



North Dakota Legislative Management Interim Healthcare Study

Executive Summary



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



North Dakota
Insurance Department
Jon Godfread, Commissioner

Jan. 8, 2021

Legislative Leaders, Stakeholders and North Dakotans:

During the 66th Legislative Session the North Dakota Insurance Department was tasked with assisting Legislative Management in conducting an interim study of health insurance premium trends. The study is unique because the legislature foresaw the need to look beyond insurance carriers and authorized the collection of data from the state's hospitals.

To conduct this study the Insurance Department contracted JWHammer, LLC for project management services, and Horizon Government Affairs for actuarial services. JWHammer and Horizon both have experience in the insurance and healthcare fields.

The following study was done in cooperation with a great number of stakeholders, including both hospitals and insurers. I want to personally thank them for their willingness to be open and transparent throughout the process. As with any study, different conclusions may be drawn from the data presented. However, those conclusions are best left to the policy making branch of our government, this study should serve as an opportunity to guide a discussion on health care delivery and health care insurance coverage in our great state.

The report is an account of driving factors in the expense of healthcare and how that may impact the premiums consumers pay. The data, analysis, and recommendations will be vital as the state policy makers consider policies aimed at ensuring that North Dakotans are receiving quality healthcare at a fair and reasonable price.

I am proud of the work that was completed, the accuracy of the data, and the in-depth policy options provided. This is just the beginning of the discussion and I look forward to continuing to work together with the stakeholders of this report as well as legislative leaders to benefit all North Dakotans.

Sincerely,

A handwritten signature in black ink, appearing to read "JGdhe".

Jon Godfread
Insurance Commissioner

Final Report January 2021
ND Legislative Management Interim Healthcare Study
January 8, 2021

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Background

In October 2019, the North Dakota Insurance Department (NDID) engaged JWHammer, LLC and consultant Horizon Government Affairs (HGA) to develop a multi-pronged study of North Dakota's health costs, including data gathering and analysis, baseline current-policy projections for the next several years, development of policy alternatives, and cost estimates of alternative policies relative to baseline.

This final report updates our September 2020 interim final report.¹ The main updates are new data for 2019 on North Dakota and 50-state insurance markets from the National Association of Insurance Commissioners (NAIC), and some new data on North Dakota hospitals in 2019 from the Medicare Cost Report system.

Covid-19 has had an extreme impact on the U.S. health care system and in North Dakota. As we reported in September, North Dakota's health costs dipped in April 2020, but rebounded by June, as more normal care patterns re-emerged and deferred care was delivered. By September, we estimate that monthly claims costs rose to considerably above their prior-year levels as Covid cases surged in North Dakota. As of mid-December 2020, North Dakota had recorded over 1,000 deaths directly attributed to Covid-19,² and the CDC estimated that all-cause deaths in North Dakota during the pandemic were 10 percent higher than expected.³ Due to the pandemic, we did not attempt to formally gather additional data from hospitals and in-state insurers in late 2020.

In this report, we use the terms "discharges" and "admissions" synonymously. Likewise, "Covid-19" and "Covid." Years may be marked as calendar years or hospital cost report years. Calendar years are used for most hospital-to-hospital comparisons; Medicare Cost Report years are used for most of the broader state-to-state comparisons. Insurance comparisons are in calendar years.

¹<https://www.insurance.nd.gov/sites/www/files/documents/Communications/Reports/20200910%20North%20Dakota%20Legislative%20Management%20Interim%20Health%20Care%20Study.pdf>

² <https://www.health.nd.gov/diseases-conditions/coronavirus/north-dakota-coronavirus-cases> (accessed December 18, 2020).

³ <https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm> (accessed December 18, 2020).

We view this report as a living document. Ongoing comments and feedback from state officials and stakeholders, particularly for the data comparisons, policy alternatives, and preliminary cost estimates are appreciated.

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Executive Summary

Health Costs in North Dakota

In October 2019, the North Dakota Insurance Department (NDID) engaged JWHammer, LLC and consultant Horizon Government Affairs (HGA) to develop a multi-pronged study of North Dakota's health costs, including comparisons with all 50 states, development of policy alternatives, and cost estimates of alternative policies. We have focused mainly on hospital and insurance costs – those most closely monitored by North Dakota state agencies – and on policy alternatives the state could implement using in-state revenues. This final report updates our interim report from September 2020. Major changes include updated NAIC data for insurers' costs in all 50 states and updated 2019 data from the Medicare cost reports for North Dakota hospitals.

Hospital Costs. We gathered data on hospitals' overall costs and revenues in all the states from the Medicare cost reports. The data in these cost reports is not audited, so we compared it with data provided directly to us from the largest nine hospitals in North Dakota. In general, we found that the data for 2010-2018⁴ matched well, giving us confidence that the Medicare cost report data was a good source for 50-state comparisons.

On a per-capita basis, hospital expenses in North Dakota were highest in the nation in 2018, and their growth rate of about 8% per year since 2010 was among the fastest in the U.S. (see Summary Figure 1 and Summary Table 2). That 8% growth was comprised of a 1.5% growth in utilization (inpatient days, outpatient visits etc.) and about 6.5% growth in unit costs between 2010 and 2019 (see Summary Table 1). The hospitals' largest expense is wages and benefits. We estimate that among the 9 largest hospitals in North Dakota, aggregate wages and benefits grew by about 7% annually between 2010 and 2019. This growth, in turn, was comprised of employment growth of about 3% annually, and wage and benefit growth per employee of about 4%. North Dakota's average wage per full-time equivalent employee (FTE) was about \$88,000 in 2019, and wages grew rapidly between 2010 and 2019 (see Summary Figure 2).

