2023 HOUSE HUMAN SERVICES

HB 1416

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1416
2/6/2023

Relating to freedom of choice for health care services.

Chairman Weisz called the meeting to order at 10:10 AM.

Chairman Robin Weisz, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich, are present.

Vice Chairman Matthew Ruby not present.

Discussion Topics:

- Patient choice for healthcare providers
- Health maintenance organizations
- Recent physician-hospital integration
- Costs of long-term healthcare
- Competition among healthcare providers
- Resources needed for patients.
- Focused network of healthcare and insurance providers
- Healthcare providers in North Dakota.
- Licensed HMO providers

Rep. Kiefert introduced HB 1416 with supportive testimony.

Duncan Ackerman, medical doctor and North Dakota citizen, supportive testimony (#19250).

April Mettler, healthcare provider and business owner in North Dakota, supportive testimony (#19215).

Karie Bowman, North Dakota citizen and parent, oral supportive testimony.

Susan Finneman, North Dakota citizen, oral supportive testimony.

Kim Bloms, North Dakota physical therapist and parent, supportive testimony (#19206).

Steven J. Broadway, Neurosurgeon from Fargo, North Dakota, supportive testimony (#19140).

Courtney Koebele, Executive Director for the North Dakota Medical Association, supportive testimony (#19174).

Joshua Ranum, MD Internal Medicine in Hettiinger ND oral supportive testimony.

Kayla Effertz Kleven, Assistant Director of First Impressions UND supportive testimony # 26300

Dylan Wheeler, Director of Government Affairs for Sanford Health, opposing testimony (#19184).

Jack McDonald, America's Health Insurance Plans, opposing testimony (#19232).

Scott Miller, Executive Director of the North Dakota Public Employees Retirement System, opposing testimony (#19259).

Andrea Pfennig, with the Greater North Dakota Chamber, opposing testimony (#19210).

Chrystal Barkusta, Life/Health/Medicare Division Director, ND Insurance Dept. , neutral testimony and answered questions from the committee.

Additional written testimony:

Stephen Churchill, physical therapist, #19201

Kaisha Lynnes, Pinnacle Health Care, #19261

Heidi Selzler – Echola, Medical Director at Canopy Medical Clinic, #19061

Chad Carlson, Open Access Healthcare, #19081

Jed Laplante, Open Access Healthcare, #19157

Catherine Caillier, Institute of Diagnostic Imaging, #19189

Erik Christenson, Heart of America Medical Center, #19196

Karlee Tebbutt, AHIP, #19231

Rachel Ness, healthcare advocate, #19202

Dustin Goetz, Pain Treatment Center Anesthesiologists, #19217

Chairman Weisz adjourned the meeting at 11:40 AM.

Phillip Jacobs, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1416
2/13/2023

Relating to freedom of choice for health care services.

Chairman Weisz called the meeting to order at 3:55 PM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich. All present.

Discussion Topics:

- Committee action

Rep. Porter moved a do pass on amendment 23.0983.01001.

Seconded by Vice Chairman Ruby.

Motion carries by voice vote.

Rep. Anderson moved a do pass as amended on HB 1416.

Seconded by Rep. McLeod.

Roll Call Vote:

Representatives	Vote
Representative Robin Weisz	Y
Representative Matthew Ruby	Y
Representative Karen A. Anderson	Y
Representative Mike Beltz	Y
Representative Jayme Davis	Y
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y
Representative Kathy Frelich	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	Y
Representative Carrie McLeod	Y
Representative Todd Porter	Y
Representative Brandon Prichard	Y
Representative Karen M. Rohr	Y

Motion carries 14-0-0.

Rep. Kiefert will carry the bill.

Chairman Weisz adjourned the meeting at 4:00 PM.

Phillip Jacobs, Committee Clerk

Adopted by the House Human Services Committee

February 13, 2023

2-13-23

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1416

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

b."

Page 1, line 12, replace "b." with "c."

Page 1, line 13, replace "policies" with "health benefit plans"

Page 1, remove lines 14 and 15

Page 1, line 17, remove "or a policy directly affiliated with or administered for a health care"

Page 1, line 18, remove the first "provider"

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1416: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1416 was placed on the Sixth order on the calendar.

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

b."

Page 1, line 12, replace "b." with "c."

Page 1, line 13, replace "policies" with "health benefit plans"

Page 1, remove lines 14 and 15

Page 1, line 17, remove "or a policy directly affiliated with or administered for a health care"

Page 1, line 18, remove the first "provider"

Renumber accordingly

2023 SENATE HUMAN SERVICES

HB 1416

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1416
3/14/2023

Relating to freedom of choice for health care services.

10:04 AM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, and Hogan** were present**.**

Discussion Topics:

- Service plans
- Healthcare access
- Out of network options
- Integrated network
- Patient provider choice

10:05 AM **Representative Kiefert** introduced HB 1416 and testified in favor verbally.

10:06 AM **Pam Sharp, Olson Effertz, Lobbying and Consulting,** introduced **Dr. Duncan Ackerman.**

10:07 AM **Duncan Ackerman, Orthopedic Surgeon North Dakotans for Open Access Healthcare,** testified in favor. #24818, #24838.

10:30 AM **Courtney Koebele, Executive Director, North Dakota Medical Association,** testified in favor. #24507.

10:32 AM **Courtney Koebele** introduced **Joshua Ranum.**

10:33 AM **Joshua Ranum, Internal Medicine Physician and President, FACP, West River Regional Medical Center and North Dakota Medical Association,** testified in favor. #24750.

10:35 AM **Gabriela Balf, Psychiatrist,** testified in favor. #24753.

10:40 AM **Rachel Ness, Dermatologist, Fargo Center for Dermatology,** testified online in favor. #23919.

10:50 AM **Marian Spitzley, patient Fargo, North Dakota** testified online verbally.

10:59 AM **April Mettler, Chief Executive Officer CC's Physical Therapy,** testified on-line in favor. #24053.

11:10 AM **Dylan Wheeler, Head of Government Affairs, Sanford Health Plan,** testified in opposition. #24708

11:29 AM **Tim Deitemeyer, Independent Insurance Agent,** testified in opposition. #23946.

11:41 AM **Rebecca Fricke, Chief Benefits Officer, North Dakota Public Retirement System,** testimony in opposition #24272.

11:45 AM **Andrea Pfennig, Director of Government Affairs, Greater North Dakota Chamber,** testified in opposition. #24599.

11:47 AM **Alex Kelsch, Lobbyist, Kelsch Ruff Kranda Nagle Ludwig,** submitted by **Karlee Tebbutt, Regional Director, State Affairs, AHIP, Guiding Greater Health,** testified in opposition. #24725.

11:49 AM **Al Berg, Senior Risk Advisor, North Risk Partners,** testified in opposition. #24561.

12:01 AM **Chrystal Bartusa**, **Life Health and Medicare Division Director, North Dakota Insurance Department,** provided additional information neutral verbally.

Additional Written Testimony:
Amana Erickson, Physical Therapist and Owner, Milestone Health Partners in favor #23982
Steven Brodway, Neurosurgeon and Founder, Northern Neurosurgery and Spine in favor #24019
Brittany Schank, Owner, Solace Counseling in favor #24229
Martin Haug, Outpatient Rehabilitation, Elite Health and Fitness in favor #24252
Michael Greenwood, Vance Thompson Vision in favor #24279
Lindy Kirby, Owner and Physical Therapist, Milestone Health Partners in favor #24287
Susan Finneman in favor #24331
Maissa Wuori in favor #24424
Stephen Smith, President and Chief Information Officer, YMCA of Cass and Clay Counties in opposition #24260
Kate Herzog, Chief Operating Officer, Downtowners Association in opposition #24341
Kristi Scholler Carlson, Lobbyist, Farmers Union Service Association in opposition #24644

12:03 PM **Madam Chair Lee** adjourned the hearing.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1416
3/28/2023

Relating to freedom of choice for health care services.

9:05 AM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, and Hogan** were present**.**

Discussion Topics:

- Expansion of plans
- Out of network options
- Federal guidelines
- Study
- Task force

9:07 AM **Chrystal Bartuska, Life Health and Medicare Division Director, ND Insurance Department,** provided information verbally.

Senator K. Roers provided information to the committee. No written testimony.

9:18 AM **Dylan Wheeler**, **Head of Government Affairs, Sanford Health,** provided information verbally.

9:25 AM **April Mettler** provided information verbally.

9:32 AM **Chrystal Bartuska, Insurance Department,** provided additional information verbally.

9:33 AM **Madam Chair Lee** called for recess.

9:33 AM **Madam Chair Lee** adjourned the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1416
3/28/2023

Relating to freedom of choice for health care services.

2:32 PM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, and Hogan** were present**.**

Discussion Topics:

- Study
- Task force
- Committee action

Senator Lee calls for discussion.

2:33 PM **Courtney Koebele, Executive Director, ND Medical Association,** provided information verbally.

Senator Hogan moved **DO PASS.**
Senator Weston seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	N
Senator Kent Weston	Y

Motion passed 4-2-0.

Senator Lee will carry HB 1416.

Additional Written Testimony:
Duncan Ackerman in opposition #26984

2:38 PM **Madam Chair Lee** adjourned the meeting.

Note: Bill was reconsidered on 3/29/2023 at 11:06 AM.

Patricia Lahr, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1416, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **DO PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1416 was placed on the Fourteenth order on the calendar. This bill does not affect workforce development.

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1416
3/29/2023

Relating to freedom of choice for health care services.

11:06 AM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, and Hogan** were present**.**

Discussion Topics:

- Study
- Task force

Senator Lee calls for discussion.

Senator K. Roers moved to reconsider prior actions.
Senator Cleary seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 6-0-0.

Senator Hogan moved to **adopt amended**, page 1 after line 20 insert, effective date, this act shall apply to health benefit plans offered, or sold after December 31, 2024.

Senator K. Roers seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 6-0-0.

Senator Hogan moved **Do PASS** as **AMENDED**.
Senator Cleary seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	N
Senator Kent Weston	Y

Motion passed 4-2-0.

Senator Lee will carry HB 1416.

11:12 AM **Madam Chair Lee** adjourned the meeting.

Patricia Lahr, Committee Clerk

23.0983.02001
Title.03000

Adopted by the Senate Human Services Committee

March 29, 2023

AG
3-29-23
(1-1)

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1416

Page 1, line 2, after "services" insert "; and to provide for application"

Page 1, after line 20, insert:

"**SECTION 2. APPLICATION.** This Act applies to health benefit plans offered or sold on or after December 31, 2024."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1416, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1416 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

Page 1, line 2, after "services" insert "; and to provide for application"

Page 1, after line 20, insert:

"**SECTION 2. APPLICATION.** This Act applies to health benefit plans offered or sold on or after December 31, 2024."

Renumber accordingly

TESTIMONY

HB 1416

100 4th St S, Ste 608
Fargo, ND, 58103
701-264-5200 (p)
701-999-2779 (f)
info@canopymedicalclinic.com

Dear Human Services House Members ,

I am the Medical Director at Canopy Medical Clinic, an independent clinic located in Fargo. I am writing in support of HB 1416, and I ask that you give this bill a **Do Pass** recommendation.

Allowing patients to choose their healthcare providers based on expertise, specialization and comfort level, is an extremely important aspect of an individual's sense of control over their healthcare needs. When patients have a choice of where they receive their healthcare services, they often feel more empowered with medical interventions that are recommended for them. Being the Medical Director of a specialty clinic, I see a large number of patients who end up paying out of pocket for their medical care, even though they have health insurance. Not being able to be in network with their insurance companies due to their insurance's exclusion policies negatively affects not only patients, but the independent medical clinics in North Dakota that choose to provide specialty care. Often independent clinics specialize in services that may be harder to access at larger healthcare facilities. This not only puts a strain on patients, but on medical business owners in our state. As a medical provider who sees the strain of healthcare costs on patients, I believe that insurance companies, state laws, and clinic policies should all work together to make sure individuals get the best care possible and have access to the medical providers of their choice.

For the reasons listed above, I again urge a **Do Pass** recommendation for this bill.

Heidi Selzler-Echola, MSN, APRN, WHNP-BC
Medical Director
Canopy Medical Clinic
hechola@canopymedicalclinic.com
701-264-5200

Chairman Weisz, Vice Chairman Ruby, and members of the House Human Services Committee,

North Dakotans for Open Access Healthcare is a coalition of independent medical practitioners, medical facilities, medical associations and independent hospitals that support patient choice. We strongly support HB 1416.

The genesis of the Patient Choice bill is the result of the increasing number of patients and providers across the state voicing their concerns about narrow network plans, particularly narrow network plans that have ZERO out-of-network coverage. The obvious difficulty with narrow network plans in a rural state is patient access to providers, particularly when it comes to medical specialists. It has become more common to hear patients' concerns when needing specialty care. Patients often experience long wait times, and in the case of rural areas, patients often drive past an *out-of-network* specialist right in their own community. HB 1416 allows patients to choose the providers they know and trust.

HB 1416 increases competition. Competition in health care markets benefits consumers because it helps contain costs, improves quality, and encourages innovation. An excerpt from the results of the North Dakota Legislative Management Interim Health Care Study shares that, "Competition stimulates innovation – lower prices and better quality. Competition is the ultimate consumer protection because it allows a consumer to walk away from a transaction to find a better partner."

It's important to remember - patient choice legislation is not "any willing provider" at "any willing price." The insurance companies still control the fee schedules, and if a provider chooses to participate the provider still needs to negotiate and agree to the insurance plans terms and conditions.

Patient choice legislation permits the patient to choose who they trust to care for their healthcare needs. Insurance companies will negotiate with all willing, licensed, and qualified healthcare providers for inclusion in their networks.

Patient Choice will increase competition and help control spiraling healthcare costs in North Dakota.

We strongly encourage a DO PASS recommendation from your committee.

Sincerely,

North Dakotans for Open Access Healthcare

Testimony in support of House Bill 1416

February 6, 2023

Good morning, Chairman Weisz, Vice-Chairman Ruby and Members of the Committee:

For the record my name is Dr. Steven Jared Broadway and I am a board-certified Neurosurgeon who founded Northern Neurosurgery and Spine in Fargo in January 2020. I graduated from the University of Arkansas for Medical Sciences in 2005, then went on to Neurosurgical residency at the University of Tennessee in Memphis which I completed in 2011. I practiced in Duluth from 2011 until late 2019 when I left the employed model to start my independent practice in Fargo. I had the opportunity to testify in favor of House Bill 1465 during the last session and am happy to reiterate my support today for all patients' freedom of choice for health care services.

Access is key:

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

Cost effective care and patient outcomes:

I am the only surgeon in the Fargo area performing spinal surgery in an ambulatory center. Healthcare is moving more and more toward the outpatient setting as surgical techniques and anesthesia delivery advance. Prior to Fargo, all of my surgical cases were performed in the hospital setting. Now with 3 years of experience performing ambulatory surgery, I can say with absolute confidence that quality and outcomes are excellent, and the cost of care is substantially lower. This not only benefits the patient, but also the insurers and society as a whole. Not allowing patients to choose their provider based on their insurance network contradicts our collective goal as a society to decrease healthcare spending.

Retention:

Everyone involved in this discussion clearly has a commitment to our beautiful North Dakota communities. It is a fact, however, that colder climates and smaller towns result in difficulties in the recruitment and retention of skilled providers. The independent medical community has a lot of "stake in the game" as concomitant small-business owners. Patients want to receive care at home but become disenfranchised when their provider leaves and/or they are referred out due to access or specialty constraints. This is an unfortunate reality, and I truly believe having a rich and robust network of independent practitioners allows for hospitals and healthcare systems to benefit by providing more choices for patients and allowing them to be served within their community. To ensure the viability and growth of these practices, we must come together to support and pass house bill 1416.

I encourage a DO PASS on HB1416

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

Chairman Weisz, Vice Chairman Ruby, and members of the House Human Services Committee,

I am a member of North Dakotans for Open Access Healthcare and strongly support HB 1416. I believe this bill has the interest of all North Dakota citizens at heart and shifts the focus of healthcare in our state to the patient rather than the provider.

Not for profit, community-based hospitals are mission driven organizations focused on meeting a community need. When these same organizations move into the health insurance industry and restrict access to other providers, it creates a situation where we are no longer focusing on meeting the needs of the community. These organizations seem to be more focused on "dominating" or "controlling" the market. The longer North Dakota allows vertically integrated health systems to control the insurance market, the closer we will creep towards a monopolistic healthcare environment.

At the end of the day, this is about patients having the ability to choose what is best for them. Each facility or provider excels in different specialties and different aspects of healthcare. Unfortunately, our health insurance market is largely decided by employers, not the patient themselves. For this reason, it's important that providers compete on cost, quality, experience and access. Healthcare providers should not simply be considered out of network when their logo isn't blue. Healthcare is one of the only industries in our state and country where transparency is far from the norm. As a healthcare professional, I can tell you that vertically integrated health systems are not the most cost-effective solution in healthcare and that there are many lower cost options available outside of hospital based walls. Unfortunately, health insurance makes those cost savings invisible to the patient and incentives are lost.

This bill is a step in the right direction in leveling the playing field in North Dakota healthcare. If even one patient is able to choose a provider they trust based on a prior recommendation or a relationship, then this bill did its job.

I strongly encourage a DO PASS recommendation from your committee.

Sincerely,

Jed LaPlante, MHA
Administrator
Center for Special Surgery
Fargo, ND

House Human Services Committee
HB 1416
February 6, 2023

Chairman Weisz and Committee Members, I am Courtney Koebele, the Executive Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA supports HB 1416.

HB 1416 provides that a health insurer that is part of an integrated delivery network may not exclude a physician/healthcare provider from its insurance products if the physician/healthcare provider is willing and fully qualified to meet the terms and conditions of participation, as established by the health insurer.

HB 1416 can reduce patient's out-of-network personal medical fees and will help control out-of-pocket costs and co-pays while improving medical outcomes. It eliminates unnecessary re-testing by providers not familiar with case histories and reduces probability of diagnostic errors. In addition, the increase in competition will aid in controlling spiraling medical costs.

This is helpful because it means providers can't be "locked out" of products with a "narrow network" and means patients have the broadest possible choice of products that can/may include their preferred physician/healthcare provider.

Having a consistent and on-going relationship with a health care provider is in the best interest of quality care and patients deserve the freedom to choose their own physician/healthcare provider. This bill allows families to see physicians and other medical providers they know and trust.

We urge a DO PASS on HB 1416. Thank you for the opportunity to testify today. I would be happy to answer any questions.

HB1416 – Any Willing Provider: Overriding Consumer Choice for Affordable Health Care

House Human Services Committee
Dylan Wheeler
2/6/2023

SANFORD HEALTH PLAN

What is a network?

General Definition:

- The makeup of facilities, providers and suppliers which a health insurer or plan has contracted to provide health care services.

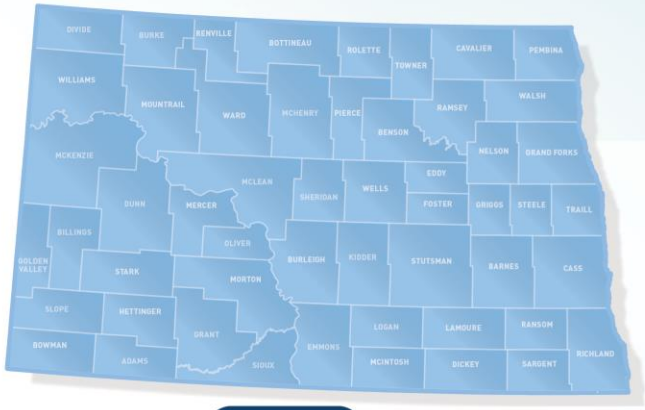
Types of Networks - Examples:

- **Broad:** a broad network typically consists of a majority – if not all - of the providers within the service area and beyond.
- **Focused:** focused networks consist of fewer providers. Providers in a focused network agree to a reduced contracted rate in exchange for the anticipated increased volume.
- **Tiered:** tiered networks consists of just that – tiers. Contracted providers and member benefits correspond with the different tiers

NETWORKS

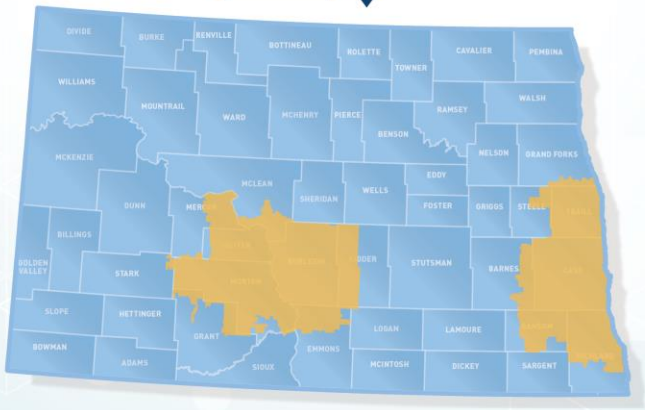
Why do health insurance companies use networks?

- **Consumer Choice:** Broad and focused Networks **empower** consumers with different options and allow the consumer to **choose** a health plan that meets their needs.
- **Cost Control:** A focused network includes fewer health care providers at a lower cost to the consumer. Broad networks — which include more health care providers — increase costs for consumers.
- Encourage a competitive market



BROAD NETWORKS

DECREASED COSTS



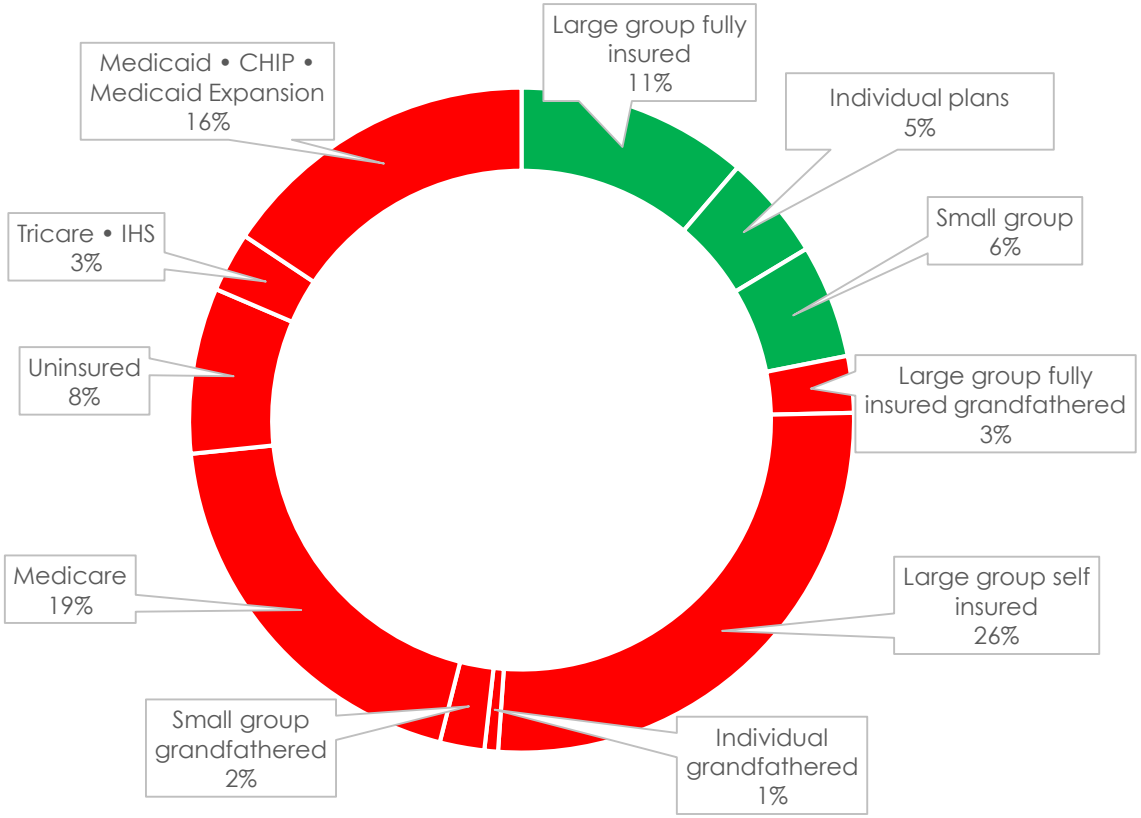
FOCUSED NETWORKS

Sanford Health Plan Focused Network availability

Health Insurance Networks and Integrated Care Delivery

- Broad and Focused networks are not unique to integrated care delivery systems – plan options are prevalent in markets nationwide.
- Almost all of North Dakota providers are included in Sanford Health Plan's Broad network current day – consumers have the choice to select that plan.
- Focused networks, on average, save a consumer 20% in premium as compared to the broad network.

Future Legislation May Limit Choice for a Small Part of the Market



Consumer Choice and Health Insurance Networks

- Consumers are empowered today to make informed decisions as to what health insurance plan meets their needs – including individuals, families and businesses.
- Choice exists on the ACA Marketplace, as well as with commercial employer coverage.
- Sanford Health Plan **requires** that employers who offer TRUE (focused network) to its employees **MUST** offer a broad network product as well.
  - An employer cannot offer just a focused network*
- The #1 complaint that is received is that the focused network product is **not offered through the whole state** – members lack that choice today outside of otherwise eligible counties.

Consumer Choice in Action – Example 1:

- ND Employer
- Group has 98% eligible for TRUE (focused network)
- Group has 67% enroll in TRUE; other 33% chose Signature Series (Broad Network)

Plan Tiers	Signature (Broad)	True (Focused)
Employee	$ 564.39	$ 452.55
Employee + Spouse	$ 1,185.22	$ 950.36
Employee + Child(ren)	$ 1,015.90	$ 814.60
Family Coverage	$ 1,693.17	$ 1,357.86

Consumer Choice in Action – Example 2

- ND Employer
- Group has 100% eligible for TRUE (focused network)
- Group has 28% enrolled in TRUE; remaining 72% chose Signature Series (Broad Network)

Plan Tiers	Signature (Broad)	True (Focused)
Employee	$652.70	$523.36
Employee + Spouse	$1,370.66	$1,099.05
Employee + Child(ren)	$1,174.86	$942.04
Family Coverage	$1,958.09	$1,570.08

Consumer Choice in Action – Example 3

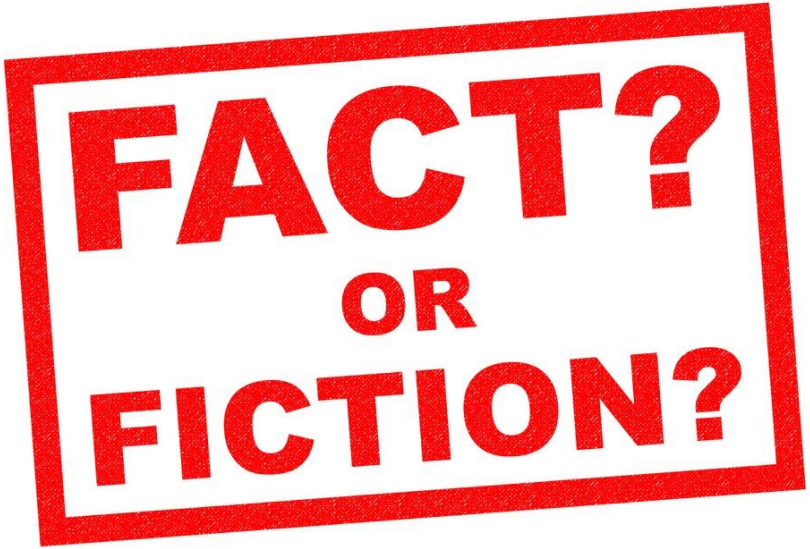
- ND Employer
- Group has 99% of its employees eligible for TRUE
- Group elected not to offer TRUE to its employees

FICTION

- Sanford only has Sanford providers in the focused network.
- Sanford only pays Sanford providers in the focused network.
- There are no local providers in a focused network.

FACT

- 45% of providers in the focused network are non-Sanford
- On average, 40%-50% of claims paid in focused network go to non-Sanford providers.
- Network adequacy standards require local access.



The **bottom line** is…

- HB1416 will remove the ability for health plans to deliver affordable coverage options.
- HB1416 will remove existing consumer choice from the market.
- HB1416 is a government mandate that supersedes an adaptable market.
- Oppose HB1416 and vote **“Do Not Pass”**

INSTITUTE of DIAGNOSTIC IMAGING

January 31, 2023

Dr. Duncan Ackerman,

RE: HB 1416 Open Access Healthcare

Institute of Diagnostic Imaging is an Independent Diagnostic Testing Facility (IDTF). Our facility provides MRI, CT, Ultrasound, Mammographic and Radiologic services. We are credentialed with most all insurance companies except for SanfordTru. Although we are credentialed with varying insurance providers that doesn't necessarily mean that our facility is "in-network" with all of them. Which is confusing to the patient/consumer and ultimately ends up being a greater cost to the consumer.

Being an IDTF we set our prices for radiology imaging at a substantially lower cost than hospital-based services. Which is a benefit to all, namely the insurance company and the consumer. I have evidence that hospital-based services charges are over double for the same CPT code. Another benefit to the patient of having open access healthcare is the timeliness of our service. Generally, our facility can get the patient scheduled within 2-3 days, unless the insurance company requires a pre-authorization. The pre-authorization process is the main reason for potential delays in getting expedited care for the patient.

