North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
JON GODFREAD, COMMISSIONER

Private
Health Insurance
Market Report
2014-2018

Prepared for the North Dakota Insurance Department by NovaRest

Table of Contents

Introduction

This report was prepared by NovaRest Consulting (NovaRest) for the North Dakota Insurance Department (Department). This report provides findings regarding health-spending costs for health insurance plans in North Dakota from 2014 to 2018.[1]

This report uses information gathered from the top 99% of health insurers by premium in North Dakota through a data request from the Department. Our goal is to ensure that we have the most accurate and complete information possible. We have noted all situations when the data request information was not complete. Additional information was extracted from statutory annual financial statements filed with the National Association of Insurance Commissioners (NAIC), the Unified Rate Review Templates (URRTs) filed by the insurers, and other public sources that we believe are credible. The following insurers were included in the 2019 data call (survey) based on their health care premium market share in North Dakota in 2018:

- Medica Health Plans Inc.[2]
- Medica Insurance Company[2]
- Blue Cross Blue Shield of North Dakota (BCBSND)
- Sanford Health Plan[3]
- Sanford Heart of America Health Plan[3]

We performed two data calls. One for 2013-2017 data and another for 2017-2018 data. The same carriers were included in both data calls. Where 2017 data was different, we used the data provided in the more recent data call. Additionally, Medica originally reported transitional business for 2017, which was in error.

Sanford provided information for the fully insured North Dakota Public Employees Retirement System (NDPERS), which is administered by Sanford, separately from their large group data.[4] We have considered this data as a separate market in all situations where Sanford provided the data separately. For questions that were requested at the insurer level, such as for non-benefit expenses and health cost drivers, NDPERS data was included in the Sanford data.

Please note the data provided does not include self-insured employer or uninsured costs.

[1] 2019 data is not yet available from insurers or from public data sources.
[2] Medica Health Plans Inc. and Medica Insurance Company provided combined responses for 2014-2016 but separated their responses for 2017-2018. For consistency, we combined them for this report.
[3] Sanford Health Plan and Sanford Heart of America Health Plan combined their responses to the data call, so they will be presented in this report combined as Sanford.
[4] NDPERS appears to be included with large group data in the NAIC Supplemental Health Care Exhibit for 2018.

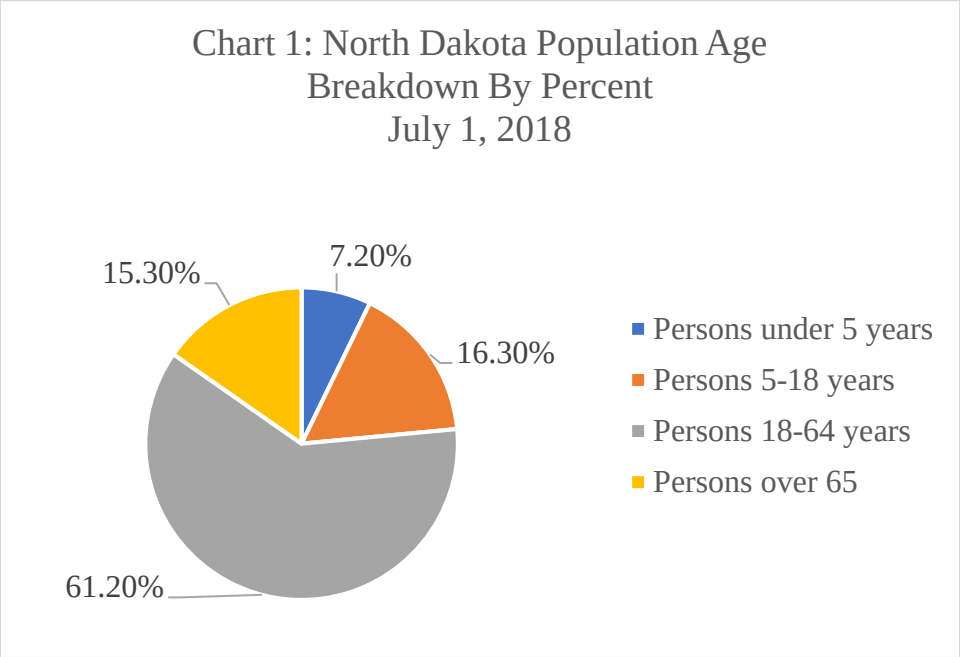
Summary

- The percentage of the North Dakota population that is uninsured has been between 7% and 8% for the past five years (2014-2018), according to the America Community Survey.[5]
- In 2018, North Dakota did not allow carriers to refile plan rates due to the federal government's decision to defund CSRs. Medica left the North Dakota ACA Individual On-Exchange market at the end of 2017 due to this decision, which led to a significant decrease in their membership from 2017 to 2018.
- Total individual market membership has decreased every year from 2016 to 2018, likely driven by large rate increases.
- An analysis of the top drivers of higher and lower health care costs shows population change, physician, inpatient hospital, and outpatient hospital as major drivers of lower health insurance costs. On a net basis, the drivers of lower health insurance costs outweigh the drivers of higher health insurance costs.

[5] "Selected Economic Characteristics." American Community Status 1-Year Estimates Subject Tables. U.S. Census Bureau. 2018. https://data.census.gov/cedsci/. Accessed Oct. 17, 2019.

Background

North Dakota's total population as of July 1, 2018 was 760,077.[6] A breakdown of the major age groups is provided in the chart below.[7]

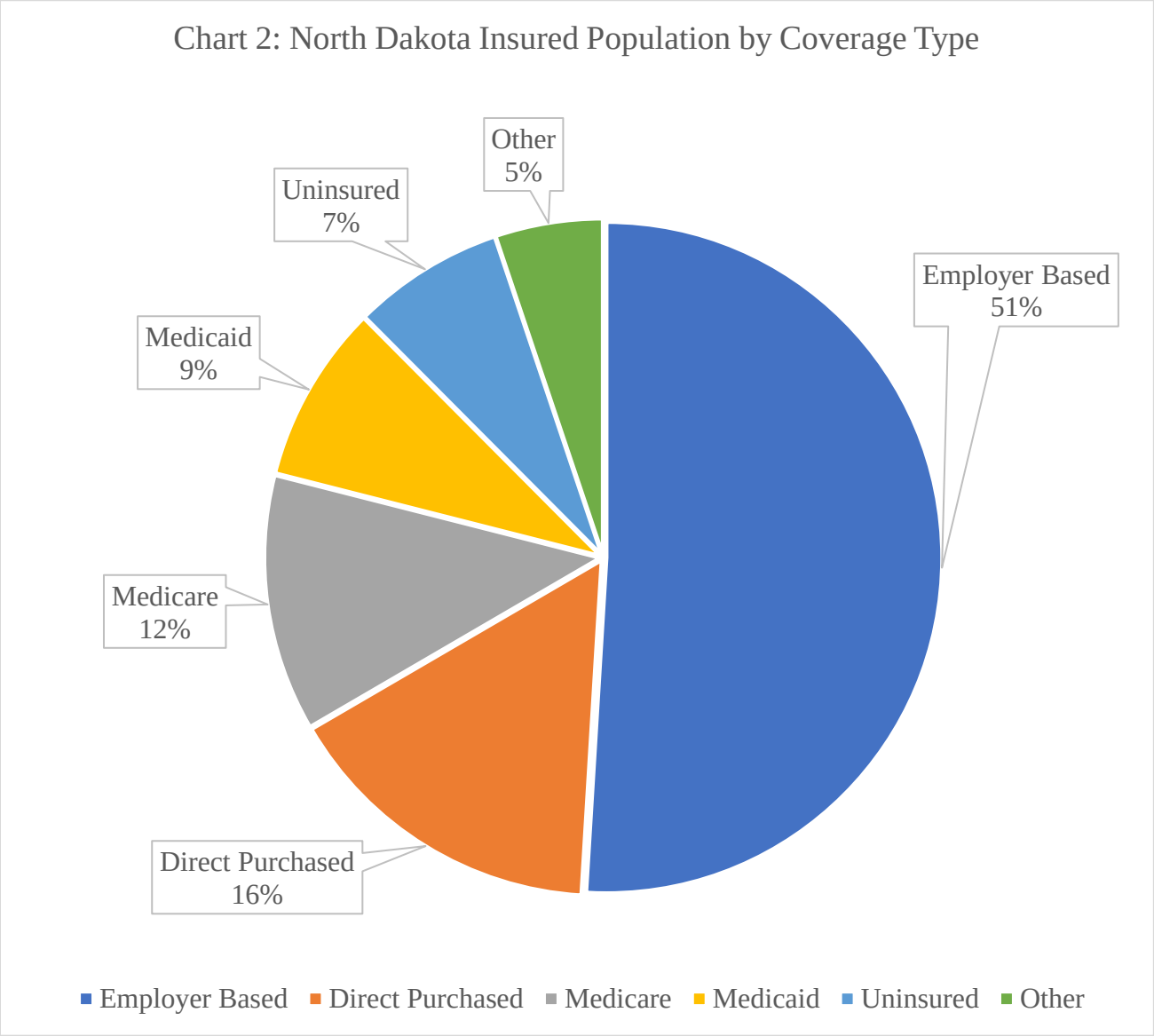


The 2018 median household income in North Dakota was $63,837, slightly higher than the overall U.S. median household income of $61,937.[8] The North Dakota unemployment rate in 2018 was about 2.8%[9] and 10.7% of the North Dakota population was considered below the poverty level.[10]

92.7% of the 2018 North Dakota noninstitutionalized population was insured by either the public and private health insurance markets, leaving 7.3% uninsured.[11] The American Community Survey provides estimates of 79.7% of insured in the private health insurance market and 26.5% of insured in the public health insurance market. We note this adds up to more than the 92.7%

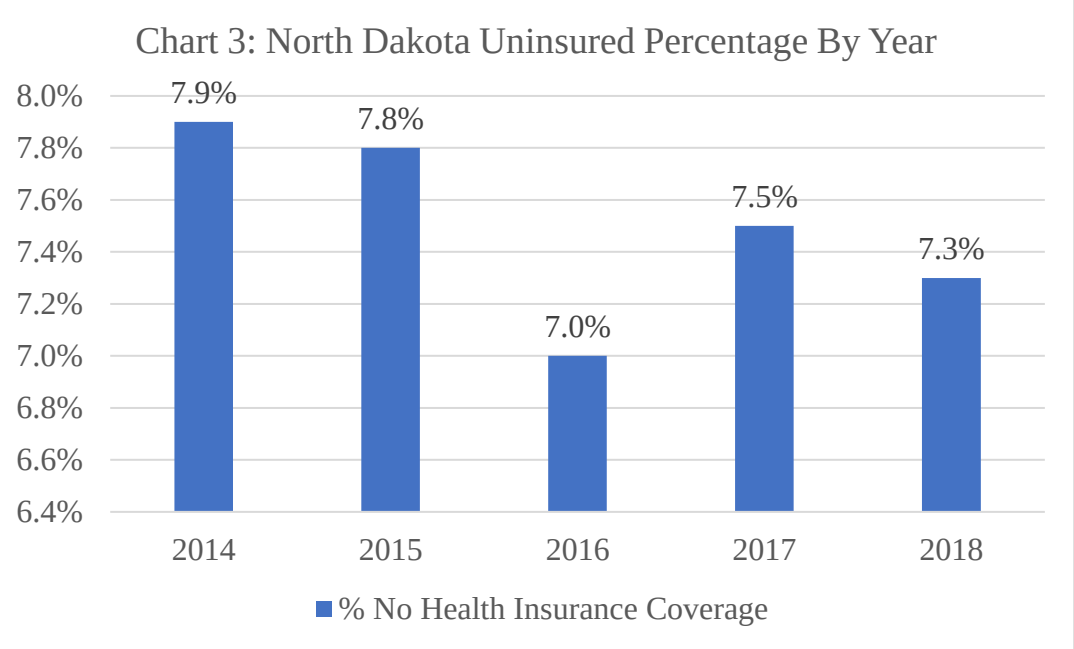
[6] "QuickFacts: North Dakota." U.S. Census Bureau. https://www.census.gov/quickfacts/fact/table/ND,US/PST045218. Accessed Oct. 10, 2019.
[7] Ibid.
[8] "2018 Median Household Income in the United States." U.S. Census Bureau. September 26, 2019. https://www.census.gov/library/visualizations/interactive/2018-median-household-income.html. Accessed Oct. 17, 2019.
[9] "Selected Economic Characteristics." American Community Status 1-Year Estimates Subject Tables. U.S. Census Bureau. 2018. https://data.census.gov/cedsci/. Accessed Oct. 17, 2019.
[10] "Poverty Status in the Past 12 Months." American Community Status 1-Year Estimates Subject Tables. U.S. Census Bureau. 2018. https://data.census.gov/cedsci/. Accessed Oct. 17, 2019.
[11] "Selected Economic Characteristics." American Community Status 1-Year Estimates Subject Tables. U.S. Census Bureau. 2018. https://data.census.gov/cedsci/. Accessed Oct. 17, 2019.

insured indicated above, suggesting there is some overlap between the public and private insurance markets. The insured population by coverage type can be seen in the following chart, where we have ratioed the percentages to add up to 100%.[12,13]



[12] "Public Health Insurance Coverage By Type and Selected Characteristics." American Community Status 1-Year Estimates Subject Tables. U.S. Census Bureau. 2018. https://data.census.gov/cedsci/. Accessed Oct. 17, 2019.
[13] Other includes Veteran Administration Health Care and Tricare.

The uninsured percentage decreased from 7.9% in 2014 to 7.3% in 2018 as can be seen in the following chart.[14]



Although a portion of the North Dakota market is enrolled in public programs or is uninsured, the focus of this report is on the commercial non-public fully-insured individual, small group, and large group markets. For those enrolled in these markets, the percentage of membership is shown in the chart on the following page.[15]

[14] "Selected Economic Characteristics." American Community Status 1-Year Estimates Subject Tables. U.S. Census Bureau. 2018. https://data.census.gov/cedsci/. Accessed Oct. 17, 2019.
[15] From Data Call

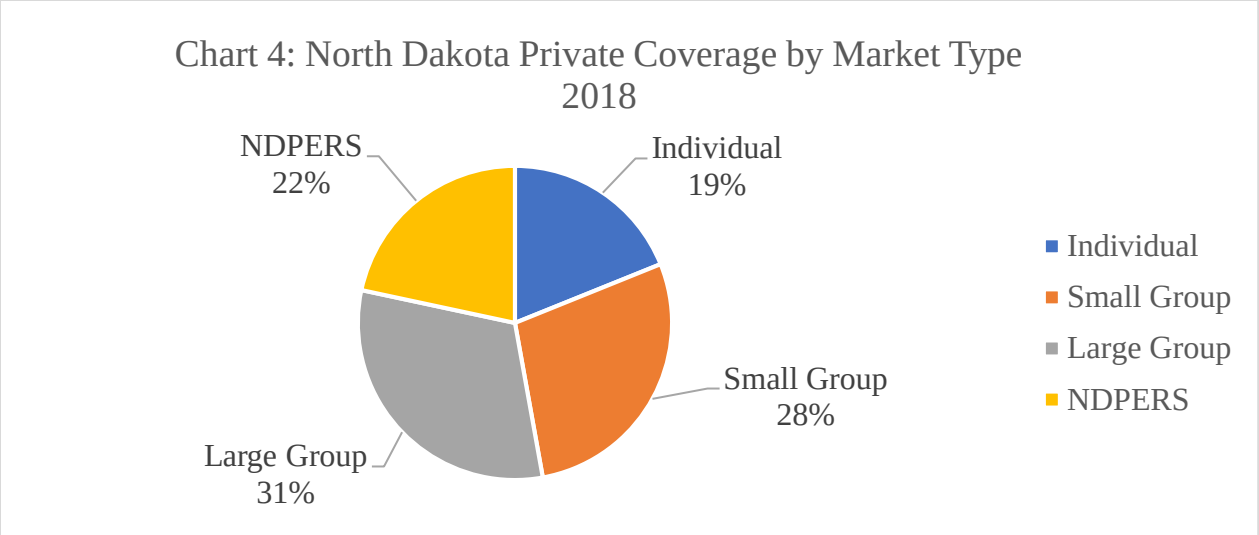


Chart 4: North Dakota Private Coverage by Market Type
2018
NDPERS
22%
Individual
19%
Small Group
28%
Large Group
31%
Individual
Small Group
Large Group
NDPERS

Enrollment

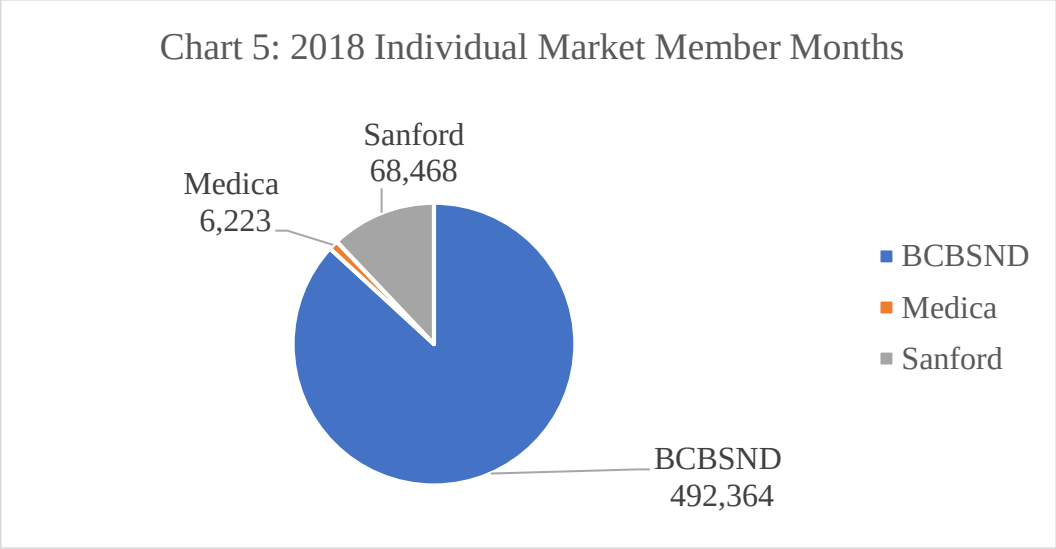
To analyze the enrollment in the North Dakota private marketplace, we requested the insurers provide member months from 2014 to 2018 for the individual, small group, and large group market. Member months are the number of total months covered for all individuals insured by an insurer in a market.

