce costs, this bill could limit future options.

We are also concerned that this legislation would take health plans in a very different direction than they are currently headed, one that results in increased healthcare costs rather than reducing those costs. Right now, the health care industry is focused on value and quality based payment methods. In fact, NDPERS has worked with Sanford Health Plan to implement something called a Value Based Care Arrangement with a number of our North Dakota provider networks. That program is designed to reduce costs in the future and bend the healthcare trend downward. This bill takes the industry in a different direction, which could result in higher costs and higher premiums.

Finally, NDPERS is concerned that HB 1465 will negatively disrupt the industry and potentially increase the cost of healthcare. If providers can forego participant contracts and join and leave networks at a whim, it will become very difficult for insurance plans to project future claims costs with any specificity. That will cause those projections to increase, which will eventually be a cost to the state. We welcome efforts to reduce cost. HB 1465 will most likely do the opposite.

Senate Human Services Committee
HB 1465
March 9, 2021

Good afternoon, I am Megan Houn, Director of Government Relations for Blue Cross Blue Shield of North Dakota (BCBSND). On behalf of Blue Cross Blue Shield of North Dakota and our over 350,000 members we respectfully oppose HB 1465.

As an initial concern identified in the amended version of HB 1465, before addressing the provider contracting and network aspects of this proposed legislation, BCBSND points out that the new amendment language introduces terms related to Medicaid into the bill. This amendment, which creates a new section in chapter 26.1-36, N.D.C.C., governing health insurance, states that a health insurer, "including the North Dakota Medicaid program" is governed by this new mandate. Currently, most, if not all, of the Medicaid statutes are set forth in chapter 50-24.1, N.D.C.C., as well as in chapter 75-02-02 of the North Dakota Administrative Code. The amendment includes terms such as "panel of providers", "the geographic coverage area" and other terms of art under Medicaid that have no reciprocal meaning under the health insurance chapter. None of these terms are defined in HB 1465 but all of them appear to be terms of art under the laws that apply to Medicaid. BCBSND respectfully asks, doesn't it make more sense to amend the Medicaid statutes than include this language under the health insurance statutes?

BCBSND is proud to offer broad access networks to our membership, allowing them ample choice in picking a provider that is right for them and their families. As the insurer with the longest standing Preferred Provider Organization (PPO) network in the state, we believe the key to successful partnerships is transparency. Making network changes can create abrasion for members and providers and our goal is to ensure providers understand our network offerings and requirements for consideration AND to provide members/employers with information about their network options.

As we strive to provide affordable health insurance to our consumers, it is important to have flexibility in network design to offer our members access to the most efficient and high-quality providers in the state. We believe it's imperative to ensure we have the ability to partner with providers on specific narrow networks that provide beneficial discounts for our members. An example would be if Provider A approaches BCBSND with a proposal to build a narrow network that includes a substantial discount for members who choose a product design based on Provider A's network of providers, we will build a network around that provider. These provider-based networks are mutually beneficial to all parties, allowing providers to market the value of their specialty network, enabling insurers the flexibility in network design to develop efficient and high-performance networks, and most importantly, providing services at a discounted rate for North Dakota consumers.

BCBSND has engaged in relationships with health care providers in North Dakota for over 50 years without the need for intervention by the legislature, and BCBSND currently enjoys an over 90-percent participation of in-state health care providers in its networks. These health care providers are sophisticated, multimillion-dollar professionals with trade associations, national business associations and large businesses that have been engaged in negotiating contracts with BCBSND for decades and this history affirms there is not any need for this legislation at this time. Similarly, the law in North Dakota already contains numerous provider protections under its current statutes that govern numerous

aspects of provider network arrangements in chapter 26.1-47, N.D.C.C., "Preferred Provider Networks". And these arrangements and agreements are subject to review and approval by the North Dakota Department of Insurance. Section 26.1-47-02(4), N.D.C.C.

Similarly, there are already laws established in North Dakota guaranteeing participation of certain health care providers that are also included in HB 1465. Section 26.1-36-12.2, N.D.C.C., creates an any willing provider law for pharmacists (chapter 43-15, N.D.C.C.). There are also statutes in place guaranteeing reimbursement for certain health care providers, protecting BCBSND's members in making their own choice of health care provider. See, Section 26.1-36-11, N.D.C.C., hospitals and medical doctors/doctors of osteopathy (chapter 43-17, N.D.C.C.); Section 26.1-36-12.1, N.D.C.C., medical doctors/doctors of osteopathy (chapter 43-17, N.D.C.C.) and chiropractors (chapter 43-06, N.D.C.C.), and Section 43-13-31, N.D.C.C. optometrists (chapter 43-13, N.D.C.C.). All of these statutes protect BCBSND member freedom of choice in selecting a health care provider and guaranteeing reimbursement for services covered by BCBSND. Leaving these health care providers in the listing of providers in the proposed amendment to HB 1465 is redundant and could lead to confusion in interpreting the current law. Adding an additional list of health care providers outside of those already identified will lead to confusion and limit the ability of all parties to freely contract with one another.

Our network- based products benefit consumers. Through a transparent arrangement, a member agrees to keep their care with a specific provider in exchange for a premium reduction. These products can help with coordination of care - making sure members can access out-of-network care when that care is medically necessary and not available within their chosen network. If members are seeking broad access without allegiance to a specific provider, they can choose one of our broad networks at a higher price.

At the very time where we need to be working together on solutions that lower health care costs, this bill will increase costs and premiums for North Dakotans. An actuarial study conducted by Deloitte on behalf of NDPERS indicated that the average network discounts agreed to by health systems is generally 30-40% for hospital care. Under the provisions of HB 1465, those discounts would be lost almost immediately, causing a significant increase in health insurance premiums for covered people in North Dakota. Due to the concerns raised above, BCBSND opposes 1465.

Respectfully submitted,
Megan Houn

Hi Senator Lee,

As you already know, I am an independent physician in Fargo and owner of Ambulatory surgery center for gastrointestinal endoscopy. I have been in the community since 2002 and opened my own clinic in 2013.

I provide services to all-comers without any discrimination and try to do my best to verify insurance and coverage so I could be reimbursed fairly and continue with my business of providing timely and high-quality care at an incredibly competitive cost (half of what hospitals charges). Unfortunately, in some instances and those instances are becoming more and more frequent, insurance claims are denied, or patients get stuck with high copays due to “out of network” clauses.

Health insurance plans are creating more categories for their members limiting care and patient choices to an exclusive network of clinicians, and not allowing independent clinicians participation.

This strategy although beneficial to the health insurance plans is detrimental to patients care and is the cause of:

- Delayed services
- Increase burden on patients
- Increase health care cost
- Decrease healthy competition
- Closure of small clinical practices

Small clinical practice like small business is at the heart of any viable and strong economy. It creates a special bound between clinician and patient that is not seen in big health care systems. I urge you to pass house bill 1465 to support small clinical practices in your community to improve patient care and allow more competitions instead of take over by out of State health systems.

Thank you!

Fadel Nammour

Dear Madam Chairman and Members of the Human Services Committee,

Thank you for holding the public hearing today on HB 1465, the *Patient Freedom of Healthcare Provider* bill.

I am a board-certified internist and pediatrician in private practice in Fargo. Over the past two decades I have watched the corporatization of health care sweep across North Dakota— and along with it the erosion of the patient-physician relationship. In my urgent care practice experience, it can take weeks, sometimes months, for a patient to secure a routine visit with her doctor, or else the patient will be assigned a "provider" with whom she does not have an existing relationship.

As the large corporations take over other practices, they always point to economies of scale and say their model decreases health care costs, but the reality is usually far the opposite. Instead of designing cost-effective policies which improve a patient's access to care, their focus is increasingly on controlling the health care market. One tool they use is to gain exclusive rights to health insurance networks. As an old-fashioned physician who realizes a duty to take care of a patient whether he can pay me or not, I have grown increasingly frustrated hearing the stories of long-standing patients who tell me they can't see me anymore because I am no longer in their insurance network. This must stop.

HB 1465 will NOT result in increased costs— by definition, the insurance company fixes the fees in these insurance plans and the physicians who participate simply accept them. Neither will it significantly increase an insurance company's administrative costs—most of us affected are already credentialed in their other plans. What HB 1465 WILL do is replace market control with patient choice and preserve the patient-physician relationship. After all, the original intent of health insurance is to mitigate against unexpected expense, not drive wedges between patients and their physicians.

I respectfully ask you to vote YES on HB 1465.

Sincerely,

Kurt Kooyer, MD, FAAP
Internal Medicine/Pediatrics
Urgent Medicine Associates, LLC
2829 University Drive South
Fargo, ND 58103
(701) 232-9000
www.urgentmed.org

3/9/2021

Dear Members of the Senate Human Services Committee,

Thank you for holding the public hearing on HB 1465 - Patient Freedom of Healthcare Provider bill. I am a physical therapist, who is a partner in the private practice, Achieve Therapy, in Grand Forks, ND.

HB 1465 will allow families to see the doctors and other medical providers they know and trust, whether they are in an insurance provider network or are outside of their designated network. Patients should always have that choice, and not be forced to go where their insurance designates.

