Prepared by the North Dakota Legislative Council
staff for the Insurance and Health Care Committee
July 1997

RURAL MANAGED HEALTH CARE - BACKGROUND MEMORANDUM

INTRODUCTION

House Concurrent Resolution No. 3033 directs the Legislative Council to study the effects of managed health care on the future viability of the health care delivery system in rural North Dakota. A copy of this resolution is attached as Appendix "A".

1997 LEGISLATION

The 1997 Legislative Assembly enacted two bills that directly relate to the delivery of health care. House Bill No. 1168 implements the requirements of the federal Health Insurance Portability and Accountability Act of 1996. House Bill No. 1418 prohibits insurers from interfering with certain medical communications or taking certain retaliatory actions solely on the basis of a medical communication. The bill also prohibits certain indemnity provisions in contracts between health care providers and third-party administrators.

PRIOR STUDIES

During the 1995-96 interim, the Legislative Council's Insurance and Health Care Committee studied the feasibility and desirability of implementing recommendations of the North Dakota Health Task Force for improving the health status of North Dakotans, monitoring the rate of health care cost increases, reviewing the impact of newly enacted programs to improve the health status of North Dakotans, and addressing unmet medical needs in rural areas. The committee did not recommend any legislation as a result of this study. A copy of the committee's final report is attached as Appendix "B".

During the 1993-94 interim, the Legislative Council's Health and Communications Committee studied the feasibility and desirability of allowing all North Dakota residents to participate in the uniform group insurance program and studied the feasibility and desirability of pooling all sources of funding for health care benefits in conjunction with the study by the North Dakota Health Task Force in exploring the control of costs and the redistribution of dollars toward improved access to services through a health care reimbursement system.

During the 1991-92 interim, the Legislative Council's Health Care Committee studied the need for and feasibility of adopting and implementing a state health policy for the purpose of providing basic medical and health care to all citizens of the state and studied the feasibility and ramifications of adopting and implementing a state-subsidized health insurance program for uninsured and underinsured residents.

MANAGED HEALTH CARE

Health Care Payment Systems

The three main types of health care payment systems are:

1. Fee for service - This is the traditional model, which involves reimbursement for each service received by the individual covered by the plan.
2. Health maintenance organization - Under this model, the individual covered by the plan is enrolled with a managed care organization that is responsible for delivering a full scope of services based on a predetermined fee.
3. Partial capitation model - This is a combination of the fee for service and health maintenance organization model which involves paying a predetermined fixed amount for each individual over a specified period of time regardless of the number or nature of services provided and other services are reimbursed on a fee for service basis.

Managed Care Health Care System

Managed care is a health care system that integrates the financing and delivery of a comprehensive set of health care services to covered individuals through an agreement with a service provider. Managed care combines the traditional roles of insurance companies (pay for health care) and health care providers (oversee and deliver care). Additional features common to managed care include contractual arrangements with selected providers to provide care to a specified group, organized arrangements for quality assurance and utilization review, and payment arrangements that typically include some degree of risk-sharing by providers.

In addition to managed care, there are a variety of hybrid systems, such as systems that integrate providers without assuming direct financial risk for the delivery of medical services.

Goals of Managed Care

The primary reason organizations change from fee for service models to managed care is managed care's potential to control the cost of health care. The goal of managed care is to reduce costs by contracting with providers for a comprehensive set of services at a fixed amount. As a result, providers are encouraged to avoid waste and unnecessary tests

because this would result in reduced net income to the providers.

Cost Control Methods

Methods used in the managed care system to control costs while maintaining service quality include:

1. Formal quality assurance, which is a process used by an organization to measure the extent to which providers conform to defined standards, and the process is based on the information, improved care, and outcome.
2. Utilization review, which is a process involving medical professionals outside the managed care organization who review the activities of medical professionals within the managed care organization. The review evaluates the medical necessity of various tests, treatments, and procedures based on guidelines for various diagnoses.
3. Standards for selection of health care providers within the managed care organization.
4. Mandates that members use providers and procedures within the managed care organization or significant financial incentives for members to use providers and procedures within the managed care organization.
5. Gatekeeping, which is a process to help ensure that members seek and receive only the necessary treatment and that the treatment a patient receives from different specialists is coordinated.

Types of Managed Care

Under the managed care system, providers generally do not receive compensation for each service provided as is done in the traditional fee for service system; instead, providers receive a predetermined amount per individual enrolled in the managed care plan.

Managed care covers a broad variety of models, with differing degrees of provider choice accorded participants and provider reimbursement techniques. The major types of managed care organizations include:

1. Health maintenance organizations (HMOs) are a group of providers that provide prepaid health care. Health maintenance organization providers make available a prearranged set of basic and supplemental health maintenance and medical services to the individuals covered by the plan. The individual's choice of providers is limited to those participating in the HMO. In an HMO, the individual member pays a fixed annual premium for comprehensive care rather than paying for each service received. The HMO assumes the risk that its expenses in providing care will not exceed the premiums charged.
2. Preferred provider organizations (PPOs) are systems in which a third party negotiates discounted rates for services directly with selected providers. Individuals covered by a PPO plan may use providers outside the member group; however, financial incentives encourage the use of the preferred providers.
3. Exclusive provider organizations (EPOs) are similar to PPOs except that EPO providers can be prohibited from treating any patient who is not enrolled in the organization and individuals covered by the plan are reimbursed for services received only from participating providers. The costs of services rendered by a nonparticipating provider are not reimbursed.
4. Point of service (POS) plans cover individuals by providing care from providers designated by the network. Care received from other providers will be reimbursed at significantly reduced levels.
5. Independent practice associations (IPAs) often are not exclusive for the provider. Under this model, providers have service agreements to provide health care to enrollees, and the providers also have other managed care or fee for service patients.

The main characteristic of all managed care models is the integration of the delivery of medical care and the financing of medical care into one system.

Advantages of Managed Care

Potential advantages of managed care include:

1. Improvement in coordination of care because in many managed care systems each enrollee is assigned to a single primary care physician who coordinates the delivery of comprehensive services designed to meet the enrollee's special needs.
2. Improvement in access to care when states contract with managed care organizations for services designed to overcome access barriers such as lack of transportation, language differences, multiple social problems, and the unavailability of providers willing to accept Medicaid patients.
3. Emphasis on preventive health care because managed care organizations have financial incentives to prevent illnesses and maintain health.

Concerns Related to Managed Care

Concerns related to managed care include:

1. Managed care is more costly to establish, administer, and monitor than fee for service

programs because significant startup costs are necessary for the acquisition of computer systems for the processing of utilization and quality data, and costs may also include expenses of contracting with an actuarial firm for the development of capitation rates.

2. Managed care organizations may increase their profits by limiting access to care or providing poor quality services.
3. Managed care organizations have little incentive to provide Medicaid recipients (who may be in the system for only a few months at a time) the kind of preventive care that produces cost savings only on a long-term basis.

RURAL MANAGED HEALTH CARE

Rural Issues

A recent national survey of rural hospital chief executive officers found that 47 percent of the hospitals were affiliated with another hospital or health system, and of those affiliated rural hospitals, 77 percent indicated they were affiliated in order to further managed care opportunities. The same survey found 54 percent of the rural hospital chief executive officers said that if they did not network with another hospital or health system, the rural hospital's survivability would be in question.

Benefits managed care may bring to rural communities include the potential to improve the traditionally poor access to care in rural communities, the potential to improve the traditionally poor continuity of care for rural citizens, and the potential to increase support services to rural practitioners.

