North Dakota Legislative Management
Interim Healthcare Study

Updated with 2019 Data

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,

Jon Godfread
Insurance Commissioner

600 E Boulevard Ave., Bismarck, ND 58505 • (701) 328-2440 • Fax (701) 328-4880 • mailto:insurance@nd.gov
Consumer hotline (800) 247-0560 • Relay N.D. TTY (800) 366-6888 • insurance.nd.gov

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North Dakota Insurance Department
PROTECTING THE PUBLIC GOOD
JON GODFREAD, COMMISSIONER

HORIZON
GOVERNMENT AFFAIRS

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

Healthcare Cost Study Program Manager: Jennifer Hammer, JWHammer, LLC (jennifer@jwhammerllc.com)
Policy Manager: J.P Wieske, Horizon Government Affairs (HGA), VP State Policy (jpweiske@horizondc.com)
Data and Analysis: Jeff Lemieux, HGA Chief Economist (jlemieux@horizondc.com)
Research Assistant: Rundell Douglas, HGA

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.

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[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 2010-2018[4] 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 report[5], 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]

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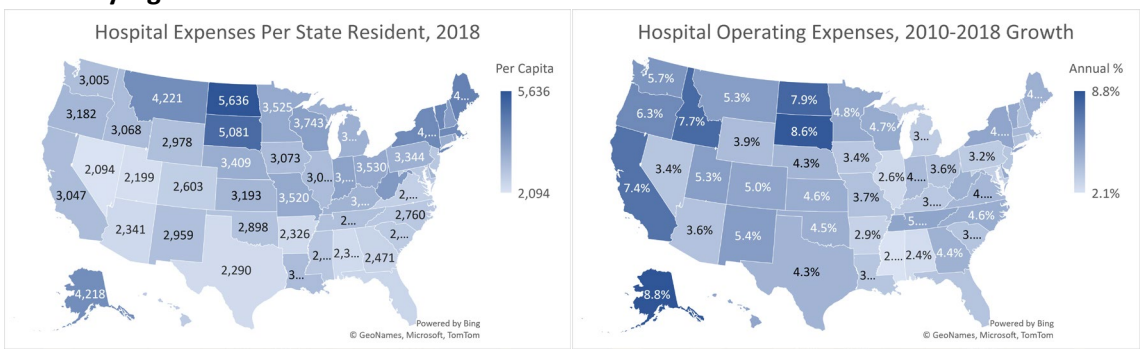
[4] For reasons of completeness of data, comparisons in this report start in 2010 or 2011, and end in 2018 or 2019.

[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.

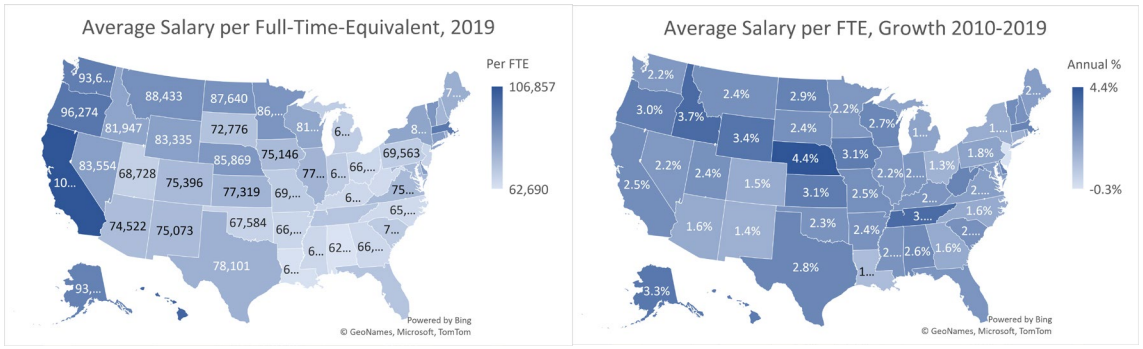
Summary Table 1.

Participating North Dakota Hospitals
Average Annual Growth in Expenses Per Unit of Use, 2010-2019

Six Large Acute Care Hospitals	Expense Growth	Utilization Growth	Unit Costs Expenses/Use
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.

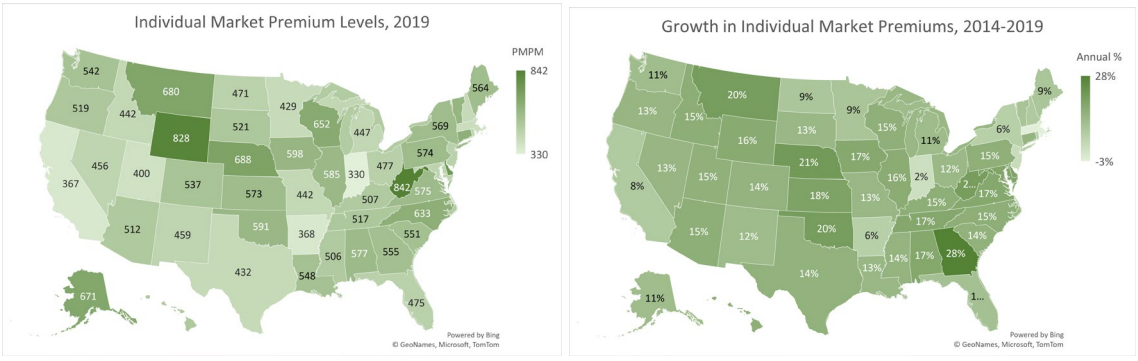
Summary Table 3.

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.

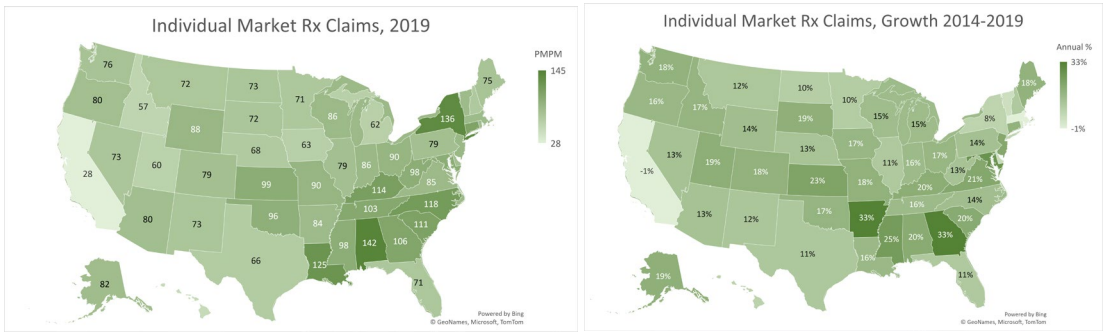
Summary Figure 3.



Source: HGA based on data from the NAIC.

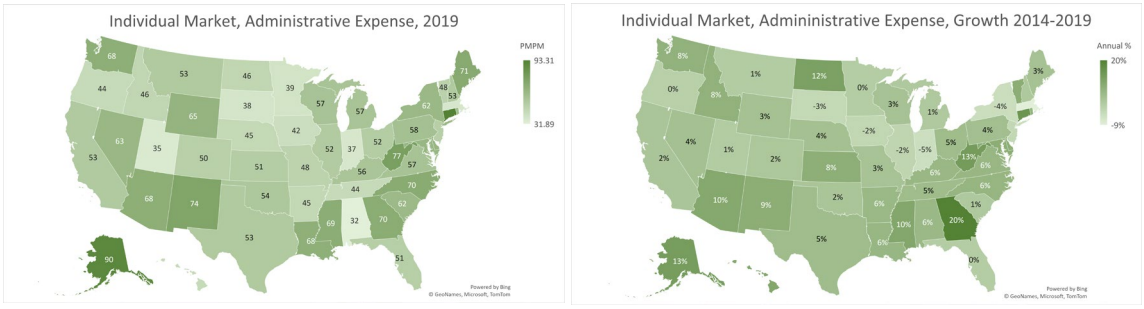
[7] At the legislative committee hearing, BCBSND noted a substantial IT upgrade during this period.
[8] CMS 2017 Marketplace Open Enrollment Period Public Use File.

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

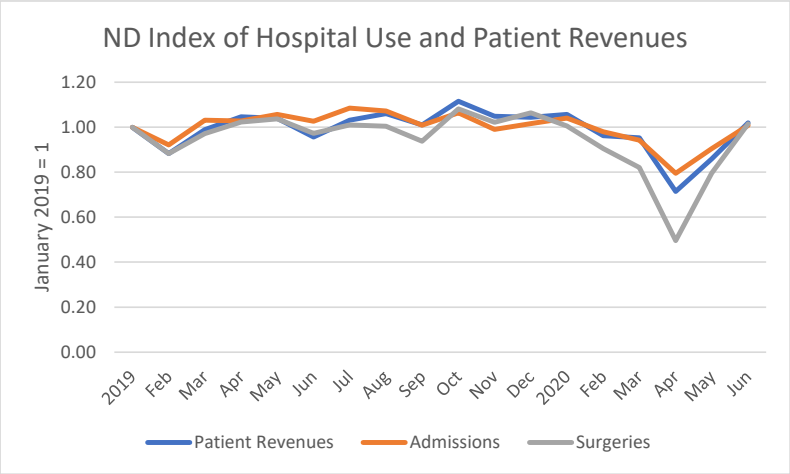
Source. HGA based on data from the Medicare Hospital Cost Reports.
Note: Level Rankings are based 2019, and Growth Rankings are based on 2014 to 2019.

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.

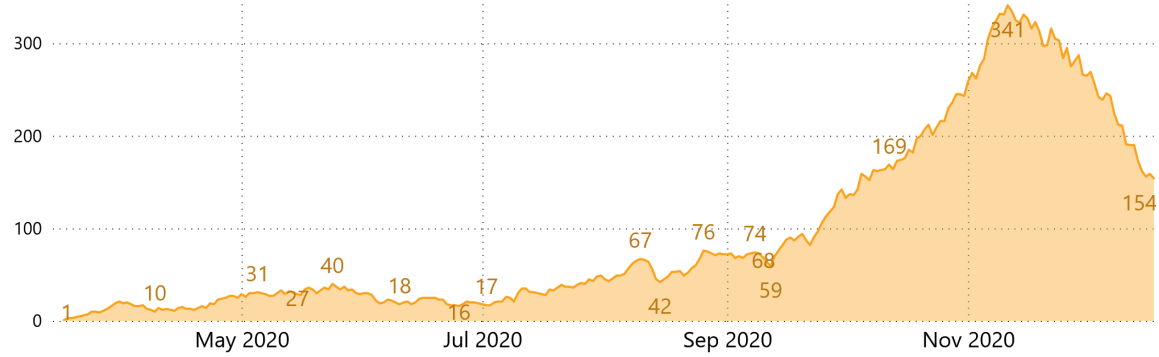


Sources: US: Bureau of Economic Analysis; ND: Horizon Government Affairs.
Note: ND index of patient revenues does not include federal emergency funding or other non-patient revenues.

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	49,969	60,915	61,565	60,654	58,788	56,728	6,759
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.)

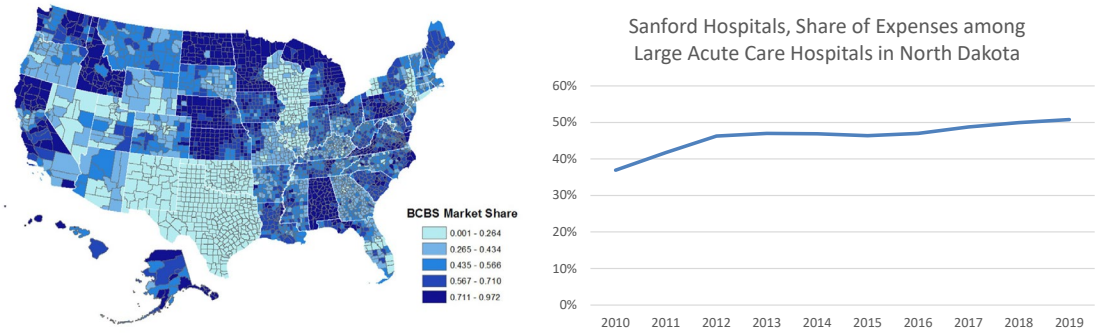
[13] https://www.insurance.nd.gov/news/godfread-announces-approved-2021-health-insurance-rates.

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.horizondc.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 Medicare[21] 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	DRAFT			
Savings in millions of dollars	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.

Section I. Hospital Data – Historical 2010-2019

Contents: Key Findings

1. Patient Utilization Measures Grew by About 1-2% Per Year
2. Hospital Revenues and Expenses Have Risen by about 7.5-8.0% Per Year
3. Growth in Costs Per Unit of Use Averaged 6.5% Per Year
4. Average Salaries Rose 4% and Employment Grew 3% Per Year
5. Case Mix Index Growth in Medicare was 1% Per Year
6. Commercial Payment Rates Grew From about 170% to Over 200% of Medicare's Rates
7. Patient Financial Assistance is About 1 Percent of Patient Revenues
8. Hospital Compensation for Top Executives and Physicians Ranged Widely

HGA's data gathering started with the purchase of multiyear Medicare Cost Report Information System (HCRIS) data, processed by RAND (https://www.hospitaldatasets.org/) for all hospitals in the U.S, organized by Medicare Provider Number. From this data, we determined that nine hospitals in North Dakota met the criteria for in-depth study: acute care, nonfederal hospitals in communities with more than 10,000 residents.

In-Depth Study of Nine North Dakota Hospitals. HGA issued a data request to these nine hospitals based on the American Hospital Association's (AHA's) annual survey, after discussion with the state's hospitals and the North Dakota Hospital Association (NDHA). NDHA arranged to have the historical data submissions for the survey sent back from the AHA to each hospital, to make the data response less burdensome. The data request is shown in Appendix A.

One key purpose of the data request was to supplement and verify the publicly available data from HCRIS, which we use for state-by-state comparisons. We used concepts and definitions from the American Hospital Association's (AHA's) annual survey, so that responding hospitals could use familiar concepts.

Our preliminary finding is that the HCRIS 2010-2018 data provides a good summary of the state's utilization, expenses, and revenues, although there were several cases where we had to make corrections to the HCRIS data for individual North Dakota hospitals based on the hospital's AHA data response and in subsequent discussion with hospitals. There are other instances where the definitions used in each dataset are different, but generally similar. We further spot-checked the results against some data reported by non-profit hospitals on their IRS form 990 disclosures. The IRS data also contain additional data on compensation of top officers, executives, and physicians, which is shown in Appendix B. The one concept where the HCRIS and AHA did differ noticeably was on the hospitals' allocations of their revenues from payers: commercial vs. Medicare and Medicaid. In general, we have defaulted to using the AHA data as a guide for our projections.

The hospital-by-hospital HCRIS data we use for in-state North Dakota hospital comparisons was updated in November 2020. However, some data points and hospitals had missing data, and we have not attempted to contact hospitals during this fall's Covid surge to ask about issues with this latest data set. The preliminary 2019 hospital-by-hospital HCRIS results included in this

report are therefore subject to considerable uncertainty. Likewise, due to the missing data, we are unable to report aggregated hospital data from HCRIS for 2019.

For Tables 1-9, regarding the 9 hospitals with in-depth data, both the HRCIS and AHA data are converted to calendar years by HGA.

Patient Utilization Measures Grew by About 1-2% Per Year. Among the 9 reporting North Dakota hospitals, inpatient admissions have been roughly flat since 2010 (0.3% average annual growth AHA data; 0.1% HCRIS data; see Table 1). Meanwhile overnight inpatient "days" have grown slowly (1.3% per year AHA data; 1.6% HCRIS), such that the average length of stay increased from about 4.1-4.2 days in 2010 to 4.6 days in 2019. Outpatient and Emergency Department (ED) visits grew more rapidly, rising at average annual growth rates of 1.2 percent and 2.0 percent, respectively, and outpatient surgeries grew rapidly (5.4% per year). HGA's overall composite utilization index, which includes admissions, days, ED and outpatient visits, outpatient surgeries, and so on, increased by 1.4% per year between 2010 and 2019, with most of that growth occurring between 2010 and 2013.

Table 1.

