2011 HOUSE HUMAN SERVICES

HB 1386

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1386
January 25, 2011
Job # 13337

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

To add Health Care Services to the statutes of Freedom of Choice for Pharmacists.

Minutes: *See attached Testimonies #1 through 5*

Chairman Weisz: Opened the hearing on HB 1386.

Rep. Kenton Onstad: From District 4, Parshall introduced the bill and testified in support. (See attached Testimony #1.) He also handed out testimony for **Mitch Leupp,** Administrator of the Mountrail County Medical Center in Stanley, ND. (See Testimony #2.)

Dean Mattern: Administrator of the Garrison Memorial Hospital and the Community Memorial Hospital in Turtle Lake testified in support of the bill. (See Testimony #3.)

Rep. Paur: If the insurance companies do not want to negotiate with you; if we force them to negotiate, they would have the ability to say that we are only going to pay a penny for a bandaid or $100 for an appendectomies? And then make the whole contract process basically non-negotiable.

Dean Mattern: That is probably technically correct. We aren't asking that they have to have a set price. That needs to be negotiated. Our cost structure might be different from some of the larger places. There are some reasons for having the insurance company have the ability to be able to negotiate that rate. It's not likely that they would waste their time in not in good faith negotiations. I don't see that happening especially not with the smaller facilities. It hasn't been our experience in the past. We get contracts from a variety of insurance companies and they have their differences. I simply want the opportunity to sit down and talk to them rather than being totally excluded.

Rep. Louser: You mentioned that as a critical access hospital you are very dependent on the locals using the services. That makes perfect sense to me. I was just wondering for lack of a better term, what is your current occupancy rate and if this were to pass, how do you see that increasing?

Dean Mattern: Currently Garrison Memorial has been operating on a fairly good occupancy level. We probably don't look at our occupancy the same way as you would think of Trinity

or a larger hospital because we use a significant amount of swing beds. We probably are running at three-quarters full in Garrison. In Turtle Lake, it is not that high. Our swing beds are a little bit lower there than they are in Garrison. I don't know if I can actually put a number on what this would do. It depends on how much new business comes into town. We are all familiar with the flood of workers going into the western part of the state. That probably affects Garrison more than Turtle Lake because we are closer to where the significant activity is. Garrison sits on the peripheral of that. We see some local housing issues where people are living and driving into the fields. I do see it increasing, but to an actual number it depends on what happens with the oil. Our financial position in small hospitals is so critical that we cannot afford to lose any opportunity for any amount of business.

Daniel Kelly: Chief Executive Officer of the McKenzie county Healthcare Systems, Inc. in Watford City, ND testified in support of the bill. (See Testimony #4.)

Rep. Porter: Is McKenzie County Medical Center currently a BC/BS participating provider?

Daniel Kelly: We are, yes.

Rep. Porter: I'm trying to figure out where the problem is. Where is the problem on redirection of patients? If a company comes in here with a different insurance company, are they contracting say with Mercy in Williston and making their employees drive that difference? Or are they not coming and talking to you? Where exactly is the problem?

Daniel Kelly: A very good question. I'm probably more sensitive to this then maybe other individuals in ND because I've only been in ND three years. I have literally been in states where this occurs. I make the point that I as a hospital administrator may not know if this is occurring from the standpoint that unless an employee would come and tell me their company does not choose my facility I wouldn't be aware of that. It is a negotiation that takes place behind the scenes. To answer your question, I think this bill is being somewhat proactive relative to McKenzie County to prevent this from happening. The point being, to answer your question directly, at present as we probably all know, Blue Cross is the major (insurance company) having a significant percentage of covered lives within the healthcare industry. We are presently a contractee with Blue Cross. I think our concern lies more with outside companies coming in from, be it Oklahoma, Colorado, Texas and choosing within their insurance realm not to contract with the local provider.

Rep. Louser: We have heard a number of times that quality of life and those sorts of things are taken into consideration. Especially with respect to access to healthcare when companies are considering moving to ND. From a business standpoint, I think it would be a poor business move to consider moving to a small town in ND and not consider coming to negotiate with you with regards to insurance. Something that jumps out here is 24 of 36 critical access hospitals lost money. That is staggering. My question was going to be, what do you think the top three reasons are? I think you answered the major one is your emergency issues. What are a couple of other issues that are causing that?

Daniel Kelly: From my assessment there are actually three reasons. Quite frankly we receive relatively low reimbursement from Blue Cross (BC). It is fairly well know within the

industry and with BC being a major insurer that is where the vast majority of our reimbursement comes from. I have some sympathy for BC also, believe it or not. In ND we have a population of 650,000 individuals. I moved from Connecticut. Hartford Connecticut has more than 650,000 people and so the reality of it is, in the insurance industry you spread risk amongst a group of individuals. In ND we have a relatively small number of individuals to spread that risk. For example, if you have two individuals with gastric bypass surgery or two individuals with open heart surgery, those are hundreds of thousands of dollars that get born by BC. I'm not here to advocate on behalf of BC, but I do understand that. The other is geography quite frankly. I go on record by saying that in other states we may not have hospitals in some of the cities that we have hospitals in, in ND. The reason we have hospitals where they are located in ND is due to geography. In my county even today it will take people thirty minutes to drive to Watford City if they live in the eastern part of the county. Again, the hospital needs to exist because of geography and as a result of that the reason we are critical access hospitals is that fact we don't have the volume that a typical hospital would need in order to sustain itself. Those quite frankly are the reasons. To your point, we are mandated to provide several levels of care and many times those are items that cause us to lose money. The other point I'd like to point out, although we are blessed in western ND to have an influx of individuals; I will tell you it also brings its whoa. In my particular facility I looked in July of this my bad debts, that is services I provided in the month of July that I will not be reimbursed for, was $77,000. That was compared to $11,000 the prior year. Not every month do I have that significant of an increase, but I will tell you relatively speaking my bad debt has gone up several hundred times. That is due to the fact that I have workers coming in from out of state who are providing false information relative to insurance and those types of things. I provide that care and I need the ability to have that offset by those individuals who choose to use my facility for routine care.

Nancy Kopp: I represent the ND Optometric Association. The ND Optometric Association (NDOA) following up and echoing some of the concerns of the previous supporters. Optometry is represented in thirty-nine of the fifty-three counties in ND so you can see we service in rural as well as urban areas. I appear before you in support of HB 1386 this morning probably from a different direction. That being from the point of view from a private practitioner. There are some plans within BC/BS, one mainly as Select Choice, but our optometric members have difficulty in accessing the preferred provider organization. Normally that plan will negotiate with a major healthcare system. Let me give you an example of the difficulties that we experience. Say a patient has vision services which is a vision plan that provides routine eye care and they go to optometrist and get the examination. The Optometrist discovers a medical program, so then if that private practitioner is not participating in the PPO (Preferred Provider Organization) they must refer that patient to the participating (inaudible) facility. That creates an access issue for the optometrist who must refer because he is not allowed to participate in the plan and therefore could increase costs either to the patient or the examination and or further medical testing. For those reasons it is an access issue for providers as well as the patients. I ask that you support this and allow all providers to meet the terms of contracts if they so desire.

Howard Anderson: I'm a pharmacist and had a business in Turtle Lake for many years and I'm here today mostly because Representative Onstad asked me to comment because I was here when the legislature passed this bill in the first place. I don't look that old I know, but I was here. When we asked that this bill be passed, we thought that it would do certain

things. I think we thought it was going to do what the testimony today is telling you that it does. And that is, make all of these contracts available to all the pharmacies on an equal basis so they could serve the patients in their communities. I want to say to that the insurance commissioner didn't always look at it the same way as we did. I don't think the insurance commissioner always looks at it the same way you are thinking based on the testimony you are hearing. So, I would encourage you to ask your insurance commissioner what this bill means so you have something in the record to make sure that the enforcement matches what your intent is. Let me give you an example what happens in pharmacy. A company, let's take an example of somebody out of Texas and they are going to ship a hundred workers up here; they say to their insurance company, do we have coverage up there? And they say, yeah, we have thirty percent of the market contracted to provide services. The guy from Hartford, Connecticut, he looks at it and if thirty percent of the pharmacies in Hartford, Connecticut are in this deal, the patient is not going to drive more than a mile or two to get to a pharmacy that is under the contract. But, if thirty percent of the market in ND is covered or even western or northwestern ND, that patient may have to drive a hundred miles to get to preferred provider pharmacies. That is what we intended to prevent by this. We didn't say you couldn't contract for services, but once you decide that thing you should include all of the willing providers in that group so they can all take care of their patients. That isn't the way the insurance commissioner has enforced this provision. He has kind of looked at it and I don't want to put words in his mouth. This isn't this insurance commissioner. This is previous insurance commissioners basically who looked at it and it is mostly the attorneys with the department that has to interpret these things for the insurance commissioner. They have looked at it as, as long as you are treating all of the patients out there who are covered by the insurance the same, it's not so much worried about the providers. We haven't always seen that this came about, but we do see those scenarios and I think that is what these people are talking about. Once you contract with a certain amount of providers it looks to the guy who is the administrator of the company in Houston, Texas like he has coverage in western ND. But, when his patient goes to Stanley, ND and they don't happen to be a signed up provider and that patient is told he has to pay the bill because his insurance company is not contracted with them, you can see how that works out. That guy who came to their emergency room or walk-in clinic is not interested in paying his bill because he thinks his insurance company; his employer is going to pay that bill. He leaves, the bill is unpaid and these guys are stuck trying to chase the bill. It doesn't work quite that way in pharmacy because we have the on-line claims thing and we know right away if they are going to pay it or not. And if we are not a provider, but we are still stuck telling the patient standing in front of you that your insurance company is not contracted with us and won't contract with us, so that means you have to pay for your prescription. Just wanted to explain to you how it has worked over the years with us and certainly see no downside in adding all healthcare providers to the bill. If it is enforced as we intended it and I think as you're thinking, it should work alright. It is not always being enforced that way.

OPPOSITION

Dan Ulmer: Representing BC/BS of ND opposed the bill. (See Testimony # 5.)

Rep. Porter: In the case of some of the examples given, let's say a company, Continental Resources is insured through BC of Oklahoma and McKenzie County wouldn't be a

participated provider. When that employee comes in, then they fall under the BC/BS of ND contracts and can be steered to providing facilities out inside of the existing BC/BS network because of your agreements with all fifty of the Blue Cross and Blue Shields in the country?

Dan: Ulmer: To clarify, they are non par?

Rep. Porter: Yes.

Dan Ulmer: Yes, I guess would be the answer?

Rep. Porter: A question comes to mind as they were discussing Mr. Kelly from McKenzie County about the increase in non-collectibles. In the situation of them being in the non-provider status, the transient worker being here for 3-6 months to a year, uses services of a non-participating facility, and the payment is mailed to them; then it increases the difficulty of the facilities to collect off of those. Is there a mechanism in place for those transient type workers that would allow direct payment in a non-participating provider situation or how do we fix their collectible situations out there in rural ND?

Dan Ulmer: Many insurance companies do not pay the provider directly as we do. That is the advantage of being a participating provider is that you would get a direct payment from us. As a non-par provider (drops sentence). As well the other advantage of being a participating provider would also be that the provider agrees to accept what we of BC pay as payment in full. If they are a non-participating provider, then we would send the check to the member and the provider would be allowed to collect the remainder of the charge from the patient. The detail in that is that we have discounts based on our volume which I mentioned in my testimony. If the provider billed us a hundred dollars, then we have a participating agreement the provider would agree to accept that at eighty dollars. That would be our normal fee and we agree to accept that as payment in full. Under a non-participating arrangement, then the provider could under this arrangement, whatever the insurance company paid, the provider would be allowed to collect the remainder of the bill charged. As I think you are all aware of.

