2025 HOUSE HUMAN SERVICES

HB 1594

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1594
1/29/2025

Relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

3:22 p.m. Chairman M. Ruby opened the hearing.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Price and quality
- Price versus charge
- Insurance benefits
- Unnecessary redundancy
- Proposed amendments to remove nursing homes and basic care from the bill.

3:22 p.m. Representative Jared Hendrix, District 10, introduced the bill.

3:33 p.m. Chris Jones, Senior Fellow, VP of Health Care Policy at the Cicero Institute,

testified in favor.

3:52 p.m. Representative Nelson, District 14, testified in favor.

4:01 p.m. John Godfread, North Dakota Insurance Commissioner, testified in favor.

4:13 p.m. Tim Blasl, President of the North Dakota Hospital Association, testified in opposition and submitted testimony, #32395.

4:22 p.m. Nikki Wegner, President of ND Long Term Care Association, testified in opposition.

Additional written testimony:
Steven Nagel, 180 Health Solutions, submitted testimony in favor, #32346.

4:24 p.m. Chairman M. Ruby closed the hearing.

Jackson Toman, Committee Clerk

Testimony in Support HB1594

Human Services Committee and Chairman Ruby,

I'm writing in support of HB1594, to make price transparency a reality in today's healthcare marketplace.

My own experience with this as a practitioner as well as a patient makes this all-the-more clear this is something that needs to happen.

I went through an experience where I'd asked for costs up front for a procedure I needed performed, that ended up per their wishes being in-patient. I was not allowed to know anything about the fees that would be charged. Shortly after the event, I was sent a bill for over $20,000. I specifically asked for a charge sheet (among other things), of which I was denied repeatedly. When I finally received it after months of back-and-forth with the billing department, there were multiple things wrong with the bill, and the charges for some procedures and supplies would make your jaw drop. I'd received multiple bills of different amounts, some duplicating the same procedures on different bills/charge sheets. I ended up finally having to hire a lawyer to represent me and get actual clarity on what I was actually spending my money on and they admitted there were major problems with what I was billed for.

Had I been third party pay, the company would have likely been allowed to skate by without anyone knowing about the overcharging, duplicate charging, and simply insane prices.

In private practice, we do our best to notify our patients, once we know what we will need to do with them, the fees for our services and to accept a case. It is extra work although it is expected of us and I believe it to be fair to the patient. They want to know 1. If they can be helped. 2. What we need to do. 3. How much time it will take. 4. What is the cost?

For some reason, we've let the sheer size and power of the medical industry negate these very necessary and reasonable requests. "Because we can" is not an adequate answer.

Further, price transparency will help to address price gouging and insurance/pharmacy benefit manager dealings by forcing health care facilities to reveal some of these backdoor agreements by the very nature of requiring a cost structure. Dual fee schedules are supposed to be illegal, as I understand. But for some reason these large facilities are able to enter into contracts with insurance companies and their counterparts to contractually agree to something we are taught is illegal elsewhere.

Please support this bill, and thank you for your time.

Dr. Steve Nagel, DC

2025 HB 1594

House Human Services Committee

Representative Matthew Ruby, Chairman

January 29, 2025

Chairman Ruby and members of the House Human Services Committee, I am Tim Blasl, President of the North Dakota Hospital Association. I am here to testify in opposition to House Bill 1594. I ask that you give this bill a **Do Not Pass** recommendation.

I would like this committee to understand that hospitals support having price/cost transparency available to the public. However, we feel this bill is unnecessary.

On January 1, 2021, the Centers for Medicare and Medicaid Services (CMS) implemented price transparency requirements for hospitals. It requires a hospital operating within the United States to make public a list of the hospital's standard charges for items and services provided by the hospital. In addition to listing their standard charges hospitals are required to publicly list their negotiated rates with insurance companies.

CMS does perform hospital price transparency audits. Hospitals face monetary penalties for non-compliance. Besides fines, CMS can take other enforcement actions including warning notices and requests for corrective action plans.

In summary, the cost transparency language in this bill would duplicate what CMS implemented in 2021 for hospitals. As I stated above, we feel this bill is unnecessary and ask that you give the bill a **Do Not Pass** recommendation.

I would be happy to respond to any questions you may have. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1594
2/18/2025

Relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

9:22 a.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Committee action
- Proposed amendments relating to penalties

9:24 a.m. Christopher Jones, Senior Fellow of the Cicero Institute, introduced the proposed amendments and answered questions, LC#25.1237.01001, #45226.

9:30 a.m. Representative Holle moved to adopt the amendments LC#25.1237.01001.

9:30 a.m. Representative Bolinske seconded the motion.

9:30 a.m. Voice vote passed.

9:31 a.m. Representative Rohr moved a Do Pass as amended.

9:31 a.m. Representative Hendrix seconded the motion.