Although there is virtually no general literature about the effects of managed care on costs, patterns of care, or access in rural areas, there has been nearly 20 years of speculation, and there are some managed health care issues that are of specific interest to rural communities and states.

Medicare

The February 1997 issue of *Rural Policy Brief* addresses what the fair and reasonable means of determining capitated payment for Medicare beneficiaries is in rural counties. Medicare capitation "is an issue of equity for rural Medicare beneficiaries, where equity is achieved when rural residents have the same option as their urban counterparts to choose among competing health plans." The policy brief states "the rate must be sufficiently high to attract managed care organizations to the Medicare market, . . . [and] the rate must be sufficiently low to generate savings for the Medicare program, as compared to what would otherwise be spent."

Managed care reimbursement rates are typically set by reference to Medicare fee for service rates, which are typically more likely to provide adequate revenues for managed care plans in states where Medicaid provides a generous package of benefits than in states where benefits are more limited.

Providers

One provider issue unique to rural communities is the possible difficulty of recruiting providers. Although roughly 23 percent of Americans live in rural areas, only 12 percent of physicians practice in rural areas, and up to 25 percent of these rural physicians will retire by the year 2000.

Physician attitudes can impair the acceptance of managed care in rural communities. Many physicians practicing in rural communities may find the corporate culture of managed care foreign and, as a result, physicians may be unwilling to participate in managed care until their patients change to managed care plans. Some rural providers also fear increased malpractice claims based on the community's perception of corporate deep pockets.

Rural communities may not have the luxury of selecting participants from multiple providers, resulting in shallow provider pools for participants. However, one drawback of traditional competition is that it can result in splitting the purchasing power of rural communities, reducing the ability of the community to finance adequate health care services.

Another provider concern is that managed care systems generally rely heavily on primary care physicians. Rural communities generally do not have enough primary care physicians or the primary care physicians may be difficult to recruit. Related to this issue of low numbers of physicians in rural communities, some rural physicians cannot meet board certification or eligibility requirements imposed by some managed care plans.

Participants

Rural areas remain relatively unattractive to managed care firms because managed care has been most successful where it has marketed itself to large employers. Large employers are the exception in rural communities.

Managed Care Firms

One concern related to rural managed care is that competition from urban-based plans could destroy or inadequately supplant the fragile safety nets of services to some rural communities that are sustained only by committed local physicians and community-supported hospitals and clinics. Managed care plans that fail to recognize the special needs of rural communities can damage local economies, drive away existing medical providers, and leave rural areas with fewer health care resources than before.

Economies of Scale

Some rural communities do not have large enough population bases to support the array of practitioners and services necessary to provide cost-efficient, quality health care. Economies of scale is of particular concern to hospitals. Managed care plans may be reluctant to contract with small, low-volume hospitals due to quality concerns, and excluded hospitals would lose needed revenues and financial viability.

Not-for-profit managed care providers may have an advantage when it comes to economies of scale in rural communities because not for profits do not have to generate profits for shareholders.

Antitrust Law

Some rural states fear rural health care systems will run into problems with federal and state antitrust laws. Antitrust law generally prohibits conduct by market participants that can be perceived as reducing competition or fixing prices.

NORTH DAKOTA LAW

Insurance Law

North Dakota Century Code (NDCC) Chapter 26.1-36 addresses traditional accident and health insurance requirements along with some requirements for nonprofit health service corporations and health maintenance organizations.

North Dakota Century Code Chapter 26.1-18.1 addresses the regulation of health maintenance organizations within the state. The chapter provides the powers and fiduciary responsibilities of health maintenance organizations, including reporting, mandatory enrollee grievance procedures, and information that must be provided to enrollees.

North Dakota Century Code Section 26.1-07.1-01 provides any person providing coverage for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether by direct payment, reimbursement, or otherwise, is presumed to be subject to the jurisdiction of the Commissioner of Insurance. Therefore, failure of an insurer or a third-party payer of health care to fit a particular classification does not exempt the provider from insurance regulation.

Antitrust Law

North Dakota has adopted the Uniform State Antitrust Act, which is codified as NDCC Chapter 51-08.1. Under Section 51-08.1-02, a contract, combination, or conspiracy between two or more persons in restraint of, or to monopolize, trade, or commerce in a relevant market is unlawful. Violation of state antitrust provisions may result in injunctive relief or other equitable relief, money damages, assessment of costs and attorney fees, and civil penalties.

North Dakota Century Code Chapter 23-17.5 (attached as Appendix "C") addresses cooperative agreements between health care providers. This chapter addresses antitrust issues for health care providers or third-party payers that enter into agreements that may reduce competition but benefit health care consumers. Section 23-17.5-10 provides that compliance with Chapter 23-17.5 is intended to provide state action immunity from federal antitrust laws.

STUDY APPROACH

Managed care is becoming more common in North Dakota. There are numerous sources of information relating to rural health needs and managed care in North Dakota. The State Department of Health will be a valuable source of information relating to the provision of health care services to rural North Dakotans. The University of North Dakota Rural Health Research Center has a wealth of information and expertise in local and national rural health issues. The Commissioner of Insurance will be valuable in presenting testimony relating to the trends in managed care in the state. Managed care providers and non-managed care providers' perspectives should provide needed real life insight to the issue of rural managed care. Managed care enrollees may also add a real life perspective to the issue of rural managed care in North Dakota.

The committee approach to this study may turn on how the committee views managed care in North Dakota. If managed care is perceived as a necessary evil, regulatory provisions and coping provisions may be addressed. If managed care is embraced as an opportunity to improve rural health, incentive legislation may be addressed. It is likely both the positive and negative aspects of rural managed care will need to be addressed by the committee.

Incentive legislation might address encouraging providers to network and participate in managed care, encouraging primary care physicians to practice in rural communities, increasing the breadth of existing antitrust avoidance statutes, or directly encouraging managed care companies to participate in North Dakota by lessening government regulation of managed care or providing other incentives.

Legislation might further regulate managed care in North Dakota by specifically addressing the state requirements for each type of managed care system, limiting the size and monopolistic allowances made for health providers, or increasing the barriers to larger, out-of-state, corporate managed care providers. Using this information, the committee can address existing rural health needs and anticipated rural health needs.

ATTACH:3

Fifty-fifth Legislative Assembly, State of North Dakota, begun in the Capitol in the City of Bismarck, on Monday, the sixth day of January, one thousand nine hundred and ninety-seven

HOUSE CONCURRENT RESOLUTION NO. 3033
(Representatives Callahan, Sveen, Price, Warner)
(Senator DeMers)

A concurrent resolution directing the Legislative Council to study the effects of managed health care on the future viability of the health care delivery system in rural North Dakota.

WHEREAS, the health care delivery system in rural North Dakota has been under increasing economic pressure for several years; and

WHEREAS, the system of health care financing is undergoing fundamental changes that may further adversely affect rural health care providers; and

WHEREAS, many rural areas have had a longstanding difficulty in recruiting and retaining health care personnel; and

WHEREAS, the continued viability of the health care delivery system in rural North Dakota is a necessary condition for economic development;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF NORTH DAKOTA, THE SENATE CONCURRING THEREIN:

That the Legislative Council study the effects of managed health care on the future viability of the health care delivery system in rural North Dakota; and

BE IT FURTHER RESOLVED, that the Legislative Council report its findings and recommendations, together with any legislation required to implement the recommendations, to the Fifty-sixth Legislative Assembly.