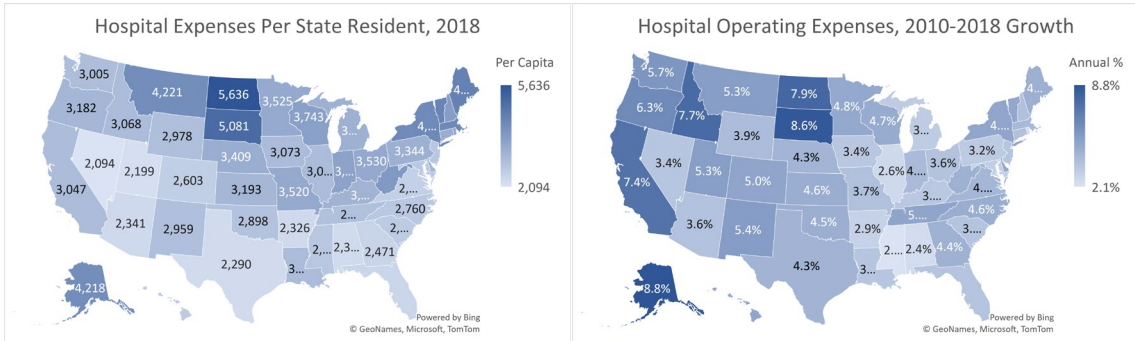
As Summary Table 1 shows, hospital expense growth was not uniform across North Dakota's hospitals. In particular, expense growth was higher-than-average at Sanford Health's Bismarck and Fargo hospitals. At the committee hearing that discussed the interim version of this report⁵, Sanford noted that their Fargo hospital had been certified as the state's first Level 1 trauma center during this period of rapid expenditure growth. However, the contrast between North Dakota's hospital costs and those of other states cannot be fully explained by service upgrades. For example, Minnesota's per-capita hospital costs were one-third less than North Dakota's in 2018, yet the state has 5 Level 1 trauma facilities.⁶

⁴ For reasons of completeness of data, comparisons in this report start in 2010 or 2011, and end in 2018 or 2019.

⁵ <http://video.legis.nd.gov/en/PowerBrowser/PowerBrowserV2/20200910/-1/18285>.

⁶ <https://www.health.state.mn.us/facilities/traumasystem/designatedhospitals.html>. In the 2010-2019 period, North Dakota and Minnesota had similar results for Medicare's Case Mix Index – an indication of the complexity of cases among Medicare patients – with each state's results ranging from about 1.5 to 1.8 during the period. A fuller state-by-state and hospital-to-hospital comparison of indicators of patient outcomes, mortality and adverse event rates, readmissions, and other quality measures, for all patients (not just Medicare enrollees), is beyond the scope of this report.

Summary Figure 1.



Source: Horizon Government Affairs based on data from CMS.

Summary Table 1.

Participating North Dakota Hospitals

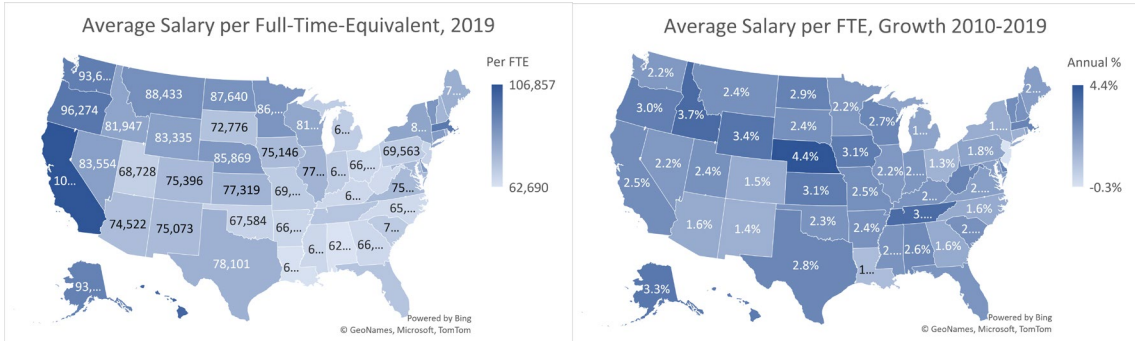
Average Annual Growth in Expenses Per Unit of Use, 2010-2019

	Expense Utilization		Unit Costs
	Growth	Growth	Expenses/Use
Six Large Acute Care Hospitals			
St Alexius	4.0%	-1.0%	5.0%
Sanford Bismarck	8.9%	4.4%	4.3%
Essentia	5.1%	0.8%	4.3%
Sanford Fargo	14.0%	2.4%	11.3%
Altru	6.0%	1.4%	4.5%
Trinity	3.1%	-1.0%	4.1%
Large Hospitals Weighted Average	8.0%	1.5%	6.5%
Three Critical Access Hospitals	7.4%	0.2%	7.2%
All 9 Hospitals Weighted Average	8.0%	1.4%	6.5%

Source: Horizon Government Affairs.

Note: Weighting is a custom blend of inpatient and outpatient utilization by HGA.

Summary Figure 2.



Source: Horizon Government Affairs based on data from CMS.

Summary Table 2.

North Dakota Hospital Rankings vs. Other States, 2010-2019*	Rank (highest to lowest)	
	Level	Growth
Inpatient Discharges		19
Inpatient Days		5
Inpatient Days per 1,000 People	4	18
Average Length of Stay	3	5
Occupancy Rate	37	24
Beds Per Person	5	16
Operating Expenses		3
Operating Expenses per Person	1	4
Operating Revenues		4
Operating Revenues per Person	2	4
Average Salaries per FTE	8	9
Inpatient Revenue per Discharge	6	2
Commercial to Medicare Rate Ratio	7	5
Medicare Case Mix Index	35	32
Medicare Revenues per Enrollee	2	2
Medicare Inpatient Revenues		6
Medicare Inpatient Revenue per Discharge +	33	6
Medicare Outpatient Revenues		4
Medicare Outpatient Revenues per Enrollee	1	3
Medicaid Revenues		3
Medicaid Inpatient Discharges		7
Medicaid Inpatient Days		7
Medicaid Revenues per Enrollee	1	1
Private Patient Revenues per Private Insurance Enrollee	3	10
Patient Financial Assistance	35	3

Source. HGA based on data from the Medicare Hospital Cost Reports.

Level Rankings are based on 2018 or 2019, and Growth Rankings are based on 2010 or 2011 to 2018 or 2019, depending on data availability.

Insurance Costs. Individual market premiums jumped by about 15 percent in 2018, and HGA estimates they rose by another 10 percent in 2019. However, premiums fell in 2020 by about 9 percent due to the establishment of North Dakota’s reinsurance program. Premiums in the small group and large group markets have been a bit more stable, growing by roughly 4-6 percent per year on average in recent years (see Summary Table 3).