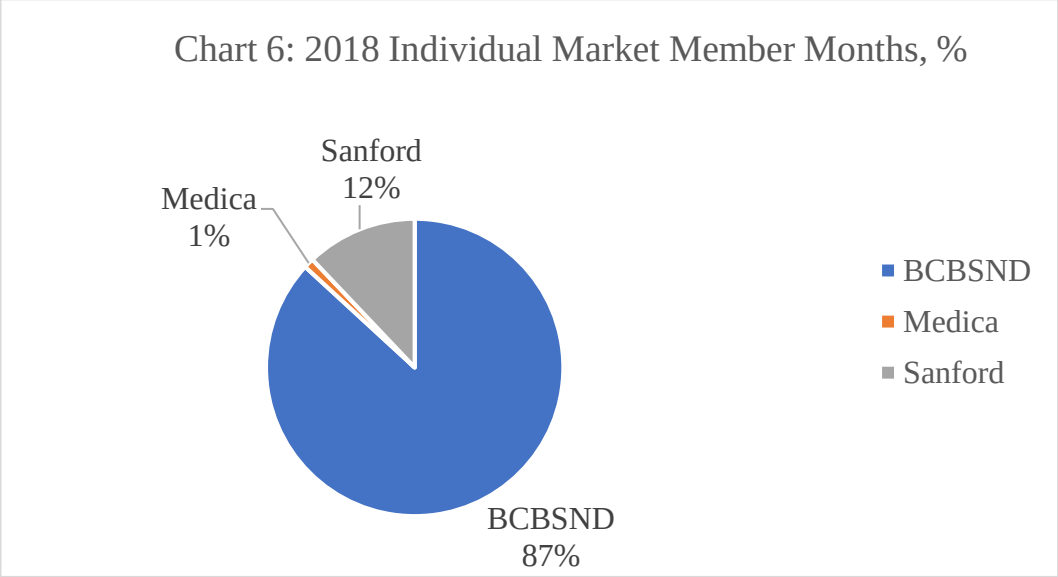
BCBSND holds the highest percentage of the membership market share in all three markets (87% in the individual market, 90% in the small group market, and 84% in the large group market). BCBSND's 2018 membership market share increased in the individual and large group markets from 2017.

We will provide member-weighted averages throughout this report even though there are significant differences between insurers. We weight by member months, to result in averages closer to what most members are experiencing. Taking the rate increases as an example, the weighted average will result in the same value as if a surveyor totaled and averaged the rate increases across all members in North Dakota. By averaging across members rather than insurers we will attain a better estimate of the rate increases experienced by the population in North Dakota.

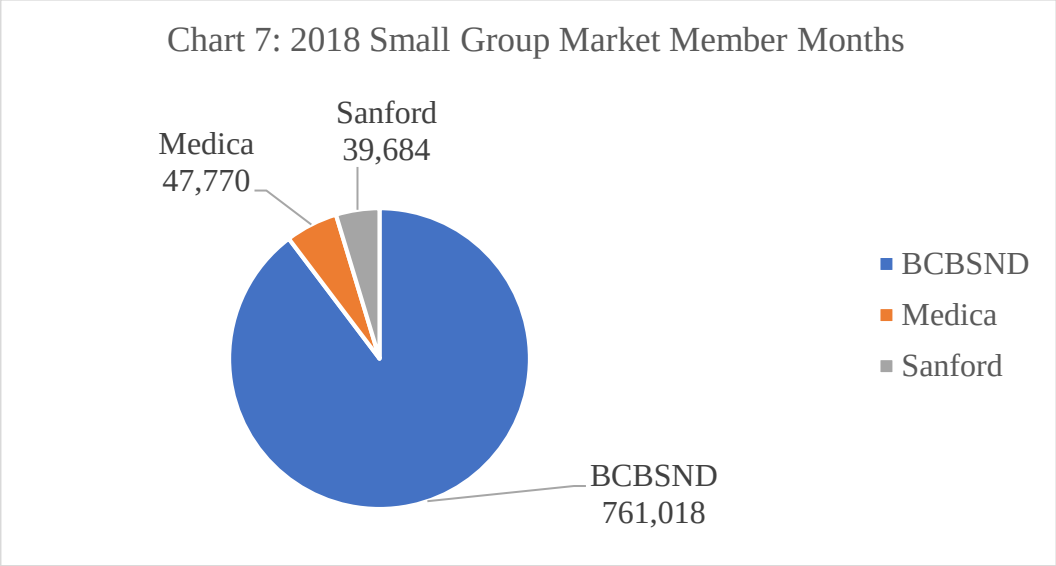
We have provided pie charts of the 2018 member months to demonstrate the variance in enrollment by insurer in North Dakota.

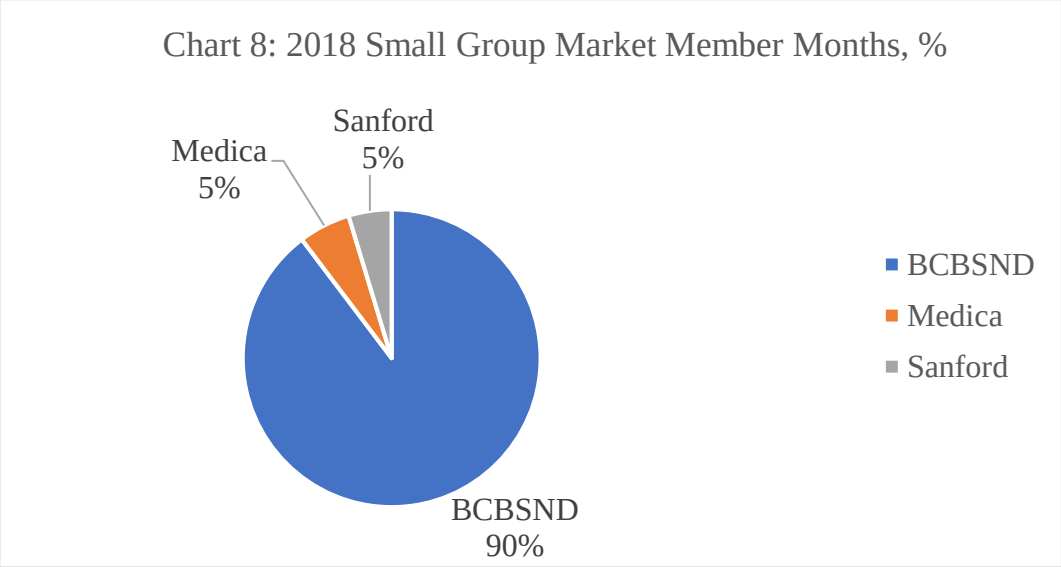
Individual Market



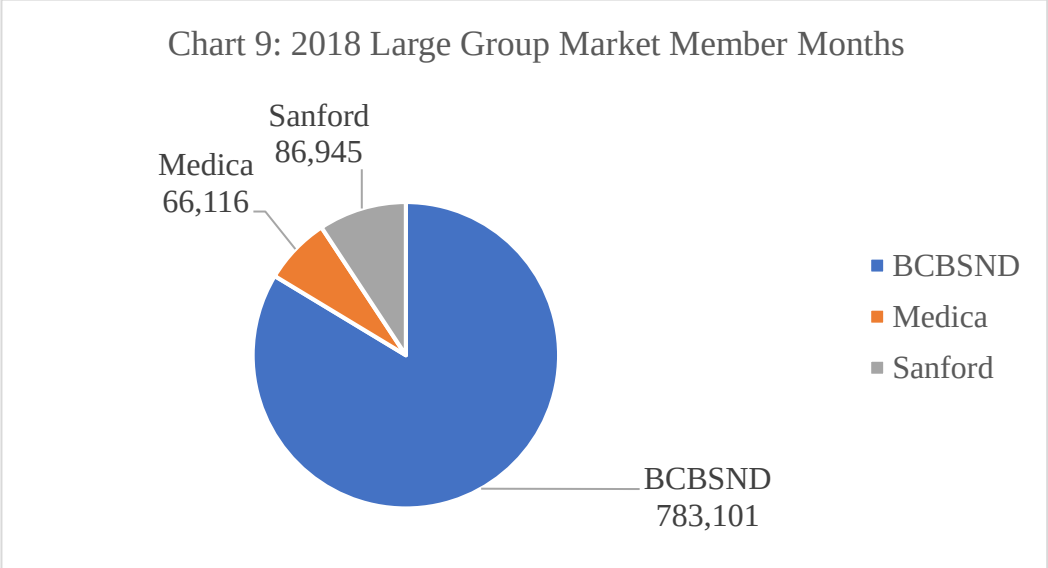


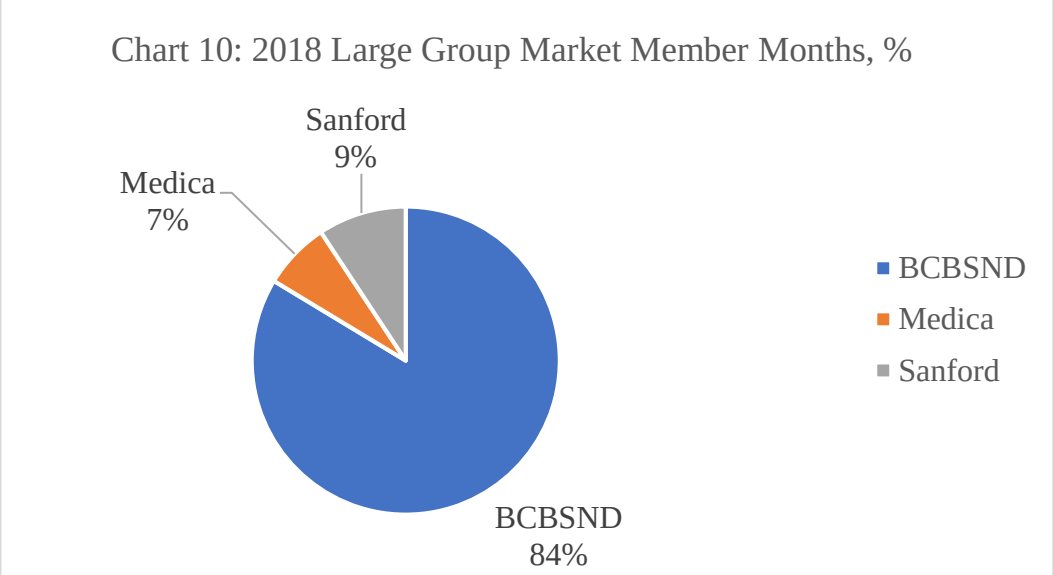
Small Group Market





***Large Group Market*[16]**





[16] The large group numbers provided exclude NDPERs.

NDPERS[17]

Sanford reported 649,631 member months for NDPERS in 2018.

When the Affordable Care Act (ACA) was implemented in 2014, the individual and small group markets were further split into ACA compliant plans (ACA), pre-ACA plans (Grandfathered)[18], and pre-ACA plans that are not grandfathered plans (Transitional).[19] Neither grandfathered nor transitional plans are available for new enrollees to purchase but may be renewed subject to certain rules. The insurer data shows that grandfathered and transitional markets have been shrinking as more enrollees enter the ACA market.

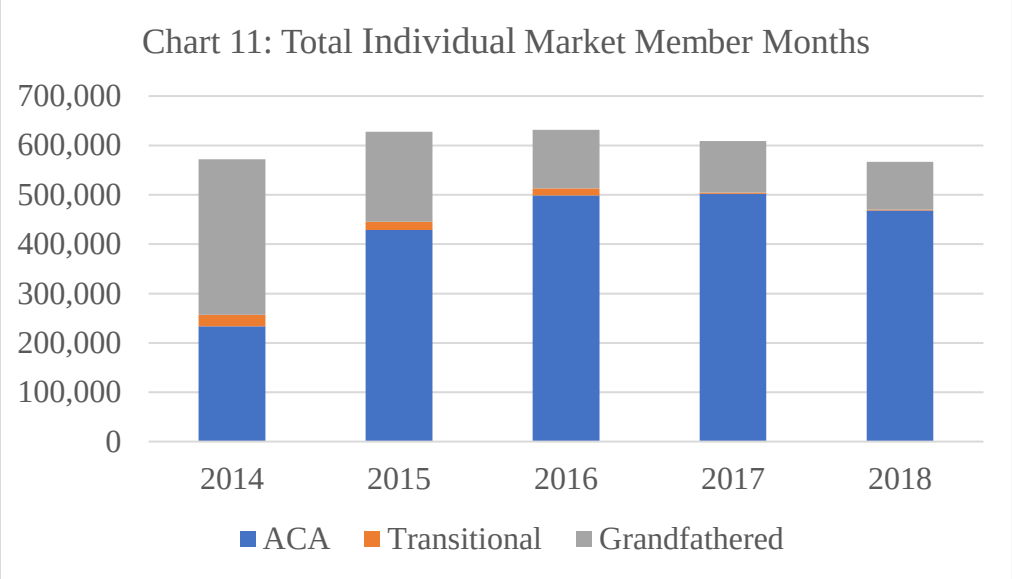
As part of our data call, we had the insurers further break out their member month data into ACA, transitional, and grandfathered business in the individual and small group markets from 2014 to 2018. Grandfathered and transitional plans are not applicable in the large group market or NDPERS. The breakout is presented in the tables and charts below, first in total and then by insurer for the individual and small group market. The charts show the portion of the total member months that are represented by each market.

[17] The North Dakota Public Employees Retirement System (NDPERS) is 100% administered by Sanford. Because information was provided separately from the large group market by Sanford, we have also separated the NDPERS information from the large group market.
[18] Grandfathered plans are health plans that were in existence prior to ACA being signed into law. Grandfathered plans are not subject to many of the requirements under ACA and may retain their grandfathered status as long as they do not undergo specified design plan changes.
[19] Transitional (or grandmothered) plans are non-grandfathered plans that were issued after the ACA was signed into law but before 2014 and are subject to HHS's transition policy. These policies are also not subject to all ACA requirements. HHS extended transitional policies to policy years beginning on or before Oct. 1, 2020, provided that all policies end by Dec. 31, 2020.