Aggregate Utilization Measures (AHA Data vs. HCRIS)

Nine Responding Plans (by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
					DRAFT						
Admissions				**AHA Historical Data**							
Medicare	33,327	33,734	33,991	32,447	32,033	32,892	33,266	34,081	34,850	35,016	0.6%
Medicaid	11,395	12,010	11,550	10,543	11,624	13,287	15,540	15,659	16,227	16,447	4.2%
Private/Other	35,648	36,899	39,871	39,410	37,116	34,288	29,914	30,295	30,009	31,147	-1.5%
Total	80,370	82,643	85,411	82,399	80,773	80,467	78,719	80,034	81,085	82,610	0.3%
Days											
Medicare	165,591	172,163	178,394	177,299	171,340	179,089	175,646	172,764	175,152	173,370	0.5%
Medicaid	47,813	50,064	51,015	51,457	63,848	73,616	83,832	84,841	86,288	86,551	6.8%
Private/Other	124,500	128,035	139,158	137,875	130,317	125,119	119,596	113,605	114,437	120,147	-0.4%
Total	337,903	350,262	368,567	366,630	366,805	379,124	379,073	371,210	375,877	380,068	1.3%
Inpatient Surgeries	25,872	25,684	26,030	25,702	24,987	24,696	24,635	24,718	24,202	24,156	-0.8%
ED Visits	206,738	224,232	244,550	244,103	252,343	256,880	253,005	246,322	244,994	247,200	2.0%
Outpatient Visits	1,809,797	1,838,424	1,958,487	2,083,629	2,148,674	2,156,467	2,171,771	2,109,200	2,061,083	2,013,684	1.2%
Outpatient Surgeries	43,231	53,934	61,136	63,953	66,806	68,218	68,734	69,183	69,905	69,564	5.4%
Beds	1,554	1,593	1,588	1,603	1,634	1,638	1,631	1,668	1,700	1,675	0.8%
Occupancy Rate	59.6%	60.3%	63.6%	62.7%	61.5%	63.4%	63.7%	61.0%	60.6%	62.2%	0.5%
Average Length of Stay (days per admission)											
Medicare	5.0	5.1	5.2	5.5	5.3	5.4	5.3	5.1	5.0	5.0	0.0%
Medicaid	4.2	4.2	4.4	4.9	5.5	5.5	5.4	5.4	5.3	5.3	2.5%
Private/Other	3.5	3.5	3.5	3.5	3.5	3.6	4.0	3.8	3.8	3.9	1.1%
Weighted Average	4.2	4.2	4.3	4.4	4.5	4.7	4.8	4.6	4.6	4.6	1.0%
Overall Utilization Index, 2010=1 \a	1.00	1.04	1.11	1.12	1.13	1.15	1.14	1.13	1.13	1.13	1.4%
Admissions				**HCRIS Data**							
Medicare	26,680	26,921	27,699	27,191	27,753	28,782	29,288	30,106	30,354		1.6%
Medicaid	10,095	10,334	9,921	8,798	9,210	10,145	11,133	10,850	11,555		1.7%
Private/Other	39,380	40,528	39,610	39,613	36,258	35,500	35,670	36,442	35,008		-1.5%
Total	76,155	77,783	77,230	75,602	73,221	74,428	76,092	77,398	76,917		0.1%
Days											
Medicare	122,885	129,796	135,946	136,284	137,920	147,385	149,090	148,579	148,875		2.4%
Medicaid	49,019	49,788	53,843	55,584	65,111	70,929	73,126	71,768	69,828		4.5%
Private/Other	136,558	142,672	145,570	141,440	134,108	130,901	130,184	130,771	132,611		-0.4%
Total	308,463	322,257	335,359	333,308	337,139	349,215	352,400	351,118	351,315		1.6%
Beds	1,308	1,312	1,337	1,442	1,388	1,436	1,452	1,475	1,475		1.5%
Occupancy Rate	64.6%	67.3%	68.7%	63.3%	66.5%	66.6%	66.5%	65.2%	65.2%		
Average Length of Stay (days per admission)											
Medicare	4.6	4.8	4.9	5.0	5.0	5.1	5.1	4.9	4.9		0.8%
Medicaid	4.9	4.8	5.4	6.3	7.1	7.0	6.6	6.6	6.0		2.8%
Private/Other	3.5	3.5	3.7	3.6	3.7	3.7	3.6	3.6	3.8		1.1%
Weighted Average	4.1	4.1	4.3	4.4	4.6	4.7	4.6	4.5	4.6		1.5%

Source: Horizon Government Affairs. HCRIS data via RAND, vintage 11-4-19.

Note: Average annual growth rate is 2010-2019 for AHA data; 2010-2018 for HCRIS data.

\a Overall utilization composite index is calculated by HGA using data from the AHA survey responses. It is not an AHA calculation.

1. ***Hospital Revenues and Expenses Have Risen by about 7.5-8.0% Per Year***. Total expenses and revenues of the nine reporting hospitals grew by about 7.5-8.0% per year in the 2010-2019 period, with only slight differences in the AHA and HCRIS estimates (see Table 2).

Table 2.

Aggregate Revenues and Expenses (AHA Data vs. HCRIS), All Nine Reporting Hospitals **DRAFT**

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
		AHA-Style Data									
AHA Data											
Payroll	947	1,062	1,187	1,226	1,261	1,360	1,467	1,561	1,631	1,681	6.6%
Benefits	169	188	210	214	220	242	271	288	298	309	6.9%
Total, Wages and Benefits	1,116	1,250	1,397	1,440	1,481	1,602	1,739	1,850	1,929	1,990	6.6%
Interest Expense	30	32	34	36	39	42	43	46	49	47	5.4%
Other Expenses	754	886	1,126	1,223	1,315	1,395	1,459	1,532	1,649	1,747	9.8%
Total, Expenses	1,899	2,169	2,556	2,699	2,835	3,038	3,240	3,428	3,627	3,784	8.0%
Patient Revenues	1,934	2,195	2,521	2,618	2,824	3,072	3,221	3,360	3,495	3,598	7.1%
Non-Patient, Non-Oper. Revenue	102	105	130	183	199	170	183	203	256	327	13.8%
Total, Revenues	2,036	2,300	2,651	2,801	3,023	3,241	3,404	3,563	3,751	3,925	7.6%
Margin	136	131	94	103	188	203	164	135	124	140	
Margin %	7%	6%	4%	4%	6%	6%	5%	4%	3%	4%	
Medicare Cost Reports		**HCRIS Data**									
Total Wages and Benefits	1,008	1,171	1,370	1,437	1,489	1,572	1,650	1,711	1,744		7.1%
Interest Expense	32	35	36	38	40	42	43	48	52		6.5%
Other Expenses	930	1,089	1,260	1,335	1,429	1,537	1,667	1,766	1,851		9.0%
Operating Expenses	1,970	2,295	2,666	2,810	2,958	3,152	3,361	3,526	3,647		8.0%
Patient Revenues	2,012	2,336	2,622	2,729	2,944	3,190	3,323	3,419	3,532		7.3%
Non-Patient, Non-Oper. Revenue	102	94	108	164	181	155	192	230	239		11.2%
Total, Revenues	2,114	2,430	2,730	2,893	3,125	3,344	3,514	3,649	3,771		7.5%
Margin	102	94	108	164	181	155	192	230	239		
Margin %	5%	4%	4%	6%	6%	5%	5%	6%	6%		

Source: Tabulations and calculations by Horizon Government Affairs. HCRIS data as processed by RAND vintage 11-4-2019.
Note: Average annual growth rate is 2010-2019 for AHA data; 2010-2018 for HCRIS data.

2. ***Growth in Costs Per Unit of Use Averaged 6.5% Per Year***. We compared average annual growth in expenses with growth in HGA's composite index of growth in utilization (see Tables 3 and 4). By this measure, the weighted average annual growth in expenses per unit of use was about 6.5 percent between 2010 and 2019. On a per-hospital basis, the range of annualized growth in expenses per unit of use ranged from a low of 4 percent to more than 11 percent. The hospital with the fastest-growing costs, Sanford Fargo, had annual utilization growth of 2.4 percent per year, with expense growth per unit of utilization growth of about 11 percent per year.

Table 3.

Composite Utilization and Expenses — DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
6 Large Acute Care Hospitals	**HGA Composite Utilization Index (2010 = 1)**										
St Alexius	1.00	1.04	1.09	1.08	1.07	1.03	0.92	0.87	0.88	0.92	-1.0%
Sanford Bismarck	1.00	1.07	1.18	1.20	1.25	1.29	1.31	1.37	1.40	1.48	4.4%
Essentia	1.00	0.97	0.96	1.03	1.07	1.13	1.19	1.15	1.08	1.07	0.8%
Sanford Fargo	1.00	1.08	1.15	1.15	1.15	1.17	1.17	1.17	1.21	1.24	2.4%
Altru	1.00	1.06	1.16	1.16	1.16	1.20	1.26	1.23	1.21	1.14	1.4%
Trinity	1.00	1.02	1.04	1.04	1.04	1.03	0.98	0.94	0.92	0.91	-1.0%
Weighted Average	1.00	1.05	1.12	1.12	1.13	1.15	1.15	1.13	1.14	1.14	1.5%
3 Critical Access Hospitals	1.00	0.99	0.94	1.02	1.05	1.18	1.05	1.06	1.04	1.02	0.2%
All 9 Hospitals Weighted Average	1.00	1.04	1.11	1.12	1.13	1.15	1.14	1.13	1.13	1.13	1.4%
6 Large Acute Care Hospitals	**Aggregate Expenses (HCRIS, millions)**										
St Alexius	223	238	257	267	286	314	322	313	305	308	4.0%
Sanford Bismarck	265	308	361	405	431	452	497	509	526	586	8.9%
Essentia	254	263	285	313	328	351	375	379	378	378	5.1%
Sanford Fargo	420	597	806	842	877	926	994	1,113	1,195	1,243	14.0%
Altru	363	386	429	449	461	493	533	556	578	610	6.0%
Trinity	330	374	383	377	406	437	450	457	463	476	3.1%
Total	1,856	2,166	2,522	2,653	2,789	2,973	3,170	3,327	3,446	3,602	8.0%
3 Critical Access Hospitals	114	128	144	157	169	178	190	199	202	204	7.4%
All 9 Hospitals Total	1,970	2,295	2,666	2,810	2,958	3,152	3,361	3,526	3,647	3,806	8.0%

Source: Horizon Government Affairs. HCRIS via RAND vintage 11-4-2019. 2019 HCRIS expenses projected by HGA.
Note: Weighting for the composite index of inpatient and outpatient utilization measures by HGA. HCRIS 2019 expenses projected by HGA.

Table 4.

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

Six Large Acute Care Hospitals	Expense Growth	Utilization Growth	Unit Costs Expenses/Use
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.

3. ***Average Salaries Rose 4% and Employment Grew 3% Per Year.*** Overall wages and employee benefits grew by more than 7 percent per year, comprised of 4 percent annual wage growth and 3 percent growth in the number of full time equivalent (FTE) employees. Average salaries per FTE grew to $103,000 in 2018 (see Tables 5, 6 and 7).

Table 5.

Aggregate Wages and Benefits (HCRIS Data) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
				HCRIS Wages and Benefits							
6 Large Acute Care Hospitals											
St Alexius	122	132	138	152	156	165	163	154	136	138	1.4%
Sanford Bismarck	142	159	201	208	216	235	252	251	254	276	7.6%
Essentia \a	117	121	130	136	140	143	145	149	153	156	3.4%
Sanford Fargo	183	282	381	398	415	439	470	514	544	564	14.6%
Altru	237	250	274	287	298	309	325	340	350	358	5.0%
Trinity	149	162	177	185	191	206	216	220	222	226	4.6%
Total	949	1,107	1,301	1,366	1,416	1,497	1,571	1,628	1,659	1,719	7.2%
3 Critical Access Hospitals											
Total	59	64	69	72	73	75	80	84	85	85	4.7%
All Reporting Hospitals	1,008	1,171	1,370	1,437	1,489	1,572	1,650	1,711	1,744	1,804	7.1%

Source: HCRIS/RAND Vintage 11-4-19. Calculations and Tabulation by Horizon Government Affairs.
Note: HCRIS 2019 figures are projected by HGA.
\a 2019 is based on 2017-2018 trend.

Table 6.

FTEs (HCRIS Data) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
				HCRIS Number of Full-Time Equivalent Employees (FTEs)							
6 Large Acute Care Hospitals											
St Alexius	1,828	1,813	1,866	1,945	1,956	1,992	1,850	1,512	1,276	1,212	-4.5%
Sanford Bismarck	1,993	1,994	2,285	2,289	2,383	2,526	2,487	2,614	2,383	\a	2.6%
Essentia	1,632	1,623	1,694	1,694	1,694	1,694	1,694	1,580	1,628	1,581	-0.4%
Sanford Fargo	2,297	3,039	3,859	4,164	4,355	4,553	4,681	4,990	5,299	5,714	10.7%
Altru	2,876	2,999	3,015	3,107	3,086	3,111	3,196	3,153	3,119	\a	1.0%
Trinity	\b	2,061	2,237	2,275	2,391	2,176	2,449	2,499	2,222	2,158	0.6%
Total	12,626	13,529	14,957	15,475	15,866	16,053	16,357	16,347	15,927	\a	2.9%
3 Critical Access Hospitals	798	809	909	933	900	860	861	916	933	913	1.5%
All Reporting Hospitals	13,424	14,338	15,867	16,408	16,765	16,913	17,217	17,263	16,860	\a	2.9%

Source: HCRIS via RAND vintage 11-4-2019. Additional Calculations and Tabulation by Horizon Government Affairs.
Note: 2019 approximated by HGA based on data from HCRIS via RAND vintage 11-1-2020.
\a No 2019 data available. Average annual growth in calculated 2010-2018.
\b No 2010 data available; Average annual growth is calculated 2011-2019.

Table 7.

Average Salaries (HCRIS Data) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	Average Annual Growth
				HCRIS Wages and Salaries per FTE						
6 Large Acute Care Hospitals										
St Alexius	66,688	72,970	73,775	78,038	79,763	82,923	88,278	101,845	106,813	6.1%
Sanford Bismarck	70,999	79,883	87,866	88,893	89,920	86,573	100,681	97,246	103,652	4.8%
Essentia	72,667	71,527	74,581	78,618	81,676	83,275	85,040	92,315	93,902	3.3%
Sanford Fargo	79,517	90,554	98,717	95,554	95,203	96,490	100,311	103,115	102,572	3.2%
Altru	82,330	83,528	90,990	92,367	96,429	99,393	101,598	107,803	112,262	4.0%
Trinity \a	75,000	75,027	75,897	81,238	77,714	90,581	87,712	86,785	100,138	4.2%
Weighted Average	76,175	81,754	87,583	88,527	89,487	92,278	96,403	100,402	104,313	4.0%
3 Critical Access Hospitals										
Jamestown	71,088	72,469	75,005	74,807	76,079	81,821	89,217	81,652	87,322	2.6%
Dickinson	63,473	79,882	79,882	85,063	90,865	95,036	101,822	97,886	94,557	5.1%
Williston	71,560	84,470	79,205	67,530	74,404	74,404	89,186	95,240	90,427	3.0%
Weighted Average	68,565	79,824	78,296	75,573	80,402	83,195	93,680	92,507	91,113	3.6%
All Reporting Hospitals	75,682	81,638	87,047	87,747	88,905	91,704	96,239	99,924	103,532	4.0%

Source: HCRIS via RAND vintage 11-4-2019. Additional Calculation and Estimates by Horizon Government Affairs.
Note: Weighting is a custom blend of inpatient and outpatient utilization by HGA.
\a 2010 figure is a rough approximation; Average annual growth is calculated 2011-2018.

4. ***Case Mix Index Growth in Medicare was 1% Per Year.*** Although we do not have a direct estimate of the overall intensity of all patient stays, Medicare's case mix index – a proxy for the complexity or difficulty of cases – among Medicare patients rose by about 1 percent per year in the 2010-2018 period, with most of the growth between 2010 and 2014 (see Table 8).

Table 8.

Medicare Casemix Index (HCRIS Data, Approximated by RAND)

DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth /a
6 Large Acute Care Hospitals				**HCRIS/RAND Calculations ("impact_cmi")**							
St Alexius	2.03	2.10	2.08	2.08	2.08	2.01	2.02	1.99	2.04	1.92	-0.6%
Sanford Bismarck	1.75	1.85	1.83	1.78	1.87	1.89	1.90	1.92	1.89	1.89	0.8%
Essentia	1.77	1.78	1.77	1.84	1.97	1.80	1.82	1.87	1.80	1.87	0.6%
Sanford Fargo	1.89	1.86	1.89	1.96	2.07	2.04	2.13	2.13	2.13	2.14	1.4%
Altru	1.72	1.68	1.70	1.86	1.84	1.82	1.81	1.79	1.84	/a	0.9%
Trinity	1.64	1.69	1.68	1.67	1.65	1.65	1.80	1.90	1.87	1.87	1.5%
Weighted Average	1.81	1.82	1.83	1.88	1.94	1.90	1.94	1.96	1.96	/a	1.0%
				Year-to Year Growth Rate							
St Alexius		3.5%	-0.7%	-0.4%	0.3%	-3.4%	0.2%	-1.2%	2.4%	-5.9%	
Sanford Bismarck		5.4%	-1.1%	-2.7%	5.4%	1.2%	0.3%	0.8%	-1.1%	-0.2%	
Essentia		0.7%	-0.5%	4.1%	6.6%	-8.6%	1.2%	3.0%	-4.1%	4.0%	
Sanford Fargo		-1.7%	1.4%	3.8%	5.7%	-1.4%	4.5%	-0.2%	0.2%	0.4%	
Altru		-2.4%	1.6%	9.2%	-1.1%	-1.2%	-0.4%	-1.0%	2.9%	/a	
Trinity		3.1%	-0.4%	-0.2%	-1.3%	-0.3%	9.3%	5.6%	-1.7%	0.0%	
Weighted Average		0.5%	0.5%	3.1%	2.7%	-1.9%	2.4%	0.6%	0.4%	/a	

Source: HCRIS data RAND vintage 11-4-2019 and vintage 11-1-2020. Additional Calculations and Tabulation by Horizon Government Affairs.
Note: Weighting is a custom blend of inpatient and outpatient utilization by HGA.
/a Data may be missing for 2019. Average annual growth from 2010 to last year shown, 2018 or 2019, depending on data availability.

