2021 HB 1012

House Appropriations Committee Human Resources Division

Jon Nelson, Chairman

January 21, 2021

Chairman Nelson and members of the House Appropriations Committee Human Resources Division, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I am here to offer comments in support of HB 1012 and specifically in response to the interim health care study performed by the Insurance Commissioner.

First, I want to stress that North Dakota hospitals strongly support reforms to promote health care access and affordability, including efforts to reform health markets, increase telehealth, improve health care price transparency, promote value-based care, and strengthen patient adherence to medications. We take responsibility for driving cost containment and improving quality. Hospitals stand ready to discuss ways in which we can all work together to help patients better manage their care, drive quality, and reduce costs. But we all need to operate from the same set of facts in order to move those initiatives forward.

We believe that all North Dakotans should have access to high quality, affordable health insurance. We are lucky to have some of the lowest premiums in the country. Premiums are a reflection of not only health care cost, but also of market circumstances and the amount of health care used by patients. As you are probably aware, North Dakota does not have a competitive health insurance market. Approximately 92% of payments to hospitals is fixed – meaning hospitals have no ability to negotiate a different rate. Government payers such as Medicare, Medicaid, and military programs do not negotiate rates. And, because we do not have a competitive commercial health insurance market, the dominant payer - which has about 85% market share - dictates rates paid to hospitals with no negotiation. I recently confirmed with our larger hospitals that they are not able to negotiate rates with the dominant payer. In any case, if hospitals do not manage their costs well, payers do not pay them more. The bottom line is that

hospital expenses do not drive prices; prices in North Dakota are set by Medicare, Medicaid, and the dominant commercial insurer.

It is important to point out some concerns we have with some of the data and how it is presumed to apply to North Dakota. For example, the study draws conclusions regarding the rates paid by private health plans as compared to Medicare rates. The study asserts that private insurers in North Dakota went from paying 170% to 200% of Medicare rates during the nine years covered by the study. This has been pointed out as evidence that hospitals do negotiate rates with payers. First, I do not know how the consultants calculated these figures. I spoke with the two major commercial insurers in the state yesterday and they both confirmed that their rates are between 175 and 180% of Medicare. Had the consultants wanted to provide useful data on which to base policy decisions, North Dakota specific data would have been more helpful.

In addition to the concern we have with the data and assumptions, we are unsure how relevant the study is given the current Coronavirus pandemic. Hospitals have stepped up in unprecedented ways to meet the challenges of COVID-19. They ramped up testing efforts, bought additional personal protective equipment (PPE), added ICU bed capacity, paid for expensive temporary staff to care for additional patients, and created COVID-19 isolation units. In the midst of incurring these additional expenses, revenue plummeted. Hospitals cancelled non-emergency procedures to save scarce PPE and bed space, and many patients postponed care due to fear of the virus. While federal assistance, such as CARES Act funding helped, it is nowhere close to replacing the enormous revenue lost due to the pandemic.

Despite what the study authors assert, hospitals are not "back to normal". North Dakota hospital revenue crashed in March, April, and May 2020. Some of the rebound that happened after that was due to pent up demand from patients who were delaying care but could no longer. Hospitals took care of sicker, more fragile patients because care had been postponed. Hospitals meanwhile also took care of a record number of COVID patients. Hospitals came perilously close to being overwhelmed just eight weeks ago when they had a record 334 COVID patients. Please keep in mind that is an additional 300 patients on top of the other patients they cared for. As a comparison, in our first spike last May, there were 40 COVID patients hospitalized. We do not know if we will see additional spikes or if this represents a return to normal. No one will know what "normal" health care is going to look like for some time. And, as the study notes,

hospital margins are small - roughly 2%. With such thin margins, there is no cushion to absorb such losses.

We are also concerned with the report's conclusion that there was a large jump in hospital cost without an analysis of the reasons why it may appear that way. The study's inclusion of hospital expense data from 2010 in the growth calculations grossly skews the results. We requested adjustment, or at least an annotation, to data skewed by hospitals switching to provider-based billing between 2010 and 2019. Including this data causes what looks like a jump in expenses when, in reality, it is the product of a different methodology of reflecting costs. We also asked if the consultants considered that three of the six PPS hospitals have major patient populations from Minnesota, which means hospital costs are not all born by North Dakotans. They did not take this into consideration. They also did not analyze how increasing wages due to oil activity factored in. Wages constitute 60% of hospitals' cost. These are examples of how cost is driven by market forces that hospitals do not control.