Rep. Porter: I didn't hear from anyone that said that they weren't at least a participating provider with BC/BS at a particular level. Because they wouldn't fit that select choice or other levels of insurance on those transient type programs coming from other states; that would still allow them to be considered participating in ND?

Dan Ulmer: Are you asking if they had a Blue Card in Oklahoma how does that work in ND?

Rep. Porter: Yes

Dan Ulmer: We have a program called Blue Card that we would pay whatever our going rate is if you are a participating provider. For instance, if you went to MAYO with the Blue Card, we would pay whatever the Blue Card of Minnesota would pay. It is an agreement we have that wherever you go in the country with the Blue Card as long as you go to a participating provider. It is a different game if you go to a non-par.

Rep. Porter: In that scenario, I was looking for some of these other programs like the Select Choice, the Blue Choice, something else that maybe a fairly restrictive PPO in Oklahoma, using my example again. With that individual coming to ND and just going to a regular BC/BS participating type provider not in one of these narrowed down programs. They would still be under those rules of reciprocity; they would still be considered participating and still fall under the programs for payment and reimbursement that you currently have in place.

Dan Ulmer: Yes, they would be out of network, but we would pay at our rate.

Rep. Paur: You said in your testimony that BC/BS has further credential requirements as a pre-requisite to participating, such as mal-practice insurance. You go on to say that this amended statute would restrict the ability to assert such minimum requirements. Can you tell or show me where you believe that is restricted in the bill?

Dan Ulmer: How it restricts us is that it doesn't allow us to look or ask. We just have to go with any willing provider.

Rep. Paur: Well you would have to negotiate with them, but doesn't (drops sentence).

Dan Ulmer: In terms of credential, ensuring that this particular provider has the credentials, maybe it is in some neonatology, rheumatoid something or other, we want to make sure this person is indeed credentialed. That they are qualified to do what they do. Under any willing provider, the scenario doesn't matter; we just have to sign up with them. I need to add one other thing into this issue and we confronted it already in Grand Forks. Grand Forks wants to build a new hospital; we so far have refused to participate with them under the notion that we're not sure whether Grand Forks needs a new hospital. We did the same thing with Innovis now Essentia in Fargo. If this bill passes, we won't be able to make those choices. This has an even higher affect on one of our competitors another larger healthcare system in ND in terms of being able to work with their patients. It is a huge deal. We are basically saying, the bottom line is that folks have a freedom of choice issue. Under the laws, they can go to the folks they want, but if we are going to talk about bending the cost curve, we are going to be talking about seriously getting a hold of the issues that the real problem's in healthcare, then don't pass this bill.

Rep. Porter: In your testimony you talked about a couple of different plans that are available through BC/BS. If a person is a part of the Select Choice or the Blue Choice and their PPO is in Minot and they are working in Stanley and they want to see a doctor for a cold or flu and go to the clinic to see the physician. Then is that paid to that provider as an out of network service because they are a BC/BS provider in all of the other programs accept this is outside of the network and they can't get to the network to take care of this because they have to be at work at 3? How does that scenario going to work?

Dan Porter: I'm not sure whether or not we repealed this act, but I remember in the mid 90's there was a piece that said if you were within fifty miles, then you got paid at the network rate. I know that Rep. Wald made it a huge thing because we had HMO's that were creating the problem that you are alluding to. They were only allowed to go to this particular facility. Not familiar if they pulled that or not.

Chairman Weisz: Anymore opposition to HB 1386. If not, we will close the hearing on HB 1386.

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1386
February 1, 2011
Job #13777

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Called the meeting to order on HB 1386. This is the one that says (inaudible) insurer offers a contract to one he has to offer them to everybody. For example, the early days of PERS they had three plans. They had an EPO, PPO and the standard plan. This would eliminate it. EPO by definition is an exclusive (drops sentence). They are willing to give the Blues a better deal in exchange for the exclusivity of the contract. At that point if we had signed up an EPO I think it was a 90/10 instead of an 80/20. I would have paid less out of pocket if I had signed up for that plan.

Rep. Conklin: Are those plans out there anymore?

Chairman Weisz: Select Choice is still out there, but PERS doesn't have that. MEDIQ home is still out there.

Rep. Kilichowski: Does this mean that all insurance providers in the state would have to allow every healthcare provider with a contract?

Chairman Weisz: That is correct. If any insurer had a contract; whatever it was with anybody they would have to offer it to every provider in the state. All the CAH's are providers of Blue Cross, but they don't all have contracts for example, like Select Choice.

Rep. Holman: The result of this would be one rate for every provider. Since the Blues do about 80%. So we would have one rate for every provider in the state which basically is price fixing in a sense.

Rep. Porter: I don't look at it as price fixing I would look at it as not allowing the insurance industry to set the levels of competition inside of the industry. One concern I think that hasn't really surfaced yet is Sanford Health out of Sioux Falls also has Sanford Insurance in Sioux Falls and it is interesting in a critical healthcare situation we have in ND. As we have heard from a number of bills relating to critical access hospitals and major tertiary facilities that are just walking that narrow line of survive ability. That you would be able to have an insurance company that is also a provider of services that could move into any community that is close to their many tertiary facilities and put private clinics and other non-profit clinics out of business by capturing the insurance market. And then saying we won't let you be a provider in our insurance market. One example is currently happening in Valley City where

there is a Sanford Health Clinic and hospital based clinic that one can have Sanford Health employees and one can't. There are some major implications with not passing this type of legislation inside of how this industry is set to change over the next couple of years with new insurance providers. I can't disagree with Blue Cross's testimony as the majority stakeholder that they can control the market right now. They can control the completion, growth in the industry and everything. They hold a pretty big hammer by having his kind of legislation not on the books controlling the providers of the state. I think there was a concern we really didn't hear about. I wasn't happy with the way the bill was presented. I think they beat around the bush as to what the real problem was. When you start getting into healthcare systems that are the payer and provider, you lock down and force other providers out of business. They can run those contracts and force the flow of patients to just their facility and have a true monopoly over a small rural healthcare system. I think this is a serious potential problem out there.

Rep. Holman: Suppose Sanford bids on the PERS plan. Now you have 30,000 or so and you have that competition. What would the end result be?

Chairman Weisz: I find it interesting that we were so worried the Blues were the monopoly in ND and now we seem to be concerned that somebody could take the Blues out and become the new monopoly. My understanding is that Sanford Health does not support the bill.

Rep. Porter: I would believe that. They don't need to support the bill.

Chairman Weisz: I said that wrong. Sanford Health supports the bill. Sanford Insurance doesn't. There is a division within there (drops sentence). Sanford Health supports the bill because they don't want to be excluded on the provider end. Everyone is a provider for the Blues in the state. They don't all have a contract. The Blues are going to pay that provider. They may pay 80/20 rather than 90/10 because that hospital doesn't have the EPO Blue Cross contract.

Rep. Porter: They have a major stake in Jamestown and stand alone clinics all over the area. Let's say you had a private practice surgeon in a small community that was a standalone business owner and they came in and got all of the insurance side of it. When someone needed elective surgery they would be told to go Fargo and not have it done in the local community. If the local hospital is not a part of the network people with have to go where a hospital is part of the network so the bill can be paid. I don't know if this would have a big effect on the urbans, but it would have a huge one on the rural areas. And it will have a huge effect on competition of healthcare where an insurance company can say no you can't build a hospital here even if you prove you need it. The INNOVIS is an example of that is where BC/BS said, we aren't going to allow you to participate as a hospital and they did it anyway. Then Grand Forks is another example where they said, no we are not going to allow you to do that. We've already set it up in law that they can do this and is that right that we gave them that big of a hammer. Or, does it need to be more of a level playing field where someone can say, sure I'll take that as a contract.

Rep. Paur: I highlighted in my Mr. Ulmer's testimony, that BC/BS has further credential requirement as a pre-requisite for participating, such as malpractice insurance. And this

statute would restrict them the ability to search such minimal requirements. That sounds a little like the dental deal where they are putting requirements outside of what they are paying. He went on to say that ND already has not but one, but two Freedom of Choice Statutes requiring that BC/BS reimburse members for covered services received from a litany of healthcare providers. Therefore, any willing provider statute is not necessary. Century Code provides any provision in any accident or health insurance policy issued by any insurance company denying the insurer in case of accident or sickness, the right to consult or employ any doctor licensed to practice in this state. The insurer may choose or enter into any hospital or sanitarium, etc. etc. But, it sounds like that kind of addresses Mr. Porter's (stops).

Chairman Weisz: That is true. The difference being is, let's say I'm Sanford insured and I go to this facility Rep. Porter is talking about. I can have it done there if medically necessary, but now I have to pay the bill and have to submit the bill to Sanford and have them pay whatever they will based on my insurance contract. It may pay at a lower rate than if I had gone to Fargo. Our law may make the insurance company pay, but they don't have to make it easy.

Rep. Paur: But, this bill would change that.

Chairman Weisz: It would change it from the standpoint that let's say Rugby would be willing to take the terms that Sanford has, I can do it and they can't exclude them from the contract. Rugby can bill Sanford directly.

Rep. Porter: On the part of Mr. Ulmer's testimony about the malpractice and the credentialing they like to have over and above the state licensure, I think is covered on page 1 line 20. It says, it accepts the terms of the third party payer's contract. I don't see that as an issue.

Chairman Weisz: I agree.

Rep. Holman: Looking at sponsors on the bill it seems like part of the origin of this is coming out of oil country. There must be a purpose of something that is happening with this influx of oil workers that is causing a problem.

Chairman Weisz: This doesn't affect any self-funded or ERISA plans. I think that is part of the problem they are having in the oil fields is you have these large companies coming out of Texas. They have an ERISA plan and the hospital is having difficulty getting paid and whatever we do on this bill will have no affect on that.

Rep. Conklin: I move a Do Pass.

Rep. Schmidt: Second

Rep. Louser: It seems to me that it is allowing a patient to have a choice of where they want to have their healthcare services that is going to come at a cost to everybody in increased premiums with BC. And they are going to react quicker than the law is and that is the tradeoff here. Am I reading this wrong?

Chairman Weisz: To a degree you are right because some of these plans I think would definitely go away.

Rep. Schmidt: My concern lies with a little hospital in Elgin and trying to keep that alive. I don't totally understand the impacts of this bill, I would like for the folks that live outside of Elgin not to have to drive to Bismarck or Mandan to receive hospital benefits. I would like them to be able to stop in Elgin and get what they need there. Based on comments by Dean Matern, "by passing HB 1386 you are insuring the vitality of our smaller communities and insuring patients have the ability to choose the facilities they would like to utilize for their healthcare needs. My expectation is this bill allows that for the hospitals. Am I wrong with that thought?

Chairman Weisz: I think the language that he uses may be a little strong. Like out west the self-funded ERISA plans are covered under this. Their problem is going to continue. All of the hospitals have provider agreements with the Blues so it shouldn't have any effect on any of Select Choice type plans or the MEDIQ plans that the Blues have shouldn't affect Elgin. Rep. Porter's scenario has validity.

Rep. Porter: Going back to Rep. Louser's comment. I don't see it as increase in premium costs either. If the Blue Choice and Select plans are still out there and still popular for an employer group for someone to have; all it is saying is if you as a provider is getting paid X for seeing a Blue Choice patient, then your competition and choose to get X as part of it too. It would actually drive the cost down rather than drive it up.