A Patient's Bill of Rights should allow the patient to choose where they would like their imaging services performed. It should not be controlled by the insurance company and/or where their provider tells them where to go.

In addition, an IDTF is required to be accredited by an accredited organization. Most common is the American College of Radiology (ACR). The ACR evaluates equipment and staff to promote high standards in all aspects of practice. ACR keeps practices accountable. However, hospital-based practices **are NOT required** to maintain accreditation.

If you have any further questions, please feel free to contact me. I would be happy to discuss the benefits of having open access to **affordable** healthcare for all patients.

Cathy Caillier

Manager, Clinical Services

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Heart of America medical center

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February 6, 2023

Testimony on House Bill 1416

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

Erik Christenson, PharmD, MBA
CEO
Heart of America Medical Center
Rugby, ND 58368

I wish to share with the representatives of the State of North Dakota my experience as a pharmacist and administrator in rural health care and how these experiences relate to freedom of choice for health care services. I started as a pharmacist in Rugby, North Dakota in 2000. I have worked as a hospital and retail pharmacist, pharmacy owner, director of pharmacy, and most recently as a hospital administrator. Much of my professional life has been dedicated to providing health care to rural North Dakotans and I have a passion to assure that these patients continue to have viable access to good health care.

One of the major concerns expressed by the patients I have worked with over the years is the concern of having the freedom to choose the providers they wish to see for their health care needs. Most recently, this concern was raised when the Heart of America Medical Center joined a new accountable care organization. I have and will continue to work hard to assure our community has choice when it comes to the providers they see. This is a valid concern as these patients often have limited resources and they must be able to choose a provider that meets their needs given these limited resources.

I have the unique perspective regarding limited networks of care as a pharmacist. The pharmacy industry over the years has seen a rise in limited provider choices due to insurers narrowing the pharmacy selection available to patients. Many patients are forced to choose a mail order pharmacy over their local pharmacy provider. This limited network can serve to increase confusion and frustration for the patients. It also does not appear that these limited networks are saving money for the patients or society as a whole. From 2012 to 2022 the annual prescription drug expenditures for Medicare have increased from $67.5 Billion to $143.2 Billion. (CMS, 2023) The narrowed networks created by the large

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pharmacies, pharmacy benefit managers, and insurers are not allowing for a competitive environment that would help reducing costs. Instead, these large companies are cornering the market and forcing our communities to pay more for needed medications.

So in summary, I support the passage of this legislation as I feel that it is important to assure that our citizens have access to good care and that insurance companies not inhibit that access. Also, I believe there is good reason to believe that limiting access does not save money for the patients or the community as a whole. Good health care is important to North Dakotans and I feel this bill will help to assure good health care continues.

Respectfully,

Erik Christenson

Reference:

CMS (2023). National Health Expenditure Data. Centers for Medicare and Medicaid Services. Retrieved on February, 5 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet

Chairman Weisz and Members of the Human Services Committee:

The purpose of this letter is to lend my support to HB 1416 so that patient's have the freedom to choose their healthcare provider. I have been practicing physical therapy in Bismarck for almost 26 years and the last 18 years as a private practice owner. Prior to this I practiced in Phoenix Arizona and Davenport Iowa for a total of five years. I have been frustrated at times with the limited options patients have to see me for specialized services in Bismarck as they are confined to a specific network insurance product, often chosen by their employer group. Unfortunately, this has forced them to see an inexperienced provider within their network with at times leading to less than desirable outcomes.

HB 1416 will allow patients to see providers of all types that specialize in the care they need without paying out of pocket or being inconvenienced by poor treatment outcomes. In addition, this bill will help prevent patients from being forced by their insurer to see an in-network provider a great distance from their home. I have seen many examples of this in Bismarck when patients are required to travel to another city even though there are experienced and qualified local providers that are excluded from the network. This leads to increased costs for the patient and the healthcare system in general not to mention the inconvenience to the patient and their family.

I have also seen patients suffer unnecessarily while waiting many weeks or even months to see an in-network pain management provider for a spinal injection even though an independent provider was available that same week. This is not healthcare and certainly not humane.

I appreciate your time and consideration and urge you to vote yes on HB 1416. Please feel free to contact me if you have any questions regarding my position on this bill or any other matter involving my experiences with healthcare in North Dakota.

Sincerely,

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

Physical Therapy

FARGO CENTER FOR DERMATOLOGY
MEDICAL | SURGICAL | AESTHETIC

www.fargoderm.com
Phone 701-478-8780
Fax 701-478-8781

To whom it may concern,

RE: HB 1416 Legislative Bill to eliminate restrictive networks and improve patient access

I am writing on behalf of my patients and to serve as their healthcare access advocate. I am a board-certified dermatologist from North Dakota, graduate of University of North Dakota Medical School and I have provided dermatology care to the patients of North Dakota since 2008. In my almost 15 years of clinical practice and running an independent clinic in ND, I have been able to see the evolving negative impacts over the years as restricted insurance networks have increased in numbers and narrowed in access and greatly affected patient access. I will speak specifically to the negative ramifications I have seen in dermatology with these restricted insurance networks, but my patients also share their struggles with me on access for other general and specialty medical care in the state of ND. These scenarios occur in all ages from infants to the elderly that we see in our clinic. Some of the most common scenarios I have seen due to network restrictions are delay of care or lack of care due to not having access to a dermatologist across the entire state. I see patients who have delayed diagnosis of skin cancers, advanced stage melanoma skin cancers that could have had different outcomes if they had been given access to diagnosis and treatment earlier. I see delay in severe atopic dermatitis, psoriasis, rashes, autoimmune skin disease that have led to advanced disease requiring unnecessary hospitalizations and requiring systemic immunosuppressant drugs due to delay or lack of dermatology access. It has been a slow and steady increase in restrictions for my patients over the last 5 years and never have I seen such an access issue as I have in the last 1-2 years.

Common scenarios I have seen over the last couple of years:

- Dermatology patients that I have seen for over a decade and taken care of their skin cancers or severe complicated skin diseases that are now being told by their network insurance restrictions that they can NO longer be seen by our dermatology clinic but instead but wait 6-12 months to get into a dermatologist in their network when some need to be seen much more often due to urgent disease.
- Long waits for patients to even get into any dermatology provider (PA or NP in their network), only to learn they have a skin cancer/melanoma but then can't get into their dermatology surgeon in their network (MD) for 6-12 months. These patients will often chose to leave their network as their anxiety tells them appropriately that they should not wait many months to treat a skin cancer or other urgent need. (patient is left with unnecessary stress and financial impacts)
- Patient will come for an appointment desperately from across the state to see us via their only cash pay option for their office visit, then they are faced with a decision on how to afford their needed procedures, biopsies, and skin cancer removal procedures that we deem medically necessary. (their restrictive insurance networks would rather have their network patients wait many months and delay their cancer treatments instead of covering their medical care available at an out of network facility)
- There is a small percentage of patients that are financially fortunate enough that get so desperate for care, they chose to go outside of their restrictive networks and elect to cash pay for services at our clinic because they become so desperate to treat their diseases. Unfortunately most patient do not have this financial ability.

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I have tried to be an advocate for my patients. The insurance I see the most patient dermatology access issues is with the Sanford Health Plan and it's restrictive networks. Our clinic has sent an annual letter to the Sanford Health Plan for the last 4 years and have called 2-3 times per year for the last 4 years to find out the status of our inquiry and we have yet to receive a response in 4 years. We are simply inquiring to see if we can help these patients that are showing up in our clinic and calling to get urgent dermatology care (that is available in our office but not in their network). We have advocated to see if we can have these patient's urgent dermatology care be covered under their restricted network that is unable to get these patients in for 6-12 months at times in their own network. There of course are times when access is better than others but this delayed access to care has been consistent for several years and whenever the wait times get to be 6 months or more, we send correspondence to see if we can help these patients to their network with no response. The patients nor our clinic can get any response from their restricted health plans. In Healthcare, we are to put the patient first. I ask all those reading this letter to put themselves or their family members in this situation. Would you not hope someone would advocate for you or your family member if you have cancer or a debilitating dermatological condition that affects your ability to work or affects your daily quality of life.

Please reach out to me with any further information or questions as I would feel fortunate to continue to advocate for my fellow North Dakota patients. I feel that North Dakota provides some of the best health care in the country and want to make sure all our citizens have the ability to access this great care.

Thank you for your time and consideration,

Rachel Ness

Rachel Ness MD, FAAD, Board Certified Dermatologist
Faculty at University of North Dakota School of Medicine and Sciences
Owner and Founder of Fargo Center for Dermatology
701-306-6757
ness@fargoderm.com

Chairman Weisz and members of the House Human Services Committee,

My name is Kimberly Bloms and I am the owner and physical therapist at Kids In Motion Pediatric Therapy in Mandan. We provide Physical Therapy, Occupational Therapy, and Speech services to children with complex diseases and disabilities.

Kids In Motion values our families and the reasons people choose our clinic are because we take a holistic approach to healthcare. We build relationships with families navigating child development and disease so that families can return to daily routines that you and I take for granted. Keeping their aggressive child in daycare, having friends, being able to make yourself a meal, move independently with a wheelchair, sitting through a class, learning a child has a rare disease and now navigating this new norm. This is the day to day of my patients and parents.

Kids in Motion provides many specialty services and we are the experts in our field in pediatric pelvic health. An example of this is helping 8-year-olds who are not able to control their bowel or bladder and is having accidents in school, playing with friends, or at a friend's sleepover and the impact it has on his relationships with others.

Being a pediatric provider in my field means spending 3-4 HOURS a week with families helping their child with repetition, 8-12 weeks at a time, and sometimes for a year, off and on, over the course of their life time. Teaching families to be an advocate, Education about condition, Education about supports and resources, and fast results leading to decreased financial burden on families is our priority. These are not the same values that every clinic in the town, state, or region has.

ACTUAL PATIENT:
Our five-year-old had been diagnosed with a small Lipoma in her spinal cord. After multiple scans and neurology appointments, the outlook was surgery to help her with bladder control. When we went through Urology we were told that therapy could maybe help, but most likely a need for a bladder test and then spinal surgery would be our only long-term options. We opted for bowel and bladder programming at Kids In Motion. She responded so well to the therapy and program at Kids in Motion. Within months, she was fully potty trained. I'm so thankful we didn't choose spinal surgery. The pros and cons were so obvious to us. Pull-ups and tracking food/bladder/bowel with weekly appointments or surgery... We're so glad we opted for the option for her to learn about her own body, rather than making alterations. We are so thankful to everyone at Kids In Motion for all their work with helping our daughter grow into herself.

Let me tell you about another child who had complex cerebral palsy and dislocated hips who required both hips to be reconstructed. The family chose Gillette's Children's specialty hospital for the procedure because they could reconstruct both hips at the same time. This option was denied by their narrow network insurance plan. The patient was required to go to an in-network facility and the child was required to have two separate surgeries, two separate days and

recoveries. This is just another way that narrow network providers are driving up cost for consumers by increasing travel for the family, missed time from work, cost for two hospitalization, hospitalization time, and now putting a fragile child under anesthetic twice. Talk about family burden. If you are a parent of a child and are already running nonstop for medical appointments these additional burdens are painful and time consuming.

In 2021 Kids in Motion registered to be on a fundraising team sponsored by a local VIN for monies to support children with CP and other diseases. Families from anywhere could apply for funds to help fund wheelchairs, out of pocket therapy costs, home modifications, etc I had started to learn that the VIN was changing the way money was distributed and that the foundation money was being funneled into other things such as therapist continuing education and equipment for The VINs personal clinics. I reached out to the foundation to find out what percent was being spent on the kids and families and what percent goes to VIN Children's. The response I got was "we purposefully haven't set an exact percentage to ensure that our funds for our families remain the top priority. This year we will use the funds raised to fund applications and a portion of what remains will be used to support Children's Therapy Clinics." There are a number of individual providers, companies, clinics, independent providers who are not VIN affiliated that participated in fundraising because of the notion that it was for the kids. Why would outside providers fund VIN programs?

One example from the BISMARCK MOMMIES PAGE:
I will fully admit that I am not on top of things, however does anybody find it ridiculous that for a well child visit they are scheduling 4+ weeks out currently at the VIN? Have providers cut hours? Are there less providers? I just find it slightly odd.

ND is still very rural in terms of health care in pediatrics. Specialty providers such as endocrinology, physical medicine and rehab, pediatric neurology, gastroenterology are very few and far between. That in itself is a narrow network. Many of my patients have to travel to access VIN specific clinics.

I cannot count the times I have heard my families say
"I was told that I needed to stay in VIN clinics because it is easier to share information in our system versus collaborating with outside providers" "We want to refer to you but it is highly discouraged. If we can, we do"

In 2021 I inquired with provider relations to become an in-network provider of a VIN and was told that they have sufficient numbers of providers in the network to provide services.
Most individuals who have a plan with zero out-of-network options that call my clinic to set up evaluations, 5 kids a month, are unaware that they chose a plan without options. Most people in here don't know how to navigate deductibles, co pays, co-insurance, provider options, etc. Imagine having a six year old child that is now diagnosed with a rare genetic disease, who is having seizures, medical emergencies, surgeries and you can't choose who helps you. It is devastating. Choosing that plan without understanding the ramifications and now you are stuck with a plan that has

limited choices, lack of specialties, lack of timely care, long wait lists, poor communication because the providers are overwhelmed.

I am a Leukemia Survivor, I spent 6 months in the mayo clinic in 2016. Bismarck told me they could treat me but the reality of that is that if I would have stayed I wouldn't be standing in front of you to give this testimony. The resources I needed were beyond what a rural hospital community could provide. Transfusions, transplant, kidney operations. Freedom of patient choice is ultimate what saved my life.

Please provide our patients choice by voting DO PASS on HB 1416

Kimberly Bloms

GREATER NORTH DAKOTA CHAMBER
HB 1416
House Human Services Committee
Chair Robin Weisz
February 5, 2023

Mr. Chairman and members of the House Human Services Committee, my name is Andrea Pfennig with the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** of House Bill 1416.

Recently, GNDC partnered with the NDSU Challey Institute for Global Innovation and Growth to complete a survey about the business climate in North Dakota. The survey found that 37% of respondents felt the second highest factor negatively affecting business performance was high healthcare costs.

While HB 1416 is intended to provide freedom of choice for health care services, we have concerns that it will eliminate the ability to choose a health insurance plan that provides significant savings.

Our members oppose general regulatory changes and mandates that would increase business burdens and costs. We urge you enable employers and employees to keep narrow networks as an option with a Do Not Pass recommendation.

Chairman Weisz, Vice-Chairman Ruby, members of the House Human Service Committee,

Good morning. My name is April Mettler and I am here today in support of Bill 1416 as a health care provider, business owner, and a mother to three; this is the Patient's Choice Bill.

Purpose and passion are two of the cornerstones of my private outpatient physical therapy clinic, CC's Physical Therapy located here in Bismarck. These elements are engrained in the decisions made in all facets of my life and career to benefit not only my own life's well-being but more importantly my patients and family around me. The Patient's Choice bill in discussion today, if passed, will continue to protect our patients and communities from narrow networks, foster a medical community of competitors for excellence, and reduce the risk of higher long term health care costs.

In our practice, addressing physical concerns lies on the forefront of our daily operations. We have made a stake in the industry as the trend setters pushing our profession into higher standards of care and formulating what we like to call PT 2.0. As part of that, our core values are focused on our patients: providing them with excellence, focusing on their personal goals, advocating and assisting in their health care decisions and as we call it "we will change your mind". We are open late, we are open early. We base business decisions with patients' best interests in mind working tirelessly to ensure their needs are addressed in a timely fashion and all necessary information to have their services covered by insurance is completed prior to their visit. The prevalence of narrow network insurance plans presented by our patients has increased significantly over my 12 years of private practice, namely the last 5 years. As patients and employers continue to look for ways to save money on escalating out of pocket health care premiums and costs, the eye-catching lights of "lower premiums" is often the driving decision for the patient or employer when selecting their health care plans. It often isn't until these narrow network members call to seek our services they discover their lack of *any* out of network coverages or what "no out of network coverage" really implies. How many of us in this room have read their insurance coverage fine print or 135 page manual of coverages and rules in language only known by the authors themselves? This leaves these prospective patients with 3 options: pay out of pocket with no application to their health coverage cost share, attempt to go elsewhere within the narrow network to receive the same skilled services, or not receive coverage at all. Most patients, choose the option of no services rendered due to the inability to find what we offer or simply cannot afford all of the out of pocket expenses associated with cash pay when they already are paying health coverage premiums. Another option, these patients choose the "easy" way out seeking pain management through medications/narcotics to cope with their symptoms as these "services" are covered by their narrow network. Take the 27 year old with debilitating and severe pelvic pain living on her own working a full time job with hours 8-430 Mon-Fri on the outskirts of town that took the narrow network health plan offered by her employer. Our out of network facility is open at 7, provides advanced manual interventions intended specifically for her condition, and has an established relationship with the patient from successfully treated conditions fixed under her parent's health plan at the age of 25. She cannot afford to pay out of pocket costs and therefore opts for medicating her symptoms that will most likely progress into more severe symptoms leaving her unable to work and a long road of progressive disability due to her condition that could have easily been treated with conservative care in my clinic. My patient doesn't need narcotics or to be on disability. She needs a health care plan that allows her to make her own choice on her place of services.

As a business owner and employer of 13, I have always offered a mid-grade, more expensive open market health care plan in our company to ensure my employees and their families if ever faced with serious medical conditions have the freedom to seek out their choice of healthcare options no matter the distance they desire to travel or where they see the best fit for their care. The importance of this decision came to a head in my own family as we were faced with difficult medical decisions in the care of my second son at the age of 6 months old. Blake was diagnosed with idiopathic hydrocephalus after a 6 month well check gone wrong. Essentially, based on MRI and presentation of symptoms, no one could understand the reason for the sudden onset of excessive cerebrospinal fluid encompassing his brain creating immense pressure on his skull and brain drastically enlarging his head in what felt like a time span of overnight. Asymptomatic hydrocephalus in a child at six months of age lead to prompt discussion and immediate referrals for treatment options that inevitably we got to choose for our child. With the brain, time is a critical factor as once visible signs of damage are observed, the damages are permanent. Brain damage is essentially irreversible. We didn't know how much time we had before the possibility of permanent changes in our child's life would occur. We didn't have time to mess with insurance. We needed to act with vigor and intensity with only our son's best outcomes in mind. In our case, one facility gave us the option of putting a shunt in my child's brain; a shunt he would have to deal with and manage his entire life. The other facility gave us the option of simply "re plumbing" his brain with no down time or lifelong management. Naturally, we CHOSE the physician that had the most confidence and expertise in his treatment plan with no long term ramifications. Choices. We made a medical decision for our child not based on insurance limitations but rather chose the option that we felt best suited us and what we hoped for his life. Had I been an employer trying to cut costs and provide the "cheapest" health care option, we could be living in a much different situation for him and I'm thankful I don't have to think about those decisions anymore.

Members of the committee. I urge you to think about your own medical choice. Do you feel confident the best provider for any condition that could arise in your lifetime or the lives of your family members would always be available in a narrow network plan? Could you rest assured that when faced with a medical crisis the best hands are readily available to serve you with the best in modern practice?

Support Bill 1416 and rest easy that the choice of your medical decisions will continue to be in your hands. I encourage a DO PASS on HB1416.

April Mettler

Pain Treatment Center Anesthesiologists

202 East Greenfield Ln STE 100

Bismarck, ND 58503

Phone: 701-250-7822

Re: HB1416 (Patient Choice Bill)

Dear Chairman Weisz, Vice-Chairman Ruby, and members of the House Human Services Committee

The Pain Treatment Center Anesthesiologists (PTCA) strongly supports HB1416 which allows patients the choice of which facility and provider they would like to receive care. Currently there are some insurances that provide zero out of network options forcing patients to be seen at a specific facility and by specific providers. HB1416 provides the ability for patients to choose where and by whom to be seen.

PTCA is an independent interventional chronic pain treatment facility. We have been providing care to Bismarck and rural North Dakota for many years. Over this time it has been our goal to provide quality care that is easy and accessible. Accessibility and time to treatment are extremely important to an individual suffering in pain. By allowing zero out of network options, the patients who have these plans will see longer wait times, have more appointments, and be forced to travel further distances.

At other pain treatment centers in the area, an initial visit can take up to 3 months. At PTCA we are usually able to accommodate patient's initial visit within 2 weeks, thus decreasing the time to initial treatment. At other pain treatment centers in the area, 2 appointments are required. One appointment is for the evaluation and one is for the procedure. At PTCA we accommodate out of town individuals by scheduling the initial visit and tentative procedure on the same day, thus decreasing the number of appointments and distance traveled. By allowing zero out of pocket networks to exist, patients with these plans do not have the option to choose quicker and more convenient care.

HB1416 allows patients to have a choice. A choice for a trusted provider. A choice for quicker and convenient care. We are asking for a DO PASS recommendation in order to provide all individuals in the community this choice.

Sincerely,

Attas Boutros, MD

Hugh Carlson, MD

Dustin Goetz, MD

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February 6, 2023

Chairman Robin Weisz
House Human Services Committee
North Dakota State Capitol, Pioneer Room
600 East Boulevard Avenue
Bismarck, North Dakota 58505

RE: AHIP Concerns on HB 1416, *Freedom of Choice in Health Care Services*

Dear Chairman Weisz and Committee Members,

I write today on behalf of AHIP to respectfully oppose HB 1416, *Freedom of Choice in Health Care Services*. We appreciate the opportunity to provide comments and your consideration of our concerns.

Every American deserves access to affordable, comprehensive, high-quality coverage and care. Health insurance providers are committed to working together to encourage more robust competition, which is essential to providing North Dakotans with more health care choices, better quality, and lower costs.

HB 1416 would require health insurance providers with networks to contract with any health care provider willing to meet the plan's contract terms – even if the health insurance provider's network already includes an adequate and broad array of high-quality providers to meet patient needs and contractual geographic requirements.

While the intent of this mandate, commonly referred as "any willing provider" (AWP), may appear to provide North Dakotans with more health care choices, AWP laws actually impede the quality-of-care patients receive, increase health insurance costs, provide some parties with an anti-competitive advantage, and further limit North Dakota employers' and consumers' choices of health plans that fit their needs.

High prices for health care are driven, in large part, by the high prices charged by hospitals, providers, and drug manufacturers[1]. From consolidated hospital markets, to private-equity-controlled physician groups, and anti-competitive contracting practices, there are already too many ways in which the competition that would lower health care prices for consumers is being impeded. We should be working to restore, rather than impede, competition in our health care system. For the reasons discussed below, AHIP is opposed to HB 1416.

- **AWP laws make it more difficult for health insurance providers to negotiate discounts from doctors and hospitals, which can lead to higher premiums for consumers.** There is wide variation on prices that doctors and hospitals charge for services. Requiring health plans to contract with "any willing provider" reduces a health insurance providers' ability to obtain

[1] AHIP, Where Does Your Health Care Dollar Go?, September 6, 2022.

price discounts. For years, the Federal Trade Commission has expressed concerns about the impact AWP laws have on competition.

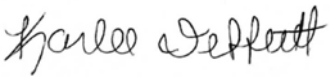
- **HB 1416 would create a presumed "right to employment or contract" -- a right that does not exist in any other industry, or even elsewhere within the health care sector.** Initiating an AWP mandate destroys incentives for improved competition and provides health care providers with rights not given to other service providers. For example, schools are not required to hire "any willing teacher", airlines are not required to hire "any willing pilot", physician group practices are not required to admit "any willing doctor", and hospitals are not obliged to accept any willing physician, nurse, or other health care professionals.

- **Quality of care diminishes with universal acceptance of all interested providers.** High-value provider networks are a critical tool health plans utilize to reduce costs and ensure their members have access to, and receive care from safe, qualified providers. High-quality care, that is also cost-effective, should be the focus of carriers and legislators alike. By forcing a health insurance provider to accept any provider who states a willingness to meet contract terms, AWP requirements undermine a health plan's effort to ensure only the doctors and hospitals that provide the highest quality and most cost-efficient care are available to their enrollees.

AHIP is committed to working with federal and state leaders on solutions to improve competition, access, and affordability for everyone. AHIP believes greater competition means more consumer choices and more patient control over their health care. AHIP's *Healthier People Through Healthier Markets* initiative lays out a roadmap designed to improve competition in key areas of our health care system to increase affordability and access for every American. We would welcome the opportunity to work with members of the Human Services Committee to highlight best practices in delivering more choices, better quality, and lower costs.

Thank you for the opportunity to provide feedback. We appreciate your consideration of our concerns and look forward to continuing to work with you on this important issue. For additional information and questions, please contact me at ktebbutt@ahip.org or 720-556-8908.

Sincerely,



Karlee Tebbutt
Regional Director, State Affairs
AHIP – Guiding Greater Health

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

February 6, 2023

House Human Services Committee
HB 1416

CHAIRMAN WEISZ AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP. AHIP opposes this bill and asks for a no vote.

I call your attention to written testimony submitted by Karlee Tebbutt, AHIP's regional director for North Dakota. It provides an abundance of data to support a no vote.

In addition, your own Employee Benefits Committee, meeting last Friday, voted to give this bill an unfavorable recommendation, based on analyses from Deloitte Consulting, LLP – the international consulting firm contracted by the Legislative Council – and on comments from your own Public Employees Retirement System.

While the intent of this bill may seem like a straightforward approach, these mandates end up having the opposite effect. They actually impede the quality-of-care patients receive, increase costs, and harm market competition.

By forcing health plans to accept any provider who states willingness to meet contract terms, these "any willing provider (AWP) " requirements undermine efforts to provide access to doctors and hospitals with a track record of providing the highest quality and most cost-efficient care to patients.

Requiring health plans to contract with any willing provider reduces their ability to obtain price discounts and conduct effective utilization review due to interference with standard contracting principles. In the past, the Federal Trade Commission (FTC) has expressed concerns about AWP laws because they make it more difficult for health plans to negotiate discounts from providers, which can lead to higher premiums for consumers. The provision of high quality care that is also cost-effective should be everyone's focus.

AWP mandates destroy incentives for improved competition, giving health care providers rights not given to other service providers. For example: schools are not required to hire “any willing teacher;” airlines are not required to hire “any willing pilot;” physician group practices are not required to admit “any willing doctor;” and hospitals are not obliged to accept any willing physician, nurse, or other health care professional. This creates a presumed “right to employment or contract” -- a right that does not exist in any other industry or even elsewhere within the health care sector.

Health plans are motivated to assure that they have enough qualified providers in their networks so patients have adequate access to a broad array of providers. Given the market forces already in place as well as the cost and quality implications to consumers and the adverse effect on market competition of this proposal, we respectfully request a no vote on HB 1416.

Thank you for your time and consideration. I’d be happy to answer any questions.

HB 1416
Patient Choice

- House Human Services Committee
- February 6th, 2023

North Dakotans for Open Access Healthcare

Duncan B. Ackerman, MD

Duncan B. Ackerman, MD

- Born and raised in Minot, North Dakota
- Graduate from Minot High School
- Undergraduate education -- Concordia College Moorhead, MN
- Medical School -- University of North Dakota School of Medicine and Health Sciences
- Orthopedic Surgery residency -- Mayo Clinic Rochester, MN
- Hand and Microvascular Surgery Fellowship -- Mayo Clinic Rochester, MN
- Partner at The Bone & Joint Center Bismarck, ND
- Partner at Bismarck Surgical Associates Bismarck, ND

HB 1416

- The genesis of the bill is patient choice of health care provider
- HB 1416 allows patients to choose the providers they know and trust
- Our rural state, our small resident population, and our small population of health care providers makes insurance plans with ZERO out-of-network coverage difficult on consumers

HB 1416 History

- 2021 Legislative Session similar bill – HB 1465

- HB 1465
  - DO PASS out of Human Services Committee. Passed House Floor.
  - Was converted to study after significant debate in the Senate Human Services Committee. Passed as a study on the floor

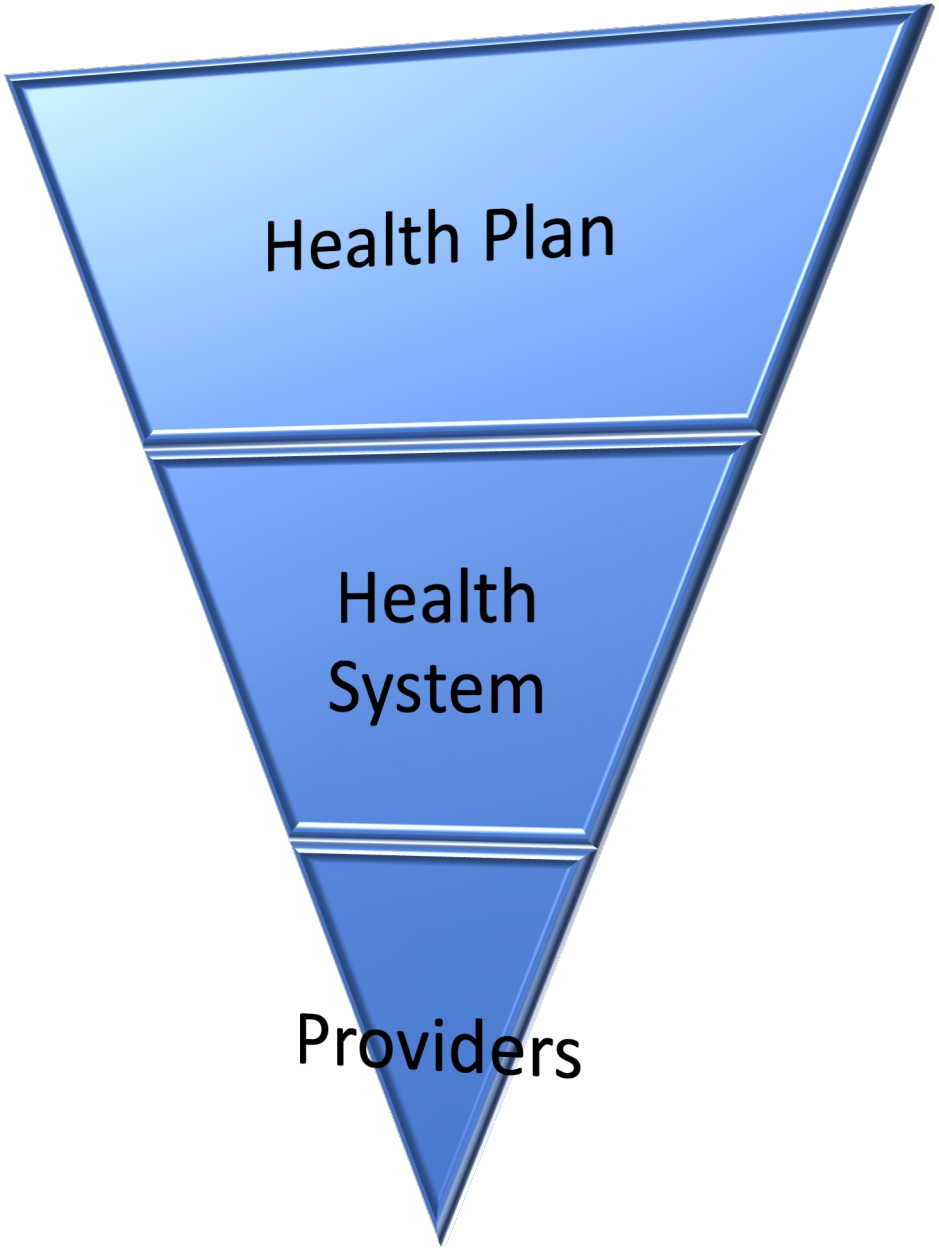
What did we learn?