Despite higher-than-average hospital costs, North Dakota’s premium levels compare favorably with those of other states. For example, Summary Figure 3 shows premiums for the individual market on a per-member-per-month basis and as an average annual growth rate from 2014 through 2019, the period in which the ACA benefit mandates were in force. Summary Table 4 shows North Dakota’s rank among the 50 states on measures of premiums, benefit costs, and administrative costs for the individual, small group, and large group markets.

There are several possible explanations for North Dakota’s lower-than-average premium costs. First, North Dakota’s prescription drug claims have been moderate (see Summary Figure 4). Second, the state’s insurers have had lower-than-average administrative costs (see Summary Figure 5), although those costs in North Dakota rose rapidly in the 2014-2019 period.⁷ Third, North Dakota’s individual market demographics are more favorable than most other states. A CMS study of enrollment in 2017 pegged North Dakota’s enrollment of children under age 18 (who collectively tend to have lower claims costs than older enrollees) at 60% higher than the national average, while enrollment of people aged 35-64 (usually higher cost) was 12 percent less than the average nationally.⁸ Finally, we suspect that North Dakota’s health plans have relatively high average deductibles compared with other states. In the individual market, we estimate that deductibles currently average more than \$4,000.

Summary Table 3.

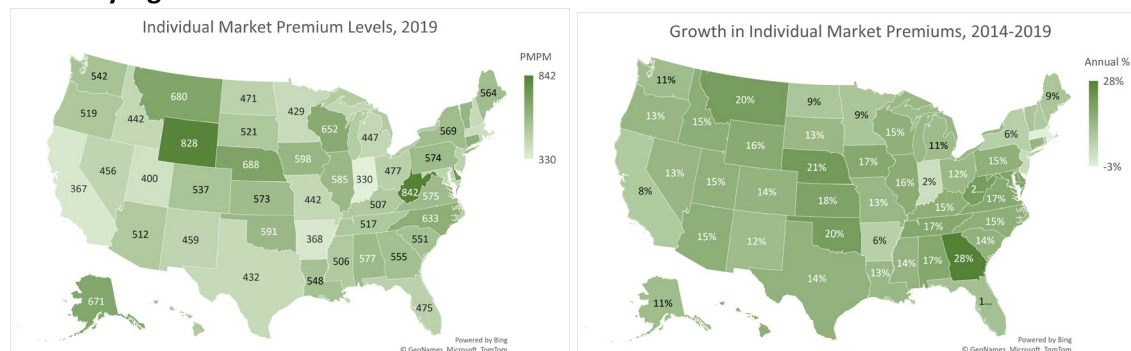
North Dakota Insurance Coverage and Premiums

	2014	2015	2016	2017	2018	2019e	2020e
Individual Market							
Covered Lives	48,356	53,234	51,183	48,968	45,294	43,747	41,547
Premiums (per member per month)	326	369	404	407	467	512	468
Growth		13%	9%	1%	15%	10%	-9%
Small Group Market							
Covered Lives	64,497	64,424	62,179	60,381	60,028	61,351	59,314
Premiums (per member per month)	369	401	397	422	447	467	498
Growth		8%	-1%	6%	6%	4%	7%
Large Group Market							
Covered Lives	160,820	149,872	151,322	149,111	154,872	156,685	152,178
Premiums (per member per month)	367	388	402	419	440	451	487
Growth		6%	3%	4%	5%	3%	8%

Sources: Large and Small Group market from NAIC. Individual market by HGA based on data from the NAIC, NDID/Novarest, and CMS. Estimates for 2019 and 2020 by HGA.

Note: Large group market does not include coverage by self-funded firms.

Summary Figure 3.

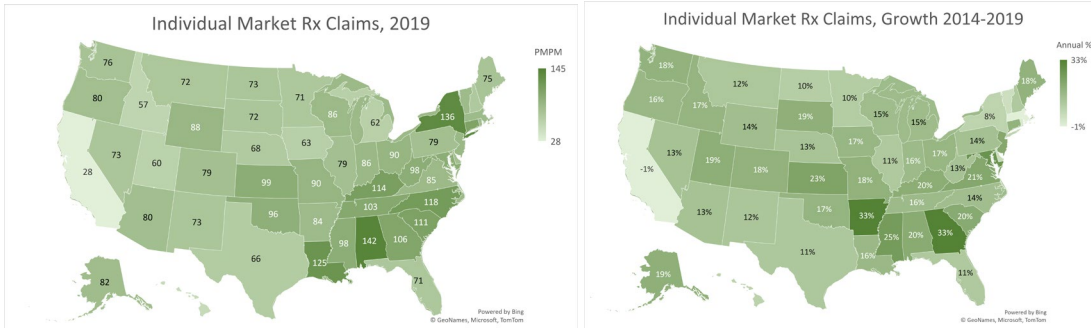


Source: HGA based on data from the NAIC.

⁷ At the legislative committee hearing, BCBSND noted a substantial IT upgrade during this period.

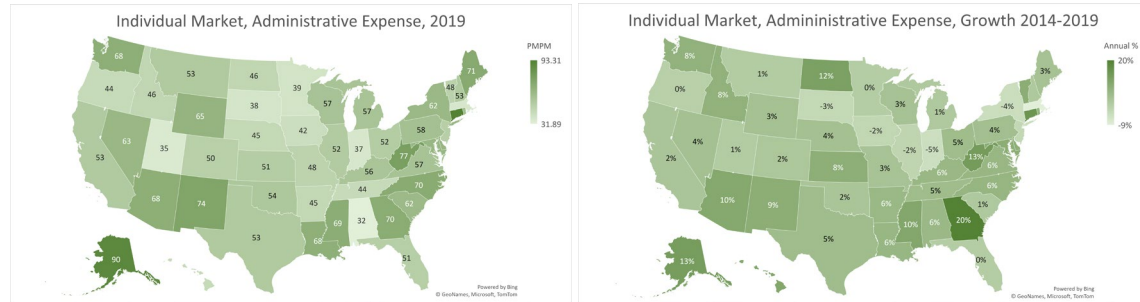
⁸ CMS 2017 Marketplace Open Enrollment Period Public Use File.