Chairman Weisz: It equates to rising premiums from the standpoint of why would anybody participate, say in a select because you already have reimbursement rates? So, why would a facility voluntarily go in and give a lower rate? They do it so that potentially it will increase the volume or some efficiencies. If everybody else has it, why would any facility participate in the plan and take a 10% reduction in reimbursement because they will end up with greater volume which greater efficiencies which will make it back? There is no incentive for them to do that anymore. The assumption would be those plans would go away because the Blues can't offer them anything in exchange.

Roll Call Vote: Do Pass 5 y 8 n DP FAILED

Rep. Devlin: I move a Do Not Pass

Rep. Anderson: Second.

Roll Call Vote: 9 y 4 n DNP Carried

Bill Carrier: Rep. Weisz

Date: 2-1-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1386

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Conklin Seconded By Rep. Schmidt

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ		✓	REP. CONKLIN	✓	
VICE-CHAIR PIETSCH		✓	REP. HOLMAN	✓	
REP. ANDERSON		✓	REP. KILICHOWSKI	✓	
REP. DAMSCHEN		✓			
REP. DEVLIN		✓			
REP. HOFSTAD		✓			
REP. LOUSER		✓			
REP. PAUR		✓			
REP. PORTER	✓				
REP. SCHMIDT	✓				

Total (Yes) 5 No 8

Absent _____

Floor Assignment _____

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

motion failed

Date: 2-1-11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1386

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Devlin Seconded By Rep. Anderson

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN		✓
VICE-CHAIR PIETSCH	✓		REP. HOLMAN	✓	
REP. ANDERSON	✓		REP. KILICHOWSKI		✓
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD	✓				
REP. LOUSER	✓				
REP. PAUR	✓				
REP. PORTER		✓			
REP. SCHMIDT		✓			

Total (Yes) 9 No 4

Absent _____

Floor Assignment Rep. Weisz

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

DNP carried

REPORT OF STANDING COMMITTEE

HB 1386: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (9 YEAS, 4 NAYS, 0 ABSENT AND NOT VOTING). HB 1386 was placed on the Eleventh order on the calendar.

2011 SENATE HUMAN SERVICES

HB 1386

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1386
3-8-2011
Job Number 15129

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to freedom of choice for health care services.

Minutes: Attachments.

Senator Judy Lee opened the hearing on HB 1386.

Representative Kenton Onstad (District 4) introduced HB 1386. Attachment #1 includes letters from hospital administrators.

Senator Judy Lee asked for clarification on the first page of his testimony where it says "HB 1386 asks that Health Care Services have the ability to deny."

Rep. Onstad explained that now if a clinic looks to contract with a carrier the carrier doesn't have to offer them a plan. He is saying to flip that side around and let the clinic say they would like to have a plan with the carrier. The clinic would then have to agree to the terms of the carrier.

Senator Tim Mathern said the movement from pharmacy to health care services is a fairly broad expansion and asked what the rationale was in terms of putting the bill together to open it up to all providers.

Rep. Onstad replied that it started with the critical access hospitals having the ability. Then he realized there was a hospital in Fargo that has been denied. There are physical therapists trying to set up practice in Bismarck that have a hard time finding enough insurance carriers that will work with them. It is broader picture than just the smaller communities.

Senator Spencer Berry asked who is included in the health care providers.

Rep.Onstad said there is a definition but it basically includes pharmacists, clinics, hospitals, chiropractors, dentists, physical therapists.

Senator Spencer Berry asked if this is mainly directed at independents.

Rep. Onstad explained that is part of it but it also deals with opportunities that are rising in relocation of businesses into ND and the main offices are out of state.
There are several states have freedom of choice for all their health care providers. This legislation was not drawn off model legislation from other states. It was just looking at the freedom of choice that pharmacists have and how that could be changed so other health care providers could have the same opportunities.

Senator Dick Dever stated there are two major providers in Bismarck and his insurance says he goes to one – would this mean he could go to the other one two.

Rep. Onstad replied that he could still go to both but how he pays for the bill in the end would be different.

Rep. Phil Mueller (District 24) serves on the hospital board at Mercy Hospital in Valley City and read the testimony from **Keith Heuser**, Administer at Mercy Hospital. That testimony is part of Attachment #1.

Senator Judy Lee referred to restricting the moratorium on the number of long term care beds in ND and part of the reason being to control the costs. She made some comparisons and wondered why this doesn't contribute to higher health care costs when we are struggling with health care costs the way they are.

Rep. Mueller replied that the short answer was consumer choice. It is a free market and access to that free market would make sense in the case of this bill.

Dean Mattern (Administrator/Garrison Memorial Hospital and Community Memorial Hospital in Turtle Lake) testified in support of 1386. Attachment #2

Senator Tim Mathern said there are a numbers of factors before them this session regarding critical access hospitals. He wondered if this one rises to the point of a make it or break it situation for hospitals. Will hospitals close without this type of legislation in place?

Mr. Mattern thought that this is a step that could potentially affect a lot of hospitals if it is not in place. In his personal opinion preferred provider organizations have not worked well in ND in general.

Out of network costs were discussed. Hospitals would end up with less money in an out of network situation as well as the patient paying more. When an individual has to pay more out of pocket they will not stop for their care but will go on to where it is cheaper.
If a person goes to a non preferred hospital that person has to pay their own bill and then bill their insurance company.

Senator Gerald Uglem asked if any of our critical access hospitals are being refused at this time to participate with insurance companies.

Mr. Mattern – none that he is aware of at this time.

Tony Hollar (MPT) testified in support. Attachment #3

Senator Spencer Berry asked him about the comment he made that negotiations for a smaller amount of services would result in a higher reimbursement for those services.

Mr. Hollar said that is where it would allow the critical access hospital to maybe sit down with the insurance company and work something out.

Senator Judy Lee commented on emergency situations away from the primary care provider and didn't think the insurance company would deny coverage. There might be a higher deductible.
The providers of care need to find out about insurance coverage ahead of time.

Nancy Kopp (ND Optometric Association) provided written testimony in support of HB 1386. Attachment #4
She also provided written testimony on behalf of **Dr. Kevin Melicher** (Fargo). Attachment #5

Dr. Brian Beattie (Practicing Optometrist in Bismarck) testified in support of HB 1386. Attachment #6

Senator Judy Lee asked if he is totally excluded from reimbursement or just from the preferred provider group.

Dr. Beattie replied that at this point he thought they were just excluded from provider and pay a higher co-pay.

Senator Judy Lee agreed that it would be important to be reimbursable but also important to clarify whether they get zero or they get x dollars and the patient has to pay more.

Senator Dick Dever asked how many of the 32 optometrist in Bismarck/Mandan are independent business people not affiliated with the doctor, clinic, or hospital.

Dr. Beattie said 24 would be independent.

Howard Anderson (Executive Director of the Board of Pharmacy) testified in support. Attachment #7

Senator Dick Dever asked if other states have similar kinds of legislation.

Mr. Anderson replied that this legislation has been asked to be passed in many other states.

Senator Gerald Uglem asked if the contract is the same for everyone in the state or are there different reimbursement levels for different groups.

Mr. Anderson said the contract is usually the same.

Senator Spencer Berry asked what the financial incentive would be for the insurance company not to allow payment.

Mr. Anderson guessed that it is easier for them. The other thing is that it can work insidiously to hold down costs.

Max Laird (Bismarck, representing himself) testified in favor. Attachment #8

Senator Judy Lee asked if the challenges he is facing are because the Grand Forks Public Schools would have negotiated its insurance with Altru as its preferred provider.

Mr. Laird – yes, Grand Forks would have negotiated with Altru to create the system whereby if you move out of town you are considered out of network.

Senator Judy Lee asked if it would be reasonable to assume that BC/BS is the administrator of the plan put together by the Grand Forks Public Schools and it is not a BC/BS plan.

Mr. Laird – yes.

The COBRA plan was discussed.

Lisa Carlson (Sanford Health) gave opposing testimony. Attachment #9

Senator Spencer Berry asked for an explanation of self funded ERISA programs.

Ms. Carlson explained the most important aspect is that it is not subject to state mandates and state laws. She explained the differences between the self funded and the fully insured. The bulk of North Dakotans seem to be affected by the self funded plans.

Senator Tim Mathern asked if, in the Sanford system, they miss the mark can they shift that cost to their medical provider system. Is it interchangeable?

Ms. Carlson said it's looked at as a whole. They don't push the mistakes they make on to their providers. It is their responsibility as a health insurance company to make sure they don't miss the mark and they do have reserves set aside for when they do.

Senator Judy Lee explained more about ERISA plans.

Dan Ulmer (Blue Cross/Blue Shield) testified in opposition. Attachment #10

Senator Dick Dever asked about the ability of providers to reach across state lines to recoup expenses.

Michael Fix (Director/Life and Health of the Actuary for the Ins. Dept.) answered that if they received a call from a consumer that had an issue with that they would have to send them to the other state's department of insurance. At this point there is no agreement that would

say ND has regulatory authority over a company domiciled in another state but not licensed in ND.

Senator Dick Dever – Then as far as the provider is concerned it's "Buyer Beware".

Discussion continued – The state of domicile is the regulating state. Insurance exchanges in the health care reform as part of the solution – changes are not known at this time. Unintended consequences could very well be that the costs will go significantly higher.

With no further testimony the hearing on HB 138 was closed.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1386
3-15-2011
Job Number 15491

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes: Attachment.

Senator Judy Lee opened HB 1386 for committee work.

Senator Tim Mathern offered amendments .02001 and explained them. Attachment #11 This provides for a legislative management study during the interim and is supported by Rep. Onstad. It is essentially a hog house of the bill.

Senator Gerald Uglem asked if it was intentional that it says "shall study" instead of "shall consider study".

Senator Tim Mathern said it is intentional.

Senator Judy Lee had a concern about that and also wondered if they could say the Insurance Dept. "shall" assist.

Senator Tim Mathern thought they could say it but they don't need to.

Senator Judy Lee felt if it was a legislative study then it should be driven by the legislature.

Discussion on the use of shall or may.

Senator Tim Mathern moved the amendment with changes from "shall study" to "shall consider studying" and the Insurance Dept. "may" assist.

Major medical was also discussed as a descriptor. This was drafted by legislative council and the intent on the part of Sen. Mathern was that all the providers that would have been considered in the original bill would be in this.

Seconded by **Senator Dick Dever.**

Discussion on the study resolution versus the bill as it is. Some of the providers have indicated that the solution they are looking for may not be this bill. The solution may be determined through a study.

Senator Judy Lee said they are not hearing anything about the consumer in this from the standpoint of what cost containment opportunities there might be. That is what concerns her about this bill. It opens it up to reduce efficiencies and will lead to already higher costs. She would rather have the amendment than the bill.

Senator Tim Mathern felt that passing this in the form of the study resolution and getting people around the table to work on it is much better.
There are a lot of forces that are concerned about unfair practices in health care in our state. That is kind of the energy behind this bill.

Roll call vote 5-0-0. **Amendment adopted**.

Senator Tim Mathern moved a **Do Pass as Amended**.

Seconded by **Senator Dick Dever.**

Roll call vote 3-2-0. **Motion carried**.

Carrier is **Senator Dick Dever**.

11.0576.02001
Title.

Prepared by the Legislative Council staff for
Representative Onstad
March 15, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1386

Page 1, line 1, after "A BILL" replace the remainder of the bill with "to provide for a legislative management study and a report from the insurance department.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - REPORT FROM INSURANCE DEPARTMENT.