- Significant discussions:
  - Patients
  - Providers
  - Independent Critical Access Hospitals
  - Independent medical practices
  - Independent medical facilities
  - Medical Associations
  - Insurance carriers

What did we learn?

- We learned the common concern was the Vertically Integrated Healthcare Delivery Network in North Dakota
- Vertically Integrated Network (VIN)

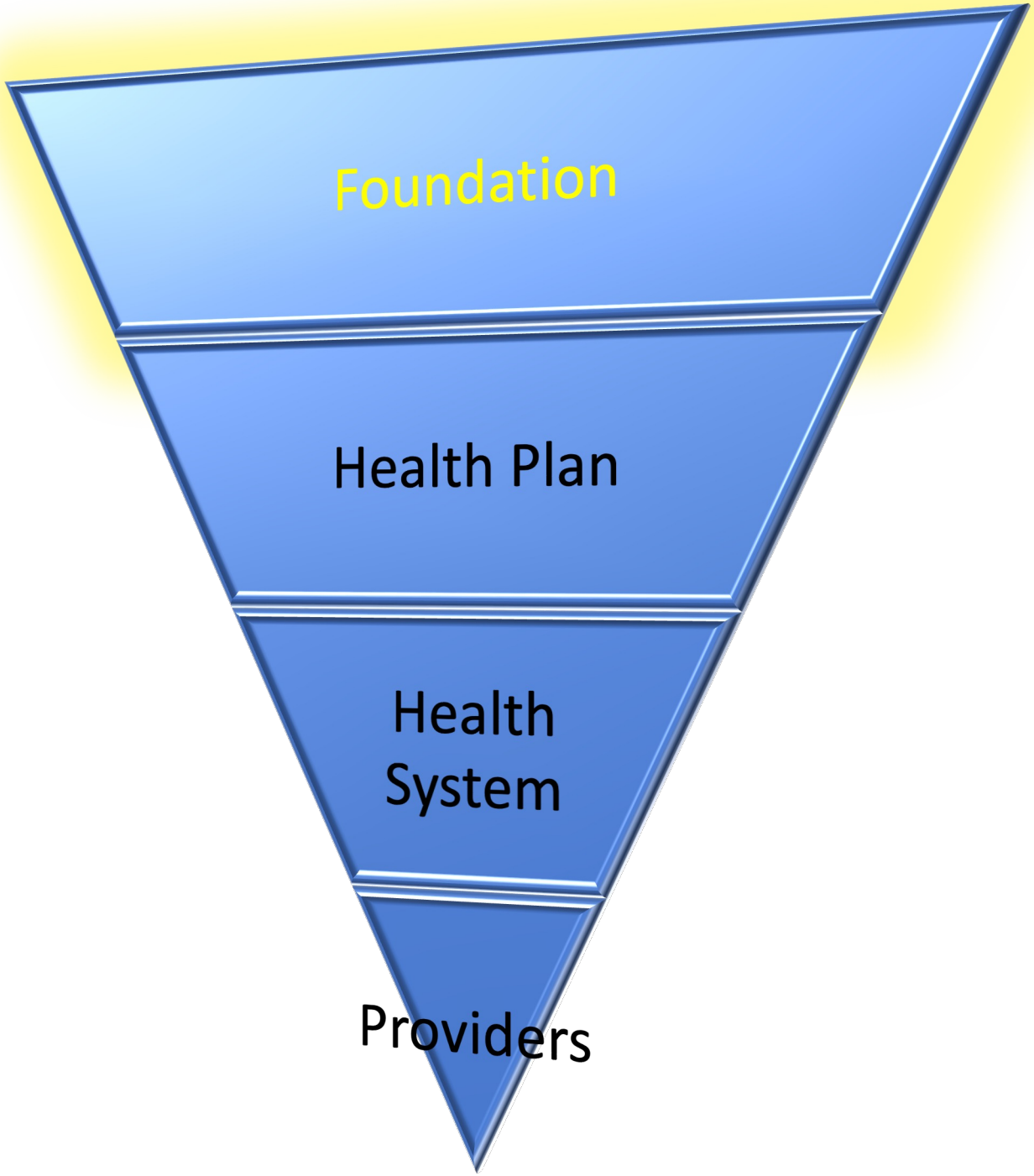
What is a Vertically Integrated Network (VIN)?



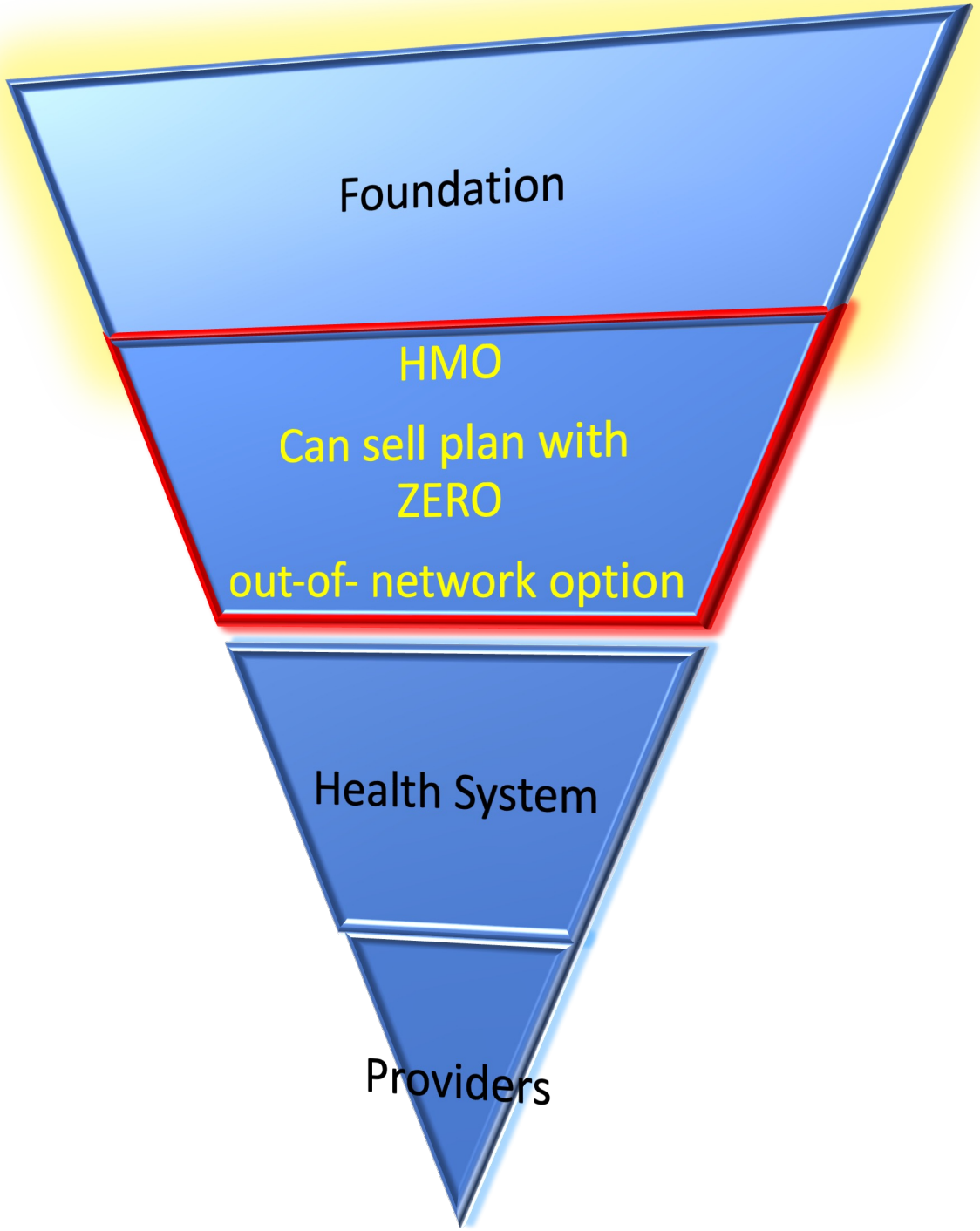
Vertically Integrated Network (VIN)

VIN houses the health plan, the health system, the providers and services provided

Distinct Advantages of VIN in North Dakota, Large Foundation

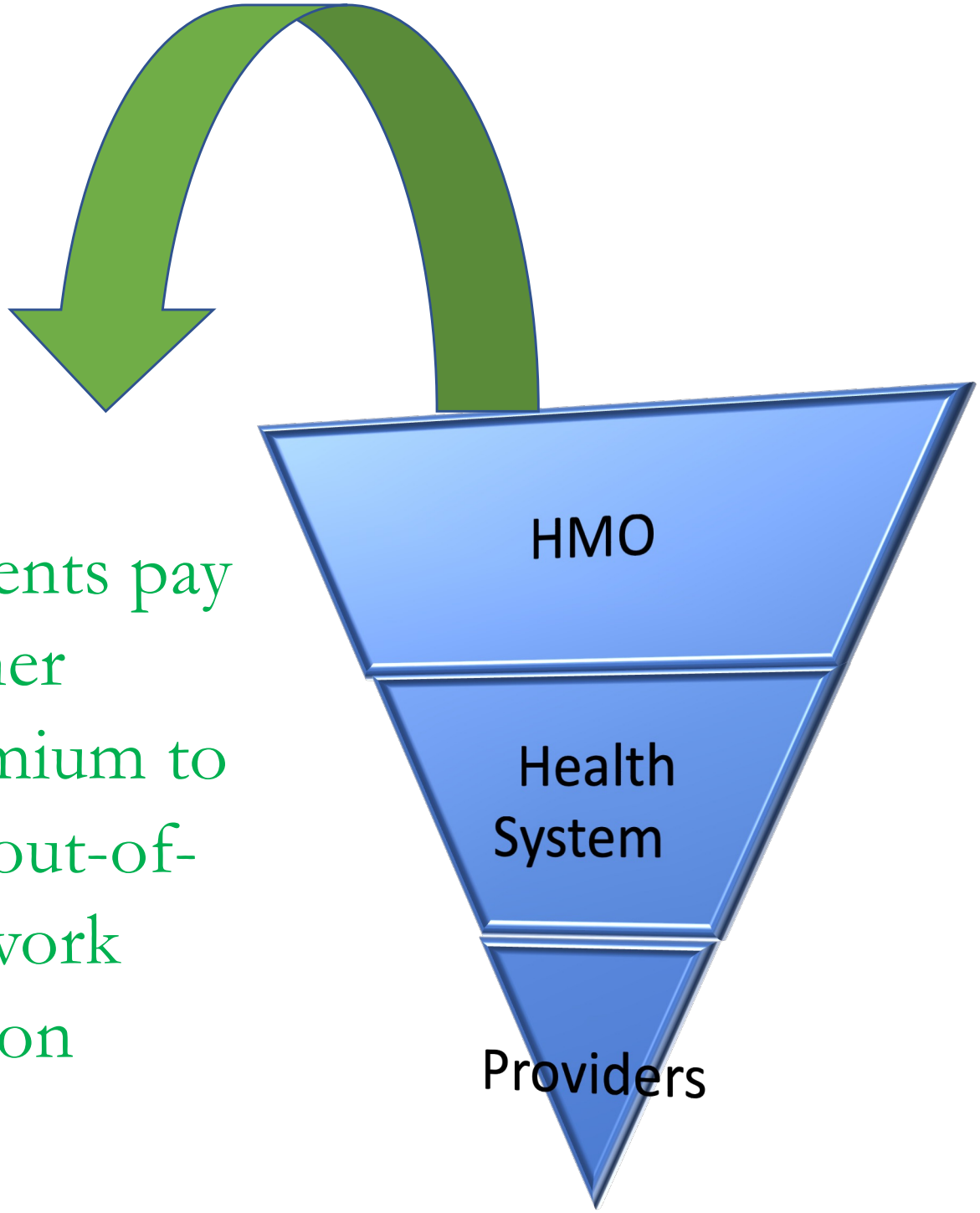


Distinct Advantages of VIN in North Dakota, Health Maintenance Organization (HMO)

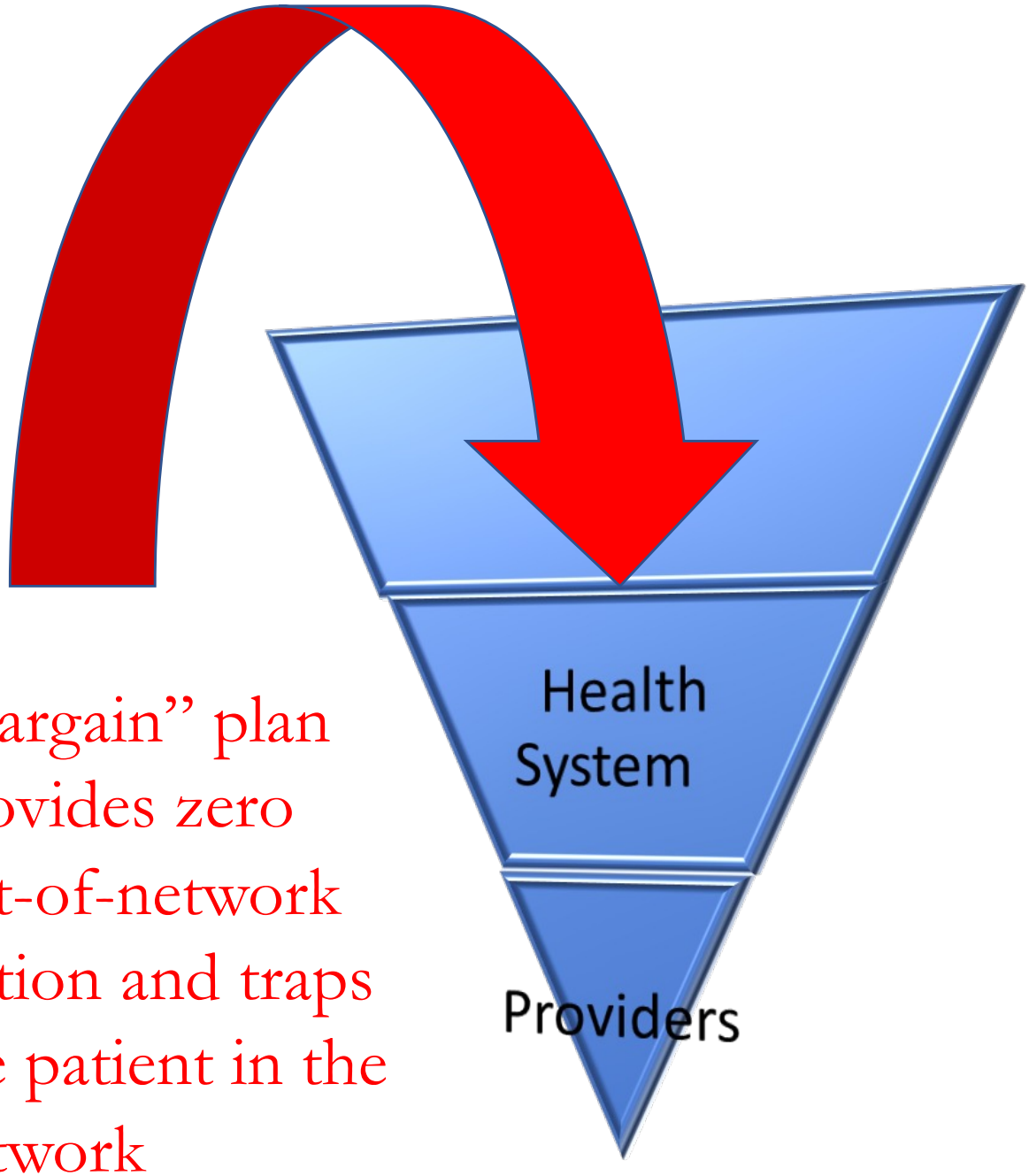


Distinct Advantages of VIN in North Dakota, HMO

Patients pay higher premium to get out-of-network option



Distinct Advantages of VIN in North Dakota, HMO



"Bargain" plan provides zero out-of-network option and traps the patient in the network

Financial Disparity Should NOT handcuff a patient's ability to choose a health care provider

- In 2014, a similar bill (Measure 17) was passed in South Dakota, with 61.81% of South Dakotans support.

- "Those who want more choice and are willing to pay more for it have that option."
  Dave Hewett, South Dakota Associations Of Healthcare Organizations.

- That comment should resonate….and so should the following question……what if you are unable afford to pay more for that choice?

- What if your employer doesn't allow an out-of-network option?

- HB 1416 answers these questions

Question from last session..can HB 1416 Apply to HMOs?

- **2013 Wyoming Statutes**
  TITLE 26 - INSURANCE CODE
  CHAPTER 34 - HEALTH MAINTENANCE ORGANIZATIONS
  26-34-134. Written agreement with providers; discrimination prohibited.
- **Universal Citation:** WY Stat § 26-34-134 (2013)
- 26-34-134. Written agreement with providers; discrimination prohibited.

- In no event shall any Wyoming provider willing to meet the established terms and conditions be denied the right to enter into any written agreement.

- Wyoming: https://law.justia.com/codes/wyoming/2013/title-26/chapter-34/section-26-34-134

Question from last session..can HB 1416 apply to Employee Retirement Security Act plans (ERISA)?

that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 00–1471

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS *v.* JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[April 2, 2003]

http://supct.law.cornell.edu/supct/html/00-1471.ZS.html

https://www.crowell.com/NewsEvents/AlertsNewsletters/all/US-Supreme-Court-Upholds-Kentucky-Any-Willing-Provider-Laws-that-Restrict-HMOs-Ability-to-Select-Providers

Question from last..session can HB 1416 apply to ERISA plans?

- YES, There is legal precedence that HB 1416 can be applied to HMOs and self-insured ERISA plans.

What is the main argument against HB 1416?:

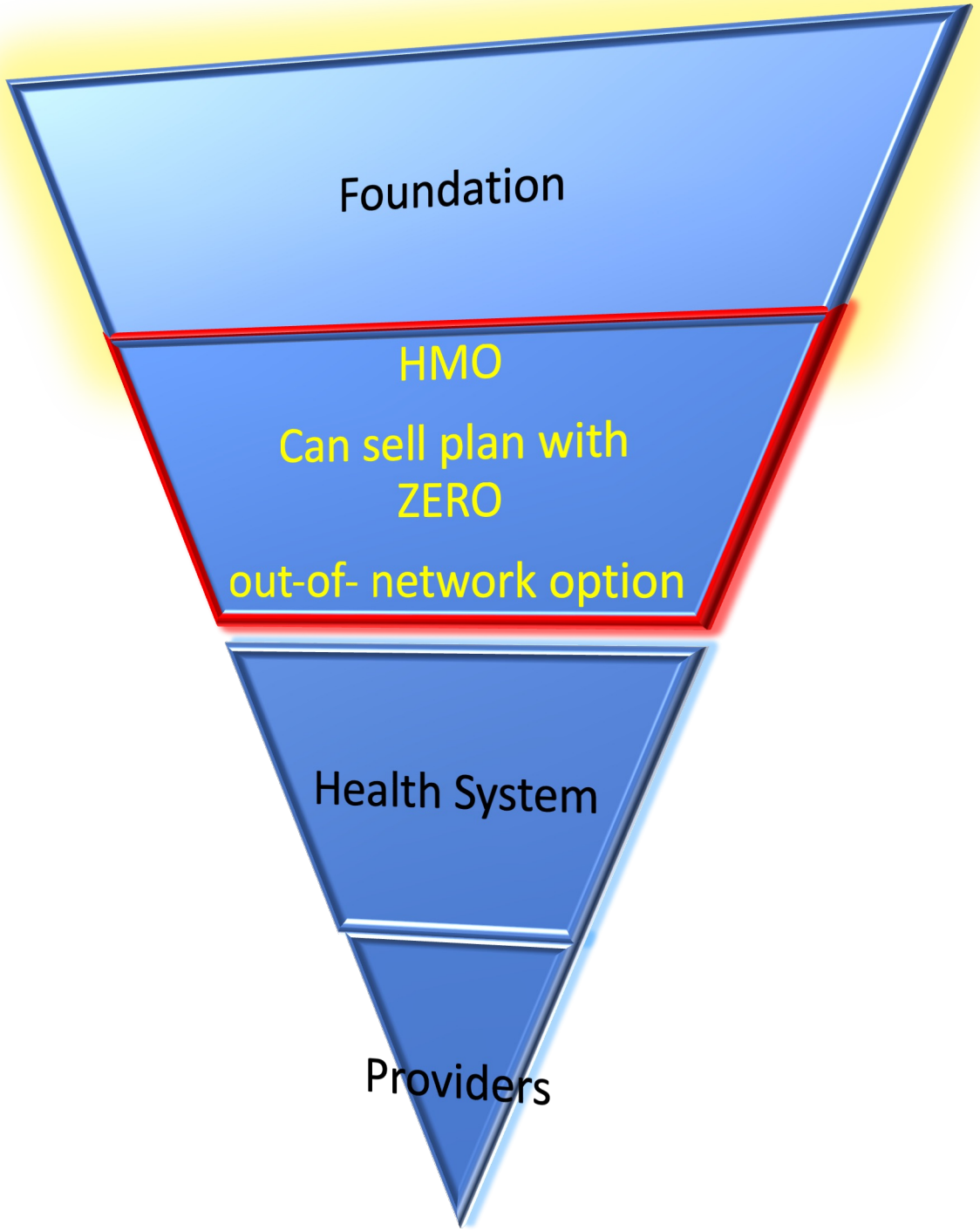
Increase cost

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

North Dakota Legislative Management

Interim Healthcare Study, Final report January 2021

Does the VIN model in North Dakota promote competition?



California Health Care Foundation

CF Our Work The CHCF Blog Publications Grants Innovation Fund Events

CHCF BLOG

Is Vertical Integration Bad for Health Care Consumers?

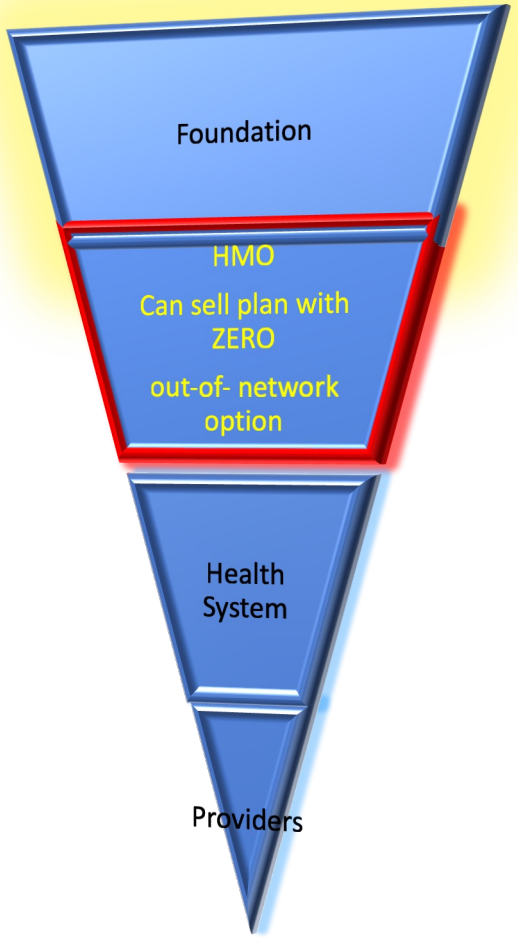
Stories that caught our attention this week

JUNE 21, 2019

[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

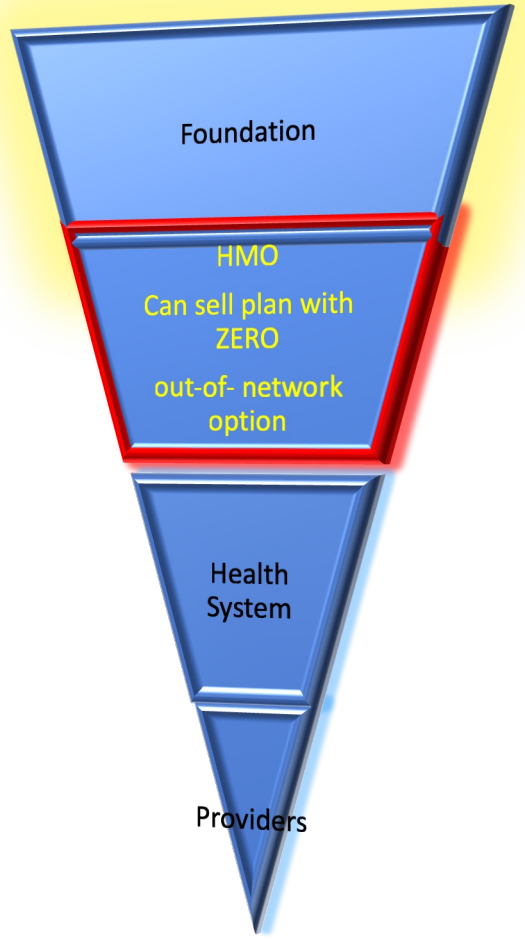
- "vertical integration can easily enable market power to use in an anticompetitive manner, allowing the merged firm to use its new structure to the disadvantage of others, and in some cases, to the harm of consumers."



Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)

Summary to article:

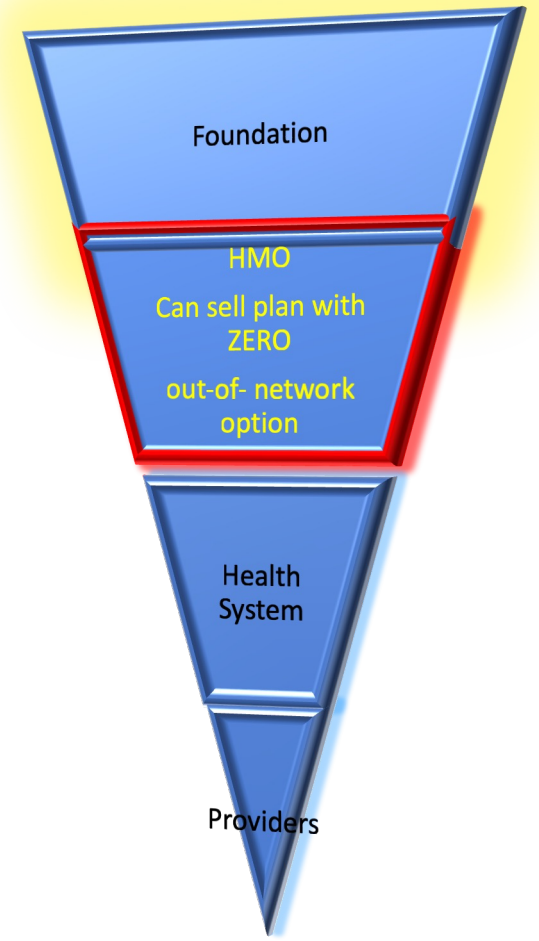
- "hospital ownership of physician practices leads to higher prices and higher levels of hospital spending."



