1999 SENATE INDUSTRY, BUSINESS AND LABOR

SB 2396

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2396

Senate Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date February 10, 1999

Tape Number	Side A	Side B	Meter #
1	x	x	0-end, 0-2350
Committee Clerk Signature			

Minutes:

Senator Mutch opened the hearing on SB2396. All senators were present.

Senator Traynor introduced SB2396.

Representative Nicholas testified in support of SB2396.

Tim Tracy testified in support of SB2396. His testimony is included.

Greg Hanson, Chair of Hospitals, testified in support of SB2396. Feels that North Dakota residents are intelligent enough to make their own decision on who gets the benefits. Senator Thompson asked him who is making the change of the reimbursement amounts. He said that Noridian is making that change.

Mike Tomasco testified in support of SB2396. His testimony is included.

Rynn Pitts testified in opposition to SB2396. Her testimony is included. Senator Klein asked her if the discount was the same for every hospital. She said that the discount will go up and down.

Senator Heitkamp said that it sounds fair as long as your not the provider. He asked Rynn if this was putting the providers in a box. She said that she did not feel that it did.

Bob Lamp testified in support of SB2396.

Dick Eagle testified in opposition to SB2396.

Trent Heinemeyer testified in a neutral position to SB2396.

Senator Mutch closed the hearing on SB2396.

Senator Sand motioned for a do pass committee recommendation on SB2396. Senator Heitkamp seconded the motion. The motion carried with a 7-0-0 vote.

Senator Sand will carry the bill.

Date: 2/10/99
Roll Call Vote #: 1

SR 28254D

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
SENATE **BILL/RESOLUTION NO.** 2396

Senate INDUSTRY, BUSINESS AND LABOR COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS

Motion Made By SAND Seconded By HEITKAMP

Senators	Yes	No	Senators	Yes	No
Senator Mutch	X				
Senator Sand	X				
Senator Krebsbach	X				
Senator Klein	X				
Senator Mathern	X				
Senator Heitkamp	X				
Senator Thompson	X				

Total (Yes) 7 No 0

Absent 0

Floor Assignment SAND

REPORT OF STANDING COMMITTEE

SB 2396: Industry, Business and Labor Committee (Sen. Mutch, Chairman) recommends **DO PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2396 was placed on the Eleventh order on the calendar.

1999 HOUSE INDUSTRY, BUSINESS AND LABOR

SB 2396

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2396

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 3-3-99

Tape Number	Side A	Side B	Meter #
1	x		45 - end
1		x	0 - 1849
2	x		3772 - end
2		x	0 - 2006
Committee Clerk Signature	Lisa Horner		

Minutes: **SB 2396**

Senator Traynor: Introduced SB 2396 relating to the transferability of health insurance policies. This bill will allow an insured person to assign the benefit of a health insurance policy. What has happened in communities with smaller hospitals this has been a very difficult thing for them.

Rep. Nicholas: Those of you from the rural areas of ND know that the squeeze by BC/BS on our bottom line with our increase in premium and decrease in reimbursement is causing a number of problems for many of these rural hospitals. We know that as we move forward changes must be made. States like South Dakota have already implemented an assignment program that is much more beneficial to the rural hospitals of the states. As we struggle for survival out there we know that we must have some changes made if we are to go on and provide the high quality service. This bill will be a benefit to the consumer and will give him the opportunity to do what he wants to with that assignment. We must always be cost competitive with the surrounding areas.

Greg Hanson: President of Saint Joseph's Hospital in Dickinson ND testified in support of SB 2396. (See written testimony)

Tim Tracy: Administrator of Towner County Medical Center in Cando, ND. testified in support of SB 2396. (See written testimony)

Chairman Berg: You have patients that have assigned their benefits to your hospital. What is the benefit for the hospital for those patients who have assigned their benefits to you vs. one that receives those benefits directly?

Tim Tracy: The way we work with third party insurance carriers is that if the patient chooses to assign benefits, we do the billing on their part by billing the insurance department directly and then the patient pays us directly. Because BC/BS doesn't allow assignment of benefits unless we are a participating provider, it forces the hospital boards to make the decision whether to contract or not with Noridian based on that ability to receive assignment of benefits.

Chairman Berg: How will the rural hospital receive more compensation with passage of this bill?

Tim Tracy: This is about treating all insurance companies the same. Making Noridian accept the assignment of benefits by doing that it removes the barrier to the hospitals when it comes to participation. This is to try and get BC/BS to the negotiating table.

Rep. Keiser: If this were to pass and be signed by the Governor, what would happen to this bill?

Tim Tracy: The likelihood, because of the market dominance that Noridian has, the people in the health care provision would opt not to participate.

Vice Chairman Kempenich: What if BC/BS decides not to participate in the process?

Tim Tracy: Then it's the job of the hospitals to go out to the public and make our case. They should have the choice to decide for then selves.

Jim Long: Administrator of the West River Regional Medical Center in Hettinger testified in support of SB 2396. (See written testimony)

Rep. Keiser: The discussion has been that the insured should have more say in assignments. Given the industry pays the significant portion of the all the insurance premiums in the state for the BC/BS program, what do you think the industry voice should be on whether or not to continue the current assignment policy?

Jim Long: Speaking from the rural environment, I think that the rural industry should speak up on this bill. Noridian has not been subjected to the market pressures that is should be.

Mike Tomasko: On behalf of the NDMGMA testified in support of SB 2396. (See written testimony)

Rep. Glassheim: What will the affect be on the urban hospitals?

Mike Tomasko: This will bring us to the table on an equal level.

Rep. Severson: After listening to testimony, my fear is that if you raise reimbursement the same is going to happen with premiums. Do you have any idea what impact that will have on premium increases?

Mike Tomasko: We have asked the same question about the reimbursements going down and premiums increasing and where is the money going. We do not have an answer to that.

Opposition

Trent Heinemeyer: Deputy Commissioner, testified in opposition of SB 2396. (See written testimony)

Chairman Berg: It's indicated that if there is a group that holds a policy, if that group decides they want the ability to assign, if everyone in that group agrees they can do that but an individual can not do that?

Trent Heinemeyer: There seems to be a lack of clarity in this statute that SB 2396 proposes to amend. The individual policy holder may at any time assign their policy. BC/BS or any other insurance company can not dictate to them that they can't. As to the group side, the law is quite clear and requires an agreement of the three parties, the group contract holder, the certificate holder and the insurance company.

Rep. Lemieux: Does any other insurance provider besides Noridian have a pay schedule of participating and non participating that would have such a deviation in the reimbursement?

Trent Heinemeyer: I don't have specific information about the number of insurance companies that have set up networks like BC/BS. It is my general understanding that every time there is a network established each of those insurance companies establishes a difference between a network provider or a participating provider and a reimbursement level for a non provider.

Rep. Glassheim: Why did the department allow an increase in rates and a decrease in reimbursements, and why did you approved it?

Trent Heinemeyer: We don't regulate the reimbursement levels that BC/BS negotiates with the providers around the state. As to the increase in premiums my understanding is that BC/BS incurred a significant underwriting loss last year, they paid out more in claims than they collected in premiums. The premiums are based on utilization of services.

Ryn Pitts: Senior Vice President of Health Care and Member Services Division of Noridian Mutual Insurance Company testified in opposition of SB 2396. (See written testimony)

End of tape 1 side A, start side B.

Vice Chairman Kempenich: What is the BC/BS negotiating practice?

Ryn Pitts: Our system of uniform payment rates were developed years ago.

Rep. Keiser: When BC/BS distributed their new rate structure did any of the health care facilitates offer to pay for a third independent party to do a review of the cost structure in an attempt to provide documentation as to why your rates weren't going to work for them?

Ryn Pitts: If I understand the basis of the question the answer is no.

Rep. Martinson: I sense a lot of frustration with the people who support this bill about the desire to get BC/BS to negotiate. Do you have any reaction to that frustration?

Ryn Pitts: I'm somewhat in the dark as well. We have 34 hospitals that we refer to as rural hospitals that we make payments to. Of these 34, 22 of those receive payments that are higher than their charges. If we are paying them more already then I don't understand what they want to negotiate.

Rep. Koppang: Why do you want to pay more than they request? It doesn't happen in any other insurance claims.

Ryn Pitts: This is an interesting situation. It's best understood in the historical context of the positive relationship that the client has always had with the providers. Back at the time when the uniform payment system was in place, it was a concern with BC/BS that they needed access to hospital provider care for all our members. It was also an inspiration that reimbursement should be fair and equitable and that it should not be greater in one part of the state any other. This is really the basis for payments.

Rep. Glassheim: Apparently what set this off is some of the decreases in what you are paying. Can you explain what more about these decreases as to whether they are fair or not, and what is the rationale of BC/BS for this?

Ryn Pitts: You heard Trent mention that we had an underwriting loss for $20 million in 1998. The company needed to put together a get well plan that involved a premium increase and some administrative reduction and deductions of other payments. Rural hospitals were not part of this in any way. I will also point out that while payment reductions were made on a per unit basis in the pay schedule for certain procedures, in fact the total payment that we made to providers has gone up. So when we talk about payment reductions, understand that this is on a per unit basis.

Rep. Stefonowicz: The bill before us is very simple. It asks that if the benefits can be assigned even though it's a non participating hospital. In reality is this going to have any detrimental effect on BC/BS?

Ryn Pitts: Ironically in the short run, I think that there will be an unfair burden that will go to all its members.

Mary Ann Johnson of Knife River Corporation testified in opposition to SB 2396. (See written testimony)

Dean Peterson of North American Coal Corporation testified in opposition of SB 2396. (See written testimony)

Katy Allen of the ND Public Employees Retirement System gave informational testimony.

Chairman Berg closed the hearing.

Tape 2, side A. Meter No. 3772.

Committee discussion

Rep. Ekstrom: I have a question as to whether the urban hospitals paid better reimbursement rates than the rural hospitals?

Ryn Pitts: I stated earlier that we have a uniform payment system. To explain the next level of detail, what this means for hospitals is that we have one base rate that we pay to all hospitals, both rural and urban. However, every hospital has a slightly different case mix. This means that some hospitals have more patient resources, and others have less.

Rep. Keiser: Has any health care provider or facility make a request of BC/BS to pay for a fiscal review, audit or anything like that using a third neutral party that they could bring the data to BC/BS and have a discussion regarding their pay structure?

Ryn Pitts: No. We have been approached by our providers for an independent audit of the target that we have used in one of our managed care products. The product, Blue Choice, is a shared risk product with the providers. By that, I mean it's a capitated like product where the provider and BC/BS share in the losses if there is a loss. They also share in the gains. In controversy, is whether or not the target that BC put forth is actuarially accurate.

Rep. Klein: Earlier I asked you if I were to go to a participating hospital and I asked for the payment to come to me. You said that I would get less that what would be paid to the hospital. Is that correct?

Ryn Pitts: I misunderstood your question. No, you would not get less. You would get the same payment as the hospital.

Rep. Stefonowicz: In the event that it was a nonparticipating hospital, who would get the payment?

Ryn Pitts: In this case the payment would be 80% of the amount paid to the patient.

Rep. Klein: In some cases, the payment you receive from BC is higher than your normal charge. Would you explain this?

Jim Long: Yes. That has been the case in the past years with the GRD system with BC only on the inpatients. If you blend together and total the payment of inpatient and outpatient, I don't think you will find that to be the case. With this re-weighting, I don't even expect this to happen on the inpatients.

End of side A, tape 2. Start side B.

Vice Chairman Kempenich: If you are charging less, how are you going to make up the difference?

Jim Long: It will be difficult to try and pass that on when there is a very limited number of people left after you take out Medicare, Medicaid, Workers Comp, and others. You only end up with a small percentage left and we won't raise their rates.

Chairman Berg: The issue with this bill is that it is a negotiating leverage. You have no choice whether or not to be a participating hospital, because if you don't then all of the patients are going to go to the next place that is before they will pay out more money.

Tim Tracy: This bill is nothing more than to try and get Blue Cross to the negotiating table. They do it in other states so why not here? Don't let them fool you into thinking that their rates are fair because they are not. Our rates have decreased disproportionately because when they did the re-weight they also decreased the base.

Chairman Berg: If we pass this and Blue Cross says to you, here is your choice, either you're in or out, make your decision. You say you're out. Where will your consumers go? Do you think they would actually go there because they are participating and you are not?

Tim Tracy: Some of them are doing that. They go to the nearest place.

Chairman Berg closed the hearing.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2396 3-9-99

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 3-9-99

Tape Number	Side A	Side B	Meter #
1	x		3750 - end
		x	0 - 2870
Committee Clerk Signature Lisa Horner			

Minutes: **SB2396**

Chairman Berg explained the bill to the committee. They want the right to assign. I don't believe this will give any more leverage to the rural hospital's, because if the rural hospital is not a participating hospital, then the patients in their trade area will be going to the next place that is a participating hospital. People will not pay more at a local hospital if the same service will cost less somewhere else. The real concern with what BC/BS has done is when they reweighted this DRG. What the rural hospital would like is to get to the table with BC/BS. They want the legislature to set the rates, which could create a real problem. One of the issues is that BC/BS should go back and look at the DRG's. I'm concerned with the legislature getting involved with in setting reimbursement rates. What we have already done, be it good or bad, is create a monopoly with BC/BS of ND by wanting to control and hold down health care costs.

The problem with this is that it affects the health care providers in our state. The providers in the small margins are the ones that are affected the most.

Chairman Berg hands out and explains the amendments. The amendment would require BC/BS and Noridian to go in and reexamine its reimbursement rates to rural hospitals, and hopefully create an environment where the rural hospitals are willing to provide the information to then. They would have to then reevaluate their reimbursement and submit a report to the legislative council on Oct. 1st. If they didn't submit the report, them the bill would go into effect. It would allow the assignability of a patient's health care. We have defined the rural hospital as one with less than 100 staffed acute care beds and the community of less than 10,000 population.

Mike Hamerlik explained further the definition of rural hospitals. Generally, smaller hospitals that have had the financial stress of not getting enough patients and experience operating losses are these hospitals.

Rep. Johnson: As I understand the amendments, all it does it submit a study?

Chairman Berg: Yes.

Rep. Froseth: One of the observations was that after all the testimony and discussion was that the small rural hospitals could not get Noridian to the bargaining table. Noridian was setting rates and telling them this is it. They lost their credibility to participate in negotiations. This amendment would allow this to happen.

Rep. Glassheim: My conclusion was that it doesn't matter. BC/BS did the right thing by rebalancing the rates, and that in fact they are justified in terms of DRG's. However, the effect on smaller hospitals, because of population, is dead. If we really want to do anything about it, we will have to send money to the rural hospitals. We will need to put more money in to the

hospitals just like the phone co-ops and REC's. There are not enough people per square mile to make them survive.

Rep. Klein: On line 15, is this saying that the insured, whether the hospital is participating or not, if I'm the insured I can assign that? Then I could assign it directly to the hospital?

Chairman Berg: Yes. The amendment isolates it just rural hospitals.

Rep. Martinson: What is the reason for excluding the larger hospitals in the assignment of benefits issue?

Chairman Berg: It was to narrow the scope. It could be open to all hospitals.

There was more general discussion among the committee members about different ways to write the amendments. The Chairman closed the hearing.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2396 3-10-99

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 3-10-99

Tape Number	Side A	Side B	Meter #
1	x		67 - end
Committee Clerk Signature	Lisa Horner		

Minutes: **SB 2396**

Chairman Berg opened the discussion of SB 2396. He handed out and explained a new set of amendments to the committee.

Rep. Ekstrom: handed out a list of the hospitals and the number of beds in each place.

Chip Thomas: What this amendment is attempting to do is establish a basis of information that involves a joint entity that includes both BC/BS and the hospitals.

Rep. Severson: This is to be reported to the legislative council by January 1st. So, basically all this amendment provides is information. Would it be helpful not only to have information but a plan of action where we say we can go with this?

Chip Thomas: Once the factual base is there, all parties involved will begin to derive implications from that factual information and begin to seek out assistance as appropriate in terms of what the information says.

Mike Hamerlik of BC/BS: We did look at the amendments and there are a couple of things missing. First of all, the time frames are too tight. It sounds simple when you just put a sentence into a statute. It's more complicated than that. We are not sure that everything can be accomplished in that time and we want to do our best. The reexamination requires the analysis on an individual basis for every hospital. This will require a lot of time. That means when we analyze what the smaller places get paid, we also analyze what the larger hospitals get paid. There is only so much money to go around and if we have to take money to pay the rural hospitals more, then the money has to come from some where. There is an entity missing from this. That is the policy holder and the premium payer. The state is a major payer for the employees. I'm assuming that would be part of the mix or analysis.

Chairman Berg: I think the language in this that talks about an individual basis is not so much to reexamine each individual hospital, but that there were hospitals that didn't want to provide financial information, that they wouldn't be holding you up from going ahead and looking at everyone else. This is for those who participate.

Vice Chairman Kempenich: The intent for this is for the information to be made available with out necessarily targeting an individual.

Mike Hamerlik: I agree, but what I'm saying is that we offered to do it before and they didn't participate. There needs to be a requirement in order for us to fulfill our obligation and provide a report. If they don't provide us with those audited financial statements, we can't provide a report that has any validity or significance to you or anyone else.

Chairman Berg: The issue before us is how valuable is this review is going to be unless we have all the hospitals participating and whether or not we want to make that a requirement.

Chip Thomas: This is an all hospital issue. I don't see any reason that you wish to mandate it. It becomes critically important because we do have two out of the 48 that are governed differently. In the mandate the third party is critical, whether it's audited or Medicare financed, the information is what's important.

Rep. Stefonowicz: Why would you now select to participate when you did not before other than the mandate is there?