5. ***Commercial Payment Rates Grew From about 170% to Over 200% of Medicare's Rates.*** An indirect method of computing payment rates, using charge to revenue ratios, suggests that average commercial payment rates rose from about 170 percent of Medicare rates in 2011 to more than 200 percent in 2018, with most of the growth occurring in the 2014-2018 period (see Table 9). Note that the individual hospitals had widely varying ratios from year to year by this measure, so we view the individual hospital data as particularly uncertain.

Table 9.

Approximate Private to Medicare Payment Rates (HCRIS Data, Approximated by RAND) DRAFT

(by calendar year)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
6 Large Acute Care Hospitals		**HCRIS/RAND Calculations ("commercial_to_mdcr_est")**								
St Alexius		1.95	1.94	1.88	1.90	2.27	2.23	1.99	2.01	1.53
Sanford Bismarck		1.93	1.51	1.92	1.82	2.08	2.17	2.03	1.95	2.19
Essentia		2.07	1.87	2.05	2.54	2.42	2.47	2.06	3.01	3.22
Sanford Fargo		1.45	1.99	1.93	1.97	1.94	2.18	2.07	2.11	2.03
Altru		1.36	1.39	1.37	1.37	1.45	1.50	1.51	1.67	/a
Trinity		2.17	2.18	1.18	1.92	2.53	2.73	2.66	2.53	2.48
Weighted Average		1.70	1.80	1.72	1.85	2.00	2.11	1.99	2.11	/a
3 Critical Access Hospitals										
Jamestown		1.48	1.25	1.34	1.21	1.17	1.32	1.35	1.46	1.45
Dickinson		1.76	1.48	1.41	1.18	1.06	1.13	1.10	1.21	1.24
Williston		2.05	1.67	1.60	1.15	1.07	1.36	1.43	1.77	1.93
Weighted Average		1.70	1.48	1.47	1.17	1.13	1.15	1.29	1.49	/a
All Reporting Hospitals		1.70	1.78	1.70	1.81	1.94	2.05	1.94	2.07	/a

Source: HCRIS data via RAND vintage 11-1-2020. Additional Calculations and Tabulation by Horizon Government Affairs.

Note: Calculated as ratio of commercial charge-to-revenue ratio to Medicare charge-to-revenue ratio. Weighting is a custom blend of inpatient and outpatient utilization by HGA.

6. ***Financial Assistance is About 1 Percent of Patient Revenues***. Table 10 shows our tabulations of total financial assistance provided to patients (both insured and uninsured) qualifying for hospitals' financial assistance programs. These amounts are HCRIS tabulations of the approximate cost of care for patients in financial assistance programs less partial patient payments.

   In general, financial assistance levels were about 1 percent of net patient revenues for all North Dakota hospitals. However, reported financial assistance grew rapidly during the 2011-2018 period, with average growth of nearly 10 percent per year. Appendix C shows the HCRIS tabulations in greater detail for all North Dakota Hospitals.

Table 10.

Financial Assistance (Uninsured and Insured Patients) DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Annual Growth
Raw HCRIS Data (by cost report year, millions of dollars)											
6 Large Acute Care Hospitals											
St Alexius		1	1	1	0	3	4	3	2	2	18.4%
Sanford Bismarck		5	13	7	6	8	5	5	6	4	-1.0%
Essentia		2	1	2	1	3	2	4	4	5	10.1%
Sanford Fargo		4	5	9	17	17	12	13	16	18	22.4%
Altru		2	1	2	2	1	1	1	4	/a	12.7%
Trinity \a		0	0	0	3	1	5	6	11	2	-10.2%
Total		13	22	21	30	33	30	32	43	/a	9.6%
3 Critical Access Hospitals		3	2	2	2	1	1	2	3	4	1.3%
Other Critical Access Hospitals		2	2	3	2	1	1	3	3	/a	12.4%
All North Dakota Hospials		19	27	25	34	36	32	36	49	/a	9.8%
As a Percentage of Net Patient Revenues											
6 Large Acute Care Hospitals											
St Alexius		0.3%	0.5%	0.5%	0.2%	1.0%	1.3%	1.1%	0.7%		
Sanford Bismarck		1.5%	4.1%	3.9%	1.7%	1.9%	1.0%	0.9%	1.2%		
Essentia		0.9%	0.3%	0.6%	0.3%	0.9%	0.6%	1.1%	1.0%		
Sanford Fargo		0.7%	0.7%	1.1%	1.9%	1.8%	1.2%	1.2%	1.4%		
Altru		0.4%	0.3%	0.4%	0.4%	0.3%	0.3%	0.2%	0.7%		
Trinity		0.0%	0.0%	0.0%	0.8%	0.2%	1.1%	1.3%	2.4%		
Total		0.6%	0.9%	0.9%	1.1%	1.1%	1.0%	1.0%	1.3%		
3 Critical Access Hospitals		2.9%	1.8%	1.2%	1.3%	0.4%	0.7%	1.0%	1.4%		
Other Critical Access Hospitals		0.9%	0.7%	0.8%	0.6%	0.5%	0.3%	0.8%	0.9%		
All North Dakota Hospitals		0.8%	0.9%	0.9%	1.1%	1.0%	0.9%	1.0%	1.3%		

Source: Tabulations and calculations by Horizon Government Affairs. HCRIS data as processed by RAND vintage 11-4-2019; 2019 figures from vintage 11-1-2020.
Note: Average annual growth rate calculations are from 2011-2019 except as noted.
\a Data for some hospitals is missing for 2019. Average annual growth is computed from 2011-2018. Trinity reported zero financial assistance in 2011-2013; growth is calculated as 2014-2019.

7. ***Executive and Top Physician Compensation Ranged Widely***. HGA looked at the IRS form 990s to collect data on compensation of top executives and physicians at the non-profit hospitals studied. Importantly, some of the non-profit hospitals report as part of a larger group, so the top executive and physician compensation reported may not be in North Dakota. For example, many of the top executives and physicians reporting on the Sanford Group's form 990 may be based in South Dakota (see Table 11 and Appendix B).

Table 11.

Top Executive and Physician Compensation Reported on IRS Form 990 **DRAFT**

Millions of Dollars	2010	2011	2012	2013	2014	2015	2016	2017	Average Annual Growth
Top Executives				**St Alexius**					
Highest	0.61	0.50	0.70	0.56	0.80	0.76	0.61	0.62	0%
2nd	0.48	0.50	0.55	0.43	0.67	0.65	0.57	0.56	2%
3rd	0.25	0.28	0.30	0.23	0.38	0.53	0.29	0.40	7%
Top Physicians									
Highest	1.50	1.67	1.98	1.96	2.30	2.00	2.09	1.70	2%
2nd	1.40	1.65	1.60	1.56	2.10	1.98	1.30	1.46	1%
3rd	0.91	0.80	1.00	0.76	1.00	1.20	0.99	1.04	2%
Top Executives				**Sanford (group, includes other states)**					
Highest	1.85	2.07	2.15	4.80	2.50	4.60	4.17	3.16	8%
2nd	1.08	1.20	1.11	3.78	1.36	1.18	3.03	1.48	5%
3rd	1.00	0.99	0.87	1.95	1.02	1.15	1.17	1.10	1%
Top Physicians									
Highest	2.30	2.10	2.12	2.63	3.40	2.92	2.93	2.92	3%
2nd	2.30	2.08	2.10	2.43	2.49	2.68	2.68	2.69	2%
3rd	1.80	2.06	2.09	2.29	2.30	2.49	2.58	2.68	6%
Top Executives				**Altru**					
Highest	0.42	0.50	0.54	0.57	0.69	1.08	1.09	0.85	11%
2nd	0.35	0.33	0.39	0.47	0.43	0.66	0.76	0.75	12%
3rd	0.32	0.30	0.35	0.31	0.42	0.65	0.68	0.56	8%
Top Physicians									
Highest	1.60	1.77	1.85	1.86	1.19	1.20	1.36	1.40	-2%
2nd	1.10	1.08	1.07	1.10	1.03	0.99	1.00	1.18	1%
3rd	1.05	1.08	1.04	0.99	1.03	0.91	0.97	1.01	-1%
Top Executives				**Trinity**					
Highest	0.41	0.44	0.49	0.56	0.68	0.83	0.76	0.84	11%
2nd	0.29	0.26	0.26	0.25	0.30	0.35	0.37	0.38	4%
3rd	0.22	0.24	0.22	0.21	0.25	0.28	0.28	0.29	4%
Top Physicians									
Highest	0.99	1.01	0.82	1.08	0.62	0.55	0.85	0.78	-3%
2nd	0.71	0.84	0.55	0.75	0.13	0.20	0.58	0.60	-2%

Source: Tabulations and calculations by Horizon Government Affairs.

Note: Average annual growth rate calculations are from 2010-2017.

II. Hospitals – 50 State Comparisons

Contents: Measures Compared Across All States	ND Rank (highest to lowest)		
	Level		
	BEGIN*	END*	Growth
9. Inpatient Discharges			19
10. Inpatient Days			5
Inpatient Days per 1,000 People	7	4	18
11. Average Length of Stay	11	3	5
12. Occupancy Rate	42	37	24
13. Beds Per Person	5	5	16
14. Operating Expenses			3
Operating Expenses per Person	2	1	4
15. Operating Revenues			4
Operating Revenues per Person	2	2	4
16. Average Salaries per FTE	15	8	9
17. Inpatient Revenue per Discharge	21	6	2
18. Commercial to Medicare Rate Ratio	30	7	5
19. Medicare Case Mix Index	24	35	32
20. Medicare Revenues per Enrollee	3	2	2
21. Medicare Inpatient Revenues			6
22. Medicare Inpatient Revenue per Discharge [+]	42	33	6
23. Medicare Outpatient Revenues			4
24. Medicare Outpatient Revenues per Enrollee	1	1	3
25. Medicaid Revenues			3
26. Medicaid Inpatient Discharges			7
Medicaid Inpatient Days			7
27. Medicaid Revenues per Enrollee	3	1	1
28. Private Patient Revenues per Private Insurance Enrollee	4	3	10
29. Patient Financial Assistance	50	35	3

Source. HGA based on data from the Medicare Hospital Cost Reports.
*Beginning points are 2010 or 2011 and endpoints are 2018 or 2019, depending on data completeness. Growth is based on 2010 or 2011 to 2018 or 2019.

HGA used HCRIS data to make several types of comparisons of North Dakota's hospital costs and utilization with measures from the other states and the nation as a whole. Importantly, these tabulations include data from all hospitals in North Dakota and other states, including federal hospitals, specialty hospitals in the HRCIS data, and additional critical access North Dakota hospitals that did not participate in the data request for this project and whose data were not included in the tables in the prior section. The 50-state comparisons below are based on HCRIS data processed by RAND vintage 8-1-2020.

The 50-state data are shown in cost reporting years, and some data for 2019 may be incomplete. Note that the national totals include Puerto Rico, but data from U.S. territories is not otherwise shown in the tables or rankings. Because some 2019 data may be incomplete – for several measures that are not ratios or averages, we show average annual growth rates for 2010-2018. Other tabulations are based on data that were first reported in 2011. Growth rates for these items may be 2011-2018 or 2011-2019.

8. ***Inpatient Discharges.*** The growth of inpatient discharges (admissions) in North Dakota has been roughly flat in the 2010-2018 period (-0.1% annual growth), while the nationwide trend was for a slight decline during that period (-0.6% per year). Much of the growth in North Dakota admissions was during the 2010-2012 period; the number of admissions in the state has leveled off or declined slowly since 2012 (see Table 12 and Figure 1).

Figure 1.

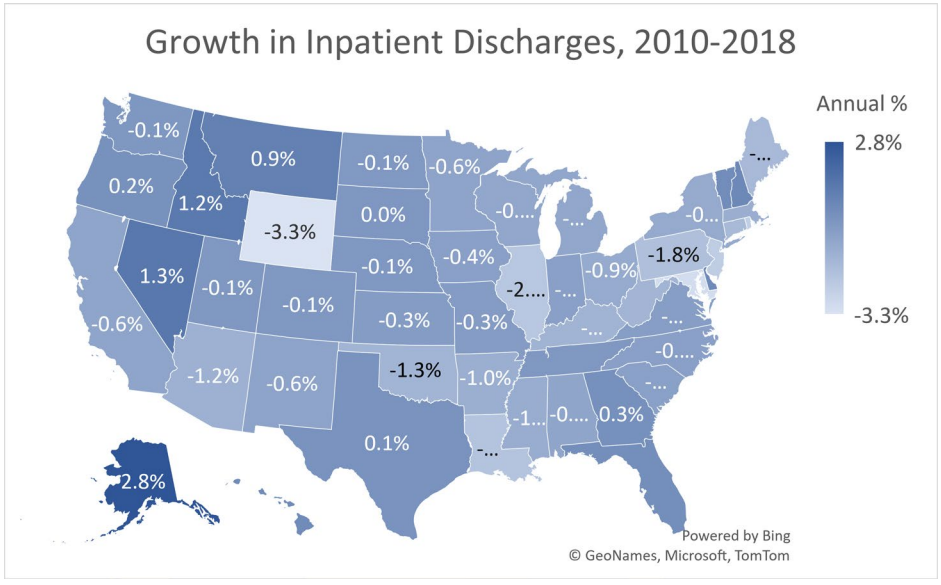


Table 12.