[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

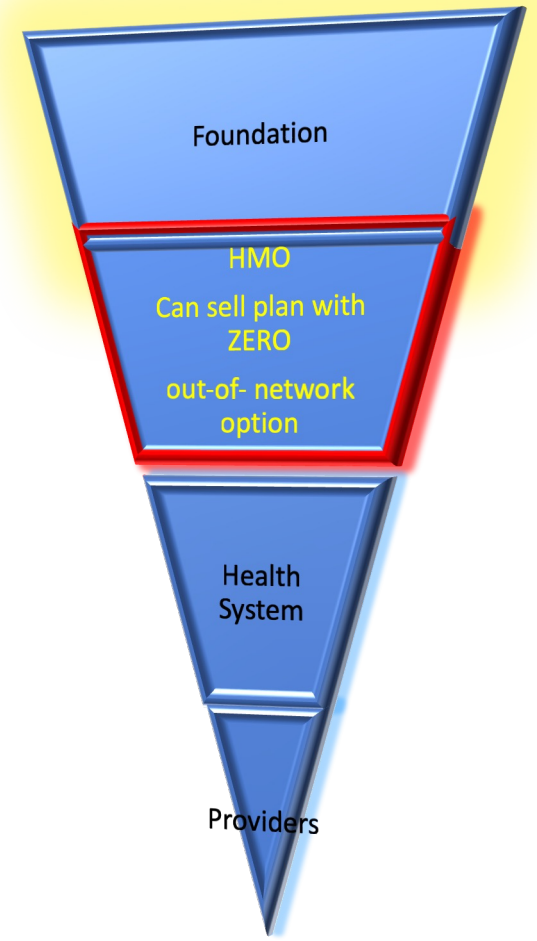
- Vertical integration increased hospital's bargaining power with the insurers, meaning the dominant hospitals can demand higher costs and limit competition.



[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

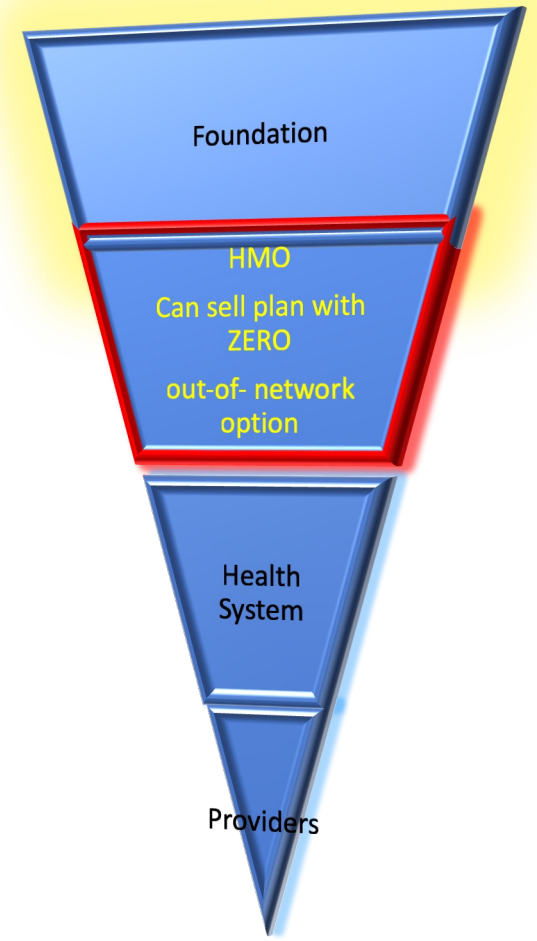
- Physician groups owned by large hospital systems were more than 50% more expensive than those owned exclusively by physicians.



[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

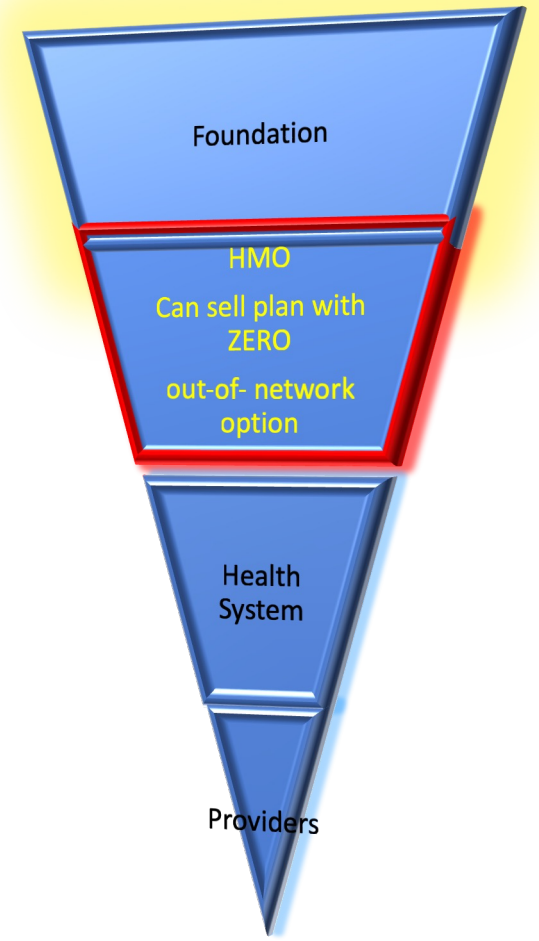
- Recent increases in vertical integration in California were associated with higher prices for primary care, more expensive specialty care, and higher health insurance premiums.



[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

- “Physician-Hospital integration did not improve the quality of care for the overwhelming majority of quality measures.”



Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)

STATE EFFORTS TO ADDRESS HEALTH CARE CONSOLIDATION AND COSTS

THE SOURCE
ON HEALTHCARE PRICE & COMPETITION

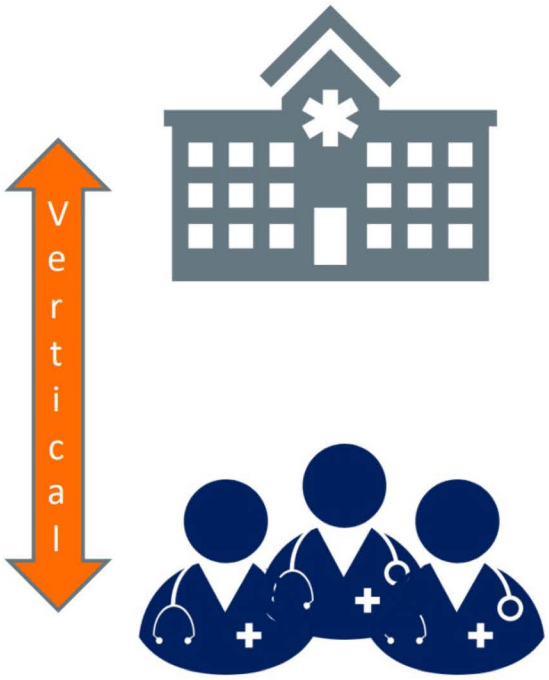
September 14, 2021

Katherine L. Gudiksen, Ph.D., M.S.

WHY ARE U.S. HEALTHCARE PRICES SO HIGH?

- Failure to protect a free market – lack of transparency
- Failure to protect competition and rigorously enforce antitrust laws
- Failure of policymakers to act when competition no longer exists

DATA ON RESULTS FROM HEALTHCARE MERGERS



Vertical Mergers

- **Higher Physician Prices**: Physician prices increase post-merger by an average of 14%
  (Capps, Dranove, & Ody, 2018)
  - Cardiologist prices increased by 33.5%
    (Capps, Dranove, & Ody, 2018)
  - Orthopedist prices increased by 12-20%
    (Koch and Ulrick, 2017)
- **Higher Clinic Prices:** Hospital-acquired clinic prices increased 32–47% within four years
  (Carlin, Feldman & Dowd, 2017)
- **Higher Hospital Prices** (Baker, Bundorf, Kessler, 2014)
- **Little to no quality improvements** (McWilliams et al. 2013; Neprash et al. 2015; Short and Ho, 2019)

Issue Brief

Hospital and Provider Consolidation: Negative Impact on Affordability for Consumers

November, 2014

America's Health Insurance Plans

AHIP Statement for Senate Hearing Highlights Concerns About Vertical Provider Consolidation

Article

PUBLISHED JUN 12, 2019 • BY AHIP

How Hospital Consolidation Hurts Americans

Article

PUBLISHED AUG 26, 2021 • BY AHIP

Lower hospital competition equals higher health care costs

Diminished quality of care

VERTICAL INTEGRATION AND THE MONOPOLY PROBLEM*

CORWIN D. EDWARDS
Bureau of Industrial Economics, Federal Trade Commission

Corwin D. Edwards. Journal of Marketing Vol.17, No.4 (Apr, 1953), pp. 404-410

VERTICAL INTEGRATION AND THE MARKET POWER CRISIS

ISSUE BRIEF BY **ADIL ABDELA**, **KRISTINA KARLSSON**, AND **MARSHALL STEINBAUM**
APRIL 2019

We define "market power" as the ability to skew market outcomes in one's own interest, without creating value or serving the public good.

This "walled-garden" business model has harmed consumers, independent content creators, and innovation.

RI-Vertical-Integration-and-Market-Power-Crisis-Issue-brief-201904.pdf (rooseveltinstitute.org)

VERTICAL INTEGRATION AND THE MARKET POWER CRISIS

ISSUE BRIEF BY **ADIL ABDELA**, **KRISTINA KARLSSON**, AND **MARSHALL STEINBAUM**
APRIL 2019

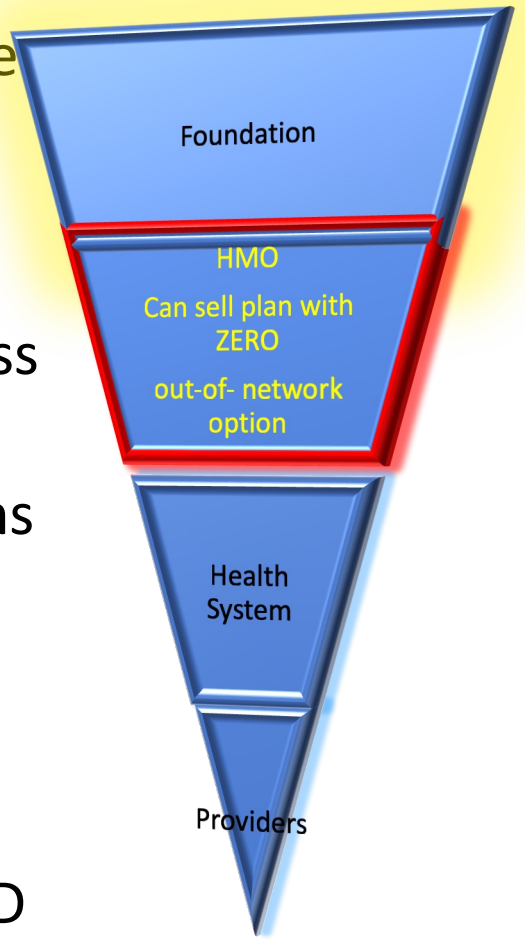
We define "market power" as the ability to skew market outcomes in one's own interest, without creating value or serving the public good.

The real problem is the legalization of highly profitable business models that suppress competition and exploit stakeholders throughout the supply chain, no matter how large or small the parties to any given merger are.

Is ND at risk of a monopoly in healthcare?

YES

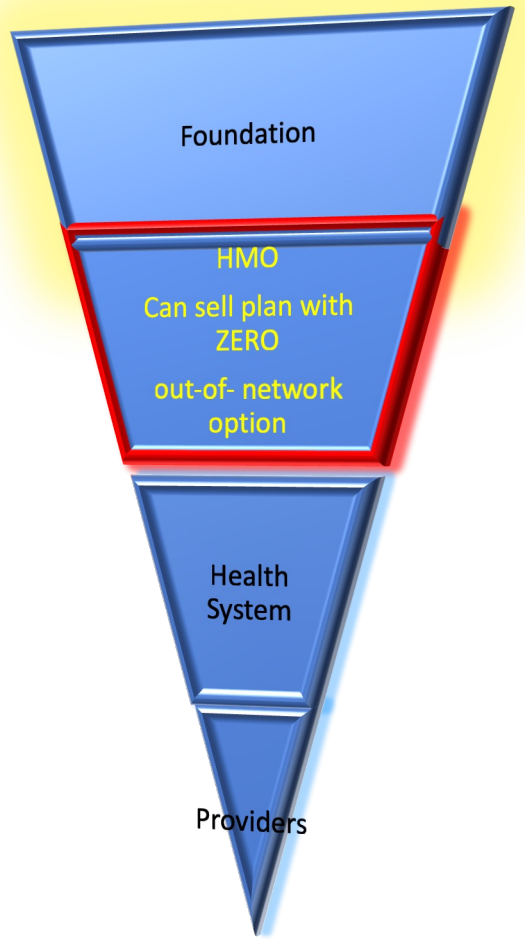
1) Vertically Integrated Network
2) Large foundation to support anti-competitive growth
3) HMO with zero out-of-network options, with planned expansion across ND
4) Struggling health systems at risk for consolidation
5) Struggling provider practices at risk for consolidation
6) Difficulty to recruit to ND in an anti-competitive environment = less competition



Is ND at risk of a monopoly in healthcare?

YES

1) HB 1416 - Allowing patients to choose a trusted provider helps solve one small piece of the monopoly risk



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

North Dakota Legislative Management

Interim Healthcare Study, Final report January 2021

How will HB 1416 control or even decrease cost?

1) HB 1416 – Is not “any willing provider” at “any willing price” - provider still needs to negotiate and meet the terms and conditions to participate
2) Fail First mechanisms employed by insurance companies
3) Independent provider practices cannot provider base bill (bill facility fee and professional fee)
4) Provide access to Ambulatory Surgery Centers vs Hospital Outpatient Departments (ASC up to 50% cost savings vs HOPD)
5) Patient access to the providers they need, avoid redundant visits
6) Value based contracting arrangements

Deloitte.

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

Tel: 612 397 4463
Fax: 612 692 4463
www.deloitte.com

Memo

Date: January 24, 2023

To: Scott Miller
Executive Director, North Dakota Public Employees Retirement System

From: Tim Egan & Dan Plante & Drew Rasmussen, Deloitte Consulting LLP

Subject: **ACTUARIAL REVIEW OF PROPOSED HOUSE BILL 1416**

"Deloitte's comments are limited to the scope of the uniform group insurance program. The legislation is anticipated to have a financial impact on the uniform group insurance program but the impact cannot be estimated with confidence because the costs will be dependent on provider contracting arrangements with the health insurer that administers the uniform group insurance program"

Deloitte.

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Subject: **ACTUARIAL REVIEW OF PROPOSED HOUSE BILL 1416**

"Conceptually, eliminating the ability for health insurers to exclude any providers from their networks removes some of the incentive for providers to agree to competitive reimbursements. The average discounts agree to by health systems (e.g., usually 30-40% for hospital care) could be reduced, or eliminated, IF providers could charge higher rates without any impact to patient volume. Any reduction in the discounts could lead to significant increase in health insurance premiums for all covered participants under the uniform group insurance program."

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50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

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Memo

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To: Scott Miller
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Subject: **ACTUARIAL REVIEW OF PROPOSED HOUSE BILL 1416**

program includes 100% of hospitals and over 96% of physicians in the State. Given the breadth of the network participation in the State, the legislation may not have the effect of expanding provider participation. Additionally, since there is such broad provider participation, the financial impact of the proposed legislation could be immaterial if provider reimbursement rates do not increase as a result of the legislation (since there are no hospitals and relatively few providers that are not under contract today).

What HB 1416 Does Do?

Allows patient to see the provider of their choice, IF the provider agrees to the terms and conditions established by the insurer

Allows insurance companies to determine the terms and condition offered to the provider

Increases competition

Gives patients the choice to request access to a local provider instead of traveling great distances to see in network providers

What HB 1416 Does Do

Lowers cost by allowing patients to select lower cost centers

Allows patients to select and out of network option when no option exists

Decreases the risk of future health care monopolization in North Dakota

HB 1416
Patient Choice

- House Human Services Committee
- February 6th, 2023

TESTIMONY OF SCOTT MILLER

House Bill 1416 – Health Care Providers

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in opposition to House Bill 1416.

The bill requires health insurers, including the Medicaid program, which is part of an integrated delivery network or policy directly affiliated with, or administered for, a health care provider may not exclude any provider from the network that is licensed in the State, is located in the geographic coverage area of the health benefit plan, and is willing and qualified to meet the terms and conditions of participation, as established by the health insurer

This bill arguably creates a mandate regarding health insurance "payment for specified providers of services". Assuming this is a health insurance plan payment mandate, this bill does not appear to comply with the statutory requirement in NDCC section 54-03-28(3) that health insurance plan mandates first apply to NDPERS. I do not know whether a cost-benefit analysis has been requested or received. Pursuant to NDCC 54-03-28, both of those issues must be corrected before this Committee can act on HB 1416.

Consultant Notes:

- The legislation is anticipated to have a financial impact on the uniform group insurance program but the impact cannot be estimated with confidence because the costs will be dependent on provider contracting arrangements with the health insurer that administers the uniform group insurance program
- Creating and maintaining provider networks is a core function of a health insurer. A primary reason that health insurers develop provider networks is to reduce the cost of care.
- Conceptually, eliminating the ability for health insurers to exclude any providers from their networks removes some of the incentive for providers to agree to competitive reimbursements.
- However, according to Sanford Health Plan, the provider network for the uniform group insurance program includes 100% of hospitals and over 96% of physicians in the State. Given the breadth of the network participation in the State, the legislation may not have the effect of expanding provider participation.
- Additionally, since there is such broad provider participation, the financial impact of the proposed legislation could be immaterial if provider reimbursement rates

do not increase as a result of the legislation (since there are no hospitals and relatively few providers that are not under contract today).

- Participating network providers agree to not balance-bill any patients for amounts above the contracted in-network reimbursement rates. Without this provision, participants may receive unexpected bills from their providers for amounts not covered by insurance.

To The Office of North Dakota State Legislature,

Pinnacle Health Care is a pediatric and family medicine clinic located in Fargo, North Dakota. We support bill HB 1416.

As an independent health care facility our focus is on providing quality, affordable, and accessible care to our community. Quality health care depends upon trust and availability between patient and providers. Our patients are affected by closed networks that limit their access to providers whom they trust with their well-being.

Narrow networks are a barrier between business opportunities for growth in our area.

Thank you for your time.

The Team at Pinnacle Health Care

2829 University Drive S Suite 204

Fargo, ND 58103

FARGO CENTER FOR DERMATOLOGY
MEDICAL | SURGICAL | AESTHETIC

www.fargoderm.com
Phone 701-478-8780
Fax 701-478-8781

3/12/2023

To Dear Madam Chair Lee, Vice Chairman Cleary and members of the Senate Human Services Committee:

RE: Support of HB 1416 Legislative Bill to eliminate restrictive networks and improve patient access

I am writing on behalf of my patients and to serve as their healthcare access advocate. I am a board-certified dermatologist from North Dakota, graduate of University of North Dakota Medical School and I have provided dermatology care to the patients of North Dakota since 2008. I have lived my entire life in the great state of ND except for the time I had to leave the state to get my dermatology residency training. In my almost 15 years of clinical practice in ND, I have been able to see the evolving negative impacts over the years as restricted insurance networks have increased in numbers and narrowed in access and greatly affected patient access. I will speak specifically to the negative ramifications I have seen in dermatology with these restricted insurance networks. Although I will share direct dermatology access struggles I encounter, my patients also share their struggles with me on access for other general and specialty medical care in the state of ND. I am frequently reminded by my patients that this issue expands way beyond the field of dermatology.

These scenarios occur in all ages from infants to the elderly that we see in our dermatology clinic. Some of the most common scenarios I have seen due to network restrictions are delay of care or lack of time appropriate care due to not having access to a dermatologist across the entire state. A common scenario is seeing patients who have delayed diagnosis of skin cancer or advanced stage melanoma skin cancers that could have had different outcomes if they had been given access to diagnosis and treatment earlier. I see delay in severe atopic dermatitis, psoriasis, rashes, autoimmune skin disease that have led to advanced disease requiring unnecessary hospitalizations and requiring systemic immunosuppressant drugs due to delay or lack of dermatology access. I personally witness all too frequently the unnecessary morbidity of a disease that could have been lessened or all together prevented if a patient had not encountered these unnecessary restricted network barriers. It has been a slow and steady increase in restrictions for my patients over the last 15 years and never have I seen such an administrative barrier to patient access as I have in the last 2-3 years. Patients are now being asked to be their own medical advocate to navigating around these administrative barriers and are being put in scenarios that they are not equipped. Most of these patients do not have the medical knowledge to be taking on the tricky and ever-changing rules and regulations of insurance approvals and requests to be seen outside of their network if medical necessary. Medical Providers including myself are frequently being asked to assist the patients with these approvals and appeals and insurances are now asking medical providers to write more and more letters of appeals and to schedule lengthy phone call appointments with the medical reviewers of these insurance companies to verbally advocate for their patients and explain why these patients need to be seen outside of their restricted network. Many of times, these medical reviewers from the insurance company that I am asked to schedule an appeal phone appointment have no knowledge or expertise in dermatology and some are not even Medical Doctors. Dermatology access for patients in general is difficult right now in the state of North Dakota and definitely exists in many other areas of medicine. The time that all these written and verbal phone appeals are taking from our patient care time are compounding the access issues by taking our time away from just being able to see other patients. Instead of seeing patients, I have now had to increase the percentage of my time spent on these unnecessary administrative steps. I currently chose to do this as my number one priority is great patient care and outcomes. I do not feel the current administrative burden and the pace at which it is increasing is sustainable nor appropriate for medical providers or patients. In the end, the medical care of the residents of North Dakota will be increasingly compromised if something is not changed.

I will be testifying on March 14th, 2023, in support of bill HB 1416 and I will be bringing one of my patients who is currently a victim of this administrative process to testify and tell her personal story. She is a patient who had a recent diagnosis of cancer and has been stuck in the administrative process of her restricted network and unable to get her cancer treated not because she does not have access to a dermatologist to care for her, but because she

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has not able to get into the restricted network that her insurance has restricted her to. She has spent countless hours calling her insurance with no reasonable outcomes and is emotionally exhausted and defeated. She is losing sleep over not being able to get her cancer treated and being asked to navigate the complicated medical appeal process as a non-medical person. I wish I could tell you this patient's scenario is unique. Many patients are in this circumstance, and this just happens to be THE patient in this common scenario THIS week as we present this issue in Bismarck. I am advocating for my patients and for ALL the patients of North Dakota. I hope that you do no not find yourself, your family, your friends, or your constituents in this situation in the weeks that follow. Unfortunately, there has been and will be others in this situation continually if something does not change.

Common scenarios I have seen over the last couple of years:

- Dermatology patients that I have seen for over a decade and taken care of their numerous skin cancers or severe complicated skin diseases that are now being told by their network insurance restrictions that they can NO longer be seen by their established dermatologist but instead must wait 6-12 months to get into a new dermatologist unfamiliar with their disease or history in their network when some need to be seen much more often due to urgent disease and rapidly progressive disease. Or they are asked to be seen now by a non-physician provider in their network when their complex disease requires them to see a highly trained board-certified dermatologist.
- Long waits for patients to even get into ANY dermatology provider (non-physician provider, PA or NP in their network), only to learn they have a skin cancer but then can't get into their dermatology surgeon in their network (MD) for 3-9 months for treatment. These patients will often choose to leave their network as their anxiety tells them appropriately that they should not wait many months to treat a skin cancer or other urgent needs. (Patient is left with unnecessary stress and financial impacts)
- Patient will drive from hours away for an appointment desperately from across the state of ND to see us via their only cash pay option for their office visit, then they are faced with a decision on how to afford their needed procedures, biopsies, and skin cancer removal procedures that we deem medically necessary. Their restrictive insurance networks would rather have their network patients wait many months and delay their cancer diagnosis or treatments instead of covering their medical care available at an out of network facility.
- There is a small percentage of patients that are financially fortunate enough that get so desperate for care that they chose to go outside of their restrictive networks and elect to cash pay for services at our clinic because they become so desperate to treat their diseases. Unfortunately, most patient do not have this financial ability.

I have tried to be an advocate for my patients. In Healthcare, we are trained to put the patient first. I ask all those reading this letter to put themselves or their family members in this situation. Would you not hope someone would advocate for you or your family member if you have cancer or a debilitating dermatological condition that affects your ability to work or affects your daily quality of life. Please reach out to me with any further information or questions as I would feel fortunate to continue to advocate for my fellow North Dakota patients. I feel that North Dakota has some of the best health care providers in the country and want to make sure all our citizens have the ability to access this great care.

Thank you for your time and consideration,

Rachel Ness

Rachel Ness MD, FAAD, Board Certified Dermatologist
Lifelong North Dakota Resident
Faculty at University of North Dakota School of Medicine and Sciences
701-306-6757
ness@fargoderm.com

HB 1416 Opposition from Tim Deitemeyer, Independent Insurance Agent Fargo ND.

Thank-you members of Senate Human Services Committee for having these hearings and taking input from concerned parties on behalf of the great people of ND!!

I'm Tim Deitemeyer an independent insurance agent in Fargo and since 1995 I've been working with ND individuals, families, and small businesses in person to help navigate and secure affordable and quality health insurance.

Please oppose HB 1416, while the description, "freedom of choice for health care services" sounds great, who wouldn't want that, but if this bill was to pass it would eliminate choice and lead to ND health insurance consumers paying a significantly higher price for additional health insurance they don't need or utilize. Why be forced to pay for something you do not use? Especially when you have the option on an annual basis to pay more for something you choose to use in the future!

This bill creates more questions than answers: Why is Sanford Health Plans being targeted within Section 1: C. "Integrated delivery network"? Aren't their already rules and laws that HMO's, healthcare providers, and health insurance companies operate within? What gives the right for Government to dictate what entities have network design options and what entities do not have network design options? What about the consumer who has always utilized a certain healthcare system for their healthcare and is willing to continue utilizing that system for their non-emergency healthcare, why can't they have the option to have a significant reduction in health insurance premiums for utilizing the system they already use? Why does this bill even mention Medicaid? Why is ND spending taxpayer time and Government resources that eliminate health insurance network design options that work for the people who qualify and choose the option of have having a focused network? How will this legislation if passed be tested in the court systems? What will be the costs of implementing this bill? What will need to be addressed in the next legislative session in ND, will it be a bunch of legislation and efforts to allow for health insurance consumers in ND to have options that are more affordable? Because more affordable options for health insurance for everyday North Dakotan's is what you are looking at eliminating with this bill.

As a health insurance agent, who works directly with consumers in ND of which the majority are in Cass county, there are limited options in designing a health insurance plan that is affordable and helps meet the healthcare needs for the individual, instead of limiting those options further, please allow for ND health insurance consumers to have the option to choose a plan that is somewhat affordable and that works for them! Network design is one of the few areas where health insurance plans can be individually structured for the consumer that lives in a county that allows.

I'm thankful that here in ND that we have competition for healthcare and health insurance, competition is a great way to help and motivate each of us to deliver the best possible service! Competition is restricted when consumer choices are removed, let's not remove the option of health insurance consumers that are in the Fargo and Bismarck area to be able to purchase lower cost insurance!

Please oppose HB1416 and allow for options for the ND consumer to design a plan that works for them.

MILESTONE
HEALTH PARTNERS

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Written Testimony in Support of Bill HBD 1416

My name is Amanda Erickson, I am a physical therapist who owns and works in a small, private practice in Williston, ND. I am in support of HBD 1416 for many reasons. As a mother of 3 small children, I want to have the autonomy to choose who my children and I see for their healthcare needs and not have it based on which insurance I have for our family and the medical experts that are in our network. I feel if we limit the providers that we are able to see for healthcare needs it will decrease the quality of care that we receive. The providers won't have as much competition to keep their schedules full, so the motivation to provider excellent, quality care will decrease. We are becoming a nation full of "freedom of choice" at this point in time, this should not be where we stop with that movement. I urge you to consider passing HBD 1416. Thank you for your time.

Sincerely,

Dr. Amanda Erickson, PT, DPT

Pediatric Physical Therapist

amanda@milestonehealthpartners.com

Testimony in support of House Bill 1416

March 12, 2023

Respected Senate Human Services Committee,

My name is Dr. Steven Jared Broadway and I am a board-certified Neurosurgeon who founded Northern Neurosurgery and Spine in Fargo in January 2020. I graduated from the University of Arkansas for Medical Sciences in 2005, then went on to Neurosurgical residency at the University of Tennessee in Memphis which I completed in 2011. I practiced in Duluth from 2011 until late 2019 when I left the employed model to start my independent practice in Fargo. I had the opportunity to testify in favor of House Bill 1465 during the last session and am happy to reiterate my support today for all patients' freedom of choice for health care services.

Access is key:

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

Cost effective care and patient outcomes:

I am the only surgeon in the Fargo area performing spinal surgery in an ambulatory center. Healthcare is moving more and more toward the outpatient setting as surgical techniques and anesthesia delivery advance. Prior to Fargo, all of my surgical cases were performed in the hospital setting. Now with 3 years of experience performing ambulatory surgery, I can say with absolute confidence that quality and outcomes are excellent, and the cost of care is substantially lower. This not only benefits the patient, but also the insurers and society as a whole. Not allowing patients to choose their provider based on their insurance network contradicts our collective goal as a society to decrease healthcare spending.