As a private practice owner, trying to navigate continued decreases in reimbursement from insurances to include private and federally funded programming, it is also very difficult to see more of our patients unable to see us, not due to their choice, but rather due to their insurance constraints, thereby further decreasing our ability to keep our heads above water.

This is a common sense bill that helps keep healthcare system costs lower and gives patients who need it the most, the option to determine the best care for themselves and their families.

I appreciate your consideration and urge you to vote YES on HB 1465. If you have any questions, feel free to contact me.

Sincerely,

Laurie Holte, PT

Dear Madam Chairman and Members of the Human Services Committee,

As we approach the hearing on HB 1465, I find myself excited for the possibility of North Dakota healthcare moving in a direction where patients can choose their healthcare provider based on a multitude of factors. As a healthcare professional and a patient myself, I know there is no single best institution for the wide array of conditions and injuries a person can endure. I have spent the majority of my professional career in Fargo as an Ambulatory Surgery Center Administrator and find my time consumed with insurance network issues on a day to day basis. Many patients approach us for our expertise and we are unable to help them due to their narrow network of providers, even though we are almost always the lower cost option.

Narrow networks, when based on the logo on the outside of the healthcare provider's institution, ignore the individual provider's quality, decreases access, and assumes the patient's experience will be sufficient even if there may be a more qualified healthcare provider across the street. In a state as rural as North Dakota, I ask you take this opportunity to remove barriers to care and put our focus on what's most important, the patient.

Thank you for all you do to make North Dakota a better place to live. I ask for your support and a "Do Pass" on HB 1465.

Sincerely,

Jed LaPlante, MHA
Administrator
Center for Special Surgery
Cell: 218-205-7084
Fargo, ND

March 8, 2021

Madam Chair Lee and Members of the Senate Human Services Committee:

My name is Dr. Joe Carlson and I practice at the Bone & Joint Center as an Orthopedic Surgeon, specializing in knee and shoulder surgery. I also practice in Turtle Lake and believe House Bill 1465 would be of significant benefit for patients in that region of North Dakota.

The real issue that I see in Turtle Lake is the number of patients that actually see a Sanford physician first, then ultimately wind up becoming a patient of mine. Invariably they talk about the fact that since they had Sanford insurance, they felt compelled to see a Sanford doctor to receive treatment. While this might seem appropriate in most circumstances, patients should not be forced into this situation, if it doesn't make sense either from a treatment or logistical standpoint.

Patient choice, or any willing provider bills have been passed in multiple states. I think this bill is particularly important in our area as we have a health insurance plan that is named, unfortunately but purposely I suspect, almost identical to a healthcare provider. As you are aware this leads to an innate and I suspect purposeful confusion. House Bill 1465, in my opinion, would not only serve to save patients money in the long run but would also serve as basically Ground Zero, sending patients a message that they can see any physician that is willing to provide them care – under the same terms, conditions and price as any other provider – whether or not they are part of a narrow network. This is true patient choice. Patients we (and legislators) serve.

I respectfully request the Committee recommend a DO PASS on House Bill 1465.

Dear Madam Chairman and Members of the Human Services Committee:

The purpose of this letter is to lend my support to HB 1465 for patient freedom of provider choice. I have been practicing physical therapy in Bismarck for almost 24 years and the last 16 years as a private practice owner. Prior to this I practiced in Phoenix Arizona and Davenport Iowa for a total of five years. I have been frustrated at times with the limited options patients have to see me for specialized services in Bismarck as they are confined to a specific network insurance product, often chosen by their employer group. Unfortunately, this has forced them to see an inexperienced provider within their network with at times leading to less than desirable outcomes.

HB 1465 will allow patients to see providers of all types that specialize in the care they need without paying out of pocket or being inconvenienced by poor treatment outcomes. In addition, this bill will help prevent patients from being forced by their insurer to see an in-network provider a great distance from their home. I have seen many examples of this in Bismarck when patients are required to travel to another city even though there are experienced and qualified local providers that are excluded from the network. This leads to increased costs for the patient and the healthcare system in general not to mention the inconvenience to the patient and their family.

I appreciate your time and consideration and urge you to vote yes on HB 1465. Please feel free to contact me if you have any questions regarding my position on this bill or any other matter involving my experiences with healthcare in North Dakota.

Sincerely,

Stephen Churchill, PT/ATC
AIM Physical Therapy Clinic, LLC
Bismarck, ND 58503
701-258-7730

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

#7696

Written testimony to:

67th Legislative Assembly
Senate Human Service Committee

HB 1465

Chairman Senator Judy Lee and Committee Members

I am Paula Moch, Legislative Liaison for the North Dakota Nurse Practitioner Association (NDNPA). I am also a North Dakota resident. I am writing this written testimony on behalf of the NDNPA. The NDNPA supports HB 1465 as written.

The NDNPA supports legislation that removes barriers for the resident's in North Dakota to access quality healthcare from Advanced Practice Registered Nurses (APRN). There are currently 1830 APRNs in North Dakota as of March 7, 2021. If a policy excludes qualified healthcare providers, such as APRNs, licensed under the laws of North Dakota, it is a restriction on a North Dakota residents' right to choose a healthcare provider. This policy exclusion also puts undue purden/hardship on some North Dakota residents.

Restricting a North Dakota resident's right to choose a health care provider is North Dakota often puts undue hardship on North Dakota's most vulnerable residents. 30% of APRNs practice in rural areas (2019 North Dakota Board of Nursing) The APRN can be the only option available in a town or county. An example would be Kidder County ND, population 2466 with the only healthcare clinic in Steele, population of 740 (2019 statistics) that has one provider, an APRN. If a policy eliminates this provider, these residents need to travel outside of their town, county for healthcare. This is only one of many examples of this scenario.

This concludes my written testimony in support of HB 1465 on behalf of the NDNPA. I am happy to answer any questions in writing or via telephone.

Thank you for your time.

Paula M Moch BSN, MSN, FNP-BC
NDNPA Legislative Liaison 2021
ndnpalegislative@gmail.com
701-321-3193

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.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000
Fax: 612 397 4450
www.deloitte.com

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.

#8021

PO Box 9310
Minneapolis, MN 55440-9310
952-992-2900

MEDICA®

March 9, 2021

Senator Judy Lee
Chair, Senate Human Services Committee
North Dakota State Capitol
600 E Boulevard Ave
Bismarck, ND 58505

Dear Chair Lee,

On behalf of Medica, I want to express our opposition to HB 1465. As the Committee may be aware, Any Willing Provider (AWP) laws began appearing in some states in the 1980s. The laws permit providers who are willing to agree to an insurer's terms and conditions for inclusion in a network to demand inclusion in that network. Medica opposes AWP laws, as they stifle innovation and exacerbate increasing health care costs.

One of the roles we play as an insurer is to negotiate with providers on behalf of our members. It is consistently our goal to ensure that our members have access to affordable, quality medical care. Requiring insurers to contract with any willing provider undermines efforts to provide enrollees with access to doctors and facilities who provide the highest quality and the most cost-efficient care to our enrollees.

At present, 17 states have AWP laws that apply to either hospitals, physicians, or both. Such laws have subsequently led to higher health spending and a corresponding increase in health insurance premiums. The Federal Trade Commission (FTC) has expressed concerns about AWP mandates as regulations can result in higher premiums and may increase the number of uninsured.

"These laws can make it more difficult for health insurers or PBMs to negotiate discounts from providers; if plans cannot give providers any assurance of favorable treatment or greater volume in exchange for lower prices, then the incentive for providers to bid aggressively for the plan's business – to offer better rates – is undercut. AWP and [Freedom of Choice] FOC laws also can limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of choice. These restrictions on competition may result in insurance companies paying higher fees to providers, which, in turn, generally results in higher premiums, and may increase the number of people without coverage."[1]

[1] Federal Trade Commission Letter to Hon. James L. Seward, Senator, 51st District, New York; August 8, 2011. Accessed at http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-james-l.seward-concerning-new-york-assembly-bill-5502-bregulate-use-mail-order-pharmacies-health-plans/110808healthcarecomment.pdf.

PO Box 9310
Minneapolis, MN 55440-9310
952-992-2900

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AWP laws give health care providers rights that aren't given to other service providers. "Guaranteed" contracting or employment is nonexistent in other industries. Schools are not required to hire "any willing teacher." Airlines are not required to hire "any willing pilot." AWP mandates create 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. We note that the problem the Legislature is attempting to solve with HB 1465 (i.e., vertically-integrated health plans limiting their network offerings only to their affiliated health care providers), would actually continue to disproportionately benefit those same vertically-integrated providers. The providers affiliated with a vertically-integrated plan could demand exorbitant rate increases from the other health plans.

Looking forward, Medica supports the approach of allowing health plans to work directly with providers to build on those strategies that work, with a focus on preserving accessibility, affordability, and ensuring quality. Alternatively, the Legislature could consider requiring health insurers in the fully-insured markets to offer a broad access product wherever the insurer offers a care-system, or ACO, product. This approach was used to much success in Minnesota, and we would be happy to work with the Legislature on an amendment.

We appreciate the opportunity to offer our concerns, and are happy answer any questions related to our concerns.

