NORTH DAKOTA MEDICAL ASSOCIATION

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Industry, Business & Labor Committee
ND Legislative Council
August 6, 2009

Chairman Keiser and Committee Members, I'm Bruce Levi and I represent the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota physicians, residents and medical students.

The NDMA offers whatever assistance it can provide the Committee in the coming months in studying factors impacting the cost of health insurance. My purpose today is to provide some general information and determine from you what additional information may be helpful in your study. We are in fact in the throes of Congressional activity on national health system reform, doing our best to ensure that any legislation being considered would accomplish results that are in the best interests of North Dakota.

Physician involvement in providing health insurance in North Dakota goes back many years – perhaps to 1946 when North Dakota Physicians Service, a Blue Shield plan, was organized to cover the patient's cost for physician care. More recently, NDMA has involved itself in many issues relating specifically to health insurance, and our members work daily with insurers addressing coverage and payment issues on behalf of their patients.

In addressing rising health care costs, the ultimate public policy goal should be to achieve better value for health care spending. Rising health care costs have been fueled by a prevalence of preventable chronic disease, clinical risk factors, and unhealthy behaviors. While North Dakota is one of the more efficient deliverers of quality care, there are major inefficiencies in the health care system nationally and an inequitable Medicare payment system for reimbursing physician and hospital services applies in states like North Dakota where high quality and efficient care is delivered. Physicians play in a key role in addressing health care costs, and are focusing on strategies to: (a) reduce the burden of preventable disease; (b) improve the efficiency of health care delivery; (c) reduce non-clinical health system costs that do not contribute

value to patient care; and (d) improve health-related decision-making processes. Certainly, many of these concepts are being debated at the federal level.

NDMA Involvement in Insurance Issues

NDMA has been actively involved in bring insurance issues to the ND Legislative Assembly. In 1997, the BCBSND mutualization legislation was introduced at the request of NDMA and we worked to usher that legislation through the session. In 1999, legislation was introduced at the request of NDMA to address patients' rights issues resulting primarily from concerns over the impacts of managed care. In 2006, NDMA objected to BCBSND premium rebates in 2006, calling instead for premium reductions and appropriate provider reimbursement for 2007.

More recently, in our view, we were fortunate the Insurance Commissioner used the rate filing procedure this past year to require BCBSND to change its provider contracts to prohibit unilateral payment withholds and reductions at any time. For many years, NDMA has advocated for fair contracts. The existing BCBSND "contracts" for all practical purposes are nothing more than an annual, unilateral announcement of terms.

We requested introduction this past session of SB 2397, which was not successful, which would have established fair contracting standards for insurance companies. The bill would have clarified the authority of the Insurance Commissioner to review the contracts that insurance carriers execute with health care providers, identify a number of fair contracting standards that would apply to that review, and address enforcement of those fair contract standards. Our testimony is also included in our handout materials, and we continue to believe that fair contracting standards would be an appropriate addition to the ND Century Code.

Health Insurance Competition

In 2006, NDMA provided a forum for discussion of the pros and cons of health insurance competition in North Dakota. A summary of that forum is included in my handout.

Milliman Study of Premiums and Reimbursement

The lack of competition in the health insurance market in North Dakota has allowed BCBSND over many years, in our view, to systematically underfund reimbursements for physicians and

hospitals. BCBSND pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region.

At the request of NDMA, the six major health systems in North Dakota and BCBSND, the consulting firm Milliman prepared a report comparing health insurance premiums and provider reimbursement levels in North Dakota against other nearby states. Milliman was tasked with a comparison against other states in CMS' West North Central Region (Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska and South Dakota). In general, Milliman found that North Dakota has lower premiums, provider costs and provider reimbursement levels than the benchmark comparison states. The BCBSND average premium of $332 compares to the other states' average of $399, or a BCBSND premium that is 83% of the premium in other states in our region. The BCBSND Private Payer Hospital Reimbursement per RVU (geographically adjusted) is $66 compared to the rest of the region's average of $96, or only 69% of that compared to other states in the region. The Private Payer Physician Reimbursement as a percentage of Medicare (geographically adjusted) is 152% of Medicare compared to the rest of the region's average of 164%, or 93% of that compared to the rest of the region. Hospital costs are 91% of that compared to the rest of the region; however, hospital margins are considerably less at 1.8% compared to 6.9% in the rest of the region.

We are hoping to work further with BCBSND and the Insurance Department in addressing our concerns regarding the need for adequate resources to fund our state's health care system. The physicians of North Dakota are very concerned that this continuing trend of poor payment does not bode well for the future of health care in our state or for retaining and recruiting the healthcare workforce we need. This is compounded by poor payments from Medicare which are reimbursed using geographic formulas that result in payment among the lowest in the country. We are grateful the 2009 ND Legislative Assembly and Governor worked to provide Medicaid reimbursement at a level closer to cost for physicians and at cost for hospitals.

Thank you Mr. Chairman for this opportunity to comment. We look forward to working with you the committee on these issues.

Principles for Medicare Reform
Medicare Payment Task Force
April 17, 2009

The Medicare Payment Task Force has explored various options for Medicare hospital and physician payment reform. Many of those options are reviewed in *Options for Improving Medicare Payments to North Dakota's Healthcare Providers* by Harold D. Miller [Options Paper), Center for Healthcare Quality and Payment Reform, February 2009. We recommend that the North Dakota Congressional Delegation pursue multiple options for Medicare hospital and physician payment reform:

Pursue modifications to the current physician payment system and hospital prospective system (GPCI adjustments; wage index); and

Ensure that any new payment systems (ACOs, bundling payment, global) are appropriate for ND, assessing risks and rewards, and recognizing ND goals for cost containment and accountability.