1. During the 2011-12 interim, the legislative management shall consider study whether steps can be taken to improve health care service providers' access to third-party payer reimbursement network systems in order to improve North Dakotans' access to health care services and to contain their health care costs and out-of-pocket expenses. For purposes of this study, health care services include major medical as well as dental and vision services. The study may include consideration of:

   a. Whether it would improve patients' freedom of choice by allowing all health care service providers the opportunity to be included in network systems and negotiating deeper discounts with third-party payers;

   b. Whether a third-party payer for health care services should have the ability to deny a health care service provider the right to provide services or to negotiate a contract for services that do not cover the the provider's entire scope of practice;

   c. Whether current practices in preferred provider arrangements allow third-party payers to interfere with a patient's continuity of care; and

   d. The positive or negative impact any changes in the current practice may have on:

      (1) Insurance companies doing business in the state, including managed care companies and health management organizations; and

      (2) Health insurance premiums.

2. As part of the study, the insurance department ~~shall~~ may assist the legislative management by gathering information regarding current practices, including whether health care providers are being denied provider contracts by insurance companies and other third-party payers. The department ~~shall~~ may make periodic reports to the legislative management on the status of this information gathering.

3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

Date: 3-15-11

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1386

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☑ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment _____

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

Date: 3-15-11

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1386

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.0576.02002 Title 03000

Action Taken: ☑ Do Pass ☐ Do Not Pass ☑ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman		✓	Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair		✓			
Sen. Spencer Berry	✓				

Total (Yes) 3 No 2

Absent 0

Floor Assignment Senator Dever

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

REPORT OF STANDING COMMITTEE

HB 1386: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (3 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1386 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "to provide for a legislative management study and a report from the insurance department.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - REPORT FROM INSURANCE DEPARTMENT.

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   b. Whether a third-party payer for health care services should have the ability to deny a health care service provider the right to provide services or to negotiate a contract for services that do not cover the the provider's entire scope of practice;

   c. Whether current practices in preferred provider arrangements allow third-party payers to interfere with a patient's continuity of care; and

   d. The positive or negative impact any changes in the current practice may have on:

      (1) Insurance companies doing business in the state, including managed care companies and health management organizations; and

      (2) Health insurance premiums.

2. As part of the study, the insurance department may assist the legislative management by gathering information regarding current practices, including whether health care providers are being denied provider contracts by insurance companies and other third-party payers. The department shall make periodic reports to the legislative management on the status of this information gathering.

3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

2011 TESTIMONY

HB 1386

#1

Testimony HB 1386

Good Morning Chairman Weisz and members of the Human Service committee

Kenton Onstad, District 4, Parshall

HB 1386 asks to change the current statutes of Freedom of Choice for Pharmacist to add Health Care Services. Health Care Services already includes Pharmacists, so it doesn't eliminate pharmacists but adds clinics, hospitals, chiropractors etc.

Current law allows an insurance carrier to deny the ability for a clinic to become a preferred provider.

HB 1386 asks that a clinic have the ability to deny the opportunity. A Health Care provider still must agree to the terms of the third Party payer's contract.

I look at the current law goes against accessible health care to the rural areas. When different companies come into western part of the state, as well as anywhere in the state, they all have different insurance providers. There is no legislation that says they have to contract with all healthcare providers.

It wouldn't be hard to for them to contract with a tertiary facility (Trinity) and tell their employees to drive past Stanley and go directly to Trinity for service. Critical access hospitals have a hard time maintaining a bottom line an if we don't continue to look out for them, they may close, and accessible health care in our rural areas is further diminished. This further impacts the entire community and economic development.

HB 1386 just allows all healthcare service providers the ability to contract with them. It provides equal access. This allows the consumers to be able to stay in their local communities and receive services. If you go into a clinic and they can't process my insurance, I have to pay full price and submit the bill to my insurance carrier.

We have a transient workforce currently in Western North Dakota. Many work schedules are 7 days on and 7 days off or 12 days on and 12 days off. They elect to use emergency services. This practice has seen costs at local hospitals and clinics rise dramatically.

Chairman Weisz and members of the Human Service committee, I hope you look favorable to HB 1386 and give it a positive recommendation

Thank You and I stand for questions.

#2

Mountrail County Health Center

Many Avenues - One Goal... Your Health

To: Representative Weisz and members of the Human Services Committee

Re: HOUSE BILL NO. 1386

I would like to indicate my support for House Bill No. 1386.

As a health care administrator in a community that has seen a great influx of different workers in the oil industry and all of the spin off jobs that are coming with that industry it is important that we have the opportunity to serve those workers.

Our emergency room volume has increased by over 40% in the past two years. Most of this increase is due to the oil industry and much of this business is paid for by Workforce Safety/Workers Compensation. This reimbursement is paid on a fee schedule and does not meet the costs associated with the care delivered in the Emergency Room.

We must be able to deliver the other services afforded under the workers regular insurance coverage to expand our base of services for the regular healthcare services to assist in covering the cost of operating a hospital.

By enacting HB 1386 you will help to ensure that our hospital is better able to meet our financial obligations to continue to operate and provide not only the emergency care that is required in this region given the oil impact but also to continue to provide the clinic and ancillary services that are needed for the people in our service area.

Thank you for your consideration in regard to this legislation and I ask for you support on HB1386.

Sincerely,

Mitch Leupp
Administrator
Mountrail County Medical Center
Stanley, ND

Mountrail Bethel Home
PO Box 700 • 615 6th St. SE
Stanley, ND 58784
Phone 701.628.2442 • Fax 701.628.3990
www.stanleyhealth.org

Mountrail County Medical Center
PO Box 399 • 615 6th St. SE
Stanley, ND 58784
Phone 701.628.2424 • Fax 701.628.3990
www.stanleyhealth.org

Mountrail County Rural Health Clinic
PO Box 399 • 615 6th St. SE
Stanley, ND 58784
Phone 701.628.2505 • Fax 701.628.3078
www.stanleyhealth.org

#3

Human Services Committee
Tuesday, January 25, 2011
HB 1386 – Freedom of Choice for Healthcare Service Providers

Chairman Weisz and members of the House Human Services Committee, my name is Dean Mattern, and I am the Administrator of the Garrison Memorial Hospital and the Community Memorial Hospital in Turtle Lake. I testify today in support for HB 1386.

The Garrison Memorial Hospital is a 22 bed critical access hospital with an additional 28 bed long term care facility. Our service area covers McLean, Mountrail, Sheridan and Ward Counties. Community Memorial Hospital is a 25 bed critical access hospital serving Sheridan and McLean Counties. We also provide clinic services in Washburn and Garrison, ND.

As a rural health provider, our facilities rely on the support of our local communities to remain viable. Whether it is acute care, post surgical rehabilitation or clinic services; the income generated from patients in our community is very important.

As North Dakota's economy continues to grow in our region, businesses are relocating to our service territory on a daily basis. With each new business comes a different insurance carrier and different ways to handle each claim. This adds an additional burden to our billings department to accommodate their processes for payment.

Under current state law – the insurance carrier for these companies don't have to enter into a negotiated contract for services with our rural facility. This contract is crucial because it establishes the rates for services and streamlines the process for payment of those services. In essence, the insurance carrier can pick and choose which facilities they would like to do business with.

Through the expansion of the Freedom of Choice Act, all health service providers would be given the opportunity to ask for a contract. This contract is not a mandate, but gives us the ability to sit down with these providers and negotiate a rate that will cover the costs of providing that service.

This expansion will do two things:

1. **Allow us to provide in-network coverage for services.** Without an in-network provider contract, we put more of a burden on the patient to pay for the services through out-of-network coverage. This increases our bad debt. The other avenue would be to balance bill the patient for services. Balance billing creates an additional stress on the patient and quite frankly makes patients very upset when they need to process their claims personally.

2. **Enable us to provide routine and preventative services through clinic visits and rehabilitation.** In a rural health facility, our volume of acute care is much less than that of a tertiary facility. We tend to rely on clinic visits, physical therapy, cardiac rehabilitation and other types of routine care to complement the care of tertiary facilities. Patients are willing to travel for surgery, but like to keep their routine visits in their area. Without this legislation, current practice could potentially eliminate the ability for our local patients to continue their visits at our facility.

As you already know, the quality of healthcare facilities like ours provide is crucial to the healthcare delivery system of our state. Our smaller communities rely on our services to attract businesses and keep the local economies thriving.

By passing HB 1386, you are ensuring the vitality of our smaller communities and ensuring patients have the ability to choose the facilities they would like to utilize for their healthcare needs. Thank you for your time and I hope you will vote a do pass on this important legislation.

This completes my testimony. I would be happy to answer any questions you may have.

#4

Testimony on HB 1386
House Human Services Committee
January 24, 2011

Chairman Weisz and members of the House Human Services Committee, thank you for the opportunity to testify on HB 1386. My name is Daniel Kelly, Chief Executive Officer of the McKenzie County Healthcare Systems, Inc. in Watford City, North Dakota. I wish to go on record supporting HB 1386.

North Dakota has 42 hospitals providing acute medical services. Of that number, 36 are considered Critical Access Hospitals. I offer support for House Bill 1386 for two reasons:

Two/Thirds of North Dakota Critical Access Hospitals Experience an Operating Loss: For the past three years data has been gathered and assessed which reflect that many North Dakota Critical Access Hospital's lose money. This past year, 24 of North Dakota's 36 Critical Access Hospitals lost money. We need to offer whatever assistance we can to sustain our healthcare system.

Rural Hospitals are Safety Net Providers: For many rural North Dakotans those Critical Access Hospitals are safety net providers of medical care. We provide the initial medical assessment and stabilization for routine emergencies as well as trauma cases. In McKenzie County we have experienced a 20% increase in emergency room visits. Much of that increase is due to the oil activity occurring in Western North Dakota. The public is well aware of "the golden hour" those critical 6o minutes when lifesaving care must be initiated in order to increase survival of severely injured patients. For many in rural North Dakota if their local hospital did not exist they might be anywhere from 30 to 60 minutes from local emergency room care. Those 30-60 minutes often makes the difference whether a patient lives or dies. Every hospital in North Dakota treats all individuals who present themselves for emergent care to our emergency rooms. For many hospitals the reimbursement we receive for that care does not financially cover the cost of providing such.

HB 1386 is an excellent approach to assure that residents are given the opportunity to use the services of their local medical provider given that provider meets the quality and credentialing standards maintained by the insurer.

Let's continue to send a positive message of to our medical community and to the citizenship of North Dakota. Your consideration of HB 1386 is appreciated.

Daniel Kelly, CEO
McKenzie County Healthcare Systems, Inc.
516 North Main Street
Watford City, North Dakota 58854
(701) 842-3000

#5

Testimony on HB 1386

House Human Services Committee 1/25/11

Mr Chairman and members of the committee I'm Dan Ulmer representing Blue Cross Blue Shield of North Dakota and we oppose this bill.

The decision of whether or not to extend a participating contract to a health care provider is one of the two fundamental provider contracting philosophies traditionally followed and relied upon by BCBSND in its reimbursement dealings with providers, combined with the ability to restrict assignment of payments to members for seeking services from non-participating providers. Any legislative measure that requires BCBSND to extend participating contracts to health care providers is a significant intrusion into this philosophical approach in that it changes the dynamics between BCBSND and health care providers from "will BCBSND contract with me and do we want to contract with BCBSND" to "BCBSND is required to contract with me but do I need to contract with them" thereby shifting the negotiation power of the parties through legislation instead of allowing the market to determine such a fundamental business operation.

What is the basis for such a protective measure for providers, rural or urban, in North Dakota? What basis is there for tilting the playing field in favor of health care providers on this issue? Past executive administrations (Clinton, Bush, Obama), as well as the Federal Trade Commission oppose "any willing provider" laws as anti-competitive and anti-consumer because these protect providers and increase health care costs at the expense of the insured. Opponents of "any willing provider" laws assert that the ability of managed care plans to contract with some providers while refusing to contract with others (without specifying the reasons) enables plans to control use of resources and maintain quality of care. Without the ability to select the providers to offer participating contracts to, health plans and insurers may be unable to obtain volume discounts because they would be powerless to channel patients to selected providers. In addition, "any willing provider" laws reduce quality of care because increases in the number of providers in a network or restricted or limited credentialing criteria make care more difficult to monitor and coordinate.