Filed March 18, 1997

INSURANCE AND HEALTH CARE COMMITTEE

The Insurance and Health Care Committee was assigned four studies. Section 39 of House Bill No. 1050 directed a study of the feasibility and desirability of requiring mental health services and alcohol and drug addiction related services to be included as health insurance covered services. House Concurrent Resolution No. 3008 directed a study of the feasibility and desirability of implementing recommendations by the North Dakota Health Task Force for improving the health status of North Dakotans, the rate of health care cost increases, the impact of newly enacted programs to improve the health status of North Dakotans, and the unmet medical needs in rural areas. House Concurrent Resolution No. 3023 directed a study of the availability, coverage, and regulation of long-term care insurance. Section 1 of Senate Bill No. 2460 required a study, in conjunction with the Health Council, of the certificate of need process and other means of planning and decisionmaking in relation to the growth of the health care industry in North Dakota. The Legislative Council also assigned to the committee the responsibility to receive reports from the Commissioner of Insurance relating to basic health insurance coverage and to the progress of the partnership for long-term care program.

Committee members were Representatives Ken Svedjan (Chairman), Eliot Glassheim, G. Jane Gunter, Dale Henegar, George Keiser, RaeAnn Kelsch, Bruce Laughlin, John Mahoney, David Monson, Marv Mutzenberger, Doug Payne, Clara Sue Price, Jim Torgerson, and Francis J. Wald and Senators Judy L. DeMers, Judy Lee, Tim Mathern, and Russell T. Thane.

The committee submitted this report to the Legislative Council at the biennial meeting of the Council in November 1996. The Council accepted the report for submission to the 55th Legislative Assembly.

MENTAL HEALTH AND ALCOHOL AND DRUG ADDICTION INSURANCE STUDY

Background

Mental health services and substance addiction related services are required to be covered services by health insurance in certain instances. North Dakota Century Code (NDCC) Section 26.1-36-08 provides that an insurance company, nonprofit health services corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group, blanket, franchise, or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illnesses.

North Dakota Century Code Section 26.1-36-09 provides that an insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group, blanket, franchise, or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of mental disorders and other related illnesses.

During the 1995 legislative session, an amendment was proposed to House Bill No. 1050 to require a basic health plan and a standard health plan issued on an individual or group basis to include coverage for the treatment of substance abuse and mental disorders which meets or exceeds the minimum requirements of NDCC Sections 26.1-36-08 and 26.1-36-09. The proposed amendment failed to pass.

The issue of mandating health insurance coverage in North Dakota was reviewed by the Legislative Council's Industry and Business Committee during the 1989-90 interim. Mandated coverages for health services in North Dakota include coverage for health services performed by an advanced registered nurse practitioner (NDCC Section 26.1-36-09.5); certain coverage for the diagnosis, evaluation, and treatment of alcoholism or drug addiction under group health policies and health service contracts (NDCC Section 26.1-36-08); certain coverage for the diagnosis, evaluation, and treatment of mental disorders under group health policies and health service contracts (NDCC Section 26.1-36-09); certain coverage for mammogram examinations (NDCC Section 26.1-36-09.1); certain coverage for involuntary complications of pregnancy (NDCC Section 26.1-36-09.2); coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorders (NDCC Section 26.1-36-09.3); nondiscrimination provisions relating to chiropractic services (NDCC Section 26.1-36-12.1); and nondiscrimination provisions relating to optometric services (NDCC Section 43-13-31).

Testimony to that committee indicated the problem of increased unaffordability of health insurance coverage could be due to the increasing number of providers and legislatively mandated benefits and coverages. That committee recommended House Bill No. 1043 (1991) to prohibit the introduction of legislation or the consideration of amendments mandating health insurance coverage unless the proposal is accompanied by a report prepared by the Commissioner of Insurance which assesses the impact of the proposal. The bill failed to pass the Senate.

That committee also recommended House Bill No. 1042 (1991), which allowed the offering of a basic health insurance coverage plan, free of certain mandated coverages, to individuals and employers with fewer than 25 employees who have been without health insurance coverage for at least 12 months preceding the date of application for the coverage. The bill was passed by the Legislative Assembly.

Testimony and Committee Considerations

Mental health and substance abuse mandates only apply to group policies. Testimony indicated approximately 90 percent of all health insurance written in the state is on a group basis, and Blue Cross Blue Shield of North Dakota opts to include these mandates in its individual policies. Employer self-funded Employee Retirement Income Security Act group plans are exempt from state jurisdiction, and therefore are not required to comply with state mandates. Data from Blue Cross Blue Shield of North Dakota indicated approximately one-half of its self-funded businesses provide the state-mandated coverage. Approximately three to four percent of the individual insurance contracts written in the state do not contain these mandates.

Representatives of the Mental Health Association of North Dakota and the North Dakota Treatment Providers Coalition testified that mental illness and alcohol and drug addiction are illnesses that should be treated on an equal basis (parity) with insurance coverage for physical illnesses. They suggested the committee recommend legislation either granting mental health and drug and alcohol addiction treatment parity coverage with that for physical illnesses or rearrange the current limits set for mental health and drug and alcohol addiction coverage so the limits better address the types of treatment used today. The coalition testified that current insurance coverage for drug and alcohol addiction needs to be revamped to reflect the need for more outpatient treatment and less restrictive treatment.

A representative of Blue Cross Blue Shield of North Dakota testified North Dakota already has parity coverage for mental health and substance abuse services in that other disorders have limits similar to the mental health and substance abuse limits.

Representatives of insurers suggested that parity is not necessary for mental health and drug and alcohol addiction treatment in this state. Testimony also indicated that North Dakota's limits for mental health and drug and alcohol addiction insurance coverage are already higher than most other states and that most policyholders did not reach the limits for mental health and drug and alcohol addiction treatment. Insurers testified that a small minority of individuals--the seriously mentally ill--cost the system the largest amount of money, and it is these individuals who reach the caps of mental health insurance coverage.

The testimony indicated insurers want to maintain annual use limits for three reasons--without limits, more subscribers may use more services; limits encourage wise use of benefits; and limits provide a point at which cases are evaluated for medical necessity before approving funding for services beyond the limit. It was suggested that if caps are removed, something else will be needed to keep premiums down, such as sliding copayments, higher copayments, or aggressively managed care.

The committee received information on studies in other states which concluded that medical costs decrease as a result of parity coverage. The information indicated that parity has shown cost savings where there is a closed panel situation, a significant gatekeeper, and a single employer situation. The committee also reviewed data concerning parity legislation in other states and Manitoba, Canada. The data indicated coverage provided by parity legislation varies significantly from state to state.

The committee also received testimony from the medical assistance office of the Department of Human Services regarding the impact of mental health and drug and alcohol addiction treatment on Medicaid funds. In many instances, the services provided under Medicaid funds have become a safety net for individuals without mental health insurance coverage, or individuals whose mental health coverage only provides limited benefits. The Medicaid program also provides mental health clinic services through human service centers, payments for psychiatric and psychological services, and services for certain groups of patients at the State Hospital. Testimony indicated that although the Medicaid program does provide mental health services, the services may not be flexible enough to meet the needs of the mentally ill and thus Medicaid recipients may not always receive needed care in the least restrictive environment. Testimony indicated that a managed care environment could have a positive effect on Medicaid services for the mentally ill.

The committee received testimony that most mental health expenditures are for inpatient treatment, which is the treatment primarily responsible for the rising mental health costs; a large percentage of inpatient treatment can be effectively delivered in outpatient settings; and outpatient treatment is less costly than inpatient treatment.

A member of the North Dakota Treatment Providers Coalition recommended that current insurance coverage for substance addiction be changed to reflect the need for more outpatient and less restrictive treatment. The coalition member testified that increased lengths of stay in outpatient treatment programs improve patient outcome, and the trend to move from inpatient to outpatient programs has resulted in decreased treatment costs. Testimony disputed whether these recommendations would save money right away or whether it would instead save money in the long term.