Chip Thomas: There are two reasons. First, not all hospitals saw this as an issue. Second, the proprietary disclosure concern to a payer directly sets a precedence which down the road may be not appropriate.

Rep. Glassheim: Explains the amendments he handed out to the committee.

Rep. Lemieux: Would this be directed at Noridians premiums or at all of the health care providers premiums.

Rep. Glassheim: My first thought was since the way the bill came up, it had to do with preferred provider plans where hospitals and people were made to take a reduction by belonging to them. It would just apply to those and not to some of the private insurers that reimburse on a cost basis.

Rep. Keiser: If we go ahead with the amendments, we have to do a study. We have to see if those are viable institutions. We don't need to increase rates simply to try and keep alive something that is going to die in three years. Maybe the study will result in a redistribution of dollars that will offset some of these desolate places. Until a study is done, I'm not prepared to vote for increasing rates or to create any special fund without having the knowledge of the end decision.

Rep. Martinson: handed out and explained an amendment.

Chairman Berg: I will have something drafted that incorporates all of the things that we have talked about and we can discuss this later.

The committee adjourned.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2396.1

House Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date 3-16-99

Tape Number	Side A	Side B	Meter #
1	x		2.9 - 59.8
1		x	0
Committee Clerk Signature	Lisa Horner		

Minutes:

SB 2396.1

Chairman Berg opened the meeting on the bill and went on to explain proposed amendments to the bill.

Arnold Thomas "Chip", ND Health care Association, explained the amendments as being acceptable to his group.

Keiser agrees that the bill is above and beyond what is necessary.

Chip said it was the companies prerogative.

Keiser said the reimbursement rate is set by cooperation in the evaluation and to him it means that hospitals can choose. Keiser thought this could be a cherry picking process if they can choose freely.

Chip said all information must be disclosed.

Rod Larson, Blue Cross and Blue Shield, said they supported the amendments as well as the bill.

Larson said his group was willing to do the study.

Ekstrom asked if they ran any what if situations

Larson said that the changes are extensive and believes everything is covered in the study.

The committee discussed drug costs in detail including the act of getting drugs in Canada. Someone is making a good profit on drugs and the U.S. is not getting their share because in Canada drug costs are must more reasonable.

Larson said increased use in new drugs is caused by research and studies across the country.

Glassheim made it clear that the hospitals will have a choice of using a third party. All agreed.

Berg clarified the point that what the bill contained is in front of them now because everything else has been deleted.

Berg went on to say the next action to be taken by the committee on the bill would be approve it or kill it and ask for new amendments. Glassheim said this would be the amendment to hog house the bill. Realistically rural care providers are loosing money through demographics and the level of care they are providing. We ask for an external subsidy rather than an internal subsidy by having meridian rasing rates beyond where they should be. Every policy should pay about $4.00 per year into a rural hospital assistance fund.

Kempenich said his understanding in South Dakota is trying to move beyond this issue but they also realize that not all institutions can be kept open.

Kline asked if money might be wasted. It appears if more money is wasted then more money might be forthcoming. It does not appear to be cost effective.

Glassheim said maybe the entire bill should be killed and do a large study. Hospitals that are on the margin can make it with some help from these programs.

Stefonowicz said his idea was to use language that states if something doesn't work then their is another plan to be used. Glassheims amendments can be used for fall back positions.

Berg said this bill has raised much interest and people know that the IBL Committee feels strongly about the issues.

Motion by Kempenich to adopt the amendments, second by Froseth

by roll vote, 5 yes, 10 no, 0 absent, motion failed

Committee members agreed that this was a very important issue and suggested further study on the issue.

Kline said he did not want to mandate participation because the data would still be good.

Berg suggested that the committee decide who should be included in participation. Legislative Council can draft language with no surprises.

Motion by Keiser that an amendment be drafted to require that all hospitals participate. This would exclude the for profits.

By roll vote, 10 yes, 5 no, 0 absent, motion carried.

The committee discussed amendment language in general and the affects on hospitals and insurance.

Berg said the committee must make a decision on the bill.

Moved by Keiser to adopt amendments, second by Froseth

by voice vote all yes, o no, 2 absent

Moved by Keiser for do pass as amended, second by Eckstrom

by roll vote, 13 yes, 0 no, 2 absent, motion carried

Rep. Klein will carry the bill.

Chairman Berg closed the meeting on the bill.

Date: 3-10-99
Roll Call Vote #: 1

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB2396

House Industry, Business and Labor Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken do pass as amended

Motion Made By Keiser Seconded By Ekstrom

Representatives	Yes	No	Representatives	Yes	No
Chairman Berg	✓		Rep. Thorpe	✓	
Vice Chairman Kempenich	✓				
Rep. Brekke	✓				
Rep. Ekstrom	✓				
Rep. Froseth	✓				
Rep. Glassheim					
Rep.Johnson	✓				
Rep. Keiser	✓				
Rep.Klein					
Rep. Koppang	✓				
Rep. Lemieux	✓				
Rep. Martinson	✓				
Rep. Severson	✓				
Rep. Stefonowicz	✓				

Total (Yes) 13 No 0

Absent 2

Floor Assignment Klein

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

Prepared by the Legislative Council staff for
Representative Berg
March 9, 1999

PROPOSED AMENDMENTS TO SENATE BILL NO. 2396

Page 1, line 1, after "to" insert "provide for nonprofit mutual insurance companies to reexamine hospital reimbursement rates; to"

Page 1, line 2, after "policies" insert "; and to provide an effective date"

Page 1, after line 3, insert:

"**SECTION 1. NONPROFIT MUTUAL INSURANCE COMPANIES - REEXAMINATION OF HOSPITAL REIMBURSEMENT RATES - REPORT.** Before October 1, 1999, every nonprofit health service corporation that has become a nonprofit mutual insurance company in accordance with section 26.1-17-33.1 shall reexamine hospital reimbursement rates for health care services. The reexamination must include a review of the equity and fairness of the rate of reimbursement of rural hospitals. In order to encourage the participation of hospitals in this reexamination, a nonprofit mutual insurance company may contract for the services of a certified public accountant in performing this reexamination. Every nonprofit mutual insurance company subject to this section shall file a report of the findings and conclusions of this reexamination with the legislative council before October 1, 1999."

Page 1, line 15, after "assign" insert "to a hospital with less than one hundred staffed acute care beds in a community with less than ten thousand population"

Page 1, line 16, after "contract" insert "for services provided by that hospital"

Page 1, after line 21, insert:

"**SECTION 3. EFFECTIVE DATE.** Section 2 of this Act becomes effective on October 1, 1999, unless every nonprofit mutual insurance company subject to section 1 of this Act has filed with the legislative council before October 1, 1999, the report required under section 1 of this Act. The insurance commissioner shall certify to the legislative council by September 30, 1999, the name of every nonprofit mutual insurance company subject to section 1 of this Act."

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Martinson
March 10, 1999

PROPOSED AMENDMENTS TO SENATE BILL NO. 2396

Page 1, line 1, after "to" insert "provide for nonprofit mutual insurance companies to reexamine hospital reimbursement rates; to"

Page 1, line 2, after "policies" insert "; and to provide an effective date"

Page 1, after line 3, insert:

"**SECTION 1. NONPROFIT MUTUAL INSURANCE COMPANIES - REEXAMINATION OF HOSPITAL REIMBURSEMENT RATES - REPORT.** Before October 1, 1999, every nonprofit health service corporation that has become a nonprofit mutual insurance company in accordance with section 26.1-17-33.1 in cooperation with representatives of rural hospitals, shall reexamine hospital reimbursement rates for health care services. The reexamination must include a review of the equity and fairness of the rate of reimbursement of rural hospitals. In order to encourage the participation of hospitals in this reexamination, a nonprofit mutual insurance company may contract for the services of a certified public accountant in performing this reexamination. Every nonprofit mutual insurance company subject to this section shall file a report of the findings, conclusions, and action plan resulting from this reexamination with the legislative council before October 1, 1999."

Page 1, line 16, after "contract" insert "for services provided by that hospital"

Page 1, after line 21, insert:

"**SECTION 3. EFFECTIVE DATE.** Section 2 of this Act becomes effective on October 1, 1999, unless every nonprofit mutual insurance company subject to section 1 of this Act has filed with the legislative council before October 1, 1999, the report required under section 1 of this Act. The insurance commissioner shall certify to the legislative council by September 30, 1999, the name of every nonprofit mutual insurance company subject to section 1 of this Act."

Renumber accordingly

90806.0105
Title.

Prepared by the Legislative Council staff for
Representative Berg
March 16, 1999

PROPOSED AMENDMENTS TO SENATE BILL NO. 2396

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for nonprofit mutual insurance companies to evaluate hospital reimbursement rates; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Nonprofit mutual insurance companies - Evaluation of hospital reimbursement rates - Report. Before December 1, 1999, every nonprofit mutual insurance company domiciled in this state, in cooperation with acute care hospitals in this state, shall evaluate the company's reimbursement rates for health care services provided by the hospitals. The evaluation must include a review of the financial impact the reimbursement rates have on each hospital cooperating in the evaluation. The evaluation must also include consideration of premium rates and the financial condition of the nonprofit mutual insurance company. ~~In order to facilitate the cooperation of hospitals in the evaluation, the nonprofit mutual insurance company shall select and contract for the services of a third party to receive requested data and information from the hospitals for submission to the company~~. Hospitals cooperating in the evaluation shall provide audited financial statements to the third party ~~selected to receive such information~~. ~~The company is responsible for one-half of the costs of the third party, and the cooperating hospitals are responsible for one-half of the costs of the third party~~. Each nonprofit mutual insurance company subject to this section shall file a report of the findings of the evaluation with the legislative council before December 1, 1999.

SECTION 2. EXPIRATION DATE. This Act is effective through June 30, 2000, and after that date is ineffective."

Renumber accordingly

new Profit Mutual Insurance Company directly and through a

Prepared by the Legislative Council staff for
Representative Glassheim
March 12, 1999

PROPOSED AMENDMENTS TO SENATE BILL NO. 2396

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 26.1-47 of the North Dakota Century Code, relating to financial assistance for rural hospitals; and to provide for a continuing appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Rural hospital assistance fund - Continuing appropriation.

1. Every health care insurer that enters a preferred provide agreement affecting a health insurance policy or subscriber agreement that prohibits the assignment of benefits payable under that policy or agreement shall remit annually to the state treasurer for deposit in the rural hospital assistance fund in the state treasury an amount equal to four dollars for each such policy or subscriber agreement in effect during the previous year. The moneys in the fund and income of the fund are appropriated to the insurance commissioner on a continuing basis for distribution to rural hospitals as provided by this section.

2. The commissioner shall distribute moneys in the rural hospital assistance fund to every hospital that:

   a. Has no more than sixty staffed acute care beds; and

   b. Is in a community with a population not exceeding two thousand; and

   c. Had operating losses in the previous year, exclusive of any money received from the rural hospital assistance fund.

3. The commissioner shall distribute the moneys under subsection 2 based on a formula established by the commissioner which considers the amount of hospital billing for health care services and the amount of the operating loss. The commissioner shall develop any forms necessary to implement this section."

Renumber accordingly

Date: 3-16-99
Roll Call Vote #: 1

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Industry, Business and Labor Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number 90806.[redacted] 0104

Action Taken do pass amendment

Motion Made By Glassheim Seconded By Thorpe

Representatives	Yes	No	Representatives	Yes	No
Chairman Berg		✓	Rep. Thorpe	✓	
Vice Chairman Kempenich		✓			
Rep. Brekke		✓			
Rep. Ekstrom	✓				
Rep. Froseth		✓			
Rep. Glassheim	✓				
Rep.Johnson		✓			
Rep. Keiser		✓			
Rep.Klein		✓			
Rep. Koppang		✓			
Rep. Lemieux	✓				
Rep. Martinson		✓			
Rep. Severson		✓			
Rep. Stefonowicz	✓				

Total (Yes) 5 No 10

Absent _____

Floor Assignment motion failed

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

VR
3/16/99

90806.0106
Title.0200

Prepared by the Legislative Council staff for
Representative Berg
March 16, 1999

HOUSE AMENDMENTS TO SENATE BILL NO. 2396 **IBL 3-17-99**

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for nonprofit mutual insurance companies to evaluate hospital reimbursement rates; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Nonprofit mutual insurance companies - Evaluation of hospital reimbursement rates - Report. Before December 1, 1999, every nonprofit mutual insurance company domiciled in this state, in cooperation with every nonprofit hospital in this state, shall evaluate the company's reimbursement rates for health care services provided by the hospitals. The evaluation must include a review of the financial impact the reimbursement rates have on each nonprofit hospital. The evaluation must also include consideration of premium rates and the financial condition of the nonprofit mutual insurance company. Each nonprofit hospital shall provide audited financial statements to the nonprofit mutual insurance company directly or through a third party. Each nonprofit mutual insurance company subject to this section shall file a report of the findings of the evaluation with the legislative council before December 1, 1999.

SECTION 2. EXPIRATION DATE. This Act is effective through June 30, 2000, and after that date is ineffective."

Renumber accordingly

Date: 3/16-99
Roll Call Vote #: 2

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO.

House Industry, Business and Labor Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken new amendments from committee

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Berg		/	Rep. Thorpe	/	
Vice Chairman Kempenich		/			
Rep. Brekke		/			
Rep. Ekstrom	/				
Rep. Froseth	/				
Rep. Glassheim	/				
Rep.Johnson		/			
Rep. Keiser	/				
Rep.Klein		/			
Rep. Koppang	/				
Rep. Lemieux	/				
Rep. Martinson	/				
Rep. Severson	/				
Rep. Stefonowicz	/				

Total (Yes) 10 No 5

Absent _____

Floor Assignment _____

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

REPORT OF STANDING COMMITTEE

SB 2396: Industry, Business and Labor Committee (Rep. Berg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). SB 2396 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for nonprofit mutual insurance companies to evaluate hospital reimbursement rates; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Nonprofit mutual insurance companies - Evaluation of hospital reimbursement rates - Report. Before December 1, 1999, every nonprofit mutual insurance company domiciled in this state, in cooperation with every nonprofit hospital in this state, shall evaluate the company's reimbursement rates for health care services provided by the hospitals. The evaluation must include a review of the financial impact the reimbursement rates have on each nonprofit hospital. The evaluation must also include consideration of premium rates and the financial condition of the nonprofit mutual insurance company. Each nonprofit hospital shall provide audited financial statements to the nonprofit mutual insurance company directly or through a third party. Each nonprofit mutual insurance company subject to this section shall file a report of the findings of the evaluation with the legislative council before December 1, 1999.

SECTION 2. EXPIRATION DATE. This Act is effective through June 30, 2000, and after that date is ineffective."

Renumber accordingly

1999 SENATE INDUSTRY, BUSINESS AND LABOR

SB 2396

CONFERENCE COMMITTEE

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB2396

Senate Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date April 6, 1999

Tape Number	Side A	Side B	Meter #
1	x		0-3250
Committee Clerk Signature			

Minutes:

Senator Sand opened the conference committee hearing on SB2396. All were present.

Senator Sand asked for the house to explain their amendments.

Rep. Berg explained the amendments. He said that in their discussion it was their opinion that all hospitals are participating now. Ultimately they did not know how a hospital could not be a participating provider. They felt that many of rural hospitals are struggling because 75% of their income is Medicare or Medicaid dollars. He said that, by having rural hospitals. is there a big picture savings to have them help hold down the cost of health care throughout the state. He said that the intent of their amendments was to take a step back and have the hospitals submit their information and then request that Noridian take a look at how they are reimbursing the hospitals.

Senator Krebsbach motioned that the Senate accede to the House amendments on SB2396.

Rep. Keiser seconded the motion. The motion carried with a 6-0-0 vote.

==========

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE) - 420

==========

07398

SR667015

(Bill Number) 2396 (, as (re)engrossed):

Your Conference Committee

For the Senate:	YES	NO
SAND	X	
(m) KREIDLER	X	
THOMPSON	X	

For the House:	YES	NO
BELL	X	
(s) KEISER	X	
LEMEUX	X	

☐ recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)
723/724 725/726 S724/H726 S723/H725
the (Senate/House) amendments on (SJ/HJ) page(s) ~~800~~ 773 - _____

☐ and place _____ on the Seventh order.
727

☐ , adopt (further) amendments as follows, and place

_____ on the Seventh order:

☐ having been unable to agree, recommends that the committee be discharged and a new committee be appointed. 690/515

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

==========

DATE: ____/____/____

CARRIER: _____

LC NO. _____ . _____ of amendment

LC NO. _____ . _____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

==========

(1) LC (2) LC (3) DESK (4) COMM.

REPORT OF CONFERENCE COMMITTEE

SB 2396, as engrossed: Your conference committee (Sens. Sand, Krebsbach, Thompson and Reps. Berg, Keiser, Lemieux) recommends that the **SENATE ACCEDE** to the House amendments on SJ page 772 and place SB 2396 on the Seventh order.

Engrossed SB 2396 was placed on the Seventh order of business on the calendar.

1999 TESTIMONY

SB 2396

North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Chip

SB 2396 Testimony

A child breaks his ankle and is taken to a local ER. During admission, his Mom is asked the name of her insurance company. She says "Mutual of Omaha." The next question is whether the child's Mom will authorize the hospital to be paid directly by Mutual of Omaha for the cost of the child's care. She says " yes" and signs a form that authorizes the hospital to directly receive payment from her insurance company for her child's treatment. This authorization is called assignment.

If the charges for the child's broken ankle are $500, and Mutual of Omaha pays the $500, that's called payment in full. If the charges for the broken ankle are $500 and Mutual of Omaha pays only $400, the hospital then sends a bill to the child's Mom for the remaining $100. This is called balanced billing.