Inpatient Discharges, Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**33,037,591**	**32,258,915**	**32,719,872**	**31,503,146**	**30,776,651**	**30,687,975**	**32,034,872**	**31,662,942**	**31,559,922**	**19,551,291**	**-4%**	**-0.6%**	
AK	40,692	41,482	42,289	49,545	48,288	48,260	50,100	50,237	50,927	8,830	25%	**2.8%**	1
NV	267,527	261,706	249,316	261,473	255,033	259,236	270,488	285,072	297,338	96,852	11%	**1.3%**	2
ID	118,519	115,691	124,040	122,410	121,066	124,914	129,032	132,179	130,863	100,023	10%	**1.2%**	3
MT	92,334	83,364	99,207	90,570	89,092	84,282	100,345	97,470	99,508	35,456	8%	**0.9%**	4
NH	111,194	111,788	103,205	106,978	107,199	110,559	114,779	116,987	116,410	99,392	5%	**0.6%**	5
DE	89,337	89,181	88,620	94,729	95,113	89,683	88,651	91,988	92,991	93,905	4%	**0.5%**	6
HI	91,739	93,825	91,791	94,323	90,513	94,364	93,523	93,100	95,307	61,426	4%	**0.5%**	7
VT	46,297	47,886	47,349	47,339	44,910	44,622	46,752	46,864	47,835	46,247	3%	**0.4%**	8
FL	2,363,259	2,341,619	2,375,930	2,352,639	2,360,140	2,416,881	2,467,503	2,472,978	2,427,187	1,622,253	3%	**0.3%**	9
GA	916,968	884,869	899,501	879,943	883,735	871,283	907,059	931,909	936,231	781,810	2%	**0.3%**	10
OR	336,758	288,249	369,530	321,063	323,385	293,452	375,318	345,530	342,292	164,771	2%	**0.2%**	11
TX	2,461,360	2,411,139	2,481,632	2,401,209	2,337,733	2,393,099	2,487,318	2,466,108	2,491,042	1,761,962	1%	**0.1%**	12
SD	103,577	99,342	99,770	100,575	97,718	97,970	97,877	102,227	103,348	108,636	0%	**0.0%**	13
WA	571,455	554,365	582,838	580,512	551,181	559,676	589,621	554,478	569,009	282,777	0%	**-0.1%**	14
UT	206,061	201,654	212,108	203,658	200,155	198,953	214,122	207,050	205,042	195,637	0%	**-0.1%**	15
CO	410,949	387,526	381,995	373,552	379,145	389,878	395,032	421,390	408,914	210,071	0%	**-0.1%**	16
TN	785,805	743,901	794,957	753,693	746,869	742,592	783,682	802,705	781,692	615,133	-1%	**-0.1%**	17
NE	189,795	191,521	193,495	198,700	183,925	176,314	186,660	190,506	188,573	114,483	-1%	**-0.1%**	18
ND	82,990	87,166	86,149	79,069	80,761	81,276	82,040	83,878	82,269	62,460	-1%	**-0.1%**	19
MO	732,462	691,669	745,962	695,055	689,384	677,482	730,363	691,287	717,693	336,609	-2%	**-0.3%**	20
KS	292,683	284,120	280,314	280,476	277,957	272,034	297,418	291,326	286,707	178,537	-2%	**-0.3%**	21
VA	744,925	733,653	774,700	728,623	694,182	676,563	731,579	722,805	725,153	381,851	-3%	**-0.3%**	22
IN	713,687	721,925	721,932	702,492	673,891	688,125	692,112	685,090	690,096	259,309	-3%	**-0.4%**	23
NC	1,009,792	1,009,166	997,541	983,960	958,917	962,361	958,341	966,085	975,842	703,440	-3%	**-0.4%**	24
IA	309,814	312,337	309,771	302,547	294,715	310,145	305,099	301,643	299,331	237,092	-3%	**-0.4%**	25
SC	491,913	465,421	501,943	476,718	464,124	442,391	487,072	473,829	474,519	389,888	-4%	**-0.4%**	26
NM	176,967	168,374	176,950	175,056	174,025	162,435	177,610	171,178	168,878	96,883	-5%	**-0.6%**	27
MN	533,341	527,131	523,774	514,292	476,431	479,894	482,795	503,350	508,303	147,326	-5%	**-0.6%**	28
CA	3,230,631	3,154,326	3,209,418	3,065,715	3,003,841	3,070,356	3,078,808	3,088,245	3,077,032	1,788,987	-5%	**-0.6%**	29
AL	597,085	547,275	626,000	566,274	548,897	492,071	626,256	570,868	566,382	477,873	-5%	**-0.7%**	30
WI	539,141	527,930	539,659	516,295	507,205	503,236	502,927	504,864	509,112	296,400	-6%	**-0.7%**	31
MI	1,135,201	1,104,030	1,125,269	1,077,565	1,064,629	1,076,685	1,096,118	1,073,652	1,070,885	874,871	-6%	**-0.7%**	32
NY	2,221,877	2,275,337	2,219,632	2,093,975	2,062,251	2,013,226	2,061,254	2,061,174	2,072,839	438,858	-7%	**-0.9%**	33
OH	1,347,787	1,350,913	1,336,688	1,310,339	1,263,643	1,248,253	1,249,710	1,256,955	1,256,532	413,371	-7%	**-0.9%**	34
MS	364,386	344,505	377,666	352,430	332,670	332,069	342,804	333,548	337,207	271,635	-7%	**-1.0%**	35
MA	785,358	753,916	736,848	723,530	692,853	712,309	706,249	717,291	722,789	630,193	-8%	**-1.0%**	36
AR	349,177	326,810	335,577	324,306	312,872	314,803	331,147	322,906	321,186	211,089	-8%	**-1.0%**	37
AZ	678,162	651,399	676,185	629,611	638,468	629,402	636,368	606,802	617,754	276,444	-9%	**-1.2%**	38
KY	583,222	551,789	567,364	538,996	515,465	522,580	559,468	534,777	526,848	351,228	-10%	**-1.3%**	39
OK	444,286	432,975	427,673	421,976	406,501	395,526	402,277	399,046	399,621	313,107	-10%	**-1.3%**	40
WV	245,246	248,142	253,189	236,906	221,918	222,731	217,829	221,933	220,430	141,671	-10%	**-1.3%**	41
ME	141,510	137,366	136,350	131,826	126,161	131,765	127,130	127,949	125,396	109,281	-11%	**-1.5%**	42
CT	386,211	376,133	373,104	366,212	350,809	350,288	354,290	347,916	341,196	324,788	-12%	**-1.5%**	43
DC	114,221	107,552	111,409	91,258	107,206	108,008	106,666	103,900	99,492	72,374	-13%	**-1.7%**	44
PA	1,628,719	1,604,566	1,550,042	1,476,463	1,463,650	1,461,563	1,453,960	1,465,430	1,407,853	1,366,297	-14%	**-1.8%**	45
LA	576,720	550,827	557,297	521,281	494,754	472,563	507,349	492,256	492,084	274,274	-15%	**-2.0%**	46
IL	1,431,844	1,376,797	1,386,853	1,347,141	1,279,093	1,247,594	1,305,143	1,233,313	1,209,676	846,495	-16%	**-2.1%**	47
NJ	1,041,444	1,021,535	972,289	944,768	907,687	907,874	938,255	886,615	861,765	119,912	-17%	**-2.3%**	48
RI	127,860	114,518	111,130	107,116	110,333	109,127	107,068	109,866	104,831	92,764	-18%	**-2.5%**	49
MD	728,299	707,619	692,254	646,818	626,322	577,057	585,125	572,312	568,628	517,448	-22%	**-3.0%**	50
WY	47,004	42,586	41,372	41,146	39,836	40,166	38,970	37,932	35,892	33,673	-24%	**-3.3%**	51

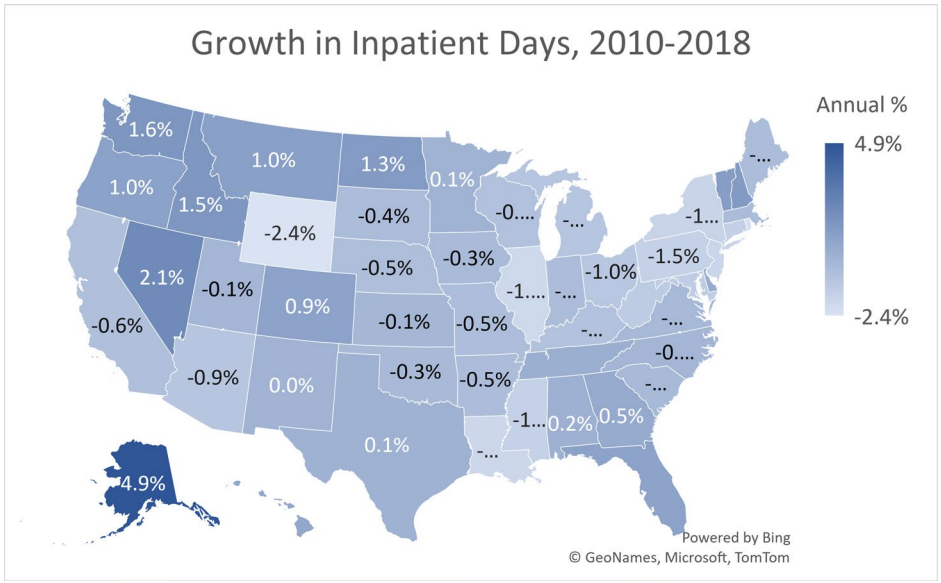
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

9. ***Inpatient Days.*** The number of inpatient days in North Dakota hospitals grew by about 1.3 percent per year from 2010 to 2018, considerably higher than the national trend of negative 0.3 percent per year. North Dakota ranked 4th nationally in the number of hospital inpatient days per person, behind DC, Kentucky, and West Virginia (see Tables 13-14 and Figure 2). In 2010, North Dakota ranked 7th on this measure.

Figure 2.



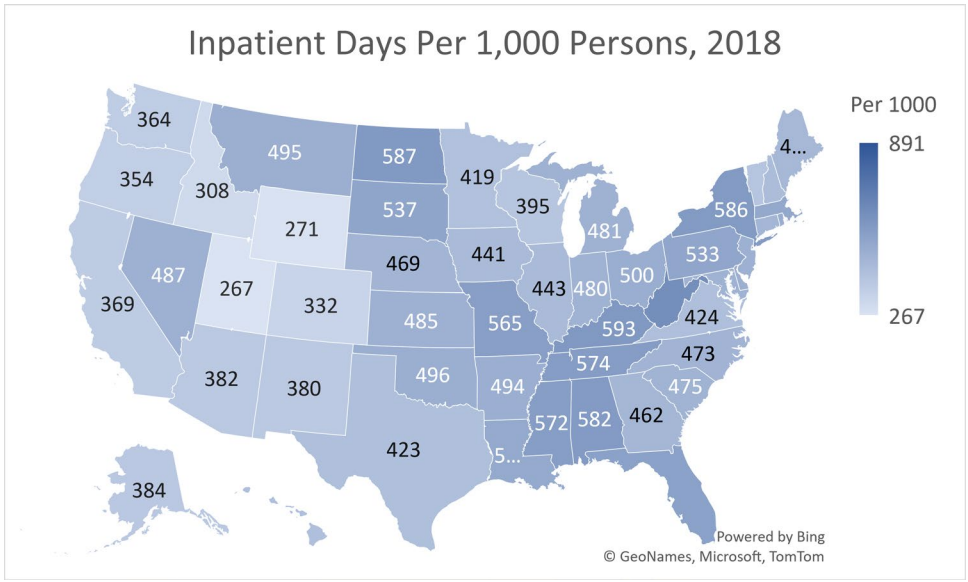


Table 13.

Inpatient Days, Ranked by 2010-2018 Growth					DRAFT						Pct Growth	Avg Annual	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**153,709,358**	**150,570,693**	**151,544,617**	**147,803,091**	**146,181,249**	**146,160,757**	**152,503,841**	**150,461,141**	**150,223,687**	**94,227,228**	**-2%**	**-0.3%**	
AK	190,663	196,536	195,642	245,295	240,087	247,681	264,318	267,155	272,532	38,771	43%	**4.9%**	1
NV	1,222,824	1,214,909	1,177,236	1,228,866	1,232,810	1,256,791	1,323,595	1,418,470	1,454,295	489,828	19%	**2.1%**	2
WA	2,349,729	2,278,286	2,376,738	2,402,490	2,434,733	2,462,416	2,620,805	2,621,780	2,683,497	1,344,038	14%	**1.6%**	3
ID	473,202	455,846	470,769	482,313	484,002	505,666	517,808	525,502	529,459	411,097	12%	**1.5%**	4
ND	399,847	397,282	426,239	397,195	421,771	429,461	448,663	438,657	428,937	346,839	7%	**1.3%**	5
NH	510,709	528,124	488,068	518,035	518,953	539,367	536,246	559,662	568,968	495,852	11%	**1.3%**	6
VT	216,454	223,721	219,831	222,921	218,946	229,578	228,457	234,270	238,734	234,472	10%	**1.1%**	7
MT	473,396	439,615	500,366	481,998	480,263	459,952	527,581	509,262	511,638	245,461	8%	**1.0%**	8
OR	1,389,232	1,190,349	1,515,140	1,342,753	1,382,478	1,240,508	1,646,384	1,486,407	1,457,231	800,267	5%	**1.0%**	9
FL	11,088,086	11,103,036	11,115,773	11,058,176	11,160,129	11,608,367	11,769,094	11,804,165	11,543,506	7,700,295	4%	**0.9%**	10
CO	1,759,573	1,722,659	1,666,509	1,692,146	1,719,615	1,748,526	1,786,734	1,869,663	1,842,222	1,004,663	5%	**0.9%**	11
HI	526,037	533,130	524,279	534,894	524,772	548,447	550,242	550,232	568,381	375,431	8%	**0.6%**	12
GA	4,443,023	4,329,961	4,358,978	4,372,041	4,393,146	4,402,283	4,498,989	4,605,105	4,713,550	3,966,220	6%	**0.5%**	13
DE	440,564	429,432	421,116	420,959	441,072	448,707	438,436	452,946	460,579	470,640	5%	**0.4%**	14
TN	3,793,987	3,639,546	3,876,252	3,693,227	3,644,059	3,649,854	3,852,256	3,866,000	3,781,638	3,061,624	0%	**0.3%**	15
AL	2,778,408	2,615,225	2,935,803	2,742,294	2,703,597	2,442,597	3,104,962	2,810,658	2,766,184	2,309,037	0%	**0.2%**	16
TX	11,627,651	11,365,911	11,541,087	11,416,539	11,332,185	11,600,263	12,095,231	11,730,300	11,853,026	8,259,134	2%	**0.1%**	17
MN	2,211,145	2,211,580	2,201,939	2,158,545	2,148,066	2,169,159	2,204,353	2,223,098	2,297,233	674,177	4%	**0.1%**	18
NM	765,019	730,062	770,542	756,340	759,157	721,219	812,994	767,038	777,408	448,155	2%	**0.0%**	19
UT	860,817	837,537	870,906	842,445	834,036	830,896	889,264	854,173	830,379	800,208	-4%	**-0.1%**	20
NC	4,720,961	4,712,882	4,686,449	4,634,788	4,532,773	4,648,325	4,626,257	4,682,560	4,752,567	3,529,067	1%	**-0.1%**	21
KS	1,385,560	1,361,471	1,359,793	1,358,771	1,337,193	1,295,846	1,382,822	1,372,605	1,366,490	885,208	-1%	**-0.1%**	22
VA	3,501,795	3,416,844	3,638,762	3,449,465	3,409,536	3,293,515	3,514,547	3,446,495	3,472,784	1,895,664	-1%	**-0.2%**	23
DC	622,109	584,753	595,005	601,567	599,213	615,423	615,547	611,140	595,346	483,191	-4%	**-0.3%**	24
SC	2,391,514	2,296,009	2,429,413	2,342,687	2,310,801	2,247,490	2,434,013	2,343,355	2,341,395	1,994,851	-2%	**-0.3%**	25
OK	1,945,806	2,025,458	1,987,106	1,999,194	1,931,363	1,889,134	1,916,544	1,905,415	1,892,813	1,602,447	-3%	**-0.3%**	26
IA	1,404,474	1,422,231	1,380,210	1,366,233	1,370,053	1,389,802	1,374,183	1,371,707	1,348,317	1,118,446	-4%	**-0.3%**	27
MA	3,511,870	3,440,396	3,365,692	3,412,396	3,332,239	3,405,606	3,359,144	3,418,138	3,474,748	3,110,494	-1%	**-0.4%**	28
SD	480,601	458,469	466,439	467,791	458,228	462,227	468,426	467,706	456,096	492,312	-5%	**-0.4%**	29
ME	623,516	622,660	612,484	608,919	596,522	626,367	606,747	604,364	590,898	546,548	-5%	**-0.4%**	30
IN	3,232,183	3,245,114	3,262,140	3,237,724	3,119,823	3,148,789	3,169,442	3,130,019	3,115,153	1,157,442	-4%	**-0.5%**	31
AR	1,488,404	1,441,193	1,466,380	1,431,886	1,395,500	1,407,086	1,456,542	1,439,177	1,443,282	956,119	-3%	**-0.5%**	32
MO	3,422,387	3,238,832	3,472,774	3,213,822	3,211,181	3,153,999	3,475,597	3,308,126	3,351,426	1,607,777	-2%	**-0.5%**	33
NE	907,711	891,017	886,565	898,811	850,902	842,313	872,382	874,399	876,520	542,938	-3%	**-0.5%**	34
CA	14,825,019	14,540,464	14,442,698	14,049,792	13,808,521	14,131,843	14,317,030	14,205,178	14,289,729	8,628,451	-4%	**-0.6%**	35
WI	2,323,338	2,297,030	2,280,543	2,199,785	2,228,566	2,248,174	2,212,111	2,216,117	2,234,787	1,322,894	-4%	**-0.7%**	36
KY	2,754,486	2,620,549	2,665,857	2,575,393	2,490,856	2,489,726	2,724,635	2,618,446	2,562,047	1,713,966	-7%	**-0.7%**	37
MI	5,088,109	5,012,382	5,012,976	4,865,093	4,802,119	4,787,733	4,838,107	4,781,209	4,700,209	3,914,442	-8%	**-0.9%**	38
AZ	2,819,369	2,697,701	2,763,464	2,639,135	2,699,790	2,655,640	2,768,782	2,643,867	2,677,263	1,171,798	-5%	**-0.9%**	39
OH	6,015,522	5,995,580	5,950,661	5,770,570	5,673,305	5,656,582	5,613,562	5,616,708	5,673,148	1,974,795	-6%	**-1.0%**	40
WV	1,188,826	1,176,358	1,189,070	1,130,279	1,095,694	1,089,238	1,063,963	1,090,474	1,117,270	689,385	-6%	**-1.2%**	41
MD	3,138,118	3,131,509	3,073,319	2,938,385	2,966,812	2,883,584	2,905,389	2,863,325	2,812,642	2,659,627	-10%	**-1.3%**	42
CT	1,785,427	1,794,358	1,733,046	1,770,671	1,697,910	1,690,443	1,630,544	1,614,909	1,612,834	1,548,358	-10%	**-1.4%**	43
MS	1,827,533	1,720,521	1,892,324	1,761,510	1,682,951	1,709,375	1,734,821	1,642,681	1,646,255	1,399,007	-10%	**-1.5%**	44
PA	7,644,619	7,528,047	7,291,373	7,016,280	6,880,096	6,806,438	6,755,301	6,865,321	6,605,541	6,418,052	-14%	**-1.5%**	45
NY	12,455,087	12,292,605	11,990,625	11,406,386	11,328,085	10,989,221	11,217,798	11,094,547	11,138,353	2,327,199	-11%	**-1.6%**	46
NJ	4,817,824	4,748,172	4,565,961	4,416,920	4,396,627	4,407,866	4,278,035	4,253,786	4,244,497	555,875	-12%	**-1.8%**	47
LA	2,706,573	2,529,634	2,625,090	2,510,911	2,409,905	2,294,566	2,468,175	2,382,164	2,343,736	1,313,438	-13%	**-1.8%**	48
IL	6,382,330	6,139,383	6,101,276	6,031,966	5,804,332	5,669,310	5,888,273	5,586,883	5,511,848	3,904,712	-14%	**-1.9%**	49
RI	594,423	577,989	533,809	519,672	524,043	520,596	502,862	507,158	506,741	439,639	-15%	**-2.2%**	50
WY	183,499	168,336	170,102	166,818	162,434	162,763	161,344	154,532	151,841	140,898	-17%	**-2.4%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

Table 14.