Summary Figure 4.



Source: HGA based on data from the NAIC.

Summary Figure 5.



Source: HGA based on data from the NAIC.

Summary Table 4.

Insurance Measures Compared	North Dakota Rank (highest to lowest)	
	Level	Growth
Individual Market Premiums (PMPM)	35	43
Individual Market Claims	26	38
Individual Market Admin. Costs	38	5
Small Group Market Premiums	30	22
Small Group Market Claims	27	25
Small Group Market Admin. Costs	24	1
Large Group Market Premiums	18	12
Large Group Market Claims	16	13
Large Group Market Admin. Costs	41	3

Source: HGA based on data from the Medicare Hospital Cost Reports.

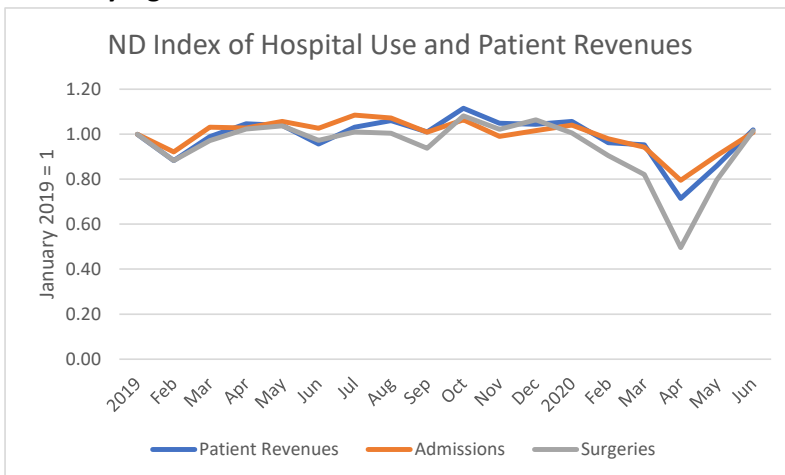
Note: Level Rankings are based 2019, and Growth Rankings are based on 2014 to 2019.

Covid-19 and Baseline Projections

The impact of Covid-19 on the medical community and insurance costs have defied predictions. For some medical providers, it initially led to an unprecedented drop in demand for medical services, despite the pandemic. For insurers in some states, this drop in demand has led to a significant drop in claims.⁹ Early reports indicated that treatment of heart attacks and strokes fell considerably at the onset of the pandemic – likely a reflection of individuals forgoing needed care.¹⁰ By late 2020, however, both providers and insurers were facing sizable pent-up demand, as well as a surging pandemic, which led to increasing utilization and costs.

Our initial post-Covid surveys of North Dakota hospitals and insurance companies showed that while health care claims and utilization fell in April 2020, they had resumed their prior levels by June (see Summary Figure 6). The dip and recovery pattern was also evident in our surveys of North Dakota insurers, with cumulative claims per-member per-month in 2020 only slightly above levels for the same months by Summer of 2019.

Summary Figure 6.



Sources: US: Bureau of Economic Analysis; ND: Horizon Government Affairs.

Note: ND index of patient revenues does not include federal emergency funding or other non-patient revenues.

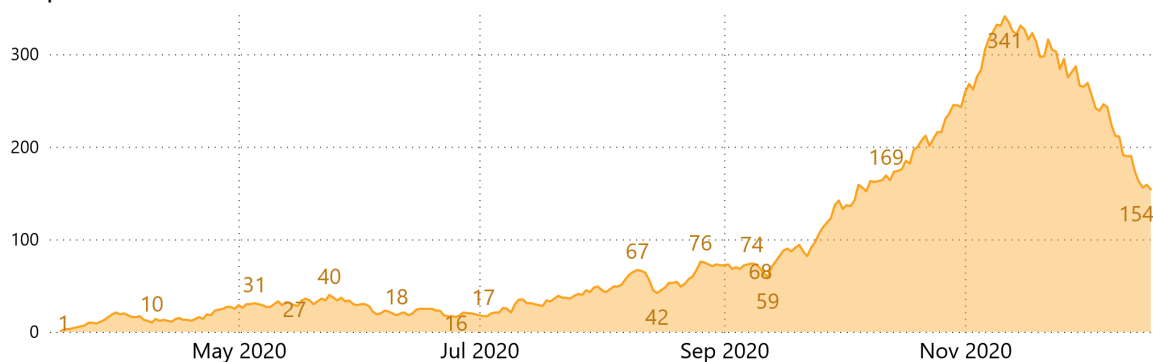
However, by August and September 2020, North Dakota’s Covid-19 case counts started increasing rapidly and by October and November, hospitalization rates jumped to among the highest in the nation (see Summary Figure 7). Hospitalization rates were declining as of late December, but we believe that by September through November, insurers’ claims costs were running nearly 10 percent above costs for those months in 2019.

⁹ <https://www.houstonchronicle.com/business/article/Insurer-Anthem-s-2Q-profit-swells-helped-by-drop-15442284.php>

¹⁰ <https://medicalxpress.com/news/2020-07-decline-emergent-hospitalizations-early-phase.html>

Summary Figure 7.

Hospitalizations for Covid-19 in North Dakota



Source: North Dakota Covid Dashboard (accessed December 19, 2020) <https://www.health.nd.gov/diseases-conditions/coronavirus/north-dakota-coronavirus-cases> .

During the initial Covid recession in the 2nd quarter of 2020, North Dakota lost about 8 percent of its payroll jobs (non-farm). The state’s unemployment rate peaked at 9 percent in May, before falling to 6 percent by June and further to 4.5 percent in November.¹¹ Our surveys noted a corresponding decline in private insurance coverage mid-2020, which we reflected in our baseline projections.

Anecdotal indications from insurers show continuing reductions in private insurance coverage through November. The combination of accelerating numbers of Covid cases and the withdrawal of some federal economic relief in August led to a 5 percent decline in personal income in the state in the third quarter of 2020, which likely put further pressure on employers and individuals trying to maintain coverage.¹² Our baseline projections reflect the assumption that the state’s economic outlook will remain weak heading into early 2021.