The committee received testimony regarding the cost of addictive and mental disorders and the effectiveness of treatment. Persons untreated for mental illness and substance abuse may end up in penal or other state institutions. Ninety to 95 percent of people in penal or other state institutions have a substance addiction problem.

Proposals Considered

Members of the North Dakota Treatment Providers Coalition presented recommendations for substance abuse legislation. The recommendations included reducing the psychiatric inpatient mandate from 60 days to 30 days, increasing the outpatient mandate from 20 sessions to 75 sessions of intensive outpatient treatment, and adding 48 sessions of low intensity outpatient treatment. These mandates would apply to both individual and group health insurance plans. Proponents said this plan might increase costs in the short term, but long term it would be cost-effective because of the resulting reduction in crime and other social problems.

In response to an effort by the coalition, Blue Cross Blue Shield of North Dakota, treatment providers, and the Division of Alcoholism and Drug Abuse, members of the coalition presented a second proposal, this time to amend NDCC Section 26.1-36-08 to expand the number of facilities that can provide substance abuse services to include addiction treatment programs, and to expand the definition of partial hospitalization to include medically necessary treatment services provided by licensed professionals.

A member of the North Dakota District Branch of the American Psychiatric Association expressed concern over the coalition's proposal because psychiatrists are an integral part of treating individuals with both substance abuse and psychological problems.

Testimony was received that the treatment of mental health conditions has evolved in the last 10 to 15 years from the traditional inpatient and outpatient treatment programs to one that provides for the assignment of a case manager to design a treatment program for a particular person, psychosocial rehabilitation, and when appropriate, residential treatment.

The committee considered adding residential treatment, case management, and psychiatric rehabilitation to the current coverage required for mental health services. A representative of insurers requested these terms be statutorily defined.

Recommendations

The committee recommends Senate Bill No. 2040 to require group mental health policy coverage to include residential treatment. This bill also deletes the definition of "partial hospitalization" that is currently in the statute.

The committee recommends Senate Bill No. 2041 to require group health substance abuse policy coverage to include licensed addiction treatment programs. The bill also provides that medically necessary treatment services provided under partial hospitalization no longer must be provided under the supervision of a licensed physician.

NORTH DAKOTA HEALTH TASK FORCE RECOMMENDATIONS STUDY

Recent Legislative Council Health Insurance Studies

During the 1987-88 interim, the Legislative Council's Budget Committee on Government Administration studied the health care insurance needs of individuals who did not have access to insurance coverage. Information presented to that committee indicated that between 10.6 and 12 percent of the state's population was either uninsured, underinsured, or without access to health services.

During the 1989-90 interim, the Legislative Council's Industry and Business Committee studied the health care insurance needs of uninsured and underinsured persons. Testimony received by the committee indicated that approximately 8.8 percent of the state's population were without health insurance coverage. The committee concluded that, absent changes in the health care delivery system, efforts to address the needs of the uninsured and underinsured must target a well-defined population and must be sensitive to the economic environment within which the efforts are implemented.

During the 1991-92 interim, the Legislative Council's Health Care Committee studied the need for a state health policy for the purpose of providing basic medical and health care to all citizens of this state, and the feasibility of adopting a state-subsidized health insurance program for uninsured and underinsured residents of the state. During these studies, the committee was informed of the efforts of the North Dakota Health Task Force.

During the 1993-94 interim, the Legislative Council's Health and Communications Committee studied the feasibility and desirability of allowing all North Dakota residents to participate in the Public Employees Retirement System uniform group insurance program. The committee also studied the feasibility and desirability of pooling all sources of funding for health care benefits in conjunction with the North Dakota Health Task Force study of the control of costs and the redistribution of dollars toward improved access to services through a health care reimbursement system. The committee reviewed recommendations for health care reform that were prepared by the North Dakota Health Task Force. The committee also received testimony concerning the North Dakota Health Task Force recommendations, federal initiatives for health care, and the uniform group insurance program.

North Dakota Health Task Force

The State Health Council established the North Dakota Health Task Force in 1990 to identify and

address the major health issues facing the state and to develop appropriate recommendations for change. The task force identified six critical areas in its review of the health care crisis--cost, education and prevention, access, regulation, manpower, and health care policy and delivery systems. In June 1994, the task force submitted its final recommendations on health care reform to the State Health Officer, the State Health Council, and the Governor. The task force also submitted the final recommendations for improving the health status of North Dakotans. These recommendations contained the following principles:

- Emergency medical services should be available within five minutes to 90 percent of the population in urban areas and within 10 minutes to 90 percent of the population in rural areas.
- A 911 emergency number system should be extended statewide.
- Access to primary care should be available within 30 minutes at least once per week to at least 90 percent of the rural population.
- The Commissioner of Insurance and Health Insurance Advisory Committee should establish common standards for health lifestyle incentives and health promotion options for health insurance policies with appropriate areas for discounts.
- The State Health Officer should establish a broad-based Health Education Committee to develop instructional objectives for a health education curriculum for kindergarten through 12th grade.
- The State Health Council should develop a comprehensive statewide assessment of North Dakotans' health status and health care services. This information should be used to identify and prioritize areas that require actions to enhance North Dakotans' health status. A comprehensive health system strategy including evaluation methods should be developed to provide guidance for resource allocation.

Testimony and Committee Considerations

The committee received testimony from a representative of the State Health Council indicating that the council is trying to implement several of the North Dakota Health Task Force recommendations for improving the health status of North Dakotans. The State Health Officer testified the council should proceed with a study on implementing the Health Task Force recommendations for improving the health status of North Dakotans.

Emergency Medical Service Availability

Many of North Dakota's hospitals have completed the certification process to be designated Level II (urban) and Level IV (rural) trauma centers. Using 50-mile radii, 91.26 percent of the state has trauma center coverage, and 94.27 percent of the population has trauma center coverage. Using four-mile radii, ambulance and quick response services cover 12.44 percent of the state and 29.21 percent of the population; using seven-mile radii, these services cover 34.63 percent of the state and 56.29 percent of the population.

Primary Care Access

The Department of Health surveyed rural health clinics. Preliminary assessment of the survey results indicates that rural health clinics are providing primary care to the population within a 30-minute range, available at least once a week, to 90 percent of the state's population.

Health Education, Lifestyles, and Assessment

Representatives of the Department of Health testified that although health education curriculum is available throughout North Dakota, it is not being implemented uniformly across the state.

The State Health Officer described the dilemma regarding implementation of insurance incentives intended to change a person's lifestyle because the incentives need to be effective without being unduly burdensome.

Testimony indicated the Department of Health is enhancing its data system through the use of geographical information system software. The enhancements are intended to make it easy for consumers to access information on health care costs and services and to enable the department to make comparisons of health care costs and services among the various regions of the state. This data will be instrumental in the department completing a comprehensive statewide assessment of health status and health care services and identifying and prioritizing actions to enhance health status.

Impact of Newly Enacted Programs

A representative from the Department of Health testified it is too early to review the impact of newly enacted programs. The department is preparing a report on the health status of North Dakotans for selected diseases and injuries that are a major cause of death or that lead to a substantial reduction in the average life span. North Dakota is meeting or approaching national goals established under the "Healthy People 2000" project. The percentage of low weight births has been declining, the rate of Caesarean section deliveries is below the national average, and the statewide age-adjusted death rate for diabetes is within range of the national goals. However, the age-adjusted death rate for American Indians substantially exceeds national goals.