Modifications to Current Medicare Payment System

The North Dakota Healthcare Association and North Dakota Medical Association strongly agree that the current Medicare payment system must be modified as follows, working toward geographic equity, reducing the increase in costs, and improving the quality and value of our health care system:

Hospitals:

Create a wage index floor of 1.0

Reduce the labor-related share for areas with a low wage index to 50%

Extend Section 508 to reduce payment disparities (expires September 30, 2009)

Physicians:

Make permanent the work GPCI threshold of 1.0

Establish a threshold of 1.0 on the practice expense GPCI

Establish an initiative to study and correct the methodology deficiencies in the GPCI calculations, including consideration of modification of the cost share weights in the practice expense GPCI as suggested in options 2b and 2c identified in the Options Paper

Eliminate the Sustainable Growth Rate (SGR) formula (21% cut at year end) which cuts North Dakota physician payments due to higher spending in other parts of the country

Principles on New Payment Systems

In considering proposals for any new payment systems:

Ensure that North Dakota hospitals and physicians are not penalized for providing services more efficiently and at higher quality (hold harmless principle); that North Dakota is not penalized for the value achieved from the value of teamwork and accountability from its current high quality, highly efficient health care system.

Ensure that for any services currently under-provided in North Dakota (recruitment problems), that those under utilization levels not be locked in to any baseline expenditure levels that may be imposed.

Ensure that new payment systems provide a means for ND to rebuild and strengthen its primary care base.

Ensure that performance measures emphasize current ND strengths. Ensure that performance thresholds are achievable and payment differentials are of sufficient magnitude to help offset ND's payment disadvantages.

Ensure that payments for physician services be more than what they would have otherwise under the current payment system. Recognize that the current SGR formula as a nationwide spending target has resulted in Medicare payment cuts for physicians in low spending regions in large part because of high Medicare expenditures in other regions; oppose any geographic (GPCI) adjustments in future bundled physician payments unless regional quality payments and regional spending targets are also included.

Ensure that if a total pool is divided among all high-performing providers in any payment scheme, ensure that rewards emphasize performance rather than improvement.

Recognize implications of applying GPCIs to initiatives for incenting quality (e.g., PQRI) and technology (e.g., e-prescribing, health information technology).

NDHA

North Dakota Healthcare Association

NEWS RELEASE
For Immediate Release

July 16, 2009

North Dakota Medical Providers Share Congressman Pomeroy's Concerns on Health Care Reform Bill

The North Dakota Healthcare Association representing North Dakota hospitals and the North Dakota Medical Association representing North Dakota physicians released the following statement today in support of Congressman Earl Pomeroy's announcement yesterday that he is opposed to the House health care reform bill in its present form:

"Like Congressman Pomeroy, we strongly support the goal of bringing affordable health care to all North Dakotans.

"The House health care reform proposal, while it includes many important features including permanent reforms of the unsustainable formula for providing resources for physician services, does not go far enough in addressing the unfair geographic inequity in how health care resources are allocated among states such as North Dakota. In addition, we agree with Congressman Pomeroy that there must be appropriate payment for any new programs that cover the uninsured. The House health care proposal creates a flawed public health insurance option that risks dismantling of North Dakota's health care delivery infrastructure, jeopardizing access to much needed care and services.

"Congressman Pomeroy's decision to oppose the House reform bill in its present form is appropriate, and we look forward to working with him and Senators Conrad and Dorgan to bring about health care reform that helps, rather than hurts, North Dakota."

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Barriers to Health Insurance

A joint education session between the ND Medical Group Management Association and the North Dakota Medical Association featured lively discussion on competition in the health insurance market in North Dakota.

The panel was moderated by NDMA President Dr. Shari Orser, and the audience included several legislators. Orser said that, across the country, there has been considerable debate about competition in the health insurance market. "The American Medical Association has for several years undertaken a comprehensive study of U.S. markets," she said, "designed to identify problem markets where competition is diminished and to prompt discussion about the long-term impact of consolidated health insurance markets on the health care system." She said the study found that in 95 percent of markets, a single insurer had a market share of 30 percent or greater, and in 56 percent of the markets, a single insurer had a market share of 50 percent or greater. Orser said significant barriers to entry into the health insurance market include state regulatory requirements, the cost of developing a physician network, and the development of sufficient business to permit the spreading of risk.

She queried the panelists - Do these barriers exist in North Dakota? And is the result good or bad?

Discounts create "chicken and egg" for new carriers

Jim Poolman, currently serving in his second term as ND Insurance Commissioner, gave a snapshot of the health insurance marketplace before discussing what lack of competition means for the marketplace – and why there isn't more competition.

Commissioner Poolman reviewed the major medical market in North Dakota which is dominated by BlueCross BlueShield of North Dakota with 90% of the total earned premium for large and small group and individual policies. "I don't put these figures out there to beat up on any particular carrier," said Poolman, "My job is to inform and then to tell you my ideas about what I think needs to happen in our marketplace as a protector of consumers."

Commissioner Poolman said the Blues in North Dakota have the most dominant market share in the country – dominance being most common in rural, smaller population states including states like Alaska, Alabama, Rhode Island and Maine.