Preliminary Baseline Projections. Cost estimates of policy alternatives begin with a “baseline” projection of costs absent any policy change. Importantly, baseline projections aren’t necessarily intended to be predictions of the future. Instead, they are used as a neutral benchmark against which the impact of policy alternatives can be assessed. In general, we project that rates of growth in both North Dakota’s economy and its health sector will be quite subdued for an extended period.

Summary Table 5 shows our projections of enrollment by primary insurance type. Comparing post-Covid 2020 and beyond with pre-Covid 2019, we are assuming a small decline in individual coverage, some continued erosion of group coverage, particularly in the small group and large group non-ERISA markets, expansions of Medicare and Medicaid coverage, and an uptick in the number of uninsured.

¹¹ Bureau of Labor Statistics (<https://www.bls.gov/web/laus/laumstrk.htm>, accessed December 19, 2020).

¹² Bureau of Economic Analysis (<https://www.bea.gov/data/income-saving/personal-income-by-state> (accessed December 18, 2020). The 5 percent decline is based on a reported 20.6 percent decline in the third quarter expressed as an annual rate (approximately 4 times the on-the-ground quarterly decline).

Relative to the interim final report, the adjustments to the coverage model in this final report are relatively minor. We updated large and small group coverage levels from the 2019 NAIC Supplemental Health Care Exhibit, which became available in November. We also updated some data for Medicaid and Medicare coverage for 2019 based on new compilations from the Kaiser Family Foundation, which are, in turn, based on new data from the U.S. Census Annual Community Survey (annual data).

Summary Table 5.

Baseline Enrollment Model

Primary Coverage for Acute Care	2019	2020	2021	2022	2023	2024	Change 2019-2024
	Number of Covered Lives						
Individual Market	43,747	41,547	41,538	41,581	41,673	41,810	-1,937
Small Group Employer	61,351	59,314	58,531	57,173	55,846	54,550	-6,801
Large Group Employer	156,685	152,178	152,365	152,553	153,504	154,461	-2,224
Large Group ERISA	201,187	197,551	195,957	196,335	196,713	197,093	-4,094
Medicaid	73,767	75,170	76,599	78,056	79,540	81,053	7,286
Medicare	114,549	116,803	119,102	121,447	123,837	126,274	11,726
Military and Other	29,745	28,932	28,164	27,439	26,754	26,106	-3,639
Uninsured	<u>49,969</u>	<u>60,915</u>	<u>61,565</u>	<u>60,654</u>	<u>58,788</u>	<u>56,728</u>	<u>6,759</u>
Total Population	731,000	732,410	733,822	735,237	736,655	738,076	7,076

Source: Horizon Government Affairs.

Summary Table 6 illustrates the basic contours of HGA’s baseline assumptions about growth in the state’s health costs. We assume hospital utilization continues to grow very slowly in the 2020-2024 period, while unit costs (costs per unit of utilization) rise by about 5 percent annually. We estimate that prescription drug costs (net of manufacturer rebates) will also continue growing relatively slowly, at about 4 percent per year on average. Compared with the interim report, we have made only one small modification to projections of claims and premium costs on a per-member per-month (PMPM) basis for this final report: a small reduction in the growth of costs in the small group market in 2021, which is based on the recent announcement by NDID of approved rates in that market.¹³

Summary Table 6.

Baseline Insurance Projections

	2019	2020	2021	2022	2023	2024
	Premiums PMPM					
Individual Market	512	468	481	511	543	577
Small Group Employer	467	498	506	529	559	591
Large Group Employer	451	487	511	538	565	594
	Annual Growth					
Individual Market		-8.7%	2.8%	6.3%	6.2%	6.2%
Small Group Employer		6.6%	1.6%	4.6%	5.6%	5.6%
Large Group Employer		7.9%	5.1%	5.1%	5.1%	5.1%
Memorandum:						
Growth of Hospital Unit Costs \1	4.0%	4.1%	4.5%	5.0%	5.0%	5.0%
Growth of Rx Claims (net of rebates)	3.9%	4.0%	4.2%	4.8%	5.4%	5.4%
Average Deductible (Individual Market)	\$4,000	\$4,500	\$4,800	\$5,100	\$5,400	\$5,700

Source: Horizon Government Affairs.

Notes: PMPM = per member per month; large group employer does not include self-funded (ERISA) plans.

\1 Overall hospital expenses per HGA composite index of utilization (admissions, outpatient visits etc.)

¹³ <https://www.insurance.nd.gov/news/godfread-announces-approved-2021-health-insurance-rates>.

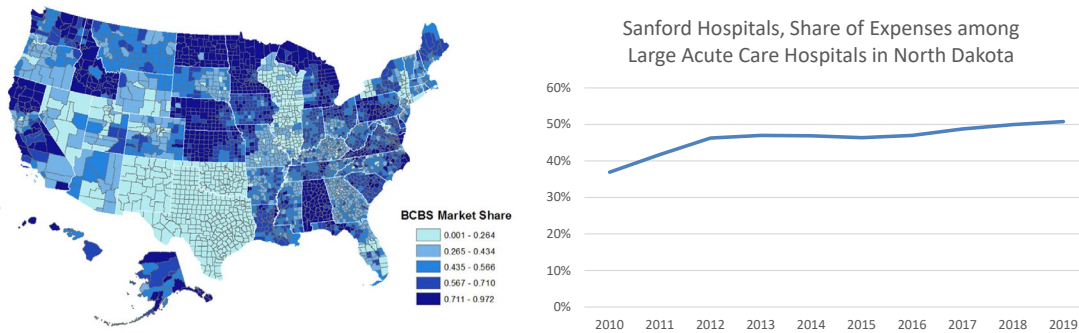
Competition and Markets. Although several insurers serve the North Dakota market, the dominant presence is Blue Cross Blue Shield of North Dakota, particularly in the individual market. Two metro areas (Bismarck and Fargo) host two hospitals; other cities and towns in North Dakota have at most one. Sanford Health Group owns the state’s two fastest-growing hospitals, accounting for more than 50 percent share of the state’s hospital expenses among large acute care facilities (see Summary Figure 8).