Individual Market

Total – Individual Market

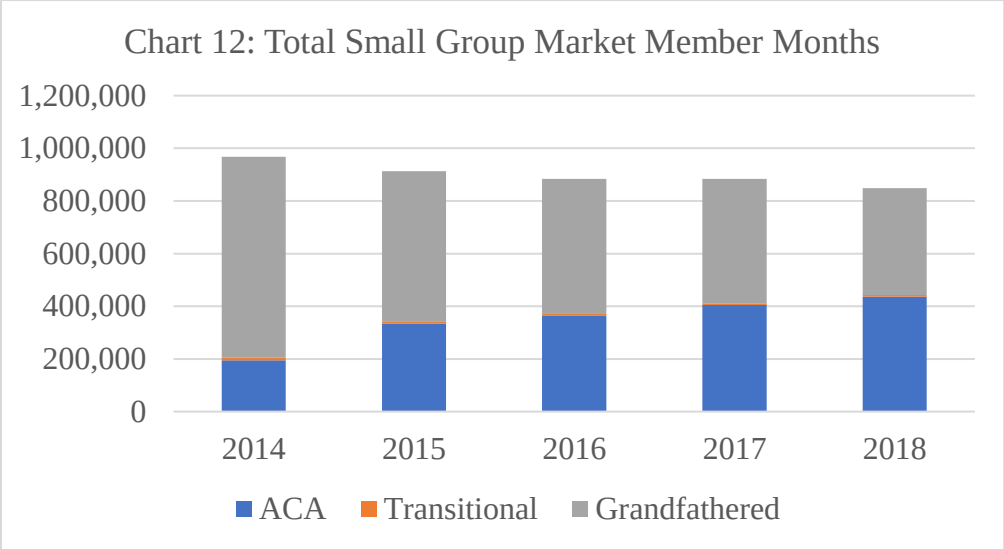
Table 1					
Total Market Member Months	**2014**	**2015**	**2016**	**2017**	**2018**
ACA	233,334	428,442	499,009	502,008	468,125
Transitional	23,514	16,838	13,815	2,212	1,891
Grandfathered	314,807	182,535	118,951	104,709	97,039
Total	**571,655**	**627,815**	**631,775**	**608,929**	**567,055**



Small Group Market

Total – Small Group Market

Table 2					
Total Market Member Months	**2014**	**2015**	**2016**	**2017**	**2018**
ACA	195,167	334,224	363,527	404,703	436,256
Transitional	10,348	8,903	7,019	6,826	6,456
Grandfathered	762,133	569,273	513,394	472,820	405,760
Total	**967,648**	**912,400**	**883,940**	**884,349**	**848,472**

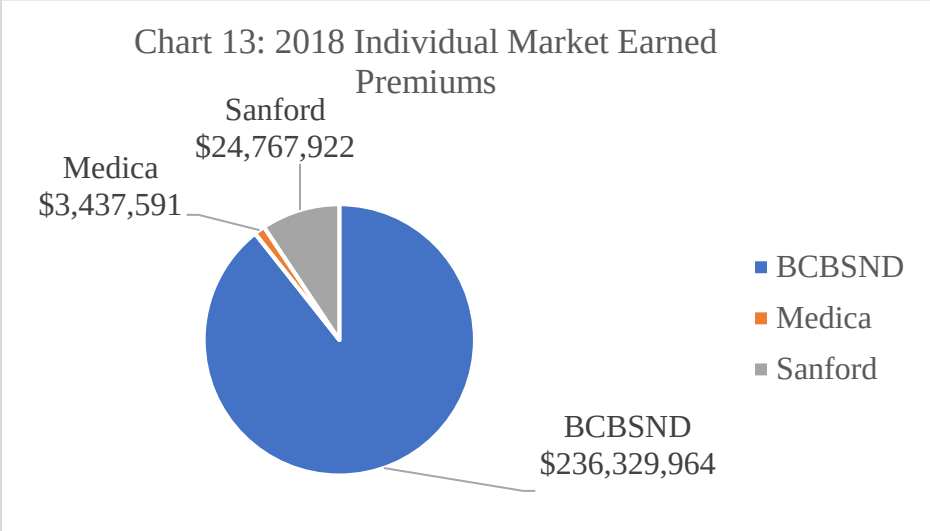


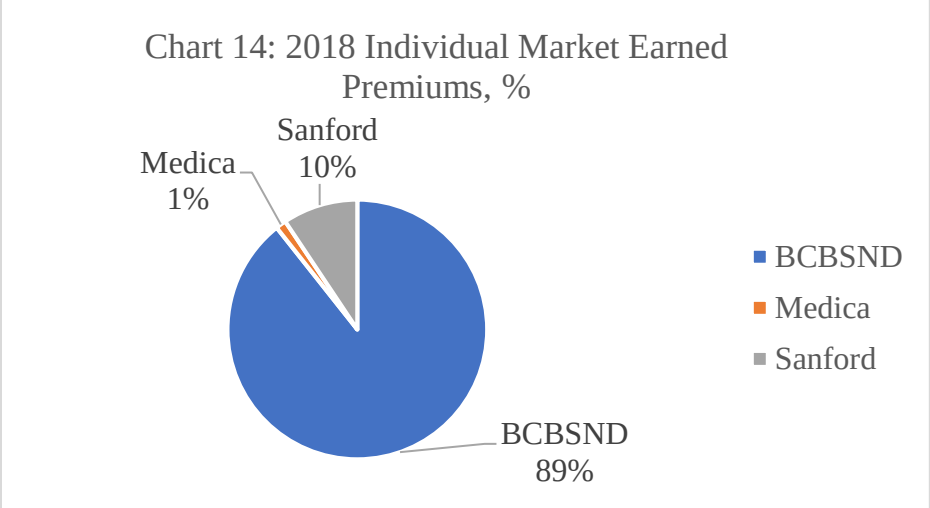
Earned Premiums

Earned premium is the portion of an insurance premium that paid for a portion of time in which the insurance policy was in effect but has now passed and expired.[20]

When considering market share as a percent of total premiums earned in the marketplace BCBSND continues to hold the highest percentage of the market in all markets with 89%, 90%, and 85% in the individual, small group, and large group markets respectively. The charts below show the market share by earned premiums in 2018.

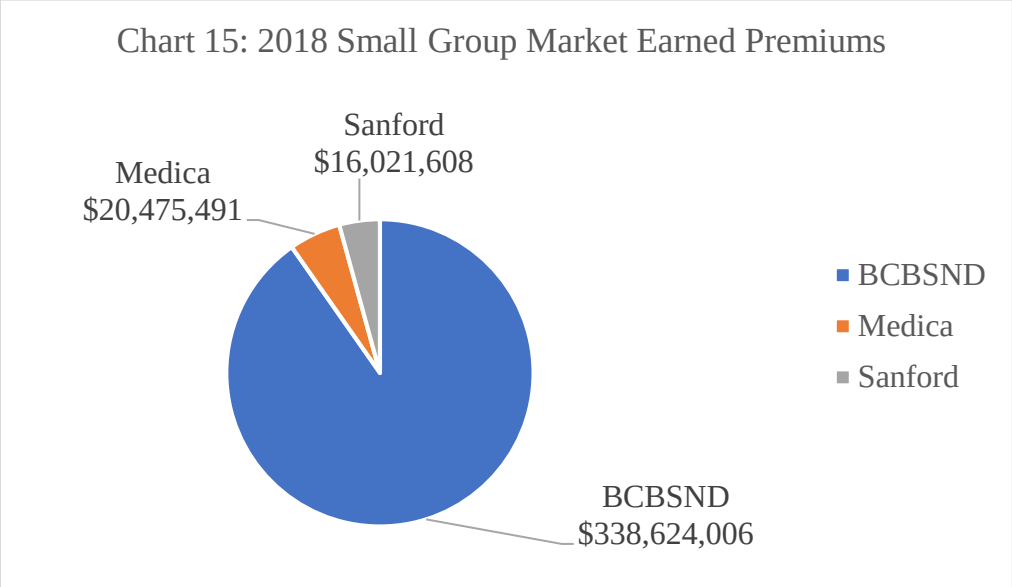
Individual Market

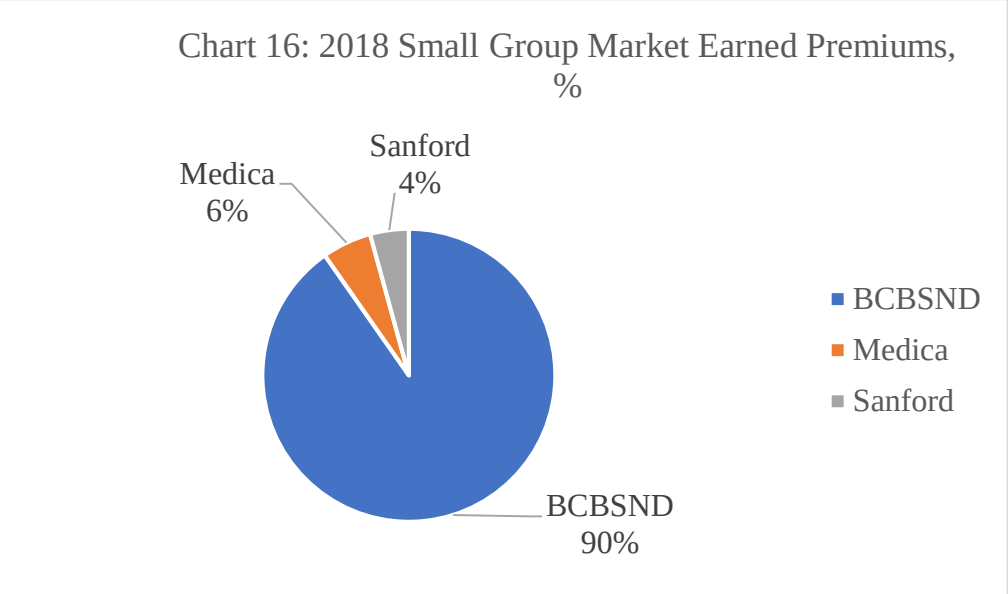




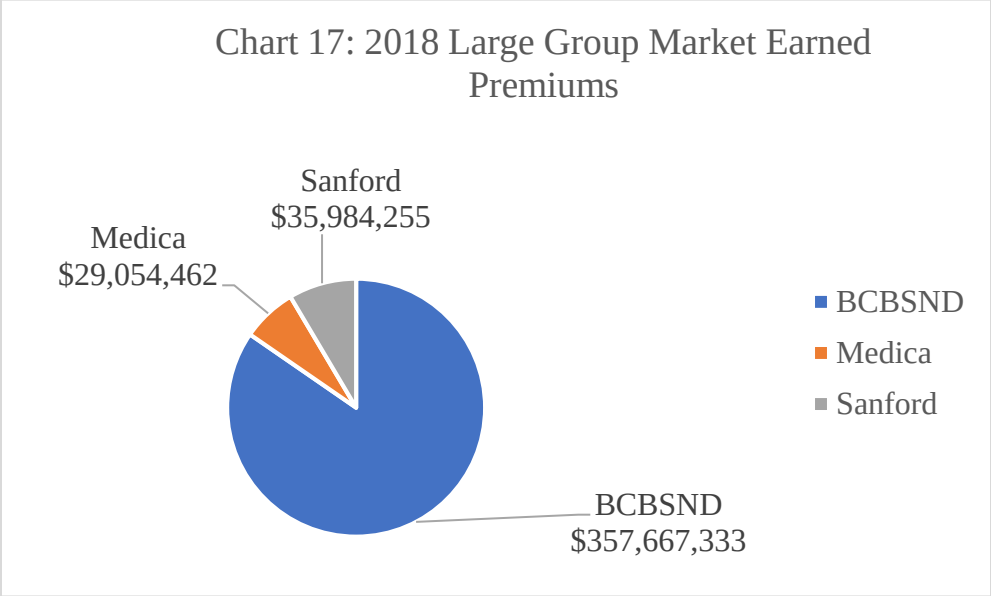
[20] "Actuarial Toolkit." Society of Actuaries. https://actuarialtoolkit.soa.org/tool/glossary/earned-premium. Accessed Oct. 18, 2019.

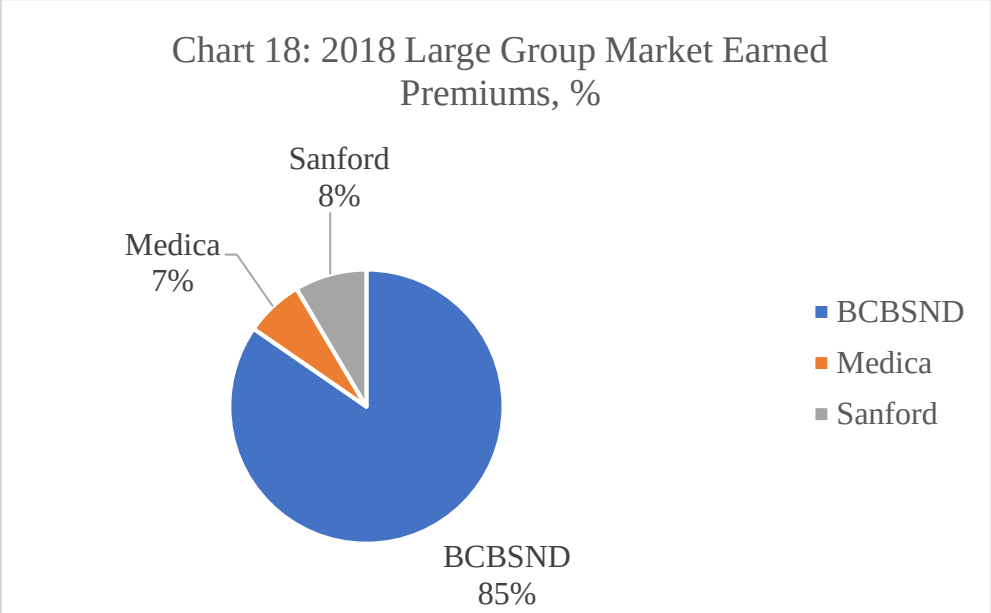
Small Group Market





Large Group Market[21]





[21] The large group data excludes NDPERs

NDPERS[22]

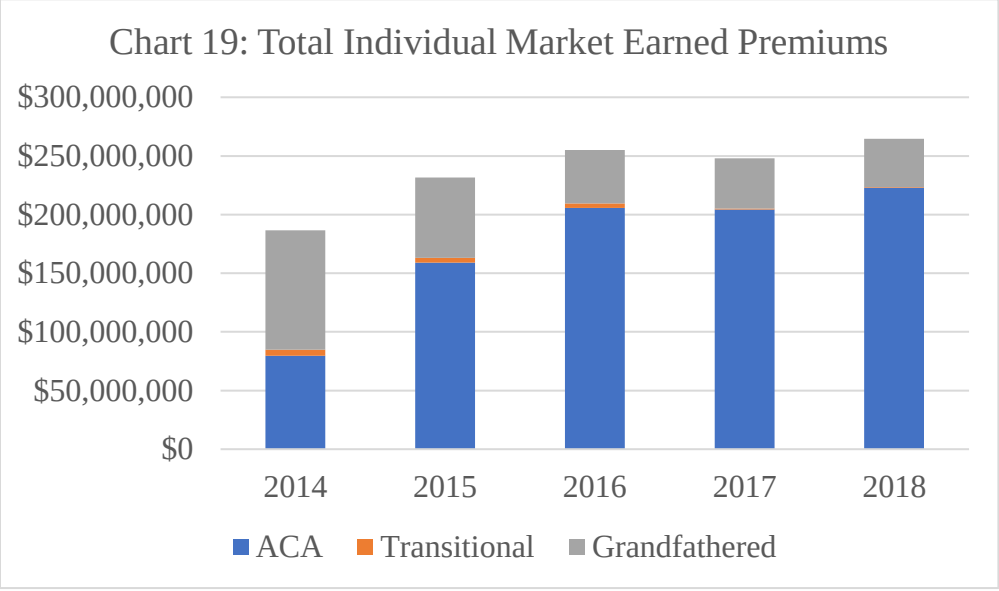
Sanford reported $301,493,309 in earned premiums for NDPERs.

As with the enrollment above, the breakout of earned premium for the individual and small group markets into ACA, grandfathered, and transitional business is presented in the following charts, first in total and then by insurer.