Representatives	Vote
Representative Matthew Ruby	Y
Representative Kathy Frelich	Y
Representative Karen Anderson	Y
Representative Mike Beltz	Y
Representative Macy Bolinske	Y
Representative Jayme Davis	Y
Representative Gretchen Dobervich	Y
Representative Cleyton Fegley	Y
Representative Jared Hendrix	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	y
Representative Nico Rios	Y
Representative Karen Rohr	Y

9:32 a.m. Motion passed 13-0-0.
Representative Fegley will carry the bill.

9:32 a.m. Chairman M. Ruby closed the meeting.
Jackson Toman, Committee Clerk

25.1237.01001
Title.02000

Sixty-ninth
Legislative Assembly
of North Dakota

Prepared by the Legislative Council
staff for Representative Hendrix
February 12, 2025

2-18-25
1 of 4

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1594

Introduced by

Representatives Hendrix, Conmy, Frelich, Kasper, Koppelman, Rohr, Nelson, D. Johnston

Senators Mathern, Weston, Magrum

A BILL for an Act to create and enact a new section to chapter 23-12 ~~and~~of the North Dakota Century Code, relating to medical costs transparency for health care facilities; to amend and reenact section 26.1-47-02 of the North Dakota Century Code, relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 23-12 of the North Dakota Century Code is created and enacted as follows:

Medical costs transparency for health care facilities - Penalty.

1. For purposes of this section:
   a. "Health care facility" means those facilities licensed under chapter 23-16, except for nursing facilities and basic care facilities.
   b. "Items and services" means any item or service, including individual items or service packages, which could be provided by a health care facility to a patient in connection with an inpatient admission or an outpatient visit for which the health care facility has established a standard charge, including supplies and procedures, room and board, use of facility, and services performed by health care facility staff.
2. Health care facilities shall:
   a. Make available to the public a list of standard charges for:

(1) Items and services; and

(2) Shoppable services, as outlined in title 45, Code of Federal Regulations, part 180, subpart B.

b. Produce the list in a format consistent with rules adopted by the centers for Medicare and Medicaid services.

3. ~~The department of health and human services may refuse to issue, refuse to renew, revoke, or suspend the license of a health care facility that violates this section.~~

~~4.~~ A health care facility that violates a provision of this section may be assessed a civil penalty ~~not to exceed one thousand dollars for each violation and for each day the~~by the insurance commissioner. A penalty for a violation by a health care facility with more than twenty-five beds must be ten dollars per bed per day, not to exceed five thousand five hundred dollars per day, for each day the violation continues. A penalty for a violation by any other health care facility may be up to one hundred dollars per day for each day the violation continues, plus interest and any costs incurred by the ~~department~~insurance commissioner to enforce this penalty. The civil penalty may be imposed by a court in a civil proceeding or by the ~~department~~insurance commissioner through an administrative hearing under chapter 28-32. The assessment of a civil penalty does not preclude the imposition of other sanctions authorized by rules adopted under this ~~chapter~~title.

SECTION 2. AMENDMENT. Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-02. Preferred provider arrangements.

Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:

a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.

b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to review and control the utilization of health care

services and establish a procedure for determining whether health care services rendered are medically necessary.

c. Include mechanisms which are designed to preserve the quality of health care.

d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

e. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.

f. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.

g. Provide that either party terminating the contract without cause provide the other party at least sixty days' advance written notice of the termination.

h. Provide that if a preferred provider has failed to comply with federal transparency rules and regulations, the health care insurer may terminate the contract without consent.

2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

3. Preferred provider arrangements may not restrict a health care provider from entering into preferred provider arrangements or other arrangements with other health care insurers.

4. A health care insurer must file all its preferred provider arrangements with the commissioner within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the

commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.

5. A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.

6. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health care insurer which jeopardizes patient health or welfare.

7. A preferred provider arrangement must include an attestation from the preferred provider that the preferred provider is in compliance with federal transparency rules and regulations.

REPORT OF STANDING COMMITTEE
HB 1594

Human Services Committee (Rep. M. Ruby, Chairman) recommends **AMENDMENTS (25.1237.01001)** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). HB 1594 was placed on the Sixth order on the calendar.

25.1237.01001
Title.02000

Prepared by the Legislative Council
staff for Representative Hendrix
February 12, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1594

Introduced by

Representatives Hendrix, Conmy, Frelich, Kasper, Koppelman, Rohr, Nelson, D. Johnston

Senators Mathern, Weston, Magrum

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   a. Make available to the public a list of standard charges for:

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(2) Shoppable services, as outlined in title 45, Code of Federal Regulations, part 180, subpart B.

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3. ~~The department of health and human services may refuse to issue, refuse to renew, revoke, or suspend the license of a health care facility that violates this section.~~

~~4.~~ A health care facility that violates a provision of this section may be assessed a civil penalty ~~not to exceed one thousand dollars for each violation and for each day the~~by the insurance commissioner. A penalty for a violation by a health care facility with more than twenty-five beds must be ten dollars per bed per day, not to exceed five thousand five hundred dollars per day, for each day the violation continues. A penalty for a violation by any other health care facility may be up to one hundred dollars per day for each day the violation continues, plus interest and any costs incurred by the ~~department~~insurance commissioner to enforce this penalty. The civil penalty may be imposed by a court in a civil proceeding or by the ~~department~~insurance commissioner through an administrative hearing under chapter 28-32. The assessment of a civil penalty does not preclude the imposition of other sanctions authorized by rules adopted under this ~~chapter~~title.