From an outsider’s perspective at least, there are some areas of concern in North Dakota’s health markets. Sanford hospital group is operating under a Corporate Integrity Agreement with the federal Department of Health and Human Services Office of Inspector General, resulting from whistleblower claims of unnecessary surgeries and self-dealing.¹⁴ BCBS was recently fined following a market conduct exam, based on findings of improper payments for telehealth, mental health, and other services.¹⁵

North Dakota has few managed care plans and limited use of value-based payment methods, population health efforts or care coordination programs. Based on our pre-Covid interviews, the state’s health system was characterized as a fee-for-service reimbursement regime, with providers competing to offer lucrative elective surgeries and insurers concentrating on holding down reimbursement rates across the board, with little regard for value of specific providers or patient outcomes from various care patterns.

Summary Figure 8.

Estimated Blue Cross Blue Shield and Sanford Group Market Share



Sources Horizon Government Affairs. BCBS data from Cooper et al. “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured” *The Quarterly Journal of Economics* (2019), 51–107. doi:10.1093/qje/qjy020 (Oxford University Press), Supplemental Appendices, page 81. Data from HealthLeaders Interstudy and U.S. Census.

¹⁴ See <https://www.justice.gov/opa/pr/sanford-health-entities-pay-2025-million-settle-false-claims-act-allegations-regarding> and https://oig.hhs.gov/fraud/cia/agreements/Sanford_Health_Sanford_Clinic_and_Sanford_Medical_Center_10252019.pdf (PDF).

¹⁵ See <https://www.insurance.nd.gov/news/insurance-commissioner-fines-blue-cross-blue-shield-north-dakota-125000-result-market-conduct> and <https://www.nd.gov/ndins/sites/www/files/documents/Enforcement/Market%20Conduct%20Exams/2018-19%20BCBSND%20Exam%20Report%20-%20Signed%20-%20FINAL.pdf>.

Certainly, North Dakota is not unique in this regard. On a nationwide basis, the pandemic has exposed problems with existing markets for health care delivery and financing. In general, we assume that competitive markets produce efficient and desirable outcomes. In theory, and in practice in most industries, competitive market outcomes provide choices and value. However, it's not clear that North Dakota has benefited to the fullest extent from competitive efficiencies and innovations.

A key question for North Dakota is: Are competitive markets in health care possible? If so, can we strengthen them? If not, can the state work with health care providers and insurers to approximate competitive-style outcomes under a more collaborative system? What degree of public transparency and/or cooperation could lead to more dynamic outcomes without falling into the trap of over-regulation?

Early on in this project, we interviewed representatives from a coalition of hospitals attempting to develop a plan to convert North Dakota's health system from an old-fashioned fee-for-service and hospital dominated approach to better population health and care management.

We believe that the Covid-19 emergency has the potential to spark a more serious discussion of how North Dakota could re-wire its existing health system, while also maintaining and encouraging new competition. Hospitals accustomed to competing for lucrative patients or physicians may need to refocus their efforts on population health and monitoring, using common data. The state's dominant insurer may need to develop population-health and outcomes-based global reimbursement systems rather than simply paying under the same fee-for-service regime year after year. The idea of getting more competitive results, either through additional competition, better directed competition, or public-private cooperation and transparency runs through the policy alternatives discussed below.

Policy Alternatives

As part of our charge, we propose a variety of policy alternatives. Ultimately these policy alternatives reflect value judgements that must be made by North Dakotans and not by outside consultants. Not all of these policy alternatives will work for North Dakota. Some may even contradict one another. We have provided, what we hope, is sufficient information for the North Dakota Legislature, Insurance Commissioner, and Governor to make informed decisions on a path forward to lowering health insurance premiums, lowering health care costs, and providing better population health for North Dakotans.

Important disclosures – Horizon Government Affairs represents clients and coalition members who provide real-time benefit and pricing information for prescription drugs and who provide telehealth services; expansion of both services is recommended below. JWHammer LLC has clients that could potentially offer services to North Dakota under these recommendations. Additional disclosures are listed in the footnote.¹⁶

¹⁶ Horizon Government Affairs (HGA) is a Washington, D.C.-based government affairs consulting firm that serves a number of clients in the health care industry and operates a number of coalitions that are similarly focused on health care issues. Horizon is not aware of, nor do we have reason to believe, that any of the recommendations included in this report would substantially benefit any of our clients or coalition members. None of the recommendations

Utilization & Care Management. Medication nonadherence and the related hospital admissions and emergency department visits are a significant driver of health care costs. Aligning the interests of the insurer, consumer and medical provider are key to driving down costs and moving consumers to better health.

1. **Benchmark Plan Revisions - Optimized Medication Plans:** The estimated annual cost of prescription drug-related morbidity and mortality resulting from nonoptimized medication therapy was \$528.4 billion in 2016 US dollars.¹⁷ Creating a medication optimization plan can have great health benefit for patients and save money.
2. **Private Insurance (Group) Mandate - Optimized Medication Plans:** Similar to the Benchmark Plan revisions, huge strides could be made in the group market. Small and large group plans could be required to offer an optimization program.
3. **Integrated Health Homes:** Our health system has become increasingly byzantine in its complexity and a consumer's ability to manage their own health care. The chronically ill face many issues usually including the management of multiple medical issues. Creating an integrated health home can help patients better manage their health conditions.
4. **Medicaid Strict Managed Care/Value-based Benefit Design** The state should encourage the use of value-based design in the state employee health plan and consider providing incentives for adherence. An outside vendor – not a PBM – may be able to assist state workers in managing their prescriptions and helping with adherence.¹⁸
5. **Other Options:**

Limit Medicaid expansion to 100% of poverty. Currently North Dakota has expanded eligibility for Medicaid to 138% of poverty. However, the Affordable Care Act provides subsidies for private insurance to all individuals over 100% of poverty. This option would place people in the 100-138% of poverty range back into ACA subsidized private coverage. Note, the state savings may be limited due to federal matching of 90 percent for Medicaid expansion enrollees in the 100-138% of poverty range.