Health Care Expenditures

A representative of the Department of Health testified the department is working on a project to measure the health care costs of North Dakotans. The goal of the study is to adjust expenditures for border crossings and for services provided by the Indian Health Service, the Veterans Administration, and military hospitals in order to develop a better estimate of the total and per capita expenditures for health care received by citizens of

North Dakota.

A preliminary analysis of health care expenditures in North Dakota indicates that per capita health care expenditures in the state and the trend in those expenditures are both below national averages. Data indicates North Dakota is consistent with national reports indicating a substantial reduction in the growth of health care expenditures during 1994-95.

Impact of 1995 Legislation on Insurance Costs

A representative of the Commissioner of Insurance testified it is the consensus of insurance companies in the state that the insurance reforms passed in 1995 will not have a large impact on insurance premiums and have had very little effect on the small group market.

Testimony from representatives of the North Dakota Association of Life Underwriters indicated that several one-gender businesses will not be able to afford premiums because of the gender rating reform. The data received by the committee indicates some businesses' insurance premiums have increased, while others have decreased.

A representative from Blue Cross Blue Shield of North Dakota testified the small group insurance reforms passed in 1993 and the insurance reform legislation in 1995 have had a positive effect on the marketplace, and there have not been any major negative consequences during the implementation process. Testimony indicated that there has not been a significant change in the number of insured persons in the state over the past several years.

The committee received testimony regarding the impact the 1995 legislation had on two areas under the jurisdiction of the Department of Human Services. First, the increase in the medically needy income levels has allowed individuals who have worked and earned Social Security benefits to keep some additional funds to meet their maintenance needs that would have otherwise been applied to recipient liability. Second, the addition to the Medicaid program of poverty-level children born before September 30, 1983, who have family income at or below 100 percent of the federal poverty level, has resulted in an increase in eligible children, and has reduced the number of medically needy children who would have been required to incur a recipient liability before Medicaid would have begun paying for medical services.

Conclusion

The committee urges the State Health Council continue studying the implementation of the Health Task Force recommendations for improving the health status of North Dakotans.

LONG-TERM CARE INSURANCE STUDY

Background

Long-term care consists of services for the chronically ill or infirm, senior citizen adult day care, senior citizen hospice care, and senior citizen home health care. Long-term care insurance is any insurance policy primarily advertised, marketed, offered, or designed to provide coverage for not less than one year for each covered person on an expense-incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Long-term care insurance in North Dakota is governed under NDCC Chapter 26.1-45. Several insurance companies offer long-term care insurance policies in this state.

In 1993 the Legislative Assembly passed Senate Bill No. 2311, which provided an income tax credit for premiums paid for long-term care insurance for taxpayers using the long form for income taxes. This legislation was codified as NDCC Section 57-38-29.2.

In 1995 the Legislative Assembly enacted Senate Bill No. 2538 relating to the effect of nursing home insurance on medical assistance eligibility.

Three other bills were introduced in 1995 that related to long-term care insurance but they failed to pass. Senate Bill No. 2436 would have provided an income tax deduction for premiums paid for long-term care insurance coverage. Senate Bill No. 2083 would have provided an income tax credit for premiums paid for long-term care insurance coverage for persons using the short-form income tax form. Both bills failed to pass the Senate. Senate Bill No. 2161 would have provided long-term care insurance nonforfeiture benefits. Senate Bill No. 2161 failed to pass the House.

Medicaid

The Medicaid program was established in 1965 under Title XIX of the Social Security Act. All states are required to offer basic health care services to certain low-income individuals and families. The federal government reimburses states for part of the cost of providing required services. States are allowed to include additional services, as Medicaid-covered services, and may receive federal reimbursement for part of the cost of the additional services.

The Health Care Financing Administration, a division of the United States Department of Health and Human Services, administers Medicaid at the federal level. States are required to follow Medicaid rules and guidelines set by the Health Care Financing Administration. States may also establish their own guidelines and rules for the administration of Medicaid at the state level. All state Medicaid programs must stay within the scope of the federal rules and regulations, but there may be a variation among state programs.

The Department of Human Services is responsible for administering the Medicaid program at the state level.

Testimony and Committee Considerations

The committee received testimony indicating that long-term care insurance is more accepted in

North Dakota than in other states. It is estimated that four percent of nursing home residents in North Dakota have their care paid for by a private, long-term care insurance policy compared to only two percent nationwide. A representative of the Commissioner of Insurance testified that a long-term care insurance policy is generally not considered suitable for someone with less than $200,000 in assets.

The committee received testimony indicating the Medicaid program is the primary payer of institutional long-term care services in North Dakota. Although only 12 percent of the people on Medicaid are in nursing homes, they use up to 60 percent of Medicaid funds. Medicaid assists 58 percent of the nursing facility residents in North Dakota.

Annual Medicaid expenditures for nursing facility services exceeded $100 million for the first time during fiscal year 1995. The committee reviewed alternatives to the use of nursing facility services for long-term care. The Department of Human Services operates several programs that provide funds for alternatives to institutional long-term care by allowing individuals to remain in the community, including the home and community-based services (HCBS) program, which uses federal waivers to help fund the program, and the service payments for elderly and disabled (SPED) program, which is funded by state and local funds and is provided for those individuals who do not meet requirements of the home and community-based services program. The Medicaid program expended $1.7 million for home and community-based care in fiscal year 1995 as compared to $100.6 million for nursing facility care.

Senate Bill No. 2538 (1995)

Senate Bill No. 2538 provided that an individual who secures insurance to cover necessary medical and nursing home care may provide proof of that insurance to demonstrate that an asset was disposed of exclusively for a purpose other than to qualify for medical assistance.

A working group on the implementation of Senate Bill No. 2538 consisting of representatives from the Department of Human Services, the Commissioner of Insurance, the insurance industry, and the long-term care industry, has concluded:

- Long-term care insurance should be described in terms of the daily benefit amount and set at 125 percent of the average daily cost of nursing home care in North Dakota for the year the policy is issued. The minimum term would be a total of three years.
- In addition to the long-term care coverage, persons with Medicare benefits would be required to secure a substantial Medicare supplement policy. Persons without Medicare coverage would be required to secure substantial major medical coverage with a maximum annual deductible of $5,000 and a lifetime maximum benefit of $1 million or more.
- There is no single way of providing proof of the insurance, but the working group designed some forms to be used by insurance agents as one means of demonstrating verification.

The working group developed draft rules for consideration by the Department of Human Services. After the rules are adopted, the intent is to inform the public about the insurance product.

Testimony also indicated concern as to the need for the insurance product available under Senate Bill No. 2538 (the insurance product acts as a financial planning tool by allowing a person to retain that person's assets longer), and a concern over public awareness of the insurance product.

Long-Term Care Task Force Recommendations

A member of the North Dakota Long-Term Care Task Force recommended the Legislative Assembly enact legislation that:

- Mandates that spousal impoverishment be extended to individuals who access home and community-based services to ensure that the same policies are applied to everyone using long-term care services through the Medicaid program.
- Creates a Comprehensive Health Association of North Dakota (CHAND)-type product for an individual who, because of preexisting conditions, is refused coverage for long-term care insurance.
- Requires long-term care insurance plans to allow a provider of home and community-based care to meet a qualifying standard, such as a qualified service provider (an agency or individual limited to providing care that does not require nurse supervision or a license, but who meets competency standards established by the Department of Human Services) that is less extensive than the current licensing requirement.
- Allows an individual who purchases long-term care insurance to claim a tax credit of 25 percent of the premium up to a maximum of $100 on the short-form income tax form.
- Allows a private business that offers long-term care insurance to its employees a tax deduction or credit.
- Provides, with specific exceptions, a person who transfers an asset for less than fair market value under certain conditions would have the right to get the asset back, thereby creating an asset that may be counted in determining Medicaid eligibility.