(For the purpose of this example and the one to follow, assume coverage, co-payments and deductibles are not an issue)

Let's assume for a minute that this is before 1995 – when Blue Cross Blue Shield was a health services corporation: the same child breaks his ankle and is taken to the local ER. When asked which insurance company she uses, the child's Mom says Blue Cross Blue Shield (BCBS). The child's Mom is not asked to sign a form assigning benefits because the hospital has a contract with BCBS. This contract permits the hospital to bill BCBS for the medical services provided and the amount that Blue Cross pays is accepted by the hospital as payment in full. This arrangement is called is a participating agreement. Under this agreement if the charge for fixing the child's broken ankle was $500, but the agreement between the hospital and the Plan only pays $450, the hospital accepts this amount as payment in full and can not charge the mother the $50 difference.

Don't forget the history behind this arrangement. Hospitals organized Blue Cross. They knew a majority of hospitals were needed to participate in the plan if it was to work. Hospital interests were represented on the Blue Cross board and there was ample opportunity to negotiate the terms of such contracts.

There were other incentives for hospitals to support BCBS. If a hospital did not, it would be paid at a significantly reduced amount and it could not receive payment directly from the plan as assignment was not permitted.

1120 College Drive, #214 PO Box 7340 Bismarck, ND 58507-7340
Phone 701-224-9732 Fax 701-224-9529

What this absence of a participating agreement means in terms of our earlier example is that if the child with the broken ankle appeared in the ER for treatment, the child would still be treated. However, while the hospital would send the bill for its services to the Plan, the Plan would send the payment to the child's mom.

For Blue Cross prohibiting assignment was a wonderful marketing tool. And, hospitals considering the merit of non-participation faced a potential administrative nightmare. Non-participation meant having no way of knowing whether or not a claim was complete, whether the claim was paid or whether the payment was used to meet other family financial obligations.

Before 1995, this type of situation was nothing more than a potential problem as all hospitals had participation contracts with Blue Cross.

But, times have changed and so too has Blue Cross. It's no longer a health services corporation governed by health care providers. It is now a full fledged non-profit mutual insurance company called Noridian. As an insurance company, it is no different than a Mutual of Omaha -- or a Prudential.

Although there have been significant changes in the corporate structure of Noridian there has been no change in its manner of doing business with hospitals. For some rural hospitals, there is increasing concern that continuing a participation agreement relationship between the plan and the hospital may no longer be in the local hospitals best interest. Particularly if hospital payments schedules continue to be tied to the financial solvency of Noridian.

Because of a number of different expense factors Noridian has had to cut some of its standard payment rates by as much as fifty percent to some rural providers. The reality is that in the interest of their own viability, some of these hospitals no longer can afford to link their own financial stability to that of BCBS. If BCBS payments are not adequate, hospitals should not be restricted from billing BCBS beneficiaries because of a contractual arrangement that does not apply to traditional insurance companies.

These hospitals ask you to treat all insurance companies in the same way. Today, when a child breaks his ankle and his Mom says her insurance coverage is through Mutual of Omaha, the hospital can ask her to assign her benefits. With her signature, she can allow the hospital to bill Mutual of Omaha and thereafter, to bill her for any amount not paid by Mutual of Omaha. The hospitals of this state believe that now that Noridian is an insurance company similar to a Mutual of Omaha or Prudential, hospital should be able to treat BCBS subscribers the same as any other beneficiary with respect to assignment.

SB 2396 ensures that one insurance company does not have an undue advantage over the others. It treats all insurance companies equally. We believe this is sound and appropriate public policy and ask for your support of SB 2396.

Mr. Chairman, there are several hospital administrators in the audience today and they would like the opportunity to share with you what this bill means for their facilities and their ability to offer healthcare services to your constituents. Perhaps after you have had an opportunity to hear their presentations, we could make ourselves available to you as a group and at that time address any questions you or members of the committee might have.

Testimony on Senate Bill 2396
By
Timothy J. Tracy

February 10, 1999

Good Morning! I would like to begin by thanking the members of the committee for allowing me the time to provide input on Senate Bill 2396. My name is Tim Tracy. I am the administrator of Towner County Medical Center in Cando. I would also like to introduce to you the Chairman of our Board of Directors, Mr. Robert Spencer who joins me in delivering this testimony on behalf of our organization and community.

The medical center includes a hospital and a physician office practice both which are impacted by assignment of insurance benefits which Senate Bill 2396 addresses.

This bill is being introduced to create a level playing field for all insurance companies. Several years ago Blue Cross/Blue Shield of North Dakota was allowed to change the way it conducts business. Their structure changed from that of a health services corporation, which partnered with providers of health care, to just another mutual insurance company. The market dominance, which in part resulted from that collaborative relationship with health care providers, is still enjoyed today by Blue Cross/Blue Shield, now called Noridian.

That market dominance is now used to balance the budget of Noridian on the backs of those very same providers of health care which historically partnered with Blue Cross / Blue Shield. Rural providers such as the medical center in Cando are facing very difficult economic times. Times which are providing a more than adequate challenge. The payment strategies now unilaterally being employed by Noridian as a mutual insurance company will push some rural hospitals over the edge.

How does this apply to assignment of benefits? All insurance companies (except Noridian) allow Towner County Medical Center to ask patients for their permission to bill the insurance company directly and be paid directly for the services provided. Noridian provides assignment through their contracts with participating providers of health care in North Dakota. But what if you are not a participating provider? Assignment is not allowed nor honored.

Let me pose a question. What if, because of Noridian's change in organizational structure, change in their corporate philosophy, and their payment initiatives, the Board of Directors of Towner County Medical Center decide they can not longer contract with Noridian. The decision to discontinue contracting with Noridian would create a situation which Towner County Medical Center could not take assignment of insurance benefits. This one item (assignment of insurance benefits) is a deterrent to making a decision to withdraw. This barrier is enjoyed only by Noridian. Lack of ability to obtain assignment of insurance benefits with Noridian as a non-participating facility literally forces and insures participation by all health care providers and therefore allows continued market dominance along with the luxury of unilateral decision making without consequence.

Committee members, I have a unique prospective in dealing with Blue Cross / Blue Shield having been the administrator of a hospital and physician practice in the State of South Dakota. During my tenure as an administrator in that state, the facility I worked for enjoyed assignment of benefits from all insurance companies regardless of participation agreements. South Dakota by statue (similar to the bill being proposed) requires insurance companies to accept assignment of benefits paying benefits for services directly to hospitals. Assignment of benefits therefore in South Dakota was not a consideration when contracting with health insurance companies. Some health care providers did not participate during my tenure.

Payment mechanisms for rural hospitals as participating providers in South Dakota recognized their unique role in maintaining access to health care. Noridian apparently does not feel that responsibility and have publicly acknowledged market pricing as their role and access to rural health as a governmental function. Now that they are no longer a health services corporation, no longer partnering or collaborating with health care providers, no longer have or accept any responsibility for rural health care -- they are just another insurance company afforded competitive rights that have not been extended to other commercial insurance companies.

The Board of Directors of Towner County Medical Center have a responsibility to maintain access to health care services for the citizens of our area. Please allow my governing body the ability to exercise their fiduciary responsibility without barriers which prevent competition when dealing with Noridian. Consider a vote of support for Senate Bill 2396 allowing assignment of insurance benefits by patients, regardless of which insurance carrier they choose.

Again thank you for your time. If there are any questions, I would be very happy to attempt to answer them.

58-17-58. Waiver of required deductible or co-payment for charitable purposes permitted. However, a person may waive any required deductible or co-payment for charitable purposes if:

(1) The person who provides the health care determines that the services are necessary for the immediate health and welfare of the insured;

(2) The waiver is made on a case-by-case basis and the person who provides the health care determines that payment of the deductible or co-payment would create a substantial financial hardship for the insured; and

(3) The waiver is not a regular business practice of the person who provides the health care.

Source: SL 1989, ch 429, § 2.

58-17-59. When waiver presumed. Any person who provides health care and who waives the deductible or co-payment for more than one-fourth of his patients during any calendar year, excluding waivers under § 58-17-58, or who advertises that he will accept from any third-party payor, as payment in full for services rendered, the amount the third-party payor covers, is presumed to be waiving the deductible or co-payment as a regular business practice.

Source: SL 1989, ch 429, § 3.

58-17-60. Certain payments exempt. Payments made pursuant to federal medicare laws or payments made to the health-care provider according to a contract or agreement between an employer and employee which requires a third-party payor to pay the full amount for health-care services are exempt from §§ 58-17-57 to 58-17-60, inclusive.

Source: SL 1989, ch 429, § 4.

58-17-61. Assignment of health insurance proceeds to certain hospitals authorized. Any person insured by a health insurance company, health maintenance organization, preferred provider organization, individual practice association or nonprofit hospital service corporation may assign in writing benefits from such policy, contract or certificate to a hospital licensed pursuant to chapter 34-12. If such assignment is executed and written notice thereof is given, the insurance company, health maintenance organization, preferred provider organization, individual practice association or nonprofit hospital service corporation shall pay the benefits directly to the hospital.

Nothing in this section modifies the scope of coverage or the amount of benefits payable under a health insurance policy, contract or certificate.

Source: SL 1989, ch 430.

58-17-62. Coverage for phenylketonuria. Every policy of health insurance that is delivered, issued for delivery or renewed in this state, except for

Consultant Comments

from David Montgomery

Group Benefits Consultant
Phone 701-572-4535 • Fax 701-572-2028

January 18, 1999

Blue Cross Blue Shield
of North Dakota
PO Box 2628
504 East Broadway
Williston, ND 58801
An Independent Licensee of the Blue Cross & Blue Shield Assn.

RURAL HEALTHCARE

As part of a three point plan to improve its bottom line, Blue Cross Blue Shield of North Dakota introduced revised physician and hospital fee schedules on January 1. The schedules dictate how much money providers are paid for services to BCBSND subscribers.

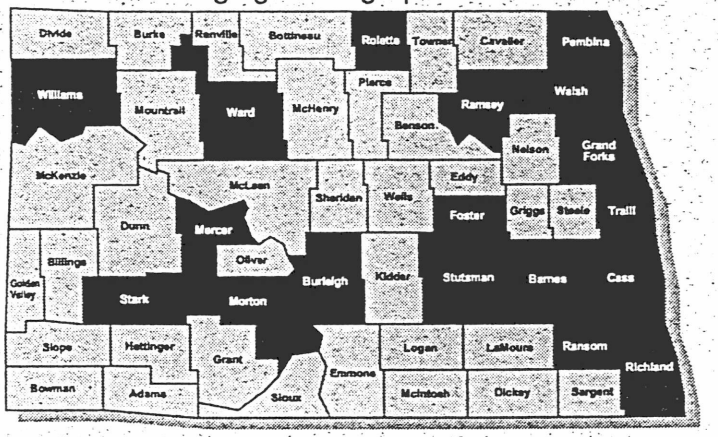
BCBSND Senior Vice President Ryn Pitts says the fee schedules are based on a reweighting of fixed payments for specific treatments and procedures. Generally, she said, the affect is to redistribute payments from simpler procedures and increase reimbursements for more complicated procedures. The net effect could be savings approaching $10 million.

Some of the 33 rural hospitals in North Dakota have expressed concern that because they perform the simpler procedures, their total reimbursements will decrease. In a lengthy article published in *The Forum*, December 6, BCBSND President Michael Unhjem said, "Our decisions on reimbursement policies are not aimed at rural hospitals. What we have done is set a fair and equitable price for services with the goal of providing quality care for our members in the most cost-effective setting possible."

"We need health care in rural communities," Pitts said. "But times have changed. Perhaps what we need most is a system that can deal with the aging population in these small towns. We need emergency care and some type of triage system. A system that stabilizes patients and subsequently transfers them to a regional medical center better equipped to manage the care may be a more feasible role for rural hospitals than maintaining in-patient beds and duplicating services."

Unhjem added, "Our role is to assure our members that the price we pay on their behalf is a fair market price." He posed the question, "Is it our premium payers' responsibility to provide a subsidy to keep rural hospitals open? I don't think so." Unhjem said if there is to be a subsidy of rural hospitals, it needs to be a public policy decision.

Changing Demographics in ND



Two thirds—35 out of 53—of the counties in North Dakota have fewer than six people per square mile and are commonly referred to as "frontier counties".

RX DEVELOPMENTS

Quoting from an article in *Employee Benefit News*, "Employers should brace for some run-ups in pharmacy benefit costs as drug companies begin to recoup the billions of dollars being invested annually in product research and development and direct-to-consumer advertising."

The November article indicates that cost increases are already showing up, as employer expenditures for pharmacy benefits increased an average of 15% in 1997 with similar final numbers anticipated for 1998. Some forecasters believe pharmacy costs could triple within three years as new products are unleashed.

The prevailing advice is to analyze prescription costs and utilization before they start wreaking serious havoc on benefits budgets. Companies may want to evaluate their copays, designed to let employees pay a fair share of the cost of prescription medicine.

"If the goal is to get employees to pay about 20% of the costs, that's not a $5 copay anymore," says Barbara Hawes, a consultant for Towers Perrin in Atlanta. "You don't want to have copays so low that you discourage employees with the flu from trying self-care and over-the-counter medicines first, instead of opting for a high-powered $50 antibiotic."

SENATE INDUSTRY BUSINESS
AND
LABOR COMMITTEE

Wednesday - February 10, 1999 - 9:00 am
Duane Mutch, Chairman

I'm here today to ask for your support regarding SB 2396.

Before you today there are several rural hospital administrators in attendance.

We are here asking that all insurance companies are treated equally and that rural facilities are given an opportunity to make independent fiduciary decisions based on their community needs as directed by their administrators and boards.

I quote from William O Cleverly, PHd, CPA President of The Center for Healthcare Industry Performance Studies and Professor at Ohio State University; *"North Dakota hospitals with annual revenues of less than $5 million are in a precarious position."* Dr. Cleverly predicts financial problems and significant closure rates in North Dakota of rural hospitals.

From Chris Champ, Eide Bailly, Fargo; *"Our firm is genuinely concerned about the short and long term viability of a number of rural facilities in the state."*

"While the Blue Cross Blue Shield of North Dakota changes are not the only reimbursement changes affecting these hospitals (i.e.. the Medicare Balanced Budget Act), they are the most significant and provide the least amount of flexibility for these hospitals."

Greg Hanson - St. Joe's Hospital/Dickinson
Chair ND Hospital Assn.

Robert Spencer - Towner County Medical Assn.

"However, we still feel that the significance of the dollar impact as projected by these facilities from the Blue Cross Blue Shield proposed contract will make it impossible for them to continue operating as an acute care facilities under the current reimbursement methodologies."

FACTS

- ND has only 9 cities above 10,000
- 17 cities above 2500
- 366 incorporated cities
- 35 of 53 counties are classified as frontier – we are rural

In healthcare there are no favorite organizations, each facility is regulated by the same laws - Federal and State.

No one yet has an edge over their competition.

I am here about equal treatment for all business and competitors.

This is about reimbursement.
This is about accessibility.

We as rural hospital administrators are asking to level the playing field. Let's treat all insurance companies alike.

They - Blue Cross - asked to be an insurance company. Let's now make them act like one.

Let rural hospitals be responsible for making decisions on their own viability - to take assignment or not should not be governed by the past or by legislation.

Can take assignments only if the hospital participates

Michael Tomasko

Opposition

PROCEDURES:

CODE	DESCRIPTION	CREW	SUCCESS
1	Assessment		
2	Vital Signs		
3	Oxygen		
4	Airway Clear		
5	Oral/Nasal Airway		
6	Abdom. Thurst		
7	Chest Thrust		
8	Bleed Control		
9	CPR		
10	Extrication		
11	Mast Trousers		
12	OB Delivery		
13	Restraints		
14	Spinal Immob.		
15	Splint Extrm.		
16	Suction		
17	Ventilation		
18	Other BLS		

CODE	DESCRIPTION	CREW	SUCCESS
19	Blood Draw		
20	Central IV		
21	Peripheral IV		
22	Cardiac Monitor		
23	Auto-Defib.		
24	Manual Defib.		
25	EOA/EGTA		
26	Nasal Intubation		
27	Oral Intubation		
28	Cardioversion		
29	Drug Administration		
30	External Jugular		
31	Intraoss. Inf.		
32	Needle Thoracic		
33	Pacing		
34	Cricothyrot		
35	Glucose Eval.		
36	Pulse Oximetry		
37	Other ALS		

CODE	DESCRIPTION	CREW	SUCCESS
38	Cervical Collars		
39	Intecept		
40	Paperwork on Time		
41	Paperwork Completed Properly		
42	Signature Obtained		
43	MC1 Helicopter Flight		
44	Fixed Wing Transfer		
45	No Transport		
46	Rotation Patient		

WAIVER OF LIABILITY

I refuse treatment and/or transportation by Metro-Area Ambulance Service, Inc. I understand in doing so I assume responsibility for my own, or my child's own, medical treatment. I have been advised to seek the attention of a physician. I release Metro-Area Ambulance Service, Inc., its employees, officers and directors from any liabilty resulting from my own, or my child's own refusal of medical treatment or transportation.

X _____

Signature Date

If signing for a minor:

X _____

Name Relationship

1.5% Interest added toward all accounts if not paid by the first of each month.

Authorization To Pay Insurance Benefits: I hereby authorize payment directly to the Metro-Area Ambulance Service of the ambulance benefits otherwise payable to me but not to exceed the ambulance regular charges for the period of service. I understand I am responsible to the ambulance service for charges not covered by this authorization. I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to Metro-Area Ambulance for any services furnished me by that supplier. I authorize any holder of hospital or medical information about me to be released to Metro-Area, the Health Care Financing Administration and/or my insurance carrier, and their agents, any other information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the supplier for all services in the future until such time as I revoke this authorization in writing.