Re-form Medicaid expansion as an exclusively managed care model. The importance of a medical home is highlighted above, but a number of states have begun using a similar managed care model in Medicaid. The idea is to eliminate

included herein have been generated for the purpose of directly or indirectly benefitting HGA's direct clients or coalition members. Additional information on HGA is available at www.horizoncdc.com. Information on our coalitions, including member organizations are available at the following websites: Council for Affordable Health Coverage (www.cahc.net), Health Innovation Alliance (www.health-innovation.org), Health Benefits Institute (www.thehealthbenefitsinstitute.org). J W Hammer, LLC is a Springfield, IL based law and consulting firm that serves clients in multiple industries and states, including clients that may or may not respond to the state's future requests for proposals that may be the result of this report, including but not limited to Aon and Affinity. It is unclear whether Hammer's clients may or may not substantially benefit from recommendations included herein. None of the recommendations included herein have been generated solely for the purpose of directly or indirectly benefitting Hammer's direct clients. Additional information regarding J W Hammer, LLC is available at www.jwhammerllc.com.

¹⁷ Watanabe JH, Mcinnis T, Hirsch JD. Cost of prescription drug-related morbidity and mortality. *Ann Pharmacother*. 2018;1060028018765159. doi: 10.1177/1060028018765159.

¹⁸ <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf>.

a fee-for-service program in its entirety and require insurers to manage the health of Medicaid recipients. This could streamline state efforts if the state managed a single risk pool rather than two separate pools paying different rates and managed differently.

Prices, Coverage, and Insurance Initiatives. Pricing reforms have the potential to restrain the ever-upward push of commercial rates, improve coverage for telehealth services, and consider an alternative method of providing reinsurance coverage. The rate cap policy is explained in more detail by researchers from RAND, who offer it as a less disruptive alternative to broader rate setting or public option proposals.

6. **Cap on Out-of-Network Payment Rates:** Medicare's payment rates are commonly used as a benchmark for insurers, and rates relative to Medicare have been rising in North Dakota. By limiting rates to a percentage of Medicare in the out-of-network market, North Dakota would effectively stem the ever-upward drift of commercial payment rates.
7. **Private Reinsurance:** To supplement the cost-saving efforts of the 1332 waiver program, the State should evaluate purchasing private reinsurance to further reduce costs for individual taxpayers participating in the State's healthcare marketplace. Private reinsurance can assist in driving down/stabilizing rates and preventing spikes, providing consistency for taxpayers/users.
8. **Telehealth:** If structured properly, telehealth services may increase access to needed care while also controlling costs. For North Dakota, proper utilization of telehealth could have an overwhelming impact considering the 6,000% increase in telehealth visits in the Midwest between April 2019 and April 2020.¹⁹ Consumers are increasingly becoming accustomed to telehealth, and states should consider whether existing regulatory barriers are necessary.

Transparency. Price transparency is seen as a panacea to our health system and blame for opaque pricing is assigned to hospitals, insurance companies, government policy, consumer disinterest, and an overly complicated health care system. The truth is, there is more than enough blame to go around. The most important issue to understand about price transparency is that it is a means to an end. Transparency is necessary to encourage competition. Competition stimulates innovation – lower prices and better quality.

9. **Direct to Consumer Pricing: Disclosure of Consumer Prices.** We used a secret shopper to compare prices at several hospitals in North Dakota for three common procedures: colonoscopy, normal vaginal delivery, and caesarian section (see Summary Table 7). What we found was drastically different price estimates. For consumers, these price differences are confusing. We suggest using Medicare rates as a reference and requiring hospitals to disclose their prices as a percentage of Medicare.
10. **Right to Shop:** As highlighted above, there is significant cost variation for common procedures across North Dakota providers. Consumers often are referred by the

¹⁹ <https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/apr-2020-midwest-telehealth.pdf>

medical provider to the most convenient care delivery center. However, there may be cheaper alternatives with equal or even better-quality outcomes. Right to Shop legislation would allow insurers to make a cash payment back to a consumer when the consumer has shopped for and chosen a less expensive option.

Summary Table 7.

Hospital-Reported Prices for Selected Common Procedures

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

Source: JWHammer LLC.

Program Integrity. Program Integrity focuses on maximizing taxpayer resources by ensuring that North Dakotans receiving health benefits are covered by the correct payer. For example, a Medicaid recipient shouldn't be covered by Medicaid if they are eligible for a group health plan. Whether it is mission creep, shifting priorities or just loss of focus, states stray away from dedicating time and resources to program integrity. Program integrity can provide quick and consistent wins.

- 11. Medicaid Integrity Audit:** When a consumer receives financial assistance, North Dakota law allows for full assignment of benefits with no time limit. It is important for the state to periodically audit Medicaid benefits for other responsible payers. In some cases, children may be eligible for coverage under a non-custodial parent. Some recipients have opted out of their employer coverage. In other cases, the care received was reimbursed as part of a lawsuit. Contingency fee contracts provide vendors the opportunity to find savings for the state. The state also has an opportunity to build program integrity requirements into the RFP for the Medicaid expansion.
- 12. State Group Health Integrity Audit:** This effort is similar to the Medicaid audit but would be applied to the state employee health plan.
- 13. State Group Health Waiver:** The state currently provides no-cost health insurance to state employees and their families but the offer of "free" health insurance can lead to double coverage regardless of whether or not their spouse works for the state. Offering a small bonus to state employees who choose to opt entirely out of coverage may lower overall benefits expenses.
- 14. Coordination of Benefits:** Coordination of Benefits rules in health insurance clarify which insurer is responsible for paying for certain benefits. The rules work entirely automatically and are a great example of program integrity. The North Dakota Department of Insurance could consider the benefits of adopting the newer National Association of Insurance Commissioner's model.

Employer Coverage. The vast majority of consumers receive coverage through their employer. As employer coverage continues to erode due to rising costs, states need to find new solutions to help employers.

15. Study Combined Individual and Small Group Market : Most states have an unstable individual market but North Dakota appears to be in good shape. A number of states have combined their individual and small group markets to make it easier for small employers to offer coverage. For example, employers offering coverage in the District of Columbia Exchange set their subsidy level (an amount or plan level) and the employee chooses coverage. It provides administrative simplicity for the small employer and choice of benefits for the employee.