Respectfully,

Matt Schafer

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
3/23/2021

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 3:35 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Surprise Bills V.S. Balance Bills
- Premium prices

[3:36] Senator Howard Anderson, District 8. Provided the committee with an overview of HB 1465 analysis from South Dakota (testimony #10574) and Christina Dahl, Diabetics Care Clinic testimony #10502 in favor.

Senator Anderson move **DO PASS.**
Senator Hogan seconded.

[3:36] Senator Kristin Roers, District 27. Provided the committee with an overview of Blue Cross and Blue Shields concerns with HB 1465.

[3:38] Jon Godfread, ND State Insurance Commissioner. Provided clarification to the committee on "surprise bills" V.S. "balance bills".

[3:46] Chrystal Bartuska, Director, Life and Health/Medicare Division, ND State Insurance Department. Provided clarification to the committee on provider contracts with insurers and the intention of HB 1465.

Senator Hogan moved to **TABLE DO PASS MOTION.**
Senator K. Roers seconded.

Voice Vote – Motion Passed.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on HB 1465 at 4:05 p.m.

Justin Velez, Committee Clerk

HB 1465 ANALYSIS:

In South Dakota, No Negative Financial Impact From Patient Choice:

Utilizing the data from The North Dakota Legislative Management Interim Healthcare Study (NDLMIHS) the goal of this analysis is to illustrate that HB 1465 will NOT increase costs in North Dakota. It seems obvious to utilize a comparison to South Dakota as South Dakota was the most recent state to have passed an "any willing provider" law in 2014. HB 1465 mirrors Measure 17 in SD.

CONCLUSION:
PATIENT CHOICE DOES NOT CAUSE SIGNIFICANT ADMINISTRATIVE COSTS

SOUTH DAKOTA AMONG THE BEST STATES IN LIMITING ADMINISTRATIVE COST GROWTH

Individual Markets: From 2014-2019, individual market administrative expense in ND had an average annual increase of 12%. For the same time period, individual administrative expense in SD had an average annual DECREASE by 3% and ranked 47th lowest in the country. Measure 17 has not negatively impacted administrative costs, and one could argue it may positively impact administrative costs. (Page 83 NDLMIHS)

Small Group Markets: From 2014-2019, Small group market administrative costs in ND had an average annual increase of 15%. For the same time period, small group market administrative costs in SD had an average annual increase of 1% and ranked 44th lowest in the country. Again, Measure 17 has not negatively impacted administrative costs in South Dakota. (Page 88 NDLMIHS)

Large Group Markets: From 2014-2019, Large group administrative costs for large group market in ND had an average annual increase of 11%. For the same time period, large group administrative costs in SD had an average annual increase of 2% and ranked 43rd lowest in the country. Measure 17 has not negatively impacted administrative costs in SD, and one again could argue that is may positively impact administrative costs. (Page 91 NDLMIHS)

CONCLUSION:
PATIENT CHOICE DOES NOT LEAD TO HIGHER INSURANCE PREMIUMS

From 2014-2019, Small group market net adjusted premiums in ND had an average annual increase of 6%. For the same time period, small market net adjusted premiums in SD had an average annual increase of 5%. South Dakota's increase was below the US average of 6%. (Page 85 NDLMIHS)

From 2014-2019, Net adjusted premiums for large group market in ND had an average annual increase of 5%. For the same time period, premiums for large group market in SD had an average annual increase of 4%. The average annual increase in the US was also 4%. (Page 89 NDLMIHS)

CONCLUSION: **NO LOSS TO HOSPITAL REVENUES**	From 2015-2018, hospital operating revenues in ND increased from $3.7 billion to $4.1 billion, a net increase of $400 million. For the same time period hospital operating revenues in SD increased from $3.9 billion to $4.6 billion, a net increase of $700 million. South Dakota had $300 million more in net revenue compared to North Dakota. Measure 17 has NOT negatively impacted hospital operating revenues in SD, and one could argue it may have positive impact on hospital revenues. (Page 44 NDLMIHS)
CONCLUSION: **NO IMPACT ON HOSPITAL OPERATING EXPENSES**	From 2015-2018, hospital operating expenses in ND increased from $3.4 billion to $4.1 billion, a net increase in $700 million. For the same time period the hospital operating expenses in SD increased from $3.6 billion to $4.3 billion, a net increase in $700 million. The net increase in operating expenses between SD and ND is the same from 2015-2018, 3 years after passing Measure 17 in SD (Page 41 NDLMIHS)

Conclusion: It seems clear from the recent data gathered for the NDLMIHS that Measure 17 in South Dakota has NOT had a negative impact on hospital operating expense, hospital operating income, premiums for individual, small, and large market insured, or administrative costs for these plans.

NORTH DAKOTA NEEDS HB 1465: **In a state where many patients are forced to travel long distances for medical care, HB 1465 allows patients to choose a local provider with the same specialties without added burden and costs to the health care system.**

Supported by North Dakotans for Open Access Healthcare, Duncan Ackerman, M.D. | dackerman@bone-joint.com

DIABETES CARE CLINIC

March 22, 2021

Good evening Senators,

My name is Christina Dahl and I am a Nurse Practitioner at Diabetes Care Clinic in Fargo, and I am a supporter of North Dakotans for Open Access Healthcare.

I urge your support for HB 1465 to give patients the right to choose their medical provider. As shown in the group's testimony and data, this is a win for patients while not burdening the health care system with significant costs.

This is not a fight about whether consolidated health care systems or independents are better for patients. Each gives many and differing benefits to patients. Instead, HB 1465 gives patients the ability to choose the right provider for each particular ailment. Their choice might depend on severity, attention and quality of care, trust, travel and proximity to home/family, specialty skills, year of experience, hours of operation, wait times and availability, and more.

These are serious considerations for a patient. However, the consolidation of health care prevents patients from truly choosing their care. Limited networks are very often chosen by employers and/or family members, not the patient. In our small state, consolidation threatens to push out specialty providers who wish to remain independent but cannot maintain adequate volumes as insurance networks tighten. Likewise, recruitment of such providers will also prove more difficult.

This bill would certainly be more questionable if it imposed significant cost and administrative burdens on insurers, but it does not. As the data shows, South Dakota saw no discernable cost impact from its patient choice law and, as most providers are already credentialed with each insurer for their other plans, insurers cannot expect a wave of new providers to credential.

This is a good bill for North Dakota patients. They deserve the ability to choose their own care. Please vote in support of HB 1465.

Sincerely,

Christina Dahl NP-C, BC-ADM

Christina Dahl, NP-C, BC-ADM

Phone: 701.540.9822 Fax: 701.540.9824
e-mail: info@dccfargo.com
website: www.dccfargo.com

1665 43rd Street South
Suite 102
Fargo, ND 58103

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
3/24/2021 AM

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 10:24 a.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Out-of-network reimbursement
- High performer rate negotiations
- Narrow network plan capability
- Availability of marketplace plans
- Self-funded V.S. fully/hybrid funded
- Consumer insurance plan options

[10:26] Senator Howard Anderson, District 8. Provided the committee with HB 1465 ND Legislative Management Interim Healthcare Study, Final Report (testimony #10648).

[10:28] Megan Houn, Blue Cross and Blue Shield. Provided clarification to the committee on high performance networks.

[10:34] Dylan Wheeler, Sanford Health Plan. Provided clarification to the committee on narrow network plan options.

[10:47] Megan Houn, Blue Cross and Blue Shield. Provided clarification to the committee on narrow network plan re-imbursement.

[10:49] Chrystal Bartuska, ND State Insurance Department. Provided clarification to the committee on ERISA, self-funded, and fully funded insurance plans authority.

[11:15] Dylan Wheeler, Sanford Health Plan. Provided the committee with an update on percentage of narrow network plans utilized.

[11:17] Courtney Koeble, Executive Director, ND Medical Association. Provided clarification to the committee on the intent of HB 1465.

Additional written testimony: N/A

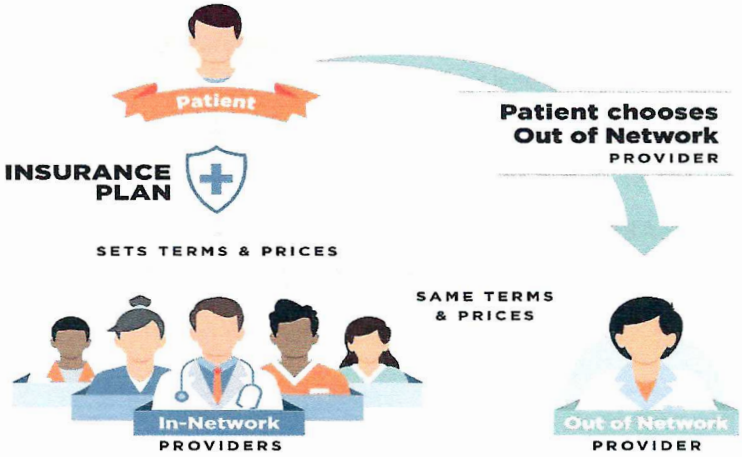
Madam Chair Lee closed the discussion on HB 1465 at 11:22 a.m.