Inpatient Days per 1,000 Residents, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**511**	**497**	**496**	**481**	**471**	**467**	**485**	**475**	**472**	**292**	**-8%**	**-1.0%**	
DC	1,091	1,001	998	986	961	969	955	929	**891**	712	-18%	-2.5%	1
WV	661	653	660	629	612	608	597	619	**638**	396	-4%	-0.4%	2
KY	655	620	629	604	584	581	635	608	**593**	396	-9%	-1.2%	3
ND	618	605	634	573	595	591	618	604	**587**	472	-5%	-0.6%	4
NY	660	649	630	597	590	570	584	574	**586**	124	-11%	-1.5%	5
AL	597	559	625	583	574	516	656	593	**582**	485	-3%	-0.3%	6
TN	613	584	617	584	572	568	596	591	**574**	461	-6%	-0.8%	7
MS	637	598	656	610	583	592	601	569	**572**	487	-10%	-1.3%	8
MO	590	556	596	549	547	535	589	559	**565**	270	-4%	-0.5%	9
FL	603	596	589	579	574	586	584	575	**554**	364	-8%	-1.1%	10
SD	611	579	583	576	558	558	560	559	**537**	572	-12%	-1.6%	11
PA	622	611	591	568	556	550	546	554	**533**	518	-14%	-1.9%	12
MA	555	541	525	529	512	519	511	516	**522**	464	-6%	-0.8%	13
LA	615	571	589	560	535	506	545	525	**519**	292	-16%	-2.1%	14
RI	589	574	530	515	517	513	496	499	**500**	434	-15%	-2.0%	15
OH	536	534	530	513	503	501	498	496	**500**	173	-7%	-0.9%	16
OK	535	553	539	536	515	499	504	501	**496**	419	-7%	-0.9%	17
MT	492	452	511	489	483	457	520	498	**495**	235	1%	0.1%	18
AR	525	506	513	499	485	488	503	495	**494**	326	-6%	-0.8%	19
DE	505	488	474	469	487	489	474	486	**491**	499	-3%	-0.4%	20
NV	460	454	434	448	441	442	458	481	**487**	162	6%	0.7%	21
NJ	559	550	526	507	502	502	488	482	**486**	64	-13%	-1.7%	22
KS	502	491	488	486	476	460	491	487	**485**	315	-3%	-0.4%	23
MI	527	519	519	503	496	494	499	492	**481**	399	-9%	-1.1%	24
IN	514	514	515	509	488	491	493	485	**480**	178	-7%	-0.8%	25
MD	558	552	537	509	510	494	496	486	**479**	455	-14%	-1.9%	26
SC	534	508	532	507	494	475	507	482	**475**	399	-11%	-1.5%	27
NC	511	504	496	487	471	478	471	471	**473**	348	-7%	-1.0%	28
NE	513	500	494	496	467	458	473	470	**469**	289	-8%	-1.1%	29
CT	515	518	498	509	488	486	471	464	**465**	448	-10%	-1.3%	30
GA	472	455	453	451	449	444	450	455	**462**	385	-2%	-0.3%	31
ME	483	482	474	471	461	485	469	465	**455**	421	-6%	-0.8%	32
IL	509	489	485	480	462	452	471	447	**443**	315	-13%	-1.7%	33
IA	476	480	464	457	456	460	453	450	**441**	365	-7%	-1.0%	34
NH	400	413	381	404	403	419	415	432	**434**	375	8%	1.0%	35
VA	455	439	463	434	426	409	435	423	**424**	231	-7%	-0.9%	36
TX	473	455	455	443	431	433	445	425	**423**	290	-11%	-1.4%	37
HI	404	406	394	402	389	403	403	406	**420**	277	4%	0.5%	38
MN	426	423	419	408	403	404	409	408	**419**	122	-2%	-0.2%	39
VT	361	373	366	370	365	381	381	390	**397**	390	10%	1.2%	40
WI	420	414	410	393	398	400	393	393	**395**	233	-6%	-0.8%	41
AK	279	282	277	348	340	350	370	376	**384**	55	38%	4.1%	42
AZ	451	427	433	408	412	399	410	386	**382**	163	-15%	-2.0%	43
NM	379	358	378	371	373	354	401	376	**380**	218	0%	0.0%	44
CA	406	394	388	375	364	369	372	367	**369**	223	-9%	-1.2%	45
WA	357	342	353	353	353	352	368	362	**364**	179	2%	0.2%	46
OR	369	314	396	349	355	314	410	366	**354**	192	-4%	-0.5%	47
CO	358	346	330	330	330	329	331	342	**332**	178	-7%	-0.9%	48
ID	307	295	301	305	303	313	314	312	**308**	234	0%	0.0%	49
WY	335	305	304	294	286	286	283	274	**271**	253	-19%	-2.6%	50
UT	316	303	311	296	288	282	296	280	**267**	253	-15%	-2.1%	51

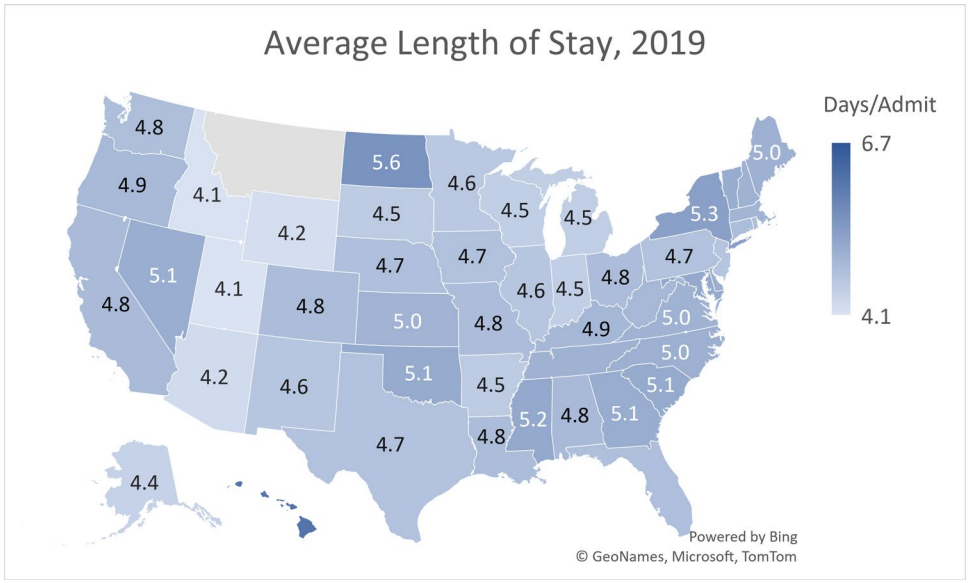
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

10. Average Length of Stay. The average number of inpatient days per discharge nationwide has remained roughly constant at about 4.7-4.8 days. However, North Dakota's average length of stay increased from 4.8 to 5.5 between 2010 and 2019, a rate of growth among the highest in the nation (see Table 15 and Figure 3). As a result, North Dakota's rank on average length of stay rose from 11th in 2010 to 3rd in 2019.

Figure 3.



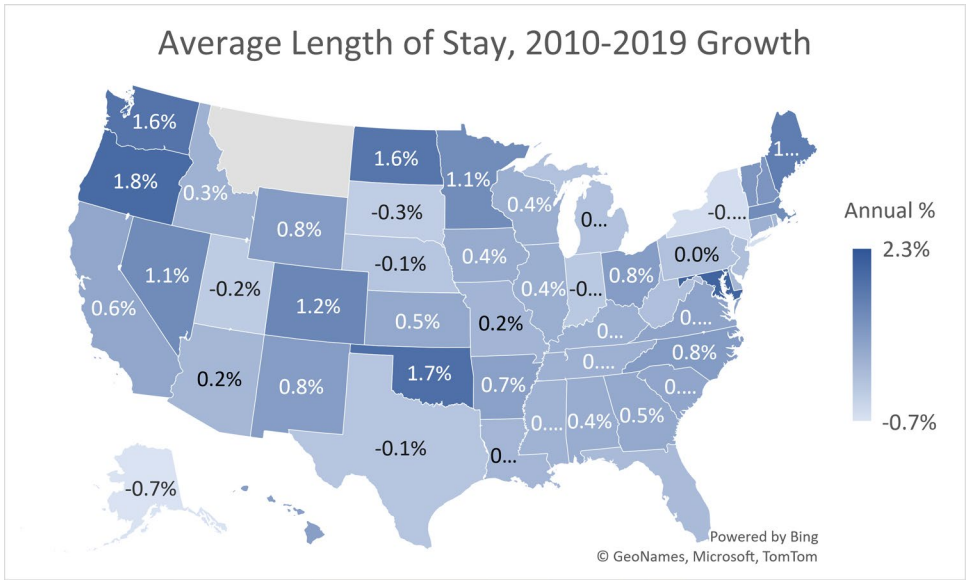


Table 15.

Average Length of Inpatient Stay (number of days), Ranked by 2019 Level							DRAFT				Pct Growth Avg Annual		
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019	Growth	Rank
US	**4.65**	**4.67**	**4.63**	**4.69**	**4.75**	**4.76**	**4.76**	**4.75**	**4.76**	**4.82**	**4%**	**0.4%**	
DC	5.45	5.44	5.34	6.59	5.59	5.70	5.77	5.88	5.98	**6.68**	23%	2.3%	1
HI	5.73	5.68	5.71	5.67	5.80	5.81	5.88	5.91	5.96	**6.11**	7%	0.7%	2
ND	4.82	4.56	4.95	5.02	5.22	5.28	5.47	5.23	5.21	**5.55**	15%	1.6%	3
NY	5.61	5.40	5.40	5.45	5.49	5.46	5.44	5.38	5.37	**5.30**	-5%	-0.6%	4
MS	5.02	4.99	5.01	5.00	5.06	5.15	5.06	4.92	4.88	**5.15**	3%	0.3%	5
MD	4.31	4.43	4.44	4.54	4.74	5.00	4.97	5.00	4.95	**5.14**	19%	2.0%	6
OK	4.38	4.68	4.65	4.74	4.75	4.78	4.76	4.77	4.74	**5.12**	17%	1.7%	7
SC	4.86	4.93	4.84	4.91	4.98	5.08	5.00	4.95	4.93	**5.12**	5%	0.6%	8
GA	4.85	4.89	4.85	4.97	4.97	5.05	4.96	4.94	5.03	**5.07**	5%	0.5%	9
VT	4.68	4.67	4.64	4.71	4.88	5.14	4.89	5.00	4.99	**5.07**	8%	0.9%	10
NV	4.57	4.64	4.72	4.70	4.83	4.85	4.89	4.98	4.89	**5.06**	11%	1.1%	11
NC	4.68	4.67	4.70	4.71	4.73	4.83	4.83	4.85	4.87	**5.02**	7%	0.8%	12
DE	4.93	4.82	4.75	4.44	4.64	5.00	4.95	4.92	4.95	**5.01**	2%	0.2%	13
ME	4.41	4.53	4.49	4.62	4.73	4.75	4.77	4.72	4.71	**5.00**	14%	1.4%	14
NH	4.59	4.72	4.73	4.84	4.84	4.88	4.67	4.78	4.89	**4.99**	9%	0.9%	15
TN	4.83	4.89	4.88	4.90	4.88	4.92	4.92	4.82	4.84	**4.98**	3%	0.3%	16
VA	4.70	4.66	4.70	4.73	4.91	4.87	4.80	4.77	4.79	**4.96**	6%	0.6%	17
KS	4.73	4.79	4.85	4.84	4.81	4.76	4.65	4.71	4.77	**4.96**	5%	0.5%	18
MA	4.47	4.56	4.57	4.72	4.81	4.78	4.76	4.77	4.81	**4.94**	10%	1.1%	19
KY	4.72	4.75	4.70	4.78	4.83	4.76	4.87	4.90	4.86	**4.88**	3%	0.4%	20
WV	4.85	4.74	4.70	4.77	4.94	4.89	4.88	4.91	5.07	**4.87**	0%	0.0%	21
OR	4.13	4.13	4.10	4.18	4.28	4.23	4.39	4.30	4.26	**4.86**	18%	1.8%	22
AL	4.65	4.78	4.69	4.84	4.93	4.96	4.96	4.92	4.88	**4.83**	4%	0.4%	23
CA	4.59	4.61	4.50	4.58	4.60	4.60	4.65	4.60	4.64	**4.82**	5%	0.6%	24
LA	4.69	4.59	4.71	4.82	4.87	4.86	4.86	4.84	4.76	**4.79**	2%	0.2%	25
CO	4.28	4.45	4.36	4.53	4.54	4.48	4.52	4.44	4.51	**4.78**	12%	1.2%	26
OH	4.46	4.44	4.45	4.40	4.49	4.53	4.49	4.47	4.51	**4.78**	7%	0.8%	27
MO	4.67	4.68	4.66	4.62	4.66	4.66	4.76	4.79	4.67	**4.78**	2%	0.2%	28
CT	4.62	4.77	4.64	4.84	4.84	4.83	4.60	4.64	4.73	**4.77**	3%	0.3%	29
WA	4.11	4.11	4.08	4.14	4.42	4.40	4.44	4.73	4.72	**4.75**	16%	1.6%	30
FL	4.69	4.74	4.68	4.70	4.73	4.80	4.77	4.77	4.76	**4.75**	1%	0.1%	31
NE	4.78	4.65	4.58	4.52	4.63	4.78	4.67	4.59	4.65	**4.74**	-1%	-0.1%	32
RI	4.65	5.05	4.80	4.85	4.75	4.77	4.70	4.62	4.83	**4.74**	2%	0.2%	33
IA	4.53	4.55	4.46	4.52	4.65	4.48	4.50	4.55	4.50	**4.72**	4%	0.4%	34
PA	4.69	4.69	4.70	4.75	4.70	4.66	4.65	4.68	4.69	**4.70**	0%	0.0%	35
TX	4.72	4.71	4.65	4.75	4.85	4.85	4.86	4.76	4.76	**4.69**	-1%	-0.1%	36
NJ	4.63	4.65	4.70	4.68	4.84	4.86	4.56	4.80	4.93	**4.64**	0%	0.0%	37
NM	4.32	4.34	4.35	4.32	4.36	4.44	4.58	4.48	4.60	**4.63**	7%	0.8%	38
IL	4.46	4.46	4.40	4.48	4.54	4.54	4.51	4.53	4.56	**4.61**	3%	0.4%	39
MN	4.15	4.20	4.20	4.20	4.51	4.52	4.57	4.42	4.52	**4.58**	10%	1.1%	40
SD	4.64	4.62	4.68	4.65	4.69	4.72	4.79	4.58	4.41	**4.53**	-2%	-0.3%	41
AR	4.26	4.41	4.37	4.42	4.46	4.47	4.40	4.46	4.49	**4.53**	6%	0.7%	42
MI	4.48	4.54	4.45	4.51	4.51	4.45	4.41	4.45	4.39	**4.47**	0%	0.0%	43
IN	4.53	4.50	4.52	4.61	4.63	4.58	4.58	4.57	4.51	**4.46**	-1%	-0.2%	44
WI	4.31	4.35	4.23	4.26	4.39	4.47	4.40	4.39	4.39	**4.46**	4%	0.4%	45
AK	4.69	4.74	4.63	4.95	4.97	5.13	5.28	5.32	5.35	**4.39**	-6%	-0.7%	46
AZ	4.16	4.14	4.09	4.19	4.23	4.22	4.35	4.36	4.33	**4.24**	2%	0.2%	47
WY	3.90	3.95	4.11	4.05	4.08	4.05	4.14	4.07	4.23	**4.18**	7%	0.8%	48
ID	3.99	3.94	3.80	3.94	4.00	4.05	4.01	3.98	4.05	**4.11**	3%	0.3%	49
UT	4.18	4.15	4.11	4.14	4.17	4.18	4.15	4.13	4.05	**4.09**	-2%	-0.2%	50
MT	5.13	5.27	5.04	5.32	5.39	5.46	5.26	5.22	5.14	*	0%	0.0%	

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete, but the ratio should be consistent with prior years -- average Annual Growth from 2010-2019. Montana growth 2010-2018.