Crisis & Pandemic Planning. It seems clear that some hospitals and insurers nationally were caught flat-footed by the pandemic. However, the Covid-19 crisis shouldn't have been a complete surprise, based on experience with numerous prior pandemics. Based on our preliminary analysis, the effects on North Dakota hospitals haven't been as dramatic as in harder-hit states. But this pandemic is not yet over.

16. Risk Assessments:

Hospital and Insurer Own Risk Solvency Assessment. Domestic insurers are required to file a highly confidential report that details the risks to their business called the Own Risk Solvency Assessment or ORSA. This board level report is expected to detail all of the potential risks facing an insurer. North Dakota could consider adding a pandemic requirement for insurers and requiring hospitals to address potential public health risks with a required confidential report reviewed by the hospital's Board of Directors.

Cost and Impact Estimates

For some of the policy alternatives noted above we have prepared preliminary cost estimates and discussion. It may seem odd to discuss cost containment during a pandemic, when many health care providers are pushed to heroic limits. However, the pandemic won't last forever, and nuts and bolts discussions of the growth of health costs vs. affordability for government, employer, and consumer budgets will inevitably return to the spotlight.

Option: Cap Patients' and Insurers' Responsibility for Out-of-Network Charges. In March 2020, researchers at the RAND Corporation published a report demonstrating the savings and impact of capping hospitals rates for out-of-network services.²⁰ This policy would effectively stem the ever-upward drift of commercial payment rates relative to those paid by Medicare by limiting the amounts payable to out-of-network health care providers to a percentage of Medicare rates.

²⁰ Erin Lindsey Duffy, Christopher Whaley, Chapin White, *The Price and Spending Impacts of Limits on Payments to Hospitals for Out-of-Network Care*, RAND (March 20,2020)

https://www.rand.org/pubs/research_reports/RR4378.html

While this policy would not directly affect rates for in-network providers, it would indirectly put downward pressure on in-network rates over time. If insurers would otherwise face in-network rates higher than the cap, they could switch the provider to out-of-network status and pay a lower amount. We would view an out-of-network cap as potentially the least disruptive approach to limiting rates, compared with other policy alternatives such as public rate setting regime or public option alternative.

Summary Table 8 below shows the potential impact for a flat cap that remained at 220 percent from 2021 through 2024. Claims would be reduced by \$7 million in the individual market and \$29 million in the large group (insured) market by 2024, and premiums would be lowered by 2-3%, by that year. In dollars, premiums would be lowered by \$166-187 per year or about \$15 per member per month (PMPM) by 2024. Under an option where the cap was gradually lowered from 220 percent in 2021 to 190 percent in 2024, claims costs and premium reductions would be larger, with premiums falling by approximately \$500 per year or about \$40 PMPM by 2024.

Option: Re-Pricing Payment Rates for the Medicaid Expansion Population. For Medicaid expansion enrollees, North Dakota pays healthcare providers at rates more typical for commercial payers than those usually used for Medicaid enrollees not part of the expansion program. This option illustrates the magnitude of possible savings from bringing those rates down to those used in the rest of North Dakota’s Medicaid program.

However, since the state’s share of costs for the Medicaid expansion population is small, the savings from this proposal would mostly accrue to the federal government. We estimate that possible state savings from this policy could range from \$5 to \$8 million in 2021, growing to \$6 to \$9 million in 2024.

Option: Require Stricter Managed Care and Full Risk Health Plans in Medicaid. The Congressional Budget Office has issued two recent reports on potential savings from managed care in Medicare²¹ and Medicaid.²² To be fair, neither report directly specifies CBO’s estimate of savings from tighter management of care by Medicaid or Medicare managed care organizations (MCOs). Nevertheless, we infer that the reports imply a potential savings of about 10 percent over time from the conversion of fee-for-service coverage to a strict managed care approach, and perhaps half of that potential savings from the conversion of loosely managed care to a stricter model.

We applied those potential savings amounts to North Dakota’s Medicaid program, assuming the greater savings potential from the conversion of the non-expansion enrollee populations to strictly managed care, and the lesser savings from converting the current Medicaid expansion MCO to a stricter model. We estimate that the net savings for North Dakota would be low at first, but would grow to about \$25 million by the year 2024 (see Summary Table 8).

²¹ Congressional Budget Office, A Premium Support System for Medicare: Updated Analysis of Illustrative Options (October 5, 2017) <https://www.cbo.gov/publication/53077>

²² Congressional Budget Office, Exploring the Growth of Medicaid Managed Care (August 7, 2018) <https://www.cbo.gov/publication/54235>

Summary Table 8.

Potential Cost Savings From Various Policy Options

Savings in millions of dollars	DRAFT			
	2021	2022	2023	2024
Cap Out-of-Network Rates at 220% of Medicare Rates				
Reduction in Premiums, Individual Market PMPM	-1	-5	-9	-14
Reduction in Premiums, Small Group Market PMPM	-1	-5	-10	-15
Federal Savings (millions)	-1	-5	-9	-14
Cap Out-of-Network Rates at 220% in 2021, Declining to 190% by 2024				
Reduction in Premiums, Individual Market PMPM	-1	-13	-25	-39
Reduction in Premiums, Small Group Market PMPM	-1	-14	-28	-43
Federal Savings (millions)	-1	-13	-25	-38
Re-Price Medicaid Expansion at Regular Medicaid Rates				
Federal Savings (millions) -- Higher End Estimate	-81	-85	-89	-93
State Savings	-8	-8	-9	-9
Federal Savings (millions) -- Lower End Estimate	-53	-57	-61	-65
State Savings	-5	-6	-6	-6
Tighter Managed Care and Population Health Requirements in Medicaid				
Total Original Medicaid FFS (non-institutionalized enrollees) Federal + State	-2	-15	-29	-45
State Share	-2	-9	-16	-23
Expansion MCO	1	-3	-7	-12
State Share	0	0	-1	-1
Net State Cost (+) or Savings (-)	-2	-9	-17	-25

Source: Horizon Government Affairs.

Notes: PMPM = per member per month. FFS = fee for service. MCO = Managed Care Organization.

Components may not sum exactly to totals due to rounding.