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b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to review and control the utilization of health care

services and establish a procedure for determining whether health care services rendered are medically necessary.

c. Include mechanisms which are designed to preserve the quality of health care.

d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

e. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.

f. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.

g. Provide that either party terminating the contract without cause provide the other party at least sixty days' advance written notice of the termination.

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2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

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commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.

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6. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health care insurer which jeopardizes patient health or welfare.

7. A preferred provider arrangement must include an attestation from the preferred provider that the preferred provider is in compliance with federal transparency rules and regulations.

2025 SENATE HUMAN SERVICES

HB 1594

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1594
3/18/2025

Relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

9:58 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Federal Regulations
- Long-term Benefits
- Charitable Care

10:00 a.m. Representative Hendrix introduced the bill and submitted testimony #42713.

10:22 a.m. John Arnold, Deputy Insurance Commissioner, testified in favor and submitted testimony #42824.

10:36 a.m. Adam M. Meier, Public Policy with Cicero Institute/Cicero Action, testified in neutral and submitted testimony #42578 and #42579.

10:46 a.m. Tim Blasl, President of North Dakota Hospital Association, testified in opposition and submitted testimony #42616.

10:54 a.m. Jonathan Alm, Department of Health and Human Services, testified in neutral and submitted testimony #42766.

Additional written testimony:

Michael Connelly submitted written testimony in favor #42703.

Nikki Wegner, ND Long Term Care Association, submitted written testimony in neutral #41960.

10:56 a.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

Testimony on Medical Cost Transparency
Senate Human Services
March 18, 2025
House Bill 1594

Chair Lee and members of the Committee, my name is Nikki Wegner, President of the North Dakota Long Term Care Association (NDLTCA). I represent 182 nursing, basic care, and assisted living facilities. Thank you for the opportunity to provide testimony on engrossed HB 1594. We have not taken a position on this bill, however, write in support of the language on pg. 1, lines 11-12 in the engrossed bill.

HB 1594 is about medical cost transparency requirements. Section 1 states that a health care facility means those licensed under Chapter 23-16 are subject to the requirements in HB 1594 except nursing and basic care facilities. Chapter 23-16 pertains to hospitals, nursing homes and basic care facilities, thus this legislation would pertain to all three groups without this exception. The provisions in HB 1594 pertain to hospitals, patients, inpatient and outpatient admissions and preferred provider arrangements, not to the issues impacting nursing homes and basic care facilities.

We are grateful to the sponsor of the bill and House Human Services for amending the original bill to exclude nursing facilities and basic care facilities. We respectfully ask that you keep that language intact on page 1, lines 11-12. Today basic care and nursing facility rates are publicly shared and posted on the North Dakota Department of Health and Human Services website.

Thank you for your time. Please reach out with any questions you may have.

Nikki Wegner MS, OTR/L, President
North Dakota Long Term Care Association
1900 North 11th Street, Bismarck, ND 58501
(701) 354-9773; nikki@ndltca.org

Testimony submitted on behalf of the Cicero Institute/Cicero Action regarding HB 1594.

BY: Adam Meier, Senior Fellow and Legal Counsel, the Cicero Institute/Cicero Action

Position: Neutral

Thank you Chair Lee, Vice Chair and members of the Committee.

My name is Adam Meier and I'm a Senior Fellow and Legal Counsel for the Cicero Institute and Cicero Action, a nonprofit that advances entrepreneurial solutions to public policy problems nationwide. Before joining Cicero, I served as the HHS Cabinet Secretary in Montana and Kentucky. Thank you for allowing me to testify on HB1594, sponsored by Representative Hendrix.

The healthcare sector lacks the hallmarks of most other functioning markets. In most markets, price transparency exists—consumers know the prices—yet in healthcare, the prices for the same goods or services vary significantly, and it's often difficult for patients to know in advance what they will be paying.

Certainly, recent efforts have been made to improve cost visibility and transparency, such as requirements to provide good faith estimates for out-of-pocket expenses and federal transparency efforts requiring price disclosure for the most common procedures at hospitals. Yet, significant gaps remain. Many services are provided outside of the hospital setting, and significant inconsistency remains in how services are priced within these settings.

This is probably best demonstrated through our study at the Cicero Institute in 2023. We surveyed several providers in the Nashville area to request the cash price for diagnostic colonoscopies (CPT code 45378), including normal services within that procedure bundle. Cash prices ranged from $541 to $4629, while the average insurance rate ranged from $2,126 to $2,592. We also found that it was not always easy to get such providers to disclose cash prices.

The study authors identified several reasons for why cash prices could or would not be disclosed, such as…

1. Patients must set an appointment with the provider to conduct an assessment for medical necessity before the provider would offer a cash price quote.