11. ***Occupancy Rate.*** Table 16 shows that North Dakota had slightly lower-than-average statewide occupancy rate in the 2010-2019 period, with a 2019 rate of 54 percent, compared with a U.S. average of 62 percent. However, North Dakota's measured occupancy rate in the HCRIS data is somewhat higher than that of other rural states in the region, such as South Dakota, Montana, and Wyoming. Importantly, HCRIS and AHA measures of occupancy rates were quite different for some hospitals, so it is possible that the HCRIS measure shown here is somewhat uncertain, particularly in the absolute amount. Nevertheless, we believe the HCRIS measures are suitable for comparisons from state to state.

Figure 4.

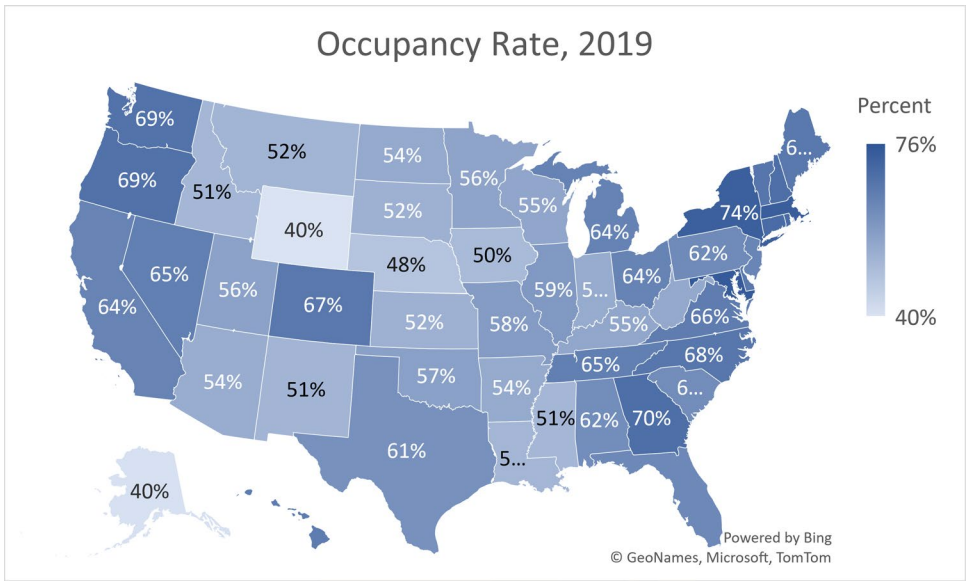


Table 16.

Occupancy Rate, Ranked by 2019 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019	Growth	Rank
US	**63%**	**62%**	**61%**	**60%**	**60%**	**61%**	**61%**	**61%**	**62%**	**62%**	**0%**	**-0.1%**	
DC	74%	71%	70%	71%	73%	75%	76%	76%	75%	**76%**	3%	0.3%	1
MD	76%	76%	75%	75%	74%	75%	75%	75%	73%	**75%**	-1%	-0.1%	2
MA	71%	71%	68%	68%	68%	70%	69%	70%	71%	**74%**	4%	0.4%	3
NY	78%	78%	76%	75%	74%	75%	75%	75%	75%	**74%**	-6%	-0.6%	4
RI	71%	69%	64%	62%	59%	63%	62%	62%	64%	**70%**	-1%	-0.1%	5
CT	73%	72%	71%	71%	69%	70%	67%	65%	67%	**70%**	-4%	-0.4%	6
NH	61%	63%	62%	63%	63%	66%	64%	67%	68%	**70%**	14%	1.5%	7
GA	64%	63%	62%	64%	65%	66%	66%	67%	69%	**70%**	9%	1.0%	8
OR	62%	61%	60%	60%	60%	62%	65%	65%	64%	**69%**	11%	1.1%	9
WA	66%	64%	63%	65%	65%	69%	69%	70%	69%	**69%**	4%	0.4%	10
VT	64%	64%	63%	66%	63%	65%	64%	65%	66%	**68%**	6%	0.6%	11
NC	67%	66%	66%	65%	64%	66%	65%	66%	66%	**68%**	1%	0.1%	12
CO	61%	60%	59%	59%	59%	60%	59%	59%	61%	**67%**	11%	1.1%	13
ME	57%	58%	56%	56%	58%	60%	61%	61%	62%	**67%**	18%	1.9%	14
DE	67%	65%	64%	67%	68%	69%	64%	65%	65%	**67%**	0%	0.0%	15
HI	63%	63%	71%	74%	73%	72%	71%	70%	66%	**66%**	5%	0.5%	16
VA	61%	63%	60%	61%	60%	63%	61%	64%	64%	**66%**	7%	0.8%	17
TN	59%	60%	58%	58%	58%	62%	62%	63%	63%	**65%**	10%	1.1%	18
NV	66%	67%	66%	66%	70%	71%	71%	72%	73%	**65%**	-1%	-0.1%	19
MI	64%	64%	63%	63%	63%	64%	62%	62%	63%	**64%**	1%	0.1%	20
OH	61%	61%	61%	60%	60%	61%	60%	59%	60%	**64%**	4%	0.5%	21
CA	64%	63%	60%	59%	58%	59%	60%	60%	60%	**64%**	1%	0.1%	22
NJ	72%	70%	69%	68%	68%	67%	67%	66%	67%	**64%**	-11%	-1.3%	23
FL	62%	62%	61%	61%	62%	65%	65%	65%	64%	**63%**	1%	0.1%	24
PA	67%	66%	63%	62%	60%	61%	61%	62%	62%	**62%**	-6%	-0.7%	25
SC	62%	62%	61%	60%	60%	61%	61%	61%	61%	**62%**	0%	0.0%	26
AL	56%	55%	54%	56%	56%	58%	58%	58%	59%	**62%**	11%	1.1%	27
TX	59%	58%	57%	58%	58%	60%	60%	60%	61%	**61%**	3%	0.3%	28
IL	61%	61%	59%	57%	57%	59%	57%	57%	57%	**59%**	-4%	-0.5%	29
MO	58%	57%	56%	55%	56%	58%	58%	57%	59%	**58%**	-1%	-0.1%	30
OK	53%	54%	51%	51%	51%	52%	50%	52%	52%	**57%**	7%	0.7%	31
UT	56%	57%	54%	54%	54%	56%	54%	54%	53%	**56%**	1%	0.1%	32
MN	58%	58%	57%	57%	57%	58%	59%	60%	61%	**56%**	-4%	-0.4%	33
WI	55%	55%	54%	54%	53%	54%	54%	54%	56%	**55%**	0%	0.0%	34
KY	60%	59%	58%	57%	55%	56%	58%	58%	57%	**55%**	-8%	-0.9%	35
WV	55%	57%	55%	54%	54%	53%	53%	53%	57%	**55%**	-2%	-0.2%	36
ND	54%	55%	55%	54%	55%	56%	54%	54%	53%	**54%**	0%	0.0%	37
AR	54%	54%	53%	51%	52%	52%	52%	52%	53%	**54%**	0%	0.0%	38
IN	57%	58%	57%	57%	55%	57%	57%	57%	57%	**54%**	-6%	-0.7%	39
AZ	63%	62%	59%	58%	57%	57%	58%	58%	59%	**54%**	-15%	-1.8%	40
SD	48%	48%	48%	46%	46%	48%	48%	48%	47%	**52%**	10%	1.1%	41
KS	50%	49%	49%	48%	48%	49%	50%	50%	51%	**52%**	6%	0.6%	42
MT	53%	53%	52%	54%	51%	52%	51%	52%	52%	**52%**	-3%	-0.4%	43
NM	57%	57%	55%	52%	52%	53%	56%	56%	57%	**51%**	-10%	-1.2%	44
LA	55%	53%	51%	50%	50%	49%	50%	51%	51%	**51%**	-7%	-0.8%	45
MS	51%	51%	48%	49%	48%	49%	47%	46%	49%	**51%**	0%	0.0%	46
ID	49%	49%	48%	50%	49%	51%	52%	53%	52%	**51%**	3%	0.4%	47
IA	50%	51%	50%	50%	50%	51%	51%	52%	51%	**50%**	0%	0.0%	48
NE	51%	50%	48%	47%	48%	49%	49%	50%	50%	**48%**	-8%	-0.9%	49
AK	53%	54%	52%	58%	56%	57%	59%	57%	58%	**40%**	-25%	-3.1%	50
WY	42%	39%	39%	38%	39%	39%	38%	37%	35%	**40%**	-5%	-0.6%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete.

12. ***Beds Per Capita.*** Table 17 shows North Dakota's inpatient beds per 1,000 people, ranked by the 2017 ratios for each state (2018 data was incomplete). Among the states, North Dakota was 5th highest in inpatient beds per resident, behind only Mississippi, DC, West Virginia, and South Dakota.

Figure 5.

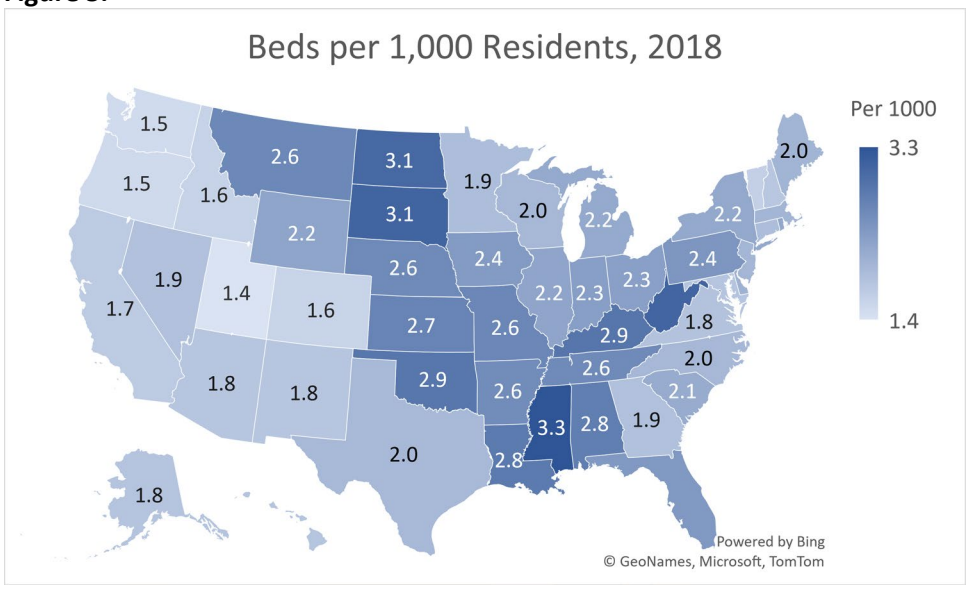


Table 17.

Inpatient Beds Per Thousand Residents, Ranked by 2018 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**2.3**	**2.2**	**2.3**	**2.2**	**2.2**	**2.1**	**2.2**	**2.1**	**2.1**	**1.3**	**-6%**	**-0.7%**	
MS	3.5	3.3	3.8	3.5	3.6	3.4	3.6	3.4	**3.3**	2.7	-5%	-0.7%	1
DC	4.4	4.0	3.9	3.8	3.6	3.6	3.4	3.4	**3.2**	2.6	-26%	-3.7%	2
SD	3.4	3.4	3.3	3.4	3.3	3.2	3.2	3.2	**3.1**	3.3	-9%	-1.1%	3
WV	3.3	3.3	3.4	3.2	3.2	3.2	3.1	3.3	**3.1**	2.0	-7%	-1.0%	4
ND	3.1	3.1	3.1	3.1	3.0	2.9	3.1	3.0	**3.1**	2.5	-2%	-0.3%	5
KY	3.0	2.9	3.1	2.9	2.9	2.9	3.0	2.9	**2.9**	2.0	-5%	-0.6%	6
OK	2.8	2.9	3.0	2.9	2.8	2.6	2.8	2.8	**2.9**	2.1	2%	0.2%	7
LA	3.1	3.0	3.2	3.3	3.0	2.9	3.1	2.9	**2.8**	1.7	-10%	-1.3%	8
AL	3.0	2.9	3.2	2.8	2.9	2.6	3.3	2.8	**2.8**	2.2	-8%	-1.0%	9
KS	2.8	2.7	2.9	2.8	2.7	2.6	2.7	2.7	**2.7**	1.7	-4%	-0.5%	10
MO	2.8	2.7	2.9	2.8	2.7	2.6	2.8	2.7	**2.6**	1.3	-7%	-0.9%	11
MT	2.6	2.3	2.7	2.5	2.8	2.5	2.8	2.6	**2.6**	1.3	2%	0.3%	12
NE	2.7	2.7	2.9	3.1	2.7	2.6	2.7	2.6	**2.6**	1.7	-3%	-0.4%	13
TN	2.9	2.7	2.9	2.8	2.8	2.6	2.7	2.6	**2.6**	1.9	-10%	-1.3%	14
AR	2.6	2.6	2.7	2.7	2.7	2.6	2.7	2.7	**2.6**	1.8	-3%	-0.3%	15
PA	2.6	2.6	2.6	2.6	2.6	2.5	2.5	2.6	**2.4**	2.3	-5%	-0.6%	16
FL	2.7	2.7	2.6	2.6	2.6	2.5	2.5	2.5	**2.4**	1.6	-9%	-1.2%	17
IA	2.6	2.6	2.6	2.5	2.4	2.5	2.4	2.4	**2.4**	2.1	-9%	-1.1%	18
IN	2.5	2.4	2.5	2.5	2.4	2.4	2.4	2.3	**2.3**	0.9	-6%	-0.7%	19
OH	2.4	2.4	2.4	2.3	2.3	2.3	2.3	2.3	**2.3**	0.8	-5%	-0.7%	20
WY	2.2	2.1	2.2	2.1	2.1	2.0	2.0	2.1	**2.2**	1.8	2%	0.2%	21
IL	2.3	2.2	2.3	2.3	2.2	2.1	2.3	2.2	**2.2**	1.5	-2%	-0.3%	22
RI	2.3	2.3	2.3	2.3	2.8	2.2	2.2	2.2	**2.2**	1.7	-4%	-0.5%	23
NY	2.4	2.3	2.3	2.3	2.2	2.2	2.2	2.1	**2.2**	0.5	-7%	-1.0%	24
MI	2.3	2.2	2.3	2.2	2.2	2.2	2.2	2.2	**2.2**	1.7	-5%	-0.7%	25
SC	2.4	2.3	2.5	2.4	2.3	2.1	2.4	2.2	**2.1**	1.9	-10%	-1.3%	26
DE	2.1	2.1	2.0	2.0	2.0	2.0	2.0	2.1	**2.1**	2.1	0%	0.0%	27
ME	2.3	2.4	2.3	2.3	2.3	2.2	2.1	2.1	**2.0**	2.0	-14%	-1.8%	28
MA	2.1	2.1	2.1	2.3	2.1	2.0	2.0	2.0	**2.0**	1.7	-5%	-0.7%	29
NJ	2.2	2.2	2.1	2.1	2.1	2.1	2.1	2.0	**2.0**	0.3	-8%	-1.0%	30
NC	2.1	2.1	2.1	2.1	2.1	2.1	2.0	2.0	**2.0**	1.5	-6%	-0.8%	31
WI	2.1	2.1	2.1	2.1	2.1	2.0	2.0	2.0	**2.0**	1.2	-5%	-0.7%	32
TX	2.2	2.1	2.2	2.1	2.1	2.0	2.0	2.0	**2.0**	1.3	-12%	-1.6%	33
CT	1.9	2.0	1.9	2.0	1.9	1.9	1.6	2.0	**1.9**	1.8	-2%	-0.2%	34
MN	2.0	2.0	2.0	2.0	2.0	1.9	1.9	1.9	**1.9**	0.6	-6%	-0.8%	35
GA	2.1	2.0	2.0	2.0	1.9	1.9	2.0	1.9	**1.9**	1.6	-9%	-1.2%	36
NV	1.9	1.9	1.8	1.9	1.7	1.7	1.8	1.8	**1.9**	0.7	-2%	-0.3%	37
VA	2.0	1.9	2.1	2.0	2.0	1.8	2.0	1.8	**1.8**	1.0	-9%	-1.2%	38
AK	1.4	1.4	1.5	1.7	1.7	1.7	1.7	1.8	**1.8**	0.4	26%	2.9%	39
HI	1.8	1.8	1.5	1.5	1.5	1.5	1.5	1.6	**1.8**	1.2	3%	0.4%	40
MD	2.0	2.0	2.0	1.9	1.9	1.8	1.8	1.8	**1.8**	1.7	-12%	-1.6%	41
NM	1.8	1.8	1.9	2.0	1.9	1.8	2.0	1.9	**1.8**	1.2	-2%	-0.3%	42
AZ	2.0	1.9	2.0	2.0	2.1	2.1	2.0	1.9	**1.8**	0.9	-10%	-1.3%	43
NH	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.9	**1.8**	1.5	-1%	-0.2%	44
CA	1.8	1.7	1.8	1.8	1.7	1.7	1.7	1.7	**1.7**	1.0	-2%	-0.3%	45
VT	1.5	1.6	1.6	1.5	1.6	1.6	1.6	1.7	**1.7**	1.6	8%	0.9%	46
ID	1.7	1.6	1.7	1.7	1.7	1.7	1.7	1.6	**1.6**	1.3	-6%	-0.7%	47
CO	1.6	1.6	1.6	1.5	1.5	1.5	1.6	1.6	**1.6**	0.7	-2%	-0.2%	48
OR	1.7	1.4	1.8	1.6	1.6	1.4	1.8	1.5	**1.5**	0.8	-9%	-1.2%	49
WA	1.5	1.6	1.6	1.5	1.5	1.4	1.5	1.5	**1.5**	0.7	1%	0.1%	50
UT	1.6	1.5	1.6	1.5	1.5	1.4	1.5	1.4	**1.4**	1.2	-11%	-1.4%	51