X _____

Signature Date

TESTIMONY ON SB 2396

North Dakota Medical Group Management Association

Chairman Mutch and Members of the Committee, my name is Mike Tomasko and I come before you today, in support of SB 2396, on behalf of the 100 professionals who are members of the North Dakota Medical Group Managers Association, representing the majority of health care providers in North Dakota. In my other life, I am an Administrator of the PrimeCare health group and CEO of Mid Dakota Clinic, here in Bismarck.

It is my hope that the lively debate on SB 2396 won't drive any of you to the steps of the Capitol for a cigarette, but that's where I am headed after this is finished!

I am told that Chairman Mutch prefers that we get to the heart of the matter, that is, tell us what the problem is, how to fix it, and why this bill is before us, and I will attempt to do that directly.

You have heard already, and you will hear more, about the peripheral issues surrounding SB 2396. Cutting to the chaise, SB 2396 is simply about letting the subscriber, the patient, direct the insurance company to pay the Doctor, Hospital, Chiropractor, Dentist, etc. for services that have already been provided to the subscriber / patient, without regard to any contrary provisions of the policy and/or provider contracts. This same right is accorded by all other health insurers providing coverage in North Dakota, including Medicare, save one.

You will most likely hear from them that the passage of SB 2396 will mean increased costs to their subscribers, our patients, commonly referred to as balanced-billing. Balanced-billing is simply a leverage used by this insurer to force provider participation with their company; a company that holds a monopoly in the health care insurance market in North Dakota. We submit that allowing this leverage to continue, may actually increase the cost to subscribers/patients because other healthcare insurers, HMO's, PPO's, etc. cannot compete with this monopoly and for that reason refrain from entering the North Dakota market, resulting in very little premium competition within the State. This creates an unfair competitive advantage for one insurer, as it concerns other healthcare insurers. Insurers already have another form of leverage, which is acceptable and common to the health care

industry and employed by most health care insurers, and that is differing reimbursement levels between participating and non-participating providers, and thus we believe the marketplace, the subscribers, our patients, will encourage provider participation in the health insurance program to which they subscribe, to ensure the highest level of payment for their health insurance bills.

You will most likely hear from them that passage of SB 2396 will mean some providers may not participate with this insurer. In the urban centers, our participation with any health care insurer is governed by the purchasers of health insurance, that is, the employers. If they buy their health care insurance from Blue Cross Blue Shield of North Dakota, from Aetna/U S Healthcare, from Blue Cross Blue Shield of Minnesota, Allina, or whomever, it would be impossible for the providers in that community to not accede to the wishes of the employers and do business with their chosen health care insurer.

In the rural centers, we believe, as you have already heard today, that their very existence is dependent upon them making a sound business decision as to their participation with one insurer or another. Forcing their participation, can only result in reduced healthcare to rural North Dakota and the closing of rural health care facilities.

We agree with the recent remarks of the President of Blue Cross Blue Shield, it is not the insurer's responsibility to keep rural hospitals open, nor is it the responsibility of this body. It is the responsibility of us, the providers, and that is why as you scan North Dakota, you will find MeritCare, Dakota, Trinity, Medcenter, St. Alexius/PrimeCare health group, Greater Plains Health Group, West River Health Network in Hettinger and others, day after day, working with local rural providers to ensure health care in rural North Dakota, at great cost, and often at a substantial financial loss.

We believe the rural providers and the urban providers, should have the same right as the insurers and that is to decide their participation with any insurer on a purely business basis and the cost of doing business. This is essential to the survival of health care in rural North Dakota. It is the same right that accrues to each health care insurer doing business in the State, that is to make a business decision as to whether or not to offer a particular product. To determine the actuarial cost of their products, the administrative cost and their profit margin, resulting in the premiums you and I are charged for our health care insurance.

We submit that this Assignment Bill, SB 2396, has nothing to do with the issue of balanced-billing and the only reason an insurer would be opposed to this bill would be their loss of leverage in forcing providers to participate with their insurance company. We believe it affords the insurer an unfair advantage and reduces their incentive to negotiate with the providers, and further that it stifles premium competition as witnessed in their corporate policy of predatory premium pricing resulting in reduced premium competition.

SB 2396, levels the playing field. All health care insurers are treated equally and fairly. For years the providers participated, as did the State, with Blue Cross Blue Shield of North Dakota under the provisions of the Health Services Corporation Act. We were pleased to do so in partnership. In the last session, the Blues sought, and were granted approval to mutualize, removing them from the provisions of the Health Services Corporation Act, so that they could become like any other insurance company. .We believe, if that is what they wish to be, then they should be treated like all other health care insurers.

Besides leveling the playing field, SB 2396 is about the survival of rural health care, the rights of other health care insurers, the responsibility of a monopoly, premium competition or lack thereof, freedom of choice for the patient, and the subscriber / patient's right to simply say, I do or do not want my insurance payment to go direct to my health care provider who has already provided the services to me without restriction by a health care insurer.

For that reason we support SB 2396. Thank you for allowing me to appear before you, I would be happy to answer any questions you might have, however I am sure others are biting at the bit to take the floor.

TESTIMONY BEFORE THE SENATE INDUSTRY, BUSINESS AND LABOR COMMITTEE
Concerning SB2396
February 10, 1999
Dean Peterson, THE NORTH AMERICAN COAL CORPORATION

Mr. Chairman and members of the Committee, my name is Dean Peterson. I am here today representing The North American Coal Corporation – North Dakota's largest lignite producer. North American Coal produces over 23 million tons of lignite each year for energy conversion facilities located in North Dakota. Our subsidiary mining operations, The Coteau Properties Company and The Falkirk Mining Company employ over 600 people.

North American Coal is **opposed to SB2396** for the same reasons outlined in testimony given by Ms. Ryn Pitts, Senior Vice President, of the Health Care and Member Services Division of Noridian Mutual Insurance Company, the Blue Cross Blue Shield Plan in North Dakota (BCBSND). We believe that SB2396 will adversely affect our ability to keep health care costs under control for both the company and our employees.

Therefore, North American respectfully asks this committee to support a **do not pass** position for SB2396.

BlueCross BlueShield of North Dakota

NORIDIAN℠
*Mutual Insurance Company**

4510 13th Avenue S.W.
Fargo, North Dakota 58121-0001

RYN M. PITTS
Senior Vice President
Health Care and Member Services

Phone: 701-277-2090
FAX: 701-277-2132
ryn.pitts@noridian.com

February 10, 1999

Chairman Mutch, members of the committee, I am Ryn Pitts, Senior Vice President, of the Health Care and Member Services Division of Noridian Mutual Insurance Company, at the Blue Cross Blue Shield Plan in North Dakota (BCBSND). I am pleased to appear here today to discuss our strong opposition to Senate Bill 2396. While the bill appears to be fairly simple, please be aware of the potential implications for BCBSND members. This is a complex issue so allow me give you some background information before I discuss the potential impact of SB 2396.

BCBSND provides health coverage for over 400,000 people and we take this responsibility very seriously. Our mission is to provide access to high quality and affordable coverage to our members. Throughout the long history of BCBSND in this state, a major factor in our ability to serve our members has been our **contractual relationship** with North Dakota health care providers. These contracts are also known as participation agreements. When a provider signs a contract with BCBSND, there are clear benefits to all parties: provider, BCBSND and its members.

The participating provider has three major benefits:

- Access to a large BCBSND patient population;
- Prompt, timely payment by BCBSND for medical services provided to BCBSND members; and prompt, timely pmt. - claims pd. in 14 days or less
- Direct payment to the provider by BCBSND, ensuring a predictable cash flow.

These are clearly intended as incentives for the provider to sign a contract and become a "participating provider." Non participating providers risk losing access to our members, payment is made at a reduced rate, and the payment is made directly to the patient. Thus, the non participating provider must collect the amount due for the service from the patient. *Participating providers* get paid directly by BCBSND; *Non participating providers* must collect their fees from their patients. This perhaps is the greatest incentive for a provider to "participate."

To demonstrate how well this contractual relationship has worked, currently 100% of ND (44) hospitals and 99.6% of physicians are participating providers with BCBSND.

& osteopaths (5 chose other)

34 small hospitals in state

*An independent licensee of the Blue Cross & Blue Shield Association

The BCBSND member also benefits by acquiring services from a participating provider:

- A participating provider is required to submit claims to BCBSND on behalf of the patient with BCBSND coverage. There is no paperwork for the patient; and

- The provider is required to accept BCBSND's negotiated, discounted payment as payment-in-full; there is no balance billing allowed. The patient is only responsible for any deductibles, co-payments, co-insurance amounts and non-covered services.

In other words, the difference between the provider's actual charges and BCBSND's negotiated discount cannot be passed on to the patient. In the reverse, patients who receive services from *non participating providers* submit claims themselves. But more importantly, they are responsible to pay the difference between our negotiated payment and the actual billed charge. Please refer to the attached sheet that illustrates this more clearly.

How does SB 2396 affect our contractual relationship with providers?

Instead of sending the check for medical services to our member, we would be required to pay the non participating provider directly. Therefore, this bill removes the most important incentive for providers to become participating providers with BCBSND.

Why would a provider support SB 2396?

First, SB 2396 enables the provider to maintain the major benefit of participating status, that is, direct payment from BCBSND without the burden of collecting the largest portion of the claims payment from the patient. Another less obvious concern is that providers would have the opportunity for **more revenue** because the provider could "balance bill" the patient for the BCBSND negotiated discount. This, in fact, may create a perverse incentive for providers to raise their charges.

Who gets hurt by SB 2396?

Consumers. They lose the benefit of the discounts negotiated on their behalf and are potentially vulnerable to increasing charge patterns by providers. Clearly, passing SB 2396 is not in the best interest of your constituents.

You may have heard the argument that all other insurers do it this way. It's called "honoring the assignment by a patient." While this is probably true, there are a couple important differences. Most other insurers do not have participating contracts with health care providers nor do they have the significant market presence we have. SB 2396 legislates an issue that should remain a contractual issue.

There is one other important consideration I need to mention. North Dakota is a rural state where in many areas there is not an abundant choice of providers. If you remove this incentive for a provider to participate, a BCBSND member may not have easy access to a participating provider. What happens when a rural hospital elects to become non participating? Will a patient need to drive some distance to get services at the negotiated discount price BCBSND has with participating providers? Remember, a provider can today elect not to sign a participating agreement with BCBSND. That is their prerogative. But I urge you to reject a bill that may actually encourage providers to take this step.

There is little doubt that this bill is a result of some provider reaction to our Board of Director's action late last year making adjustments in reimbursement methodology. Even though BCBSND projects total provider payments to increase in 1999, some providers may receive lower payments for their mix of services. This was done for a lot of reasons but the major consideration was health care costs increasing at a rate that we simply could not pass on to our premium payers. Even with the provider reimbursement adjustments, our average rate increases this year are in the 9-10% range. When you consider that a family rate today ranges from $410-450 a month, we are approaching a point where premiums will become unaffordable.

In conclusion, passage of SB 2396 poses a potential financial risk to North Dakotans with implications that could have a long-lasting impact. I urge you to vote to recommend a "Do Not Pass" on SB 2396. Thank you and I will be glad to answer any questions you may have.

Blue Cross Blue Shield of North Dakota

Member Cost Share Illustration*
Participating Vs. Nonparticipating

Participating		Nonparticipating	
Provider billed charge	$115	Provider billed charge	$115
BCBSND allowed charge	100	BCBSND allowed charge	100
Provider discount	(15) discount varies	Provider discount	(0)
Patient co-insurance	(20)	Patient co-insurance	(20)
BCBSND payment direct to provider	80	BCBSND payment to member (80% of par amount)	64

Summary

BCBSND payment	$80
Provider discount	(15)
Total patient cost	**20**
Total	$115

Summary

BCBSND payment	$64
Provider discount	0
Total patient cost (provider charge less BCBSND payment)	**51**
Total	$115

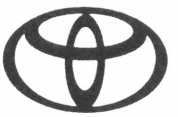
*This illustration assumes a plan with 80/20 co-insurance.

"You Can Always Deal with Theel"

CEDRIC THEEL INC.

Dodge
223-2190
Just East of Memorial Bridge

TOYOTA
1-800-866-DEAL
1144 Missouri Ave. Bismarck



Dear Chairman Mutch and Members of the Senate IBL Committee:

As an employer who provides health coverage for our employees, I became very concerned upon reviewing SB 2396. This bill could have very serious consequences for our employer group and its members.

As I understand this bill, it could act as an incentive for medical providers to not participate with BCBSND, our insurer. In the long-term, our employees could have difficulty accessing participating providers. This would put them at tremendous financial risk particularly at a time when we are all concerned with controlling health care costs.

I urge you to recommend a "Do Not Pass" on SB 2396!

Sincerely,

Carlton Heel

North Dakota Medical Group Management Association

The CORRECT facts you should know as you vote on SB 2396

Just recently you received from Blue Cross Blue Shield of North Dakota their fact sheet on SB 2396. As Paul Harvey would say, we are now pleased to provide you "...the rest of the story...".

SB 2396 is simply about letting the subscriber, the patient, direct the insurance company to pay the Doctor, Hospital, Chiropractor, Dentist, for services that already have been provided to the subscriber/patient, without regard to any contrary provisions of the policy and/or provider contracts. This same right is accorded by all other health care insurers providing coverage to North Dakota subscribers, including Medicare and Medicaid, save one: Blue Cross Blue Shield of North Dakota. **Contrary to information you received in the Blue Cross Blue Shield flyer, Medicare and Medicaid allow their subscribers to authorize direct payments to the health care provider, regardless of the provider's participation status with Medicare or Medicaid.**

You have heard from Blue Cross Blue Shield that passage of SB 2396 will mean increased costs to the consumer, commonly referred to as balance-billing. Their opposition to this bill, is simply to ensure that they continue to have the leverage to force provider participation with Blue Cross Blue Shield, a company that holds a monopoly in the health care insurance market in North Dakota. **We believe that allowing this leverage to continue, may actually increase the cost of health care insurance in North Dakota, because other health care insurers cannot compete with this monopoly and for that reason refrain from entering the North Dakota market, resulting in little premium competition in North Dakota.** This creates an unfair competitive advantage for one insurance company.

You have heard from Blue Cross Blue Shield that passage of SB 2396 will mean some providers may not participate with them. In the urban centers, our participation with any health care insurer is governed by the forces of competition and by the purchasers of health care insurance, i.e. the employers. In the rural centers, their very existence depends upon them making a sound business decision as to their participation with one insurer or another. Forcing their participation, can only result in reduced healthcare to rural North Dakota and the closing of rural health facilities.

(reverse side please)

We believe the urban and rural providers should have the same right as Blue Cross Blue Shield. Blue Cross Blue Shield makes a business decision as to the health insurance products they will offer to North Dakota citizens, they then determine the actuarial cost of those products, add on their administrative costs, and yes, their profit margin, resulting in the premiums we are charged for our health care insurance. We believe that the health care providers should have a similar right, to decide their participation with any insurance company on a business basis, the cost of doing business, and the desires and forces of the marketplace. This is essential for the rural health care providers and the survival of health care in rural North Dakota.

It is not the insurer who brings health care to rural North Dakota. It is the health care providers. As you scan across the State, you will find providers in every major city, working with rural providers to ensure health care to rural North Dakota. We do so at great cost, and often at a substantial financial loss.

We submit that SB 2396, has nothing to do with the issue of balance-billing, and the only reason Blue Cross Blue Shield opposes this bill, is their loss of leverage in forcing providers to participate with their company. We believe it affords the insurer an unfair advantage over other health care insurers, reduces the incentive for Blue Cross Blue Shield to negotiate with the providers, stifles premium competition of which there is almost none within the State, and may actually raise the cost of health care insurance.

SB 2396 levels the playing field. For years, the providers partnered with Blue Cross Blue Shield, and the State of North Dakota, in bringing health care insurance to the people of North Dakota under the provisions of the Health Services Corporation Act. In the last session, Blue Cross Blue Shield sought approval to mutualize, removing them from the provisions of the Health Services Corporation Act, so that they could become like any other insurance company, so we were told. We believe, if that is what they wish to be, then they should be treated like any other insurance company.

Besides leveling the playing field, SB 2396 is about the survival of rural health care, the rights of other health care insurers, the responsibility of a health insurance monopoly, premium competition or lack thereof, and freedom of choice for the consumer/subscriber/patient to simply say: **I do or do not want <u>MY</u> insurance payment to go direct to my health care provider, who has already provided services to me, without restriction by a health care insurer.**

We support the **<u>unanimous</u>** vote of the Senate IBL Committee, and ask you to join them and us in supporting SB 2396, with your **<u>YES</u>** vote!

BlueCross BlueShield of North Dakota

DAN ULMER
Director
Government Relations

Tuscany Square
107 West Main Avenue
P.O. Box 2657
Bismarck, North Dakota 58502

(701) 255-5572
FAX (701) 255-5595

Facts you should know before voting on SB 2396:

The Senate IBL Committee gave a *Do Pass* recommendation to Senate Bill 2396 last week. There was considerable confusion at the hearing about the real impact of the bill on Blue Cross Blue Shield members. The fact is, SB 2396 could raise out-of-pocket health care costs for North Dakotans with Blue Cross Blue Shield coverage.