Individual Market

Total – Individual Market

Table 3					
Total Earned Premiums	**2014**	**2015**	**2016**	**2017**	**2018**
ACA	$79,753,553	$158,927,772	$205,771,630	$204,400,397	$222,866,703
Transitional	$5,148,797	$4,295,640	$3,615,958	$657,946	$634,427
Grandfathered	$101,556,471	$68,395,473	$45,735,855	$42,829,132	$41,034,348
Total	**$186,458,821**	**$231,618,885**	**$255,123,443**	**$247,887,475**	**$264,535,478**

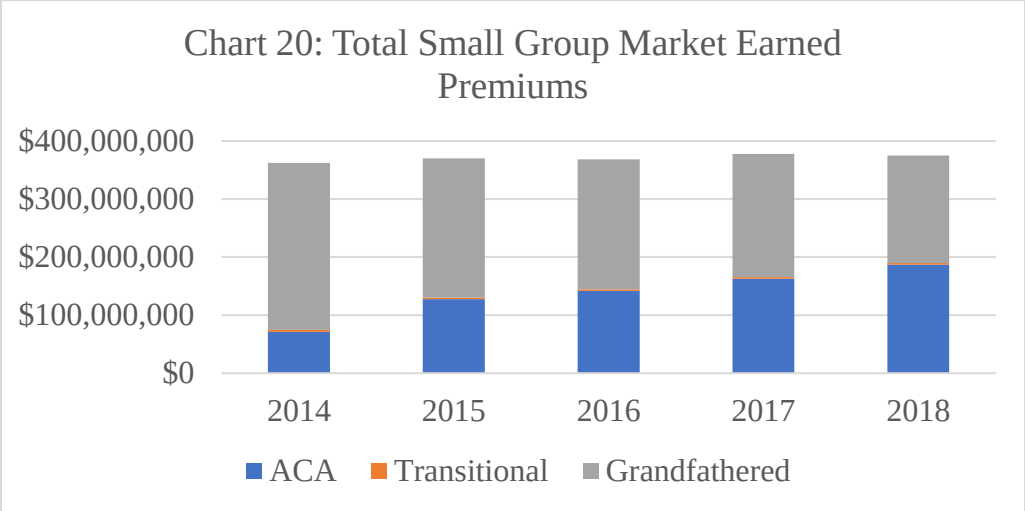


[22] The North Dakota Public Employees Retirement System (NDPERS) is 100% administered by Sanford. Because information was provided separately from the large group market by Sanford, we have also separated the NDPERS information from the large group market.

Small Group Market

Total – Small Group Market

Table 4					
Total Earned Premiums	**2014**	**2015**	**2016**	**2017**	**2018**
ACA	$71,319,892	$127,434,348	$141,637,022	$162,684,935	$186,888,458
Transitional	$3,169,171	$3,043,458	$2,692,603	$2,787,174	$2,799,262
Grandfathered	$287,946,143	$239,368,655	$224,243,165	$212,095,442	$185,433,383
Total	**$362,435,206**	**$369,846,461**	**$368,572,791**	**$377,567,551**	**$375,121,104**



Incurred Claims

Incurred claims are claims that are paid by an insurer over a certain period plus an estimate of claims that were incurred but have not been paid. Information was requested from insurers for the total incurred claims.

We also received member months, so we calculated the incurred claims on a per-member-per-month (PMPM) basis, which provides more comparability. The PMPM represents the claims that an average enrollee will incur in one month. Factors such as wide variation in plan benefit design can affect comparability between insurers. That said, incurred PMPM claims costs do provide some insight into affordability of health insurance in North Dakota because higher incurred PMPM health care costs result in higher health insurance premiums. The table below provides the total incurred PMPM claims cost.[23]

Table 5

Incurred Claims PMPM	2014	2015	2016	2017	2018
Individual ACA	$291.38	$313.85	$369.37	$400.23	$434.90
Individual Transitional	$128.95	$153.28	$220.85	$449.00	$310.09
Individual Grandfathered	$309.93	$321.35	$341.31	$335.33	$343.32
Average Individual Market	**$294.92**	**$311.73**	**$360.84**	**$389.25**	**$418.81**
Small Group ACA	$287.95	$309.80	$342.27	$345.68	$382.79
Small Group Transitional	$274.05	$261.40	$253.63	$294.04	$276.33
Small Group Grandfathered	$313.14	$349.93	$364.60	$371.02	$423.43
Average Small Group Market	**$307.64**	**$334.36**	**$354.54**	**$358.83**	**$401.41**
Large Group Market	**$330.04**	**$356.67**	**$378.56**	**$403.27**	**$415.26**
NDPERS		**$446.30**	**$441.45**	**$440.65**	**$454.03**

[23] The average individual and small group market incurred PMPM costs are weighted by membership.

The following tables show how incurred claims have been increasing. This first table shows the overall increase over a period (for example, 4-year increase from 2014 to 2018).

Table 6				
Incurred Claims % Increase	**2014-2018 4-Year Increase**	**2015-2018 3-Year Increase**	**2016-2018 2-Year Increase**	**2017-2018 1-Year Increase**
Individual ACA	49.3%	38.6%	17.7%	8.7%
Individual Transitional	140.5%	102.3%	40.4%	-30.9%
Individual Grandfathered	10.8%	6.8%	0.6%	2.4%
Individual Market	**42.0%**	**34.4%**	**16.1%**	**7.6%**
Small Group ACA	32.9%	23.6%	11.8%	10.7%
Small Group Transitional	0.8%	5.7%	9.0%	-6.0%
Small Group Grandfathered	35.2%	21.0%	16.1%	14.1%
Small Group Market	**30.5%**	**20.1%**	**13.2%**	**11.9%**
Large Group Market	**25.8%**	**16.4%**	**9.7%**	**3.0%**
NDPERS		**1.7%**	**2.9%**	**3.0%**

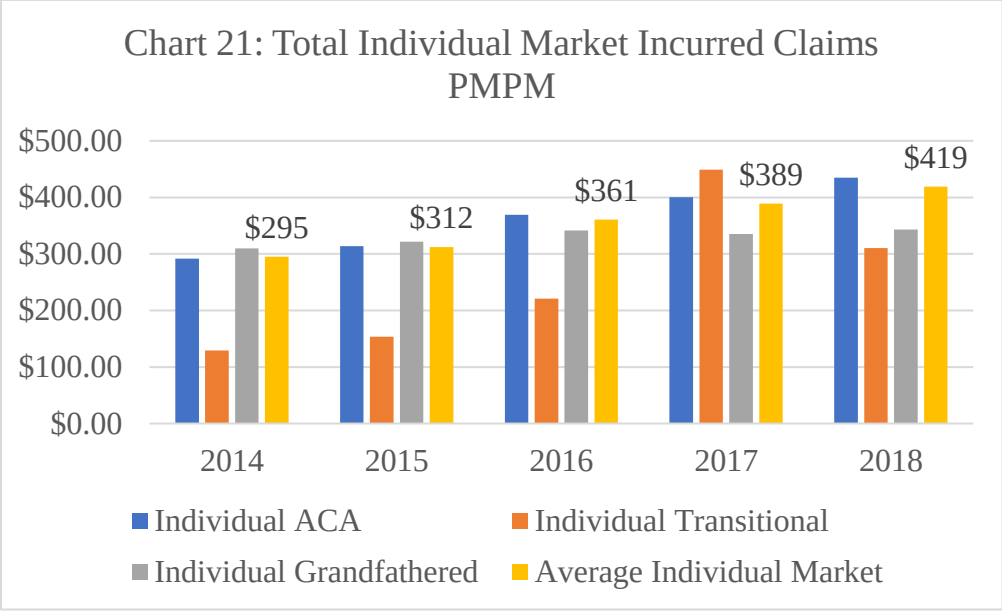
This table also shows how incurred claims have been increasing; however, it is provided on an annualized basis, which is the average annual increase over that period.

Table 7				
Incurred Claims Annualized % Increase	**2014-2018 4-Year Increase (Annualized)**	**2015-2018 3-Year Increase (Annualized)**	**2016-2018 2-Year Increase (Annualized)**	**2017-2018 1-Year Increase (Annualized)**
Individual ACA	10.5%	11.5%	8.5%	8.7%
Individual Transitional	24.5%	26.5%	18.5%	-30.9%
Individual Grandfathered	2.6%	2.2%	0.3%	2.4%
Individual Market	**9.2%**	**10.3%**	**7.7%**	**7.6%**
Small Group ACA	7.4%	7.3%	5.8%	10.7%
Small Group Transitional	0.2%	1.9%	4.4%	-6.0%
Small Group Grandfathered	7.8%	6.6%	7.8%	14.1%
Small Group Market	**6.9%**	**6.3%**	**6.4%**	**11.9%**
Large Group Market	**5.9%**	**5.2%**	**4.7%**	**3.0%**
NDPERS		**0.6%**	**1.4%**	**3.0%**

The following charts show the changes in incurred PMPM claims cost for the past five years in total and then by insurer. Note, only average values are shown for readability.

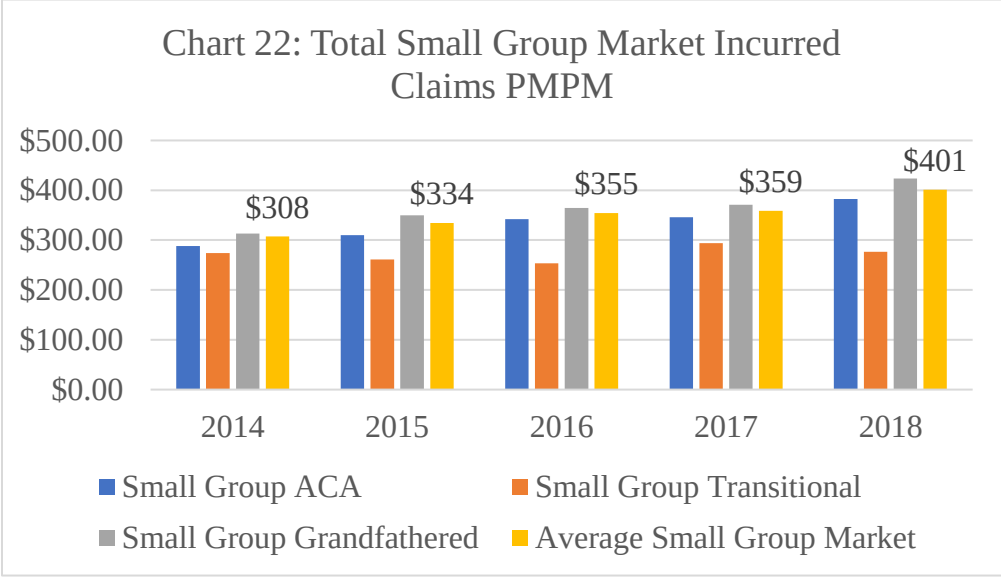
Individual Market

Total – Individual Market



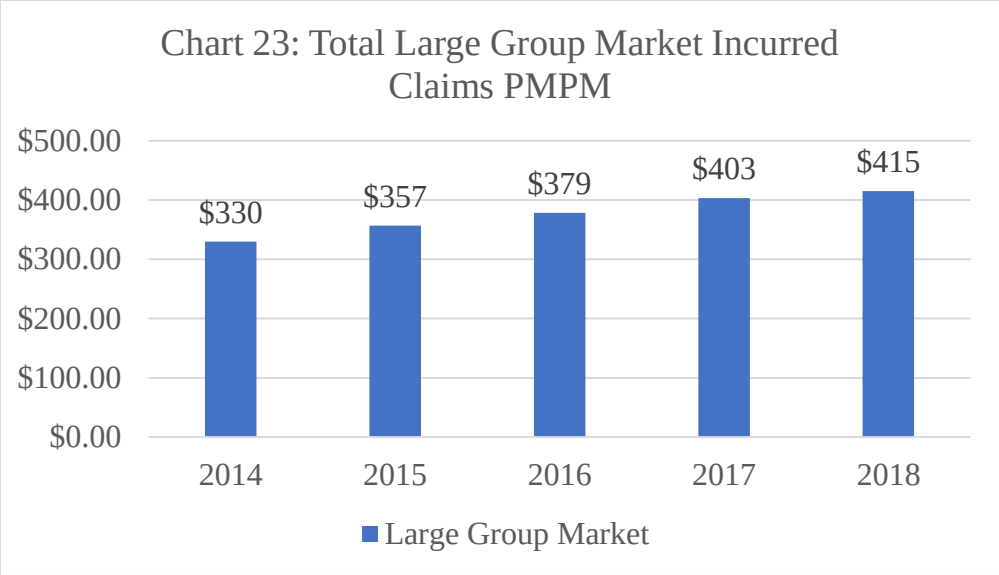
Small Group Market

Total – Small Group Market

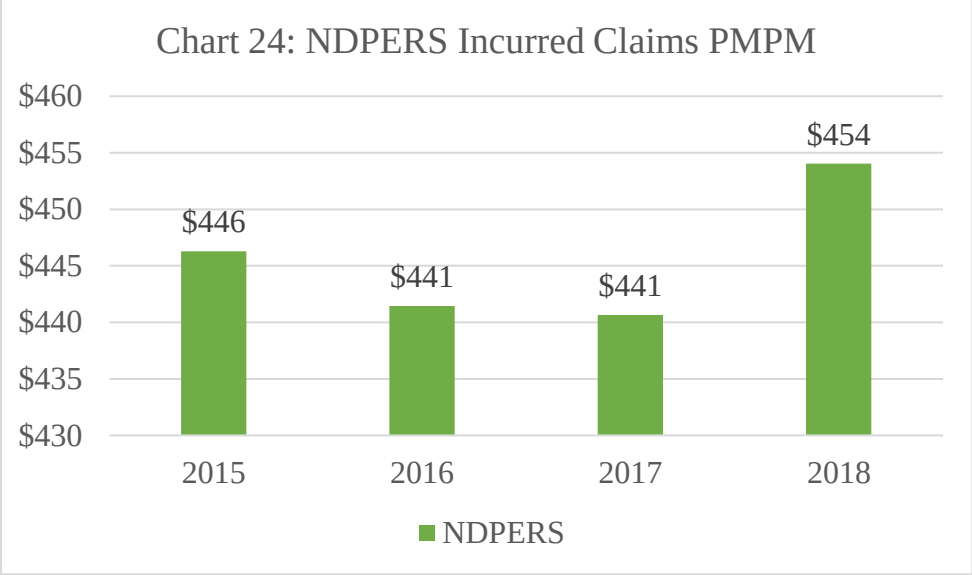


Large Group Market

Total – Large Group Market



NDPERS

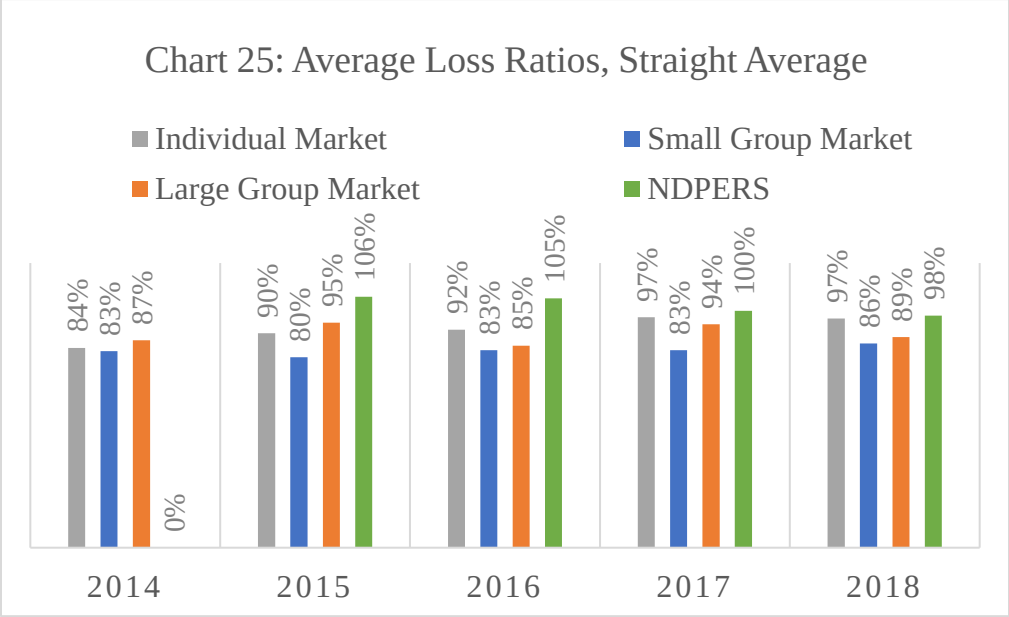


Loss Ratios

A loss ratio is the ratio of claims to premiums. We calculated the traditional loss ratio as the ratio of incurred claims to earned premiums.[24] No specific definition of claims was provided to insurers. In addition to direct claims payments for medical services, the claims used in the loss ratio may include case management services, the cost of quality improvement efforts and other costs related to health care services not directly delivered to members.

It is important to note that because of Risk Adjustment, loss ratios alone do not provide a complete picture of profitability for carriers' individual and small group lines of business. A company with a high traditional loss ratio could be enrolling a sicker population than the state average, meaning they would receive a payment from the carriers with a healthier population.

The 2018 average loss ratios are 97%, 86%, and 89% for individual, small group, and large group respectively on a straight average basis. The chart below show the straight average loss ratios by market for 2014-2018.