Why is the North Dakota market not more competitive? Poolman said North Dakota's small population base is part of the reason. "It's tough to break in with a dominant carrier," said Poolman. While BCBSND has been a "good corporate citizen by and large," he said, it's tough for other carriers to break into the market due to pricing barriers and a "chicken and egg" situation on discounts. Poolman said other carriers are not able to garner the same discounts from providers as BCBSND can, which he said acts as a "buying service" for health care in the state. "What we hear from carriers that want to do business here," said Poolman, is "'we can't get the same discount that your dominant carrier gets in the marketplace.'"

What to do? Commissioner Poolman said "[i]f we are to make a more competitive marketplace here in North Dakota, hospitals, physicians, clinics, pharmacists and everybody

The Panel: ND Insurance Commissioner Jim Poolman, Ted Lofness, MD, Medica, John Frederick, MD, Preferred One, Paul Geiwitz, Preferred One, Michael Hamerlik, BCBSND, and Rep. Jim Kasper.

Competition: Good or Bad?

else are going to have to help us in creating that marketplace by negotiating with and creating provider networks with other health insurance companies."

He added, "In fact, it is such a problem, some may even consider legislation to make wholesale changes in state law to mandate that those other insurance companies get the same discounts."

Poolman discussed other areas in which legislative changes are being considered including the appropriate minimum standard of loss ratio for health insurers.

Commissioner Poolman said the lack of competition affects the quality and delivery of healthcare in North Dakota. Any reimbursement and plan design changes by the Blues result in changes in healthcare delivery. "We've almost formed a single payer system here in North Dakota," said Poolman, "and we need to make a fundamental choice of whether or not we're going to move away from that type of system." He said everyone needs to work together to change the legislative and regulatory impediments to more competition, and health care providers need to do what they can to make the market more competitive.

Difficult for proven carriers to compete

Medica is an independent, non-profit regional health plan – the largest Minnesota PPO and HMO with growing service to ND, SD, Wisconsin and nationally. The carrier has 1.3 million members.

Ted Loftness, MD, Vice President of Regional Health Services for Medica, said while considerably smaller in its market share, Medica is the second largest carrier in total earned premium in the major medical market in North Dakota. "Medica has been in the North Dakota market for eleven years," said Loftness, "but its perplexing to me that in those years we've grown by only 5,000 members."

Dr. Loftness said Medica has grown its membership by 40% over the last four years and has seen growth in other states including South Dakota, Wisconsin and Minnesota. He said Medica intends to move into additional North Dakota markets but has not been able to compete with discounts garnered by BCBSND from providers.

Medica has great tools and innovative products to meet employer needs, reduce healthcare costs and provide service excellence, said Loftness, as well as exercising good stewardship of the premium dollar in using only 7.5 cents of each dollar for administrative expenses. Dr. Loftness reviewed the many ways Medica assists physicians by providing health management in keeping the healthy well and identifying

those at risk, and through innovation in technology and good customer service and provider relations.

"What do you want in your market?" Loftness asked of the audience of physicians and clinic managers. "Do you want competition and to move to more than one payer? If I can't get discounts I can't price appropriately." As for the future of Medica in North Dakota, he said, "we intend to be here for the long term."

BCBSND: "Contrived" competition will result in unintended consequences

Michael Hamerlik is Executive Vice President of Corporate and Government Operations for BlueCross BlueShield of North Dakota. He said it's important to have these conversations to better understand the North Dakota market and to understand the policy consequences – both intended and unintended - from any action taken.

Hamerlik said people buy insurance to protect themselves and their families from catastrophic financial loss. The core concept of insurance, he said, is that "big numbers work." The BCBSND risk pool is approximately 300,000 members, he said, but some insurance companies would consider this member base too small to rate and risk. The realities of the market place in North Dakota, said Hamerlik, suggest that the health insurance market is typical of any mature industry with few dominant players. "Options do exist in the North Dakota health insurance marketplace," said Hamerlik. He said several large and committed insurance companies are licensed and actively marketing insurance in North Dakota. He said "choice is price sensitive" for consumers in North Dakota. "Few buyers," he said, "are looking for a higher-priced health insurance choice." He noted that most purchasing decisions are made by employers, not employees, but employers generally balance and reflect employee preferences.


Michael Hamerlik

Hamerlik suggested that "neither competition nor choice will result in lower premiums, higher provider payments, or better value in health insurance choices; in fact the opposite is likely." Why not? Because North Dakota does not have the big numbers in terms of a risk pool to create those results. The reality, he said, is that a low and declining population in North Dakota "does not provide the basis for robust competition" which affects health insurance in many of the same ways it has affected other sectors including public schools, churches, the delivery of medical services, colleges and universities, and small towns. Hamerlik said even in larger states, the nature of the mature health insurance market provides a handful of dominant players in most markets. "Market opportunities just aren't present in the state," he said. HMO's in the mid-1980's in North Dakota couldn't survive even with good enrollment, he said, because they were not financially viable.

Hamerlik said BCBSND pays providers fairly and has provided physician fee schedule adjustments in 2002 through 2006. "We try to be fair," he said. "Look at the job you have – and that is to go into a national market to attract physicians – sometimes paying 10% above the national average to get them to come to North Dakota and then they move here and there is per capita income that is 12% below average; we have a 22% gap just starting out. So what do we do – where do we find the money? That's the challenge we face on a daily basis in setting reimbursement and we try to be fair about it."