2. Providers required surveyors to be a current patient within their system before disclosing the price over the phone.

3. Billing representatives that suspected surveyors had health insurance refused to disclose the cash price because they believed the surveyor had another form of payment and actively tried steering them away from paying out-of-pocket.

This all demonstrates how complicated and opaque healthcare pricing is, even for someone who is motivated to shop for lower-cost care.

The provisions included in HB 1594 would build upon federal transparency efforts, extending requirements currently on hospitals to most other North Dakota providers. This would provide patients with access to more information needed to shop for healthcare services.

Finally, it is worth noting that North Dakota would not be in uncharted territories here. Other states have passed similar requirements, and other still are considering similar actions.

For example, even as of 2020, a study showed that Minnesota, Alaska, Massachusetts, Florida, Nebraska and Tennessee require carriers and/or providers to supply price information to patients, and more than a dozen overall had some sort of price transparency requirement. States have began to build on those policies, adding requirements for deductible credit for those who shop and pay cash or services, even when out of network (see, e.g., AZ, TN, TX, ME).

Thank you again for the opportunity to speak on the bill and healthcare price transparency.

Can Cash Prices for Healthcare be More Affordable Than Insurance Rates?

Survey Finds That New Tennessee Law Will Give Patients Access to Cash Prices That are Often Less Expensive Than Insurance Rates

Introduction

Many patients and elected officials assume their health insurance company negotiates the lowest rates for in-network care in the area. We set out to test this assumption, starting in Nashville, Tennessee.

The legislature passed and Governor Bill Lee signed into law an exciting reform that allows a patient to get deductible credit if they pay cash for a more affordable covered service. That law went into effect July 1st and has the potential to create a real market for healthcare regardless of insurance plan and/or design.

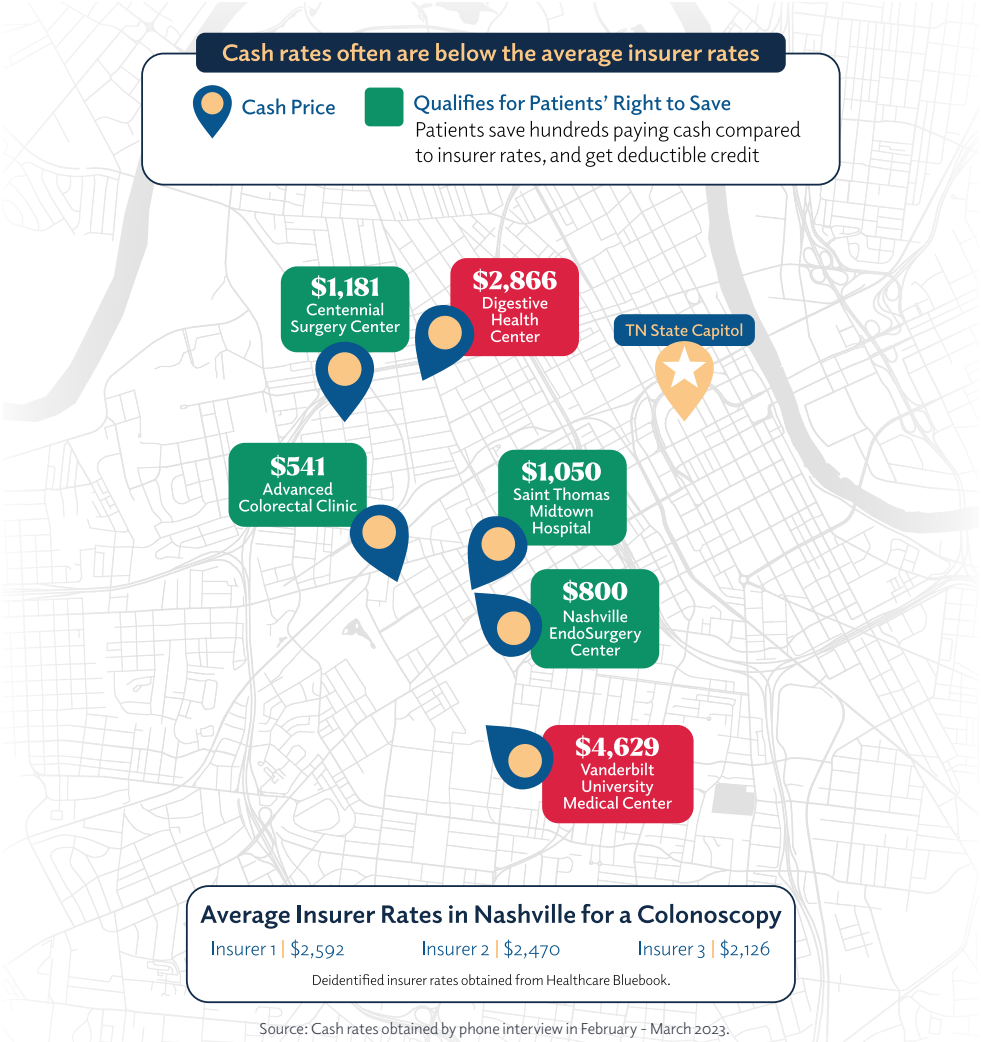
Our survey found there is a huge opportunity for patients to save significant amounts of money under a version of Cicero's Patient's Right to Save Act, which helped inform the new Tennessee law.