Justin Velez, Committee Clerk

HB 1465: A Patient's Freedom to Choose a Healthcare Provider

HB1465 gives patients the freedom to choose their health care provider by guaranteeing medical providers have the opportunity to negotiate inclusion in health insurance networks.

THE PROBLEM: As healthcare networks have consolidated across the country, some insurance plans provide patients with fewer choices to see local medical experts. Consolidated market power reduces competition and patient choices. HB 1465 provides patients with the option to see the healthcare provider of their choice, provided the healthcare provider is willing, licensed, and qualified.



HB 1465 INCREASES PATIENT CHOICE: House Bill 1465 permits the patient to make the choice of who they trust to care for their healthcare needs. Insurance companies will negotiate with all willing, licensed, and qualified healthcare providers for inclusion in their networks. This will increase competition and help to control spiraling healthcare costs.

HB 1465 OPENS CHOICE FOR MORE THAN JUST DOCTORS: HB 1465 expands patient choice for healthcare providers including family physicians, surgeons, specialty physicians, dieticians, physical and occupational therapists, chiropractors, nurse practitioners, mental health providers and more.

"Competition stimulates innovation – lower prices and better quality. Competition is the ultimate consumer protection because it allows a consumer to walk away from a transaction to find a better partner."

North Dakota Legislative Management
Interim Healthcare Study, Final Report January 2021

HB 1465 GUARANTEES ACCESS TO LOWER COST PROVIDERS: HB 1465 guarantees patient access to ambulatory surgical centers (ASCs), usually referred to as outpatient centers. These facilities operate with lower costs and significantly lower prices to patients. In fact, ASCs charge 43 percent less than in-patient hospital facilities and providers outside of a hospital setting cannot charge facility charges usually charged by providers attached to hospital facilities.

> Ambulatory surgical centers charge 43 percent less than hospital outpatient facilities.
>
> **CMS Data for Medicare & Medicaid**

Below is an example of the quoted consumer price of a colonoscopy. Brightside Surgical provided its pricing and hospital pricing was identified with a secret shopper by JWHammer and was included in the Interim Healthcare Study, Final Report January 2021 by North Dakota Legislative Management.

	Brightside ASC in Bismarck	Brightside Avg. Savings	Hospital-Reported Minimum	Hospital-Reported Average	Hospital-Reported Maximum
Cost:	**$1,200**	**63.4%**	**$1,775**	**$3,282**	**$5,509**

Source: Brightside Surgical, LLC and JWHammer LLC, from the Interim Healthcare Study, Final Report January 2021

HB 1465 LOWERS PATIENT COSTS & TRAVEL: This bill allows North Dakota patients to visit their chosen provider without paying more. HB1465 will allow patients to see healthcare providers they know and trust, often in their local communities. HB1465 virtually eliminates out-of-network personal medical fees and will help control out-of-pocket costs and co-pays while improving medical outcomes. With no credible research that costs will increase, patients will spend less on care and travel.

PHARMACISTS HAVE HELD THIS ACCESS FOR DECADES: Since 1989, North Dakota pharmacists have been guaranteed the ability to be included in health insurance networks.

NORTH DAKOTA NEEDS HB 1465: In a state where many patients are forced to travel long distances for medical care, HB 1465 allows patients to choose a local provider with the same specialties without added burden and costs to the health care system.

Supported by North Dakotans for Open Access Healthcare, Duncan Ackerman, M.D. | dackerman@bone-joint.com

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
3/24/2021 PM

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 2:59 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Lower premiums
- Patient choice
- HMO/ERISA plans

Senator K. Roers moves to **REMOVE TABLED VOTE FOR RECONSIDERATION**
Senator Hogan seconded.

Voice Vote – Motion Passed.

Current motion is **DO PASS.**

Senators	Vote
Senator Judy Lee	Y
Senator Kristin Roers	N
Senator Howard C. Anderson, Jr.	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Oley Larsen	N

The motion failed 3-3-0

Senator O. Larsen moves **DO NOT PASS.**
Senator Clemens seconded.

Senators	Vote
Senator Judy Lee	N
Senator Kristin Roers	Y
Senator Howard C. Anderson, Jr.	N
Senator David A. Clemens	Y
Senator Kathy Hogan	N
Senator Oley Larsen	Y

The motion failed 3-3-0

[3:05] Chrystal Bartuska, ND State Insurance Department. Provided clarification to the committee on the intent of HB 1465 and the effects on insurance plans and consumers.

Madam Chair Lee will hold HB 1465 pending additional information from the ND State Insurance Department.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on HB 1465 at 3:14 p.m.

Justin Velez, Committee Clerk

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
3/29/2021

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 3:28 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Provider/financial impact
- Employer cost sharing
- Narrow network plans
- HMO plans
- Insurance premium plans
- Out-of-network provider coverage
- Medicaid

[3:29] Dylan Wheeler, Sanford Health Plan. Introduced Blayne Hagan to the committee.

[3:29] Blayne Hagen, Attorney, Sanford Health Plan. Provided clarification on South Dakota's any willing provider law.

[3:47] Chrystal Bartuska, ND Insurance Department. Provided clarification to the committee on the concept and implementation of freedom of choice for health care.

[3:59] Senator Judy Lee, District 13. Provided the committee with a copy of issues that farmers/ranchers have pertaining to insurance coverage in the individual market (testimony #10985).

[4:05] Dylan Wheeler, Sanford Health Plan. Provided the committee with clarification on coverage in areas not covered in an insurance policy.

[4:06] Duncan Ackerman, MD, Bone and Joint Center. Provided clarification on HMO insurance plan coverage.

Additional written testimony: N/A

Madam Chair Lee closed the hearing on HB 1465 at 4:18 p.m.

Justin Velez, Committee Clerk

ISSUES I WANT TO DISCUSS DURING THE MEETING ABOUT INS.

PREMIUMS--- PREMIUMS HAVE JUMP WHILE THE COVERAGE DROPS

DEDUCTIBLES--- THERE IS NOT ONE DEDUCTIBLE BUT INDIVIDUAL AS WELL AS FAMILY PLUS CO INSURANCE

MY POLICY INCLUDES PEDIATRIC VISION AND DENTAL BUT WHEN WE GO TO THE EYE DR IT IS OUT OF POCKET CAN'T MEET THE DEDUCTIBLE

OBAMA CARE--- THIS IS NOT AN OPTION FOR PEOPLE WHO ARE SELF EMPLOYEED AS RANCHERS OR FARMERS WE ARE NOT ABLE TO GUESS OUR SALARY FOR THE UP COMING YEAR. WITH THIS IN MIND YOU ARE THEN PENALIZED FOR MAKING OVER THE PROJECTED AMOUNT.

WHO IS THE FEDERAL GOVERNMENT AND HOW ARE THEY ABLE TO REGULATE THE PREMIUMS AND DEDUCTIBLE'S. HOW DO THEY COME UP WITH THIS.

HOW FAIR IS IT THAT MY DEDUCTIBLE JUMPED FROM $750 TO $2000 IN ONE YEAR PLUS AN INCREASE IN PREMIUMS.

WHAT WE PAY FOR 1 MONTH OF INSURANCE $1875.87 WHICH IS $22,510.44 A YEAR THEN HAVING TO PAY $2000.00 PER INDIVIDUAL PLUS A FAMILY DECDUCTIBLE PLUS CO INSURANCE. THIS RAISES THE TOTAL TO WELL OVER $30,000.00 A YEAR.

MY INSURANCE USE TO BE 80/20 I DID NOT CHOOSE TO CHANGE IT TO 70/30 THEY DID. THE PREMIUM DID NOT GO DOWN BECAUSE OF THE CHANGE BUT ONLY WENT UP ALONG WITH COVERAGE CHANGES.

INDIVIDUALS WHO ARE SELF EMPLOYEED SEEM TO BE COVERING THE COST OF PEOPLE WHO ARE NOT INSURED AND/OR PEOPLE WHO ARE ON WELFARE. I HAVE A GREAT EXAMPLE ON THIS ONE!!

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
3/30/2021

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 4:04 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Catastrophic health insurance plan

[4:04] Senator Judy Lee, District 13. Advised the committee on pending information in relation to insurance contracts from Millbank Memorial Fund, Rachel Block.

Additional written testimony: (1)

Marnie Walth, Sanford Health Plan. Written neutral testimony #11016.

Madam Chair Lee closed the discussion on HB 1465 at 4:13 p.m.

Justin Velez, Committee Clerk

Walth,Marnie

Subject: Attestation

Coverage Election

Select Your Plan Sanford TRUE $1,750

I understand that my network consists of Sanford Health providers and facilities.

Your Initials TV

I understand that this plan does not have out-of-network coverage.

Your Initials TV

I understand that when traveling outside the Sanford Health Plan service area I only have coverage and emergent services.

Your Initials TV

Note: The Sanford *Simplicity* Catastrophic $8,550 and Sanford TRUE Catastrophic $8,550 are avai individuals who are under the age of 30 before the plan year begins, or have received a hardship e certification from the Marketplace.

Agreement and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am applying for coverage as indicated on this application which is under Sanford Health Plan providing the specific health care coverage. I further understand that coverage ap will not start until after this application is accepted by Sanford Health Plan and the appropriate premium amount is received.