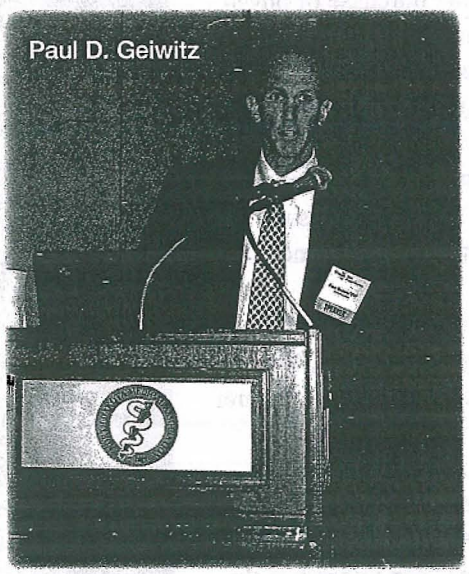
Another reason why competition may not be as robust in North Dakota, Hamerlik said, is that BCBSND has provided good service to providers and members by timely claims payment and few claims denials. "We're pretty good at what we do," said Hamerlik.

"We are local and respond locally as well with offices in nine North Dakota cities, a Board of Directors comprised of all North Dakotans, being responsive to local concerns and allowing North Dakota providers to have input into medical policy and reimbursement issues," said Hamerlik. At the same time, he said, BCBSND premiums are the lowest of all Blue Cross plans in the country – North Dakota's per member/per month premium in 2005 was the lowest of all Blue Cross and Blue Shield plans and North Dakota's administrative (operating) costs are the fourth lowest of the Blue's plans.

Hamerlik said "contrived competition" will cause higher premiums for many policy holders since new insurance companies will obviously select risks that are more profitable. He said the money is removed from the state, from the providers, and from the insurance risk pool. As a result of contrived competition, he said, survival will require at least one function of the premium to be reduced, i.e., the number of services provided (cherry picking), the rate paid to providers (deep discounts), or the cost of administration. He said the public policy question would be then which component should be reduced. "So which will it be," he said, "fewer claims paid or less payment to providers?" He suggested contrived competition created by non-market forces will create fewer economies of scale since fixed costs to operate will remain the same, marketing and distribution costs will increase for everyone, and provider reimbursement and consumer premiums will destabilize due to higher risk uncertainty.

Sustainable competition requires comparable provider reimbursement

PreferredOne is a provider-owned PPO, community health plan, insurance company and provider of administrative services. **Paul D. Geiwitz**, Executive Vice President and Chief Marketing Officer of PreferredOne, said: "To have sustainable competition, payers must have comparable provider reimbursement."


Paul D. Geiwitz

Geiwitz cited an 8% provider reimbursement difference as a major disadvantage for carriers wanting to do business in North Dakota, which is a barrier to entry for those carriers.

Several innovation initiatives of PreferredOne were discussed by Geiwitz, including Internet reporting, a "medical cost navigator" that assists patients in assessing the costs of medical care, an Internet-based provider cost menu by condition, and a re-pricing mechanism for comparing claim costs among network providers. He said competition will bring options and innovation to the North Dakota medical insurance market and better serve underserved markets in the state.

John P. Frederick, MD, is Executive Vice President Chief Medical Officer of PreferredOne. He encouraged the audience to recognize the long-term implications of more competition for patients, employers, and providers.

Dr. Frederick reviewed the following excerpt from a study by the American Medical Association on the negative impact of dominant carriers on patient care:

"Today it appears that the physician's role as patient advocate is being systematically undermined as dominant insurers impose take-it-or-leave-it contracts that directly impact the provision of care and the patient-physician relationship. This role has never been more important. Physicians have a professional and ethical obligation to their patients; health insurers' primary legal obligation is to their shareholders.

"The U.S. Department of Justice (DOJ) has recognized that monopsony power is an important consideration in health insurance markets. While the DOJ has only challenged two health insurer mergers in the past 12 years (out of more than 400), both of these challenges were based in large part on the health insurer's potential monopsony power over the purchase of physician services. In conducting its analysis of monopsony power, the DOJ focused on whether or not physicians could terminate or threaten to terminate a contract. The DOJ has also recognized that a physician practice is different from other businesses because it cannot replace lost business quickly. …

"In its most recent challenge (UnitedHealth Group/PacifiCare), the DOJ recognized that when a health insurer accounts for 30 percent or more of a physician's practice revenue, the health insurer can have monopsony power to the detriment of patients. The DOJ also found that these percentages "can understate the importance to physicians of payments from commercial health insurance to compensate for the lower revenue earned from Medicare and Medicaid business." Those physicians whose practices depend most heavily on patients covered by a particular health insurer are most vulnerable to

AMA Speaks Out in Congress on Carrier Monopsony Powers

AMA AMERICAN MEDICAL ASSOCIATION

The AMA recently testified in Congress on the monopsony impacts of dominant health insurers, expressing deep concern over the steady erosion of a competitive health care market in the U.S. The AMA is calling on Congress to reexamine the policy landscape with respect to antitrust law and policy restrictions on physicians. Absent antitrust relief, the AMA is calling for several interim steps, including that Congress instruct the Department of Justice to exercise its subpoena power to investigate whether the record profits and increased premiums posted by health plans are the result of monopoly power.

In its testimony to Congress, the AMA discussed the implications of monopsony power held by dominant carriers:

"In a substantial number of markets across the country, dominant health insurers have the potential to exercise monopsony power over physicians to the detriment of consumers. Monopsony power is the ability of a small number of buyers to lower the price paid for a good or service below the price that would prevail in a competitive market. …

"In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services). As buyers of physician services, health insurers are acting as monopsonists–lowering the prices they pay to a point at which physicians may be forced to supply fewer services to the market.