Retention:

Everyone involved in this discussion clearly has a commitment to our beautiful North Dakota communities. It is a fact, however, that colder climates and smaller towns result in difficulties in the recruitment and retention of skilled providers. The independent medical community has a lot of "stake in the game" as concomitant small-business owners. Patients want to receive care at home but become disenfranchised when their provider leaves and/or they are referred out due to access or specialty constraints. This is an unfortunate reality, and I truly believe having a rich and robust network of independent practitioners allows for hospitals and healthcare systems to benefit by providing more choices for patients and allowing them to be served within their community. To ensure the viability and growth of these practices, we must come together to support and pass house bill 1416.

I encourage a DO PASS on HB1416

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

Good morning. My name is April Mettler and I am here today in support of Bill 1416 as a health care provider, business owner, and a mother to three; this is the Patient's Choice Bill.

Purpose and passion are two of the cornerstones of my private outpatient physical therapy clinic, CC's Physical Therapy located here in Bismarck. These elements are engrained in the decisions made in all facets of my life and career to benefit not only my own life's well-being but more importantly my patients and family around me. The Patient's Choice bill in discussion today, if passed, will continue to protect our patients and communities from narrow networks, foster a medical community of competitors for excellence, and reduce the risk of higher long term health care costs.

In our practice, addressing physical concerns lies on the forefront of our daily operations. We have made a stake in the industry as the trend setters pushing our profession into higher standards of care and formulating what we like to call PT 2.0. As part of that, our core values are focused on our patients: providing them with excellence, focusing on their personal goals, advocating and assisting in their health care decisions and as we call it "we will change your mind". We are open late, we are open early. We base business decisions with patients' best interests in mind working tirelessly to ensure their needs are addressed in a timely fashion and all necessary information to have their services covered by insurance is completed prior to their visit. The prevalence of narrow network insurance plans presented by our patients has increased significantly over my 12 years of private practice, limiting access to those they said they could "get a referral for". As patients and employers continue to look for ways to save money on escalating out of pocket health care premiums and costs, the eye-catching lights of "lower premiums" is often the driving decision for the patient or employer when selecting their health care plans. It often isn't until these narrow network members call to seek our services they discover their lack of *any* out of network coverage or what "no out of network coverage" really implies. Our opposition to this bill will state that most doctors, upwards of 90%, are accessible through narrow network plans. But in further evaluation, this is only true when looking at the state as a whole and not the focused areas of the state where the plans in question can be offered. How many of us in this room have read their insurance coverage fine print or 135 page manual of coverages and rules in language only known by the authors themselves? This leaves these prospective patients with 3 options: pay out of pocket with no application to their health coverage cost share, attempt to go elsewhere within the narrow network to receive the same skilled services, or not receive coverage at all. Most patients, choose the option of no services rendered due to the inability to find what we offer or simply cannot afford all of the out of pocket expenses associated with cash pay when they already are paying health coverage premiums. Another option, these patients choose the "easy" way out seeking pain management through medications/narcotics to cope with their symptoms as these "services" are covered by their narrow network. Take the 27 year old with debilitating and severe pelvic pain living on her own working a full time job with hours 8-430 Mon-Fri on the outskirts of town that took the narrow network health plan offered by her employer. Our out of network facility is open at 7, provides advanced manual interventions intended specifically for her condition, and has an established relationship with the patient from successfully treated conditions fixed under her parent's health plan at the age of 25. She cannot afford to pay out of

pocket costs and therefore opts for medicating her symptoms that will most likely progress into more severe symptoms leaving her unable to work and a long road of progressive disability due to her condition that could have easily been treated with conservative care in my clinic. My patient doesn't need narcotics or to be on disability. She needs a health care plan that allows her to make her own choice on her place of services.

As a business owner and employer of 13, I have always offered a mid-grade, more expensive open market health care plan in our company to ensure my employees and their families if ever faced with serious medical conditions have the freedom to seek out their choice of healthcare options no matter the distance they desire to travel or where they see the best fit for their care. The importance of this decision came to a head in my own family as we were faced with difficult medical decisions in the care of my second son at the age of 6 months old. Blake was diagnosed with idiopathic hydrocephalus after a 6 month well check gone wrong. Essentially, based on MRI and presentation of symptoms, no one could understand the reason for the sudden onset of excessive cerebrospinal fluid encompassing his brain creating immense pressure on his skull and brain drastically enlarging his head in what felt like a time span of overnight. Asymptomatic hydrocephalus in a child at six months of age lead to prompt discussion and immediate referrals for treatment options that inevitably we got to choose for our child. With the brain, time is a critical factor as once visible signs of damage are observed, the damages are permanent. Brain damage is essentially irreversible. We didn't know how much time we had before the possibility of permanent changes in our child's life would occur. We didn't have time to mess with insurance. We needed to act with vigor and intensity with only our son's best outcomes in mind. In our case, one facility gave us the option of putting a shunt in my child's brain; a shunt he would have to deal with and manage his entire life. The other facility gave us the option of simply "re plumbing" his brain with no down time or lifelong management. Naturally, we CHOSE the physician that had the most confidence and expertise in his treatment plan with no long term ramifications. Choices. We made a medical decision for our child not based on insurance limitations but rather chose the option that we felt best suited us and what we hoped for his life. Had I been an employer trying to cut costs and provide the "cheapest" health care option, we could be living in a much different situation for him and I'm thankful I don't have to think about those decisions anymore.

Members of the committee. I urge you to think about your own medical choice. Do you feel confident the best provider for any condition that could arise in your lifetime or the lives of your family members would always be available in a narrow network plan? Could you rest assured that when faced with a medical crisis the best hands are readily available to serve you with the best in modern practice?

Support Bill 1416 and rest easy that the choice of your medical decisions will continue to be in your hands.

Solace Counseling PLLC
1131 Westrac Dr. Suite 100
Fargo, ND 58103
Phone: (701) 232-0760

SOLACE
COUNSELING

House Human Services Committee,

My name is Brittany Schank and I am the owner of Solace Counseling in Fargo, ND. I am in support of HB 1416 in regards to the Patient Choice Bill. This bill would allow patients to select the providers they know and trust.

Currently, the Sanford Employee plan along with the Sanford True plan does not allow the selection of providers that a patient knows at trusts, these plans require patients to be seen by Sanford providers. This has caused a large number of clients in-eligible to be seen for services at our office. This includes individuals who have been seen by their providers for a long period of time and now being required to change providers due to being a part of the Sanford Employee or Sanford True plans.

Here is just one of many examples taken from a scenario here at Solace Counseling:

A provider saw a child for 2 years and 5 monthly consistently due significant mental health needs.This child had been in inpatient hospital settings due to deteriorated mental health, struggled in school settings frequently, and struggled in the home environment. The child and therapist had a strong relationship and gains were consistently made and many were maintained with consistent therapy sessions. When the child was initially seen, they had North Dakota Medicaid insurance. During the treatment time, the child was adopted and placed under their adoptive parent's insurance, Sanford True Plan. Sanford denied all claims due to the provider not being in-network. An appeal was sent, with a letter from the clinician clearly stating "Not engaging in therapy services and/or terminating therapy services to start with a new provider would likely cause a setback in their mental health and may be detrimental to their mental health and wellbeing." Sanford denied this appeal as well. It is extremely unfortunate that Sanford True and Sanford Employee plans don't even have the option for out of network payment, like most other insurances. Sanford True and Sanford Employee plans are just flat out denying entire services, leaving it up to the member to pay for them. Due to this, the family did not have the funds available to pay out of pocket, and discontinued therapy services. Additionally, Solace Counseling did not feel it

was fair to charge this client for these denials, as this process of going back and forth with Sanford took several months while the child continued to receive much needed mental health services, therefore Solace Counseling wrote off 100% of the amount owed, which was several thousand dollars. This was devastating to the client, the family, and Solace Counseling both therapeutically, clinically, and financially. We are a small business and do not have the ability to write off balances without significant implications. We cannot write off balances like this in the future.

Another example we have had at our office several times includes Sanford employees. We have had several employees seek mental health treatment and their claims become denied due to being out of network. Patients have stated they don't feel comfortable being seen by providers they work with and/or having their mental health notes in a chart that coworkers have access to.

Please pass HB 1416 and allow patients to have access to mental health care without these unfortunate barriers. Please also pass this bill to support small businesses in being able to assist and help these clients and not continue to put us in a position of forcing people to pay a large bill that is not affordable or to write off the balance and take the financial burden.

Thank you for your time and consideration.

Respectfully,

Brittany Schank, LCSW, Solace Counseling Owner

Dear Madam Chair Lee, Vice Chairman Cleary and members of the Senate Human Services Committee

I would very much appreciate your support on HB 1416. When talking to our health club members, I have learned that 100% believe in freedom of choice when seeking healthcare services. This is coming from long-time community members/Williston natives as well as the newer faces in town. People fear they will not be able to continue with their PCP that has taken care of them for years unless they pay more out of pocket or potentially all out of pocket. When it comes to physical therapy, people have always had a choice...that has been their privilege. In Western North Dakota we need freedom to choose. Cost savings as well having the convenience of seeking a healthcare provider, that you know and are comfortable with, within close proximity may be the reasons a person seeks health care at all. Again, I/we appreciate your support on HB 1416.

Thank you,

Marty

Marty Haug, DPT, CME
Elite Health & Fitness
512 Main St
Williston, ND 58801
701-774-0320

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

As always, thank you for your service to the State of North Dakota and the citizens of our state.

I am asking that the committee oppose HB 1416.

You might not think of the YMCA as a major employer in the Fargo a'8urea, however, we have 720 staff currently working for the YMCA of Cass and Clay Counties. Of those, about 150 are eligible for our healthcare benefits and meet the requirements of fulltime status with the organization. As you can guess, we are always looking for ways to control costs related to employee expenses. We have had the ability over the last few years to offer both a narrow and broad network plan to our team and that has helped both the employee and the YMCA control healthcare expenses.

When you consider that the majority of our fulltime staff earn $16 - $19 an hour, or $33,000 to $40,000 annually, you can understand why finding tools like a narrow plan help them keep more money in their pockets each pay day. We made some small tweaks to our deductibles this year and were able to freeze our rates at last year's price points. The difference for a individual on our plans currently is: narrow network $28 per pay period and broad network $70 per pay period. A significant difference.

I believe that other medical providers should be able to join the narrow network plans by discounting their rates to match the narrow plan. This would then make those plans available to all residents of the State of North Dakota. However, I don't believe that an employer should be penalized for offering narrow plans as part of their coverage.

Please oppose HB 1416.

Yours in Service,

Steve Smith
President and CEO

YMCA OF CASS AND CLAY COUNTIES
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TESTIMONY OF REBECCA FRICKE

House Bill 1416 – Health Care Providers

Good Morning, my name is Rebecca Fricke. I am the Chief Benefits Officer of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in opposition to House Bill 1416.

The bill requires health insurers, including the Medicaid program, which is part of an integrated delivery network may not exclude any provider from the network that is licensed in the State, is located in the geographic coverage area of the health benefit plan, and is willing and qualified to meet the terms and conditions of participation, as established by the health insurer.

This bill arguably creates a mandate regarding health insurance "payment for specified providers of services". Assuming this is a health insurance plan payment mandate, this bill does not appear to comply with the statutory requirement in NDCC section 54-03-28(3) that health insurance plan mandates first apply to NDPERS. I do not know whether a cost-benefit analysis has been requested or received. Pursuant to NDCC 54-03-28, both of those issues must be corrected before this Committee can act on HB 1416.

Consultant Notes:

- The legislation is anticipated to have a financial impact on the uniform group insurance program but the impact cannot be estimated with confidence because the costs will be dependent on provider contracting arrangements with the health insurer that administers the uniform group insurance program
- Creating and maintaining provider networks is a core function of a health insurer. A primary reason that health insurers develop provider networks is to reduce the cost of care.
- Conceptually, eliminating the ability for health insurers to exclude any providers from their networks removes some of the incentive for providers to agree to competitive reimbursements.
- However, according to Sanford Health Plan, the provider network for the uniform group insurance program includes 100% of hospitals and over 96% of physicians in the State. Given the breadth of the network participation in the State, the legislation may not have the effect of expanding provider participation.
- Additionally, since there is such broad provider participation, the financial impact of the proposed legislation could be immaterial if provider reimbursement rates do not increase as a result of the legislation (since there are no hospitals and relatively few providers that are not under contract today).

- Participating network providers agree to not balance-bill any patients for amounts above the contracted in-network reimbursement rates. Without this provision, participants may receive unexpected bills from their providers for amounts not covered by insurance.

HB 1416 Support

Dear Madam Chair Lee, Vice Chairman Cleary and members of the Senate Human Services Committee

I am writing to share my support for HB 1416 and hope that you will vote in favor of HB 1416.

HB 1416 gives patients the freedom to choose their health care provider by guaranteeing medical providers have the opportunity to negotiate inclusion in health insurance networks.

HB 1416 opens choice for more than just doctors. It will expand choice to physicians, surgeons, specialty physicians, dieticians, physical and occupational health, optometrist, ophthalmologists, chiropractors, nurse practitioners, mental health providers, and more.

HB 1416 lowers patient costs and travel and will allow access to lower cost providers.

Just last week, one of our staff mothers wanted to have her surgery with us, but since she is in a narrow network plan, they were not able to have surgery with us without paying the high out of network costs. She was forced to have schedule surgery with a surgeon she doesn't know, and who does not have the same experience with the technology that we have. It is unfortunate for the patient to have to compromise on what she wants due to her insurance plan.

Thank you for your time

Michael Greenwood
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MILESTONE HEALTH PARTNERS

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Williston, ND 58801

Dear Madam Chair Lee, Vice Chairman Cleary, and members of the Senate Human Services Committee,

I am writing to you to discuss House Bill 1416 and to ask for your support in voting 'Yes' for this bill. HB 1416 gives patients the freedom to choose their health care provider by guaranteeing medical providers with the opportunity to negotiate inclusion in health insurance networks. There are already consolidated healthcare networks across the country, which gives patients fewer choices for medical providers. HB 1416 increases patient choice by allowing them to see medical experts they trust and in return helps control spiraling healthcare costs by increasing competition of in-network providers. HB 1416 allows patients to choose any healthcare provider including family physicians, surgeons, specialty physicians, dieticians, physical, occupational and speech therapists, optometrists, chiropractors, nurse practitioners and mental health providers.

My family has been faced with critical healthcare scenarios when my twins were born early, requiring them to spend 5 weeks in the Neonatal Intensive Care Unit as well as my husband suffering from a life threatening superior mesenteric vein thrombosis placing him in the Intensive Care Unit for 7 days. Both scenarios I was able to place some of our worries aside because I was able to choose the facility and the team of doctors I trusted in these sensitive and critical times. Also, living in a rural area, I was able to choose facilities in cities where I had family support to help decrease the financial burden of hotels. If HB 1416 does not pass, I personally would have been affected by it in both of these scenarios by being sent to different facilities with medical providers I did not choose and in a city I would have had no family support.

Please vote 'Yes' for HB 1416 and continue to allow patients to have the freedom to choose their healthcare provider.

Sincerely,

Lindy Kirby, Pt, DPT
Doctor of Physical Therapy

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Williston, ND 58801

Chairman Lee, Vice-Chairman Cleary, members of the Senate Human Services Committee,

My name is Susan Finneman. I live in Bismarck, ND. I was born and raised in North Dakota. I married and moved out of state. My husband worked for Burlington Northern Railroad. We lived in the Seattle area, Illinois, and the Denver area.

We retired and moved back to North Dakota in 2017. When we made this decision, the ability to obtain insured care from excellent healthcare providers of our choice was essential. This criteria was of high importance as a result of my own health issues as well as those of friends and family.

Throughout my adult life, I have been able to choose the best doctor to treat and resolve health issues. My insurance providers have been varied. Some of them through my husband's work, some through my work. All of our chosen plans have had wide networks across many different medical systems and the freedom to obtain care in other states. Through our employers, we usually had the choice between several plans including plans from vertically integrated networks (VIN) such as Kaiser Permanente, Humana, or Group Health of Seattle.

When comparing the plans, the VIN plans were more expensive for the type of care we wanted and did not provide flexibility in physician choice. Some even assigned a primary care physician to the patient without regard to their needs. Referrals were always required for consultation with specialists. If a physician outside the network was chosen, the costs were not covered or the copays were very large. I believe that this resulted in far less competition to be the best physician, nurse, clinic, or hospital. And I know it added cost to the patients.

My personal values regarding healthcare choice started when I was young. My first-grade teacher suspected that I had hearing issues. It was discovered that I had 0% hearing in one ear and 10% in the other. Our insurance allowed us to seek out and use specialists to identify and treat the problem.

This same freedom to choose saved my mobility, perhaps my life. In March of 2015, I had surgery in Colorado to repair a disc in my spine. This surgery

seemed to work but resulted in an infection in my spine. The original surgeon ignored all the clinical evidence, including bloodwork, imaging and reports from other providers. He refused to treat the infection for over 3 months. He told me that the infection markers were within normal ranges (They were off the charts.). By the end of June, I was no longer able to get in and out of bed without assistance. I bent over a walker to get around and had to crawl up and down the steps of my home. My pain was usually 9 or 10 on a scale of 10. When I lost control of my bladder and bowel, I went to the ER and was admitted to the hospital. The infection had destroyed all the repaired disc, 50% of the vertebrae above it and 30% of the vertebrae below it. I knew I needed to find another doctor.

I began what would become a 6 month course of 2 IV antibiotics that needed to be infused twice a day. That course was followed by a year on oral antibiotics. Because I had the freedom to choose among many providers from many healthcare systems, I was able to work with one of the best infection control clinics in Colorado and I was able to find a new surgeon in a different system. He specialized in spine reconstruction and had a great amount of experience treating spinal infections. My reconstruction surgery was in November of 2015. Within a day of the surgery, I was able to walk upright with little pain. Within a week, I no longer needed the walker. I firmly believe that had I been forced to stay within the original surgeon's system, I would not be standing today.

Because of my health history, it is extremely important that I have the freedom to choose the best doctor regardless of the healthcare system. This flexibility is essential to me. Thankfully, we still have insurance that covers a wide variety of doctors and systems in North Dakota. We have been able to choose providers from both major systems in Bismarck as well as several independent providers and specialists.

I encourage you to vote DO PASS on HB 1416 which allows me as a health care consumer to choose the providers I know and trust.

Thank you for your time.

Susan M Finneman

DOWNTOWNERS
BISMARCK

Senate Human Services
Chairperson and Committee Members

HB 1416 Oppose

The Downtown Business Association of Bismarck represents over 200 members with 9,000 employees in North Dakota's second largest employment district.

HB 1416 could remove an affordable option for healthcare plans in the Bismarck area. Our own Downtown Association employees also use this type of a plan to provide lower cost healthcare for our staff.
Many of our members are small business owners facing increased labor and supply costs, to remove an affordable health coverage option for them would be detrimental to our small and local businesses. Those businesses who prefer to work with out of network providers; we encourage them to choose the type of plan that is best for their business. We concur with the Greater North Dakota Chamber and AHIP's (America's Health Insurance Plans) position to oppose this bill.

We encourage your DO NOT PASS recommendation on HB 1416.
Sincerely,

Kate Herzog, COO
Chief Operating Officer
Downtown Business Association of Bismarck

President
Downtown Bismarck Community Foundation

Testimony in Favor of House Bill 1416

Dear Madam Chair Lee, Vice Chairman Cleary, and Senate Human Services Committee members,
My name is Marissa Wuori. As a nurse, I consider providing the best care for my patients a vocation, and a priority. Recently, this crossed over into my personal life. My 19 year old daughter was recently diagnosed with stage 3 ovarian cancer at a local health system, with plans for chemotherapy, radiation, and surgery which would have horrible side effects, but hopefully buy some time in a diagnosis that has a dismal prognosis. Fortunately, we did not have narrow network insurance, so were able to seek care at Mayo. While there, we were told that my daughter did NOT have cancer. In fact, she had a benign tumor for which surgery alone would be curative. We feel so blessed to have insurance that enabled us to seek care from a provider of our choice so that we could get the best care for our daughter. We feel this is something that all North Dakotans deserve. Therefore, I am asking you to Vote YES in favor of HB 1416. Thank you for your time. I am happy to answer any questions you may have.

Senate Human Services Committee
HB 1416
March 14, 2023

Chair Lee and Committee Members, I am Courtney Koebele, the Executive Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA supports HB 1416.

HB 1416 provides that a health insurer that is part of an integrated delivery network may not exclude a physician/healthcare provider from its insurance products if the physician/healthcare provider is willing and fully qualified to meet the terms and conditions of participation, as established by the health insurer.

HB 1416 can reduce patient's out-of-network personal medical fees and will help control out-of-pocket costs and co-pays while improving medical outcomes. It eliminates unnecessary re-testing by providers not familiar with case histories and reduces probability of diagnostic errors. In addition, the increase in competition will aid in controlling spiraling medical costs.

This is helpful because it means providers can't be "locked out" of products with a "narrow network" and means patients have the broadest possible choice of products that can/may include their preferred physician/healthcare provider.

Having a consistent and on-going relationship with a health care provider is in the best interest of quality care and patients deserve the freedom to choose their own physician/healthcare provider. This bill allows families to see physicians and other medical providers they know and trust.

We urge a DO PASS on HB 1416. Thank you for the opportunity to testify today. I would be happy to answer any questions.

Testimony regarding HB1416

Presented by Al Berg, Fargo, ND

March 14, 2023

Members of the Committee, thank you for the opportunity to speak to you today regarding Bill 1416. My name is Al Berg, and I'm affiliated with North Risk Partners, an employee benefits insurance agency in Fargo. My business works with employer groups throughout North Dakota to design and enroll employee benefit plans. The main benefit, of course, that most people are concerned about is health insurance.

I wish to address the provisions put forth in House Bill 1416, sometimes known as "Any Willing Provider." My focus will be on the potential "unintended consequences" this rule could have on the narrow network health plans currently being offered in the state. I think it would be helpful to understand this bill in its broader context and how it might impact consumers in North Dakota.

Over the last 30+ years, I've had the privilege of helping thousands of employees make decisions about their benefits. I wish to share from my experience on the front lines of trying to make health insurance as affordable as possible for my clients. Let me start with an example of how Any Willing Provider legislation could affect our residents, especially those who earn a lower income.

A client of mine is a non-profit organization located in Fargo. Due to rising health insurance premiums, four years ago we installed a "narrow network" program with Sanford Health Plan. Employees have the choice of participating in a traditional broad network where they can receive coverage at any provider in the Sanford Health Plan network, which includes virtually all providers in the Fargo area, not just Sanford. Or, they can enroll in a lower cost narrow network that is limited only to Sanford Health System. I'll add that if this group was in Bismarck, it would work the same way here as well.

Sanford Health Plan offers a 20 percent premium discount for those who participate in the narrow network. At the initial enrollment for this group, just over 50 percent of the employees chose the narrow network option. Since then, enrollment has grown to 71% in the narrow plan, as shown in this chart:

Cost Comparison *Fargo area Non-Profit Organization*	Sanford Signature Plan (Broad Network)	Sanford TRUE (Narrow Network)
Employees Enrolled	9	23
Employee Cost/month	$216.46	$121.42
Savings per Month		$95.04
Savings per Year		$1,140.48

This is real savings for employees of this group, many of whom are earning $45,000 or less per year. Considering that most members of a group health plan have low health care expenses in any given year, many employees are willing to accept a limited network of providers in return for significant cost savings. The insurance companies that offer narrow network plans have indicated that the proposed legislation could make it difficult to continue to offer these discounts.

I think some points of clarification might be helpful to you, along with observations from the field:

1. Sanford is not the only provider of narrow network plans. Medica has offered a narrow network option for many years through their alliance with Altru in the Grand Forks area and Essentia in southeastern North Dakota. It's important to point out that these are not vertically integrated plans; in other words, the provider and payor of services are not owned by the same entity. These are "Accountable Care Organizations," or ACOs, that are designed to monitor care within one health system in an attempt to provide efficiencies and work toward best outcomes. Much of the focus has been on Sanford, and their vertically integrated system, but Medica is also a significant provider of narrow network plans.

2. In the case of an emergency, a narrow network member is covered regardless of where they receive care.

3. If the narrow network is not equipped or staffed to treat a member's condition, the plan will refer them to a provider outside the network that is equipped to treat them. This would be done at the in-network level of coverage provided by their plan.

4. When these plans are offered in a group, the insurance companies require that both the

broad network and narrow network be included. The employer can't just go for the lowest cost and only offer the narrow network and force their employees into the corner with the cheapest option.

5. Most people enrolled in a group health plan do not incur a lot of health expenses. While those who have the claims may change from year to year, a small percentage of the population drives a large share of health costs. For those people who already get their health care services from the narrow network providers, and for those who rarely need to see a doctor, the narrow network is a great way to manage their premium cost.

6. Members can change their enrollment each year. If they are planning a procedure that doesn't need to be done right away and prefer to have it done by a provider who is not in the narrow network, they can wait until the next plan year and switch to the broad network. Then, when things are taken care of, they can move back to the narrow network if they so choose. Of course, this may not work if a condition develops and immediate treatment is required. However, many procedures can be delayed until the patient has moved to the network that includes their provider.

Looking back 50, 60, 70 years, it would have been difficult to rack up a medical bill of $100,000 in those days. Of course, services were far less expensive, but even more so, the procedures and treatments and medications simply weren't available. Even if you tried to spend the money, the treatment options weren't there.

Since then, we've experienced the development of modern technology in the health care field, and the research and development has been financed in many ways by an open-ended line of credit known as health insurance, and it's a line of credit the policyholder indirectly pays back in the future through higher premiums. Adding to that, employer-funded health insurance has made coverage accessible to the masses.

When you add all that up, the good news is that many wonderful treatments have been developed for conditions that, back in the day, people either lived with or died from. The bad news is that we've created a beast that needs to be fed. As we can increasingly do more to reduce human

suffering and improve quality of life, it's tough to ask people to give that up.

So, with our modern, but convoluted system of financing health care in the United States, insurance companies are pressured to find ways to provide more affordable coverage. One way of doing that is to exchange risk for premium through a narrow network. The insured person can take the risk of possibly not being able to see their preferred provider, in return for a substantial discount in premium. It's a risk that many people are willing to take because, in reality, for most of the population, it's a minimal risk. The names may change from year to year, but in any given year, a large segment of our population doesn't need much health care.

In my discussions with Sanford Health Plan and Medica, they have indicated that there are several thousand employees throughout the state that are enrolled in a narrow network arrangement. Passage of the legislation being considered could have an adverse impact on the insurance company's ability to provide these types of plans, and ultimately on the finances of a significant number of our residents.

I can't speak to how this legislation would play out – the financial calculations that go on behind the scenes are beyond my pay grade. I'll also say the arguments in favor of it are reasonable and valid. The intent of my testimony has been to help you consider the effect 1416 could have on a segment of our population.

Thank you for the opportunity to present this perspective to the committee. I'm willing to address any questions you may have.

Sincerely,

Al Berg
Fargo

GREATER NORTH DAKOTA CHAMBER
HB 1416
Senate Human Services Committee
Chair Judy Lee
March 13, 2023

Chair Lee and members of the Senate Human Services Committee, my name is Andrea Pfennig with the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** of House Bill 1416.

Recently, GNDC partnered with the NDSU Challey Institute for Global Innovation and Growth to complete a survey about the business climate in North Dakota. The survey found that 37% of respondents felt the second highest factor negatively affecting business performance was high healthcare costs.

While HB 1416 is intended to provide freedom of choice for health care services, we have concerns that it will eliminate the ability to choose a health insurance plan that provides significant savings.

Our members oppose general regulatory changes and mandates that would increase business burdens and costs. We urge you to enable employers and employees to keep focused networks as an option with a Do Not Pass recommendation.

701.222.0929 ndchamber@ndchamber.com ndchamber.com PO Box 2639 • Bismarck, ND 58502

Farmers Union
INSURANCE

HB 1416
Testimony before the Senate Human Services Committee
March 14, 2023
Oppose

I am Kristi Schlosser Carlson, and I represent Farmers Union Service Association, a general insurance agency providing insurance products and services in North Dakota and other states.

We oppose HB 1416.

We are contracted to market the products of nearly all health insurance companies authorized in the state, including the Sanford Health Plan. Our specialized team of health insurance agents advise individuals and businesses on benefit plan options. When our agents present health insurance plans to a customer, they gather information to understand the customer, including health care needs, preferred provider, desire for provider options, budget, and so on. Often the agent presents a number of available plans. When an agent offers Sanford Health Plan's narrow network plan, they also offer other plans as alternatives. At a minimum, in accordance with Sanford's agreements, our agents ensure that an employer who offers Sanford's narrow network plan to employees also offers a Sanford broad network plan option.

Importantly, when agents visit with customers, they are clear about weighing the narrow network plan, which often results in a lower premium for customers, against a broad network plan, which provides flexibility but typically results a higher premium. Customers are able to make the best choice that meets their needs and priorities.

We believe customers benefit from having the choice of the narrow network plan. As a result, we oppose HB 1416.

HB1416 – Any Willing Provider: Overriding Consumer Choice and Increasing Premiums

Senate Human Services Committee
Dylan Wheeler
3/14/2023

SANFORD HEALTH PLAN

What is a network?