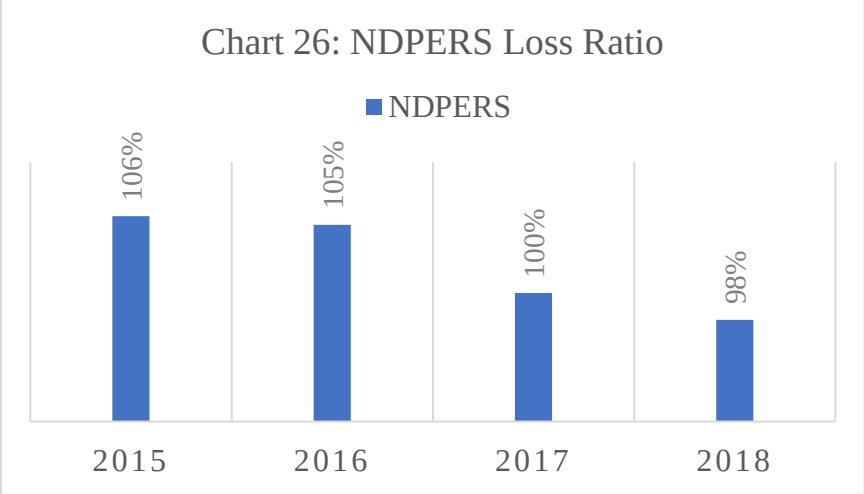
The ACA requires insurers to provide a rebate to policyholders if the insurer's loss ratio, with certain adjustments, is less than 80% for the individual or small group markets and 85% for the large group market. The federal rebate loss ratio allows the insurers to make several adjustments. For example, if an insurer has less than 75,000 life years (900,000 member months) in a market,

[24] This is not the same as the ACA rebate minimum loss ratio, which is adjusted for quality improvement, risk adjustment, and taxes.

an amount is added to the loss ratio. The result of this credibility adjustment is that insurers can have a loss ratio lower than the federal standard and still not be required to pay a rebate.[25]

The Federal Loss Ratio formula also includes an adjustment for risk adjustment payments, quality improvement expenses, and taxes and fees. For ACA business there will also be a risk adjustment transfer or receivable. We did not request non-benefit expenses broken out by market so we cannot calculate exact federal loss ratios, however, the information requested from the insurers show a weighted average of 1.0% for quality improvement and 5.4% for taxes and fees. This means, on average, adjusting to the federal loss ratio increases the traditional loss ratio by 7%.

According to the information filed in the 2018 Supplemental Health Care Exhibit (SHCE) for all insurers in the North Dakota market, $0 in rebates were paid in all three markets (individual, small group, and large group) in 2018 for the 2017 plan year. [26]
The traditional loss ratios varied significantly between insurers. Individual ACA loss ratios differed from 78% to 121% in 2018. Small group ACA and large group varied from 81% to 90% and 84% to 93% respectively.



Using the straight averages, the average loss ratios increased from 84% in 2014 to 97% in 2018 in the individual market, increased from 83% in 2014 to 86% in 2018 in the small group market, and increased from 87% in 2014 to 89% in 2018 in the large group market. The loss ratio for NDPERS decreased from 106% in 2015 (the first year it was administered by Sanford) to 98% in 2018.

[25] In North Dakota, none of the insurers enroll 75,000 life years in a market so all insurers receive a credibility adjustment.
[26] Per NAIC Supplemental Exhibit. Information related to MLR rebates paid in 2019 for 2018 are not available at this time.

Non-benefit Costs

While premiums must account for approximately 80% or 85% of claims, the remaining 20% or 15% is the amount of premium that is available for the cost of administering the insurance (commissions, administering claims, tracking enrollment changes, etc.) and for insurer profits. These costs are known as non-benefit costs. We requested non-benefit costs be broken into administrative expenses, commissions, quality improvement expenses, profit, and taxes and fees in total and as a percent of premium at the insurer level. We did not request this information at the market level as many insurers do not have the capability to provide this information in such detail.[27]

The insurers surveyed reported a wide range of commission and administrative percentages. The member weighted average commission percentage in 2018 was 0.67%, but it ranged by insurer from 0.56% to 3.14%. This is a decrease from the 0.71% member weighted average commission in 2017. Commissions for individual products are traditionally higher than for small group products and commissions for large group products are traditionally lower than for small group products. Therefore, an insurer that enrolls more individual business would tend to have higher overall commissions as a percent of premium than an insurer that enrolls more large group business.

The member weighted average for administrative expenses as a percent of premium in 2018 was 8.33%, but the percentages ranged by insurer from 2.92% to 10.76%. This is an increase from the member weighted average administrative expense percent of premium of 6.12% in 2017. The member weighted average profit as a percent of premium in 2018 was -2.34% (i.e. a 2.34% loss), but the percentages ranged by insurer from -4.19% to 2.12%. This is a decrease from the member weighted average profit percent of premium of 2.0% in 2017.

Total non-benefit costs ranged by insurer from 8% to 17% of total premiums.

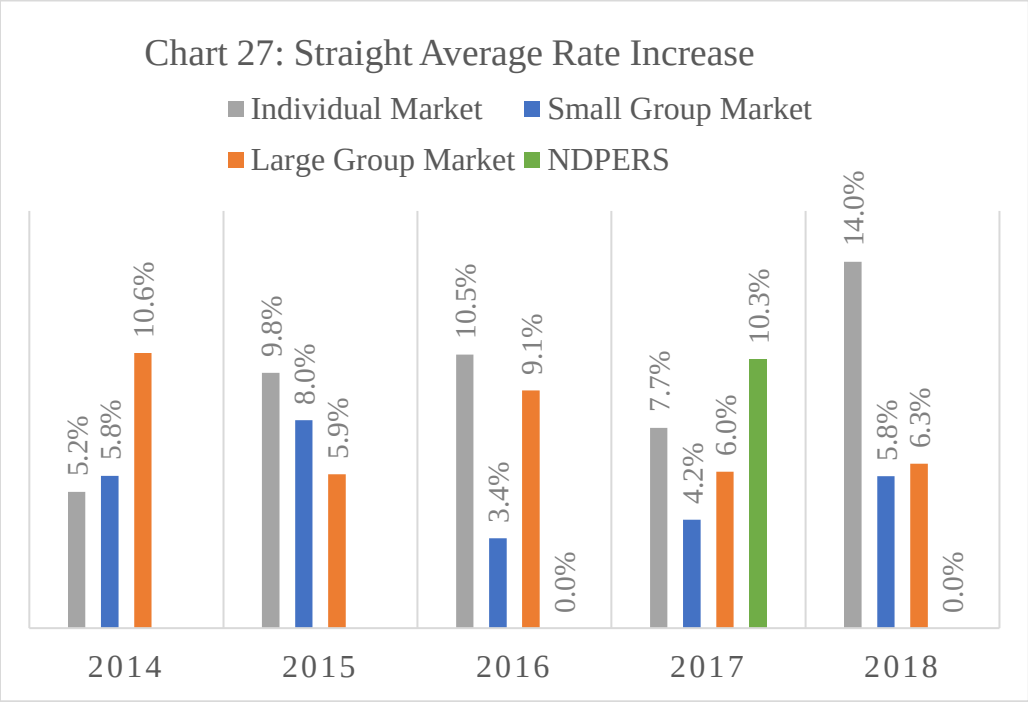
[27] NDPERS was not broken out from Sanford's other business in this section.

Rate Increases

The table below detail the average rate increases among insurers included in the data request for the past five years.

Table 8					
Average Rate Increase, Straight Average	**2014**	**2015**	**2016**	**2017**	**2018**
Individual ACA	0.0%	9.0%	12.0%	7.1%	15.6%
Individual Transitional	7.2%	14.6%	1.8%	3.3%	1.4%
Individual Grandfathered	14.4%	12.4%	2.1%	9.6%	0.0%
Individual Market	**5.2%**	**9.8%**	**10.5%**	**7.7%**	**14.0%**
Small Group ACA	0.0%	8.5%	1.0%	5.0%	7.7%
Small Group Transitional	13.4%	12.5%	10.2%	5.5%	10.4%
Small Group Grandfathered	10.4%	0.2%	8.2%	1.7%	-1.0%
Small Group Market	**5.8%**	**8.0%**	**3.4%**	**4.2%**	**5.8%**
Large Group Market	**10.6%**	**5.9%**	**9.1%**	**6.0%**	**6.3%**
NDPERS			**0.0%**	**10.3%**	**0.0%**

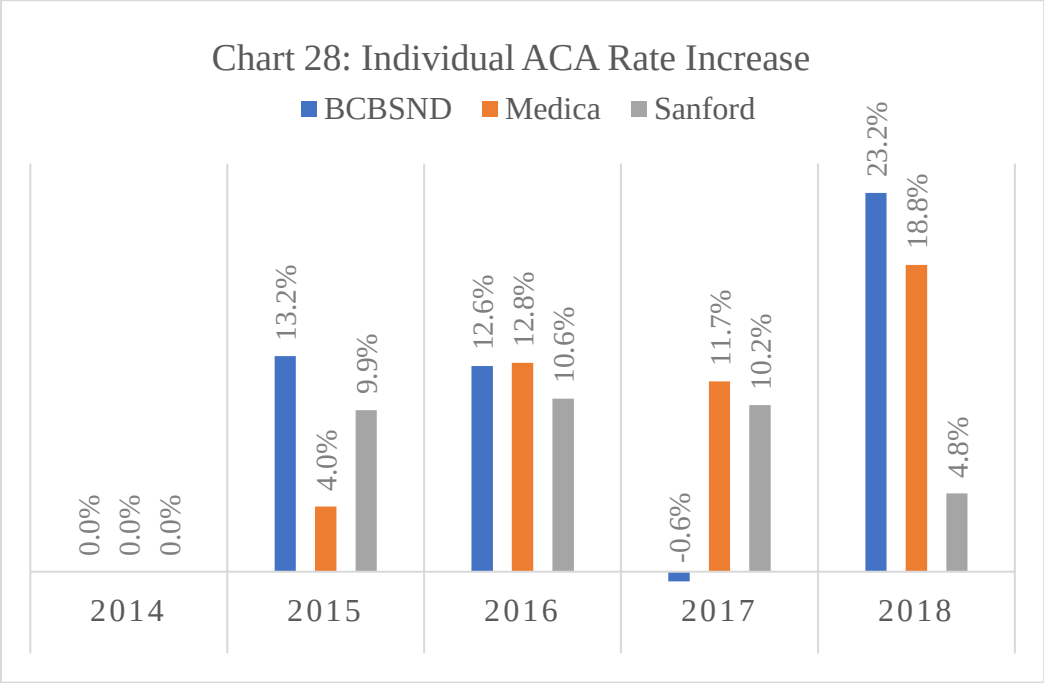
For comparative purposes, the ACA required a determination of reasonableness from the state and an explanation from the insurer for any rate increases of 15% or more.[28] The following charts show rate increases using a straight average.

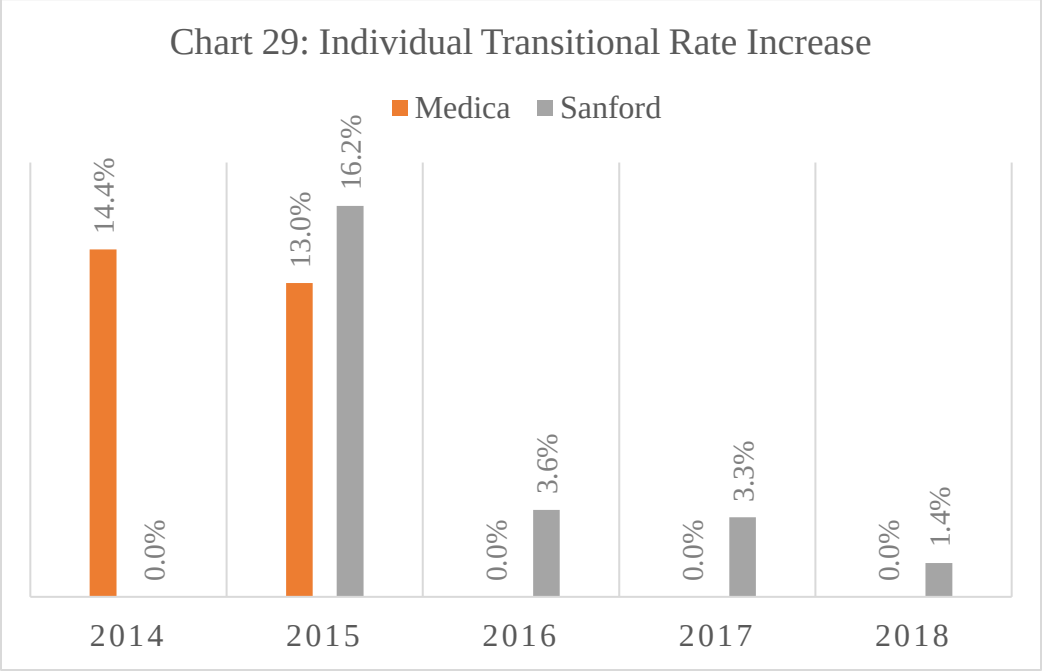


[28] Note the 15% requirement is at the plan level so an insurer would still require a determination of reasonableness if any of their plans has an increase over 15%, even if the overall average is less than 15%.

The following charts show rate increases by insurer within each market.[29]

Individual Market





[29] All ACA products were introduced in 2014 and were considered new products so they had no rate increase in 2014.