Currently, most charges for health care services are *capped* for Blue Cross Blue Shield of North Dakota members because of contracts the company has with nearly all health care providers in the state. These contracts set *specific dollar amounts* the company will pay for medical procedures and they **don't allow providers to "balance bill" their Blue Cross Blue Shield patients for charges above statewide payment maximums.**

However, SB 2396 would *guarantee* doctors, hospitals and other health care providers direct payments from Blue Cross Blue Shield of North Dakota ***without*** requiring them to accept the Blue Cross Blue Shield payment as "payment in full." Providers would then be able to bill patients directly for any charges they might choose to set in excess of Blue Cross Blue Shield's statewide maximums. **These extra charges would be charged directly to patients.**

Some rural hospitals believe SB 2396 and the opportunity for greater revenue from patients it allows would significantly improve their financial picture. **This is inaccurate and here's why:**

Since most rural hospitals receive more than **70% of their income from Medicare and Medicaid** (which also *prohibit* "balance billing"), the additional dollars they could charge *non*-Medicare/Medicaid patients – including Blue Cross Blue Shield members – could not possibly provide the additional revenue they seek.

In fact, the "balanced billing" authorization proposed in SB 2396 could result in the demise of rural hospitals. How? When patients learn a given medical procedure could be done at a *participating* hospital for hundreds or even thousands of dollars *less* than the out-of-pocket amounts they could be charged at a *non*-participating local hospital, where do you think they'll go?

Vote to help protect consumers from *uncontrolled* health care costs: Vote NO on SB 2396!

North Dakota Healthcare Association

Vision

The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission

The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Sen. Hubbard
Sen. Hutchinson

FACTS ABOUT SB 2396

1. The purpose of SB 2396 was clearly understood by the Senate IBL Committee. SB 2396 underscores an earlier policy decision of the legislature that Noridian, formerly Blue Cross and Blue Shield, is not any different Ithan any other commercial insurance carrier and should not be treated any differently than other commercial health insurers.

2. This legislation will allow balanced billing by providers not contracting with Nordian. The key to this issue is whether Nordian 's program is fair and competitive. If it's program is not fair or competitive, providers have the fiduciary responsibility not to participate.

3. SB 2396 does not guarantee any direct payments to any providers. Under SB 2396 the subscriber still has the right to assign the insurance benefit. If the subscriber elects not to assign the benefit, the benefit is not assigned.

4. SB 2396 has nothing to do with Medicare or Medicaid. It has to do with commercial insurance companies being treated equally. SB 2396 seeks equal treatment for all commercial carriers. Opponents seek special protection rather than competing with other commercial carriers.

5. Hospitals understand billing limitations. Hospitals understand these limits in their local communities better than Nordian. If hospitals overbill the patient, patients not only voice their concern, there is a high degree of risk to the hospital's viability these patients will seek out other providers in the community or outside of the community for medical services.

6. Boards of Directors are composed of community leaders. To think that the local board is less concerned about their local community than an out of town insurance company is a stretch.

7. Nordian is no longer a health services corporation operating under special statutory provisions. It is a commercial insurance carrier, no different than Mutual of Omaha or Prudential. In miscasting the intent of this bill, opponents seek to retain market benefits enjoyed as a health services corporation while enjoying less oversight by the legislature in how they conduct their business.

8. Noridan is not seeking to protect its customers. Its is seeking an unfair market advantage not practiced by its competitors.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

PROPOSED AMENDMENTS TO SENATE BILL NO. 2396

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act relating to insurance reimbursements and assignability.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Health insurance policy - Assignability. Notwithstanding the provisions of any other law, the issuer of a health insurance policy or contract may not directly or indirectly prohibit a consumer who purchases the policy or contract, on an individual or group basis, from assigning benefits payable under the consumer's policy or contract to a medical provider.

SECTION 2. Health insurance policy - Reimbursements. Reimbursements payable to or on behalf of a consumer by the issuer of a health insurance policy or contract may not be varied according to whether the medical provider rendering services to the consumer has entered into a participating agreement with the issuer of the policy or contract."

Renumber accordingly

March 3, 1999

Chairman Berg, Members of the House Industry, Business and Labor Committee. My name is Greg Hanson. I am President of St. Joseph's Hospital in Dickinson, North Dakota and Chairman of the Board of the North Dakota Health Care Association. I appear before you in both capacities in support of SB 2396.

SB 2396 says that a policyholder MAY assign their health insurance benefits to a provider, regardless of that provider's business relationship with the insurer. SB 2396 is not a mandate. It merely permits a subscriber to exercise an option of having their health insurance payment sent to a provider who rejects contracting with an insurer because it would be a poor or unsound business decision.

With me today to express the rural hospital perspective in support of SB 2396 are representatives from Tower County Medical Center, Cando, North Dakota, and West River Regional Medical Center, Hettinger, North Dakota.

If you would permit questions about this committee to be deferred until the conclusion of both presenters, questions members may have as result of the first presentation may be answered by the second. With your permission I will be happy to direct questions to the appropriate individual at the conclusion of both presenters remarks.

The first presenter will be Tim Tracy, Administrator, Towner County Medical Center, Cando, North Dakota, followed by Jim Long, Administrator, West River Regional Medical Center, Hettinger, North Dakota.

Testimony on Senate Bill 2396
Industry, Business and Labor Committee
by Timothy J. Tracy
March 3, 1999

Good morning Chairman Berg and members of the committee. Thank you for the opportunity to speak with you concerning SB 2396. My name is Tim Tracy. I am the administrator of Towner County Medical Center in Cando, N.D. I would also like to introduce the Chairman of our Board of Directors, Mr. Robert Spencer, who joins me in delivering this testimony on behalf of our organization, community, and all rural hospitals.

SB 2396 is a simple bill. This bill gives consumers the ability to have providers of health care bill for health care services provided and be paid directly by the insurance company. The bill seeks to level the playing field within the commercial insurance industry by creating an environment which all companies play by the same rules.

When SB 2396 was heard in the Senate, there was an absence of commercial insurance carriers opposing this bill with the exception of Noridian. This is because the bill does not change the claims processing practices of most commercial health insurance carriers. All commercial insurance carriers **except Noridian** currently allow patients to assign their health insurance benefits to a health care provider, who in turn bills the insurance company for those services, and subsequently is paid directly. Noridian requires health care providers to contract with them for services in order to receive assignment. If a facility or healthcare provider in North Dakota does not contract with Noridian, assignment of benefits is not allowed.

You may hear testimony that paints this bill as anti-consumer and anti-business. You may hear that it is greedy hospitals and healthcare providers that have forwarded this bill. Let me address these issues.

Anti-consumer. This bill is permissive allowing for consumer choice. Noridian has said that if this bill passes the consumer will pay more. Noridian in their discussions with large business has forwarded the message that providers of health care will pass costs (or balance bill) to policy holders. This only becomes an issue if a healthcare provider elects not to contract with Noridian. But nonetheless local boards are the only qualified individuals to make the decision to contract or withdraw. Rural hospital boards have the responsibility to evaluate contracts from all insurance companies to determine if contracts are reasonable, equitable, and fair. Because these boards must stand up to the local coffee house test, we are extremely sensitive to the needs and demands of our neighbors. Our boards are made up of local people in business, farming, as well as other vocations. Who but these boards are more concerned with the consumer (Our Neighbors). Certainly not Noridian. Question yourselves, why is Noridian really opposing this bill. Would you ask rural providers to make poor business decisions by accepting a contract which is inequitable.

Anti-business. Noridian has forwarded the message that this will increase premiums for group policy holders. Competition is the cornerstone of a free marketplace. Noridian is not competing. Noridian has favored status. This bill is about creating a competitive business environment. I would forward the thought that this bill would create competition and may stabilize premiums through that competition. I have discussed this bill with various small group policy holders in Towner County. They believe that if health care continues to erode in Towner County and rural

N.D., price is of no consequence. They believe this bill is about establishing a competitive business environment in the health insurance industry.

Health care providers are not greedy. They seek adequate and fair reimbursement. Things have changed with BC/BS. Two years ago they were allowed to become a mutual insurance company. This was a drastic organizational and philosophical change. BC/BS was founded and prospered because healthcare providers shared the risk through discounts. BC/BS, now Noridian, no longer recognizes a need to partner with healthcare providers, they fail to negotiate in good faith. The 1999 payment schedule was unilaterally mandated. The payment schedule significantly increases discounts to rural providers. Discounts maintain market share and market share continues to inhibit competition. Without the ability to take assignment of benefits from Noridian, they have **NO INCENTIVE** to negotiate. When BC/BS converted to a mutual insurance company they lost their conscience. Noridian is a company we no longer know or are familiar with.

I have worked in other states. South Dakota has an assignment of benefits statute. The states which surround North Dakota, to include Noridian's counterparts in those states, have recognized the important role rural healthcare has in providing access to health care for citizens in sparsely populated areas. Noridian's counterparts have provided rural providers different pay structures which recognize and reward their rural mission. Noridian no longer feels any responsibility for rural health care and have publicly acknowledged market pricing as their role and access to rural health as a governmental function. The market dominance gained in years past by partnering with health care providers is now used to balance the budget of Noridian on the backs of those very same healthcare providers. Rural healthcare providers such as Towner County Medical Center are facing very difficult economic times. Times which provide a more than adequate challenge for our communities. Payment strategies now being unilaterally employed by Noridian as a mutual insurance company will push some rural hospitals over the edge.

Let me pose a question. What if, because of Noridian's change in corporate structure, their change in corporate philosophy, and their payment initiatives, the Board of Directors of Towner County Medical Center decide they can no longer contract with Noridian. The decision to discontinue contracting with Noridian would create a situation which Towner County Medical Center could not take assignment of benefits. This one item(assignment of benefits) is a deterrent to making a decision to withdraw. **Assignment is Noridian's strangle hold on healthcare providers.** Lack of ability to take assignment of insurance benefits with Noridian as a non-participating healthcare provider literally forces participation by all healthcare providers and therefore allows and insures continued market dominance along with the luxury of unilateral decision making without responsibility for results. This is anti-business.

Don't be fooled by the anti-consumer, anti-business, greedy hospital smoke screen. These are simply tactics which have been employed by Noridian to scare group policy holders and you the committee. What is at stake is Noridian's market share lest they once again become good corporate citizens and neighbors. This bill is simply about equity, competition, fairness and self determination. Please send a solid unanimous do pass to the house members. Thank you for your time and consideration.

Chairman Berg, Members of the Committee:

Good morning. My name is Jim Long. I am the Administrator of the West River Regional Medical Center in Hettinger and I am here this morning to explain my strong support for Senate Bill 2396 and to ask for your favorable recommendation for a do-pass on this bill.

First of all, I think it appropriate to begin with a little history about what has led to this bill's origin. In years previous, BCBSND operated as a Health Services Corporation and, as such, had both restrictions and favorable policies governing its operations.

In a prior legislative session, BCBSND decided that it was no longer to its benefit to operate under these restrictions and petitioned the legislature to be treated as a Mutual Insurance Company. Staff of BCBSND testified that the benefits of a Health Services Corporation were no longer of enough benefit to BCBSND to retain this special distinction.

The Insurance Commissioner and the Legislature consented to the request and a new insurance company, NORIDIAN, was born. It retained some or maybe even much of the structure and operations of BCBSND but differs significantly in the application of its mission.

In years past, providing health care to the population of the state was an objective not just of the health care providers of the state but also of its Health Services Corporation, BCBSND. Now, under NORIDIAN, I have seen two separate news releases from NORIDIAN that indicate that access to healthcare in the rural areas is of no concern to them. Two of their executive officers have stated that maintaining access to medical care in rural areas is a government policy decision that does not involve NORIDIAN.

These news releases are a response to criticism from rural health care providers for planned significant reductions in payment for the upcoming year. I can not speak for all the other rural facilities but I know that in Hettinger, the premiums paid by our organization and its employees are far in excess of the claims paid.

Our most recent three year history with BCBSND indicates that providing insurance to our rural area is VERY profitable for BCBSND. Our history is as follows-

1996-		
Premiums paid	$740,000	
Claims paid	639,050	
Underwriting gain	$100,950	(14%)
1997-		
Premiums paid	$747,000	
Claims paid	573,277	
Underwriting gain	$173,723	(23%)
1998-		
Premiums paid	$722,000	
Claims paid	571,401	
Underwriting gain	$150,599	(21%)
Total 3 year gain	$425,272!!!!	

Now as we move to the year 2000, NORIDIAN wants to raise our premium rates by nearly 9% and at the same time reduce payments for services in rural areas. It says it must do this because of significant underwriting losses.

As the payment history at Hettinger indicates that NORIDIAN has a underwriting gain, I can only infer that the "new markets" that NORIDIAN wanted to compete in as a Mutual Insurance Company, are not profitable for them. They need to make up the difference from policyholders in the rural communities.

Because of the payment inequities that are being implemented by NORIDIAN, for the first time in the history of the state, rural hospitals are considering changing their insurance provider. At the same time, they are considering NOT being "participating providers" with NORIDIAN.

To be a "participating provider", a rural hospital not only accepts the payment from NORIDIAN but it automatically receives assignment of the payment. If the facility is "non-participating", then the payment can not be assigned, even if the patient wishes it to be. To add injury to insult, then NORIDIAN reduces its payment to 64% (80% of 80%) of the "prevailing charge" recognized by NORIDIAN.

We, the rural hospitals of the state, think that this is totally unacceptable. We believe that the patient should be able to assign their payment and we further believe that such payment should be at "prevailing rates" and not at 64% of such.

We also believe that rural hospitals should not be pawns in the strategy of NORIDIAN to use monies of rural policyholders to subsidize losses in their new markets. If we remain "participating providers", we are endorsing the plans and payment policies of NORIDIAN. If we become "non-participating", we subject our patients to greater out of pocket expense due to NORIDIANS "64%" policy.

For that reason, we support Senate Bill 2396. We want to change the rules so that NORIDIAN has to compete equally in the rural markets. We believe NORIDIAN should pay "prevailing rates" and that patients should be allowed to decide themselves if they wish the payment to be assigned or not. We also believe that this will not happen unless NORIDIAN is placed on an equal playing field with the other mutual insurance companies.

My Board of Directors is made up of farmers, ranchers and other business people of the region. They have a true concern for our patients. They know well the struggle not only of our maintaining access to care but also the difficulties our patients have in paying the cost of such care. Neither they nor I want to place any additional burden upon them.

We are close to our patients, much closer than any insurance company whether it be in Fargo or any other location. Rural facilities have historically charged much less than their urban brethren. I believe that this is principally because we are so close to our patients and sensitive to their financial situations.

I, for one, am insulted and appalled by the contention that NORIDIAN is the protector of our rural people in this issue. They have already stated, at least twice, that access in rural areas in not their concern. This, by itself, should make you think twice about why they oppose this bill. If the rural patient is not their concern, what is?

No matter what you decide is the answer to that question, let me make it perfectly clear that our patients and their access to healthcare, whether limited by location or price, IS OUR concern. I hope that it is yours too. Please vote yes on the passage of Senate Bill 2396.

Thank you for hearing my testimony.

Jim Long, Administrator
West River Regional Medical Center
1000 Highway 12
Hettinger, North Dakota 58639

TESTIMONY ON SB 2396

North Dakota Medical Group Management Association

Mr. Chairman and Members of the Committee, my name is Mike Tomasko and I come before you today in support of SB 2396, on behalf of the 100 professionals who are members of the North Dakota Medical Group Management Association. In my other life, I am an Administrator of the PrimeCare health group and CEO of Mid Dakota Clinic, here in Bismarck.

Section 26.1-36-24 already allows for direct assignment of payments upon agreement of the insured, the group policy holder and the insurer. Only one insurance company will not agree to allow such direct payment, and that is Blue Cross Blue Shield of North Dakota. That is different than every other commercial health insurer, all of whom allow for such direct assignment of payments. South Dakota Blue Cross Blue Shield allows for direct assignment of payments. Blue Cross Blue Shield of North Dakota allows for direct assignment of payments to out of state providers, but does not accord this same right to in state providers.

SB2396 is simply about letting the subscriber, the patient, direct the insurance company to pay the Doctor, Hospital, Chiropractor, Dentist, for services that already have been provided to the subscriber/patient, without regard to any contrary provisions of the policy and/or provider contracts. This same principle is often applied in the insurance industry, when there is an insurance claim for damage to one's automobile or home, and the insurance check is made payable to the insured and the provider of the service, the one who provides the repairs.

You will hear from Blue Cross Blue Shield that passage of SB 2396 will mean increased costs to the consumer, commonly referred to as balance-billing. The only reason for their opposition to this bill, is simply to ensure that they continue to have the leverage to force provider participation with their company, a company that holds a virtual monopoly of the health care insurance market in North Dakota. **We believe that allowing this leverage to continue, may actually increase the cost of health care insurance in the State, because other health care insurers cannot compete with the monopoly and for that reason refrain from entering the North Dakota market, resulting in little premium competition in North Dakota.** We believe that allowing this leverage

to continue, affords one insurer an unfair advantage and reduces their incentive to negotiate with the providers, and further that it stifles premium competition as expressed in their corporate policy of predatory premium pricing to keep other health insurers out of the State.

You will hear from those opposed to the passage of SB 2396, that some providers may not participate with Blue Cross Blue Shield of North Dakota. In the urban centers, our participation with any health care insurer is governed by the forces of competition and the purchasers of health care insurance, i.e. the employers. We believe that is as it should be. In the rural centers, we believe that their very existence is dependent upon them making a sound business decision as to their participation with an insurer.

We believe both urban and rural provider should have the same right as the insurer, that is to decide their participation with any insurer on the basis of the cost of doing business and the forces of the marketplace. After all, the insurer is allowed to determine what insurance products to sell, they are allowed to set the cost of that insurance product, to add on their administrative costs and to set their profit margin, resulting in the premiums you and I are charged for our health care insurance.