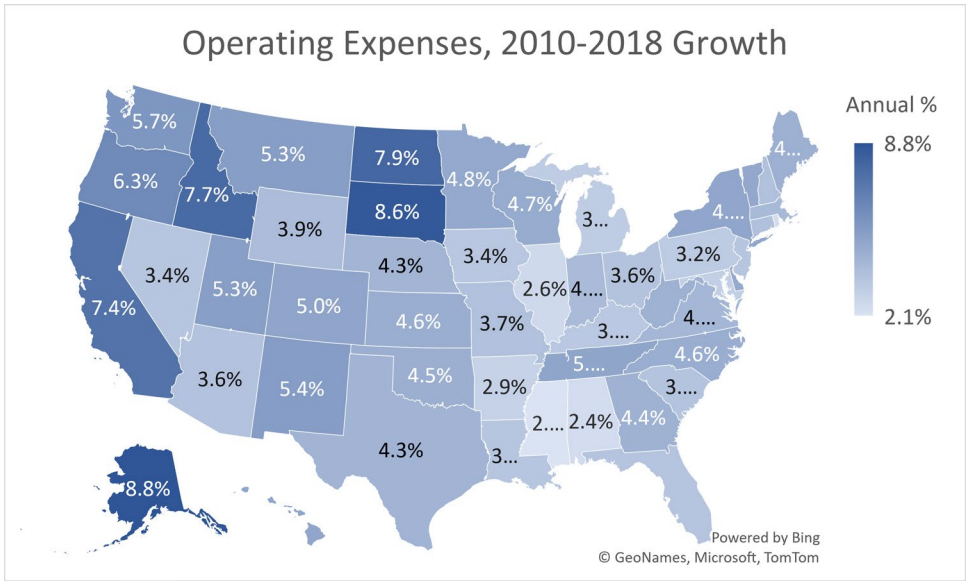
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

13. ***Operating Expenses.*** Overall operating expenses for North Dakota hospitals grew by an average of 7.9 percent annually between 2010 and 2018, well above the national average of 4.5 percent per year. Only South Dakota and Alaska had more rapid rates of growth in expenses during this period (see Tables 18-19 and Figure 6). North Dakota's hospital operating expenses per state resident were highest in the nation in 2018. Between 2010 and 2018, North Dakota overtook DC for the highest expenses per capita.

Figure 6.



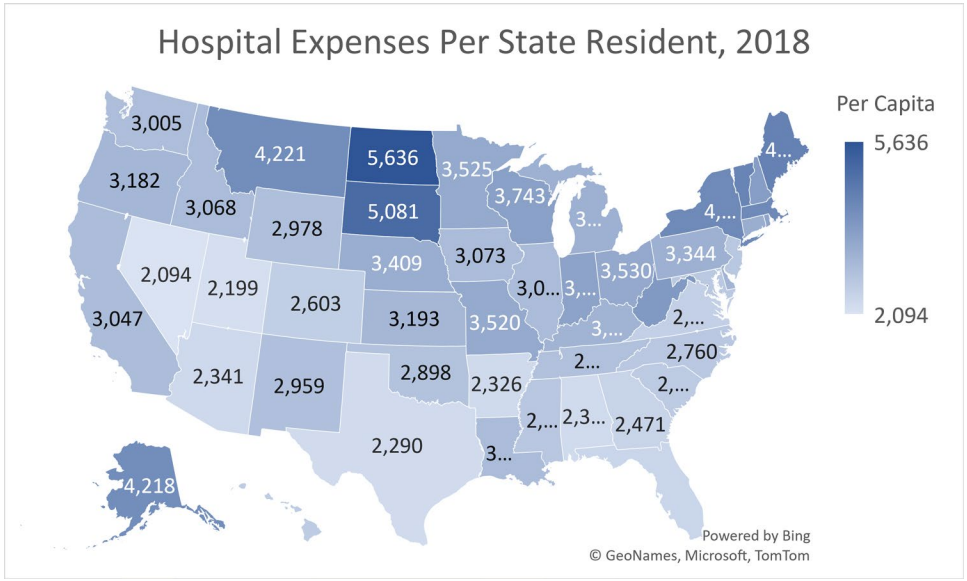


Table 18.

Operating Expenses (billions), Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**687.0**	**716.6**	**759.6**	**776.6**	**799.5**	**833.7**	**905.1**	**934.6**	**974.6**	**639.9**	**42%**	**4.5%**	
AK	1.5	1.6	1.7	2.3	2.4	2.5	2.7	2.8	3.0	1.1	96%	**8.8%**	1
SD	2.2	2.6	2.8	3.2	3.4	3.6	4.0	4.2	4.3	4.7	93%	**8.6%**	2
ND	2.2	2.3	3.0	2.9	3.3	3.4	3.8	3.9	4.1	3.4	84%	**7.9%**	3
ID	2.9	3.1	3.4	3.8	4.0	4.3	4.6	4.8	5.3	4.2	82%	**7.7%**	4
CA	66.8	81.6	86.1	89.9	90.6	99.3	106.1	111.0	118.0	76.7	77%	**7.4%**	5
OR	8.0	7.5	10.0	9.3	10.0	9.5	13.0	12.5	13.1	6.9	63%	**6.3%**	6
CO	9.8	10.1	10.2	10.8	11.5	12.2	13.0	14.5	14.5	7.7	48%	**5.0%**	7
MT	2.9	2.6	3.4	3.3	3.5	3.4	4.4	4.2	4.4	1.9	52%	**5.3%**	8
NM	4.0	4.0	4.3	4.8	4.9	5.1	5.7	5.9	6.1	4.1	52%	**5.4%**	9
WA	14.2	14.7	15.7	16.1	17.5	18.9	20.5	20.8	22.1	11.2	55%	**5.7%**	10
UT	4.5	4.5	4.9	5.0	5.2	5.5	6.3	6.5	6.8	6.9	51%	**5.3%**	11
WI	14.7	15.1	16.5	16.7	17.8	18.7	19.8	20.8	21.2	14.3	44%	**4.7%**	12
MN	13.3	13.8	14.9	15.3	15.9	16.6	17.9	18.7	19.4	6.3	46%	**4.8%**	13
KS	6.3	6.4	6.7	7.0	7.2	7.3	8.4	8.8	9.0	6.5	43%	**4.6%**	14
HI	2.5	2.6	2.6	2.7	2.9	3.1	3.3	3.4	3.6	2.7	47%	**5.0%**	15
NC	19.4	20.4	21.7	22.3	22.6	24.1	25.3	26.9	27.7	21.5	43%	**4.6%**	16
ME	4.1	4.3	4.6	4.6	4.7	5.1	5.4	5.7	5.9	5.4	42%	**4.5%**	17
TX	45.9	47.0	48.6	51.1	52.8	56.5	61.5	63.3	64.2	46.1	40%	**4.3%**	18
DE	2.1	2.2	2.3	2.2	2.5	2.6	2.8	2.9	3.0	3.2	45%	**4.8%**	19
NY	55.7	57.2	61.0	62.1	64.6	65.7	73.4	76.4	81.9	19.9	47%	**4.9%**	20
OK	7.8	8.2	8.8	9.4	9.2	10.0	10.4	10.7	11.1	8.3	43%	**4.5%**	21
NE	4.6	4.8	5.1	5.3	5.2	5.2	6.0	6.2	6.4	4.3	40%	**4.3%**	22
VT	1.8	1.9	2.0	2.1	2.2	2.2	2.4	2.5	2.7	2.7	46%	**4.8%**	23
WV	4.9	4.9	5.3	5.4	5.5	5.8	6.1	6.6	6.9	4.4	41%	**4.4%**	24
GA	17.9	18.0	18.4	19.2	20.3	21.1	22.9	24.1	25.2	22.5	41%	**4.4%**	25
TN	13.1	13.4	16.8	16.7	17.2	17.3	16.7	17.8	19.3	16.6	47%	**5.0%**	26
WY	1.2	1.2	1.3	1.4	1.4	1.5	1.6	1.6	1.7	1.6	36%	**3.9%**	27
MA	21.0	21.2	22.1	23.4	23.8	24.8	26.4	27.7	28.8	28.0	37%	**4.0%**	28
VA	15.2	15.5	16.9	16.7	17.6	17.6	19.5	19.8	21.0	12.7	38%	**4.2%**	29
AZ	12.3	12.2	13.2	13.3	14.9	15.0	15.9	16.1	16.4	8.3	33%	**3.6%**	30
PA	32.1	33.6	35.0	35.3	36.8	38.0	39.3	41.7	41.4	42.7	29%	**3.2%**	31
OH	30.2	31.6	32.9	33.1	33.8	35.1	37.3	38.7	40.1	14.2	33%	**3.6%**	32
MO	15.6	15.6	17.5	16.9	17.3	17.5	20.2	20.0	20.9	10.5	34%	**3.7%**	33
SC	10.1	9.9	10.6	10.9	11.1	11.4	12.6	12.9	13.3	11.9	32%	**3.6%**	34
KY	10.9	11.0	11.6	11.5	11.5	11.9	13.4	13.9	14.1	10.2	30%	**3.3%**	35
NH	3.7	4.0	3.6	3.9	4.0	4.2	4.5	4.7	5.0	4.9	34%	**3.7%**	36
DC	2.7	2.8	2.9	3.0	3.1	3.2	3.3	3.5	3.6	3.2	32%	**3.5%**	37
FL	38.1	40.0	39.5	39.5	40.8	44.1	46.7	48.2	50.3	37.3	32%	**3.5%**	38
CT	8.9	9.6	9.7	10.2	10.2	10.5	10.9	11.2	11.9	12.1	34%	**3.7%**	39
IN	17.5	17.8	19.2	19.6	19.5	20.0	21.5	22.1	24.0	8.0	37%	**4.0%**	40
IA	7.2	7.3	7.4	7.5	7.7	8.0	8.6	9.0	9.4	8.4	31%	**3.4%**	41
NJ	18.4	19.3	19.7	20.1	20.9	22.0	22.5	23.0	24.2	3.6	31%	**3.5%**	42
NV	4.8	4.8	5.0	5.2	5.0	5.2	5.5	5.9	6.2	2.6	31%	**3.4%**	43
LA	10.5	10.4	11.1	11.8	11.7	11.9	13.1	13.0	13.8	7.7	31%	**3.5%**	44
MI	25.4	25.5	26.8	26.8	27.2	27.9	30.5	31.4	32.5	26.4	28%	**3.2%**	45
MD	12.7	13.2	13.7	13.6	14.1	14.4	15.1	15.5	16.1	15.9	27%	**3.0%**	46
IL	31.2	31.1	32.4	33.4	33.8	35.1	38.3	37.0	38.2	29.8	23%	**2.6%**	47
AR	5.4	5.3	5.8	5.7	5.7	5.7	6.3	6.5	6.8	4.8	25%	**2.9%**	48
RI	3.1	3.1	3.2	3.2	3.3	3.3	3.5	3.6	3.7	3.4	21%	**2.4%**	49
MS	6.8	6.8	7.8	7.5	7.8	7.6	8.0	8.0	8.0	7.0	18%	**2.1%**	50
AL	9.0	8.8	10.1	9.6	9.7	8.8	11.0	10.5	10.9	9.7	21%	**2.4%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

Table 19.

Annual Hospital Operating Expenses Per Resident, Ranked by 2018 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**2,284**	**2,364**	**2,488**	**2,526**	**2,577**	**2,665**	**2,878**	**2,948**	**3,060**	**1,981**	**34%**	**3.7%**	
ND	3,458	3,523	4,464	4,243	4,682	4,729	5,259	5,398	**5,636**	4,615	63%	6.3%	1
DC	4,799	4,835	4,817	4,853	4,902	5,041	5,115	5,271	**5,400**	4,666	13%	1.5%	2
SD	2,837	3,252	3,436	3,949	4,110	4,325	4,788	5,026	**5,081**	5,484	79%	7.6%	3
ME	3,198	3,342	3,588	3,580	3,666	3,966	4,170	4,380	**4,507**	4,178	41%	4.4%	4
VT	3,048	3,111	3,281	3,498	3,587	3,731	3,953	4,129	**4,443**	4,476	46%	4.8%	5
MA	3,312	3,327	3,446	3,630	3,653	3,779	4,025	4,182	**4,319**	4,178	30%	3.4%	6
NY	2,952	3,022	3,203	3,246	3,363	3,412	3,818	3,956	**4,308**	1,063	46%	4.8%	7
MT	2,991	2,714	3,520	3,393	3,537	3,346	4,331	4,153	**4,221**	1,775	41%	4.4%	8
AK	2,231	2,351	2,424	3,234	3,326	3,525	3,769	4,000	**4,218**	1,528	89%	8.3%	9
WV	2,700	2,712	2,925	2,977	3,072	3,239	3,446	3,736	**3,918**	2,552	45%	4.8%	10
NH	2,926	3,116	2,849	3,064	3,111	3,254	3,483	3,656	**3,815**	3,684	30%	3.4%	11
WI	2,655	2,727	2,966	2,980	3,175	3,324	3,521	3,678	**3,743**	2,517	41%	4.4%	12
IN	2,790	2,823	3,036	3,079	3,050	3,120	3,343	3,423	**3,698**	1,224	33%	3.6%	13
RI	3,028	3,121	3,192	3,190	3,290	3,263	3,468	3,560	**3,636**	3,326	20%	2.3%	14
OH	2,694	2,814	2,932	2,946	2,995	3,111	3,303	3,421	**3,530**	1,243	31%	3.4%	15
MN	2,562	2,645	2,826	2,902	2,989	3,101	3,311	3,435	**3,525**	1,130	38%	4.1%	16
MO	2,695	2,683	2,993	2,889	2,949	2,971	3,421	3,384	**3,520**	1,765	31%	3.4%	17
CT	2,562	2,758	2,780	2,924	2,923	3,015	3,149	3,224	**3,424**	3,490	34%	3.7%	18
NE	2,577	2,705	2,821	2,935	2,825	2,842	3,278	3,360	**3,409**	2,302	32%	3.6%	19
PA	2,615	2,730	2,833	2,858	2,977	3,070	3,180	3,366	**3,344**	3,449	28%	3.1%	20
MI	2,627	2,637	2,776	2,775	2,810	2,874	3,143	3,226	**3,331**	2,692	27%	3.0%	21
KY	2,582	2,605	2,744	2,710	2,700	2,780	3,126	3,221	**3,272**	2,349	27%	3.0%	22
DE	2,398	2,444	2,565	2,503	2,723	2,849	2,991	3,087	**3,243**	3,425	35%	3.8%	23
KS	2,273	2,317	2,395	2,506	2,561	2,606	2,972	3,131	**3,193**	2,325	41%	4.3%	24
OR	2,136	1,984	2,621	2,411	2,581	2,398	3,238	3,069	**3,182**	1,665	49%	5.1%	25
IL	2,488	2,481	2,577	2,661	2,691	2,793	3,062	2,959	**3,074**	2,404	24%	2.7%	26
IA	2,441	2,456	2,491	2,505	2,579	2,653	2,835	2,964	**3,073**	2,743	26%	2.9%	27
ID	1,888	1,978	2,199	2,376	2,477	2,637	2,766	2,883	**3,068**	2,415	62%	6.3%	28
LA	2,392	2,346	2,499	2,625	2,590	2,628	2,887	2,865	**3,061**	1,705	28%	3.1%	29
CA	1,829	2,213	2,313	2,396	2,385	2,590	2,759	2,868	**3,047**	1,979	67%	6.6%	30
WA	2,167	2,212	2,330	2,364	2,536	2,698	2,877	2,870	**3,005**	1,492	39%	4.2%	31
WY	2,239	2,219	2,297	2,383	2,515	2,693	2,812	2,882	**2,978**	2,929	33%	3.6%	32
NM	1,971	1,967	2,114	2,355	2,405	2,492	2,822	2,871	**2,959**	2,015	50%	5.2%	33
TN	2,121	2,154	2,668	2,640	2,698	2,689	2,575	2,716	**2,937**	2,497	38%	4.2%	34
OK	2,135	2,244	2,377	2,528	2,460	2,632	2,745	2,802	**2,898**	2,170	36%	3.9%	35
MS	2,370	2,374	2,700	2,613	2,712	2,621	2,757	2,775	**2,786**	2,441	18%	2.0%	36
NJ	2,139	2,234	2,268	2,309	2,387	2,511	2,564	2,612	**2,773**	418	30%	3.3%	37
NC	2,097	2,183	2,304	2,344	2,349	2,480	2,574	2,705	**2,760**	2,117	32%	3.5%	38
MD	2,250	2,328	2,400	2,365	2,423	2,471	2,572	2,639	**2,734**	2,722	22%	2.5%	39
SC	2,246	2,188	2,321	2,351	2,379	2,412	2,619	2,642	**2,701**	2,383	20%	2.3%	40
HI	1,889	1,957	1,919	2,057	2,121	2,268	2,389	2,541	**2,672**	2,023	41%	4.4%	41
CO	1,992	2,021	2,018	2,103	2,199	2,288	2,417	2,653	**2,603**	1,366	31%	3.4%	42
VA	1,969	1,985	2,143	2,105	2,194	2,187	2,411	2,438	**2,567**	1,549	30%	3.4%	43
GA	1,898	1,890	1,911	1,979	2,068	2,133	2,294	2,380	**2,471**	2,186	30%	3.4%	44
FL	2,072	2,151	2,093	2,068	2,099	2,225	2,316	2,347	**2,415**	1,764	17%	1.9%	45
AZ	1,970	1,934	2,065	2,058	2,272	2,247	2,355	2,351	**2,341**	1,163	19%	2.2%	46
AR	1,912	1,870	2,018	1,972	1,974	1,972	2,174	2,238	**2,326**	1,645	22%	2.5%	47
AL	1,943	1,883	2,158	2,043	2,063	1,861	2,336	2,223	**2,301**	2,034	18%	2.1%	48
TX	1,866	1,879	1,915	1,981	2,010	2,111	2,265	2,290	**2,290**	1,620	23%	2.6%	49
UT	1,658	1,623	1,748	1,763	1,807	1,860	2,104	2,139	**2,199**	2,183	33%	3.6%	50
NV	1,792	1,787	1,856	1,876	1,779	1,822	1,899	2,007	**2,094**	848	17%	2.0%	51