"Moreover, because health plans have posted considerable profits without decreasing premiums, the benefits of their ability, as a buyer of services, to lower the prices they pay suppliers (physicians), have not been passed on to consumers. …

"In fact, the US Department of Justice has recognized that a health plan's power over physicians to depress reimbursement rates can be harmful to patients–the ultimate consumers of health care. … In the case of the United/PacifiCare merger, the DOJ found that where the merged company would control 30 percent of physician revenues, the plan could exercise monopsony power over physicians in a manner that would lead to a 'reduction in the quantity or quality of physician services provided to patients.'

"Health insurers with monopsony power can use the economic benefits of reduced prices in medical care to protect and extend their monopoly position and increase barriers to entry into the market. Thus, rather than producing "efficiencies," increasing monopsony power in health care markets across the country causes a number of distortions in the market that harm patients by reducing access to care.

"Any one of these characteristics individually–market share, barriers to entry, premium increases, monopsony power, and disparity in bargaining power–should send a strong warning that competition in the health care market is being compromised. The simultaneous existence of all of these features is nothing short of alarming. The current health care market exhibits all the symptoms of an ailing system that, absent intervention, has a dire prognosis." **Statement of the American Medical Association to the U.S. Senate Committee on the Judiciary, Hearing on Examining Competition in Group Health Care, Sept. 6, 2006**

unreasonable contracting terms and anti-competitive reimbursement rates.

"Our study shows unequivocally that physicians across the country have virtually no bargaining power with dominant health insurers and that those health insurers are in a position to exert monopsony power. ...


John P. Frederick, MD

"It is important to remember that physicians are the least consolidated component of the health care industry. ... Because the managed care contracts between physicians and health insurers impact so many aspects of the patient-physician relationship, the severe imbalance in bargaining power demonstrated by this study is an urgent matter that must be addressed by policymakers." **AMA 2005 Update, *Competition in Health Insurance: A Comprehensive Study of US Markets.***

Consistent with the DOJ focus, asked Dr. Frederick, "are providers in North Dakota in a position to terminate or threaten to terminate a contract with BCBSND in the current market?" One response to the lack of insurer competition in North Dakota, he said, has been the creation of larger physician groups and vertical integration with varying results for ND physicians. Dr. Frederick said a collaborative, competitive market better supports higher quality outcomes. "Patients lose out on the advantages of a competitive market," he said, including better quality created by quality improvement initiatives that otherwise do not exist in a non-competitive environment. He said Preferred One supports physicians in improving quality.

Fair and open competition benefits everyone

Rep. James Kasper is President of Asset Management Group, Inc., an employee benefits and financial planning company, and currently serves as a ND State Representative from Fargo's District 46.

Representative Kasper said North Dakota faces a tough issue in dealing with rising healthcare costs and what public policies the state should move toward. As the cost of premiums increase, he said, more and more employers will go without insurance and create a "death spiral" – resulting in a single payer system that will result in no choices for anyone. "This is the last thing we want in North Dakota," he said.

Rep. Kasper said fair and open and good competition benefits all the people of the state. He said the North Dakota legislature will wrestle with this issue. "I know there will be bills in the legislature this session to address this very issue," he said.

As an insurance broker, Rep. Kasper said, he can get competitive quotes from multiple sources on a wide variety of insurance products including group dental, long term care, disability, vision, and others. But not with health insurance. He concluded: "You as providers have the key for other health plans to compete in the North Dakota market -- will you provide them the opportunity to compete?"

Response: Market imbalance squeezes clinics and hospitals

The presentations were followed by a lively question and answer period and discussion. The audience of physicians and clinic managers raised a number of issues, even registering disagreement that BCBSND provides reimbursement at "market prices," noting that providers do not voluntarily provide discounts to BCBSND – those discounts are extracted in an environment that does not allow for negotiation.

While one physician suggested that it is unrealistic to expect providers to voluntarily discount their services, Rep. Kasper responded that medical services would still be reimbursed the same – only the source of payment would change. Only after increased competition occurs, he said, will physicians, hospitals and clinics see the benefits of competition including the ability to negotiate. While Dr. Loftness reiterated the need for parity in discounts, Mr. Hamerlik suggested that if other carriers want to be a player in the North Dakota health insurance market, they could compete better by reimbursing providers better.


Rep. James Kasper

Another physician suggested that BCBSND can't have it both ways, i.e., complaining that too much care to its policyholders is provided out of state at Mayo or the University of Minnesota while not providing adequate resources to support the provision of that care in North Dakota. It was also asserted that providers did not receive reimbursement increases for several years prior to 2000 and a substantial portion of the

Blues' current surplus and profits are a result of inadequate provider reimbursement; i.e., with fairer reimbursements in place such a surplus would not exist.

Commissioner Poolman suggested in response that premium payers built the BCBSND surplus. He said BCBSND can't be solely blamed for declining reimbursements from Medicare, Medicaid and other government payers. He said hospitals and physicians have received BCBSND reimbursement increases over the last several years, which he encouraged.

Mr. Hamerlik responded that BCBSND is not wanting it both ways as asserted, when it comes to care going out of state, but rather is engaged in a "balancing act." Commissioner Poolman noted that the Blues' dominant market share results in a situation in which public policy is made whenever the carrier acts. That is why more competition is necessary, he said, and until there is more competition BCBSND has a larger responsibility in the marketplace as a result of its dominant market share.