Additionally, it is not the State Insurance Department nor Blue Cross Blue Shield that has taken on the responsibility of ensuring rural health care. In fact, the latter has stated it is their intent to down-size rural health care. As you scan across North Dakota, you will find that it is the health systems from the urban communities, i.e. Grand Forks, Fargo, Bismarck, Minot, Dickinson, working with rural health care providers, to ensure health care in Bowman, Cooperstown, Kenmare, Rolette, and so many other rural communities, at great cost, and often at a substantial financial loss. As Mr. Al Day, Vice President of Human Resources for North American Coal Corporation recently said to me, "...it is important that we have strong rural health care in communities such as Beulah, Hazen, Garrison and Turtle Lake, communities where our employees reside...".

SB 2396 levels the playing field. For years, the providers partnered with Blue Cross Blue Shield of North Dakota, and the State of North Dakota, in bringing health care insurance to the people of this State under the provisions of the Health Services Corporation Act. In the last session, Blue Cross Blue Shield sought approval to mutualize, removing them from the provisions of the

Health Services Corporation Act, so that they could become like any other insurance company, so we were told. We believe, if that is what they wish to be, then so be it, and they should not be granted special protection rather than competing with other commercial health insurance carriers.

Besides leveling the playing field, SB 2396 is about the survival of rural health care, the rights of other health care insurers, the responsibility of a health insurance monopoly, premium competition or lack thereof, and freedom of choice for the consumer/patient/subscriber to simply say: **I do or do not want MY insurance payment to go direct to my health care provider, who has already provided me the services, without restriction by a health care insurer.**

For these reasons we support the unanimous vote of the Senate IBL Committee, the majority vote of the Senate, and ask you to join with them in supporting SB 2396.

Aside from being health care providers, we are also one of the largest employers in the State of North Dakota. We are also one of the largest consumer groups of health care insurance and health care services. We often ask ourselves the same question many of you ask: if health care insurance premiums are going up, and provider reimbursement is going down (especially to the rural providers), than where is the money going?

The health care industry, according to the NDSU Department of Agricultural Economics, using 1997 figures shows that the health care industry in North Dakota generates an estimated total of $807 million of economic activity and employs more than 14,000 people. Health care spent in excess of $700 million in North Dakota in 1997. We employed in excess of 14,000 people, creating an estimated 36,174 secondary full-time jobs, 14.8% of the state's employment, or 50,187 full-time jobs are credited to health care. In addition the health care industry provides substantial charity care which last year, for the members of the PrimeCare health group, exceeded two million dollars.

As providers, major employers, major consumers, and good citizens of this State we appreciate the debate generated by SB 2396, and we appreciate your consideration of our position on this proposed legislation, and your indulgence in allowing us to come before you.

HOUSE OF REPRESENTATIVES INDUSTRY, BUSINESS & LABOR COMMITTEE
REPRESENTATIVE RICK BERG, CHAIRMAN
MARCH 3, 1999

TESTIMONY BY
REPRESENTATIVE TODD PORTER

IN SUPPORT OF SB 2396

Chairman Berg and members of the House IBL my name is Todd Porter, Representative from District 34 in Mandan. I stand before you in favor of SB 2396.

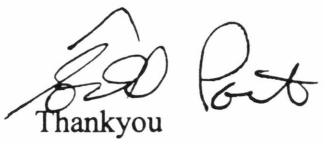
SB 2396 changes the reimbursement policies of non-participating providers. Currently in North Dakota, most ambulance services are non-participating providers with Blue Cross/Blue Shield of North Dakota. They tried late in 1998 to lure ambulance services to accept less payment in exchange for payment directly to the provider. I am unsure of how many ambulance services signed on as participating providers with BC/BS, but I am aware that a number of ambulance services, both rural volunteers and urban services that were unable to due so the reduced revenues offered.

BC/BS now will penalize those non-participating ambulance services, by sending the partial payment of benefits to the patient, even though the patient may have signed a release form asking that the payment be sent directly to the non-participating provider. This action reduces cash flow to these services. Recently we dealt with a number of bills dealing directly with ambulance services and during the interim realized that cash flow/billing management was a significant problem. The Health Department established a pilot project to assist ambulance service with billing problems.

Patients and providers need the ability to decide how their benefits are spent and how the bills are paid.

The substance of this bill does not increase the cost to the patient as you may hear, it only provides, upon the patient's consent, payment of any reimbursement directly to the provider.

Mr. Chairman, I would be more than happy to answer any questions at this time.



Thankyou

BlueCross BlueShield
of North Dakota

NORIDIAN℠
Mutual Insurance Company*

4510 13th Avenue S.W.
Fargo, North Dakota 58121-0001

RYN M. PITTS
Senior Vice President
Health Care and Member Services

Phone: 701-277-2090
FAX: 701-277-2132
ryn.pitts@noridian.com

March 3,1999

Chairman Berg, members of the committee, I am Ryn Pitts, Senior Vice President, Health Care and Member Services Division of Noridian Mutual Insurance Company, the Blue Cross Blue Shield Plan in North Dakota (BCBSND). I am pleased to appear here today to discuss our strong opposition to Senate Bill 2396. While the bill appears to be fairly simple, it is important for you to be aware of the potential implications for BCBSND members. This is a complex issue so allow me give you some background information before I discuss the potential impact of SB 2396.

BCBSND provides health coverage for over 400,000 people and we take this responsibility very seriously. Our mission is to provide access to high quality and affordable coverage to our members. Throughout the long history of BCBSND in this state, a major factor in our ability to serve our members has been our **contractual relationship** with North Dakota health care providers. These contracts are also known as participation agreements. When a provider signs a contract with BCBSND, there are clear benefits to all parties: provider, BCBSND and its members.

The participating provider has three major benefits:

- Access to a large BCBSND patient population;
- Prompt, timely payment by BCBSND for medical services provided to BCBSND members; and
- Direct payment to the provider by BCBSND, ensuring a predictable cash flow.

These are clearly intended as incentives for the provider to sign a contract and become a "participating provider." Non participating providers risk losing access to our members, payment is made at a reduced rate, and the payment is made directly to the patient. Thus, the non participating provider must collect the amount due for the service from the patient. *Participating providers* get paid directly by BCBSND; *Non participating providers* must collect their fees from their patients. This perhaps is the greatest incentive for a provider to "participate." (Note: this is also very similar to the Medicare system.)

To demonstrate how well this contractual relationship has worked, currently 100% of hospitals and 99.6% of physicians are participating providers with BCBSND.

The BCBSND member also benefits by acquiring services from a participating provider:

- A participating provider is required to submit claims to BCBSND on behalf of the patient with BCBSND coverage. There is no paperwork for the patient; and

- The provider is required to accept BCBSND's discounted payment as payment-in-full; there is no balance billing allowed. The patient is only responsible for any deductibles, co-payments or co-insurance amounts.

In other words, the difference between the provider's actual costs and BCBSND's payment cannot be passed on to the patient. In the reverse, patients who receive services from *non participating providers* must submit claims themselves. But more importantly, they are responsible to pay the difference between our payment and the actual billed charge.

How does SB 2396 affect our contractual relationship with providers?

Instead of sending the check for medical services to our member, we would be required to pay the non participating provider directly. Therefore, this bill removes the most important incentive for providers to become participating providers with BCBSND.

Why would a provider support SB 2396?

First, SB 2396 enables the provider to maintain the major benefit of participating status, that is, direct payment from BCBSND without the burden of collecting the largest portion of the claims payment from the patient. Another less obvious concern is that providers would have the opportunity for **more revenue** because the provider could "balance bill" the patient for the difference between the BCBSND payment and the actual billed charge. This, in fact, may create a perverse incentive for providers to raise their charges.

You have heard that rural hospitals support SB 2396 because some of them are having financial difficulties and need to consider nonpar status as an option. It is very clear that with Medicare payments comprising, in many cases, 60-70% of their revenue, SB 2396 is not the answer. Our payments today are significantly higher than current Medicare reimbursement. In fact, because of the payment system in place today, BCBSND actually pays a majority of rural hospitals more than their actual charges.

Who gets hurt by SB 2396?

Consumers. They lose the benefit of the discounts that are a part of our contracts and are potentially vulnerable to increasing charge patterns by providers. Clearly, passing SB 2396 is not in the best interest of your constituents.

You may have heard the argument that all other insurers do it this way. It's called "honoring the assignment by a patient." While this may be true with some other insurers, there is one important difference. Most other insurers do not have participating contracts with health care providers that include "payment-in-full" provisions.

We also firmly believe that this is a **contractual** business issue that should not be the subject of legislation. Legislating this contractual issue also impacts other portions of our contracts as well.

There is one other important consideration I need to mention. North Dakota is a rural state where in many areas there is not an abundant choice of providers. If you remove this incentive for a provider to participate, a BCBSND member may not have easy access to a participating provider. What happens if a rural hospital elects to become non participating? Will a patient need to drive some distance to get services at the discounted price BCBSND has with participating providers? Remember, a provider can today elect not to sign a participating agreement with BCBSND. That is their prerogative. But I urge you to reject a bill that may actually encourage providers to take this step.

There is little doubt that this bill is a result of some provider reaction to our Board of Director's action late last year to make adjustments to its reimbursement methodology. Even though BCBSND projects our total health care payments to increase in 1999, some providers may receive lower payments for their mix of services. This was done for a lot of reasons but the major consideration was health care costs increasing at a rate that we simply could not pass on to our premium payers. Even with the provider reimbursement adjustments, our average rate increases this year are in the 9-10% range. When you consider that a family rate today ranges from $410-450 a month, we are approaching a point where premiums will become unaffordable.

In conclusion, let me leave you with three key points on SB 2396: 1). It will negatively impact consumers. 2). It has little to do with the financial viability of rural hospitals. 3). SB 2396 legislates a contractual issue that should not be the subject of legislation. I urge you to vote to recommend a "Do Not Pass" on SB 2396. Thank you and I will be glad to answer any questions you may have.

TESTIMONY BEFORE THE HOUSE INDUSTRY, BUSINESS AND LABOR COMMITTEE
Concerning SB2396
March 3, 1999
Dean Peterson, THE NORTH AMERICAN COAL CORPORATION

Mr. Chairman and members of the Committee, my name is Dean Peterson. I am here today representing The North American Coal Corporation – North Dakota's largest lignite producer. North American Coal produces over 23 million tons of lignite each year for energy conversion facilities located in North Dakota. Our subsidiary mining operations, The Coteau Properties Company and The Falkirk Mining Company employ over 600 people.

North American Coal is **opposed to SB2396** for the same reasons outlined in testimony given today by Blue Cross Blue Shield of North Dakota (BCBSND). We believe that SB2396 will adversely affect our ability to keep health care costs under control for both the company and our employees.

Therefore, North American respectfully asks this committee to support a **do not pass** position for SB2396.

FISCAL YEAR '96

Small Hospitals

City/Hospital	# of Acute Beds	Staffed Beds	Total Beds	Total Rev.	Net Income	
Ashley, McIntosh County						
Ashley Medical Center	26		70	$4,236,307	($333,808)	-7.90%
Bottineau, Bottineau County						
St. Andrew's Health Center	35		67	$3,950,832	($185,431)	-4.70%
Bowman, Bowman County						
St. Luke's Tri-State Hospital	34	17	34	$2,402,986	($289,046)	-12.00%
Cando, Towner County						
Towner County Med. Center	22		32	$5,208,623	$117,729	2.30%
Carrington, Foster County						
Carrington Health Center	30		70	$12,434,644	$469,448	3.80%
Cavalier, Pembina County						
Pembina Cty Mem. Hospital	29		89	$6,965,678	($43,321)	-0.60%
Cooperstown, Griggs County						
Griggs County Hospital	11		11	$3,448,794	($286,794)	-8.30%
Crosby, Divide County						
St. Luke's Hospital	29		29	$2,560,721	($16,135)	-0.60%
Elgin, Grant County						
Jacobson Mem. Hosp. Center	25		50	$1,755,921	($20,353)	-1.20%
Garrison, McLean County						
Garrison Memorial Hospital	32	25	49	$4,469,095	$27,228	0.60%
Grafton, Walsh County						
Christian Unity Hospital	48	27	48	$5,762,484	($84,788)	-1.50%
Harvey, Wells County						
St. Aloisius Med. Center	48		165	$7,291,373	($135,334)	-1.90%
Hazen, Mercer County						
Sakakawea Med. Center	29		29	$9,389,161	($12,005)	-0.10%
Hettinger, Adams County						
West River Reg. Med. Center	46		46	$18,776,899	($28,248)	-0.10%
Hillsboro, Traill County						
Hillsboro Med. Med. Center	25		74	$3,452,260	$176,021	5.10%
Kenmare, Ward County						
Kenmare County Hospital	30		42	$2,210,871	$171,156	7.70%
Langdon, Cavalier County						
Cavalier Cty. Mem. Hospital	38	28	38	$3,190,200	$328,853	10.30%
Linton, Emmons County						
Linton Hospital	27		27	$3,195,405	($233,009)	-7.30%
Lisbon, Ransom County						
Community Mem. Hospital	20		70	$5,796,623	$160,516	2.80%
Mayville, Traill County						
Union Hospital	30		30	$3,428,947	$229,775	6.70%
McVille, Nelson County						
Comm. Hosp. in Nelson County	19		19	$2,129,702	($5,252)	-0.20%
Northwood, Grand Forks Cty.						
Northwood Deaconess Hosp.	12		124	$4,658,393	($317,200)	-6.80%
Oakes, Dickey County						
Oakes Community Hospital	36	30	36	$8,594,937	($85,297)	-1.00%

Park River, Walsh County						
St. Ansgar's Health Center	30	20	30	$3,342,822	($228,399)	-6.80%
Richardton, Stark County						
Richardton Health Center	26		26	$817,604	($42,024)	-5.10%
Rolla, Rolette County						
Presentation Med. Center	59		102	$9,458,862	($122,293)	-1.30%
Rugby, Pierce County						
Heart of Am. Med. Center	38		236	$11,021,928	($842,453)	-7.60%
Stanley, Mountrail County						
Stanley Comm. Hospital	25		25	$1,767,476	($2,819)	[-13%PatRev]
Tioga, Williams County						
Tioga Medical Center	29		59	$5,149,266	($288,048)	-5.60%
Turtle Lake, McLean County						
Community Mem. Hospital	35		35	$1,688,988	$96,435	5.70%
Watford City, McKenzie County						
McKenzie County Mem. Hosp.	26		26	$1,793,297	($149,546)	-8.30%
Wishek, McIntosh County						
Wishek Community Hospital	24		24	$5,651,593	$241,433	4.30%

Large Hospitals					
Bismarck, Burleigh County					
St. Alexius Medical Center	285		$133,581,766	$6,679,082	5.00%
MedcenterOne	256	204	$159,783,525	$2,066,998	1.30%
Devils Lake, Ramsey County					
Mercy Hospital	50	35	$16,246,659	$614,249	3.80%
Dickinson, Stark					
St. Joseph's Hospital	109	87	$32,067,777	-427,234	-1.30%
Fargo, Cass County					
Dakota Hospital (South Univ.)	199		$82,548,889	($19,636,151)	-23.80%
Heartland Medical Center (4th)	130		$55,788,453	$10,345,608	18.50%
Meritcare Hospital	380		$175,557,081	$26,241,761	15.00%
Grand Forks, Grand Forks Cty					
United Hospital [Altru]	277		$142,001,659	$6,097,977	4.30%
Jamestown, Stutsman County					
Jamestown Hospital	56		$14,599,606	$526,738	3.60%
Minot, Ward County					
Trinity Medical Center	251	174	$124,050,480	$3,416,362	2.80%
Unimed Medical Center (St. Jo)	165		$76,939,268	($1,695,284)	-2.20%
Valley City, Barnes County					
Mercy Hospital	74	50	$9,952,796	$1,132,327	11.40%
Williston, Williams County					
Mercy Medical Center	120		$30,618,638	($636,674)	-2.10%

ORTH DAKOTA

Resident population 638 (in thousands)
Resident population in metro areas 41.6%
Birth rate per 1,000 population 13.9
65 years and over 14.7%
Percent of persons without health insurance 13.4%

★ American Hospital Association (AHA) membership
□ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation
+ American Osteopathic Hospital Association (AOHA) membership
○ American Osteopathic Association (AOA) accreditation
△ Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation
Control codes 61, 63, 64, 71, 72 and 73 indicate hospitals listed by AOHA, but not registered by AHA. For definition of numerical codes, see page A6