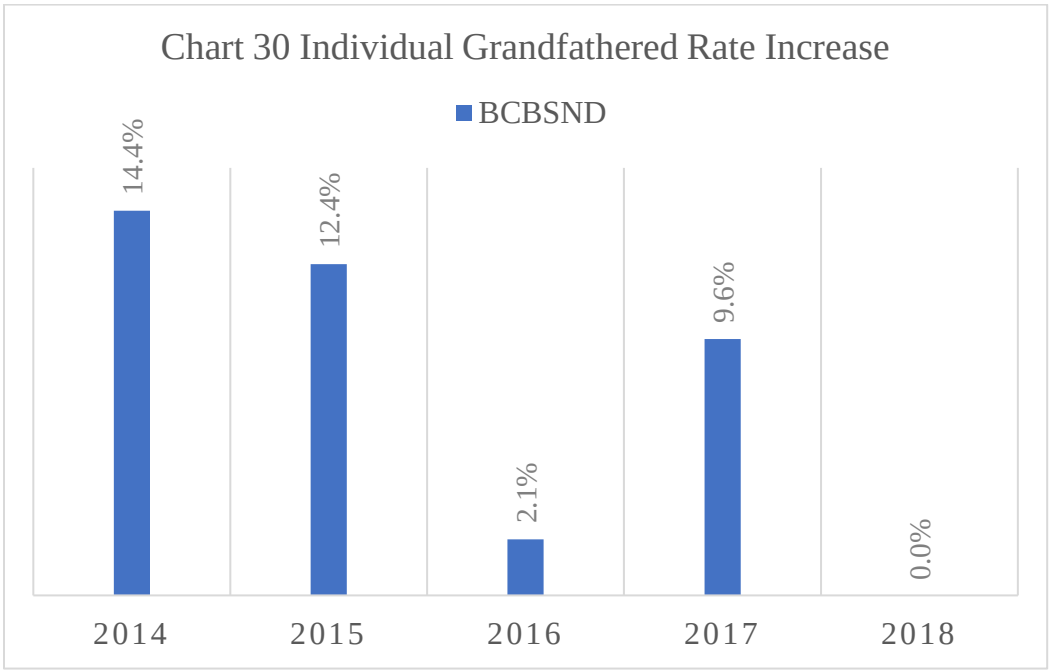
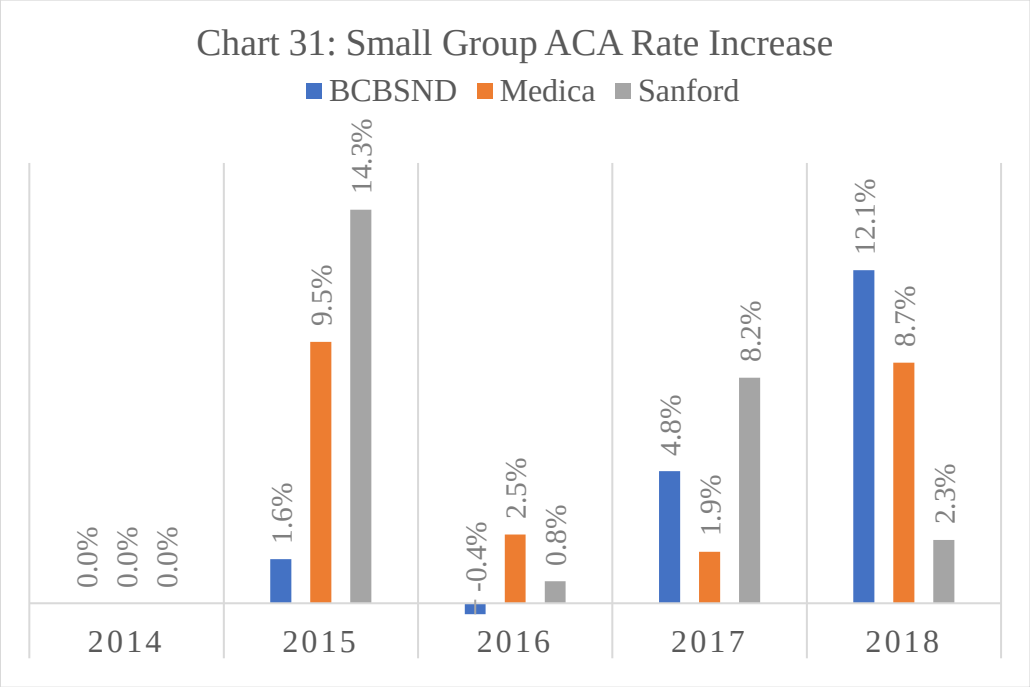
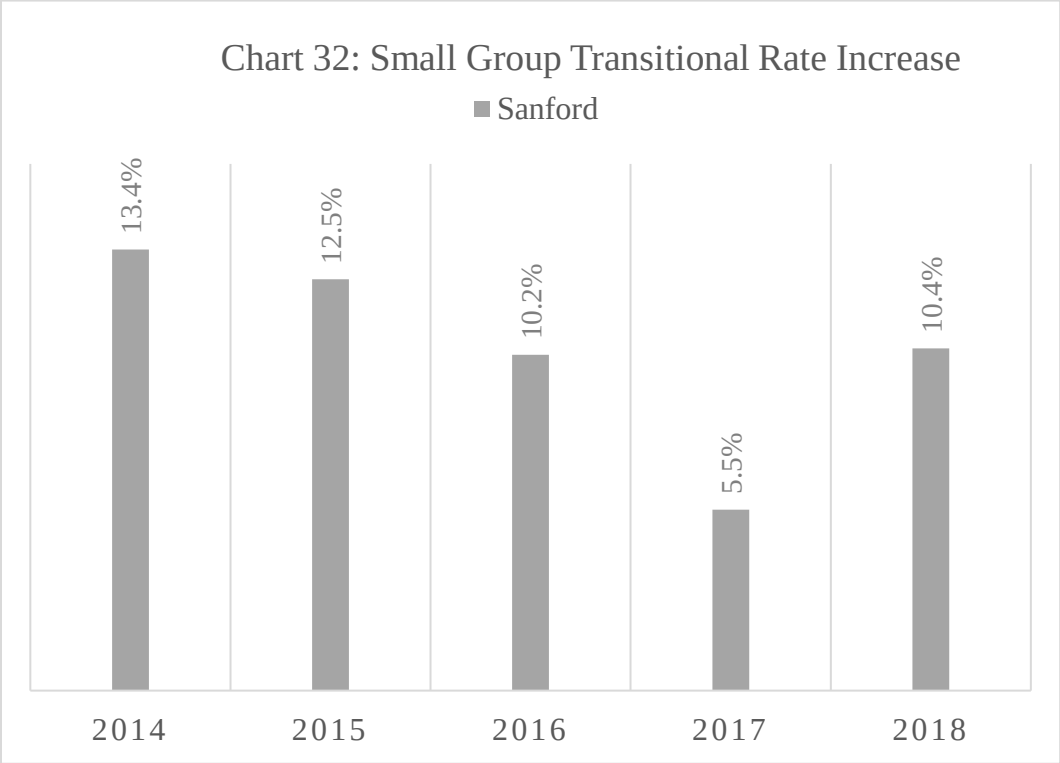


Chart 30 Individual Grandfathered Rate Increase
BCBSND
14.4%
12.4%
2.1%
9.6%
0.0%
2014
2015
2016
2017
2018

Small Group Market





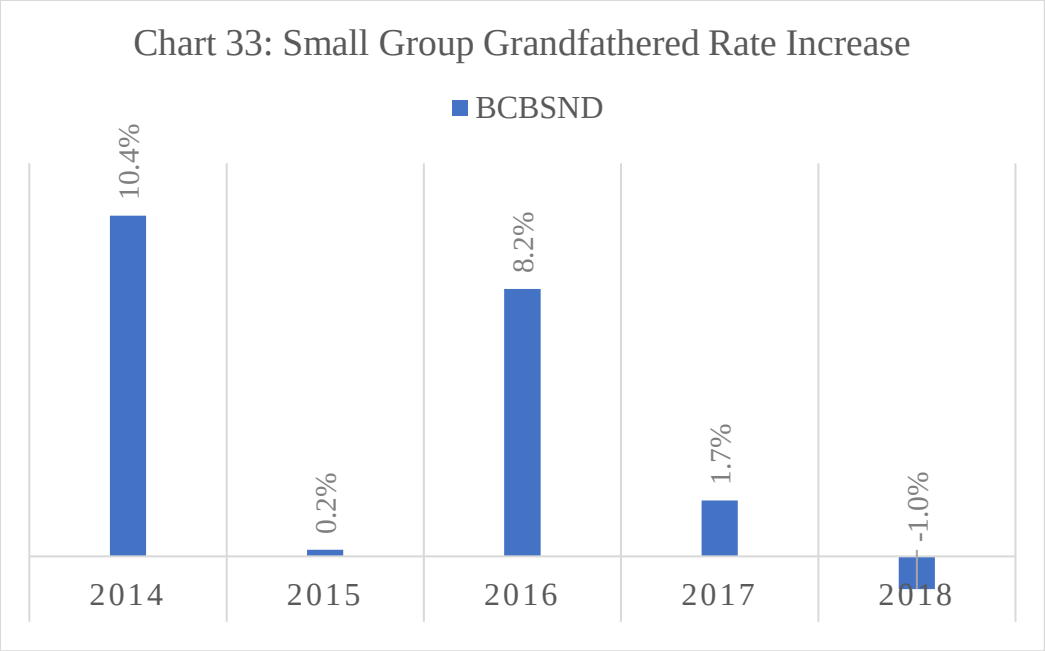
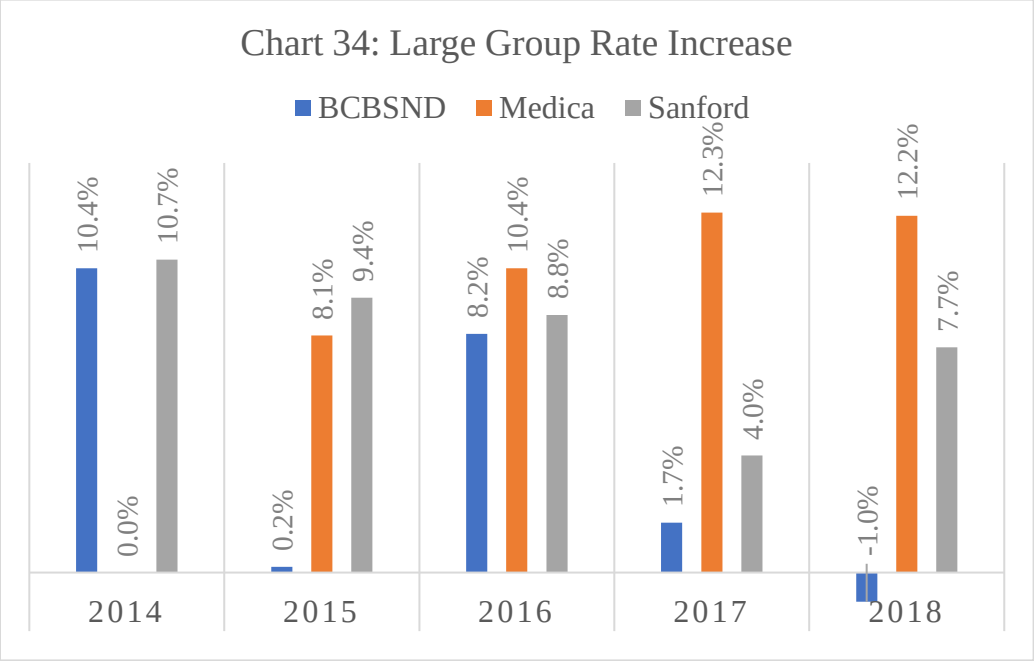


Chart 33: Small Group Grandfathered Rate Increase
BCBSND
10.4%
0.2%
8.2%
1.7%
-1.0%
2014
2015
2016
2017
2018

Large Group Market



NDPERS

NDPERS had a 10.3% rate increase in 2017, but otherwise no rate increases from 2014-2018.

Health Care Expenditures

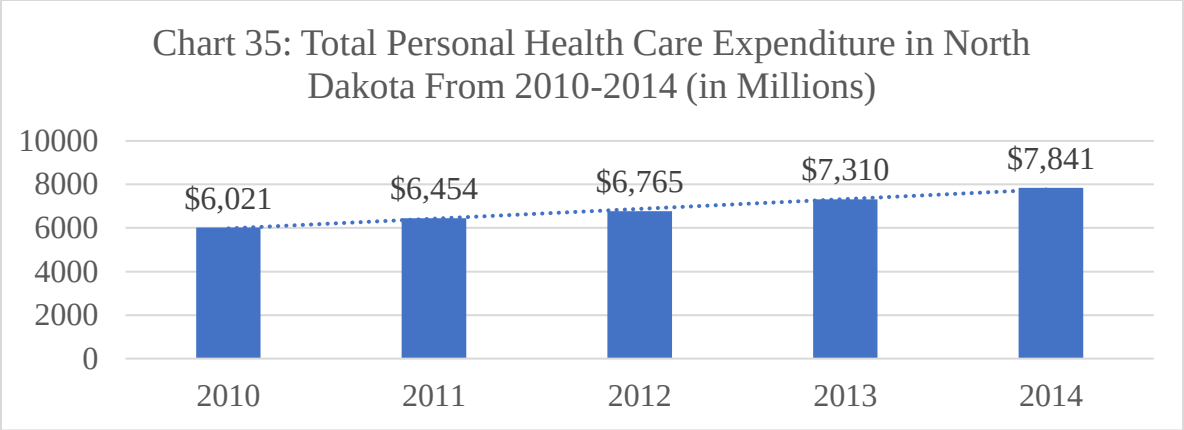
Health care expenditures drive health insurance premiums. As the cost of health care services increases due to the cost of the individual services or the use of the services, that increased cost is passed on to policyholders in the form of premium increases. Periodically, the Centers for Medicare and Medicaid Services (CMS) releases a provider expenditure report, which gives information on the annual health care expenditures for certain categories by state and by region. The latest report includes data from 1980 through 2014. The table below shows the total expenditures in millions for North Dakota, by category, for the most recent available five years included in the report.[30]

Table 9

North Dakota Expenditure Category (in millions)	2010	2011	2012	2013	2014
Hospital Care	2,642	2,974	3,142	3,528	3,827
Physician & Clinical Services	1,087	1,110	1,201	1,219	1,264
Other Professional Services	144	156	166	181	197
Dental Services	274	285	290	302	323
Home Health Care	42	50	52	54	54
Prescription Drugs	684	662	634	677	745
Other Non-durable Medical Products	110	113	121	123	124
Durable Medical Products	96	108	124	125	128
Nursing Home Care	483	505	514	549	578
Other Health, Residential, and Personal Care	459	494	521	552	602
Total Personal Health Care	6,021	6,454	6,765	7,310	7,841

The CMS report showed a consistent increase in total personal health care expenditure over the last available five years. The following graph shows the trend in total personal health care expenditure in North Dakota from 2010 to 2014.

[30] CMS.gov. "State (Provider) Health Expenditures by State of Provider, 1980-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. Accessed Oct.14, 2019.



We recognize this data, while relatively recent, is outdated due to implementation of the ACA in 2014. Even after the implementation, the market has continued to evolve and adapt to continually changing regulations and guidance.

CMS also provided a report detailing the health expenditures for personal health care by state as of 2014. The following chart compares the aggregate and per capita estimates of North Dakota (in red) to the other states.[31] According to the table, North Dakota's per capita health expenditures rank 7th highest of 51 states (including the District of Columbia).

[31] CMS.gov. "Health Expenditures by State of Residence, 1991-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html. Accessed December 25, 2018.

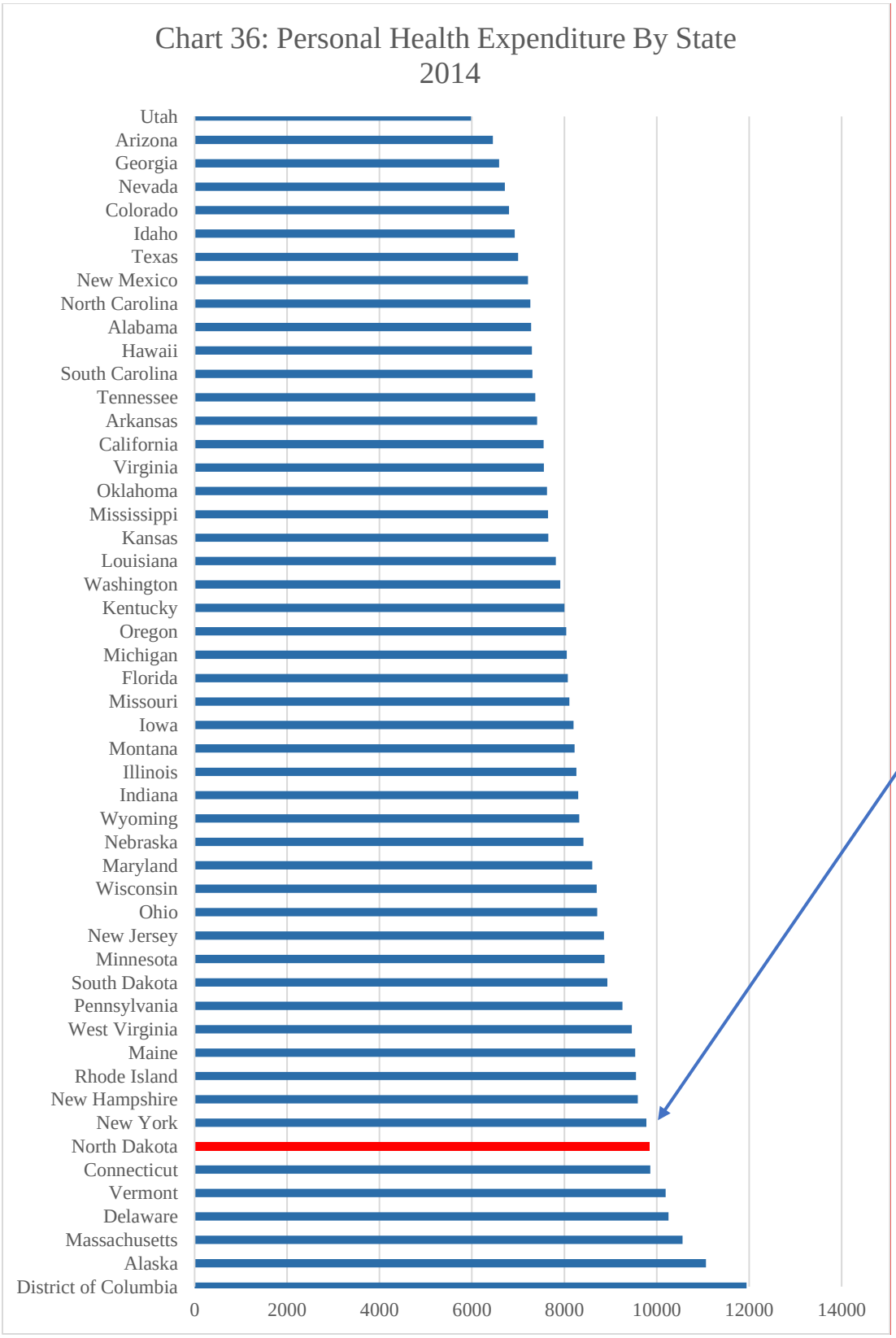


Chart 36: Personal Health Expenditure By State
2014
Utah
Arizona
Georgia
Nevada
Colorado
Idaho
Texas
New Mexico
North Carolina
Alabama
Hawaii
South Carolina
Tennessee
Arkansas
California
Virginia
Oklahoma
Mississippi
Kansas
Louisiana
Washington
Kentucky
Oregon
Michigan
Florida
Missouri
Iowa
Montana
Illinois
Indiana
Wyoming
Nebraska
Maryland
Wisconsin
Ohio
New Jersey
Minnesota
South Dakota
Pennsylvania
West Virginia
Maine
Rhode Island
New Hampshire
New York
North Dakota
Connecticut
Vermont
Delaware
Massachusetts
Alaska
District of Columbia
0
2000
4000
6000
8000
10000
12000
14000
North Dakota

Allowed Claims

Allowed claims represent the claims payable to providers, of which the insurer and the insured will each pay a portion, subject to the applicable cost sharing provisions. Incurred claims, as discussed above, are not necessarily comparable between insurers because of wide variation in benefit design. Allowed claims are less impacted by benefit design and provide more context on how health care costs change over time. We requested insurers provide allowed claims experience for the past five years. One limitation to this data is that it is not broken into detailed benefit categories.