I certify that after this application was completed, I carefully and fully read it and that the statements an set forth are full, true, and correct to the best of my knowledge and belief, and no information required t given, either expressly or by implication, has been knowingly withheld. I understand that Sanford Healt rely on the completeness and truthfulness given in the statements made in this application. An act, pra omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant insurance coverage may be used to void this application or policy and deny claims to any person cover this Policy.

I further agree, upon request, to furnish Sanford Health Plan all information required to administer the r coverage.

[x] I have read and understand this information provided in the sections above.

Application for Individual Health Insurance

Welcome to our individual enrollment system. The secure and easy way to sign up health insurance

Important Note: Beginning February 15, 2021 through May 15, 2021, a Special Enrollment Period (SEP available to new and/or existing enrollees. To inquire about this SEP for off-exchange coverage, please c our team at 888-535-4831, or reach out to your agent directly to request the appropriate application. If yc interested in obtaining on-exchange coverage, please visit healthcare.gov or contact the Marketplace Ca (1-800-318-2596) for more information on how to enroll.

How to Apply

Instructions

Applicant must reside and maintain a street address in South Dakota or North Dakota and be a United S citizen or have a permanent green card to be eligible for this plan. Sanford TRUE applicants must reside approved county.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
4/5/2021

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 3:06 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Proposed amendment
- Healthcare plan types
- Consumer choice
- Integrated delivery network
- Employer sponsored V.S. marketplace plans

[3:06] Senator Judy Lee, District 13. Provided the committee with proposed amendment 21.0988.02001 (testimony #11372 and #11373).

[3:13] Levi Andrist, GA Group. Provided clarification to the committee on the proposed amendment 21.0988.02001.

[3:19] Chrystal Bartuska, ND Insurance Department. Provided the committee with clarification on narrow networks plans and in/out of network benefits.

[3:23] Recess

[3:27] Senator Lee re-opens the discussion on HB 1465.

[3:28] Jennifer Clark, Attorney, Legislative Council. Provided the committee with clarification on the legality of the proposed amendment and intent of amendment language.

Additional written testimony: N/A

Anna Friedt, RN-BSN, Dickinson. Written testimony #11337 in favor.

Madam Chair Lee closed the discussion on HB 1465 at 3:42 p.m.

Justin Velez, Committee Clerk

21.0988.02001

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1465

Introduced by

Representatives Westlind, Tveit, Weisz

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-36-12.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36-12.7. Freedom of choice for health care services.

1. As used in this section:
   a. "Health benefit plan" has the same meaning as provided under section 26.1-36.3-01.
   b. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
   ~~b. "Policy" means a health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis~~
   c. "Integrated delivery network" means a system of health care providers and facilities which offers both health care services and health benefit plans.
2. A health insurer, ~~including the North Dakota Medicaid programa~~s part of an integrated delivery network, may not ~~obstruct~~issue or deliver a health benefit plan within an integrated delivery network that obstructs patient choice by excluding a health care provider ~~licensed under the laws of this state~~ from participating ~~on~~in the health insurer's ~~panel of providers~~network if the provider is located within the ~~geographic~~service coverage area of the health benefit plan and is willing and fully

qualified to meet the terms and conditions of participation, as established by the health insurer.

21.0988.02001
Title.

Prepared by the Legislative Council staff for
the Senate Human Services Committee
April 5, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 8, after "a." insert ""Health benefit plan" has the same meaning as provided under section 26.1-36.3-01.

b."

Page 1, remove line 12

Page 1, line 13, replace "group, individual, blanket, franchise, or association basis" with:

"c. "Integrated delivery network" means a system of health care providers and facilities which offers both health care services and health benefit plans"

Page 1, line 14, replace "including the North Dakota Medicaid program" with "as part of an integrated delivery network"

Page 1, line 14, replace "obstruct" with "issue or deliver a health benefit plan within an integrated delivery network that obstructs"

Page 1, line 15, remove "licensed under the laws of this state"

Page 1, line 16, replace "on" with "in"

Page 1, line 16, replace "panel of providers" with "network"

Page 1, line 17, replace "geographic" with "service"

Renumber accordingly

Madam Chairman Lee and Members of the Human Services Committee,

My name is Anna Friedt and I work as a primary care nurse in Dickinson. As a native to North Dakota, I have seen first hand how access to health care can positively and negatively affect the health of a community. As a rural state, patients often have to travel lengthy distances to see specialists and receive the specific care they need. Oftentimes, patients end up locked in to specific networks, which does not take into account the very specific needs of each individual patient. As a nurse, I help patients with out of network referrals, and advocate to get them the care they need and deserve. It is frustrating to see patients forced to travel farther distances, and change providers they have known for years because it is dictated by insurance. Patient care should come first, and passing HB 1465 will help make that even more of a reality.

As a patient myself, I have also seen the problem caused by insurance networks. I have been a patient at the Bone and Joint Center for several years. Shortly after having a surgical procedure, my insurance plan dropped the Bone and Joint Center from their list of in network providers. As a result, I have had to send several appeals into my insurance company. My primary care provider has had to do the same. I was able to advocate for myself, the same way I advocate for my patients, but not all patients are able to do this. As a patient, we should be able to see the providers who know us and whom we trust without worrying about the out of network costs.

I love my job and the people I work with. I care about my patients and my community. We should not have to change jobs and insurance companies, in order to receive the care we need. North Dakotans deserve the ability to advocate for themselves and choose their providers. Everyone has the right to receive the best care possible, regardless of insurance and networks. I urge you to vote yes on HB 1465.

Respectfully,

Anna Friedt, RN-BSN

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
4/6/2021 AM

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 9:23 a.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Proposed amendment

[9:25] Senator Judy Lee, District 13. Provided the committee with proposed amendment 21.0988.02002 (testimony #11393 and #11394).

Additional written testimony: (1)

Chrystal Bartuska, ND Insurance Department. Written neutral testimony #11419.

Madam Chair Lee closed the discussion on HB 1465 at 9:26 a.m.

Justin Velez, Committee Clerk

21.0988.02002

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1465

Introduced by

Representatives Westlind, Tveit, Weisz

A BILL ~~for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.~~for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

~~**SECTION 1.** Section 26.1-36-12.7 of the North Dakota Century Code is created and enacted as follows:~~

~~**26.1-36-12.7. Freedom of choice for health care services.**~~

~~1. As used in this section:~~

~~a. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.~~

~~b. "Policy" means a health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.~~

~~2. A health insurer, including the North Dakota Medicaid program, may not obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation, as established by the health insurer.~~

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, consumer choice-of-provider implications, premium differentials offered between broad and narrow networks;

b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations;

c. A comparison of health maintenance organizations and other health insurer types; and

d. An examination of the implications for individual health plans offered on the marketplace, for health plans regulated by the federal Employee Retirement Income Security Act of 1974, and of the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

21.0988.02002
Title.

Prepared by the Legislative Council staff for
Senator Lee

April 6, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, consumer choice-of-provider implications, premium differentials offered between broad and narrow networks;

   b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations;

   c. A comparison of health maintenance organizations and other health insurer types; and

   d. An examination of the implications for individual health plans offered on the marketplace, for health plans regulated by the federal Employee Retirement Income Security Act of 1974, and of the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

21.0988.02002
Title.

Prepared by the Legislative Council staff for
Senator Lee
April 6, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, consumer choice-of-provider implications, premium differentials offered between broad and narrow networks;

   b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations;

   c. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs ~~types~~; and

~~d. An examination of the implications for individual health plans offered on the marketplace, for health plans regulated by the federal Employee Retirement Income Security Act of 1974, and of the growth of value-based purchasing.~~

d. A comparison of premiums of health benefit plans offered in the individual and small group in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations,
together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

Commented [GSJ1]: Would like to see some clarification, here. The implications of what? The implications of expanding the networks to any willing provider?

Commented [BCA2]: Not sure what this would study? ERISA plans and what is value based purchasing?

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2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1465
4/6/2021 PM

A BILL for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.

Madam Chair Lee opened the discussion on HB 1465 at 3:18 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Proposed amendment
- Network comparison
- ERISA federal change

[3:18] Senator Judy Lee, District 3. Provided the committee with proposed amendment 21.0988.02002 (testimony #11393 and #11394) and proposed amendments from Chrystal Bartuska, ND Insurance Department (testimony #11419).

[3:20] Chrystal Bartuska, ND Insurance Department. Provided the committee with clarification on proposed amendment (testimony #11419).

Senator Hogan moves to **ADOPT AMENDMENT** subsection B replaced with "a review of legislative history regarding the exclusive provider organizations and the preferred provider organizations and regulations that apply to health plans regulated by the federal ERISA of 1974".
Senator Clemens seconded.

Voice Vote – Motion passed

Senator O. Larsen moves **DO NOT PASS, AS AMENDED.**
No second. Motion failed.

Senator Hogan moves to **RECONSIDER ADOPT AMENDMENT MOTION.**
Senator Anderson seconded.

Voice Vote – Motion Passed.

Senator Hogan moves to **ADOPT AMENDMENT** 21.0988.02002
Senator Lee seconded.

Voice Vote – Motion passed

Senator Hogan moves to **FURTHER AMEND** subsection B replaced with "a review of legislative history regarding the exclusive provider organizations and the preferred provider organizations and regulations that apply to health plans regulated by the federal ERISA of 1974".