Hospital, Address, Telephone, Administrator, Approval, Facility, and Physician Codes, Health Care System	Classification Codes		Utilization Data					Expense (thousands) of dollars		
	Control	Service	Beds	Admissions	Census	Outpatient Visits	Births	Total	Payroll	Personnel
ASHLEY—McIntosh County										
★ ASHLEY MEDICAL CENTER, 612 North Center Avenue, Zip 58413-0556; tel. 701/288-3433; Stephen H. Johnson, Administrator (Total facility includes 44 beds in nursing home-type unit) **A**9 10 **F**7 8 11 14 15 16 19 22 24 27 30 31 32 33 34 37 39 40 44 45 46 64 65 71 73	23	10	70	225	48	1584	0	3519	1811	104
BELCOURT—Rolette County										
✠ U.S. PUBLIC HEALTH SERVICE INDIAN HOSPITAL, Mailing Address: P.O. Box 160, Zip 58316-0130; tel. 701/477-6111; Ray Grandbois M.P.H., Service Unit Director (Nonreporting) **A**1 5 10 **S** U.S. Public Health Service Indian Health Service, Rockville, MD	47	10	42	—	—	—	—	—	—	—
BISMARCK—Burleigh County										
✠ △ MEDCENTER ONE, 300 North Seventh Street, Zip 58501-4439, Mailing Address: P.O. Box 5525, Zip 58506-5525; tel. 701/224-6100; Terrance G. Brosseau, President **A**1 2 3 5 7 9 10 **F**1 3 4 7 8 10 11 12 13 14 17 19 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 51 52 53 54 56 57 58 59 60 61 64 65 66 67 69 70 71 73 74 **P**1 3 6 **N** Medcenter One, Bismarck, ND	23	10	204	7116	127	323108	556	110040	58226	1530
✠ △ ST. ALEXIUS MEDICAL CENTER, 900 East Broadway, Zip 58501, Mailing Address: P.O. Box 5510, Zip 58506-5510; tel. 701/224-7000; Richard A. Tschider FACHE, Administrator and Chief Executive Officer **A**1 2 3 5 7 9 10 **F**3 4 5 7 8 10 12 13 15 16 17 18 19 20 21 22 24 26 27 28 29 30 31 32 33 34 35 37 38 39 40 41 42 43 44 45 47 48 49 51 52 53 54 55 56 57 58 59 61 64 65 66 67 70 71 72 73 74 **P**1 7 **S** Benedictine Sisters of the Annunciation, Bismarck, ND	21	10	289	9385	155	125305	1020	83391	41207	1300
BOTTINEAU—Bottineau County										
ST. ANDREW'S HEALTH CENTER, 316 Ohmer Street, Zip 58318-1018; tel. 701/228-2255; Keith Korman, President (Total facility includes 32 beds in nursing home-type unit) **A**5 9 10 **F**6 7 8 15 16 19 26 28 30 32 36 39 40 49 53 54 55 57 62 64 65 66 70 71 73 **P**3 **S** Sisters of Mary of the Presentation Health Corporation, Fargo, ND	23	10	67	475	40	5000	10	3057	1519	78
BOWMAN—Bowman County										
ST. LUKE'S TRI-STATE HOSPITAL, 202 Sixth Avenue S.W., Zip 58623-0009, Mailing Address: Drawer C, Zip 58623; tel. 701/523-5265; Jim Opdahl, Administrator **A**5 9 10 **F**8 19 22 30 35 44 51 64 65 71 **P**6	23	10	17	354	6	5106	1	2120	1108	—
CANDO—Towner County										
★ TOWNER COUNTY MEMORIAL HOSPITAL, Mailing Address: P.O. Box 688, Zip 58324-0688; tel. 701/968-4411; Timothy J. Tracy, Administrator (Total facility includes 10 beds in nursing home-type unit) (Nonreporting) **A**5 9 10	23	10	32	—	—	—	—	—	—	—
CARRINGTON—Foster County										
★ CARRINGTON HEALTH CENTER, 800 North Fourth Street, Zip 58421; tel. 701/652-3141; Michael A. Baumgartner, President (Total facility includes 40 beds in nursing home-type unit) **A**5 9 10 **F**7 8 15 16 19 22 26 28 30 32 34 44 49 64 65 67 71 73 **P**3 4 **S** Catholic Health Initiatives, Denver, CO	21	10	70	909	51	27209	48	7304	2565	109
CAVALIER—Pembina County										
★ PEMBINA COUNTY MEMORIAL HOSPITAL AND WEDGEWOOD MANOR, 301 Mountain Street East, Zip 58220, Mailing Address: Box 380, Zip 58220; tel. 701/265-8461; Judy Dulski, Interim Administrator (Total facility includes 60 beds in nursing home-type unit) (Nonreporting) **A**5 9 10 **S** Lutheran Health Systems, Fargo, ND	23	10	89	—	—	—	—	—	—	—
COOPERSTOWN—Griggs County										
GRIGGS COUNTY HOSPITAL AND NURSING HOME, 1200 Roberts Avenue, Zip 58425, Mailing Address: Box 728, Zip 58425; tel. 701/797-2221; Patrick J. Rafferty, Administrator (Total facility includes 58 beds in nursing home-type unit) (Nonreporting) **A**9 10 **N** Meritcare Health System, Fargo, ND	23	10	69	—	—	—	—	—	—	—
CROSBY—Divide County										
ST. LUKE'S HOSPITAL, 702 First Street Southwest, Zip 58730-0010; tel. 701/965-6384; Leslie O. Urvand, Administrator **A**9 10 **F**8 11 14 19 22 28 29 30 36 40 41 44 46 49 64 71	23	10	29	330	11	1342	2	1880	815	44
DEVILS LAKE—Ramsey County										
✠ MERCY HOSPITAL, 1031 Seventh Street, Zip 58301-2798; tel. 701/662-2131; Marlene Krein, President and Chief Executive Officer **A**1 5 9 10 **F**7 11 14 15 16 17 19 21 22 28 29 30 31 32 33 35 39 40 42 44 45 46 49 65 67 68 71 73 **P**5 **S** Catholic Health Initiatives, Denver, CO	21	10	35	1797	22	13793	272	10598	5274	200
DICKINSON—Stark County										
✠ ST. JOSEPH'S HOSPITAL AND HEALTH CENTER, 30 Seventh Street West, Zip 58601; tel. 701/225-7200; John S. Studsrud, President **A**1 5 9 10 **F**7 8 14 15 16 17 19 21 22 24 30 32 33 34 35 36 37 40 41 44 46 49 52 53 54 55 56 57 58 59 63 65 66 67 71 73 **S** Catholic Health Initiatives, Denver, CO	21	10	87	3023	48	33637	370	21647	9527	371

Hospital, Address, Telephone, Administrator, Approval, Facility, and Physician Codes, Health Care System	Classification Codes		Utilization Data					Expense (thousands) of dollars		
★ American Hospital Association (AHA) membership □ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation + American Osteopathic Hospital Association (AOHA) membership ○ American Osteopathic Association (AOA) accreditation △ Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation Control codes 61, 63, 64, 71, 72 and 73 indicate hospitals listed by AOHA, but not registered by AHA. For definition of numerical codes, see page A6	Control	Service	Beds	Admissions	Census	Outpatient Visits	Births	Total	Payroll	Personnel
ELGIN—Grant County										
JACOBSON MEMORIAL HOSPITAL CARE CENTER, 601 East Street North, Zip 58533-0376; tel. 701/584-2792; Jacqueline Seibel, Administrator (Total facility includes 25 beds in nursing home-type unit) **A**9 10 **F**7 19 22 37 40 44 64 65 70 71 73 **N** Medcenter One, Bismarck, ND	23	10	50	319	27	1446	6	1756	864	54
FARGO—Cass County										
★ △ DAKOTA HEARTLAND HEALTH SYSTEM, (Includes Dakota Heartland Health System-Island Park Campus, 510 Fourth Street South, Zip 58103; tel. 701/232-3331; Dakota Heartland Health System-South University Campus, 1720 South University Drive, Zip 58103, Mailing Address: P.O. Box 6014, Zip 58108-6014), 1720 South Univeristy Drive, Zip 58103; tel. 701/280-4100; Peter W. Thoreen, President and Chief Executive Officer (Total facility includes 28 beds in nursing home-type unit) **A**1 2 3 5 7 9 10 **F**3 4 5 6 7 8 10 11 12 13 14 15 16 17 18 19 20 21 22 24 26 27 28 29 30 31 32 33 34 35 37 38 40 41 42 43 44 45 46 49 51 52 53 54 55 56 57 58 59 60 61 65 66 67 68 69 71 72 73 74 **P**5 8 **S** Champion Healthcare Corporation, Houston, TX	33	10	261	9967	150	91134	1449	84970	33011	1217
DAKOTA HEARTLAND HEALTH SYSTEM-ISLAND PARK CAMPUS See Dakota Heartland Health System										
DAKOTA HEARTLAND HEALTH SYSTEM-SOUTH UNIVERSITY CAMPUS See Dakota Heartland Health System										
DAKOTA HOSPITAL See Dakota Heartland Health System										
HEARTLAND MEDICAL CENTER See Dakota Heartland Health System										
★ △ MERITCARE HEALTH SYSTEM, (Formerly MeritCare Medical Center), 720 Fourth Street North, Zip 58122; tel. 701/234-6000; Roger Gilbertson M.D., President; Lloyd V. Smith, Executive Vice President (Nonreporting) **A**1 2 3 5 7 9 10 **S** Meridia Health System, Mayfield Village, OH	23	10	378	—	—	—	—	—	—	—
★ VETERANS AFFAIRS MEDICAL AND REGIONAL OFFICE CENTER, 2101 Elm Street, Zip 58102-2498; tel. 701/232-3241; Douglas M. Kenyon, Director (Total facility includes 50 beds in nursing home-type unit) **A**1 3 5 **F**2 3 8 12 17 19 20 21 22 26 27 28 30 31 32 33 35 37 39 42 44 46 48 49 51 52 54 55 56 57 58 60 63 64 65 67 71 73 74 **S** Department of Veterans Affairs, Washington, DC	45	10	163	3390	80	58996	0	42433	21264	506
FORT YATES—Sioux County										
★ U.S. PUBLIC HEALTH SERVICE INDIAN HOSPITAL, Mailing Address: P.O. Box J, Zip 58538; tel. 701/854-3831; Terry Pourier, Service Unit Director (Nonreporting) **A**1 5 10 **S** U.S. Public Health Service Indian Health Service, Rockville, MD	47	10	16	—	—	—	—	—	—	—
GARRISON—McLean County										
★ GARRISON MEMORIAL HOSPITAL, 407 Third Avenue S.E., Zip 58540-0039; tel. 701/463-2275; Richard Spilovoy, Administrator (Total facility includes 24 beds in nursing home-type unit) (Nonreporting) **A**5 9 10 **S** Benedictine Sisters of the Annunciation, Bismarck, ND	21	10	49	—	—	—	—	—	—	—
GRAFTON—Walsh County										
★ UNITY MEDICAL CENTER, 164 West 13th Street, Zip 58237; tel. 701/352-1620; Steve Feltman, Chief Executive Officer **A**1 5 9 10 **F**7 8 15 16 17 19 22 28 29 30 32 34 37 40 41 42 44 49 51 54 65 67 71 73 **P**6	23	10	27	594	9	34096	59	4944	2872	99
GRAND FORKS—Grand Forks County										
MEDICAL CENTER REHABILITATION HOSPITAL See United Health Services										
★ △ UNITED HEALTH SERVICES, (Includes Medical Center Rehabilitation Hospital, 1300 South Columbia Road, Zip 58201, Mailing Address: P.O. Box 9017, Zip 58202; tel. 701/780-2311; United Hospital, 1200 South Columbia Road, Zip 58201; tel. 701/780-5000), 1200 South Columbia Road, Zip 58201; tel. 701/780-5000; Rosemary Jacobson, President and Chief Executive Officer **A**1 2 3 5 7 9 10 **F**2 3 4 6 7 10 12 13 14 15 16 18 19 21 22 23 27 28 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 65 66 67 71 73 **P**2 **N** United Hospital, Grand Forks, ND	23	10	277	10594	165	78243	1362	109511	50711	1808
UNITED HOSPITAL See United Health Services										
GRAND FORKS AFB—Grand Forks County										
★ U.S. AIR FORCE HOSPITAL, Grand Forks SAC, Zip 58205-6332; tel. 701/747-5391; Major Norman J. Latini MSC, USAF, Administrator (Nonreporting) **A**5 **S** Department of the Air Force, Washington, DC	41	10	15	—	—	—	—	—	—	—
HARVEY—Wells County										
★ ST. ALOISIUS MEDICAL CENTER, 325 East Brewster Street, Zip 58341-1605; tel. 701/324-4651; Ronald J. Volk, President (Total facility includes 116 beds in nursing home-type unit) **A**5 9 10 **F**3 6 7 8 19 22 27 28 32 35 37 40 42 44 49 53 54 58 62 64 65 67 71 73 **S** Sisters of Mary of the Presentation Health Corporation, Fargo, ND	21	10	165	671	127	5722	23	6300	3297	122
HAZEN—Mercer County										
★ SAKAKAWEA MEDICAL CENTER, 510 Eighth Avenue N.E., Zip 58545-4637; tel. 701/748-2225; Dan Howell, Chief Executive Officer **A**5 9 10 **F**3 7 8 11 15 16 19 22 26 28 30 32 35 37 39 40 44 45 64 65 67 71 73 **P**3 6	23	10	32	830	11	11629	60	5540	2648	87
HETTINGER—Adams County										
□ WEST RIVER REGIONAL MEDICAL CENTER, Mailing Address: Rural Route 2, Box 124, Zip 58639-0124; tel. 701/567-4561; Jim K. Long CPA, Administrator and Chief Executive Officer **A**1 5 9 10 **F**7 8 11 12 13 15 16 17 18 19 20 21 22 27 30 32 34 35 37 39 40 41 42 44 46 48 49 51 58 63 65 66 70 71 73 74 **P**3	23	10	45	1491	20	61168	137	12463	4268	166

Hospital, Address, Telephone, Administrator, Approval, Facility, and Physician Codes, Health Care System	Classification Codes		Utilization Data					Expense (thousands) of dollars		Personnel
American Hospital Association (AHA) membership Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation + American Osteopathic Hospital Association (AOHA) membership American Osteopathic Association (AOA) accreditation Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation Control codes 61, 63, 64, 71, 72 and 73 indicate hospitals listed by AOHA, but not registered by AHA. For definition of numerical codes, see page A6	Control	Service	Beds	Admissions	Census	Outpatient Visits	Births	Total	Payroll	
HILLSBORO—Traill County										
HILLSBORO COMMUNITY HOSPITAL, 12 Third Street S.E., Zip 58045, Mailing Address: P.O. Box 609, Zip 58045-0609; tel. 701/436-4501; Bruce D. Bowersox, Administrator (Total facility includes 50 beds in nursing home-type unit) (Nonreporting) **A5 9 10**	23	10	74	—	—	—	—	—	—	—
JAMESTOWN—Stutsman County										
⊞ JAMESTOWN HOSPITAL, 419 Fifth Street N.E., Zip 58401-3360; tel. 701/252-1050; Richard W. Hall, President **A1 5 9 10 F7 8 15 16 19 21 22 30 31 32 33 34 35 37 39 40 41 44 45 46 56 61 63 65 67 71 73**	23	10	56	2401	26	35662	304	12070	6230	213
⊞ NORTH DAKOTA STATE HOSPITAL, Mailing Address: Box 476, Zip 58402-0476; tel. 701/253-3650; Alex Schweitzer, Administrator **A1 5 9 10 F2 28 29 30 41 45 46 52 53 54 55 56 57 59 65 67 73 P6**	12	22	283	1620	221	0	0	22818	14728	587
KENMARE—Ward County										
KENMARE COMMUNITY HOSPITAL, 317 First Avenue N.W., Zip 58746, Mailing Address: P.O. Box 337, Zip 58746-0337; tel. 701/385-4296; Sister Miriam Rubel, President and Chief Executive Officer (Total facility includes 12 beds in nursing home-type unit) **A9 10 F15 16 17 19 26 28 30 32 33 36 49 53 54 55 57 58 64 65 71 73 P5 S** Sacred Heart Corporation, Denver, CO	21	49	42	146	25	—	0	1741	918	54
LANGDON—Cavalier County										
★ CAVALIER COUNTY MEMORIAL HOSPITAL, 909 Second Street, Zip 58249; tel. 701/256-6180; Daryl J. Wilkens, Administrator **A5 9 10 F8 11 19 22 28 29 30 32 34 37 40 41 44 49 71 P6**	23	10	28	529	7	10976	25	2492	1394	62
LINTON—Emmons County										
★ LINTON HOSPITAL, 518 North Broadway, Zip 58552, Mailing Address: P.O. Box 850, Zip 58552; tel. 701/254-4511; Richard Albrecht, Administrator **A5 9 10 F7 8 11 15 17 19 20 22 28 30 32 34 36 40 44 49 64 71 73 74**	23	10	25	448	5	8343	44	3002	1608	78
LISBON—Ransom County										
★ COMMUNITY MEMORIAL HOSPITAL, 905 Main, Zip 58054-0353; tel. 701/683-5241; (Total facility includes 45 beds in nursing home-type unit) (Nonreporting) **A5 9 10 S** Lutheran Health Systems, Fargo, ND	23	10	70	—	—	—	—	—	—	—
MANDAN—Morton County										
★ MEDCENTER ONE MANDAN, 1000 18th Street N.W., Zip 58554-1698; tel. 701/663-6471; James R. Hubbard, Administrator (Total facility includes 120 beds in nursing home-type unit) **A5 9 10 F1 2 4 7 8 10 11 14 15 16 17 19 21 22 23 24 26 27 30 31 32 33 34 35 37 38 39 40 41 42 43 44 47 48 49 51 52 53 54 55 56 57 58 60 61 64 65 66 67 69 71 73 74 P1 3 6 N** Medcenter One, Bismarck, ND	23	10	162	554	142	4035	0	6394	3611	176
MAYVILLE—Traill County										
★ UNION HOSPITAL, 42 Sixth Avenue S.E., Zip 58257-1598; tel. 701/786-3800; James Mackay, Jr., Chief Executive Officer **A5 9 10 F7 8 15 16 17 19 24 32 33 34 40 44 49 57 65 67 70 71 73**	23	10	30	581	11	10619	23	2818	1387	59
MCVILLE—Nelson County										
★ COMMUNITY HOSPITAL IN NELSON COUNTY, Main Street, Zip 58254, Mailing Address: P.O. Box H, Zip 58254-0787; tel. 701/322-4328; Jim Opdahl, Administrator (Nonreporting) **A9 10**	23	10	14	—	—	—	—	—	—	—
MINOT—Ward County										
⊞ △ TRINITY MEDICAL CENTER, Burdick Expressway ant Main Street, Zip 58701-5020, Mailing Address: P.O. Box 5020, Zip 58702-5020; tel. 701/857-5000; Terry G. Hoff, President (Total facility includes 294 beds in nursing home-type unit) **A1 2 3 5 7 9 10 F1 3 4 7 8 10 11 12 13 14 15 16 17 19 21 22 23 24 25 26 28 30 31 32 33 34 35 37 38 39 40 41 43 44 45 46 48 49 51 53 55 56 58 61 62 63 64 65 66 67 68 70 71 72 73 74 P1 3 4 5 6**	23	10	468	5415	389	54255	617	77047	35219	970
⊞ U.S. AIR FORCE REGIONAL HOSPITAL, 10 Missile Avenue, Zip 58705-5024; tel. 701/723-5103; Colonel Murphy A. Chesney, Commander **A1 5 F1 3 4 5 6 7 8 10 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 39 40 41 42 43 44 45 46 49 50 51 53 54 55 56 57 58 59 60 61 63 65 66 67 68 69 70 71 72 73 74 P4 7 S** Department of the Air Force, Washington, DC	41	10	39	2095	15	109616	368	—	—	392
⊞ UNIMED MEDICAL CENTER, Third Street and Burdick Expressway S.E., Zip 58702-5001; tel. 701/857-2000; Gary Kenner, President **A1 2 3 5 9 10 F2 3 4 7 8 10 11 12 13 17 18 19 20 21 24 26 27 28 29 30 31 32 33 34 35 37 39 40 41 42 43 44 45 46 49 52 53 54 55 56 57 58 59 60 65 66 67 70 71 73 74 P3 7 S** Sacred Heart Corporation, Denver, CO	21	10	173	5426	89	34000	307	47040	20351	714
NORTHWOOD—Grand Forks County										
★ NORTHWOOD DEACONESS HEALTH CENTER, 4 North Park Street, Zip 58267-0190; tel. 701/587-6459; Larry E. Feickert, Chief Administrative Officer (Total facility includes 112 beds in nursing home-type unit) **A5 9 10 F1 6 7 11 15 17 19 20 22 26 27 28 30 34 35 36 37 39 40 44 45 46 49 51 60 64 71 72 73 74 P5**	21	10	124	386	106	2391	19	4714	2649	115
OAKES—Dickey County										
⊞ OAKES COMMUNITY HOSPITAL, 314 South Eighth Street, Zip 58474-2099; tel. 701/742-3291; Sister Susan Marie Loeffen, Administrator **A1 9 10 F7 8 11 19 22 28 32 33 35 40 44 45 49 63 70 71**	21	10	30	834	10	21209	52	5946	2072	99
PARK RIVER—Walsh County										
★ ST. ANSGAR'S HEALTH CENTER, (Formerly St. Ansgar's Hospital), 115 Vivian Street, Zip 58270-0708; tel. 701/284-7500; Michael D. Mahrer, President **A9 10 F7 8 15 16 19 22 26 28 31 32 34 35 40 41 44 45 61 65 71 P5 S** Catholic Health Initiatives, Denver, CO	21	10	20	436	10	8661	13	3051	1465	68