NDMA Calls for BCBSND to Defer Premium Rebate

The board of directors of Blue Cross Blue Shield of North Dakota announced on September 14 that it had voted to refund more than $26 million to policyholders who are enrolled through a bank depositor, Nodakare or student plan and to employers who sponsor fully insured coverage for their employees. BCBSND has experienced substantial underwriting gains and net income in 2001 through 2005 with cumulative net income of $125.2 million from 2001 thru 2005 ($38.5 million in 2005) and announced the refund plan in its press release "despite the current trend of rising health care costs and use of services." Responding as quickly as possible to the announcement during its annual meeting on September 15, NDMA urged BCBSND in a formal resolution to defer action on the refunds to 2007, stating:

NDMA expresses concern over increasing profits accumulated by BlueCross BlueShield of North Dakota and urges the BlueCross BlueShield of North Dakota Board of Directors, in lieu of a surplus "refund" to some policyholders in 2006, to make appropriate premium reductions for 2007 and make additional physician and hospital payment adjustments for 2007 that recognize increasing practice costs, including necessary capital costs, health information technology needs, and health care workforce recruitment needs, and that BCBSND fully disclose how any other methodology adjustments diminish 2007 updates on a statewide basis.

The resolution noted that "BCBSND has accumulated substantial profits in a noncompetitive health care insurance market that included unilaterally-discounted reimbursement for medical services and several years of payment freezes and reductions prior to 2002 that contributed to placing North Dakota physicians, clinics and hospitals in the position of facing substantial challenges in replacing out-dated equipment and recruiting qualified health care personnel in a national market." The resolution also cited other cost pressures that compound the present situation, including Medicare and Medicaid reimbursements that are declining in relation to actual costs, workers compensation medical and hospital fee schedules that are substantially less than BCBSND reimbursement, and expected 5% cuts in Medicare physician payments for 2007.

Insurance Commissioner Jim Poolman approved the premium rebate plan on October 23. In a press release he said: "I'm glad that the Blue Cross Blue Shield board of directors has followed my recommendation. Not only is the continued financial stability of Blue Cross Blue Shield important to me, but also important is how a company treats its policyholders. Blue Cross Blue Shield's recent action shows they are willing to treat their policyholders fairly."

NDMA President Shari Orser later met with the BCBSND Board on October 27, at which it was disclosed that the BCBSND premium rebate when compounded with an approved premium rate increase less than requested of the Insurance Commissioner (7% rather than 10.8%) will result in a small projected BCBSND underwriting loss for the carrier in 2007. However, the Board told Dr. Orser it would not diminish proposed reimbursement adjustments for hospitals and physicians that had previously been discussed for 2007.

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Testimony SB No. 2397
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Chairman Klein and Committee Members. I'm Bruce Levi, and I represent the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for physicians, residents and medical students. NDMA strongly supports SB 2397, which would require that health insurance carriers engage in fair contracting practices with physicians, hospitals and other health care providers. The bill would clarify the authority of the Insurance Commissioner to review the contracts that insurance carriers execute with health care providers, identify a number of fair contracting standards that would apply to that review, and address enforcement of those fair contract standards. Before I explain the provisions in the bill, let me provide an overview of the problems this legislation is designed to address.

In past years, a number of states have developed "fair contracting" laws that afford physicians and other providers with protection in the contract process with insurance carriers. Colorado became the first state in 2007 to require insurance carriers to use uniform contract standards when negotiating with health care providers. Why the need for fair contracting standards? States recognize that most physicians face a true David and Goliath battle when negotiating contract terms with insurance carriers if, in fact, they are even able to negotiate these contracts. For example, BlueCross BlueShield of North Dakota (BCBSND) is able to exercise monopsony power with about 90% of the commercial health insurance business. Monopsony power is the ability of a small number of buyers (or a single buyer such as BCBSND) to lower the price paid for a good or service below the price that would prevail in a competitive market. In the health insurance industry, dominant health insurers like BCBSND are both sellers (of insurance to consumers) and buyers (of, for example, physicians and hospital services). As buyers of physician and hospital services, insurance carriers can lower the prices they pay to a point at

which physicians and hospitals may be forced to supply fewer services to the market.

BCBSND has historically been able to use its monopsony power, and present physicians and hospitals with take-it-or-leave it contracts. One implication of these annual "unilateral announcement of terms," is the inability of North Dakota health care providers to negotiate these terms. BCBSND pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region. At the request of NDMA, the six major health systems in North Dakota and BCBSND, the consulting firm *Milliman* prepared a report comparing health insurance premiums and provider reimbursement levels in North Dakota against other nearby states. *Milliman* was tasked with a comparison against other states in the Centers for Medicare and Medicaid (CMS) West North Central Region (Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska and South Dakota). In general, *Milliman* found that North Dakota has lower premiums, provider costs and provider reimbursement levels than the benchmark comparison states. The BCBSND Private Payer Hospital Reimbursement per RVU (geographically adjusted) is $66 compared to the rest of the region's average of $96, or only 69% of that compared to other states in the region. The Private Payer Physician Reimbursement as a percentage of Medicare (geographically adjusted) is 152% of Medicare compared to the rest of the region's average of 164%, or 93% of that compared to the rest of the region.

This is not simply a bill to address a hypothetical, future situation in North Dakota. Last spring, BCBSND attempted to take advantage of its adhesion contracts—which authorized it to unilaterally alter payment terms—by announcing an across-the-board "withhold" of payments. This was done, notwithstanding the objection of North Dakota physicians to BCBSND's decision to distribute a $26 million, one-time premium rebate in 2006, rather than holding those funds as requested by the medical community until the following year to address any volatility in utilization and to instead make premium and reimbursement adjustments in 2007. When utilization trends became an issue early last year, BCBSND attempted to shift its insurance risk to North Dakota providers by announcing the 2.5% payment withhold.