Senator Anderson seconded.

Voice Vote – Motion passed

Senator Hogan moves **DO PASS, AS AMENDED.**
Senator Lee seconded.

Senators	Vote
Senator Judy Lee	Y
Senator Kristin Roers	Y
Senator Howard C. Anderson, Jr.	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Oley Larsen	N

The motion passed 5-1-0
Senator Lee will carry HB 1465.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on HB 1465 at 3:44 p.m.

Justin Velez, Committee Clerk

Prepared by the Legislative Council staff for
Senator Lee

April 6, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, consumer choice-of-provider implications, premium differentials offered between broad and narrow networks;

   b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations;

   c. A comparison of health maintenance organizations and other health insurer types; and

   d. An examination of the implications for individual health plans offered on the marketplace, for health plans regulated by the federal Employee Retirement Income Security Act of 1974, and of the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

Adopted by the Senate Human Services Committee

April 6, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, consumer choice-of-provider implications, and premium differentials offered between broad and narrow networks;

   b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations and regulations that apply to health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs; and

   d. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1465, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed HB 1465 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

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   b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations and regulations that apply to health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs; and

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2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

21.0988.02002

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1465

Introduced by

Representatives Westlind, Tveit, Weisz

A BILL ~~for an Act to create and enact section 26.1-36-12.7 of the North Dakota Century Code, relating to freedom of choice for health care services.~~for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

~~**SECTION 1.** Section 26.1-36-12.7 of the North Dakota Century Code is created and enacted as follows:~~

~~**26.1-36-12.7. Freedom of choice for health care services.**~~

~~1. As used in this section:~~

~~a. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.~~

~~b. "Policy" means a health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.~~

~~2. A health insurer, including the North Dakota Medicaid program, may not obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation, as established by the health insurer.~~

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

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a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, consumer choice-of-provider implications, premium differentials offered between broad and narrow networks;

b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations;

c. A comparison of health maintenance organizations and other health insurer types; and

d. An examination of the implications for individual health plans offered on the marketplace, for health plans regulated by the federal Employee Retirement Income Security Act of 1974, and of the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

21.0988.02002
Title.

Prepared by the Legislative Council staff for
Senator Lee

April 6, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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   c. A comparison of health maintenance organizations and other health insurer types; and

   d. An examination of the implications for individual health plans offered on the marketplace, for health plans regulated by the federal Employee Retirement Income Security Act of 1974, and of the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

21.0988.02002
Title.

Prepared by the Legislative Council staff for
Senator Lee
April 6, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

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   b. A review of legislative history regarding the exclusive provider organizations and preferred provider organizations;

   c. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs ~~types~~; and

~~d. An examination of the implications for individual health plans offered on the marketplace, for health plans regulated by the federal Employee Retirement Income Security Act of 1974, and of the growth of value-based purchasing.~~

d. A comparison of premiums of health benefit plans offered in the individual and small group in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations,
together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

Commented [GSJ1]: Would like to see some clarification, here. The implications of what? The implications of expanding the networks to any willing provider?

Commented [BCA2]: Not sure what this would study? ERISA plans and what is value based purchasing?

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2021 CONFERENCE COMMITTEE

HB 1465

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1465
4/21/2021
Conference Committee

Relating to freedom of choice for healthcare services

Chairman Greg Westlind opened the conference committee at 11:07 a.m.

Representatives	Attendance	Senators	Attendance
Chairman Westlind	P	Chairman Howard Anderson	P
Rep. Mike Beltz	P	Sen. Judy Lee	P
Rep. Bill Devlin	P	Sen. Kathy Hogan	P

Discussion Topics:

- Study enhancements
- Policy holder costs
- Consumer options

Rep. Greg Westlind (11:07) presented proposed amendment which would "provide a clearer picture and give more data that will help with the study" - #11589

Sen. Judy Lee (11:12) moved **Senate Recede from Senate Amendments and Amend**

Sen. Kathy Hogan (11:12) second

Motion Carried Senate Recede from Senate Amendments and Amend 6-0-0

Chairman Greg Westlind adjourned at 11:17

NO STANDING COMMITTEE REPORT BECAUSE OF RECONSIDERATION ON 04/23/2021

Tamara Krause, Committee Clerk

DD 4/21/21
1 of 1

21.0988.02008
Title.04000

Adopted by the Conference Committee

April 21, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

That the Senate recede from its amendments as printed on pages 1513 and 1514 of the House Journal and pages 1256 and 1257 of the Senate Journal and that Engrossed House Bill No. 1465 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws;

   b. A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. The impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options;

   d. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs;

   e. A review of how vertical integrated networks utilize HMO plans; and

   f. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly."

Renumber accordingly

Date: 4/21/2021
Roll Call Vote #: 1

2021 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1465 as (re) engrossed

House Human Services Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen. Judy Lee Seconded by: Sen. Kathy Hogan

Representatives	4/21/21			Yes	No		Senators	4/21/21			Yes	No
Chairman Greg Westlind	P			Y			Chairman Howard Anderson	P			Y	
Rep. Mike Beltz	P			Y			Sen. Judy Lee	P			Y	
Rep. Bill Devlin	P			Y			Sen. Kathy Hogan	P			Y	
Total Rep. Vote				3			Total Senate Vote				3	

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier Rep. Greg Westlind Senate Carrier Sen. Judy Lee

LC Number 21.0988 . 02008 of amendment

LC Number 21.0988 . 04000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

21.0988.03000

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT
with Senate Amendments
ENGROSSED HOUSE BILL NO. 1465

Introduced by

Representatives Westlind, Tveit, Weisz

A BILL for an Act to provide for a legislative management study of health insurance networks.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider ~~implications~~, and premium differentials.

   ~~offered~~among states with choice-of-provider laws ~~between broad and narrow networks~~;

   b. A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and ~~regulations~~ how choice-of-provider laws apply to risk-pooled ~~that apply to~~ health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. Impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options.

   ~~c~~d. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs; ~~and~~

   ~~d~~e. A review of how vertical integrated networks utilize HMO plans.

   ~~e~~f. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth

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2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1465
4/23/2021
Conference Committee

Relating to freedom of choice for healthcare services

Chairman Greg Westlind opened the conference committee at 10:37 a.m.

Representatives	Attendance	Senators	Attendance
Chairman Westlind	P	Chairman Howard Anderson	P
Rep. Mike Beltz	P	Sen. Judy Lee	P
Rep. Bill Devlin	P	Sen. Kathy Hogan	P

RECONSIDERATION OF HB 1465

Discussion Topics:

- Executive order expiration
- Telehealth services
- E-visit and audio insurance coverage

Jennifer Clark, Legislative Council (10:40) answered committee questions

Chrystal Bartuska, North Dakota Insurance Department (10:45) presented proposed insurance department amendments - #11620

Sen. Judy Lee (10:54) moved to accept insurance department amendments "to expand ability of telehealth and codify some of the definitions that were outlined in federal guidance" and add an emergency clause

Sen. Kathy Hogan (10:55) second

Voice Vote – Motion Carried

Sen. Judy Lee (10:57) moved **Senate Recede from Senate Amendments and Amend**

Sen. Kathy Hogan (10:58) second

Roll Call Vote Passed Senate Recede from Senate Amendments and Amend 6-0-0

House Bill Carrier: Rep. Greg Westlind

Senate Bill Carrier: Sen. Judy Lee

Chairman Greg Westlind adjourned at 10:59 a.m.

NO STANDING COMMITTEE REPORT BECAUSE OF RECONSIDERATION ON 4/26/2021

Tamara Krause, Committee Clerk

Adopted by the Conference Committee

April 23, 2021

4/23/21
1 of 3

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

That the Senate recede from its amendments as printed on pages 1513 and 1514 of the House Journal and pages 1256 and 1257 of the Senate Journal and that Engrossed House Bill No. 1465 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to coverage of telehealth services; to provide for a legislative management study of health insurance networks; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-09.15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:

   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   b. "E-visit" means a face-to-face digital communication initiated by a patient to a provider through the provider's online patient portal.

   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   ~~c.~~d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   ~~d.~~e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.

   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

   ~~e.~~g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

   ~~f.~~h. "Secure connection" means a connection made using a nonpublic facing remote communication product that employs end-to-end

encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.

4/28/21
2 of 3

i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.