Moreover, depending on the scope of the types of providers this contracting "right" is extended to, this would alter the manner in which BCBSND administers its self-funded business from its fully insured business in that the self-funded benefits would not include any "expansive" list of allied providers, leading to different benefits and services administered by BCBSND which can be confusing to both providers and members.

As to specific comments related to the proposed amendment:

There is no definition of the term "health care service provider" as used in the proposed amendment in the amendment or in chapter 26.1-47, although "health care provider" [section 26.1-47-01(5), N.D.C.C.] and "health care services" [section 26.1-47-01(6), N.D.C.C.] are defined. As a result of these definitions, it is difficult to limit the types of providers covered by the amendment in that the definition of "health care services" uses the term "includes" in its recitation of providers, which does not limit it only to those outlined in the statute but

could be interpreted to include many "allied" providers that BCBSND currently does not, or does not want to, contract with.

Such a "pure" any willing provider statute as set forth in section 26.1-36-12.2, N.D.C.C. [please note that section 43-13-31, N.D.C.C., includes a similar "freedom-of-choice" provision related to the services of optometrists] act to limit the authority of an insurance company like BCBSND to determine which health care providers are qualified to enter into participation agreements (e.g., the amended statute requires only that the provider hold a license, however, BCBSND has further credentialing requirements as a prerequisite to participating such as malpractice insurance (and there are other requirements based on provider "specialties", etc.). This amended statute would restrict the ability of BCBSND to assert such minimum requirements for participation. Similarly, it is possible that such a statutory requirement would act to retard the quality management efforts that BCBSND is asserting against aberrant health care providers in that the statute requires BCBSND to contract with any provider who has a license. How could BCBSND terminate the participation contracts with aberrant providers like with this amendment to the statute? Similarly, how could BCBSND use the "carrot" of enhanced participation for projects such as MediQhome with quality improvement and coordinated care requirements if it is required to contract with all health care providers? This amendment could have a significantly deleterious impact on these programs.

North Dakota already has not one, but two, "freedom of choice" statutes requiring that BCBSND reimburse members for covered services received from a litany of health care providers and, therefore, this "any willing provider" statute is not necessary. In this regard, section 26.1-36-11, N.D.C.C., provides:

"Any provision in any accident or health insurance policy issued by any insurance company denying the insured, in case of accident or sickness, the right to consult or employ any doctor licensed to practice in this state the insured may choose, or to enter any hospital or sanitarium organized and operating under the laws of this state the insured may select is void. The insurance company shall recognize any proof of claim duly certified by such doctor or hospital or sanitarium notwithstanding any provision contained in the policy."

Similarly, section 26.1-36-12.1, N.D.C.C., states:

"Any provision in any health service contract issued by a health service corporation denying the insured or subscriber, subscriber member, officer, or employee, in case of accident or sickness, the right to consult or employ any doctor, including doctors of chiropractic, licensed to practice in this state whom the insured, subscriber, subscriber member, officer, or employee may choose, or to enter any hospital or sanitarium organized and operating under the laws of this state which the insured, subscriber, subscriber member, officer, or employee may select, is void. The health service corporation must recognize any proof of claim duly certified by the doctor, hospital, or sanitarium notwithstanding any provision contained in the contract."

In effect, what these "freedom of choice" statutes do is require payment from and insurance company for health care services a member receives from the relevant health care providers whether they are participating with the insurer or not. This is only a fractional distinction from any "rights" health care providers may gain from the proposed amendment to the "any willing provider" requirements. It seems curious that there is a push for expanding the "any willing provider"

protections in light of this guaranteed reimbursement under the "freedom of choice" laws already in place, especially in light of the fact that it appears one of the arguments in favor of the bill is to "protect" rural health care providers. What protects them more than a statutory protection that an insurance company is required to pay for their services no matter what. Albeit, the payment may go to the member and need to be collected by the provider.

As to "fixes", as far as narrowing it to rural providers only, it appears that this would involve a clear violation of the equal protection clause of the United States Constitution, and the Constitution of North Dakota as well, in that it would extend protections only to some health care providers but not all without any reasonable justification for doing the same.

In addition to concerns already noted, this bill would be the death of PPO or POS products such as SelectChoice and BlueChoice. This bill essentially overrides any steerage that these plans currently have by eliminating the out-of-network benefit penalty currently imposed in these benefit plans. If passed, it could disrupt our move towards Accountable Care Organization strategies and our increased demands for providers to better coordinate the care of patients --- if these patients are free to use any provider they prefer our providers may be less willing to take responsibility for the total care of that patient through programs like MediQhome.

Dan Ulmer AVP Government Relations BCBSND

#1

Testimony HB 1386

Good Morning Senator Lee and members of the Human Service committee

Kenton Onstad, District 4, Parshall

HB 1386 asks to change the current statutes of Freedom of Choice for Pharmacist to add Health Care Services. Health Care Services includes Pharmacists along with clinics, hospitals, chiropractors, dentists, physical therapists etc.

Current law allows an insurance carrier to deny the ability for a clinic to become a preferred provider. HB 1386 asks that Health Care Services have the ability to deny. A Health Care provider still must agree to the terms of the third Party payer's contract.

The current law goes against accessible health care to the rural areas. When different companies come into western part of the state, as well as anywhere in the state, they all have different insurance providers. There is no legislation that says they have to contract with all healthcare providers.

HB 1386 just allows all healthcare service providers the ability to contract with 3rd Party Payers. It provides equal access. This allows the consumers to be able to stay in their local communities and receive services.

Any willing provider legislation is necessary to ensure there is an opportunity for all providers to provide care and receive reimbursement if so willing. The bill would allow any provider to participate in a plan offered in the state of North Dakota. The provider still has to feel the plan being offered is fair and reasonable or it can chose not to participate. It will protect Critical Access Hospitals and other facilities from being locked out of plans that are fair and reasonable In my mind it establishes a "reasonableness" standard that all plans will have to meet and will allow all providers to be able to participate at the level of plan being offered.

HB 1386 is about that new physical therapist trying to set up shop, the optometrist that sees an opportunity in your community or that private cancer

clinic working to accommodate alternative methods for our citizens. It wouldn't be hard for a new Company to contract with a tertiary facility (Trinity) and tell their employees to drive past Stanley and go directly to Minot for service. A young family relocates in Watford City but now must drive 50 miles to Williston or 90 miles to Dickinson even though the same services can be provided in their own community.

We have a transient workforce currently in Western North Dakota. Many work schedules are 7 days on and 7 days off or 12 days on and 12 days off. They elect to use emergency services. This practice has seen costs at local hospitals and clinics rise dramatically. Critical access hospitals have a hard time maintaining a bottom line and if we don't continue to look out for them, they may close, and accessible health care in our rural areas is further diminished. This further impacts the entire community and economic development.

Madam Chair and members of the Human Service committee, HB 1386 is about making choices and having the same Freedom of Choice our pharmacists currently have. I hope you look favorable to HB 1386 and give it a positive recommendation

Thank You and I stand for questions.

Testimony on HB 1386
Senate Human Services Committee
March 8, 2011

Chairman Lee and members of the Senate Human Services Committee, I thank you for the opportunity to submit my letter of support for HB 1386. My name is Daniel Kelly, Chief Executive Officer of the McKenzie County Healthcare Systems, Inc. in Watford City, North Dakota. I wish to go on record supporting HB 1386.

North Dakota has 42 hospitals providing acute medical services. Of that number, 36 are considered Critical Access Hospitals. I offer support for House Bill 1386 for two reasons:

Two/Thirds of North Dakota Critical Access Hospitals Experience an Operating Loss: For the past three years data has been gathered and assessed which reflect that many North Dakota Critical Access Hospital's lose money. This past year, 24 of North Dakota's 36 Critical Access Hospitals lost money. We need to offer whatever assistance we can to sustain our healthcare system.

Rural Hospitals are Safety Net Providers: For many rural North Dakotans those Critical Access Hospitals are safety net providers of medical care. We provide the initial medical assessment and stabilization for routine emergencies as well as trauma cases. In McKenzie County we have experienced a 20% increase in emergency room visits. Much of that increase is due to the oil activity occurring in Western North Dakota. The public is well aware of "the golden hour" those critical 6o minutes when lifesaving care must be initiated in order to increase survival of severely injured patients. For many in rural North Dakota if their local hospital did not exist they might be anywhere from 30 to 60 minutes from local emergency room care. Those 30-60 minutes often makes the difference whether a patient lives or dies. Every hospital in North Dakota treats all individuals who present themselves for emergent care to our emergency rooms. For many hospitals the reimbursement we receive for that care does not financially cover the cost of providing such.

HB 1386 is an excellent approach to assure that residents are given the opportunity to use the services of their local medical provider given that provider meets the quality and credentialing standards maintained by the insurer.

Let's continue to send a positive message of to our medical community and to the citizenship of North Dakota. Your consideration of HB 1386 is appreciated.

Daniel Kelly, CEO
McKenzie County Healthcare Systems, Inc.
516 North Main Street
Watford City, North Dakota 58854
(701) 842-3000

To the Membership of the Senate Human Services Committee:

I am writing these brief comments to you in support of HB 1386 and I ask your support in its passage.

As with any major decision, there is opposition to the passage of this Bill and I am sure that you will be exposed to that as this testimony continues. However, please keep in mind that those who say that this Bill should not pass are centering their arguments on one core theme and that is to restrict what would be an otherwise free market. Opposition to this Bill would propose to control access to insurance products and other methods of payment for services that the payer does not even receive. I would ask that this body accept the fact that payment procedures for heath services is a flawed process at best. Any payment system that allows a payer to restrict access on behalf of the people actually receiving the services is inappropriate at best and is a prime example of restraint of trade at worst and it takes away the consumers right to choose.

However, the upside to passage of this Bill far outweighs the potential negatives. By passing this Bill it gives every interested party the chance to participate in a plan that otherwise might exclude one over another for potentially very arbitrary reasons or no reason at all. Small, rural, hospitals in today's market are constantly bombarded by threats to their long term survival simply because large businesses from other markets do not understand the value and essential role that they play in small communities. By eliminating this bias, any provider can decide for themselves if they want to compete with other market "players" on a cost and quality basis in any particular plan. By allowing the payer to decide whether they are going to "invite" a particular service provider into their plan limits fair market competition and restricts the opportunity for consumer choice in determining who is the best provider. Healthcare should not be treated as just another commodity and there is nothing wrong with requiring a payer to negotiate a fair reimbursement for ***any*** interested provider. It will not increase healthcare costs because that consumer will only go to one provider for the service and they will choose the one that offers the best quality for their needs. If a provider cannot compete on cost and quality, <u>then</u> it is time for the payer to remove the provider or structure their incentives to the consumer to choose the best price.

There are very few industries in our nation where the actual consumer of a service pays a third party to manage their money and pay for the services of a completely unrelated provider when they are rendered. Because this is an unusual arrangement, it does not give the "middle manager" of the consumer's money the right to preselect who the consumer has a right to see. Vote "YES" on HB 1386 and help ensure a free and open healthcare market for the state of North Dakota.

Keith Heuser
Administrator
Mercy Hospital
Valley City, North Dakota

Mountrail County Health Center

Many Avenues - One Goal...Your Health

To: Representative Weisz and members of the Human Services Committee

Re: HOUSE BILL NO. 1386

I would like to indicate my support for House Bill No. 1386.