General Definition:

- The makeup of facilities, providers and suppliers which a health insurer or plan has contracted to provide health care services.

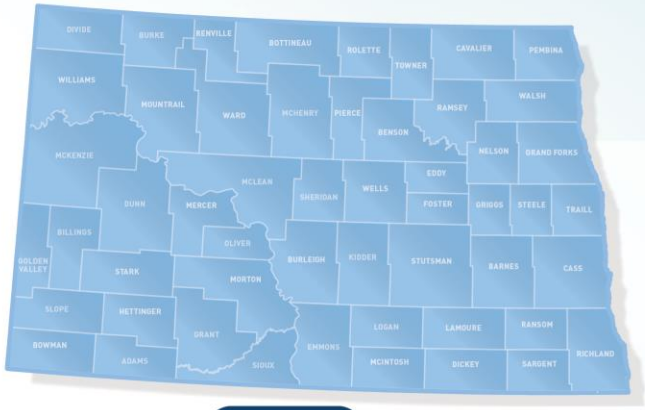
Types of Networks - Examples:

- **Broad:** a broad network typically consists of a majority – if not all - of the providers within the service area and beyond.
- **Focused:** focused networks consist of fewer providers. Providers in a focused network agree to a reduced contracted rate in exchange for the anticipated increased volume.
- **Tiered:** tiered networks consists of just that – tiers. Contracted providers and member benefits correspond with the different tiers

NETWORKS

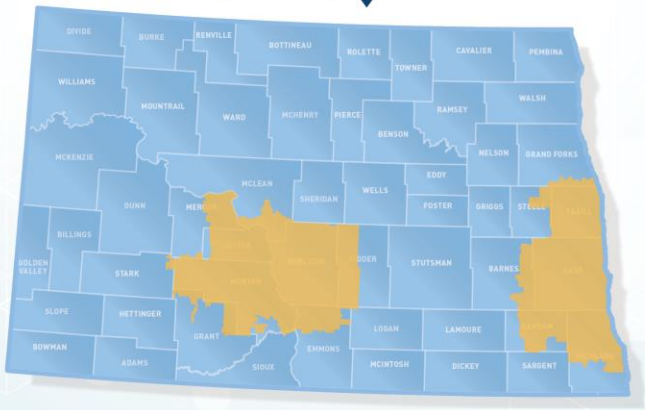
Why do health insurance companies use networks?

- **Consumer Choice:** Broad and focused Networks **empower** consumers with different options and allow the consumer to **choose** a health plan that meets their needs.
- **Cost Control:** A focused network includes fewer health care providers at a lower cost to the consumer. Broad networks — which include more health care providers — increase costs for consumers.
- Encourage a competitive market



BROAD NETWORKS

DECREASED COSTS



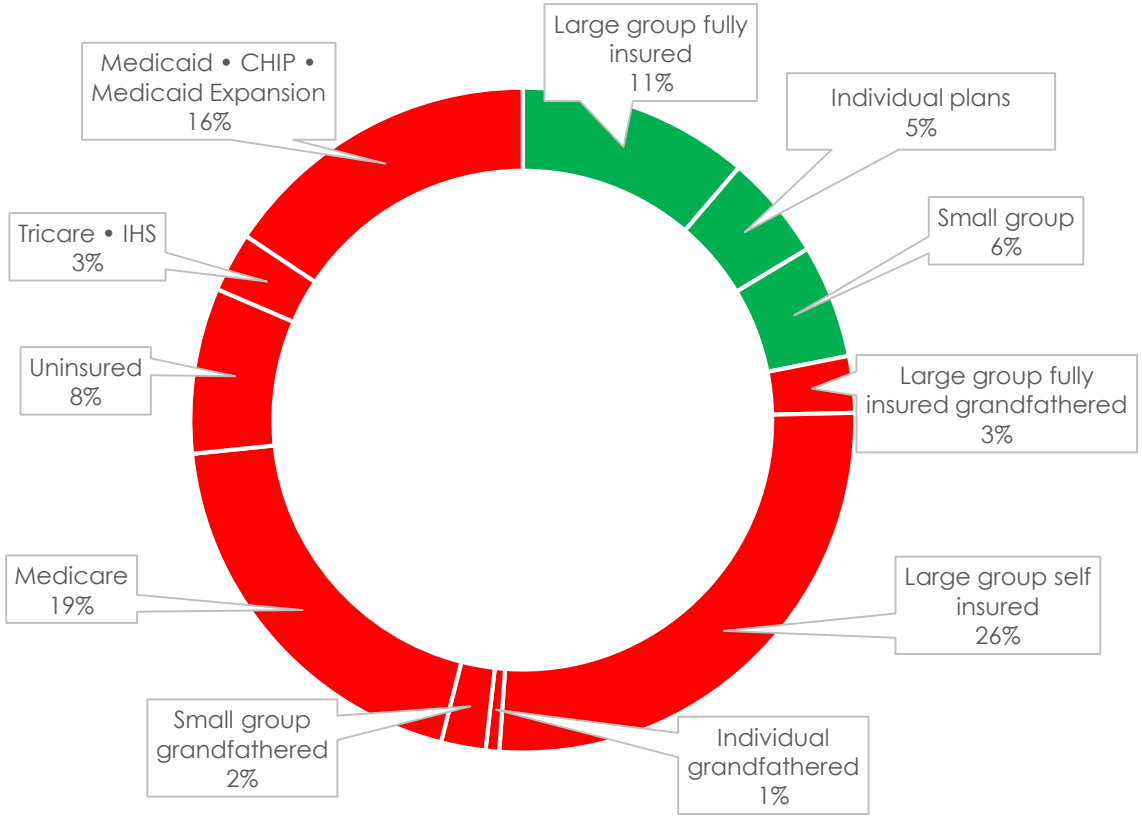
FOCUSED NETWORKS

Sanford Health Plan Focused Network availability

Health Insurance Networks and Integrated Care Delivery

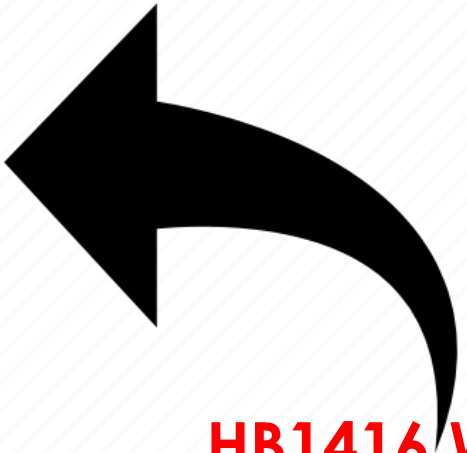
- Broad and Focused networks are not unique to integrated care delivery systems – plan options are prevalent in markets nationwide.
- Almost all of North Dakota providers are included in Sanford Health Plan's Broad network current day – consumers have the choice to select that plan.
- Focused networks, on average, save a consumer 20% in premium as compared to the broad network.
- **HB1416 singles out one business and one plan option in North Dakota.**

HB1416 Will Limit Choice for a Small Part of the Market



By the Numbers

- Groups – Sanford Health Plan Focused Network
  - Large Group: 58*
  - Small Group: 265
- Individuals – Sanford Health Plan Focused Network
  - 6879
- Sanford Providers – Focused Network
  - 1952
- Non-Sanford Providers – Focused Network
  - 1585



HB1416 WILL NEGATIVELY IMPACT…

Consumer Choice and Health Insurance Networks

- Consumers are empowered today to make informed decisions as to what health insurance plan meets their needs – including individuals, families and businesses

- Choice exists on the ACA Marketplace, as well as with commercial employer coverage.

- Sanford Health Plan **requires** that employers who offer TRUE (focused network) to its employees **MUST** offer a broad network product as well.
  - An employer cannot offer just a focused network*

- The #1 complaint that is received is that the focused network product is **not offered through the whole state** – members lack that choice today outside of otherwise eligible counties.

Consumer Choice in Action – Example 1:

- ND Employer
- Group has 98% eligible for TRUE (focused network)
- Group has 67% enroll in TRUE; other 33% chose Signature Series (Broad Network)

Plan Tiers	Signature (Broad)	True (Focused)
Employee	$ 564.39	$ 452.55
Employee + Spouse	$ 1,185.22	$ 950.36
Employee + Child(ren)	$ 1,015.90	$ 814.60
Family Coverage	$ 1,693.17	$ 1,357.86

Consumer Choice in Action – Example 2

- ND Employer
- Group has 100% eligible for TRUE (focused network)
- Group has 28% enrolled in TRUE; remaining 72% chose Signature Series (Broad Network)

Plan Tiers	Signature (Broad)	True (Focused)
Employee	$652.70	$523.36
Employee + Spouse	$1,370.66	$1,099.05
Employee + Child(ren)	$1,174.86	$942.04
Family Coverage	$1,958.09	$1,570.08

Consumer Choice in Action – Example 3

- ND Employer
- Group has 99% of its employees eligible for TRUE
- Group elected not to offer TRUE to its employees

Focused Networks – Current Status

Limited Number of Providers

+

Lower Reimbursement Rates

+

Higher Volume of Services to Contracted Providers

=

Lower Premiums for Consumers – 20% Less Per Month

Focused Networks – Future State With HB1416

~~Limited~~ **INCREASED** Number of Providers

+

~~Lower~~ **HIGHER** Reimbursement Rates

+

~~Higher~~ **LOWER** Volume of Services to Contracted Providers

=

~~Lower~~ **HIGHER** Premiums for Consumers

Cannot have FOCUSED network premiums with BROAD network of providers.

Cannot have FOCUSED network premiums with BROAD network of providers.

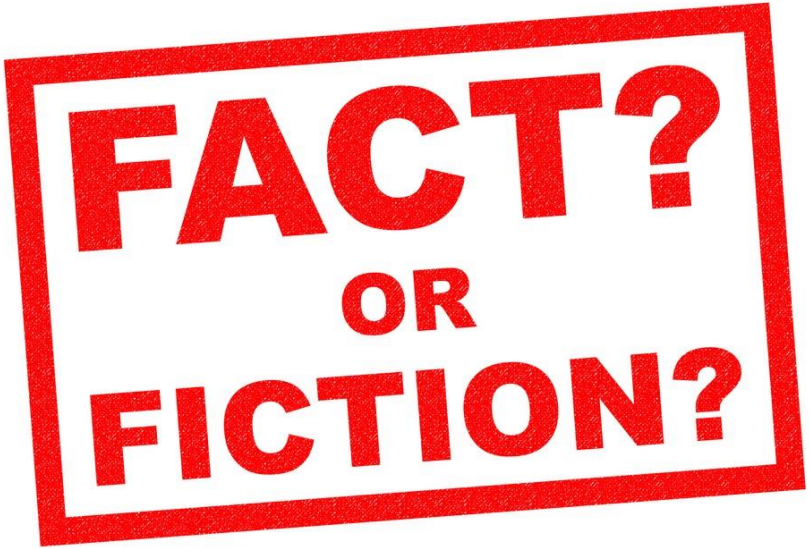
- Why Not?
  - Foundational Principles of a Focused Network
  - Current Providers in Focused Network Lose Incentive to Remain in Network at Lower Rates Because Previously Understood Volume No longer Present
  - **This results in having to contract at higher rates to keep providers in-network – resulting in higher premiums.**

FICTION

- Sanford only has Sanford providers in the focused network.
- Sanford only pays Sanford providers in the focused network.
- There are no local providers in a focused network.

FACT

- 45% of providers in the focused network are non-Sanford.
- On average, 40%-50% of claims paid in focused network go to non-Sanford providers.
- Network adequacy standards require local access.



The **bottom line** is…

- HB1416 will remove the ability for health plans to deliver affordable coverage options.
- HB1416 will remove existing consumer choice from the market.
- HB1416 is a government mandate that supersedes an adaptable market.
- HB1416 will increase premiums and impact already contracted providers.
- Oppose HB1416 and vote **"Do Not Pass"**

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
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ahip.org

March 14, 2023

Senator Judy Lee, Chairman
Senate Human Services Committee
North Dakota State Capitol
600 East Boulevard Avenue
Bismarck, North Dakota 58505

RE: AHIP Concerns on HB 1416, *Freedom of Choice in Health Care Services*

Dear Chairman Lee and Committee Members,

On behalf of AHIP, I write to respectfully oppose HB 1416, *Freedom of Choice in Health Care Services*. AHIP appreciates the opportunity to provide comments on this legislation and your consideration of our concerns.

Every American deserves access to affordable, comprehensive, high-quality coverage and care. Health insurance providers are committed to working together to encourage more robust competition, which is essential to providing North Dakotans with more health care choices, better quality, and lower costs.

HB 1416 would require health insurance providers with networks to contract with any health care provider willing to meet the plan's contract terms – even if the health insurance provider's network already includes an adequate and broad array of high-quality providers to meet patient needs and contractual geographic requirements.

While the intent of this mandate, commonly referred as "any willing provider" (AWP), may appear to provide North Dakotans with more health care choices, AWP laws actually impede the quality-of-care patients receive, increase health insurance costs, provide some parties with an anti-competitive advantage, and further limit North Dakota employers' and consumers' choices of health plans that fit their needs.

High prices for health care are driven, in large part, by the high prices charged by hospitals, providers, and drug manufacturers[1]. From consolidated hospital markets, to private-equity-controlled physician groups, and anti-competitive contracting practices, there are already too many ways in which the competition that would lower health care prices for consumers is being impeded. We should be working to restore, rather than impede, competition in our health care system. For the reasons discussed below, AHIP is opposed to HB 1416.

- **AWP laws make it more difficult for health insurance providers to negotiate discounts from doctors and hospitals, which can lead to higher premiums for consumers.** There is wide variation on prices that doctors and hospitals charge for services. Requiring health plans to contract with "any willing provider" reduces a health insurance providers' ability to obtain

[1] AHIP, Where Does Your Health Care Dollar Go?, September 6, 2022.

price discounts. For years, the Federal Trade Commission has expressed concerns about the impact AWP laws have on competition.

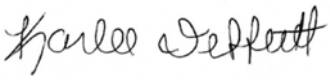
- **HB 1416 would create a presumed "right to employment or contract" -- a right that does not exist in any other industry, or even elsewhere within the health care sector.** Initiating an AWP mandate destroys incentives for improved competition and provides health care providers with rights not given to other service providers. For example, schools are not required to hire "any willing teacher", airlines are not required to hire "any willing pilot", physician group practices are not required to admit "any willing doctor", and hospitals are not obliged to accept any willing physician, nurse, or other health care professionals.

- **Quality of care diminishes with universal acceptance of all interested providers.** High-value provider networks are a critical tool health plans utilize to reduce costs and ensure their members have access to, and receive care from safe, qualified providers. High-quality care, that is also cost-effective, should be the focus of carriers and legislators alike. By forcing a health insurance provider to accept any provider who states a willingness to meet contract terms, AWP requirements undermine a health plan's effort to ensure only the doctors and hospitals that provide the highest quality and most cost-efficient care are available to their enrollees.

AHIP is committed to working with federal and state leaders on solutions to improve competition, access, and affordability for everyone. AHIP believes greater competition means more consumer choices and more patient control over their health care. AHIP's *Healthier People Through Healthier Markets* initiative lays out a roadmap designed to improve competition in key areas of our health care system to increase affordability and access for every American. We would welcome the opportunity to work with the Senate Human Services Committee to highlight best practices in delivering more choices, better quality, and lower costs.

Thank you for the opportunity to provide feedback. We appreciate your consideration of our concerns and look forward to continuing to work with you on this important issue. For additional information and questions, please contact me at ktebbutt@ahip.org or 720-556-8908.

Sincerely,



Karlee Tebbutt
Regional Director, State Affairs
AHIP – Guiding Greater Health

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

3/14/23

Chair Lee and committee members,

For the past 10 years, I have been an internal medicine physician affiliated with an independent medical center in Hettinger. Day in and day out, my patients are challenged with a variety of insurance related issues, two of which are having health insurance and having access to the right health care practitioner for their health needs. Restrictive insurance networks worsen the already challenging access issue and if left unchecked may further worsen access for patients in rural areas.

From a health systems perspective, narrow insurance networks are troubling. It's well documented that consolidated health care networks increase costs. Most recently, a large analysis by the National Bureau of Economic Research and Harvard published in the January 24 issue of JAMA showed that "Physician services delivered within health systems cost between 12 percent and 26 percent more, compared with independent practices. System-based hospital services cost 31 percent more, on average, compared with care delivered by independent hospitals."

Rural residents covered under a narrow insurance plan risk being out of network with their local independent health system. This will result in longer drive times, longer wait times (both of which we know result in worse health care outcomes and increased costs), and more ER usage.

The claim by opponents of this bill that costs will go up is refuted by a stack of data. Besides that, it just doesn't pass the common sense test when the insurer is paying the same in-network rate.

This bill is not about the state of North Dakota's insurance market at the moment. It's about what may happen in the future. Vertically integrated networks could easily restrict their network drastically in the future. The patient and practice owner issues you heard today may be the canary in the coal mine. Like dealing with the noxious weed palmar amranth, chronic wasting disease in big game, or Fufeng trying to build a milling plant it's better to deal with the issue up front rather than waiting.

Access to healthcare improves health outcomes. Restrictive insurance networks do not contain costs. Improve patient access, limit the risk of narrow networks going forward, and recommend a DO PASS on 1416.

Joshua Ranum, MD FACP
West River Regional Medical Center
North Dakota Medical Association

March 14th, 2023
From: Gabriela Balf, MD, MPH
Re: In Support of HB 1416

Madam Chair Lee, esteemed Committee Members,

My name is Gabriela Balf, I am a psychiatrist in private practice in Bismack, and I speak on my own behalf.

This bill supports my patients who are part of a health plan insurer and want to pursue the specialty care that I provide, but their plan would not cover, even if I am an in-network provider for that particular plan.

My policy and pledge to the community is to see people when they need to be seen. I will see a new patient within 2 days. I will see them as often as needed, at the intervals of care needed. A certain plan could only give the earliest appointment in six months. That plan also does NOT have in Bismarck specialists in my areas of expertise. Patients would have to travel to Fargo for appointments that may take months to happen.

Thank you for ensuring access to timely, good quality specialty care for our citizens, I urge you to vote DO PASS on HB 1416.

Respectfully yours,

Gabriela Balf, MD, MPH
Clin Assoc Prof – UND Dept of Psychiatry and Behavioral Science

HB 1416
Patient Choice

- Senate Human Services Committee
- March 14, 2023

North Dakotans for Open Access Healthcare

Duncan B. Ackerman, MD

HB 1416

- The genesis of this bill is due to the concern of expansion of plans that have ZERO out-of-network option for patients.
- HB 1416 provides a solution for patients to choose care outside of the closed network, when that network doesn't provide the option they need for their care.
- 27 states have some form of patient choice law
- 12 are similar to HB 1416
- NDCC, 26.1-36-12.2 (1989) applies to pharmacies and pharmacists

HB 1416 History

- 14-0 DO PASS out of House Human Services Committee
- 84-9 DO PASS out of House Assembly

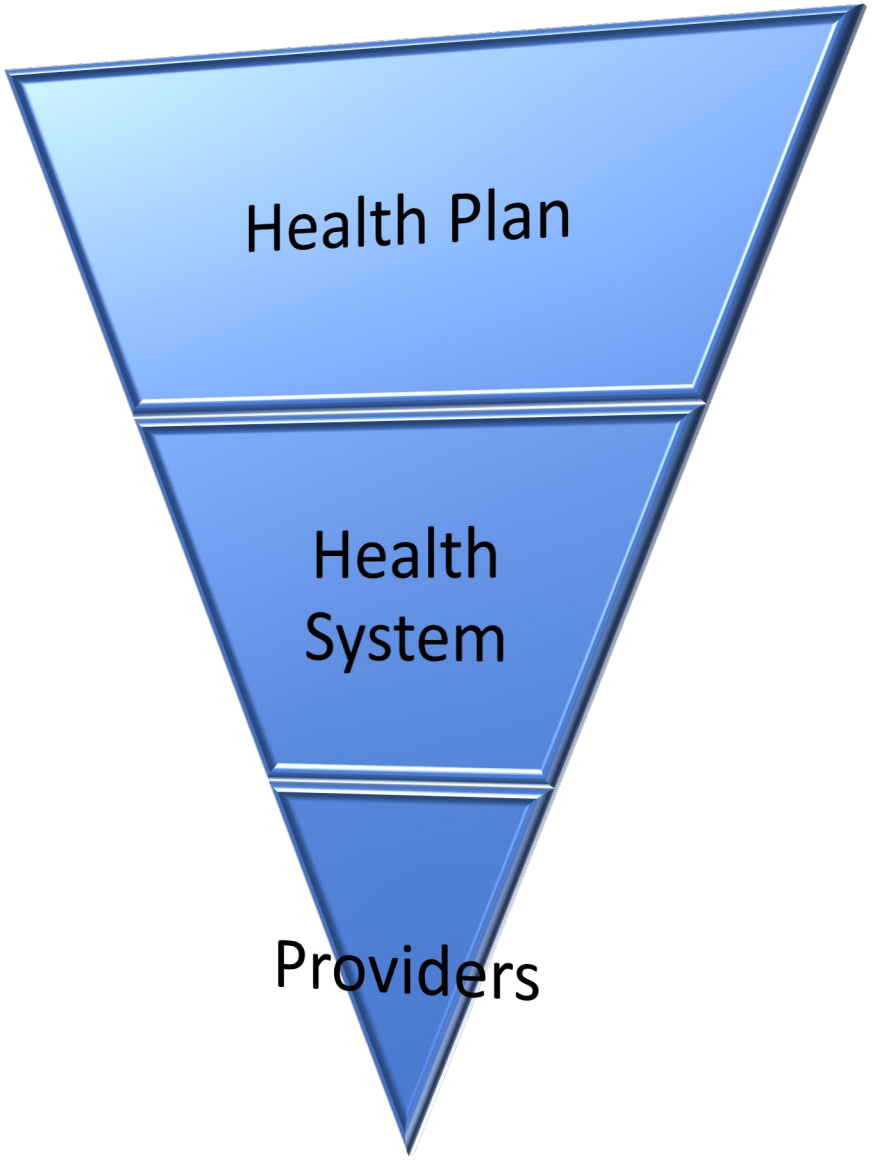
What did we learn from similar bill HB 1465 last session?

- Significant discussions:
  - Patients
  - Providers
  - Independent Critical Access Hospitals
  - Independent medical practices
  - Independent medical facilities
  - Medical Associations
  - Insurance carriers

What did we learn?

- We learned the common concern was the Vertically Integrated Healthcare Delivery Network in North Dakota
- Vertically Integrated Network (VIN)

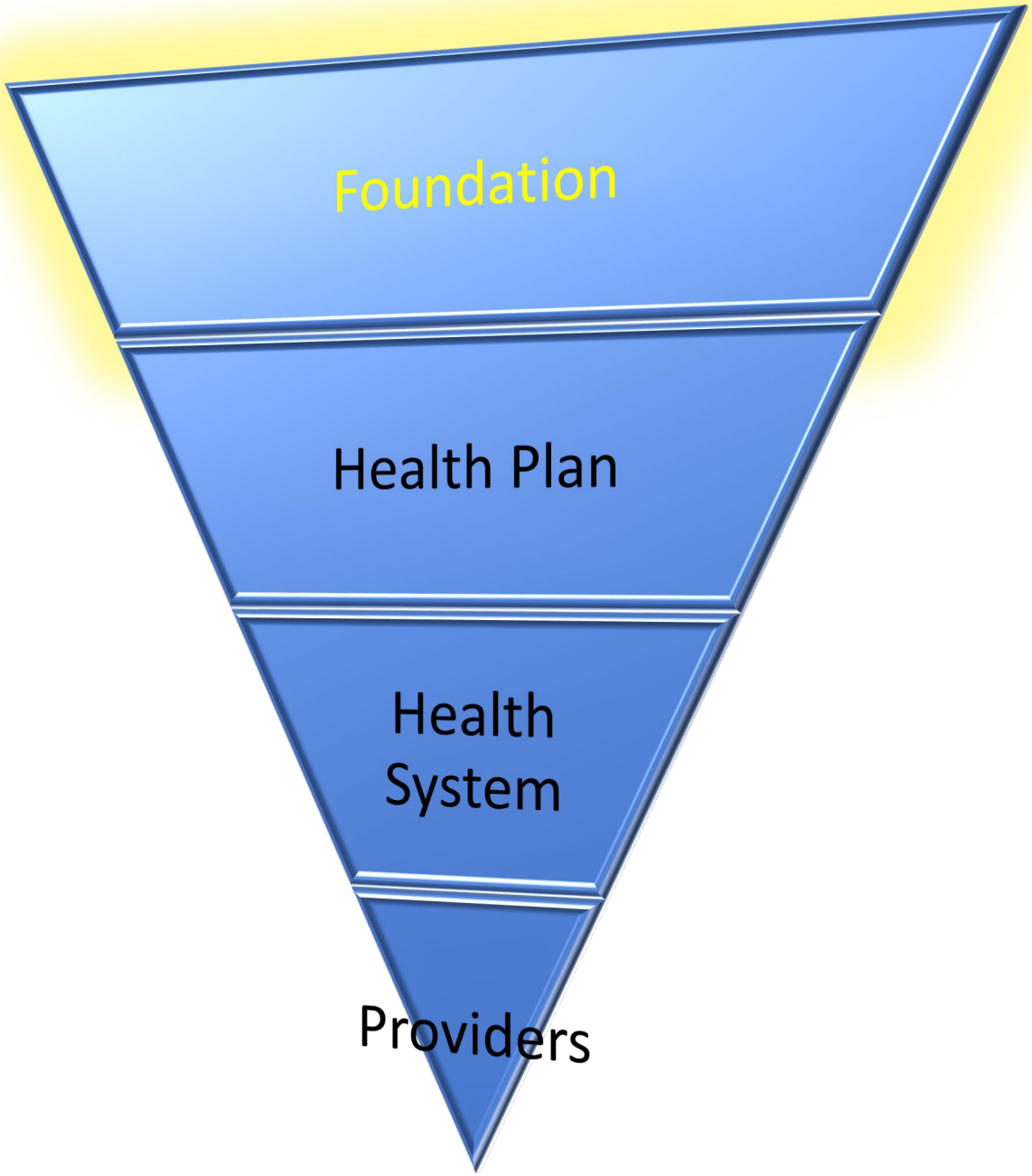
What is a Vertically Integrated Network (VIN)?