The estimated fiscal impact of allowing a 25 percent tax credit with a maximum of $100 for purchasers of long-term care insurance is $3.8 million to $4.2 million per biennium. The fiscal impact of a Comprehensive Health Association-type program for long-term care insurance was unknown, but could be quite expensive.

Recommendations

The committee recommends House Bill No. 1061 to extend medical assistance spousal impoverishment to include individuals who access home and community-based services.

The committee recommends Senate Bill No. 2042 to require insurance companies providing long-term care coverage for home and community-based services to pay providers meeting qualified service provider standards; to allow for an income tax credit on short-form income tax forms in the amount of 25 percent (not to exceed $100 in any taxable year) of any premiums paid by the taxpayer for long-term care insurance coverage for the taxpayer, the taxpayer's spouse, parent, or stepparent; and to allow an employer who provides long-term care insurance to its employees to claim a credit in the amount of 25 percent (not to exceed $100 per employee) of any premiums paid by the employer.

The committee recommends House Bill No. 1062 to provide that transfers made or obligations incurred are fraudulent as to medical creditors if the transfer was made without receiving equivalent value and the debtor was receiving or contemplated receiving medical care for which the assets of the debtor were unreasonably small in relation to the cost of the medical care, or the debtor believed or reasonably should have believed the debtor would incur debts beyond the debtor's ability to pay. If a debtor is found eligible for medical assistance, the Department of Human Services may bring an action in the name of the debtor. Certain transfers which would otherwise be fraudulent are defined as not being fraudulent if certain conditions are met; for example, transfers made to charitable organizations, transfers to family members that cumulatively do not exceed $75,000, or transfers when the transferee purchases a long-term care insurance policy for the debtor. The bill also provides for the creation of a Medicaid education fund to develop educational materials and to provide educational services to inform potential recipients of medical assistance of the limits of taxpayer-supported medical services and defines what is included in a decedent's estate subject to claim under NDCC Section 50-24.1-07.

CERTIFICATE OF NEED STUDY

Background

Certificate of need is a regulatory review process under which health care facilities and organizations are required to obtain approval from the state for capital expenditures or expansions of services. Certificate of need laws are designed to reduce health care costs by reducing hospital expenditures that are believed to be unnecessary. The idea is that unrestricted spending by hospitals on capital construction and technology is the reason for the increasing cost of health care.

The National Health Planning and Resources Development Act of 1974 required states to enact certificate of need laws or risk the loss of federal funds for health care. In response to the Act, every state except Louisiana enacted a certificate of need program. In the early 1980s, however, support for the certificate of need program decreased amid reports that certificate of need laws failed to restrain costs. In 1982 Congress removed the requirement that states enact certificate of need laws or risk loss of federal funds. In 1986 federal funds for certificate of need programs were eliminated. Today, certificate of need programs exist solely at state discretion.

Since the federal requirement to maintain a certificate of need program was removed, 12 states have repealed their certificate of need programs or allowed the programs to sunset. Some other states raised the capital expenditure threshold so all expenditures except for very large expenditures would be exempt from certificate of need review.

The states that no longer have a certificate of need program include North Dakota (effective April 1, 1995), Minnesota, South Dakota, Idaho, New Mexico, Arizona, Kansas, Texas, California, Colorado, Utah, and Wyoming.

Because of rising medical costs, some states have strengthened or are considering legislation to strengthen their certificate of need programs. For example, Georgia, West Virginia, and Delaware have strengthened their certificate of need laws by lowering the thresholds for review or adding more expenditures under the purview of certificate of need. Also, Florida, Indiana, Maryland, Missouri, Pennsylvania, and Tennessee have extended the expiration dates of their certificate of need programs. Although Minnesota has no certificate of need program, extensive capital expenditure review has been adopted in that state.

Testimony and Committee Considerations

The committee received testimony indicating circumstances unique to North Dakota lessen the usefulness of the certificate of need process. North Dakota has never had a vested interest in hospital expenditures and expansions; therefore, there is very little incentive to regulate these activities in North Dakota. Furthermore, North Dakota is the only state that has lost population within the last 15 years, and will probably be at the peak of its elderly population during the next several years.

The committee also received testimony indicating that the State Health Council and the North Dakota Long-Term Care Task Force were studying the effect of the repeal of the certificate of need law and the moratorium on the licensing of additional long-term care bed capacity. The State Health Council recommended there is no need to resume certificate of need for acute care hospitals at the present time. The North Dakota Long-Term Care Task Force recommendations regarding the moratorium were presented to the interim Budget Committee on Home and Community Care.

Conclusion

The committee makes no recommendation regarding certificate of need legislation.

BASIC HEALTH POLICY REPORT

The committee received a report from the Commissioner of Insurance on the progress of the implementation of a basic health policy. The basic health policy is available to individuals or to employers with fewer than 25 employees who have not had health insurance for at least 12 months before applying for coverage. The policy is to be offered without mandated coverage for the care and treatment of substance abuse, for the care and treatment of mental disorders, for mammogram examinations, and for surgical and nonsurgical treatment of temporomandibular joint disorder and a craniomandibular disorder.

The commissioner reported Blue Cross Blue Shield of North Dakota is the only carrier that markets the plan, and since January 1, 1992, only five policies covering 11 individuals have been sold. No group plans have been sold, and no plans are currently in force concerning group plans. No rate increases have incurred on the product since first issuance of the policies on January 1, 1992.

The commissioner reported that the basic health policy has not been a success in the marketplace. The commissioner suggested that the continuation of the basic health policy program does not appear necessary because of insurance reforms. The basic health policy program is scheduled to sunset June 30, 1997.

PARTNERSHIP FOR LONG-TERM CARE PROGRAM REPORT

The committee received a report of the Commissioner of Insurance on the progress of the partnership for long-term care program. Representatives of the commissioner disclosed that the program was never put into effect because Congress passed the Omnibus Budget Reconciliation Act of 1993, which contained provisions precluding the pursuit of the program. Because the federal law changed, the state had no further authority to pursue the program.

MISCELLANEOUS

Postdelivery Length of Hospital Stay

Background

In response to the national concern over what was being termed "drive-through deliveries," the committee reviewed practices relating to postdelivery length of hospital stay for mothers and newborns and postdischarge followup care.

Length of Stay

The committee received testimony that infant illnesses such as jaundice generally do not show up until the second or third day of life, and infant illnesses are decreased if a new infant stays in the hospital for a longer period because many of these illnesses would be diagnosed. The American Academy of Pediatrics recommends a minimum two-day hospital stay for a vaginal delivery and a four-day minimum stay for a Caesarean delivery.

The average postdelivery length of stay in North Dakota hospitals has declined from 2.66 days in 1991 to 2.49 days in 1994. Newborn jaundice accounts for almost 80 percent of North Dakota newborn readmissions for infants two to six days old. Despite a 6.4 percent decrease in length of stay, readmission numbers declined from 1991 to 1994. Compared to other states, North Dakota does not have a high newborn readmission rate. Testimony indicated the trend to reduce the length of hospital stay is not only for maternity care, but for all types of medical conditions.

Blue Cross Blue Shield of North Dakota pays all North Dakota hospitals on a diagnostic-related group (DRG) system. When a facility is paid on this system, it receives a preset payment amount regardless of how long the patient stays in the hospital. There are different DRG reimbursements for different types of deliveries. Testimony indicated that because Blue Cross Blue Shield of North Dakota bases its DRG payments on a 48-hour maximum for a normal vaginal delivery and a 96-hour maximum for an abnormal delivery or a Caesarean delivery, legislation based on those limits would probably not affect its policies.