As a health care administrator in a community that has seen a great influx of different workers in the oil industry and all of the spin off jobs that are coming with that industry it is important that we have the opportunity to serve those workers.

Our emergency room volume has increased by over 40% in the past two years. Most of this increase is due to the oil industry and much of this business is paid for by Workforce Safety/Workers Compensation. This reimbursement is paid on a fee schedule and does not meet the costs associated with the care delivered in the Emergency Room.

We must be able to deliver the other services afforded under the workers regular insurance coverage to expand our base of services for the regular healthcare services to assist in covering the cost of operating a hospital.

By enacting HB 1386 you will help to ensure that our hospital is better able to meet our financial obligations to continue to operate and provide not only the emergency care that is required in this region given the oil impact but also to continue to provide the clinic and ancillary services that are needed for the people in our service area.

Thank you for your consideration in regard to this legislation and I ask for you support on HB1386.

Sincerely,

Mitch Leupp
Administrator
Mountrail County Medical Center
Stanley, ND

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#2

Human Services Committee
Tuesday, March 8, 2011
HB 1386 – Freedom of Choice for Healthcare Service Providers

Chairman Lee and members of the Senate Human Services Committee, my name is Dean Mattern, and I am the Administrator of the Garrison Memorial Hospital and the Community Memorial Hospital in Turtle Lake. I testify today in support for HB 1386.

The Garrison Memorial Hospital is a 22 bed critical access hospital with an additional 28 bed long term care facility. Our service area covers McLean, Mountrail, Sheridan and Ward Counties. Community Memorial Hospital is a 25 bed critical access hospital serving Sheridan and McLean Counties. We also provide clinic services in Washburn and Garrison, ND.

As a rural health provider, our facilities rely on the support of our local communities to remain viable. Whether it is acute care, post surgical rehabilitation or clinic services; the income generated from patients in our community is very important.

As North Dakota's economy continues to grow in our region, businesses are relocating to our service territory on a daily basis. With each new business comes a different insurance carrier and different ways to handle each claim.

Under current state law – the insurance carrier for these companies don't have to enter into a negotiated contract for services with our rural facility. This contract is crucial because it establishes the rates for services and streamlines the process for payment of those services. In essence, the insurance carrier can pick and choose which facilities they would like to do business with.

Through the expansion of the Freedom of Choice Act, all health service providers would be given the opportunity to ask for a contract. This contract is not a mandate, but gives us the ability to sit down with these providers and negotiate a rate that will cover the costs of providing that service.

This expansion will do two things:

1. **Allow us to provide in-network coverage for services.** Without an in-network provider contract, we put more of a burden on the patient to pay for the services through out-of-network coverage. This increases our bad debt. The other avenue would be to balance bill the patient for services. Balance billing creates an additional stress on the patient and quite frankly makes patients very upset when they need to process their claims personally.

2. **Enable us to provide routine and preventative services through clinic visits and rehabilitation.** In a rural health facility, our volume of acute care is much less than that of a tertiary facility. We tend to rely on clinic visits, physical therapy, cardiac rehabilitation and other types of routine care to complement the care of tertiary facilities. Patients are willing to travel for surgery, but like to keep their routine visits in their area. Without this legislation, current practice could potentially eliminate the ability for our local patients to continue their visits at our facility.

As you already know, the quality of healthcare facilities like ours provide is crucial to the healthcare delivery system of our state. Our smaller communities rely on our services to attract businesses and keep the local economies thriving.

By passing HB 1386, you are ensuring the vitality of our smaller communities and ensuring patients have the ability to choose the facilities they would like to utilize for their healthcare needs. Thank you for your time and I hope you will vote a do pass on this important legislation.

This completes my testimony. I would be happy to answer any questions you may have.

dam Chair and Committee Members,

I am writing you in regards to House Bill 1386- Freedom of choice for health care services. As a North Dakota native, returning to the state to open a physical therapy clinic was a dream of mine since graduating from the University of Mary. Due to the nature of the networks in the state, we are finding it hard to compete in a health care environment that does not allow consumers to choose where they receive care. I would like to show you a few positive points to consider when casting your vote.

- **Small business owners**- Passing this bill would encourage more health care related small business owners and their families to return to the state to provide services in rural communities that are in great need of health care.
- **Access to care**- Currently, networks limit access to care in rural communities, for traveling families, and commuting workers. For example, an employee traveling to the oil field during the week to work whose spouse carries insurance that is networked to a hospital in Bismarck, gets sick and goes to a clinic in Williston. Their policy may not cover care received in Williston and the entire expense is considered an out of pocket expense.
- **Freedom of choice**- Networks do not allow patients to receive care at a facility that may have equipment or offer a service that is not available at their networked providers' facility or receive care at a clinic that is more conveniently located to their home or work.
- **Quality of care**- Currently, many patients are obligated to receive care at their networked provider regardless of the success/quality of previous treatment experiences. If patients are able to choose where they would like to receive their care, it incentivizes hospitals systems as well as independent providers to provide the highest quality of care in order to retain their patients. This will improve healthcare in general throughout the state, as providers begin to bring in the latest technology/techniques to compete with other providers.

Third party payers may oppose this bill stating they would be forced to negotiate agreements with providers in urban and rural areas. I would argue that this is mandated coverage. If a provider becomes licensed in the state and follows the practice acts set forth by the state and federal associations, all providers should be reimbursed for services rendered providing that they follow the terms of the third party payer's agreement.

In addition, third party payers may argue that the premiums for the consumer will need to be raised. On the contrary, if providers are given the option to negotiate terms and reimbursement for only the services that they provide, instead of mandating coverage for all services whether they are provided or not, premiums may actually go down for consumer because coverage will be based on a smaller number of procedure codes. This bill will be strongly opposed by the third party payers because it will shift out of pocket costs from the consumer to the third party payer (insurance company).

With the constant rise in health care costs, this bill moves in the right direction by providing freedom of choice, decreasing costs to the consumer, while strengthening small business and improving quality of healthcare statewide. I urge you to vote yes for House Bill 1386.

Respectfully,

Tony Hollar

Tony Hollar, MPT
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#4

HB 1386

Good Morning Madam Chair and Members of the Committee,

For the record my name is Nancy Kopp. I represent the ND Optometric Association. The ND Optometric Association is following up and echoing some of the concerns of the previous supporters. Optometry is represented in 39 of the 53 counties in ND, so you can see we service in rural, as well as urban areas.

I appear before you in support of HB 1386 this morning probably from a different direction. That being from the point of view from a private practitioner. There are some plans within BC/BS, one mainly as Select Choice, that our optometric members have difficulty in accessing the preferred provider organization. Normally the plan will negotiate with a single major healthcare system. Let me give you an example of the difficulties that we experience. As an example, a patient has vision services, which is a vision plan that provides routine eye care and they go to an optometrist and get the examination. The optometrist discovers a medical problem. If that private practitioner has not been allowed to participate in the PPO (Preferred Provider Organization), they must refer that patient to the participating facility. That creates an access issue for the optometrist who must refer, because he is not allowed to participate in the plan and therefore could increase costs either to the patient in out of pocket expenses, travel expenses or further duplicative medical testing. For those reasons, it is an access issue for providers, as well as the patients. I ask that you support HB 1386 and allow all providers to meet the terms of contracts if they so desire.

#5

House Bill # 1386.

I believe that this bill will help reduce the duplication and costs associated with health care today. In Fargo as optometrists, we are providers for Vision Services Inc, Avesis, and many vision plans which provide a "routine eye examination" only. Most patients seen in optometric practice, today, have medical issues ranging from diabetes, headaches, cataracts, dry eye issues to glaucoma evaluation and treatment. Even the most basic services, done every day in most optometry practices, with the current "select choice" insurance plans need to be referred to their in-network "select choice" provider. Some of these medical systems have been without specialties, that our patients need, creating lack of continual care. By allowing for Freedom of Choice for health care services, we would be able to treat, manage and refer patients, as needed, to the appropriate specialist based **only** on their ability to deliver the appropriate care for that patient. What a recruitment tool for our area to attract young healthcare providers! Blue Cross-Blue Shield and Microsoft are two companies that currently allow their employees to go to the provider of their choice.

Our profession is rampant with rumors of having to refer a patient to their "select choice" provider for a yearly diabetic retinal examination, well handled by an optometrist, to retinal detachment patients not being seen, admitted through the emergency room and airlifted to Minneapolis for surgery because another provider was not allowed to be in-network of the patients "select choice" insurance plan. The health care savings and patient convenience, in these two examples alone, would be substantial creating a more efficient community-wide based health care system. Less referrals "way" out-of-network would be needed as we are delivering the same or better care, more efficiently, that they might get in Minneapolis or the Mayo Clinic.

Please consider a YES vote for House Bill # 1386 to improve healthcare access for all North Dakotans.

Kevin Melicher OD FAAO

Fargo, North Dakota

Charley Hundley's response (Charley is our VP of provider relations in charge of contracting issues)

First and foremost there is "Freedom of Choice" in health care services. Any provider that meets BCBSND's credentialing and contracting requirements is allowed into the network, meaning into Select Choice. Second, our employer groups make a choice when they decide which one of our products they want to buy. A product, such as Select Choice, is a managed care product. It requires out of network referrals. The rational is we will be able to offer the product to groups at a lower price because the contracted provider is to manage the patients total care. The group has the choice of selecting the product, the provider has the choice of participating or not.

Our larger care systems, who participate in Select Choice, have optometrists on staff. These large care system employed optometrists will give the diabetic patient their well eye exam. Again managing care for that Select Care patient in the most cost efficient manner.

The retinal detachment rumor needs to be clarified. First and foremost, a detached retina is considered a medical emergency. As such, it does not require a referral. There are a limited number of physicians in the state of North Dakota that do the procedure. More often than not, and because there isn't a doctor available to treat the medical emergency, these patients are air lifted out of North Dakota. It has absolutely nothing to do with a referral. It's a medical emergency that requires treatment by a qualified physician, which happen to be in short supply in the state.

Charley Hundley
Vice President
Provider Relations & Reimbursement
Blue Cross Blue Shield ND
(701) 277-2090

Members of the Committee----I hope this helps, as you know we are strongly opposed to 1386 as it would eviscerate our ability to negotiate with providers on behalf of consumers to provide the best possible care at the lowest possible costs...as always we are available to answer your questions...

Dan Ulmer---BCBSND

#6

HB 1386 March 8, 2011

Brian Beattie, O. D.
2331 Tyler Pkwy, Suite 2
Bismarck, ND 58503

I am here today to testify in support of HB1386. I believe it is in the best interest of all North Dakotans to allow access to any doctor that they wish. As an optometrist I am excluded form being a member of a Blue Cross and Blue Shield administered Preferred Provider Organization, Prime Care. I am not sure what is gained by excluding me and my colleagues from delivering care to certain patients.

The exclusion of most optometrists from the local Prime Care PPO is an example of a policy that seems to have no basis in the economics of health care delivery. We are not talking about vision examinations. These are not covered by any medical insurance. We are talking about medical eye care. Care of glaucoma, monitoring diabetic retinopathy, treating eye infections, or removing ocular foreign bodies are some of the things we are talking about.

I mentioned that most of the local optometrists are excluded form being providers. The only optometrists that are allowed in the PPO are those employed by a medical doctor. When I was employed by an ophthalmologist 3 years ago my patients paid a $25 co-pay for a visit. Now that I am my own boss, I am not allowed to be a member of Prime Care and I must collect a $40 co-pay. If my patient wishes to take full advantage of their insurance I must refer them to another doctor who is in Prime Care. That doctor is not familiar with this patient and he must repeat tests already preformed to confirm the diagnosis which certainly is not a help to controlling costs and forces the patient to go to a doctor that is not his or her first choice.