Survey Key Takeaways

- Cash prices are dynamic and vary in range.
- Patients have multiple opportunities to pay less for high-quality care when they pay cash compared to the cost of paying and using their insurance.
- Cash price quotes over the phone were often lower than the cash rates hospitals are disclosing under federal rules.
- There is a growing and active cash market where patients can find high-quality, and more affordable care than inside their insurance network, if they are allowed to access such care without deductible discrimination.

Patient's Right to Save:

Colonoscopy Cash vs. Average Insurer Rates in Nashville, Tennessee



Source: Cash rates obtained by phone interview in February - March 2023.

Summary of the Map

The map above discloses the quoted cash prices from six providers offering diagnostic colonoscopies (CPT code 45378) located throughout the downtown Nashville area. Each cash price quote on the map includes commonly associated fees with CPT code 45378 (e.g. service, facility, pathology, and anesthesiology).

The colors represent which cash prices would qualify towards a patient's deductible and out-of-pocket requirement in the Tennessee individual and small business health insurance market, regardless if the provider has a contract with that insurer.

Green coloring shows that the cash price quote is below the average insurance rates while red coloring shows the cash price quote is above the average insurer rates, and therefore doesn't qualify for deductible credit

Unlike negotiated insurance rates or chargemaster rates set by the hospital, the cash price quotes presented on this map are the out-of-pocket estimates a provider would give an uninsured patient over the phone. This map provides a small representative sample of the 14 cash prices obtained in Nashville. The six cash price quotes listed consist of three independent provider facilities while the other three are from hospitals and centers attached to a larger provider system. Also the six cash prices listed include the lowest and highest prices in the data set (e.g., $541 - $4,629).

Case Study:

Imagine John Thorpe, a 57 year old man in Nashville, with a history of colonoscopies that have found polyps, is trying to schedule his annual procedure. He is enrolled with insurer number 2, and the average rate they pay is $2,470; which is a staggering 128 percent higher than Advanced Colorectal Clinic's $541 cash price.

John has a high deductible plan of $6,500 and, given his history, will likely pay the entire cost of the service. If John goes through his insurance he will later pay $2,470 after the clinic files a claim with his insurance. However if John decides to pay the cash price right after the service he will only be charged $541.

Essentially if John pays the cash price, under the Tennessee law, he will save $1,929 and can use that savings for whatever he wants.

The "Average Insurer Rates in Nashville for a Colonoscopy" at the bottom of the map are three deidentified average negotiated rates for CPT 45378 pulled from three major insurers offering coverage to Nashville residents. This graphic contrasts what patients can pay in cash for the service with what they would pay, on average, if they had a deductible obligation they have not met and are using their health insurer

Survey Methodology

The cash price quotes presented on this map come from a larger data set of 107 provider cash price quotes for CPT 45378 across seven city markets (Nashville, Houston, Phoenix, Tulsa, Miami, Atlanta, and Salt Lake City). We found the same trends when comparing cash rates to insurer rates in each of these markets.

We collected cash price quotes via phone survey with the following steps:

1. Surveyors identified providers offering a diagnostic through a Google search and the Turquoise Health website. The sample was limited to those that could be found through a Google search and/or Turquoise Health's hospital cash price data repository.
2. Surveyors called providers and spoke with a billing representative or department.
3. The surveyor asked for a self-pay estimate, good-faith estimate, or cash price quote for CPT 45378 (providers use different terminology for cash price quotes). After the billing representative provided a cash price quote the surveyor would confirm that price included all fees (e.g., service, facility, pathology, and anesthesiology fees).
4. In addition to the all-inclusive cash price, the surveyor recorded the date of call, and the provider's address.
5. Surveyors did not schedule appointments, but merely obtained a cash price quotation.

Discussion & Limitations

Cash Price Sampling:

The cash price quote sample collected in each city market is not wholly representative of the city markets surveyed. Not all providers located in surveyed city markets were accounted for, nor did all providers contacted share their cash price quotes, even though patients are entitled to a good faith estimate.

The reason cash prices quotes were collected in a non-randomized method is because there is not a comprehensive publicly accessible data repository that contains an accurate and up-to-date list of providers' offering CPT 45378, nor is there a data repository of cash price quotes for all provider types (e.g., hospital, ambulatory surgery centers, and independent colonoscopy/endoscopy centers etc). Currently, some companies like Turquoise Health possess a robust list of hospital cash prices, but since the CMS price transparency rules only impacts hospitals, smaller and independent providers' prices are not currently being collected in the same manner as hospitals.

Having cash prices more readily available at all care settings would help patients and providers find affordable care.