A representative of insurers testified that any legislation should not interfere with a policyholder's choice to self-insure maternity costs. Maternity coverage in indemnity policies varies depending on the policy design.

Postdischarge Followup

A representative of the North Dakota Medical Association indicated the American Medical Association and the Academy of Obstetricians and Pediatricians support the idea of a home visit following discharge. The State Health Officer testified home nursing care can be as beneficial and more cost-effective than an extended hospital stay. The home visit is intended to benefit both the mother and the newborn.

The eight largest hospitals in the state have a postdischarge home visitation program. In rural areas, the visit may be in the form of a telephone call or through a local clinic or other health care service provider. The committee considered that in rural areas of the state adequate followup visits may not always be readily available, and rural mothers may not be good candidates to be discharged early.

Recommendation

The committee recommends Senate Bill No. 2043 to require health insurance policies and health service contracts to provide maternity benefits that cover 48 hours of inpatient care for normal vaginal deliveries and at least 96 hours of inpatient care following a Caesarean section. The bill provides guidelines to follow in order to go over or under the time requirements. If a mother and newborn are released before the 48- or 96-hour requirements, a postdelivery care visit must be provided. Additionally, the bill prohibits monetary incentives to encourage early discharge and prohibits penalizing a medical provider for following the time requirements. Finally, the maternity coverage required under the bill may not exceed policy aggregate limits for this coverage.

CHAPTER 23-17.5
HEALTH CARE PROVIDER COOPERATIVE AGREEMENTS

Section

23-17.5-01. Definitions.

In this chapter, unless the context otherwise requires:

1. "Active supervision" means actual state direction, supervision, or control that results in the exercise of power by the department or the attorney general to review anticompetitive conduct that results from, or is authorized by, a cooperative agreement for which a certificate of public advantage has been issued pursuant to this chapter. The term includes the authority granted the department or attorney general by this chapter to terminate or cancel a certificate of public advantage or to investigate or enjoin a cooperative agreement, and other conditions to the certificate provided under section 23-17.5-03.1.

2. "Cooperative agreement" means:

a. An agreement among two or more health care providers or third-party payers for the sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities, or medical, diagnostic, or laboratory facilities or procedures or other services traditionally offered by health care providers; or

b. An agreement among two or more health care providers for acquisition of control, consolidation, merger, or sale of assets of those health care providers.

3. "Department" means the state department of health.

4. "Health care provider" means any person who delivers, administers, or supervises health care products or services, for profit or otherwise, in the ordinary course of business or professional practice.

5. "Third-party payer" means any insurer or other entity responsible for providing payment for health care services, including the workers compensation bureau, the comprehensive health association of North Dakota, and any self-insured entity.

Source: S.L. 1993, ch. 263, § 1; 1995, ch. 243, § 2; 1995, ch. 246, § 4.

Effective Date: The 1995 amendment of this section by section 2 of chapter 243, S.L. 1995 became effective August 1, 1995.

The 1995 amendment of this section by section 4 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 10 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Sections 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

Section 23-17.5-01 was amended twice by the 1995 Legislative Assembly. Pursuant to section 1-02-09.1, the section is printed above to harmonize and give effect to the changes made in section 4 of chapter 246, S.L. 1995, and section 2 of chapter 243, S.L. 1995.

23-17.5-02. Discussions or negotiations - Certificate of public advantage.

A health care provider may discuss preliminary matters toward, or may negotiate, a cooperative agreement with another health care provider or third-party payer if the likely benefits to health care consumers which may result from the agreement outweigh the disadvantages attributable to a potential reduction in competition that may result from the agreement. The parties to a cooperative agreement may apply to the department for a certificate of public advantage governing the agreement. Although a health care provider or third-party payer is not required to apply for a certificate of public advantage, a party that does not apply for a certificate does not receive the exclusion from state antitrust enforcement and intended federal antitrust immunity provided by section 23-17.5-10. The application must include an executed copy of the cooperative agreement and must describe the nature and scope of the cooperation in the agreement and any consideration passing to any party under the agreement. The applicants shall file a copy of the application and related materials with the attorney general and the department. The department shall review the application and shall hold a public hearing on the application. The department shall grant or deny the application within ninety days of the date of filing of the application. The decision must be in writing and must set forth the basis for the decision. The department shall furnish a copy of the decision to the applicants, the attorney general, and any intervenor.

Source: S.L. 1993, ch. 263, § 2; 1995, ch. 246, § 5.

Effective Date: The 1995 amendment of this section by section 5 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Sections 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

23-17.5-03. Standards for certification.

The department shall issue a certificate of public advantage for cooperative agreement if the department determines that the applicants have demonstrated by clear and convincing evidence that the likely benefits to health care consumers which may result from the agreement outweigh the disadvantages attributable to a potential reduction in competition that may result from the agreement. The department shall consult with the attorney general regarding its evaluation of a potential reduction in competition which may result from a cooperative agreement.

1. In evaluating the likely benefits of a cooperative agreement to health care consumers, the department shall consider whether any of the following benefits may result from the cooperative agreement:

a. Enhancement of the quality of health care services provided to residents of this state;

b. Preservation of health care facilities or services in geographical proximity to the communities traditionally served by those facilities or services;

c. Gains in the cost efficiency of services provided by the parties involved;

d. Improvements in the utilization of health care resources and equipment;

e. Avoidance of duplication of health care resources; and

f. Enhancement of the ability to cooperatively provide services to underserved or low-income patients.

2. The department's evaluation of the disadvantages attributable to a potential reduction in competition which may result from the agreement may include the following factors:

a. The extent of any likely adverse impact on the bargaining power of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payers in negotiating payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;

b. The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or persons furnishing goods or services to or in competition with providers or third-party payers that is likely to result directly or indirectly from the cooperative agreement;

c. The extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and

d. The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of likely benefits to health care consumers over disadvantages attributable to a potential reduction in competition which may result from the agreement.

Source: S.L. 1993, ch. 263, § 3; 1995, ch. 246, § 6.

Effective Date: The 1995 amendment of this section by section 6 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Sections 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public

advantage."

23-17.5-03.1. Active supervision.

The decision granting an application for a certificate of public advantage must include conditions for active supervision. The active supervision must be sufficient for the department to determine periodically whether circumstances may be present to meet the criteria for certificate termination pursuant to section 23-17.5-04 and must otherwise be structured to provide a reasonable basis for state action immunity from federal antitrust laws as interpreted by applicable laws, judicial decisions, opinions of the attorney general, and statements of antitrust enforcement policy issued by the United States department of justice and the federal trade commission. The conditions for active supervision, except the authority granted the department or attorney general by this chapter, may be modified or terminated by agreement between the parties to the cooperative agreement and the department.

Source: S.L. 1995, ch. 246, § 7.

Effective Date: This section became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Sections 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

23-17.5-04. Certificate termination.

The department may, after notice and hearing, terminate a certificate of public advantage if the department determines that:

1. The likely or actual benefits to health care consumers that result, or may result, from the certified agreement no longer outweigh the disadvantages attributable to a potential or actual reduction in competition which results, or may result, from the agreement; or

2. Performance by the parties under the certified agreement does not conform to the representations made by the parties in the application or to the provisions of any conditions attached to the certificate of public advantage by the department at the time the application was granted.

Source: S.L. 1993, ch. 263, § 4; 1995, ch. 246, § 8.