Competition has always been the basis of our economy. There are 32 optometrists in Bismarck and Mandan and only 7 ophthalmologists. These ratios are true in larger communities in the state and only optometrists are found in our smaller communities, no ophthalmologists. If access to care is considered, than limiting care of patients to only a few clinics makes no sense. It also limits competition. While health care is not totally free enterprise I can assure you that the choice of providers for PPO's is not based on the cost of that care. There are nonmember doctors that are charging less than the member doctors.

I submit to you that passing HB1386 increases competition, increases access to care, allows personal freedom of choice, and helps control costs. The present system accomplishes none of these outcomes.

BOARD OF PHARMACY
State of North Dakota

Jack Dalrymple, Governor

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Howard C. Anderson, Jr, R.Ph.
Executive Director

#1

House Bill No 1386 – Freedom of Choice
Senate Human Services Committee
Red River Room – State Capitol Bldg
9:00 AM – Tuesday – March 8th, 2011

Chairman Lee and members of the Senate Human Services Committee. The North Dakota State Board of Pharmacy supports the concept of Freedom of Choice by North Dakotans for any provider legitimately licensed in the state of North Dakota.

Pharmacy was instrumental in getting this original legislation passed many years ago. I remember our optimism about preventing **P**harmacy **B**enefit **M**anagers and insurance companies from excluding pharmacies from their contracts and thus not allowing them to serve patients that lived within their own communities and service areas. Unfortunately, the insurance commissioner's office never interpreted this legislation quite the way we, and we feel the legislature, envisioned it.

However, the expansion of this legislation to other healthcare providers is certainly not negative. Perhaps it will get the attention that it needs to make it clear that the legislature does not want certain providers excluded from the list of those from which the patient can receive their care, if they choose.

Mandatory mail-order provisions in many PBM and third party contacts have been the nemesis of pharmacies and some of their patients for quite some time. Fortunately, mail-order is not an option when you need to see the physician or a practitioner within the emergency room and this Bill may have a much more positive effect on those providers than it has on pharmacy.

Thank you for the opportunity to speak with you today.

Howard C. Anderson, Jr, R.Ph.
Executive Director
ND State Board of Pharmacy

#8

March 8 2011

Testimony: Senate Human Services Committee

I retired from teaching in Grand Forks last spring. My wife had retired the previous year and had moved to Bismarck where I joined her. We are both still covered by the GFPS health insurance plan through cobra. We pay full premiums and all other co-pays as required by the plan.

When we moved we both established primary care physicians in Bismarck. My wife sought and received referrals from her previous health care providers in Grand Forks. She received notices that the three referrals she had were rejected as "out of network" by Altru Health. Also, any medical apparatus that my wife uses for respiratory therapy must be acquired and maintained in Grand Forks.

I established my primary care with UND Family Practice in Bismarck. As a result of an injury I was referred to a physical therapy clinic in Bismarck. I was immediately notified that my insurance coverage would be reduced as the UND clinic and the the therapy clinic in Bismarck were again "out of network".

Portability of insurance within ND much less from outside ND is severely limited by these policies. It is unfair to providers and it is unfair to consumers. I can't imagine it is a high cost item as costs are already substantial and growing daily.

I would urge the committee to take some favorable action on this item and level the ND health care landscape for both consumers and providers.

Max Laird
3733 Overlook Drive
Bismarck
741 9438

#9

Lisa Carlson, representing Sanford Health Plan
Testimony on HB 1386
Senate Human Services Committee
March 8, 2011

Madam Chair and members of the committee, my name is Lisa Carlson and I'm the Director of Planning and Regulation for Sanford Health Plan. I'm here to testify today in opposition of HB 1386, otherwise known as the "any willing provider" bill. I'd like to discuss the technical aspects of the bill and its potential negative impact.

I have read through previous testimony from the proponents of this bill who believe an "any willing provider" mandate is a solution to their problem. The issue, as I understand it, is rural healthcare providers and critical access hospitals being treated as non-participating or out-of-network by foreign carriers insuring migrant/seasonal workers. These foreign carriers are not domiciled in the state of North Dakota, nor are they licensed to sell insurance to North Dakota-domiciled companies or deliver coverage to North Dakota residents. Many such companies are self-funded, governed under ERISA law. As a provider-owned Health Plan where many of our own groups are critical access hospitals and rural providers themselves, I appreciate the circumstances these providers are facing when delivering care to migrant workers. However, this bill will not solve those problems. Sanford Health Plan has significant concerns regarding HB1386:

1. There is an enforcement issue with this bill; the North Dakota Insurance Department does not have the authority to enforce an "any willing provider" mandate on insurance companies that are not marketing or providing coverage to North Dakota residents.
2. This bill will not fix the collection problems providers have when a member has to pay high out-of-pocket expenses when they receive care from non-participating providers.
3. Finally, while the bill no doubt has good intentions to help rural providers, it may actually result in market instability, adversely affecting the existing employer group market serviced by local carriers and their contracted providers who are domiciled in this state.

Before I move on, I would like to discuss two very important facts that we must not ignore throughout this discussion:

(a) the complaints we've heard today and in prior testimony involve foreign insurance carriers that are not marketing to North Dakota-based companies; and
(b) these foreign companies are not insuring North Dakota residents. These migrant workers live in Colorado, Texas or wherever and the companies they work for are domiciled in other states.

It is important to remember these two facts as I discuss the following concerns with this bill.

The first technical issue I'd like to discuss is enforcement. There is a term called an extraterritorial mandate, which basically means that a state Insurance Department has the right to force its laws onto non-North Dakota based companies and insurance carriers when those companies employ (or in the case of insurance, provide coverage for) North Dakota residents. However, North Dakota's extraterritorial authority does not apply to insurance coverage delivered to non-North Dakota based employer groups or non-North Dakota residents. So you can see the enforcement issue at hand – the Insurance Department has no authority to force a foreign insurance carrier to contract with a rural provider or critical access hospital, they will have no jurisdiction to enforce this bill.

Secondly, I would like to point the committee to one of North Dakota's existing access and availability laws NDCC 26.1-47-03.1(d) which requires carriers to pay at the in-network benefit level in cases where an insured member seeks care from a non-participating/out-of-network provider when there are no other participating providers within a 50 mile radius of that member's location. Local carriers like Sanford Health Plan and BCBSND are already held to this standard. But foreign carriers are not. This leads back to my point about enforcement issues where the state's extraterritorial mandates do not apply. Your local carriers are already taking care of their members, the foreign carriers are not, they don't have to follow this law for non-North Dakota residents.

I'd like to move onto Section 1(c) of the bill which states that a carrier must *offer* a provider a contract – it does not mandate the reimbursement levels. This effectively means this bill will not guarantee that the enrollee will incur the same out-of-pocket expenses as a preferred provider. We may experience carriers offering a multi-tier provider network to circumvent this mandate.

The last point of contention is regarding market stability and the impact this bill may have local employer groups. This bill stifles competition within North Dakota by removing the local carrier's ability to selectively contract. It reduces the carrier's ability to obtain volume provider discounts in areas where competing providers exist. I'm not talking about rural North Dakota where there's one hospital within a 100 mile radius. This "any willing provider" bill will increase the administrative costs for carriers (costs not associated with paying medical or pharmacy claims) – this will effectively cut into any potential employer rebates as outlined in the Medical Loss Ratio rules in the Accountable Care Act set to go in effect this year.

Additionally, we want to be cognizant of the post-reform market and thoughtful about fostering a market this is stable and can thrive. The Accountable Care Act encourages carriers to transition to new payment methodologies that reimburse providers based on the quality of the care they provide and how well they take care of their patients. Medicare has been doing this for years. Accomplishing this objective in the private sector means carriers will be moving towards the creation of accountable care organizations, in other words, creating provider networks and stratifying providers (and how their paid) based on the quality of care they provide (i.e. are their patients compliant with their medications, is care delivered according to the clinical care guidelines specific to their disease, do they send patient appointment reminders, do they try to prevent hospital readmissions, etc). Does the state really want to position itself in a manner that discourages paying for quality of care or from other carriers entering the state if they want to contract in such a way? I don't think that's the state's intent but that's certainly what this bill will do.

Finally, I know this was mentioned in previous testimony, but we have to address Section 1(c) of the bill. The way the bill is crafted now, it prohibits carriers from excluding providers from their network even if there are quality of care issues with that provider. For example, Sanford Health Plan, as an "Excellent" accredited plan by the National Committee for Quality Assurance (NCQA) is required to adhere to very strict credentialing standards. We need to be able to exclude providers from our network when there are documented quality of care issues such as a provider practicing outside of his/her scope or malpractice issues. Our employer groups rely on us to ensure we allow only quality providers into our network and we don't want a bill that prevents carriers from doing so.

In conclusion, Madam Chair and members of the committee, I'd like you to carefully consider these technical aspects of the bill and the unintended consequences it will have. It will not solve the problem faced by rural providers in trying to collect from patients who are not residents of this state and employed by companies based outside of North Dakota. The department of insurance will be unable to enforce this bill in the scenarios placed before you today by the bill's proponents. It will not only fail to solve these problems, but will actually create new problems by destabilizing the existing, local market and adversely impact premiums for North Dakota companies and residents.

Thank you

#10

Testimony on HB 1386
Senate Human Services Committee 3/8/11

Madam Chair and members of the committee for the record, I'm Dan Ulmer representing Blue Cross Blue Shield of North Dakota and we strongly oppose this bill. This type of law is often called an "any willing provider" bill. If this is passed, it could have consequences that would be totally contrary to the outcomes that the proponents desire. In addition this bill will have a significant negative impact on our insured members and your constituents. This bill:

- is not necessary because of the existing Freedom of Choice statutes
- Seems to be a solution in search of a problem.
- Would not fix the financial issues alluded to for rural providers in the areas of Workforce Safety or automobile injuries.
- Would not apply to self-funded health plans.
- Would have unintended consequences that could actually hurt rather than help rural providers.
- Would preclude the ability for **ANY** insurer to have PPO products or HMO systems to garner savings for their members and would severely limit insurance options for consumers.
- Prevent an insurer from denying participation to an aberrant health care service provider who is ***providing inappropriate medical care or has participated in fraudulent medical practices in the past.***
- Is anti competitive and violates free market ideals

I will explain the bullet points and also address some of the previous testimony from the proponents of this bill.

Existing Freedom of Choice Statute makes this bill unnecessary

North Dakota already has not one, but two, "freedom of choice" statutes requiring that BCBSND reimburse members for covered services received from a litany of health care providers and, therefore, this "any willing provider" statute is not necessary. In this regard, section 26.1-36-11, N.D.C.C., provides: "Any provision in any accident or health insurance policy issued by any insurance company denying the insured, in case of accident or sickness, the right to consult or employ any doctor licensed to practice in this state the insured may choose, or to enter any hospital or sanitarium organized and operating under the laws of this state the insured may select is void. The insurance company shall recognize any proof of claim duly certified by such doctor or hospital or sanitarium notwithstanding any provision contained in the policy." A similar statute can be found in NDCC 26.1-36-12.1.

In effect, what these "freedom of choice" statutes do is require payment from an insurance company for health care services a member receives from the relevant health care providers whether they are participating with the insurer or not. This is only a fractional distinction from any "rights" health care providers may gain from the proposed amendment to the "any willing provider" requirements

Solution in search of a problem

Testimony states that with the advent of new oil companies coming into the state, these companies could direct their employees to bypass their local hospital or health care provider and route them to another facility. The question to be asked is has this scenario actually happened? You will not note any

actual experiences with these scenarios. This is not the first "oil boom" in ND and the scenarios provided did not happen before with previous booms. Why is it going to happen today? BCBSND contracts with every hospital in ND. We do this to ensure that our members have an adequate network of medical service providers. In fact, the vast majority of all medical providers contract with our company. It is in our members' best interest and in the best interest of all insurers to have a wide network of participating medical providers.