It is important to note that PMPM amounts by carrier are likely not directly comparable. This is caused by different carriers having different enrolled populations in terms of demographics and morbidity levels. For the individual and small group markets (especially the individual market) carriers also have a different mix of ACA and non-ACA plans.

Similar to the incurred claims section above, the tables below indicate the member weighted average allowed claims cost PMPM.

Table 10

Allowed Claims PMPM	2014	2015	2016	2017	2018
Individual ACA	$386.16	$410.23	$474.27	$503.80	$543.96
Individual Transitional	$220.67	$233.23	$304.54	$541.21	$410.50
Individual Grandfathered	$374.04	$384.67	$394.77	$389.42	$395.77
Average Individual Market	**$372.68**	**$398.05**	**$455.59**	**$484.27**	**$518.15**
Small Group ACA	$337.68	$364.62	$398.57	$416.99	$456.05
Small Group Transitional	$352.28	$356.54	$350.52	$367.72	$361.88
Small Group Grandfathered	$379.63	$416.16	$431.17	$439.86	$497.61
Average Small Group Market	**$370.87**	**$396.70**	**$417.13**	**$428.83**	**$475.21**
Large Group Market	**$388.98**	**$419.92**	**$443.39**	**$471.57**	**$501.16**
NDPERS		**$508.98**	**$513.63**	**$516.33**	**$533.05**

The following tables show how allowed claims have been increasing. This first table shows the overall increase over a period (for example, 4-year increase from 2014 to 2018).

Table 11

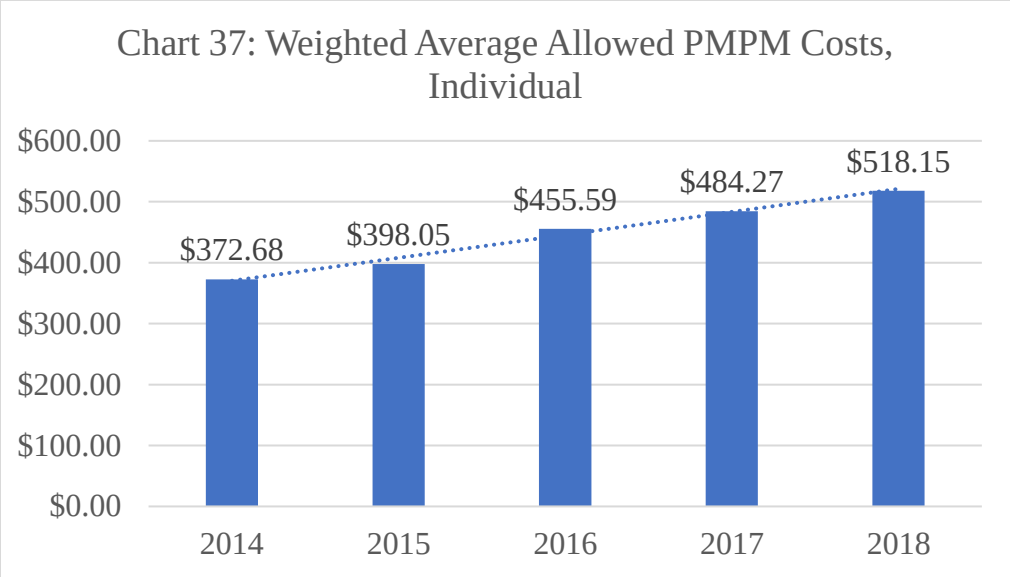
Allowed Claims % Increase	2014-2018 4-Year Increase	2015-2018 3-Year Increase	2016-2018 2-Year Increase	2017-2018 1-Year Increase
Individual ACA	40.9%	32.6%	14.7%	8.0%
Individual Transitional	86.0%	76.0%	34.8%	-24.2%
Individual Grandfathered	5.8%	2.9%	0.3%	1.6%
Average Individual Market	**39.0%**	**30.2%**	**13.7%**	**7.0%**
Small Group ACA	35.1%	25.1%	14.4%	9.4%
Small Group Transitional	2.7%	1.5%	3.2%	-1.6%
Small Group Grandfathered	31.1%	19.6%	15.4%	13.1%
Average Small Group Market	**28.1%**	**19.8%**	**13.9%**	**10.8%**
Large Group Market	**28.8%**	**19.3%**	**13.0%**	**6.3%**
NDPERS		**4.7%**	**3.8%**	**3.2%**

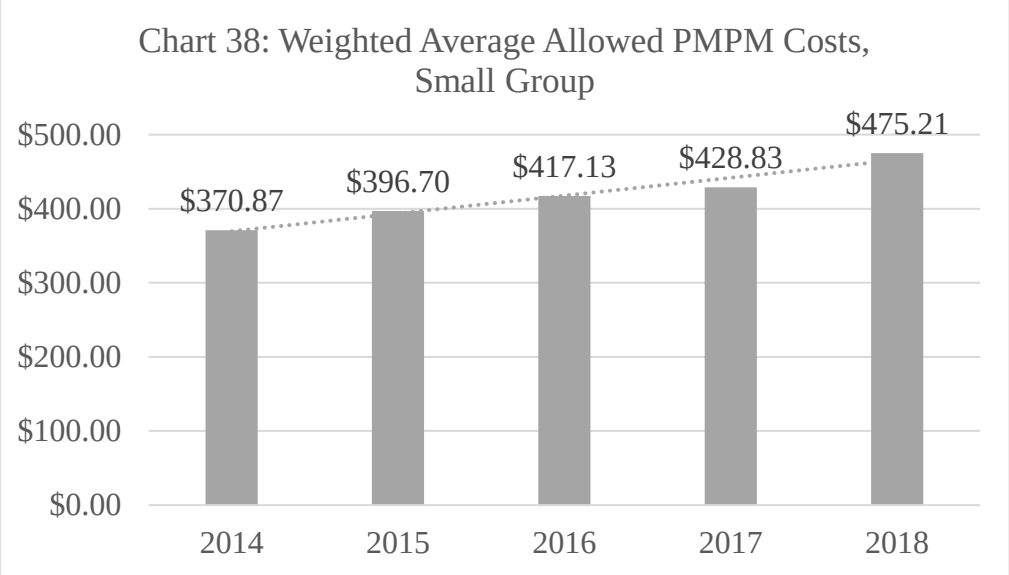
This table also shows how allowed claims have been increasing; however, it is provided on an annualized basis, which is the average annual increase over that period.

Table 12

Allowed Claims Annualized % Increase	2014-2018 4-Year Increase (Annualized)	2015-2018 3-Year Increase (Annualized)	2016-2018 2-Year Increase (Annualized)	2017-2018 1-Year Increase (Annualized)
Individual ACA	8.9%	9.9%	7.1%	8.0%
Individual Transitional	16.8%	20.7%	16.1%	-24.2%
Individual Grandfathered	1.4%	1.0%	0.1%	1.6%
Average Individual Market	**8.6%**	**9.2%**	**6.6%**	**7.0%**
Small Group ACA	7.8%	7.7%	7.0%	9.4%
Small Group Transitional	0.7%	0.5%	1.6%	-1.6%
Small Group Grandfathered	7.0%	6.1%	7.4%	13.1%
Average Small Group Market	**6.4%**	**6.2%**	**6.7%**	**10.8%**
Large Group Market	**6.5%**	**6.1%**	**6.3%**	**6.3%**
NDPERS		**1.6%**	**1.9%**	**3.2%**

The following charts show the member-weighted average allowed claims PMPM for the individual market, small group market, large group market, and NDPERS.





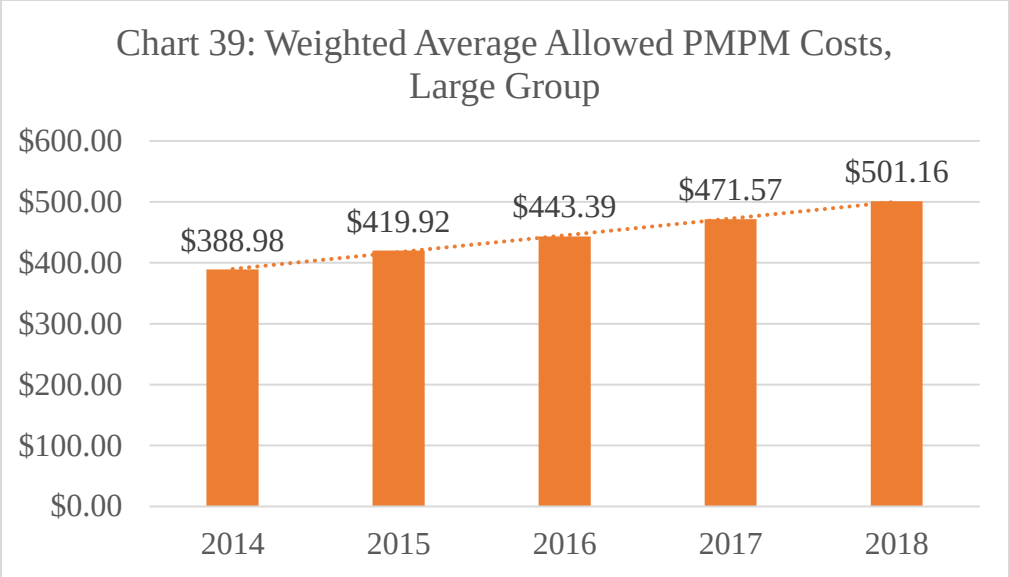


Chart 39: Weighted Average Allowed PMPM Costs, Large Group
$600.00
$500.00
$400.00
$300.00
$200.00
$100.00
$0.00
$388.98
$419.92
$443.39
$471.57
$501.16
2014
2015
2016
2017
2018

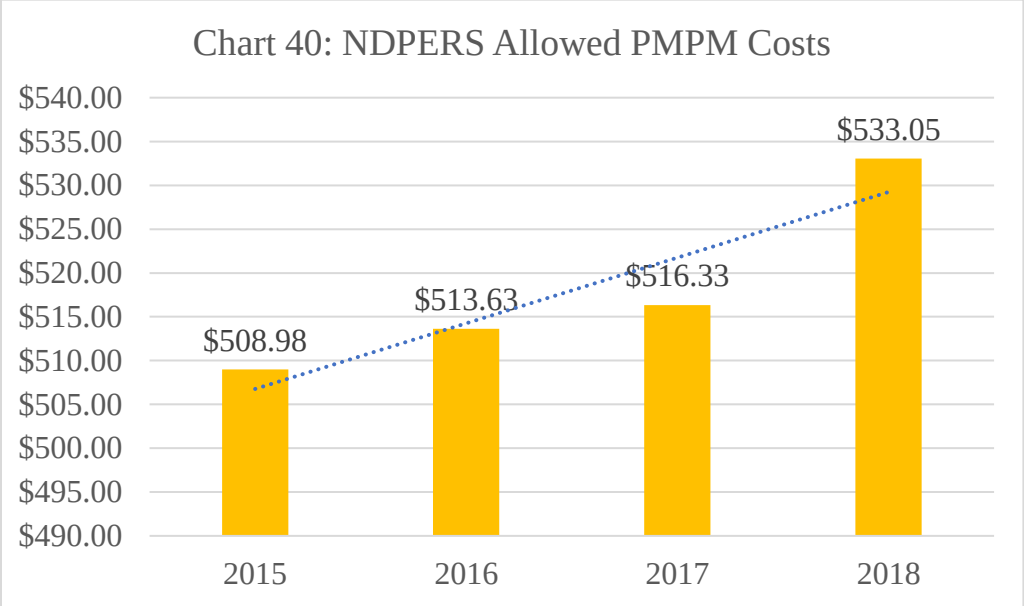


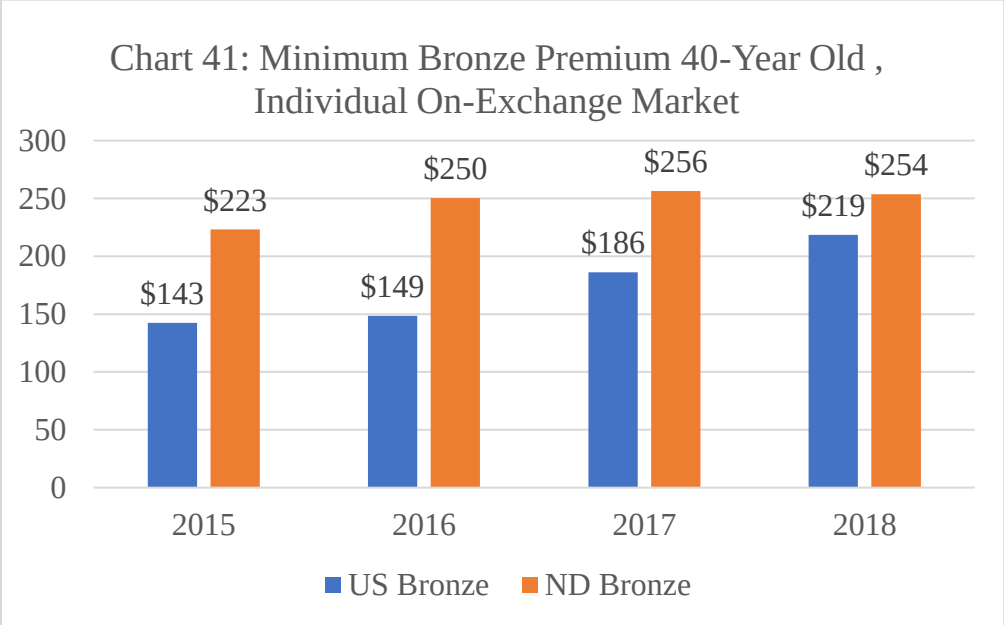
Chart 40: NDPERS Allowed PMPM Costs
$540.00
$535.00
$530.00
$525.00
$520.00
$515.00
$510.00
$505.00
$500.00
$495.00
$490.00
$508.98
$513.63
$516.33
$533.05
2015
2016
2017
2018

Premium Rates

Since premiums are typically calculated based on estimated health care claims, as health care expenditures increase, premium rates increase, although there are many reasons premiums can change at a different rate than health care expenses. One reason for higher premium increases is that deductible amounts do not increase therefore all the increases in health care dollars are used to increase premiums, which results in a higher percentage increase. For example, if a policy has a $2,000 deductible and a $5,000 estimated claims cost ($7,000 total health care costs), and health care costs are expected to increase $700 or 10%, that is added to the estimated claims cost of $5,000 for a 14% increase in claims cost. We note that for 2014-2018 the individual market premiums are increasing faster than claims, while this is not true for the group markets in North Dakota. We do not have the information to determine the difference between the premium and claims changes in these specific cases.

The charts below compare the average lowest cost ACA on-exchange premiums for a 40-year old by metal tier for North Dakota compared to the United States overall from 2015 to 2018 for the individual and small group markets.[32,33,34] Please note that these are minimum premiums which are provided for comparison purposes. Large group premiums and premium rates for transitional and grandfathered business are not available.

Individual Market



[32] Healthcare.gov. https://data.healthcare.gov/. Accessed Oct. 16, 2019.
[33] Healthcare.gov does not provide data earlier than 2015.
[34] North Dakota did not offer any on exchange platinum plans in the individual market.