Surveyors sought uninsured patient prices to learn how much a doctor would accept for their services, not how much a patient would need to pay if they have insurance, because the intent of this surveying was to obtain cash price quotes, not out-of-pocket amounts post insurance coverage. Additionally, some billing representatives refused to disclose the cash price if they suspected the surveyor to possess health insurance, or they wanted to sign the caller up for Medicaid, medical credit card, or the ACA/Obamacare exchange plans. Additionally, when surveyors did disclose they were surveying for prices in preliminary test calls, billing representatives often refused to disclose prices in that context or forcefully encouraged the surveyor to look at their website (e.g., hospitals).

Under federal law, Americans are entitled to a good faith estimate for the total out-of-pocket cost a patient would pay for getting a medical service if they want to self-pay. Our research team cannot speak to the exact reasons some providers refused to offer cash price quotes despite the law requiring it. **Reasons for refusal consisted of:**

1. Patients must set an appointment with the provider to conduct an assessment for medical necessity before the provider would offer a cash price quote.
2. Providers required surveyors to be a current patient within their system before disclosing the price over the phone.
3. Billing representatives that suspected surveyors had health insurance refused to disclose the cash price because they believed the surveyor had another form of payment and actively tried steering them away from paying out-of-pocket.

In order to get a cash price quote the research team merely sought the uninsured prices and concluded it was simpler for surveyors to claim they were uninsured.

We used phone call surveying for the following reasons:

1. Despite the Centers for Medicare and Medicaid (CMS) creating a hospital price transparency rule where hospitals are supposed to post their chargemaster and discounted cash rates on their websites, not all hospitals are yet in compliance with the rule.
2. The CMS Hospital price transparency rule only extends to hospitals meaning ambulatory surgery centers and independent practices offering CPT 45378 are excluded from posting prices on their websites.
3. As previously mentioned there is not a comprehensive and publicly accessible data repository that captures all cash prices in a given city market. Meaning there was no streamlined way to acquire cash prices through providers' websites.

4. When calling hospitals for cash price quotes it became apparent that the phone quotes did not match with the cash price listed on hospitals' websites. In most cases the cash price quote was less expensive when obtained over the phone.
5. Phone surveying was also used because it mimics what many patients would resort to doing if they were trying to pay out-of-pocket for a healthcare service, due to their being limited online resources.

Implications:

The results, while limited in scope, reveal a viable cash market with a wide range of options. Additionally, these results show that it's common to see cash prices below health insurers' average negotiated rate for CPT 45378 and, at times, below the lowest negotiated rate. While these results are not exhaustive, the range of prices captured means it's plausible that incentives can be instituted to encourage patients to find high-quality but less costly options for healthcare services.

Patients Need a Life Boat To More Affordable Care:

Patients regularly forgo care over cost concerns, and many find it difficult to find affordable options. This survey found that cash rates can be less expensive but can be difficult to find in some markets.

Cash marketplaces are growing, for example Sesame Care, Savvos Health, Sidecar Health, and MediBid, but for the tens of millions of Americans with insurance, they face plan design discrimination for seeking out these more affordable care options. That changes under the Tennessee law and Patient's Right to Save because patients now get deductible credit.

Patients need access to more than just hospital prices and those set by insurance. Patients need a lifeboat to access affordable care in and out of the network. The Tennessee law can help give patients new options by creating a robust cash market that can help every patient regardless of their insurance plan. Deductibles are growing and not all healthcare is subject to small co-payments. Patients deserve other pathways to mitigate costs wherever they can. Other states should follow Tennessee's lead and seek to end network and plan discrimination.

2025 HB 1594

Senate Human Services Committee

Senator Judy Lee, Chairman

March 18, 2025

Madam Chairman Lee and members of the Senate Human Services Committee, I am Tim Blasl, President of the North Dakota Hospital Association. I am here to testify in opposition to Engrossed House Bill 1594. I ask that you give this bill a **Do Not Pass** recommendation.

North Dakota hospitals support having price transparency made available to the public. Knowing the cost of a service or procedure can help patients make decisions.

On January 1, 2021, the Centers for Medicare and Medicaid Services (CMS) implemented price transparency requirements for hospitals. It requires a hospital operating within the United States to make public a list of the hospital's standard charges for items and services provided by the hospital. In addition to listing their standard charges hospitals are required to publicly list their negotiated rates with insurance companies.

I would like to point out the bill's price transparency requirements on lines 19-21of page 1 and lines 1-4 of page 2. They currently mirror CMS's price transparency requirements.

CMS does perform hospital price transparency audits. Hospitals face monetary penalties for non-compliance. Besides fines, CMS can take other enforcement actions including warning notices and requests for corrective action plans.

Also, on February 25, 2025, President Trump signed an executive order enforcing the price transparency regulations currently in place today.

In summary, the price transparency language in this bill will duplicate what CMS implemented in 2021 for hospitals. Why is the state trying to regulate what the federal government has implemented? I ask that you give the bill a **Do Not Pass** recommendation.