Effective Date: The 1995 amendment of this section by section 8 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Sections 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

23-17.5-05. Records.

The department shall maintain all cooperative agreements for which the certificates of public advantage remain in effect. Any party to a cooperative agreement who terminates the agreement shall file a notice of termination with the department within thirty days after termination.

Source: S.L. 1993, ch. 263, § 5.

23-17.5-06. Investigation by attorney general.

The attorney general, at any time after an application is filed under section 23-17.5-02, may require by subpoena the attendance and testimony of witnesses and the production of documents in the county in which the applicants are located for the purpose of investigating whether the cooperative agreement satisfies the standards set forth in section 23-17.5-03. The attorney general may seek an order from the district court compelling compliance with a subpoena issued under this section.

Source: S.L. 1993, ch. 263, § 6.

23-17.5-07. Cooperative agreement enjoined - Automatic stay - Standards for adjudication.

The attorney general may seek to enjoin the operation of a cooperative agreement for which an application for certificate of public advantage has been filed by filing suit against the parties to the cooperative agreement in district court. The attorney general may file an action before or after the department acts on the application for a certificate, but the action must be brought no later than forty days following the department's approval of an application for certificate of public advantage. Upon the filing of the complaint, the department's certification, if previously issued, must be stayed and the cooperative agreement is of no further force unless the court orders otherwise or until the action is concluded. The attorney general may apply to the court for ancillary temporary or preliminary relief necessary to stay the cooperative agreement pending final disposition of the case. In any action, the applicants for a certificate bear the burden of establishing by clear and convincing evidence that the likely benefits to health care consumers which may result from the cooperative agreement outweigh the disadvantages attributable to a potential reduction in competition which may result from the agreement. The court shall review whether the agreement constitutes an unreasonable restraint of trade under state or federal law in assessing the disadvantages attributable to a potential reduction in competition which may result from the agreement.

Source: S.L. 1993, ch. 263, § 7; 1995, ch. 246, § 9.

Effective Date: The 1995 amendment of this section by section 9 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Sections 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

23-17.5-08. Cancellation of a certificate of public advantage.

If, at any time following the forty-day period specified in section 23-17.5-07, the attorney general determines that, as a result of changed circumstances, the benefits to health care consumers which result from a certified agreement no longer outweigh the disadvantages attributable to a reduction in competition resulting from the agreement, the attorney general may file suit in district court seeking to cancel the certificate of public advantage. In an action brought under this section, the attorney general has the burden of establishing by a preponderance of the evidence that, as a result of changed circumstances, the likely or actual benefits to health care consumers which result, or may result, from the agreement and the unavoidable costs of canceling the agreement are outweighed by the disadvantages attributable to a potential or actual reduction in competition which results, or may result, from the agreement. If the attorney general first establishes by a preponderance of the evidence that the department's certification was obtained as a result of material misrepresentation to the department or the attorney general as the result of coercion, threats, or intimidation toward any party to the cooperative agreement, the parties to the agreement bear the burden of establishing by clear and convincing evidence that the likely or actual benefits to health care consumers which result, or may result, from the agreement and the unavoidable costs of canceling the agreement are outweighed by the disadvantages attributable to a potential or actual reduction in competition which results, or may result, from the agreement.

Source: S.L. 1993, ch. 263, § 8; 1995, ch. 246, § 10.

Effective Date: The 1995 amendment of this section by section 10 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Section 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

23-17.5-09. Resolution by consent decree - Attorney fees.

The district court may resolve any action brought by the attorney general under section 23-17.5-07 or 23-17.5-08 by entering an order that, with the consent of the parties, modifies the cooperative agreement. Upon the entry of the order, the parties to the cooperative agreement have the protection specified in section 23-17.5-10 and the cooperative agreement has the effectiveness specified in section 23-17.5-10. If the attorney general prevails in an action under section 23-17.5-06, 23-17.5-07, or 23-17.5-08, the attorney general is entitled to an award of the reasonable costs of the investigation or litigation and reasonable attorney fees, expert witness fees, and court costs incurred in litigation.

Source: S.L. 1993, ch. 263, § 9.

23-17.5-10. Exclusion from state antitrust enforcement - Federal antitrust immunity intended - Application.

A health care provider or third-party payer who participates in the discussion or negotiation of a cooperative agreement for which an application is filed is engaged in conduct for which no action may be brought pursuant to chapter 51-08.1 for penalties, damages, injunctive enforcement, or other remedies. A health care provider or third-party payer who participates in the implementation of a cooperative agreement, for which a certificate of public advantage was issued, is engaged in conduct for which no action may be brought pursuant to chapter 51-08.1 for penalties, damages, injunctive enforcement, or other remedies. The intent of this section is that the conduct be provided state action immunity from federal antitrust laws. This exclusion from state antitrust enforcement and intended federal antitrust immunity applies unless the discussion or negotiation exceeds the scope of a cooperative agreement as authorized by this chapter or the implementation exceeds the scope of the cooperative agreement for which a certificate of public advantage was issued. This section does not exempt hospitals or other health care providers from compliance with laws governing hospital cost reimbursement.

Source: S.L. 1993, ch. 263, § 10; 1995, ch. 246, § 11; 1995, ch. 254, § 5.

Effective Date: The 1995 amendment of this section by section 5 of chapter 254, S.L. 1995 became effective August 1, 1995.

The 1995 amendment of this section by section 11 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: "**RETROACTIVE APPLICATION OF ACT.** Section 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

Section 23-17.5-10 was amended twice by the 1995 Legislative Assembly. Pursuant to section 1-02-09.1, the section is printed above to harmonize and give effect to the changes made in section 11 of chapter 246, S.L. 1995, and section 5 of chapter 254, S.L. 1995.

23-17.5-11. Assessment - Health care cooperative agreement fund.

The department shall establish an assessment to be paid by each party to a cooperative agreement. The aggregate amount of the assessment for a cooperative agreement may not exceed forty thousand dollars, unless the department determines that an extraordinary need exists for an additional amount to ensure effective evaluation of the application or supervision under section 23-17.5-03.1. The parties may require that the determination of the need for an additional amount is subject to approval by the state health council. An appeal may be taken under chapter 28-32 from a determination of the health council. After consultation with the parties, the department may require the payment of the assessment on an incremental basis and may require separate payments for the process of evaluating the application or for the process of active supervision. The assessment may be modified by agreement between the department and the parties to the cooperative agreement. The department shall deposit the moneys received under this section in the health care cooperative agreement fund of the state treasury.

Source: S.L. 1993, ch. 263, § 11; 1995, ch. 246, § 12.

Effective Date: The 1995 amendment of this section by section 12 of chapter 246, S.L. 1995 became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: **"RETROACTIVE APPLICATION OF ACT.** Section 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."

23-17.5-12. Health care cooperative agreement fund.

The funds in the health care cooperative agreement fund are available to the department of health, subject to legislative appropriation, for evaluation and active supervision of cooperative agreements among health care providers or third-party payers and for reimbursement to the attorney general for expenses incurred pursuant to this chapter. Any amounts reimbursed to the attorney general under this section are hereby appropriated.

Source: S.L. 1995, ch. 246, § 13.

Effective Date: This section became effective April 3, 1995, pursuant to section 40 of chapter 246, S.L. 1995.

Note: Section 38 of chapter 246, S.L. 1995 provides: **"RETROACTIVE APPLICATION OF ACT.** Section 4 through 13 of this Act apply retroactively to discussions and negotiations for cooperative agreements beginning after July 31, 1993, and any resulting cooperative agreements and certificates of public advantage."