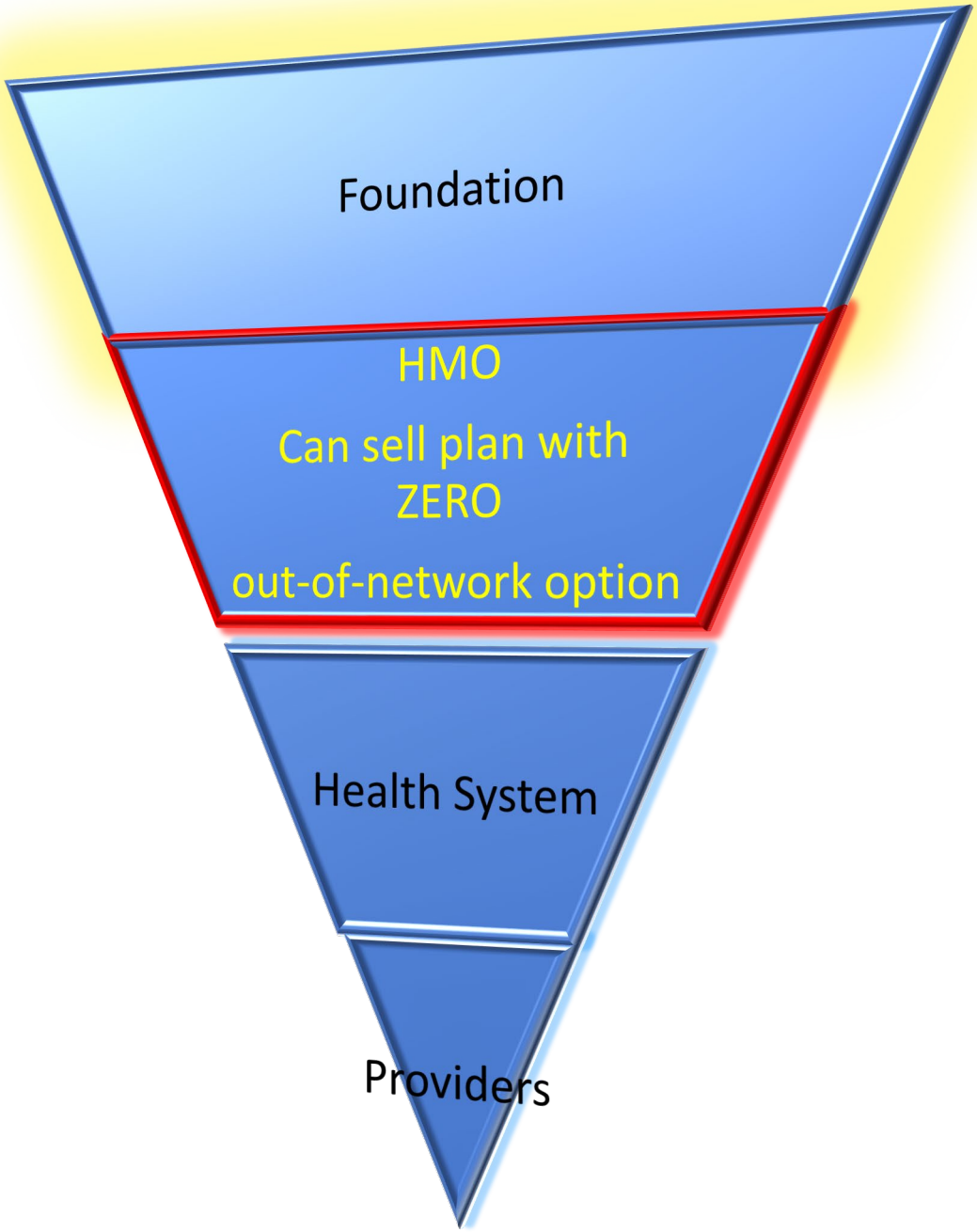
Vertically Integrated Network (VIN)

VIN houses the health plan, the health system, the providers and services provided

Distinct Advantages of VIN in North Dakota, Large Foundation

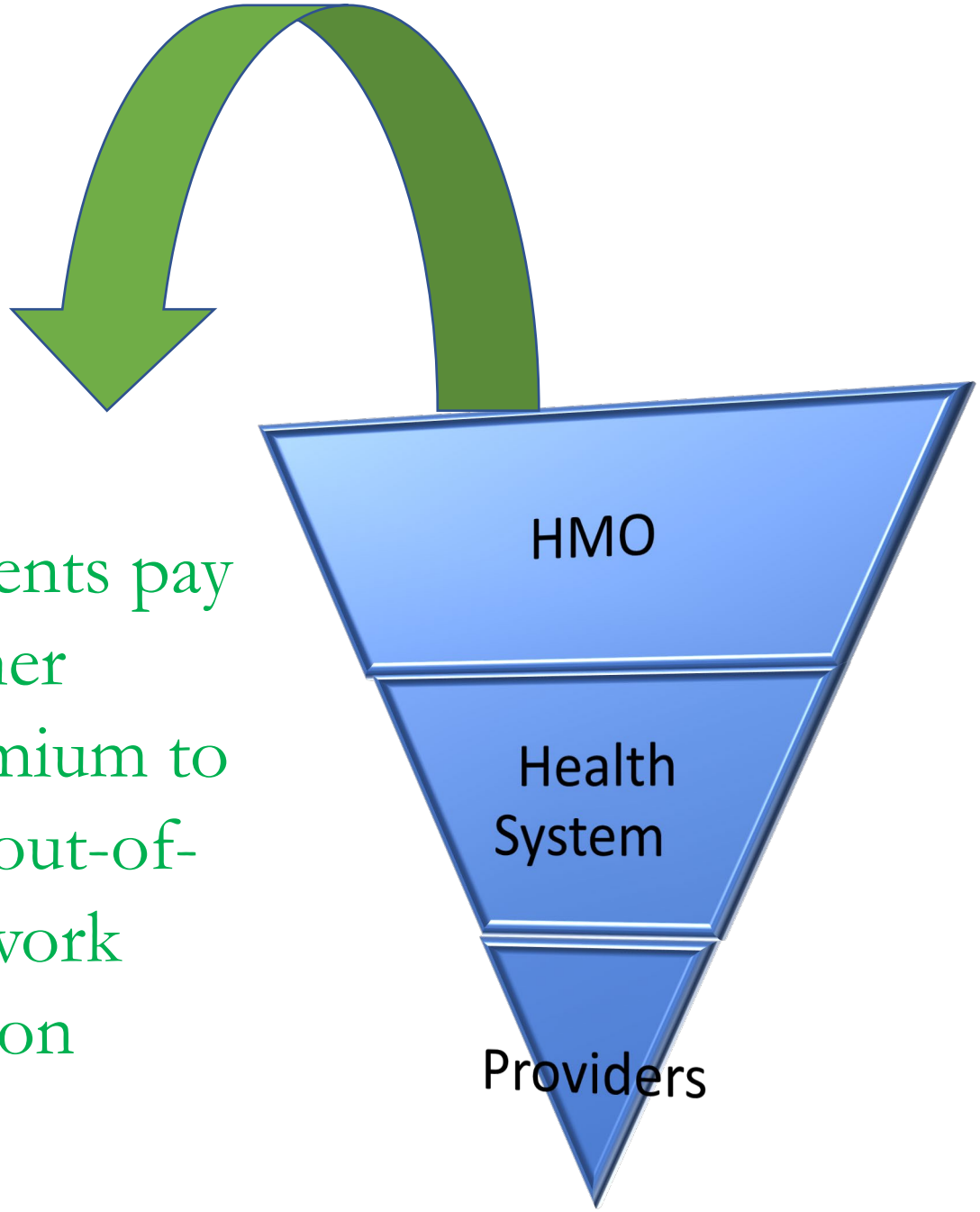


Distinct Advantages of VIN in North Dakota, Health Maintenance Organization (HMO)

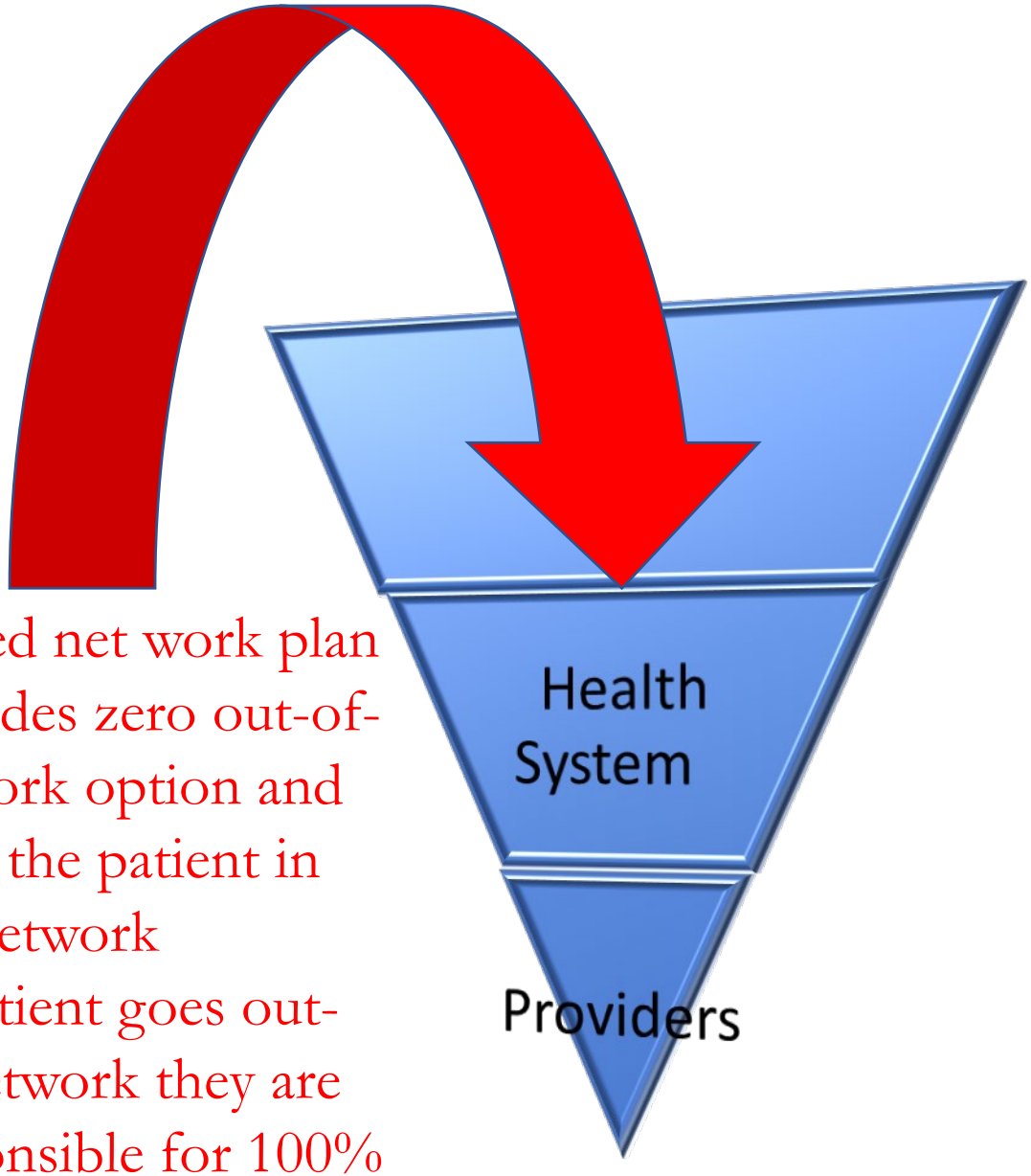


Distinct Advantages of VIN in North Dakota, HMO

Patients pay higher premium to get out-of-network option



Distinct Advantages of VIN in North Dakota, HMO



Closed net work plan provides zero out-of-network option and traps the patient in the network

If patient goes out-of-network they are responsible for 100% of charges

Financial Disparity Should NOT handcuff a patient's ability to choose a health care provider

- In 2014, a similar bill (Measure 17) was passed in South Dakota, with 61.81% of South Dakotans support.

- "Those who want more choice and are willing to pay more for it have that option."
  Dave Hewett, South Dakota Associations Of Healthcare Organizations.

- That comment should resonate….and so should the following question……

What if you are unable afford to pay more for that choice?

- HB 1416 answers this question

Question from last session..how is Measure 17 functioning in South Dakota?

STATE OF SOUTH DAKOTA) :SS
COUNTY OF MINNEHAHA)

IN CIRCUIT COURT

SECOND JUDICIAL CIRCUIT

49CIV21-2622

MEMORANDUM OPINION GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

GRANTS Plaintiffs' motion for summary judgment and DENIES Defendant's motion for summary judgment; the Court further,

DECLARES the Any Willing Provider Law enacted through Initiated Measure 17 by the voters of South Dakota does not allow a health insurer to exclude a health care provider from a health benefit plan's panel of providers who is (1) licensed under the laws of South Dakota; (2) located within the geographic coverage area of the health benefit plan; and (3) willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

Dated this 2nd day of December, 2022.

BY THE COURT:

Rachel R. Rasmussen
Circuit Court Judge

STATE OF SOUTH DAKOTA) IN CIRCUIT COURT
:SS
COUNTY OF MINNEHAHA) SECOND JUDICIAL CIRCUIT

49CIV21-2622

MEMORANDUM OPINION GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

[2] This SHP policy argument is also somewhat disingenuous. Defendant SHP claims a decision against their position would cause harm to policy holders who cannot afford a higher-cost policy, but at the same time argues that the low-cost policy complies with the AWP law because it still allows insureds who need a low-cost policy to still choose any provider by simply paying out of pocket for a provider not covered in their plan.

What is the main argument against HB 1416?:

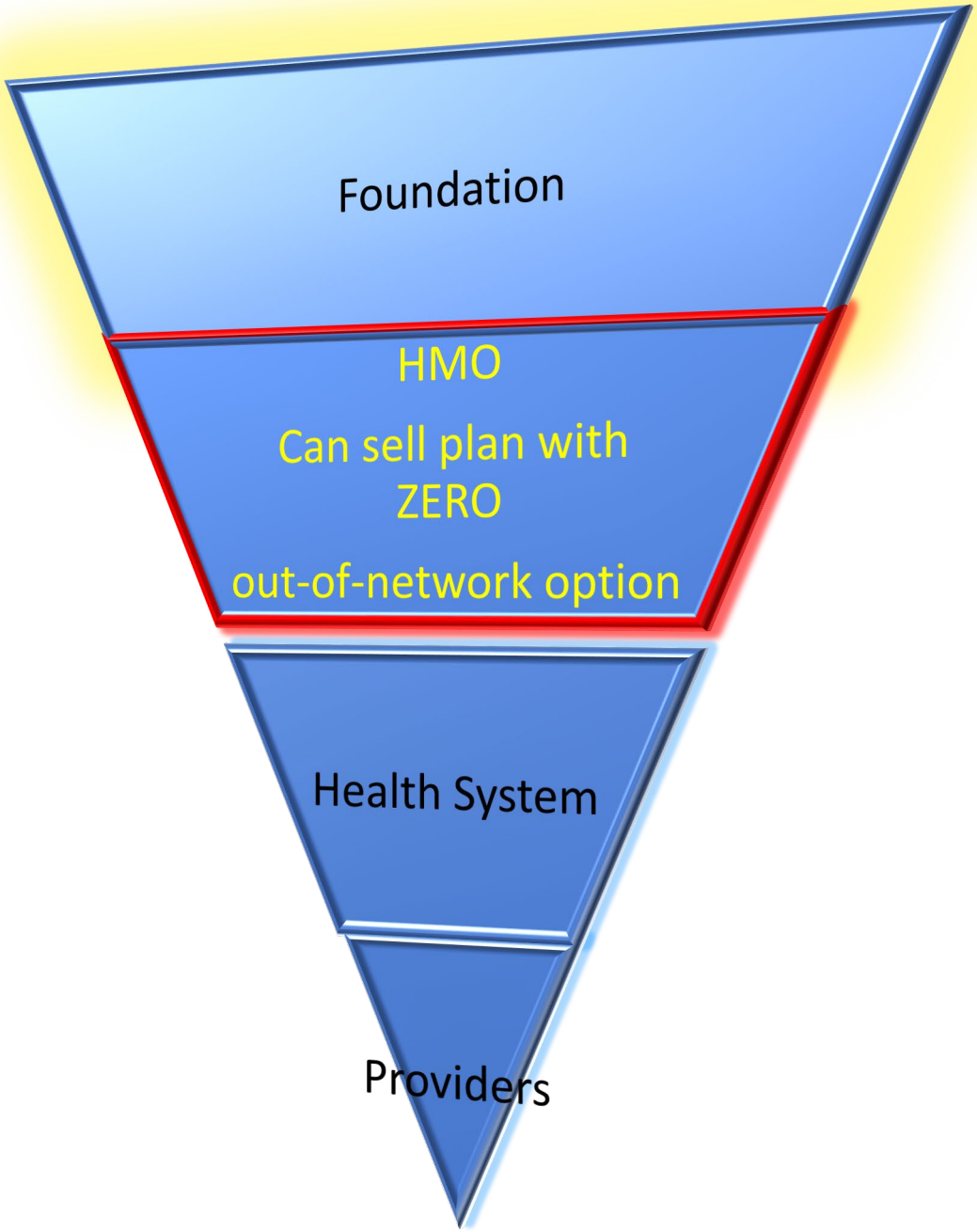
Increase in cost

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

North Dakota Legislative Management

Interim Healthcare Study, Final report January 2021

Does the VIN model in North Dakota promote competition?



California Health Care Foundation

CF Our Work The CHCF Blog Publications Grants Innovation Fund Events

CHCF BLOG

Is Vertical Integration Bad for Health Care Consumers?

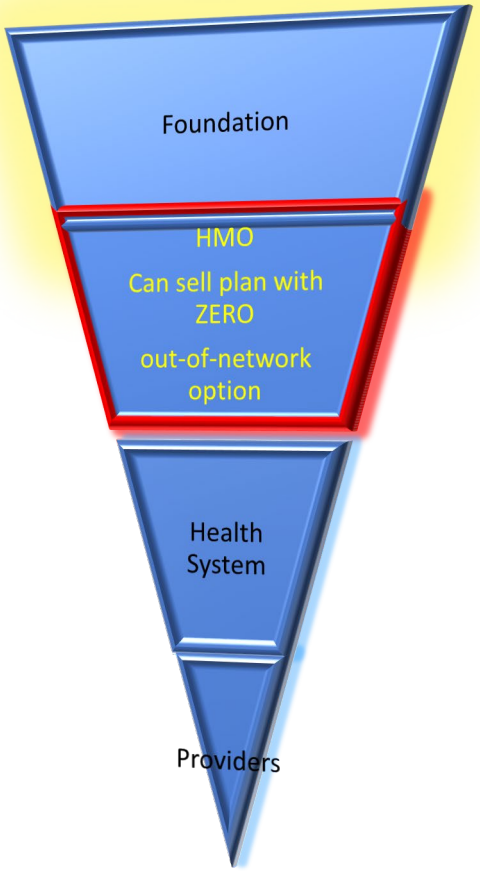
Stories that caught our attention this week

JUNE 21, 2019

[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

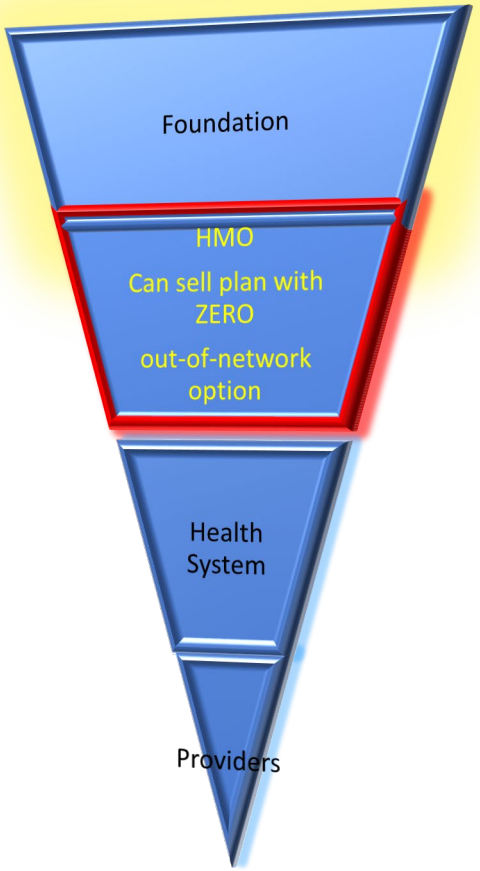
- “vertical integration can easily enable market power to use in an anticompetitive manner, allowing the merged firm to use its new structure to the disadvantage of others, and in some cases, to the harm of consumers.”



[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

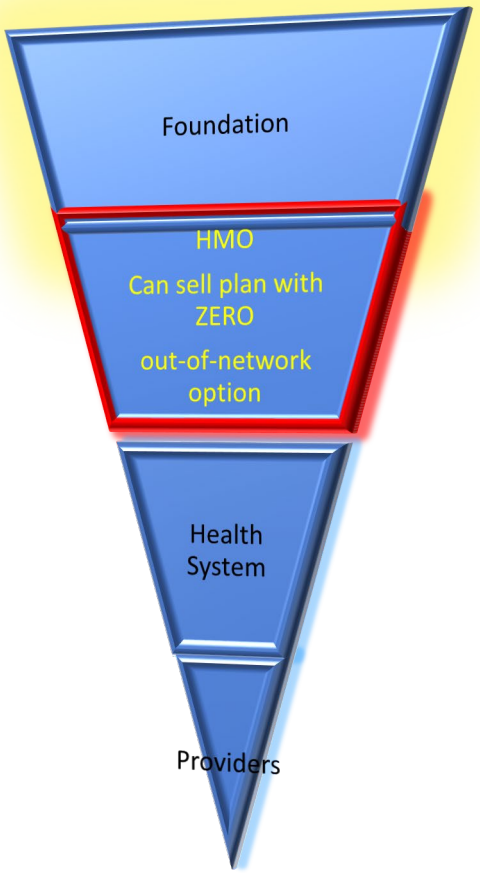
- Vertical integration increased hospital's bargaining power with the insurers, meaning the dominant hospitals can demand higher costs and limit competition.



[Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)]

Summary to article:

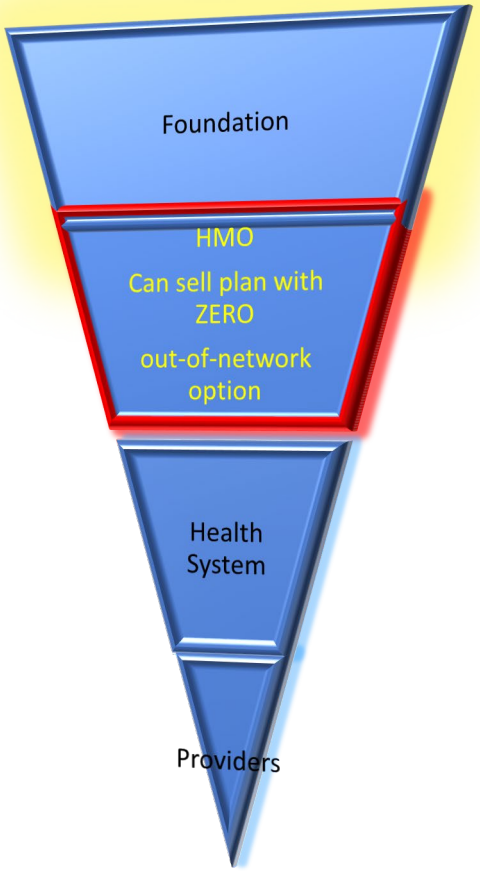
- Recent increases in vertical integration were associated with higher prices for primary care, more expensive specialty care, and higher health insurance premiums.



Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)

Summary to article:

- “Physician-Hospital integration did not improve the quality of care for the overwhelming majority of quality measures.”



Is Vertical Integration Bad for Health Care Consumers? - California Health Care Foundation (chcf.org)

STATE EFFORTS TO ADDRESS HEALTH CARE CONSOLIDATION AND COSTS

September 14, 2021

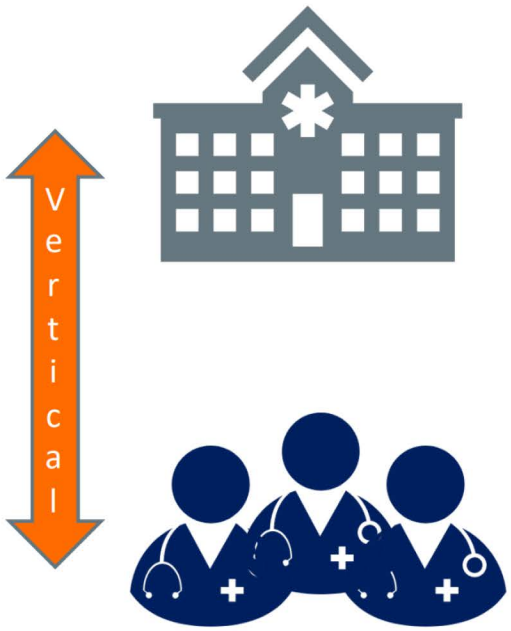
Katherine L. Gudiksen, Ph.D., M.S.

THE SOURCE
ON HEALTHCARE PRICE & COMPETITION

WHY ARE U.S. HEALTHCARE PRICES SO HIGH?

- Failure to protect a free market – lack of transparency
- Failure to protect competition and rigorously enforce antitrust laws
- Failure of policymakers to act when competition no longer exists

DATA ON RESULTS FROM HEALTHCARE MERGERS



Vertical Mergers

- **Higher Physician Prices**: Physician prices increase post-merger by an average of 14%
  (Capps, Dranove, & Ody, 2018)
  - Cardiologist prices increased by 33.5%
    (Capps, Dranove, & Ody, 2018)
  - Orthopedist prices increased by 12-20%
    (Koch and Ulrick, 2017)
- **Higher Clinic Prices:** Hospital-acquired clinic prices increased 32–47% within four years
  (Carlin, Feldman & Dowd, 2017)
- **Higher Hospital Prices** (Baker, Bundorf, Kessler, 2014)
- **Little to no quality improvements** (McWilliams et al. 2013; Neprash et al. 2015; Short and Ho, 2019)

Review > Int J Health Plann Manage. 2022 May;37(3):1252-1298. doi: 10.1002/hpm.3407. Epub 2022 Jan 4.

Vertical integration in healthcare: What does literature say about improvements on quality, access, efficiency, and costs containment?

Guilherme C Amado [1], Diogo C Ferreira [2], Alexandre M Nunes [3]

Results: A sample of 64 papers resulted from the screening process. The impact of vertical integration on costs and prices of care appears to be negative. Decreases in technical efficiency upon vertical integration are practically out of the question. Nevertheless, there is no substantial inclination to visualize a positive influence. The same happens with the quality of care.

Issue Brief

Hospital and Provider Consolidation: Negative Impact on Affordability for Consumers

November, 2014

America's Health Insurance Plans

NEWS

AHIP Statement for Senate Hearing Highlights Concerns About Vertical Provider Consolidation

Article

PUBLISHED JUN 12, 2019 • BY AHIP

How Hospital Consolidation Hurts Americans

Article

PUBLISHED AUG 26, 2021 • BY AHIP

Lower hospital competition equals higher health care costs

Diminished quality of care

VERTICAL INTEGRATION AND THE MONOPOLY PROBLEM*

CORWIN D. EDWARDS
Bureau of Industrial Economics, Federal Trade Commission

Corwin D. Edwards. Journal of Marketing Vol.17, No.4 (Apr, 1953), pp. 404-410

VERTICAL INTEGRATION AND THE MARKET POWER CRISIS

ISSUE BRIEF BY **ADIL ABDELA**, **KRISTINA KARLSSON**, AND **MARSHALL STEINBAUM**
APRIL 2019

We define "market power" as the ability to skew market outcomes in one's own interest, without creating value or serving the public good.

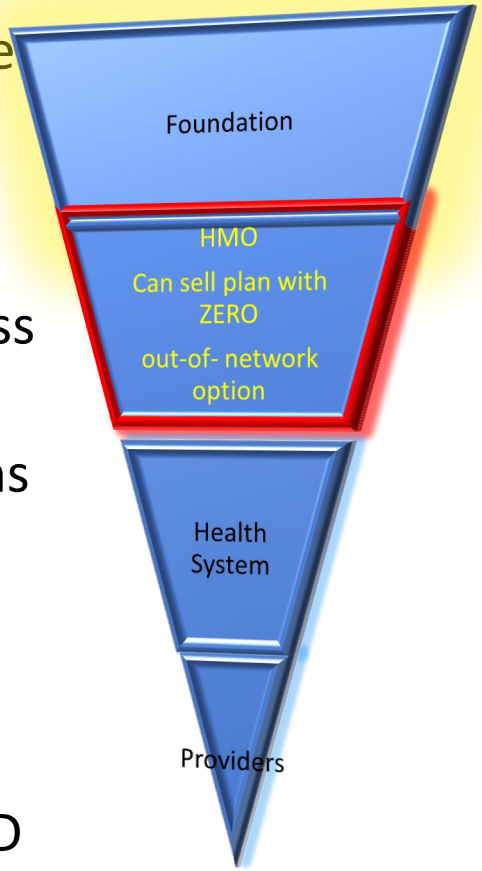
The real problem is the legalization of highly profitable business models that suppress competition and exploit stakeholders throughout the supply chain, no matter how large or small the parties to any given merger are.

RI-Vertical-Integration-and-Market-Power-Crisis-Issue-brief-201904.pdf (rooseveltinstitute.org)

Is ND at risk of a monopoly in healthcare?