~~g.~~ j. "Telehealth":

(1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as ~~the insurer with the health services providers in the same manner as~~ the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

SECTION 2. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws;

   b. A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. The impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options;

   d. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs;

   e. A review of how vertical integrated networks utilize HMO plans; and

   f. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

SECTION 3. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: 4/23/2021
Roll Call Vote #: 1

2021 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1465 as (re) engrossed

House Human Services Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen. Judy Lee Seconded by: Sen. Kathy Hogan

Representatives	4/23/21	Yes	No		Senators	4/23/21	Yes	No
Chairman Greg Westlind	P	Y			Chairman Howard Anderson	P	Y	
Rep. Mike Beltz	P	Y			Sen. Judy Lee	P	Y	
Rep. Bill Devlin	P	Y			Sen. Kathy Hogan	P	Y	
Total Rep. Vote		3			Total Senate Vote		3	

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier Rep. Greg Westlind Senate Carrier Sen. Judy Lee

LC Number 21.0988 . 02009 of amendment

LC Number 21.0988 . 05000 of engrossment

Emergency clause added

Statement of purpose of amendment

Prepared by the North Dakota
Insurance Department
April 23, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

Page 1, line 1, after "Act" insert "to amend and reenact section 26.1-36-09.5 of the North Dakota Century Code, relating to coverage of telehealth services; and"

Page 1, after line 2, insert:

"**Section 1. AMENDMENT.** Section 26.1-36-09.15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:
   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.
   b. "E-visit" means a face to face digital communication initiated by a patient to a provider through the provider's online patient portal.
   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.
   d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
   e. "Non-public facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.
   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.
   g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
   h. "Secure connection" means a connection made using a non-public facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.
   i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.
   j. "Telehealth":
      (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver

health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as ~~the insurer with the health services providers in the same manner as~~ the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary."

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1465
4/26/2021
Conference Committee

Relating to freedom of choice for healthcare services

Chairman Greg Westlind opened the conference committee at 3:34 p.m.

Representatives	Attendance	Senators	Attendance
Chairman Westlind	P	Chairman Howard Anderson	P
Rep. Mike Beltz	P	Sen. Judy Lee	P
Rep. Robin Weisz	P	Sen. Kathy Hogan	P

RECONSIDERATION OF HB 1465

Discussion Topics:

- Vaccine mandate limitation

Sen. Kathy Hogan (3:35) moved to reconsider HB 1465

Rep. Robin Weisz (3:35) second

Voice vote. Motion carried.

Rep. Robin Weisz (3:35) discussed waiting on amendments from Legislative

Council **Chairman Greg Westlind** adjourned at 3:38 p.m.

HB 1465 CARRIED OVER TO 04/27/2021

Tamara Krause, Committee Clerk

Date: 4/26/2021
Roll Call Vote #:

2021 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1465 as (re) engrossed

House Human Services Committee

Action Taken

☐ **HOUSE accede to Senate Amendments**
☐ **HOUSE accede to Senate Amendments and further amend**
☐ **SENATE recede from Senate amendments**
☐ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: _____ Seconded by: _____

Representatives	4/26/21			**Yes**	**No**		**Senators**	4/26/21			**Yes**	**No**
Chairman Greg Westlind	P						Chairman Howard Anderson	P				
Rep. Mike Beltz	P						Sen. Judy Lee	P				
Rep. Robin Weisz	P						Sen. Kathy Hogan	P				
Total Rep. Vote							Total Senate Vote					

Vote Count Yes: _____ No: _____ Absent: _____

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1465
4/27/2021 AM
Conference Committee

Relating to freedom of choice for healthcare services

Chairman Greg Westlind opened the conference committee at 9:00 a.m.

Representatives	Attendance	Senators	Attendance
Chairman Westlind	P	Chairman Howard Anderson	P
Rep. Mike Beltz	P	Sen. Judy Lee	P
Rep. Robin Weisz	P	Sen. Kathy Hogan	P

RECONSIDERATION OF HB 1465 – MOTION FOR RECONSIDERATION WAS MADE 4/26/2021

Discussion Topics:

- Telehealth language
- Vaccine passport
- School immunization exception

Rep. Robin Weisz (9:00) presented **Amendments 21.0988.02010** - #11654

Rep. Robin Weisz (9:08) moved **Senate Recede from Senate Amendments and Amend 21.0988.02011**

Rep. Mike Beltz (9:09) second

Roll Call Vote – Motion Carried 6-0-0

House Bill Carrier: Rep. Robin Weisz

Senate Bill Carrier: Sen. Judy Lee

Chairman Greg Westlind adjourned at 9:10 a.m.

NO STANDING COMMITTEE REPORT BECAUSE OF RECONSIDERATION 04/27/2021 PM

Tamara Krause, Committee Clerk

21.0988.02010
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

That the Senate recede from its amendments as printed on pages 1513 and 1514 of the House Journal and pages 1256 and 1257 of the Senate Journal and that Engrossed House Bill No. 1465 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-12 of the North Dakota Century Code, relating to vaccine information; to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to coverage of telehealth services; to provide for a legislative management study; and to declare an emergency.

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:

Vaccine and infection information.

1. Except as provided under sections 15.1-23-02, 23-01-05.3, and 23-07-17.1, neither a state government entity nor any of its subdivisions, agents, or assigns may:

   a. Require documentation, whether physical or electronic, for the purpose of certifying or otherwise communicating the following before providing access to state property, funds, or services:

      (1) An individual's vaccination status;

      (2) The presence of pathogens, antigens, or antibodies; or

      (3) An individual's post-transmission recovery status;

   b. Otherwise publish or share an individual's vaccination record or similar health information, except as specifically authorized by the individual or otherwise authorized by statute; or

   c. Require a private business to obtain documentation, whether physical or electronic, for purposes of certifying or otherwise communicating the following before employment or providing access to property, funds, or services based on:

      (1) An individual's vaccination status;

      (2) The presence of pathogens, antigens, or antibodies; or

      (3) An individual's post-transmission recovery status.

2. A private business located in this state other than a health care pro may not require a patron or customer to provide any documentation certifying vaccination or post-

transmission recovery to gain access to, entry upon, or services from the business.

3. This section may not be construed to interfere with an individual's rights to access that individual's own personal health information or with a person's right to access personal health information of others which the person otherwise has a right to access.

4. Subsection 1 is not applicable to the state board of higher education, the university system, or institutions under the control of the state board of higher education to the extent the entity has adopted policies and procedures governing the type of documentation required, the circumstances under which such documentation may be shared, and exemptions from providing such documentation.

5. This section is not applicable during a disaster or emergency declared in accordance with chapter 37-17.1.

6. This section is limited in application to a vaccination authorized by the federal food and drug administration pursuant to an emergency use authorization.

SECTION 2. AMENDMENT. Section 26.1-36-09.15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:

   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   b. "E-visit" means a face-to-face digital communication initiated by a patient to a provider through the provider's online patient portal.

   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   ~~c.~~d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   ~~d.~~e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.

   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

~~e.~~g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

~~f.~~h. "Secure connection" means a connection made using a nonpublic facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.

i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.

~~g.~~j. "Telehealth":

(1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as ~~the insurer with the health services providers in the same manner as~~ the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws;

   b. A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. The impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options;

   d. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs;

   e. A review of how vertical integrated networks utilize HMO plans; and

   f. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

21.0988.02011
Title.06000

Adopted by the Conference Committee

April 27, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

That the Senate recede from its amendments as printed on pages 1513 and 1514 of the House Journal and pages 1256 and 1257 of the Senate Journal and that Engrossed House Bill No. 1465 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-12 of the North Dakota Century Code, relating to vaccine information; to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to coverage of telehealth services; to provide for a legislative management study; and to declare an emergency.

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:

Vaccine and infection information.

1. Except as provided under sections 15.1-23-02, 23-01-05.3, and 23-07-17.1, neither a state government entity nor any of its subdivisions, agents, or assigns may:

   a. Require documentation, whether physical or electronic, for the purpose of certifying or otherwise communicating the following before providing access to state property, funds, or services:

      (1) An individual's vaccination status;

      (2) The presence of pathogens, antigens, or antibodies; or

      (3) An individual's post-transmission recovery status;

   b. Otherwise publish or share an individual's vaccination record or similar health information, except as specifically authorized by the individual or otherwise authorized by statute; or

   c. Require a private business to obtain documentation, whether physical or electronic, for purposes of certifying or otherwise communicating the following before employment or providing access to property, funds, or services based on:

      (1) An individual's vaccination status;

      (2) The presence of pathogens, antigens, or antibodies; or

      (3) An individual's post-transmission recovery status.

2. A private business located in this state may not require a patron or customer to provide any documentation certifying vaccination or post-transmission recovery to gain access to, entry upon, or services from the

business. This subsection does not apply to a health care provider including a long-term care provider.

3. This section may not be construed to interfere with an individual's rights to access that individual's own personal health information or with a person's right to access personal health information of others which the person otherwise has a right to access.

4. Subsection 1 is not applicable to the state board of higher education, the university system, or institutions under the control of the state board of higher education to the extent the entity has adopted policies and procedures governing the type of documentation required, the circumstances under which such documentation may be shared, and exemptions from providing such documentation.

5. This section is not applicable during a disaster or emergency declared in accordance with chapter 37-17.1.

6. This section is limited in application to a vaccination authorized by the federal food and drug administration pursuant to an emergency use authorization.

SECTION 2. AMENDMENT. Section 26.1-36-09.15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:

   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   b. "E-visit" means a face-to-face digital communication initiated by a patient to a provider through the provider's online patient portal.

   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   ~~c.~~d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   ~~d.~~e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.

   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

~~e.~~g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

~~f.~~h. "Secure connection" means a connection made using a nonpublic facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.

i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.