The study also implies that increased hospital costs result in increased reimbursement or more expensive insurance premiums. As already noted, hospitals do not get more reimbursement just because their costs increase. They must operate within a budget of 90% of payments that are fixed and over which they have no control. Also contradicting this point is that North Dakota health insurance premiums are among the lowest in the country. Consumers are evidently not being charged for what the study asserts is a high-cost hospital environment. These two study findings do not square.

We are also concerned that the policy recommendations do not correlate with the data. I would like to comment specifically on a few that are of most concern to us: suggested cuts to the Medicaid Expansion program and government setting of rates.

Medicaid Expansion cuts.

In North Dakota, approximately 24,000 low-income adults have gained coverage under expanded Medicaid. Without any discussion of how it would reduce hospital costs or health insurance premiums, the study suggests that Medicaid Expansion be cut in several ways.

First, they suggest cutting the number of people who qualify by reducing the eligibility limit from 138% to 100% of federal poverty level. As a preliminary matter, this is not even an option. CMS

has not approved it when requested by states. And, even if it were allowed, it is not a wise policy decision. It would likely result in higher uninsured rates and worse access to care for many near-poor adults. And it is unclear why this would even be suggested given that, as the authors acknowledge, "…the savings to North Dakota is limited." The expansion population is covered at a 90 percent federal matching rate, which means $1 million savings to North Dakota requires $10 million in cuts.

The study also suggests cutting Medicaid Expansion reimbursement to providers. We think it is important to point out that Medicaid does not pay for the cost of care. Hospitals lose money when they provide care to a patient covered under any government program – whether that be Medicare or Medicaid. Even when current expansion rates are blended with traditional Medicaid payments, hospitals still lose money. Despite this, Medicaid Expansion has been able to greatly help patients, North Dakota communities, and health care providers. Hospitals have seen a significant decrease in the amount of uncompensated care since the program started. Bad debt and charity care in North Dakota rose from $102 million in 2008 to $274 million in 2014—a nearly threefold increase. Thanks to Medicaid Expansion, bad debt dropped nearly in half to $150 million in 2016.

While cutting Medicaid Expansion payments to health care providers may save five to eight million dollars in general funds as the study points out, it fails to acknowledge the loss to the North Dakota health care system of $200 million in federal funds. Medicaid Expansion represents a huge impact on North Dakota's economy - the budgeted amount for the 2019-2021 biennium alone was $633 million. Taking that much money out of the system cannot be sustained. It is merely a cut to providers and is not cost containment. This would surely result in a cost shift to private payers. If Medicaid rates do not provide fair reimbursement, the cost must be paid by the remaining users of the system. As some pay less, others must pay more. Consequently, private payments go up, taking health insurance premiums along with them. This seems counterproductive if the aim is to reduce premiums.

This policy suggestion also fails to acknowledge that the health care sector is the largest employer in North Dakota. You cannot affect health care without affecting the entire economy of the state. Medicaid Expansion brings in $90 in federal matching funds for every $10 of state general funds invested, which flows directly into local economies supporting employment, wages, and state tax revenue. Again, it is budgeted at $633 million for this biennium. Its impact keeps the cost of health insurance low for the businesses that drive our economy. It is critical to

covering operating costs at our hospitals, the loss of which will result in staff cuts and closed facilities. Medicaid Expansion pays salaries of employees who work at those hospitals, which in turn results in income and sales tax collections in the state. The state's investment of one dollar to secure nine is a fantastic return on investment not only for the health of patients but of our entire economy. This is of such importance now as we are in the middle of a pandemic that has caused so much upheaval in our economy – especially in the health care sector. We simply cannot sustain further instability now.

Government setting of rates

The study recommends that the state government set maximum hospitals rates in the private insurance market and in the state employee plan (NDPERS) by limiting the amounts payable to out-of-network health care providers to a percentage of Medicare rates. Such policies cap the total amount that hospitals and physicians can be paid when they are not in network. These rate caps are viewed by the authors as an alternative to more rigid price setting regulations when competitive outcomes are difficult to achieve. They assert that setting maximum hospital rates provides a benchmark for negotiations with insurers. What this fails to understand is that, in North Dakota, hospitals and physicians largely participate in all networks. We do not have an out of network, surprise billing problem, as in other states. The authors state that this will also put downward pressure on in-network rates. This also fails to recognize the unique market in North Dakota in which hospitals do not have negotiating power with the dominant insurer. Rate caps would simply allow the dominant insurer to further lower its rates.

In summary, we hope that we can work together to come up with solutions that work for our state. There are many suggestions in the study we have supported in the past and will continue to do so, such as reforms to promote health care access and affordability, increase telehealth, and promote value-based care. We cannot support approaches that merely cut payment to providers and do nothing to contain costs, fail to balance patient access, and do not focus on improving quality.

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

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association