I would be happy to respond to any questions you may have. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

Senate Human Services Committee

I recommend a DO PASS on HB 1594

It is no secret that the number one reason why people end up losing their assets through and up to bankruptcy is due to medical and health changes. The expenses can be not only large but can set a person in financial ruin real quick. Audits do currently hold true as a CMS requirement from an overview standpoint, but most everyone knows they do not pick up on things like a forensic audit or a point of service audit, both of which are substantially more expensive than the CMS audits.

What is the downside of transparency? Letting people know exactly what they are getting into or what they received seems like a common sense, “the right thing to do”, expectation. What are hospitals hiding that makes them nervous?

I recommend DO PASS on HB 1594

Mike Connelly

Bismarck citizen

701-400-1839

(Disclaimer: I am stating my own opinion and not that of any organization or entity

Representative Jared Hendrix
House District 10
Testimony for HB 1594

Madame Chair Lee & Members of the Senate Human Services Committee -

In 1960, total healthcare spending in the United States was 5.0% of GDP. By 2023, it was 17.6%. Per capita, we spend $14,570, while the average in comparable counties like Germany, France and Canada is $6,651. America boasts some of the best doctors and nurses in the world, who share true compassion and devotion, but costs are skyrocketing. Over 66% of Americans who file for bankruptcy do so due to medical expenses they cannot pay.

The challenges in our healthcare system are multifaceted and impossible to address in a single piece of legislation. However, because prices incentivize efficient usage of resources, HB 1594 is an important step towards fixing this system by providing greater transparency in pricing.

When patients go to a hospital, they typically follow this sequence: First, they check in, providing insurance information and personal details. Then, medical staff assess the patients condition and recommend treatments or services. Following treatment, the hospital generates a detailed bill based on services, including tests, procedures, medications, and facility fees. The hospital negotiates prices with insurance companies, which may cover part of the costs based on the patients plan. The patient is billed for the remaining amount, which includes deductibles, co-pays, and uncovered services. Contracts between hospitals and insurers, government regulations, and hospital operating costs influence prices.

Under the Federal Hospital Price Transparency Rule, hospitals are required to publicly disclose their standard charges for items and services, including negotiated rates with insurers, in a consumer-friendly format. Unfortunately, compliance and Federal enforcement have been inconsistent nationwide. According to Patients Rights Advocate dot Org, a nonprofit focused on healthcare price transparency, their most recent November 2024 report found only 21.1% of hospitals are fully compliant. In North Dakota, it is 0%.

The 66th Legislative Assembly tasked the ND Insurance Department with helping Legislative Management conduct an interim study of health insurance premium trends. This unique study involved a secret shopper who compared hospital prices for three common procedures colonoscopy, normal vaginal delivery and Caesarian section. At Trinity Hospital in Minot, the cost was $5,058 for a C-section. At Essentia Health in Fargo, costs were $31,000, illustrating a 613% ratio of price variation.

HB 1594 strengthens medical price transparency by codifying compliance into state law, and giving the ND Insurance Commissioner tools to enforce. The penalties mirror federal penalties, but are reduced for critical access hospitals and all other providers. This includes non-hospital-owned providers, such as independently owned ambulatory surgery centers. The bill does not include skilled nursing facilities, because North Dakota is a rate-equalized state.

A lack of transparency in medical prices hurts North Dakotans. Patients often receive unexpected, confusing, and financially devastating bills for procedures they assumed were covered or reasonably priced. When price transparency is lacking, consumers lose their ability to shop for affordable care, and competition within the healthcare market is stifled.

While it may seem like there is limited options for consumers to benefit from more transparency today, having the information will help consumers compare costs across different providers, create demand for consumer options and over time, put downward pressure on prices. This legislation empowers patients to make informed financial decisions before seeking medical care. Transparency is not about price-setting or additional burdens on providers. It is about accountability, fairness, and consumer empowerment.

Thank you for your time and consideration,

Representative Jared Hendrix

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1594
Department of Health and Human Services

Page 1, lines 11 and 12:

a. "Health care facility" means those facilities licensed under chapter 23-16, except for nursing facilities ~~and~~, basic care facilities, and state hospital.

Hospital-Reported Prices for Selected Common Procedures

	Colonoscopy	Normal Vaginal Delivery	Caesarian Section
Trinity Hospital - St.Josephs (Minot)	2,980	4,343	5,058
St.Alexius Medical Center (Bismarck)	1,775	4,895	9,675
Sanford Medical Center (Fargo)	3,843	15,056	22,376
Sanford Medical Center (Bismarck)	5,509	13,603	20,386
Altru Health System (Grand Forks)	2,064	12,239	19,269
Jamestown Regional Medical Center	2,100	13,000	25,000
Innovis Health (Fargo)	4,700	11,000	31,000
Ratio of Highest to Lowest (Percent)	**310%**	**347%**	**613%**

Source: JWHammer LLC.

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1594
3/24/2025

Relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

9:55 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Shoppable Medical Services
- Limited Market Competition
- Federal Requirements
- Federal Executive Order

9:55 a.m. Chairman Lee opened discussion on limited market competition.