YES

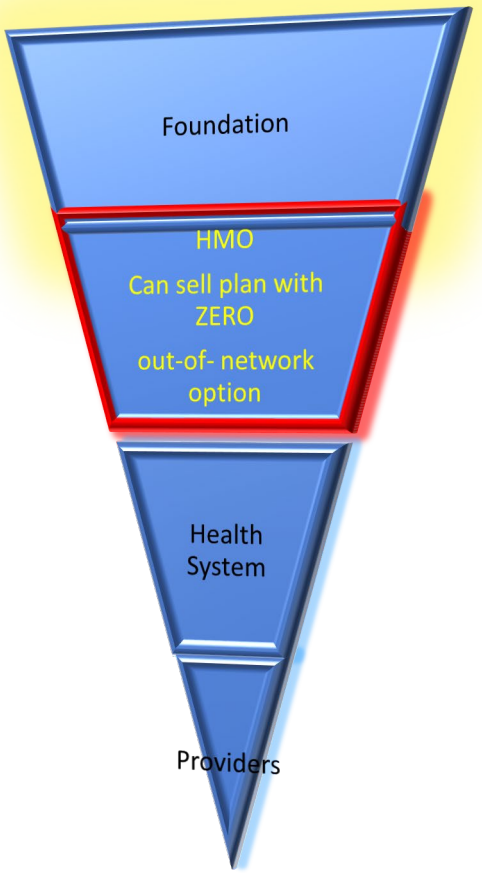
1) Vertically Integrated Network
2) Large foundation to support anti-competitive growth
3) HMO with zero out-of-network options, with planned expansion across ND
4) Struggling health systems at risk for consolidation
5) Struggling provider practices at risk for consolidation
6) Difficulty to recruit to ND in an anti-competitive environment = less competition



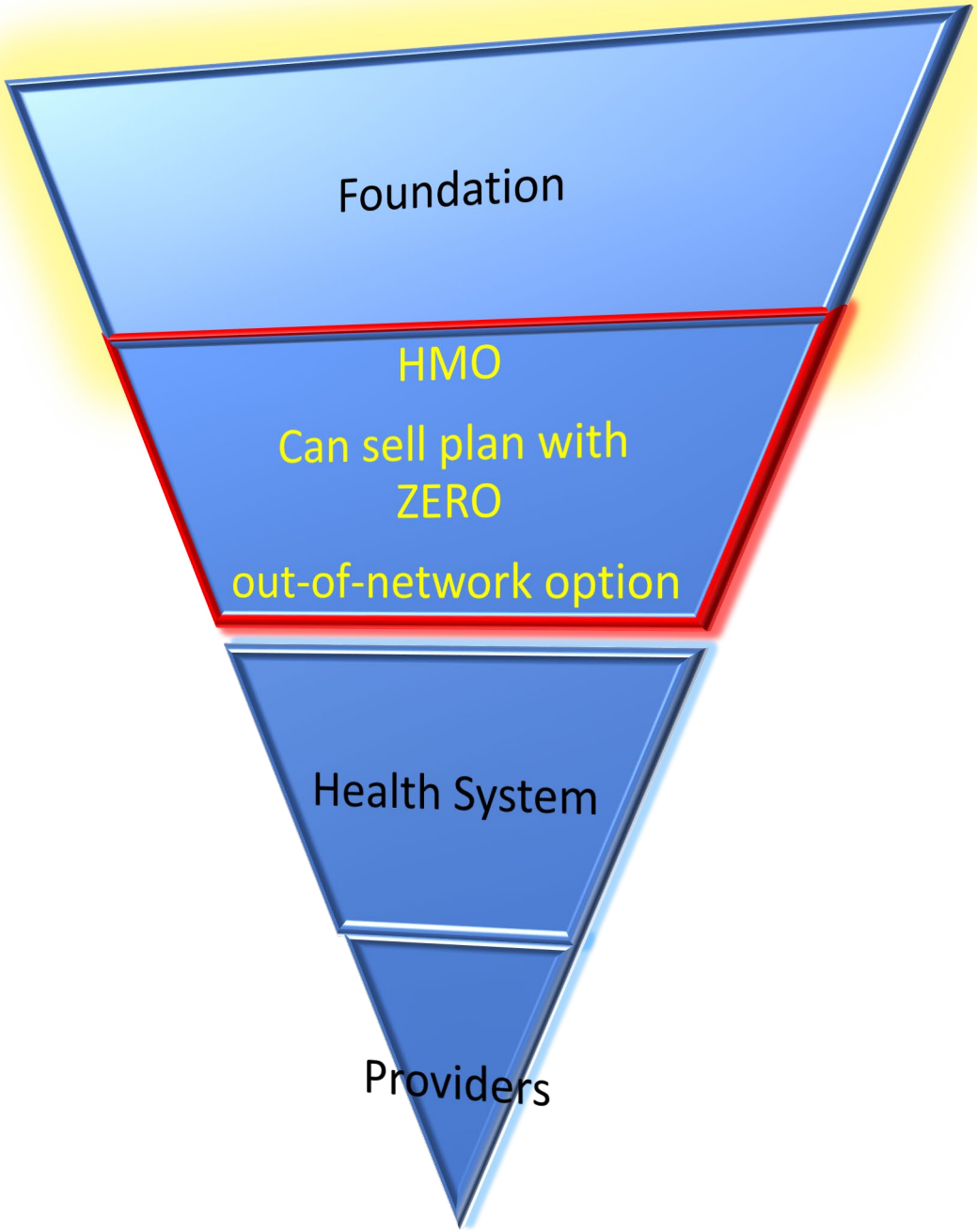
Is ND at risk of a monopoly in healthcare?

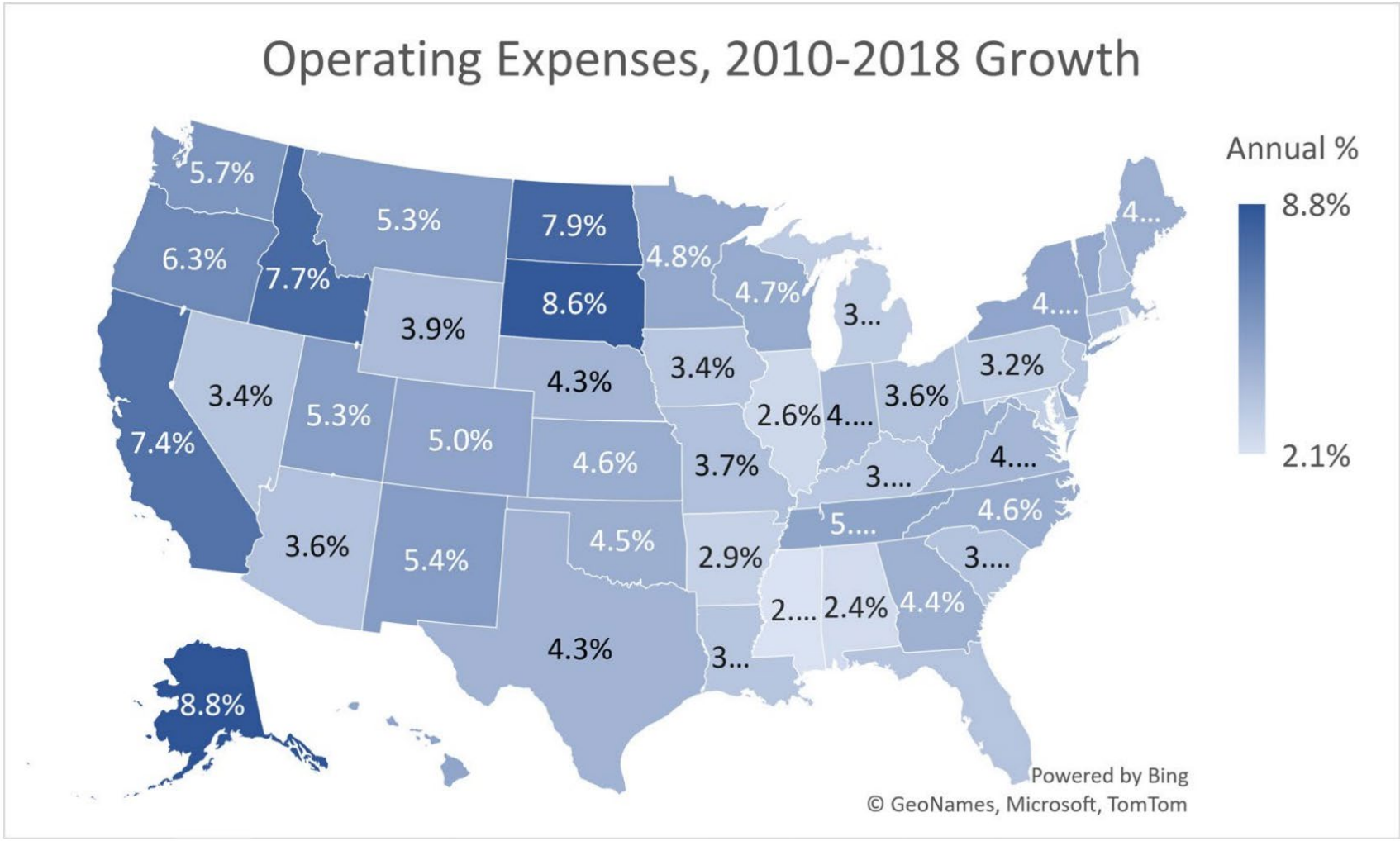
YES

1) HB 1416 - Allowing patients to choose a trusted provider helps solve one small piece of the monopoly risk



Does the VIN model in North Dakota promote cost savings?

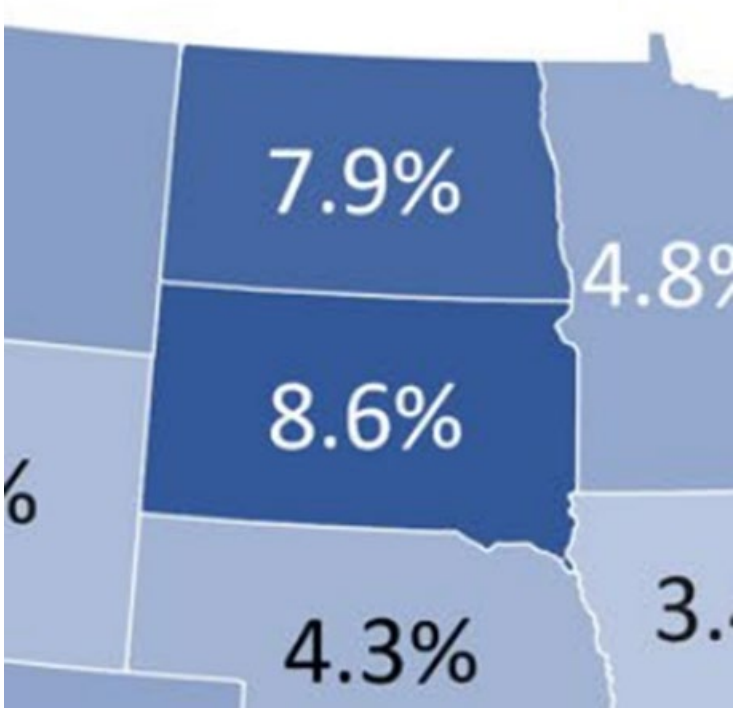




North Dakota RANKS #3 in percentage of average annual hospital operating EXPENSES GROWTH from 2010-2018

South Dakota RANKS #2 in the same category

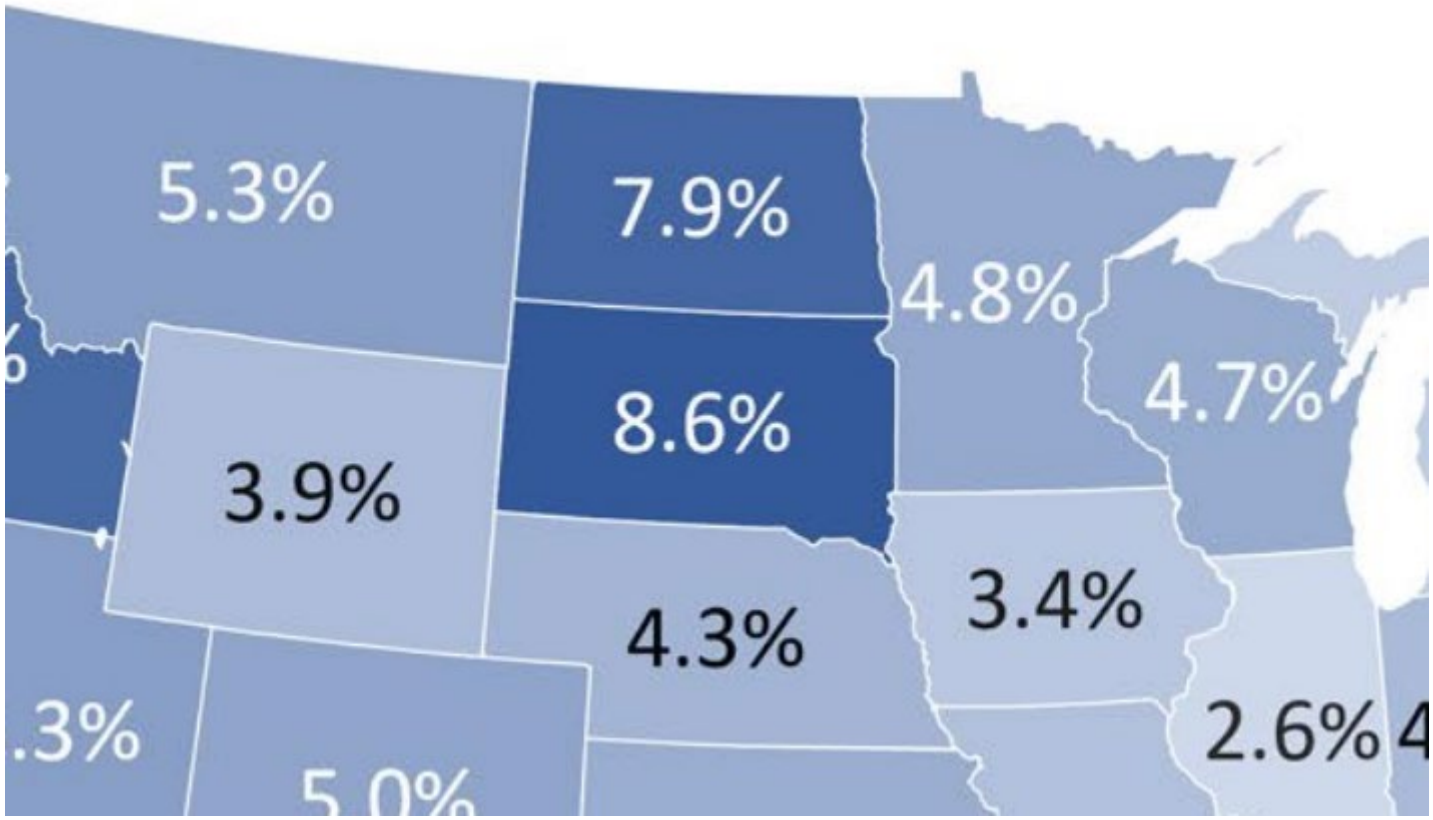
Average Annual Growth in Hospital Expenses



Hospital	Average Expense Growth
Hospital 1	4.0%
VIN	8.9%
Hospital 3	5.1%
VIN	14.0%
Hospital 5	6.0%
Hospital 6	3.1%

20210108 ND Legislative Management Interim Healthcare Study-FINAL.pdf Page 4

Operating Expenses, 2010-2018 Growth



The other 4 major hospitals in North Dakota had operating expenses growth similar to surrounding states (3.1-6%) 20210108 ND Legislative Management Interim Healthcare Study-FINAL.pdf Page 4

Hospital Related Prices for Selected Common Procedures in North Dakota

HOSPITAL	COLONOSCOPY	NORMAL VAGINAL DELIVERY
HOSPITAL 1	2,980	4,343
HOSPITAL 2	1,775	4,895
VIN HOSPITAL	3,843	15,056
VIN HOSPITAL	5,509	13,603
HOSPITAL 5	2,064	12,239
HOSPITAL 6	2,100	13,000
HOSPITAL 7	4,700	11,000

- 20210108 ND Legislative Management Interim Healthcare Study-FINAL.pdf
- North Dakota Legislative Management Interim Healthcare Study, page 15.

Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic

Code: 23412

Patient pays (average)
$774

Ambulatory surgical centers

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information

All costs are national averages

Total Cost		**$3,874**
Doctor Fee	**$876**	
Facility Fee	**$2,998**	
Medicare Pays		**$3,099**
Patient pays		**$774**

Patient pays (average)
$1,454

Hospital outpatient departments

This includes facility and doctor fees. You may need more than one doctor and additional costs may apply.

More cost information

All costs are national averages

Total Cost		**$7,273**
Doctor Fee	**$876**	
Facility Fee	**$6,397**	
Medicare Pays		**$5,818**
Patient pays		**$1,454**

Procedure Price Lookup for Outpatient Services | Medicare.gov 23412

“HOW DO WE DRIVE DOWN COSTS IN HEALTHCARE”?

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

North Dakota Legislative Management

Interim Healthcare Study, Final report January 2021

AHIP
Guiding Greater Health

Healthier People Through Healthier Markets

SOLUTIONS TO IMPROVE HEALTH CARE AFFORDABILITY AND ACCESS FOR EVERY AMERICAN

Stop Consolidated Health Systems from Stifling Negotiation and Innovation

In concentrated health system markets, prices do not flow from competitive negotiations. Instead, they are the result of the outsized leverage and inability to negotiate.

Some health systems leverage their significant market shares by requiring contracts with all affiliated facilities and preventing steering patients to lower-cost, higher-quality care. These anti-competitive contract terms, in the form of "anti-steering," "anti-tiering," and similar contract provisions, protect providers' highly inflated costs – costs that patients and consumers pay through higher premiums and out-of-pocket costs.[14]

https://www.ahip.org/resources/healthier-people-through-healthier-markets

AHIP
Guiding Greater Health

Healthier People Through Healthier Markets

SOLUTIONS TO IMPROVE HEALTH CARE AFFORDABILITY AND ACCESS FOR EVERY AMERICAN

Let's Work Together for Solutions

Increased competition will mean that patients and consumers have more choices over where to seek their health care. When patients and consumers have more control, they can get the care they need, when they need it – at a price they can afford. As demonstrated

https://www.ahip.org/resources/healthier-people-through-healthier-markets

How will HB 1416 control or even decrease cost?

1) HB 1416 – Is not “any willing provider” at “any willing price” - provider still needs to negotiate and meet the terms and conditions to participate
2) Fail First mechanisms employed by insurance companies
3) Provide access to Ambulatory Surgery Centers vs Hospital Outpatient Departments (ASC up to 50% cost savings vs HOPD)
4) Patient access to the providers they need, avoid redundant visits

How will HB 1416 control or even decrease cost?

5) Value based contracting arrangements with independent providers

6) Allows patients the Right to Shop for lower cost centers of care.

7) Allows patients to access LOWER COST centers which drives down cost, saves the patient money, saves the VIN insurance company money, allowing the VIN to offer its current closed network plan to MORE consumers.

Deloitte.

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

Tel: 612 397 4463
Fax: 612 692 4463
www.deloitte.com

Memo

Date: January 24, 2023

To: Scott Miller
Executive Director, North Dakota Public Employees Retirement System

From: Tim Egan & Dan Plante & Drew Rasmussen, Deloitte Consulting LLP

Subject: **ACTUARIAL REVIEW OF PROPOSED HOUSE BILL 1416**

"Deloitte's comments are limited to the scope of the uniform group insurance program. The legislation is anticipated to have a financial impact on the uniform group insurance program but the impact cannot be estimated with confidence because the costs will be dependent on provider contracting arrangements with the health insurer that administers the uniform group insurance program"

Deloitte.

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"Conceptually, eliminating the ability for health insurers to exclude any providers from their networks removes some of the incentive for providers to agree to competitive reimbursements. The average discounts agree to by health systems (e.g., usually 30-40% for hospital care) could be reduced, or eliminated, IF providers could charge higher rates without any impact to patient volume. Any reduction in the discounts could lead to significant increase in health insurance premiums for all covered participants under the uniform group insurance program."

Deloitte.

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Subject: **ACTUARIAL REVIEW OF PROPOSED HOUSE BILL 1416**

Program include 100% of hospitals and over 96% of physicians in the State. Given the breadth of the network participation in the State, the legislation may not have the effect of expanding provider participation. Additionally, since there is such broad provider participation, the financial impact of the proposed legislation could be immaterial if provider reimbursement rates do not increase as result of the legislation (since there are no hospitals and relatively few providers that are not under contract today).

What HB 1416 Does Do?

Allows patient to see the provider of their choice, IF the provider agrees to the terms and conditions established by the insurer

Allows insurance companies to determine the terms and condition offered to the provider (96% of physicians already contracted in other VIN plans with out-of-network options)

What HB 1416 Does Do?

Allows patients to select an out of network option when no option exists

Increases healthcare workforce capacity, by adding more providers patients can choose from for their care

What HB 1416 Does Do

Increases Competition, “evens the playing field”

Allows patients the right to shop for lower cost alternatives outside of the closed network

Decreases the risk of future health care monopolization in North Dakota

HB 1416
Patient Choice

- Senate Human Services Committee
- March 14th, 2023

NORTH DAKOTANS for Open Access Healthcare

Madam Chair Lee, Vice Chairman Cleary, and members of the Senate Human Services Committee,

North Dakotans for Open Access Healthcare is a coalition of independent medical practitioners, medical facilities, medical associations and independent hospitals that support patient choice. We strongly support HB 1416.

The genesis of the Patient Choice bill is the result of the increasing number of patients and providers across the state voicing their concerns about narrow network plans, particularly narrow network plans that have **ZERO out-of-network coverage.** The obvious difficulty with narrow network plans in a rural state is patient access to providers, particularly when it comes to medical specialists. It has become more common to hear patients' concerns when needing specialty care. Patients often experience long wait times, and in the case of rural areas, patients often drive past an out-of-network specialist right in their own community. HB 1416 allows patients to choose the providers they know and trust.

HB 1416 increases competition. Competition in health care markets benefits consumers because it helps contain costs, improves quality, and encourages innovation.

An excerpt from the results of the North Dakota Legislative Management Interim Health Care Study shares that, "Competition stimulates innovation – lower prices and better quality. Competition is the ultimate consumer protection because it allows a consumer to walk away from a transaction to find a better partner."

It's important to remember - patient choice legislation is not "any willing provider" at "any willing price." The insurance companies still control the fee schedules, and if a provider chooses to participate the provider still needs to negotiate and agree to the insurance plans terms and conditions.

Patient choice legislation permits the patient to choose who they trust to care for their healthcare needs. Insurance companies will negotiate with all willing, licensed, and qualified healthcare providers for inclusion in their networks.

Patient Choice will increase competition and help control spiraling healthcare costs in North Dakota.

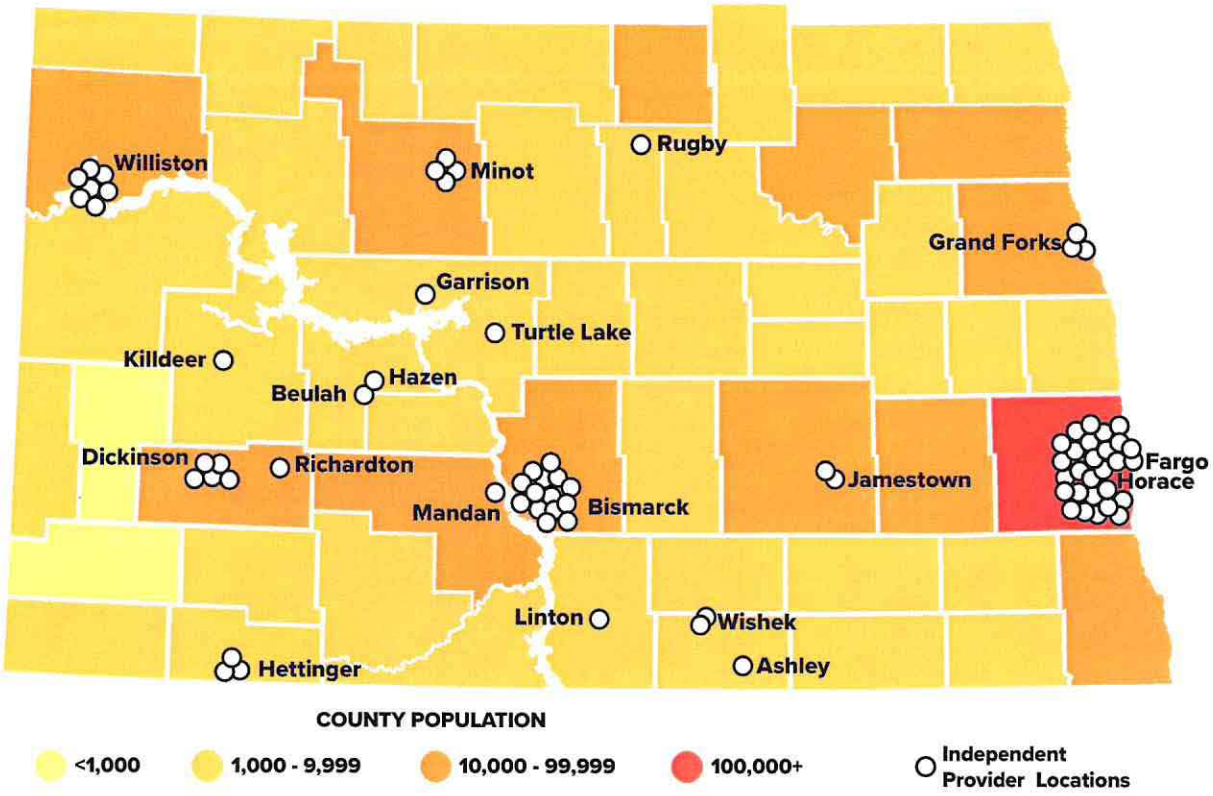
We strongly encourage a **DO PASS** recommendation from your committee.

Sincerely,

North Dakotans for Open Access Healthcare

NORTH DAKOTANS for
Open Access Healthcare

Independent Providers Supporting HB1416



- AIM Physical Therapy, Bismarck
- Bagan Strinden Vision, Fargo
- Balance Medical, Bismarck
- BeWell PT, Horace
- Bismarck Surgical Associates, Bismarck
- The Bone & Joint Center: Bismarck, Minot, Williston, Beulah, Hazen, Turtle Lake, Wishek, Garrison, Linton, Dickinson, and Hettinger
- Brightside, Bismarck
- Canopy Medical Center, Fargo
- Catalyst Medical Center: Fargo, Grand Forks, and Jamestown
- CCs Physical Therapy, Bismarck
- Center for Pain Medicine, Fargo
- Center for Plastic Surgery, Fargo
- Center Special Surgery, Fargo
- Chatter Pediatric Therapy: Williston, Dickinson, and Jamestown
- ConnectUS Therapy, Williston
- CPAP Store and Sleep Easy, Fargo and Grand Forks
- Dakota Adult and Pediatric Psych, Fargo
- Dakota Gastroenterology, Fargo
- Dakota Littles, Williston
- Elite Health and Fitness, Williston
- Elite PT, Dickinson
- Empowered Llfe Counseling, PLLC, Fargo
- Eye Clinic of ND: Bismarck, Dickinson, and Hettinger
- Eye Consultants of ND, Fargo
- Fargo Center for Dermatology, Fargo
- First Choice PT, Minot
- Heartland Healthcare Network, Fargo
- Hearth of America, Rugby
- Hetland ENT, Bismarck
- IMA Healthcare, Fargo
- Imaging Solutions, Fargo
- Institute of Diagnostic Imaging, Fargo
- Institute of Facial Surgery, Bismarck
- Jones Physical Therapy, Bismarck
- Kids in Motion, Mandan
- Live in Motion PT, Williston
- Matthys Ortho, Fargo
- Milestone Health Partners, Williston
- Minot Center for Pediatric Therapy, Minot
- North Dakota Dental Association
- North Dakota Medical Association
- North Dakota Nurse Practitioner Association
- Northern Neurosurgery, Fargo
- Origin Chiropractic Physicians, Fargo
- Ortho Dakota, Fargo and Grand Forks
- OSM Ortho Sports, Fargo
- Pain Treatment Center Anesthesiologists, Bismarck
- Pelican Health, Bismarck
- Pinnacle Health Care, Fargo
- Plains ENT, Fargo
- Solace Counseling, Fargo
- South Central Health, Wishek
- Stellar Healthcare, Fargo
- Tara B Fertility, Ashley and Bismarck
- Therapy Solutions, Dickinson, Killdeer, and Richardton
- Vance Thompson Vision, Fargo
- Van Dam Chiropractor, Fargo
- West River Health, Hettinger
- 360 Physical Therapy, Minot

NORTH DAKOTANS for Open Access Healthcare

Chairman Weisz, Vice Chairman Ruby, and members of the House Human Services Committee,

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Sincerely,

North Dakotans for Open Access Healthcare

Response to 1416 Amendment

We respect the insurance department and the healthcare providers on the committee. Unfortunately, their positive experiences with their own vertically integrated networks are not always the norm. This amendment, while well-intentioned, changes nothing. An out-of-network request process is already implemented and delays care. Putting it into code will do nothing for patients who want to receive out-of-network care for availability, treatment paths, or specialties. Companies that provide both healthcare and insurance will continue to steer patients to their doctors, and narrow-network insured patients will continue to be forced to have these paths decided for them.

Upon receiving the amendment, we realized that it does nothing to solve the issue at hand. Patients are already able to request to see out-of-network providers. Putting this into code does not change the fact that narrow-network healthcare and insurance providers will be able to deny patients the ability to see an out-of-network provider, steering patients to the doctors that they employ, forcing profits into their own pockets. This amendment takes away any ability to get a second opinion for treatment, as narrow-network reviewers will say that they already provide the treatment, and deny any second opinion. For example, there is a 15-year-old in Bismarck who got a concussion. They saw healthcare providers in their narrow network with no positive results on treatment. They found a physician with a different subspecialty in neurology on the East Coast, who undid everything healthcare providers did here. Two weeks later, he is already showing signs of improvement. His family paid cash for the treatment.

The narrative surrounding this bill has been confused. This bill does not impact Medica or Blue Cross Blue Shield as they do not provide healthcare services in addition to their insurance services. They do not force patients to their employed doctors, because they do not provide healthcare. They are simply insurers. The intent of this bill is to stop this steering for companies that provide both healthcare and narrow-network insurance plans.

In our experience, narrow-network reviewers have denied every request as long as they are able to provide the same medical specialty. The companies that steer patients to their own doctors do not consider availability of doctors, treatment paths, and sub-specialties. They simply check the box that says they "have a medical specialty of 'x'" without taking into account what the individual patient needs or potential sub-specialities in the field of medicine. If we had a special treatment with a 95% cure rate of cancer in our clinics, narrow-network reviewers would deny patients coverage because they "provide oncology treatment." Fulfillment of medical needs extends beyond healthcare provider type. It is known throughout the profession that doctors in narrow-network plans are reprimanded for even referring patients to out-of-network providers. We will be the first to tell you that our care may not be for everybody, but it is our duty to send the patient to the best care possible. This does not happen with companies that provide healthcare and narrow-network insurance plans.

The word "disingenuous" was used in this morning's committee work. To say that this amendment was "facilitated" is disingenuous. We received word that there was an amendment to the bill in a meeting at 2 PM yesterday. The amendment was not given to us until this morning's committee work. We were not a part of the conversation in drafting the amendment. This is not facilitating a compromise.

-ND for Open Access Healthcare