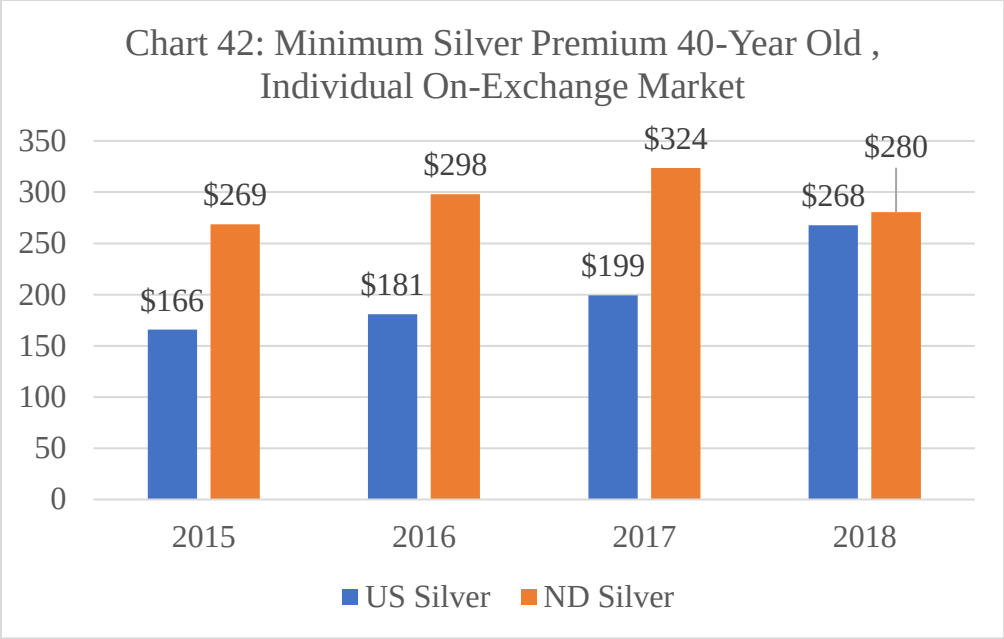


Chart 42: Minimum Silver Premium 40-Year Old , Individual On-Exchange Market
350
300
250
200
150
100
50
0
$166
$269
$181
$298
$199
$324
$268
$280
2015
2016
2017
2018
US Silver
ND Silver

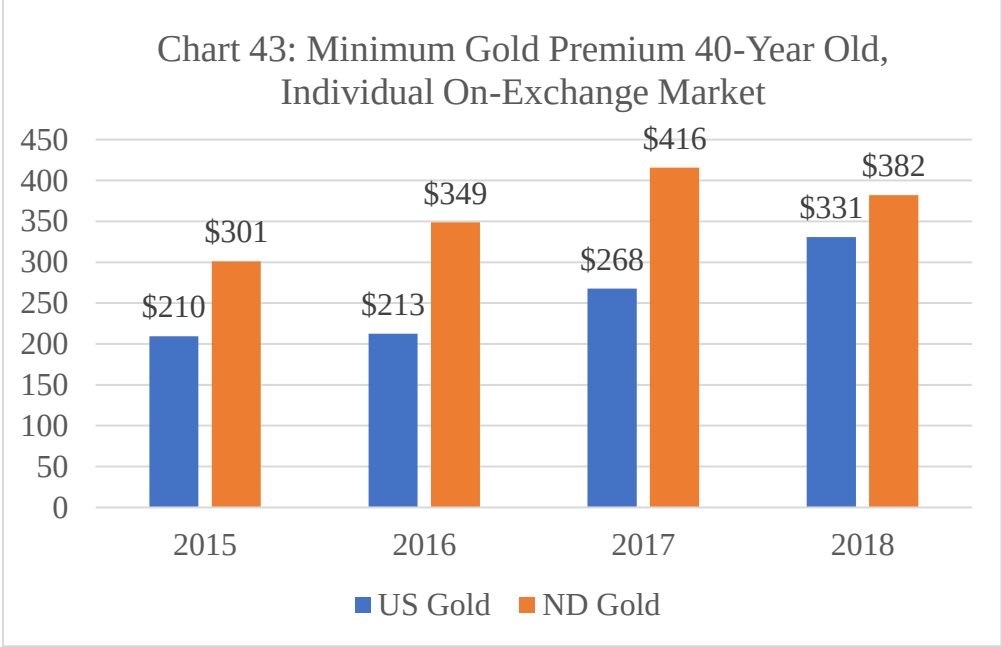


Chart 43: Minimum Gold Premium 40-Year Old, Individual On-Exchange Market
450
400
350
300
250
200
150
100
50
0
$210
$301
$213
$349
$268
$416
$331
$382
2015
2016
2017
2018
US Gold
ND Gold

Small Group

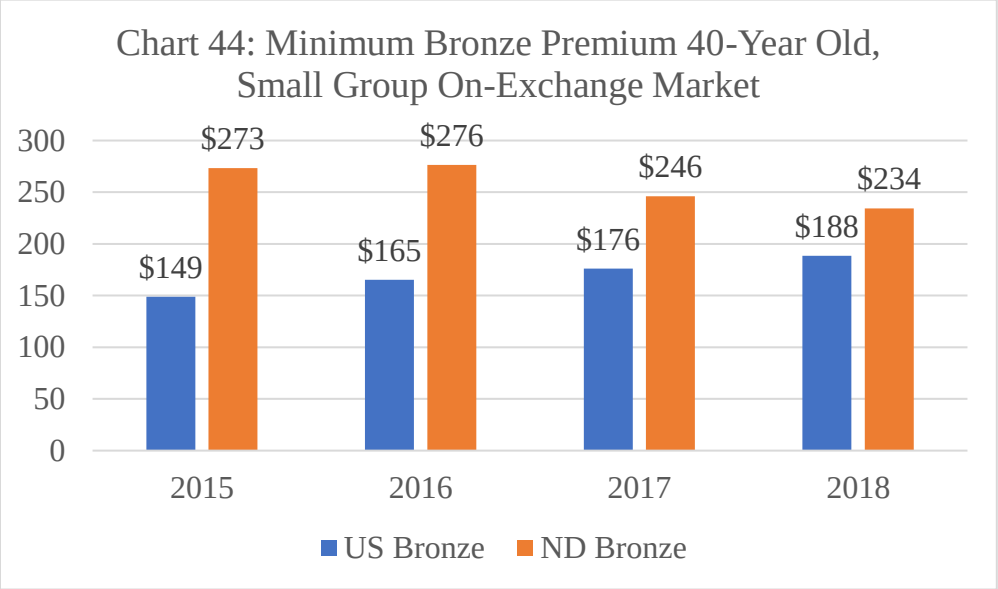


Chart 44: Minimum Bronze Premium 40-Year Old, Small Group On-Exchange Market
300
250
200
150
100
50
0
$149
$273
$165
$276
$176
$246
$188
$234
2015
2016
2017
2018
US Bronze
ND Bronze

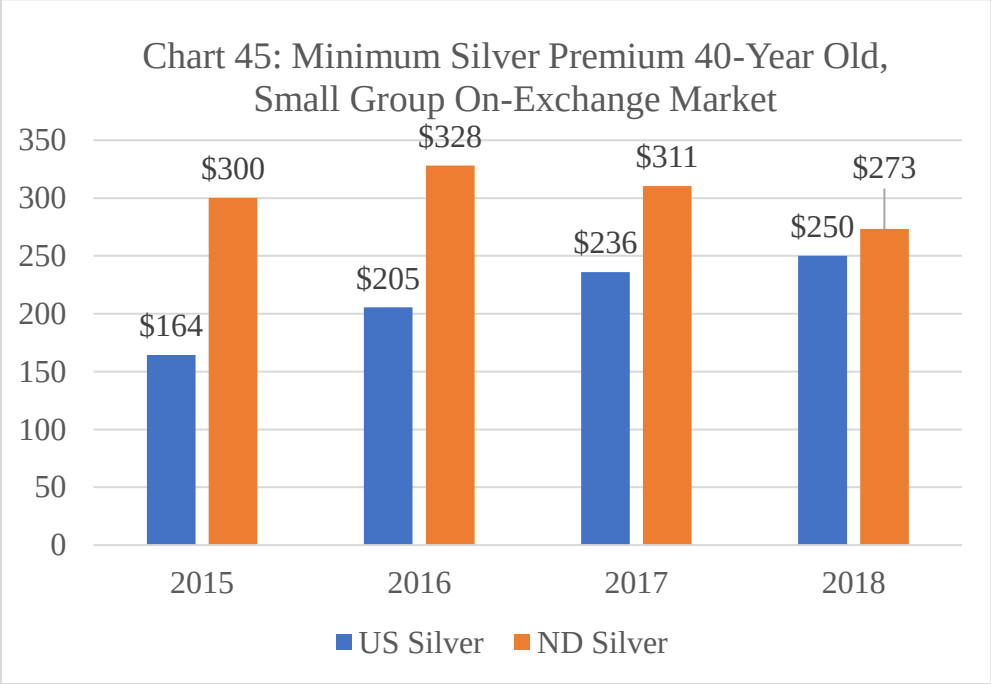


Chart 45: Minimum Silver Premium 40-Year Old, Small Group On-Exchange Market
350
300
250
200
150
100
50
0
$164
$300
$205
$328
$236
$311
$250
$273
2015
2016
2017
2018
US Silver
ND Silver

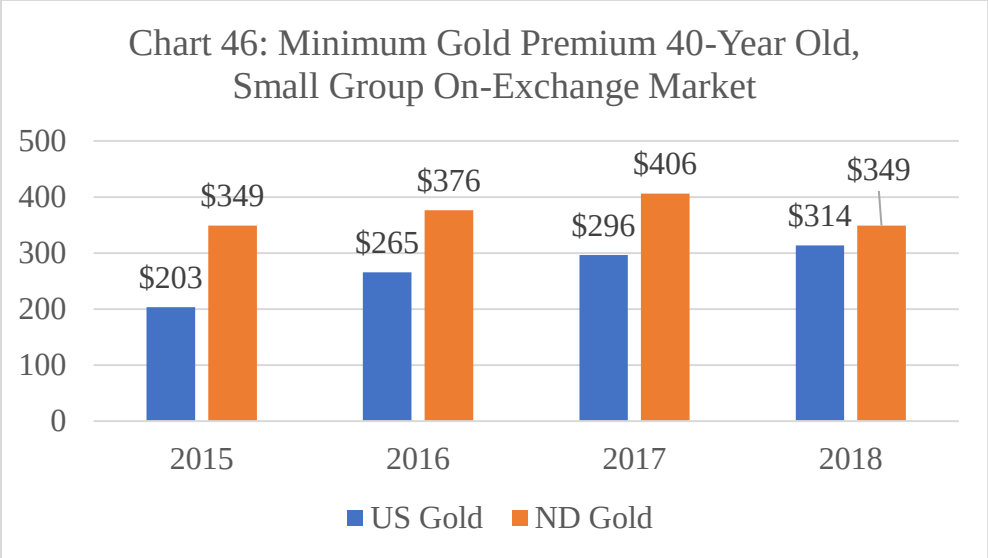


Chart 46: Minimum Gold Premium 40-Year Old, Small Group On-Exchange Market
500
400
300
200
100
0
$203
$349
$265
$376
$296
$406
$314
$349
2015
2016
2017
2018
US Gold
ND Gold

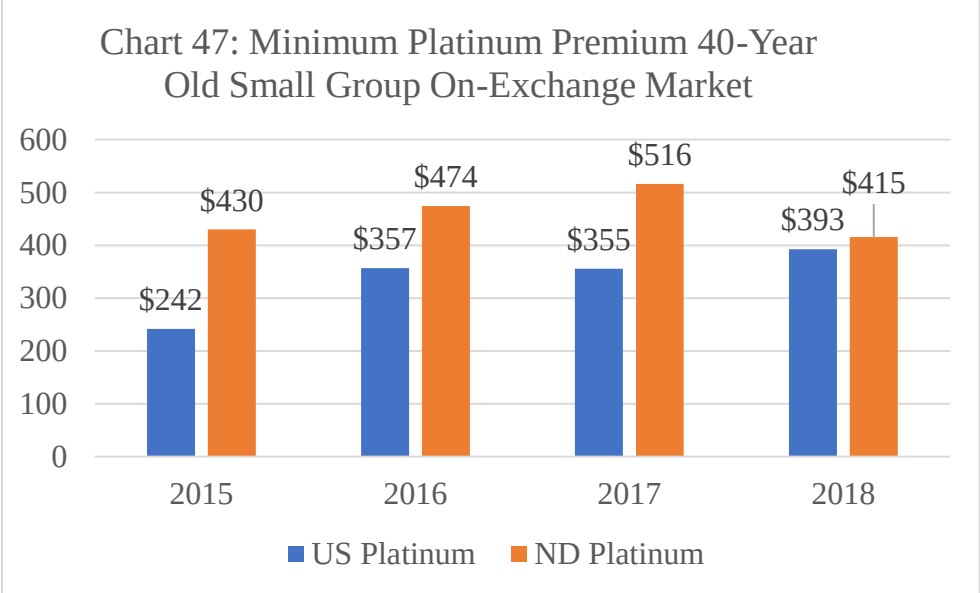


Chart 47: Minimum Platinum Premium 40-Year Old Small Group On-Exchange Market
600
500
400
300
200
100
0
$242
$430
$357
$474
$355
$516
$393
$415
2015
2016
2017
2018
US Platinum
ND Platinum

Drivers of Higher Costs and Cost Reductions

We asked insurers to provide a list of their top 10 drivers of higher and lower health insurance costs. For comparability, we asked them to categorize these drivers into uniform higher-level drivers that we provided.

Overall, insurers reported a $112.7 million rise in health care costs from the top five increase drivers and $96.8 million reduction in the top five decrease drivers. The top five increase drivers accounted for 99% of the increases. The top five decrease drivers accounted for 96% of the decreases. We interpret this to imply that the increases and decreases are largely driven by major factors.

The top five drivers of health care cost increases reported for 2018 are prescription drug, physician, inpatient hospital, outpatient hospital, and population change. The top five drivers that have decreased costs are population change, physician, inpatient hospital, outpatient hospital, and mental health/chemical dependency (MH/CD). Services can be on both lists because some aspects of a cost or service are increasing, and some are decreasing. For instance, the physician category includes services that are increasing and decreasing the cost of healthcare, which causes insurers to report physician as an increasing and decreasing cost driver, although the increase outweighs the decrease. Additionally, some insurers may consider Physician an increase factor while others may consider it a decrease factor, which would also cause it to be on both lists.

The following is a ranking of the health care services that are driving increases and decreases in health insurance premiums, as reported by insurers in North Dakota after consolidation and redefinition.

Increases:

Table 13		
Company Reported Service (Standardized Category)	**Increases**	**% of Total Listed Increases**
Prescription Drug	$25,920,779	22.8%
Physician	$24,407,000	21.4%
Inpatient Hospital	$23,813,000	20.9%
Outpatient Hospital	$19,783,000	17.4%
Population Change	$18,771,722	16.5%
Deductible Leveraging	$669,799	0.6%
Preventive	$301,000	0.3%
Diagnostic Imaging	$152,000	0.1%
Skilled Nursing Facility	$101,000	0.1%

Decreases:

Table 14		
Company Reported Service (Standardized Category)	**Decreases**	**% of Total Listed Decreases**
Population Change	(81,664,000)	80.6%
Physician	(5,569,000)	5.5%
Inpatient Hospital	(4,466,465)	4.4%
Outpatient Hospital	(2,953,661)	2.9%
MH/CD	(2,133,000)	2.1%
Professional	(1,834,481)	1.8%
Benefit Changes	(1,134,698)	1.1%
Laboratory	(469,000)	0.5%
Other	(410,000)	0.4%
X-ray	(391,000)	0.4%
Diagnostic Imaging	(162,000)	0.2%
Deductible Leveraging	(133,000)	0.1%

Increase and Decrease Netted by Service:

Table 15				
Company Reported Service (Standardized Category)	**Decreases**	**Increases**	**Net Change**	**% of Total Net Change**
Prescription Drug		$25,920,779	$25,920,779	205.7%
Inpatient Hospital	($4,466,465)	$23,813,000	$19,346,535	153.6%
Physician	($5,569,000)	$24,407,000	$18,838,000	149.5%
Outpatient Hospital	($2,953,661)	$19,783,000	$16,829,339	133.6%
Deductible Leveraging	($133,000)	$669,799	$536,799	4.3%
Preventive		$301,000	$301,000	2.4%
Skilled Nursing Facility		$101,000	$101,000	0.8%
Diagnostic Imaging	($162,000)	$152,000	($10,000)	-0.1%
X-ray	($391,000)		($391,000)	-3.1%
Other	($410,000)		($410,000)	-3.3%
Laboratory	($469,000)		($469,000)	-3.7%
Benefit Changes	($1,134,698)		($1,134,698)	-9.0%
Professional	($1,834,481)		($1,834,481)	-14.6%
MH/CD	($2,133,000)		($2,133,000)	-16.9%
Population Change	($81,664,000)	$18,771,722	($62,892,278)	-499.2%
Net Listed Changes	**($101,320,305)**	**$113,919,299**	**$12,598,994**	**100%**