10:10 a.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1594
3/25/2025

Relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

9:30 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Compliance with federal regulation
- CMS Validator Tool
- Incomplete Form Submissions
- Insurance Carrier Agreements

9:31 a.m. Tim Blasl, President at North Dakota Hospital Association, answered committee questions.

9:41 a.m. Alan O'Neil, CEO of Unity Medical Center Grafton ND, answered committee questions.

9:53 a.m. Jerry Criswell, Director of Surgery with St. Alexius, answered committee questions.

10:00 a.m. Edward Packeral answered committee questions.

10:11 a.m. Senator Hogan moved amendment LC#25.1237.02001.

10:11 a.m. Senator Weston seconded the motion.

Senators	Vote
Senator Judy Lee	Y
Senator Kent Weston	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Desiree Van Oosting	Y

Motion passed 6-0-0.

10:13 a.m. Senator Hogan moved Do Not Pass as amended.

10:13 a.m. Senator Roers seconded the motion.

Senators	Vote
Senator Judy Lee	Y
Senator Kent Weston	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Desiree Van Oosting	N

Motion Passed 5-1-0.

Senator Hogan will carry the bill.

10:15 a.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

CO
3/25/25
1 of 4

25.1237.02001
Title.03000

Adopted by the Senate Human Services Committee
March 25, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1594

Introduced by

Representatives Hendrix, Conmy, Frelich, Kasper, Koppelman, Rohr, Nelson, D. Johnston

Senators Mathern, Weston, Magrum

A BILL for an Act to create and enact a new section to chapter 23-12 of the North Dakota Century Code, relating to medical costs transparency for health care facilities; to amend and reenact section 26.1-47-02 of the North Dakota Century Code, relating to health care facility and preferred provider compliance with medical cost transparency requirements; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 23-12 of the North Dakota Century Code is created and enacted as follows:

Medical costs transparency for health care facilities - Penalty.

1. For purposes of this section:
   a. "Health care facility" means those facilities licensed under chapter 23-16, except for nursing facilities ~~and~~, basic care facilities, and the state hospital.
   b. "Items and services" means any item or service, including individual items or service packages, which could be provided by a health care facility to a patient in connection with an inpatient admission or an outpatient visit for which the health care facility has established a standard charge, including supplies and procedures, room and board, use of facility, and services performed by health care facility staff.
2. Health care facilities shall:
   a. Make available to the public a list of standard charges for:

(1) Items and services; and

(2) Shoppable services, as outlined in title 45, Code of Federal Regulations, part 180, subpart B.

b. Produce the list in a format consistent with rules adopted by the centers for Medicare and Medicaid services.

3. A health care facility that violates a provision of this section may be assessed a civil penalty by the insurance commissioner. A penalty for a violation by a health care facility with more than twenty-five beds must be ten dollars per bed per day, not to exceed five thousand five hundred dollars per day, for each day the violation continues. A penalty for a violation by any other health care facility may be up to one hundred dollars per day for each day the violation continues, plus interest and any costs incurred by the insurance commissioner to enforce this penalty. The civil penalty may be imposed by a court in a civil proceeding or by the insurance commissioner through an administrative hearing under chapter 28-32. The assessment of a civil penalty does not preclude the imposition of other sanctions authorized by rules adopted under this title.

SECTION 2. AMENDMENT. Section 26.1-47-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-02. Preferred provider arrangements.

Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements.

1. Preferred provider arrangements must:
   a. Establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers.
   b. Include mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to review and control the utilization of health care services and establish a procedure for determining whether health care services rendered are medically necessary.
   c. Include mechanisms which are designed to preserve the quality of health care.

d. With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

e. Provide that in the event the health care insurer fails to pay for health care services as set forth in the contract, the covered person is not liable to the provider for any sums owed by the health care insurer.

f. Provide that in the event of the health care insurer insolvency, services for a covered person continue for the period for which premium payment has been made and until the covered person's discharge from inpatient facilities.

g. Provide that either party terminating the contract without cause provide the other party at least sixty days' advance written notice of the termination.

h. Provide that if a preferred provider has failed to comply with federal transparency rules and regulations, the health care insurer may terminate the contract without consent.

2. Preferred provider arrangements may not unfairly deny health benefits to persons for covered medically necessary services.

3. Preferred provider arrangements may not restrict a health care provider from entering into preferred provider arrangements or other arrangements with other health care insurers.

4. A health care insurer must file all its preferred provider arrangements with the commissioner within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the commissioner may declare the contract void and disapprove the preferred provider arrangement in accordance with the procedure for policies set out in chapter 26.1-30.

5. A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.

6. A health care insurer may not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health care insurer which jeopardizes patient health or welfare.

7. A preferred provider arrangement must include an attestation from the preferred provider that the preferred provider is in compliance with federal transparency rules and regulations.

REPORT OF STANDING COMMITTEE
ENGROSSED HB 1594

Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS (25.1237.02001)** and when so amended, recommends **DO NOT PASS** (5 YEAS, 1 NAY, 0 ABSENT OR EXCUSED AND NOT VOTING). HB 1594 was placed on the Sixth order on the calendar. This bill does not affect workforce development.