Workforce Safety or automobile injuries Issue

Previous testimony references the increases that have been experienced in "emergency care" and states the much of the business is paid by Work Force Safety, whose reimbursements do not cover the facilities costs. While that may or may not be true, this bill will do nothing for that situation. This bill will not apply to Workforce Safety, which is governed by Title 65 of the ND Century Code. Other emergency issues due to auto accidents are also not relevant to this bill as those costs are covered under automobile insurance no-fault provisions and coordinated with an individual's private insurance (NDCC 26.1-41).

Self-funded health plans

Many of these new oil companies referenced in previous testimony have self-funded health plans. Self-funded plans are governed by federal law (ERISA) and ***this law would not apply to these self-funded health plans***. In fact, 50% of BCBSND's business involves self-funded health plans. With this type of plan, the employer assumes all risk with their health insurance plan, retains any gains after all claims are paid, and are generally free to design their own benefits. While we haven't experienced this, a self funded plan theoretically could severely limit their network of medical service providers to only those that provide a significant discount. ***However, this bill could not prevent that since this law could not apply to self-funded plans.***

Unintended consequences

This bill could have many unintended consequences that have ***not*** been contemplated by the proponents. Every health care provider offers a variety of services and each of these services may have a different rate of return. As has been mentioned previously, rural health care providers face many financial challenges. Probably the greatest challenge is the ever shrinking and aging population. Many people often bypass their local medical facilities and instead travel many miles to receive these services from a facility in a larger city or even out of state. In any facility, financial managers depend upon their profit centers to offset other areas within their facility where they lose money. As an insurer we recognize these hardships for our rural facilities and our board previously approved our fee schedules to reimburse the rural facilities at 125% for most out-patient claims compared to 100% for the urban facilities. We have done this to ensure an adequate network in the rural areas. With this bill if a new entity were to decide to open a facility in a community (rural or urban) and only perform a more limited number of profitable services, this bill would require our company to contract with that entity, even if we felt that this would be an unnecessary duplication of services and it would have a negative long-term impact to that community's health care system as a whole. What would happen to the facility that provided more comprehensive services for that community? They now would lose the more profitable functions to the new facility and they would have to make a decision of discontinuing some of their comprehensive services or just cease to exist because they could not compete financially. With this bill,

we would be forced to put that existing facility into an even more direr situation by contracting with a limited service provider.

PPO's and HMO's

If this bill were to pass, it is doubtful that **ANY** insurer could offer a Preferred Provider Organization (PPO) product for its members. Let me explain how these PPO products work. Insurers often design and market PPO products to garner not only lower cost share for their members, but also lower health care costs which result in lower priced premiums. An insurer will establish a PPO product which usually requires a deeper provider discount and penalties when the member goes for services out of network. Providers decide if they want to be part of this exclusive network and provide deeper discounts for their services. The advantage of participating in a PPO is that the provider incurs more patients with the tradeoff being deeper discounts. NDPERS has the option of a PPO. In each case, the member receives significant benefits for staying within the special network. As an example, their cost share may be 10% in a PPO, but would increase to 20% or more if they went outside the PPO network. If this bill were to pass, there would be absolutely no advantage for a provider to participate in a PPO and provide a deeper discount since every other provider could participate and thus seriously erode the patient volume advantage that goes along with the contract's exclusivity. The net result is the member or patient loses by not being to access cheaper premiums and lower cost sharing. Roughly 30 to 35% of BCBND's membership is in a network product. Some of those products include BlueChoice, SelectChoice, FirstChoice, TrueBlue, and even some hospital employer groups. **There would be no advantage to offer these products for the 30-35% of our membership that currently have these plans should this bill pass.**

Aberrant health care service provider

Sometimes our company has to deal with a medical provider that is providing substandard care, inappropriate claims submission, or very rarely, filing fraudulent claims. We work with these providers to ensure that the issues are resolved. These issues are normally resolved amicably and are often the result of coding errors, lack of adequate documentation, or other explainable situations. If problems continue to occur, the provider could be deemed "non-payable" and they would lose their ability to be a "participating" provider. If HB 1386 is passed, questions arise if we could in fact prohibit someone from participating in our contracts. Or if we were able to terminate their participation, could that provider reapply and would the insurer be forced to contract with that provider again?

Anti competitive and free market ideals

Madam Chair and Committee Members, HB 1386 intrudes into the private right to contract between two parties. It is quite similar to forcing McDonald's to contract with Hardee's french fry vendor. Any legislative measure that requires insurers like BCBSND to extend participating contracts to health care providers is a significant intrusion that changes the dynamics between BCBSND and health care providers from "will BCBSND contract with me and do we want to contract with BCBSND" to "BCBSND is required to contract with me but do I need to contract with them" thereby shifting the negotiation power of the parties through legislation instead of allowing the market to determine such a fundamental business operation.

BCBSND would never approach the legislature and request a statute that requires a medical doctor, hospital or other health care provider to enter into a participating contract with BCBSND. Historically, the legislature has viewed requests for legislative mandates that give a significant contractual favor to

one party over another as an intrusion into the free marketplace that severely limits the fundamental principles of private contracting. Therefore, BCBSND asks that these contractual relationships be left up to market considerations and not a statutory requirement.

Another problem with this bill is there is no definition of the term "health care service provider" as used in the proposed legislation or in chapter 26.1-47, although "health care provider" [section 26.1-47-01(5), N.D.C.C.] and "health care services" [section 26.1-47-01(6), N.D.C.C.] are defined. As a result of these definitions, it is difficult to limit the types of providers covered by the amendment in that the definition of "health care services" uses the term "includes" in its recitation of providers, which does not limit it only to those outlined in the statute but could be interpreted to include many "allied" providers that BCBSND currently does not, or does not want to, contract with.

This bill acts to limit the authority of an insurance company like BCBSND to determine which health care providers are qualified to enter into participation agreements (e.g., the amended statute requires only that the provider hold a license, however, BCBSND has further credentialing requirements as a prerequisite to participating, such as malpractice insurance and many other requirements based on provider "specialties", etc.). This amended statute would restrict the ability of BCBSND to assert such minimum requirements for participation. Similarly, it is possible that such a statutory requirement would act to retard the quality management efforts that BCBSND is asserting against aberrant health care providers as discussed earlier. How could BCBSND terminate the participation contracts with aberrant providers with this amendment to the statute? Similarly, how could BCBSND use the "carrot" of enhanced participation for projects such as MediQhome with quality improvement and coordinated care requirements if it is required to contract with all health care providers? This amendment could have a significantly deleterious impact on these programs.

Past and present administrations (Clinton, Bush, Obama), as well as the Federal Trade Commission have opposed these "any willing provider" laws as anti-competitive and anti-consumer because these laws protect providers and increase health care costs at the expense of the insured. In addition, "any willing provider" laws reduce quality of care because increases in the number of providers in a network or restricted or limited credentialing criteria make care more difficult to monitor and coordinate.

Previous testimony indicated a desire to narrow this bill to only rural providers, it appears that this would involve a clear violation of the equal protection clause of the United States Constitution, and the Constitution of North Dakota as well, in that it would extend protections only to some health care providers but not all without any reasonable justification for doing the same.

Additionally if passed, it could disrupt our move towards Accountable Care Organization strategies as specified in the Affordable Care Act. It would inhibit our goal of working with providers to better coordinate the care of patients. If these patients are free to use any provider they prefer, our providers may be less willing to take responsibility for the total care of that patient through programs like MediQhome.

The number one concern of our members is the continuing escalation of health care costs which are reflected in insurance premiums. Our company is committed to bringing down the rate of health care inflation and have partnered with many providers to address that challenge. However, flexibility in contracting is necessary in to order to be successful.

If the legislature decides to pass this bill, I have attached a list of questions that our staff has compiled that need to be answered to determine what the legislative intent is with this bill.

Madam Chair and Committee Members, I cannot emphasize enough the negative impacts of this bill. We urge you to give this bill a Do Not Pass. I would be willing to try to answer your questions.

Dan Ulmer AVP Government Relations BCBSND

Questions To Be Considered Regarding HB 1386

1. As written, could an insurer require board certification?

2. Can a contract be based on malpractice records?

3. Can an insurer require the physician or facility to have an electronic medical record in order to participate in a medical home project?

4. Can an insurer require minimum quality measurements?

5. Can the contract provide for a maximum total cost of care?

6. Can the contract for an aberrant provider be cancelled?

7. If yes to #6., is the insurer mandated to contract again with that provider at a future date?

8. Must an insurer continue to contract with a provider that has filed fraudulent claims?

9. What could insurers do to stop the following scenario-

As we analyzed this bill we wondered whether not the following scenario could occur. Let's say that St. A's health facility decided to cancel its present contract with us and demands that they get the same contract that we grant our rural facilities where we pay 125% of what we pay our large medical centers. It seems to us that under this bill we'd have to let them contract with us at 25% more. The bill basically says that we have to contract with any provider that's willing to contract with us...and the question then becomes who gets to choose the type of contract, the provider or the insurer? If this case is true then we would most likely have to void the 25% advantage we provide in our rural contracts as our members certainly would not be able to afford the cost of a 25% across the board increase for out-patient reimbursement.

10. What could insurers do to stop this scenario-

This bill requires insurers to contract with any provider willing to accept our contract. Let's say a physical therapist moves into Turtle Lake and sets up a room in his garage to provide PT and cardiac

rehabilitation services that are totally independent of Turtle Lake's hospital. Under this bill BCBSND would have no choice but to contract with him.

BCBSND has been quite diligent in our efforts to preserve North Dakota's Critical access hospitals and it's our assumption that the only way this can be accomplished is by assuring that these facilities can maintain their profit centers. Thus under this probable scenario we would have to contract with this willing PT provider thus fracturing off and eroding one of the hospital's profit centers. Obviously this bill becomes a dual edge sword as the possibility of losing profit centers is increased because under this bill insurers will have no choice about who they can contract with.

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Title.

Prepared by the Legislative Council staff for
Representative Onstad
March 15, 2011

#11

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1386

Page 1, line 1, after "A BILL" replace the remainder of the bill with "to provide for a legislative management study and a report from the insurance department.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - REPORT FROM INSURANCE DEPARTMENT.

1. During the 2011-12 interim, the legislative management shall study whether steps can be taken to improve health care service providers' access to third-party payer reimbursement network systems in order to improve North Dakotans' access to health care services and to contain their health care costs and out-of-pocket expenses. For purposes of this study, health care services include major medical as well as dental and vision services. The study may include consideration of:

   a. Whether it would improve patients' freedom of choice by allowing all health care service providers the opportunity to be included in network systems and negotiating deeper discounts with third-party payers;

   b. Whether a third-party payer for health care services should have the ability to deny a health care service provider the right to provide services or to negotiate a contract for services that do not cover the the provider's entire scope of practice;

   c. Whether current practices in preferred provider arrangements allow third-party payers to interfere with a patient's continuity of care; and

   d. The positive or negative impact any changes in the current practice may have on:

      (1) Insurance companies doing business in the state, including managed care companies and health management organizations; and

      (2) Health insurance premiums.

2. As part of the study, the insurance department shall assist the legislative management by gathering information regarding current practices, including whether health care providers are being denied provider contracts by insurance companies and other third-party payers. The department shall make periodic reports to the legislative management on the status of this information gathering.

3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."