~~g.~~j. "Telehealth":

(1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as ~~the insurer with the health services providers in the same manner as~~ the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws;

   b. A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. The impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options;

   d. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs;

   e. A review of how vertical integrated networks utilize HMO plans; and

   f. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: 4/27/2021
Roll Call Vote #: 1

2021 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1465 as (re) engrossed

House Human Services Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Rep. Robin Weisz Seconded by: Rep. Mike Beltz

Representatives	4/27/21 am	Yes	No		Senators	4/27/21 am	Yes	No
Chairman Greg Westlind	P	Y			Chair Howard Anderson	P	Y	
Rep. Mike Beltz	P	Y			Sen. Judy Lee	P	Y	
Rep. Robin Weisz	P	Y			Sen. Kathy Hogan	P	Y	
Total Rep. Vote		3			Total Senate Vote		3	

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier Rep. Robin Weisz Senate Carrier Sen. Judy Lee

LC Number 21.0988 . 02011 of amendment

LC Number 21.0988 . 06000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

21.0988.02010
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

That the Senate recede from its amendments as printed on pages 1513 and 1514 of the House Journal and pages 1256 and 1257 of the Senate Journal and that Engrossed House Bill No. 1465 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-12 of the North Dakota Century Code, relating to vaccine information; to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to coverage of telehealth services; to provide for a legislative management study; and to declare an emergency.

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:

Vaccine and infection information.

1. Except as provided under sections 15.1-23-02, 23-01-05.3, and 23-07-17.1, neither a state government entity nor any of its subdivisions, agents, or assigns may:

   a. Require documentation, whether physical or electronic, for the purpose of certifying or otherwise communicating the following before providing access to state property, funds, or services:

      (1) An individual's vaccination status;

      (2) The presence of pathogens, antigens, or antibodies; or

      (3) An individual's post-transmission recovery status;

   b. Otherwise publish or share an individual's vaccination record or similar health information, except as specifically authorized by the individual or otherwise authorized by statute; or

   c. Require a private business to obtain documentation, whether physical or electronic, for purposes of certifying or otherwise communicating the following before employment or providing access to property, funds, or services based on:

      (1) An individual's vaccination status;

      (2) The presence of pathogens, antigens, or antibodies; or

      (3) An individual's post-transmission recovery status.

2. A private business located in this state may not require a patron or customer to provide any documentation certifying vaccination or post-

OTHER THAN A HEALTH CARE PRO

transmission recovery to gain access to, entry upon, or services from the business.

3. This section may not be construed to interfere with an individual's rights to access that individual's own personal health information or with a person's right to access personal health information of others which the person otherwise has a right to access.

4. Subsection 1 is not applicable to the state board of higher education, the university system, or institutions under the control of the state board of higher education to the extent the entity has adopted policies and procedures governing the type of documentation required, the circumstances under which such documentation may be shared, and exemptions from providing such documentation.

5. This section is not applicable during a disaster or emergency declared in accordance with chapter 37-17.1.

6. This section is limited in application to a vaccination authorized by the federal food and drug administration pursuant to an emergency use authorization.

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   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

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   ~~d.~~e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.

   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

~~e.~~g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

~~f.~~h. "Secure connection" means a connection made using a nonpublic facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.

i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.

~~g.~~j. "Telehealth":

(1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.

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(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as ~~the insurer with the health services providers in the same manner as~~ the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

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c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

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   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws;

   b. A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. The impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options;

   d. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs;

   e. A review of how vertical integrated networks utilize HMO plans; and

   f. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1465
4/272021 PM
Conference Committee

Relating to freedom of choice for healthcare services

Chairman Greg Westlind opened the conference committee at 1:35 p.m.

Representatives	Attendance	Senators	Attendance
Chairman Westlind	P	Chairman Howard Anderson	P
Rep. Mike Beltz	P	Sen. Judy Lee	P
Rep. Robin Weisz	P	Sen. Kathy Hogan	P

RECONSIDERATION OF HB 1465

Discussion Topics:

- Public health disaster

Sen. Judy Lee (1:36) moved to reconsider HB 1465

Rep. Robin Weisz (1:36) second

Voice Vote – Motion Carried

Rep. Robin Weisz (1:37) explained that Page 2, Subsection 5 currently says this section is not applicable during a disaster or emergency and it should state not applicable during a "public health" disaster or emergency.

Rep. Robin Weisz (1:37) moved **Senate Recede from Senate Amendments and Amend**

Rep. Mike Beltz (1:37) second

Roll Call Vote – Motion Carried Senate Recede from Senate Amendments and Amend 6-0-0

House Bill Carrier: Rep. Robin Weisz

Senate Bill Carrier: Sen. Judy Lee

Chairman Greg Westlind adjourned at 1:38 p.m.

Tamara Krause, Committee Clerk

Adopted by the Conference Committee

April 27, 2021

4/27/21
1 of 4

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1465

That the Senate recede from its amendments as printed on pages 1513 and 1514 of the House Journal and pages 1256 and 1257 of the Senate Journal and that Engrossed House Bill No. 1465 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-12 of the North Dakota Century Code, relating to vaccine information; to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to coverage of telehealth services; to provide for a legislative management study; and to declare an emergency.

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:

Vaccine and infection information.

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   a. Require documentation, whether physical or electronic, for the purpose of certifying or otherwise communicating the following before providing access to state property, funds, or services:

      (1) An individual's vaccination status;

      (2) The presence of pathogens, antigens, or antibodies; or

      (3) An individual's post-transmission recovery status;

   b. Otherwise publish or share an individual's vaccination record or similar health information, except as specifically authorized by the individual or otherwise authorized by statute; or

   c. Require a private business to obtain documentation, whether physical or electronic, for purposes of certifying or otherwise communicating the following before employment or providing access to property, funds, or services based on:

      (1) An individual's vaccination status;

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2. A private business located in this state may not require a patron or customer to provide any documentation certifying vaccination or post-transmission recovery to gain access to, entry upon, or services from the

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business. This subsection does not apply to a health care provider including a long-term care provider.

3. This section may not be construed to interfere with an individual's rights to access that individual's own personal health information or with a person's right to access personal health information of others which the person otherwise has a right to access.

4. Subsection 1 is not applicable to the state board of higher education, the university system, or institutions under the control of the state board of higher education to the extent the entity has adopted policies and procedures governing the type of documentation required, the circumstances under which such documentation may be shared, and exemptions from providing such documentation.

5. This section is not applicable during a public health disaster or emergency declared in accordance with chapter 37-17.1.

6. This section is limited in application to a vaccination authorized by the federal food and drug administration pursuant to an emergency use authorization.

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   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

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   ~~d.~~e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.

   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

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3 of 4

~~e.~~g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

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(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

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5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

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2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Date: 4/27/2021
Roll Call Vote #: 1

2021 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1465 as (re) engrossed

House Human Services Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Rep. Robin Weisz Seconded by: Rep. Mike Beltz

Representatives	4/27/21 pm			Yes	No		Senators	4/27/21 pm			Yes	No
Chairman Greg Westlind	P			Y			Chairman Howard Anderson	P			Y	
Rep. Mike Beltz	P			Y			Sen. Judy Lee	P			Y	
Rep. Robin Weisz	P			Y			Sen. Kathy Hogan	P			Y	
Total Rep. Vote				3			Total Senate Vote				3	

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier Rep. Robin Weisz Senate Carrier Sen. Judy Lee

LC Number 21.0988 . 02012 of amendment

LC Number 21.0988 . 07000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Insert LC: 21.0988.02012
House Carrier: Weisz
Senate Carrier: Lee

REPORT OF CONFERENCE COMMITTEE

HB 1465, as engrossed: Your conference committee (Sens. Anderson, Lee, Hogan and Reps. Westlind, Beltz, Weisz) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ page 1513, adopt amendments as follows, and place HB 1465 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1513 and 1514 of the House Journal and pages 1256 and 1257 of the Senate Journal and that Engrossed House Bill No. 1465 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 23-12 of the North Dakota Century Code, relating to vaccine information; to amend and reenact section 26.1-36-09.15 of the North Dakota Century Code, relating to coverage of telehealth services; to provide for a legislative management study; and to declare an emergency.

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26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:

   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.

   b. "E-visit" means a face-to-face digital communication initiated by a patient to a provider through the provider's online patient portal.

   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.

   ~~c.~~d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

   ~~d.~~e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.

   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.

   ~~e.~~g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

   ~~f.~~h. "Secure connection" means a connection made using a nonpublic facing remote communication product that employs end-to-end

encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.

i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.

~~g.~~j. "Telehealth":

(1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.

(2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(3) Does not include the use of ~~audio-only telephone,~~ electronic mail, ~~or~~ facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as ~~the insurer with the health services providers in the same manner as~~ the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.

4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.

5. This section does not require:

a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;

b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;

c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the

policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or

d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE NETWORKS.

1. During the 2021-22 interim, the legislative management shall consider studying health insurance networks, including narrow networks. The study must include:

   a. Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws;

   b. A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974;

   c. The impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options;

   d. A comparison of health maintenance organizations provider network designs and other health insurer provider network designs;

   e. A review of how vertical integrated networks utilize HMO plans; and

   f. A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

2. The legislative management shall report its finding and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure."

Renumber accordingly

Engrossed HB 1465 was placed on the Seventh order of business on the calendar.