In July 2008, Insurance Commissioner Adam Hamm disapproved BCBSND's 14.8% premium rate request submitted for individual policies, largely because BCBSND had taken advantage of the adhesion contract, announcing the "across-the-board withhold." At the insistence of the

Insurance Department, new provider contracts were agreed upon for physicians and hospitals, incorporating some changes that result in fairer contracts, including changes that would not allow the insurance carrier to unilaterally withhold or reduce payments already agreed upon in the contract. Under the agreement between BCBSND and the Insurance Commissioner, the contracts must specify the manner of payment, the fee schedule, and methodology to calculate the fee schedule, and disclose of the effects of edits and fee schedule amendments. Nevertheless, BCBSND has asserted that the leverage the Commissioner asserted on this contract issue in the rate filing process is not appropriate, and that is one reason why SB 2397 is necessary to provide the Insurance Commissioner with appropriate authority to review and act on unfair contracts.

Now I'd like to walk you through SB 2397, which would incorporate into law this progress toward fair healthcare contracting.

Section 1, Subsections 1 through 3: Fair Contract Enforcement

Section 1, subsection 1, of the bill provides that all contracts entered into after January 1, 2010, must comply with fair contracting provisions enacted by the legislature, and invalidates provisions that conflict. These would include fair contracting standards created by SB 2397 as well as existing fair contracting standards already provided in statute. These include, but are not limited to, these existing statutes:

Interference with medical communications (NDCC 26.1-04-03(15)) - this prohibits "gag" clauses that restrict or discourage a physician from communicating to a patient information in furtherance of medically necessary care;

Unfair indemnification (NDCC 26.1-04-03(16)) – this prohibits contract clauses that unfairly shift legal liability to a health care provider;

Incentives to withhold medically necessary care (NDCC 26.1-04-03(17)) – this prohibits contract clauses that provide incentive plans that would induce a provider to deny, reduce, limit, or delay medically necessary care;

Retaliation for patient advocacy (NDCC 26.1-04-03(18)) – this prohibits a carrier from refusing to contract with a health care provider in retaliation for patient advocacy;

Unfair reimbursement (NDCC 26.1-04-03(19)) – this prohibits "most-favored nation" clauses that require health care providers to give the benefit of the lowest rate the physician negotiates with any other insurance carrier.

Section 1, subsection 2, of the bill requires the Insurance Commissioner to review contracts to ensure they conform to fair contracting standards, approve contracts that are fair, and enforce all fair contracting laws through fine and injunction. Subsection 3 provides definitions related to the first fair contracting standard relating to payment.

Section 2 of the bill would create a private cause of action for providers to remedy violations of any fair contracting standard.

The remainder of the bill identifies fair contracting standards.

Section 1, Subsection 4: Disclosure of Fee Schedules, Payment Policies and Terms

Would it not be fair to require insurance carriers to disclose payment terms and be held to those terms, as in any other reasonable contract?

Health care providers often do not have access to the fee schedules, payment policies and other payment rules developed by insurance carriers. The lack of uniformity in contracts due to differences in payment rules and procedures further aggravate the administrative burdens already placed on providers. Access to fee schedules and payment policies and terms is necessary for health care providers to decide whether a contract makes economic sense in the first instance, and also, after a contract is signed, to determine whether they are being paid correctly. Consistency in payment edits and rules across payers reduces the cost of auditing payments and enforcing payment accuracy.

Insurance carriers often unfairly reduce provider reimbursement through the use of "proprietary" code edits that are inconsistent with CPT® codes, guidelines and conventions, and through the practices of downcoding, bundling, and reassignment of CPT® codes. Multiple procedures are

sometimes "bundled" together and paid as a single procedure, or claims are "downcoded," meaning that they are submitted to the payer at one level of intensity but are reimbursed at a lower level reflecting a reduced intensity of service. Also, claims are sometimes simply "reassigned" to a different code. These practices unfairly reduce provider payment in ways that are difficult to identify, and for amounts that, while significant in the aggregate, are often too low to appeal on a claim-by-claim basis.

The first fair contracting principle provided by SB 2397 would require contracts between insurance carriers and health care providers to incorporate payment terms including any fee schedule or methodology used to calculate any fee schedule, incorporate edits that are consistent with CPT codes, and disclose downcoding and bundling edits.

Section 1, Subsection 5: Contract Amendments

Would it not be fair to require insurance carriers to provide reasonable notice of contract changes?

Contracts between health care providers and insurance carriers routinely authorize one party to the contract to unilaterally change the contract. When insurance carriers make a unilateral change to the contract or related policies and procedures, they do so without giving the provider prior notice of such amendments or allowing the provider a period of negotiation or time to terminate the contract. This unfair business practice reflects and further contributes to the inherent imbalance in negotiating power between health care providers and insurance carriers.

As a second fair contracting principle, SB 2397 would require that the provider be given 60 days notice and an opportunity to terminate the contract before a material change becomes effective, and that an insurance carrier not be allowed to unilaterally add, modify or delete material terms of the contract.

Section 1, Subsection 6: Contract Termination

Would it not be fair to require that written reasons be given by an insurance carrier for terminating a health care provider and that the carrier provide a reasonable review mechanism?