Hospital, Address, Telephone, Administrator, Approval, Facility, and Physician Codes, Health Care System	Classification Codes		Utilization Data					Expense (thousands) of dollars		
★ American Hospital Association (AHA) membership □ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation + American Osteopathic Hospital Association (AOHA) membership ○ American Osteopathic Association (AOA) accreditation △ Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation Control codes 61, 63, 64, 71, 72 and 73 indicate hospitals listed by AOHA, but not registered by AHA. For definition of numerical codes, see page A6	Control	Service	Beds	Admissions	Census	Outpatient Visits	Births	Total	Payroll	Personnel
RICHARDTON—Stark County										
RICHARDTON HEALTH CENTER, Mailing Address: P.O. Box H, Zip 58652; tel. 701/974-3304; Arlene Mack R.N., Administrator **A**9 10 **F**14 15 16 21 22 24 26 36 41 49 65 70 **P**5 **N** Medcenter One, Bismarck, ND	23	10	26	78	18	—	0	—	—	32
ROLLA—Rolette County										
PRESENTATION MEDICAL CENTER, 213 Second Avenue N.E., Zip 58367, Mailing Address: P.O. Box 759, Zip 58367-0759; tel. 701/477-3161; Kimber Wraalstad, Chief Executive Officer (Total facility includes 48 beds in nursing home-type unit) **A**9 10 **F**7 8 19 20 22 28 30 32 34 36 37 40 41 42 44 45 49 53 54 57 58 64 65 71 74 **P**6 **S** Sisters of Mary of the Presentation Health Corporation, Fargo, ND	21	10	102	845	52	19180	140	7165	3506	148
RUGBY—Pierce County										
★ HEART OF AMERICA MEDICAL CENTER, Rugby Heights, Zip 58368, Mailing Address: P.O. Box 197, Zip 58368; tel. 701/776-5261; Jerry E. Jurena, Executive Director (Total facility includes 198 beds in nursing home-type unit) **A**1 5 9 10 **F**3 7 19 21 22 26 28 31 32 33 34 36 37 39 40 41 44 64 65 66 71 73	23	10	236	1101	215	10374	77	10346	5080	254
STANLEY—Mountrail County										
★ STANLEY COMMUNITY HOSPITAL, 502 Third Street S.E., Zip 58784, Mailing Address: Box 399, Zip 58784-0399; tel. 701/628-2424; David Sandberg, Administrator **A**9 10 **F**7 8 19 22 36 44 71 **P**8	23	10	25	292	5	3872	5	1572	856	41
TIOGA—Williams County										
★ TIOGA MEDICAL CENTER, 810 North Welo Street, Zip 58852-0159, Mailing Address: P.O. Box 159, Zip 58852-0159; tel. 701/664-3305; Lowell D. Herfindahl, President and Chief Executive Officer (Total facility includes 30 beds in nursing home-type unit) **A**5 9 10 **F**7 8 11 12 19 20 21 22 26 27 32 40 42 44 45 46 49 56 57 64 65 70 71 **P**4	23	10	59	629	37	8036	13	3488	1948	48
TURTLE LAKE—McLean County										
COMMUNITY MEMORIAL HOSPITAL, 220 Fifth Avenue, Zip 58575, Mailing Address: P.O. Box 280, Zip 58575; tel. 701/448-2331; Richard Spilovoy, Administrator (Nonreporting) **A**9 10	21	10	35	—	—	—	—	—	—	—
VALLEY CITY—Barnes County										
★ MERCY HOSPITAL, 570 Chautauqua Boulevard, Zip 58072-3199; tel. 701/845-0440; Greg Hanson, President and Chief Executive Officer **A**1 5 9 10 **F**1 7 8 11 14 15 19 22 26 28 29 30 32 34 35 37 39 40 44 49 65 66 70 71 **S** Catholic Health Initiatives, Denver, CO	21	10	50	1023	38	14959	107	6693	3769	140
WATFORD CITY—McKenzie County										
★ MCKENZIE COUNTY MEMORIAL HOSPITAL, 508 North Main Street, Zip 58854, Mailing Address: P.O. Box 548, Zip 58854-0548; tel. 701/842-3000; Tim Gullingsrud, Administrator **A**9 10 **F**1 8 14 15 16 17 19 22 24 27 28 29 30 39 40 41 44 45 46 49 60 64 66 71 73 **N** Medcenter One, Bismarck, ND	23	10	24	222	4	7012	15	1590	675	35
WILLISTON—Williams County										
★ MERCY MEDICAL CENTER, 1301 15th Avenue West, Zip 58801-3896; tel. 701/774-7400; Duane D. Jerde, President and Chief Executive Officer **A**1 9 10 **F**2 3 7 8 12 15 19 21 22 23 26 28 30 32 33 35 37 39 40 41 42 44 46 49 52 53 58 65 66 67 71 73 **S** Catholic Health Initiatives, Denver, CO	21	10	113	2612	52	25302	323	22161	10232	364
WISHEK—McIntosh County										
★ WISHEK COMMUNITY HOSPITAL, 1007 Fourth Avenue South, Zip 58495, Mailing Address: P.O. Box 647, Zip 58495; tel. 701/452-2326; George A. Rohrich, Administrator **A**5 9 10 **F**8 11 14 15 16 19 25 28 30 32 34 37 44 45 48 49 64 65 70 71 73	23	10	22	620	6	8799	0	4156	2032	95

North Dakota Hospital Information
Based on Medicare Cost Reports

Provider	City	Net Income or (Loss)	(%)	Beds	Inpatient Days (excluding nursery)	Occupancy Rate
Stanley Community Hospital	Stanley	($192,844.00)	(12.26)	25	1,804	19.77%
Tioga Medical Center	Tioga	($142,268.00)	(2.84)	29	2,151	20.32%
Towner County Medical Center	Cando	$112,125.00	1.91	22	3,253	40.51%
West River Regional Medical Center	Hettinger	$1,266,585.00	6.24	40	6,978	47.79%
Carrington Health Center	Carrington	$406,193.00	3.36	30	3,296	30.10%
Heart of America Medical Center	Rugby	($658,923.00)	(6.25)	38	4,706	33.93%

SENATE BILL NO. 2396
TESTIMONY BEFORE THE HOUSE
INDUSTRY, BUSINESS AND LABOR COMMITTEE

TRENT C. HEINEMEYER
DEPUTY COMMISSIONER
NORTH DAKOTA INSURANCE DEPARTMENT

Senate Bill No. 2396 has been characterized by its proponents as creating a "level playing field" for providers of medical services by allowing them to become a nonparticipating provider with Blue Cross Blue Shield of North Dakota and to allow the providers to obtain direct payment from Blue Cross Blue Shield in the event they become a nonparticipating provider. This bill is not about creating a level playing field, it is not about Blue Cross Blue Shield, nor is it directly about assignment of benefits. Senate Bill No. 2396 is about creating the ability for providers to collect more money from their patients than insurance companies with whom they have contracted have determined appropriate for the services provided.

The North Dakota Insurance Department believes that consumers will be the loser if Senate Bill No. 2396 is passed and, therefore, urge that your recommendation be a "DO NOT PASS".

PARTICIPATING PROVIDERS

Generally, participating providers:

1. Receive payment directly from the insurer,
2. Agree to accept the amount that the insurer deems appropriate for the care provided, and
3. Cannot bill the patient (insured) for any additional amounts.

Generally, non-participating providers:

1. Receive payment from the insured, not the insurance company,
2. Receive a smaller amount than a participating provider for the same service, and
3. Can bill the patient (insured) any amount for the service provided.

If the insurance company cannot prohibit assignment of benefits, then one of the benefits of being a participating provider is eliminated.

INSURANCE COMPANY SETS REIMBURSEMENT LEVELS

All companies providing expense incurred medical insurance in North Dakota use a reimburse structure. Some call it paying "usual and customary" charges, some pay a given percentage of a predetermined reimbursement table, and some predetermine the acceptable charges and produce such. **We cannot emphasize enough that all companies in this market set reimbursement rates.**

NETWORKS

It has been law in North Dakota since 1987 that insurance companies offering health insurance could use networks. These are called preferred provider organizations (PPOs) and are in N.D. Cent. Code Chapter 26.1-47. These arrangements specifically encourage companies to develop networks that provide incentives for medical providers to become "participating." N.D. Cent. Code § 26.1-47-02(1)(b) states that PPOs must "include mechanisms which are designed to minimize the cost of health benefit plans." So, minimizing the costs of medical care for the citizens of North Dakota has been a priority for many years.

It is important to understand that **ALL** health insurance companies offering expense incurred health insurance in North Dakota use some aspects of "participation or not".

CONSEQUENCES FOR CONSUMERS

If the incentives are significantly changed for medical providers to be participating, the primary consequence for consumers will be increased charges for medical care because the natural result will be "balance billing" by the nonparticipating providers. **Some unlucky consumers will have to pay a larger percentage of a larger amount!**

As a consumer protection agency, we urge the defeat of Senate Bill No. 2396 as it will result in detrimental financial consequences to insurance consumers of North Dakota.

SB 2396
House Industry Business and Labor Committee

Chairman Berg, Members of the Committee:

My name is Mary Ann Johnson, Vice President of Administration for Knife River Corporation. I am appearing today on behalf of Knife River to express our concern about the ramifications of SB 2396 for our employees, our retirees and our company.

In North Dakota, Knife River owns and operates the Beulah Mine. We have approximately 150 active employees in the state and nearly 100 retirees, the majority of whom live in North Dakota. A number of our employees and retirees reside in smaller towns and rural areas.

Knife River has a group medical plan which covers both active employees and retirees. It is, by far, our single most expensive benefit plan and we continually seek ways to help us manage the costs so that we can maintain a group plan.

Since 1996, our coverage has been through Blue Cross Blue Shield of North Dakota. This has helped us control costs through the rates BCBS negotiates with the hospitals, clinics and professionals who agree to participate with BCBS ("participating providers"). Providers who agree to participate also agree not to bill patients for any amount above these rates. An individual retiree, an individual employee, or Knife River as an individual company is not in a position to negotiate any rates or terms with providers. We simply do not have the bargaining power.

SB 2396 would take away a major incentive for providers to participate with BCBS. Without that participation, providers would be free to bill as they see fit and charge individuals for the difference between the amount insurance covers (i.e. "reasonable and customary charges") and the amount billed.

We are concerned that SB 2396 could exacerbate the difficulties described today for rural health care facilities while creating a lot of anger and confusion among consumers in the process. If rural health care providers sever their relationships with BCBS and then bill employees or retirees for charges not covered by insurance, the rural

population would incur significantly higher out-of-pocket expenses for health care. As a result, many would end up traveling to cities like Bismarck or Minot to receive services from participating health care providers at a lower cost, thus accelerating the very problem SB 2396 is supposed to address.

We would also have a concern should all providers withdraw from participation with BCBS. That could result in a significant cost shift to employees and retirees with no increase in benefits.

In our view, SB 2396 will not resolve the painful dilemma faced by rural communities and their health care facilities and could operate in fact to the disadvantage of consumers in general – rural and urban.

For these reasons, we respectfully urge the committee to recommend a **"Do Not Pass"** on SB 2396.

HOUSE INDUSTRY BUSINESS
AND
LABOR COMMITTEE

Wednesday - March 3, 1999 - 9:00 am
Rick Berg, Chairman

I'm here today to ask for your support regarding SB 2396.

Before you today there are several rural hospital administrators in attendance.

We are here asking that all insurance companies are treated equally and that rural facilities are given an opportunity to make independent fiduciary decisions based on their community needs as directed by their administrators and boards.

I quote from William O Cleverly, PHd, CPA President of The Center for Healthcare Industry Performance Studies and Professor at Ohio State University; *"North Dakota hospitals with annual revenues of less than $5 million are in a precarious position."* Dr. Cleverly predicts financial problems and significant closure rates in North Dakota of rural hospitals.

From Chris Champ, Eide Bailly, Fargo; *"Our firm is genuinely concerned about the short and long term viability of a number of rural facilities in the state."*

"While the Blue Cross Blue Shield of North Dakota changes are not the only reimbursement changes affecting these hospitals (i.e.. the Medicare Balanced Budget Act), they are the most significant and provide the least amount of flexibility for these hospitals."

"However, we still feel that the significance of the dollar impact as projected by these facilities from the Blue Cross Blue Shield proposed contract will make it impossible for them to continue operating as an acute care facilities under the current reimbursement methodologies."

SB 2396 is simple and understandable. All health insurance companies, except for Blue Cross Blue Shield (BCBS), allow consumers to assign benefits under their health insurance contracts to healthcare providers. Blue Cross Blue Shield's contract prohibits assignment of benefits to North Dakota providers who choose not to contract with Blue Cross Blue Shield. Interestingly, the plan does allow assignment of benefits to an out-of-state non-participating provider.

In North Dakota there are 37 rural Hospitals, and 35 out of the 53 counties are classified as frontier counties.

I am here asking for equal treatment for all healthcare providers and health insurance companies.

This is about equitable reimbursement for services provided.
This is about accessibility throughout the state.

We as rural hospital administrators are asking to level the playing field. Let's treat all insurance companies alike.

Blue Cross - asked to be an insurance company. Let's now make them act like one.

Let consumers be responsible for making decisions on assignment of benefits. Assignment of benefits should not be governed by the past or by legislation

PROPOSED AMENDMENTS TO SB 2396

Page 1, line 1, after "to" insert "provide for nonprofit mutual insurance companies to reexamine hospital reimbursement rates; to"

Page 1, line 2, after "policies" insert "; and to provide an effective date"

Page 1, after line 3, insert:

"**SECTION 1. NONPROFIT MUTUAL INSURANCE COMPANIES-REEXAMINATION OF HOSPITAL REIMBURSEMENT RATES - REPORT**. Before December 1, 1999, every nonprofit health service corporation that has become a nonprofit mutual insurance company in accordance with section 26.1-17-33.1 shall reexamine North Dakota hospital reimbursement rates for health care services. The reexamination must include a review of the equity and fairness of the rate of reimbursement of hospitals on an individual basis. In order to have the participation of hospitals in this reexamination, a nonprofit mutual insurance company shall contract for the services of a certified public accountant in performing this reexamination. The costs of this reexamination shall be shared by both parties. Every nonprofit mutual insurance company subject to this section shall file a report of the findings and conclusions of this reexamination with the legislative council before January 1, 2000."

Page 1, line 15, after "assign" insert "to a hospital with less than sixty staffed acute care beds in a community with less than five thousand population"

Page 1, line 16, after "contract" insert "for services provided by that hospital"

Page 1, after line 21, insert:

"**SECTION 3. EFFECTIVE DATE.** Section 2 of this Act becomes effective on January 1, 2000, unless every nonprofit mutual insurance company subject to section 1 of this Act has filed with the legislative council before December 1, 1999, the report required under section 1 of this Act. The insurance commissioner shall certify to the legislative council by September 30, 1999, the name of every nonprofit mutual insurance company subject to section 1 of this Act."

Renumber accordingly