Provisions in insurance carrier contracts providing for termination "for cause" allow either party to end the relationship for certain clearly stated reasons in a specified time frame. These provisions are generally regarded as valid and necessary and, assuming they are bilateral, permit either party to terminate if the other party is not meeting basic contractual commitments. Unfortunately, these provisions are often not bilateral or reasonable. Termination "without cause" is the more controversial provision in contracts that typically allows either party to terminate the agreement without cause upon giving a certain number of days notice. If an insurance carrier exploits these provisions, the result can be the disruption of patient care and loss of a potentially significant patient base.

As a third fair contracting principle, SB 2397 would require an insurance carrier, prior to terminating a contract with a health care provider, to provide written reasons for the termination and provide a reasonable review mechanism, except under certain circumstances involving imminent harm to a patient's health.

Section 1, Subsection 7: Credentialing

Health care providers who are newly licensed or obtain new employment must complete and submit a credentialing application to be reviewed and approved by an insurance carrier in order for the provider to be considered in-network. In some states, particularly those with more competition in the health insurance industry than in North Dakota, the lack of uniformity in the credentialing process contributes to the length of the process during which time the insurance carrier often withholds payment from the physician. Furthermore, any undue delays in processing the paperwork could limit patients' access to health care services because the provider is not considered an in-network provider and payment may be retroactively denied.

Would it not be fair to require insurance carriers to request credentialing information in a uniform format that includes data commonly requested by insurance carriers for the purpose of credentialing, complete the credentialing process within 45 days and, immediately after a provider becomes credentialed, require the insurance carrier to retroactively compensate providers for services rendered from the date of their application?

As a fourth fair contracting principle, SB 2397 would require that credentialing information be requested in a uniform format, with a decision within 45 days of the completed application, with retroactive compensation from the date of the provider's application.

Section 1, Subsection 8: Retrospective Denials

A retrospective audit is one method used by insurance carriers to determine whether a provider has received an overpayment for services rendered. In such an audit, a carrier reviews claims paid to a provider over a certain amount of time – sometimes months and even years past. If the carrier determines that an overpayment has been made, it will look for repayment from the provider either by seeking a full sum reimbursement or by "offsetting" future payments (decreasing future reimbursements). While carriers benefit from these audits as a way to improve their financial bottom line, providers are faced with an administrative nightmare in trying to reconcile claims and maintain accurate financial records, not to mention the adequate cash flow necessary to keep their practices open.

Would it not be fair to require that retrospective payment denials be limited to a time certain?

As a fifth fair contracting principle, SB 2397 would not allow an insurance carrier to retroactively deny payment after the 6-month period from the date the claim was paid by the carrier, unless the claim is denied due to fraud. Such a retroactive denial would required to be justified in writing and if the claim results from coordination of benefits the written statement must provide the name and address of the entity acknowledging responsibility for the denied claim.

Section 1, Subsection 9: All Products Clauses

"All products" or "any products" clauses requiring health care providers to participate in less desirable product lines offered by an insurance carrier as a condition of participation or contract are particularly egregious in states where insurance carriers wield significant market power, as a provider has no choice in the matter. The provider community maintains an interest in seeing these types of clauses prohibited, or at least restricted in their application. Contracting relationships should be the result of a meeting of the minds after fair negotiation, not unfair dictates.

Would it not be fair to recognize that health care providers should be able to negotiate whether to provide medical services under a particular insurance product offered by an insurance carrier?

As a sixth fair contracting principle, SB 2397 would prohibit "any products" clauses that require providers participating in one product to participate in others.

Section 1, Subsection 10: Rental Network Market

Would it not be fair to prohibit insurance carrier from selling discounts they garner from a health care provider to other carriers without the provider's consent?

The rental network PPO market has evolved beyond the purpose of providing a provider network for a local, regional, national or increasingly international payer, into a lucrative secondary market in provider discounts characterized by a complete lack of transparency. This market has made it virtually impossible for providers to predict payments, trace claims, and/or challenge carrier determinations. It undermines the goal of transparency in health care because the provider cannot determine a patient's responsibility for payment at the time of service. In addition to adding to the already overwhelming administrative burdens placed on the physician practice, this activity deprives providers of fair payment.

As a seventh fair contracting principle, SB 2397 would preclude carriers from giving access to the provider's discounted rates to another entity, absent the provider's express consent.

Section 3: Physician Profiling Programs

Insurance carriers are increasingly developing profiling programs to evaluate the performance of physicians and other health care practitioners. A potential conflict of interest exists in these profiling programs because insurance carriers have a profit motive to steer patients away from high-quality providers that may cost more money or reduce the size of the provider network to limit access to care. To ensure that these programs do not undermine the patient- physician relationship, patients must be enabled to rely upon accurate and meaningful information on practitioner performance that include quality of care measures when making important health care decisions. Would it not be fair to ensure there are standards that apply to profiling programs?

As an eighth fair contracting principle, SB 2397 would place standards on profiling programs that are consistent with national agreements recently reached with seven of the top health insurance companies regarding their provider profiling programs. These agreements establish a process that seeks to guard against some of the risks inherent in these programs run by insurance carriers. SB 2397 would revise a current ND statute that incorporates profiling standards to ensure that rankings for physicians and other practitioners are not based solely on cost and use established national standards to measure quality and cost efficiency, including measures endorsed by the National Quality Forum (NQF); and provide a peer review appeal mechanism to resolve provider complaints.

Good public policies and principles support enactment of *comprehensive* fair contracting legislation that standardizes contract terms, requires adequate disclosure, and prohibits certain unfair contracting provisions. Passage of SB 2397 serves to enhance patient access to medically-necessary care. On behalf of the physicians of North Dakota, I urge you to recommend a "Do Pass" on SB 2397.