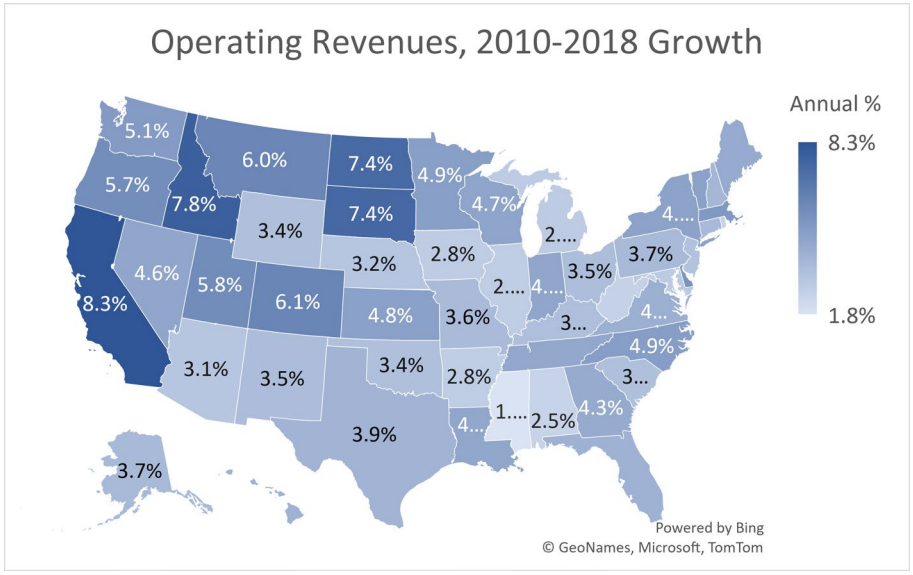
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

14. ***Operating Revenues.*** North Dakota hospitals' operating revenues grew from $2.3 billion in 2010 to $4.1 billion in 2018, a growth rate of 7.4 percent per year. That growth rate was considerably higher than the nationwide hospital revenue growth of 4.6 percent, trailing only South Dakota, Idaho and California among the states (see Table 20 and Figure 7). North Dakota's operating revenues per state resident ranked 2nd only to DC in 2018 (see Table 21). (As a regional referral center, DC has a focus of hospital beds for the region; North Dakota may also "import" some hospital patients from Minnesota.)

Figure 7.



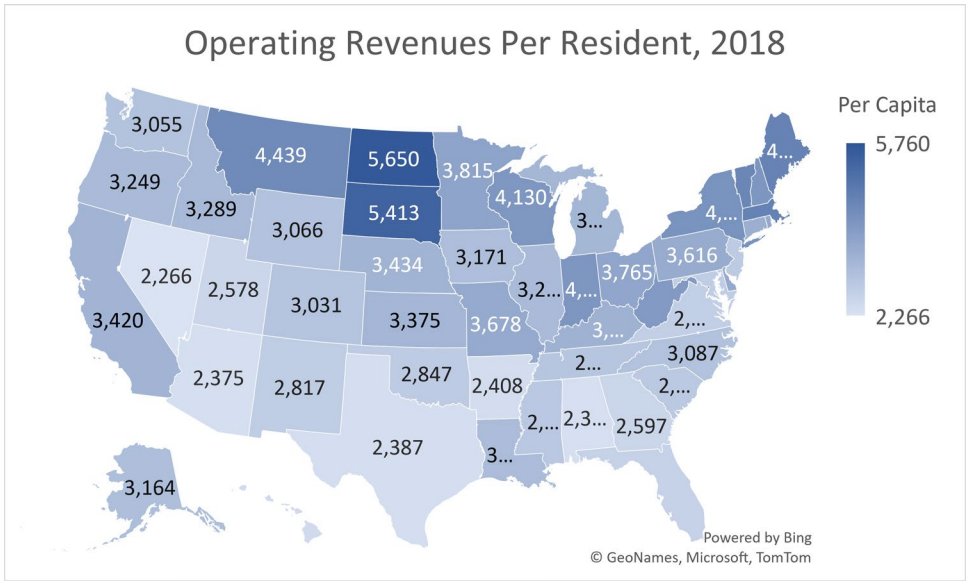


Table 20.

Operating Revenues (billions), Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**722.3**	**743.1**	**785.4**	**802.7**	**827.1**	**860.5**	**933.8**	**961.7**	**1,032.6**	**671.8**	**43%**	**4.6%**	
CA	69.9	74.1	77.3	84.2	84.1	87.8	93.5	96.7	132.5	78.6	90%	**8.3%**	1
ID	3.1	3.3	3.8	4.0	4.3	4.6	4.9	5.2	5.7	4.6	83%	**7.8%**	2
SD	2.6	2.9	3.1	3.4	3.6	3.9	4.1	4.4	4.6	5.1	77%	**7.4%**	3
ND	2.3	2.4	3.1	2.9	3.4	3.7	3.9	3.9	4.1	3.5	76%	**7.4%**	4
CO	10.5	10.7	11.1	11.7	12.7	13.8	14.7	16.3	16.8	9.4	60%	**6.1%**	5
MT	2.9	2.8	3.5	3.4	3.6	3.4	4.3	4.4	4.6	1.9	60%	**6.0%**	6
UT	5.1	5.8	5.7	5.8	6.3	6.5	7.4	7.6	8.0	8.0	57%	**5.8%**	7
OR	8.6	7.8	10.4	11.1	10.3	9.8	13.1	12.4	13.4	7.3	56%	**5.7%**	8
DE	2.3	2.5	2.5	2.5	2.8	2.9	3.0	3.3	3.4	3.5	52%	**5.4%**	9
MA	20.6	20.5	21.9	22.5	22.7	24.5	27.1	28.1	30.8	27.9	50%	**5.2%**	10
WA	15.1	15.7	16.3	17.8	18.6	19.6	20.2	21.4	22.5	12.0	49%	**5.1%**	11
NC	21.1	22.0	23.8	24.0	24.2	26.8	28.0	29.9	31.0	23.8	47%	**4.9%**	12
MN	14.3	14.9	15.8	16.3	17.1	18.0	18.9	20.0	20.9	6.4	47%	**4.9%**	13
KS	6.5	6.0	7.2	7.4	7.6	7.8	8.9	9.2	9.5	6.8	46%	**4.8%**	14
VT	1.9	1.9	2.0	2.2	2.2	2.4	2.3	2.6	2.7	2.7	46%	**4.8%**	15
NY	55.7	58.2	59.9	61.5	64.4	66.3	74.1	76.0	80.7	20.9	45%	**4.7%**	16
WI	16.3	16.6	18.2	19.0	19.9	20.8	21.6	22.7	23.4	15.7	44%	**4.7%**	17
IN	18.8	20.2	22.4	21.9	22.5	23.2	24.4	25.4	26.9	9.0	43%	**4.6%**	18
NV	4.7	4.8	5.0	5.4	5.1	5.6	5.8	6.3	6.8	2.6	43%	**4.6%**	19
LA	10.2	11.1	11.9	11.9	12.1	12.5	13.7	13.8	14.6	8.5	43%	**4.6%**	20
TN	13.8	14.7	17.3	15.8	16.1	16.1	17.4	18.9	19.6	16.4	42%	**4.5%**	21
ME	4.3	4.5	4.7	4.8	4.9	5.2	5.5	6.0	6.0	5.4	41%	**4.4%**	22
GA	18.9	20.0	19.6	20.2	20.5	22.0	24.0	25.1	26.5	23.7	41%	**4.3%**	23
VA	16.3	17.0	18.2	18.0	18.9	19.7	21.7	21.1	22.5	14.1	38%	**4.2%**	24
FL	40.7	43.0	42.3	42.8	45.3	48.0	50.8	53.7	55.8	40.1	37%	**4.0%**	25
HI	2.4	2.2	2.2	2.4	2.5	2.7	3.0	3.0	3.3	2.8	37%	**4.0%**	26
TX	49.1	50.7	52.0	52.9	56.1	60.1	64.1	64.5	66.9	48.1	36%	**3.9%**	27
NH	4.0	4.2	3.9	4.2	4.4	4.5	4.8	5.2	5.4	5.1	35%	**3.8%**	28
PA	33.5	35.6	36.6	37.2	38.0	39.8	41.8	43.8	44.8	45.5	34%	**3.7%**	29
AK	1.7	1.7	1.7	1.8	1.9	1.9	2.0	2.1	2.2	0.8	34%	**3.7%**	30
CT	9.2	9.6	10.2	10.5	10.6	10.7	11.3	11.5	12.3	12.4	33%	**3.7%**	31
MO	16.4	17.1	18.5	17.9	18.2	18.3	21.3	20.9	21.8	11.3	33%	**3.6%**	32
NM	4.4	4.2	4.5	4.5	4.7	5.0	5.6	5.6	5.8	3.7	32%	**3.5%**	33
OH	32.5	33.3	35.4	36.2	36.6	37.9	40.8	42.1	42.8	15.7	32%	**3.5%**	34
KY	11.4	11.7	11.9	11.8	12.1	12.8	14.3	14.5	15.0	10.7	31%	**3.5%**	35
WY	1.3	1.3	1.4	1.4	1.5	1.6	1.7	1.7	1.7	1.7	31%	**3.4%**	36
OK	8.3	8.4	9.1	9.2	9.4	9.8	10.3	10.6	10.9	8.7	31%	**3.4%**	37
SC	11.0	10.7	11.6	11.8	12.4	12.6	13.8	13.8	14.3	12.7	31%	**3.4%**	38
NJ	19.3	19.9	20.5	20.9	21.1	22.9	23.8	24.6	25.0	3.6	29%	**3.3%**	39
NE	5.0	5.4	5.4	5.8	5.8	5.8	6.5	6.7	6.4	4.6	28%	**3.2%**	40
AZ	13.0	10.7	13.6	13.2	14.5	13.5	15.7	16.1	16.6	7.8	28%	**3.1%**	41
DC	3.0	2.9	3.0	3.1	3.1	3.3	3.5	3.7	3.8	3.3	26%	**3.0%**	42
MD	13.0	13.8	14.2	14.2	14.9	15.0	15.6	16.2	16.5	16.4	26%	**2.9%**	43
MI	26.2	26.6	27.7	27.6	28.6	29.3	31.9	33.1	32.8	28.0	25%	**2.9%**	44
IA	7.8	7.9	8.1	8.1	8.4	8.8	9.3	9.5	9.7	8.7	25%	**2.8%**	45
IL	32.4	32.3	33.6	35.0	36.3	36.6	40.0	39.2	40.4	30.9	25%	**2.8%**	46
AR	5.6	5.4	6.0	5.7	5.8	6.0	6.6	6.7	7.0	4.9	25%	**2.8%**	47
WV	5.8	4.9	5.5	5.5	5.6	6.0	6.4	6.8	7.1	4.6	23%	**2.6%**	48
AL	9.2	8.7	10.5	10.0	10.0	9.3	11.4	10.7	11.2	10.2	22%	**2.5%**	49
RI	3.1	3.1	3.2	3.2	3.3	3.3	3.5	3.6	3.7	3.3	22%	**2.5%**	50
MS	7.3	7.2	8.3	7.8	8.1	7.9	8.3	8.1	8.4	7.2	15%	**1.8%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

Table 21.

Annual Operating Revenues Per Resident, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**2,401**	**2,452**	**2,572**	**2,610**	**2,666**	**2,751**	**2,969**	**3,033**	**3,242**	**2,080**	**35%**	**3.8%**	
DC	5,340	4,975	5,016	5,137	4,911	5,249	5,437	5,599	**5,760**	4,813	8%	1.0%	1
ND	3,614	3,722	4,568	4,193	4,751	5,088	5,376	5,416	**5,650**	4,712	56%	5.7%	2
SD	3,291	3,703	3,856	4,229	4,392	4,684	4,923	5,234	**5,413**	5,923	65%	6.4%	3
MA	3,247	3,226	3,416	3,487	3,495	3,741	4,121	4,238	**4,630**	4,170	43%	4.5%	4
ME	3,302	3,470	3,638	3,704	3,750	4,018	4,270	4,606	**4,618**	4,160	40%	4.3%	5
VT	3,126	3,158	3,359	3,659	3,735	3,909	3,838	4,267	**4,540**	4,569	45%	4.8%	6
MT	2,981	2,860	3,591	3,467	3,618	3,420	4,189	4,352	**4,439**	1,776	49%	5.1%	7
NY	2,953	3,071	3,144	3,215	3,352	3,442	3,853	3,937	**4,244**	1,115	44%	4.6%	8
IN	2,994	3,194	3,534	3,434	3,519	3,623	3,795	3,938	**4,154**	1,378	39%	4.2%	9
NH	3,151	3,268	3,048	3,280	3,405	3,483	3,722	4,011	**4,143**	3,885	31%	3.5%	10
WI	2,937	2,990	3,272	3,398	3,552	3,698	3,850	4,026	**4,130**	2,758	41%	4.4%	11
WV	3,223	2,727	3,055	3,069	3,104	3,343	3,596	3,853	**4,054**	2,630	26%	2.9%	12
MN	2,751	2,855	2,999	3,077	3,217	3,353	3,511	3,680	**3,815**	1,161	39%	4.2%	13
OH	2,897	2,967	3,157	3,223	3,248	3,359	3,618	3,717	**3,765**	1,379	30%	3.3%	14
MO	2,828	2,930	3,179	3,064	3,092	3,112	3,607	3,527	**3,678**	1,905	30%	3.3%	15
DE	2,598	2,814	2,781	2,815	3,118	3,113	3,225	3,506	**3,668**	3,761	41%	4.4%	16
RI	3,024	3,098	3,196	3,144	3,301	3,264	3,435	3,550	**3,661**	3,271	21%	2.4%	17
PA	2,727	2,886	2,962	3,012	3,076	3,211	3,378	3,535	**3,616**	3,670	33%	3.6%	18
CT	2,659	2,770	2,932	3,021	3,060	3,089	3,261	3,310	**3,541**	3,593	33%	3.6%	19
KY	2,712	2,768	2,819	2,774	2,826	2,980	3,324	3,355	**3,465**	2,467	28%	3.1%	20
NE	2,824	3,026	3,022	3,203	3,199	3,173	3,534	3,593	**3,434**	2,425	22%	2.5%	21
CA	1,914	2,011	2,076	2,245	2,213	2,290	2,433	2,498	**3,420**	2,027	79%	7.5%	22
KS	2,357	2,182	2,567	2,657	2,712	2,776	3,153	3,274	**3,375**	2,421	43%	4.6%	23
MI	2,711	2,760	2,867	2,861	2,951	3,028	3,291	3,410	**3,361**	2,848	24%	2.7%	24
ID	2,013	2,164	2,404	2,544	2,667	2,859	2,992	3,080	**3,289**	2,626	63%	6.3%	25
IL	2,582	2,572	2,675	2,783	2,887	2,918	3,203	3,136	**3,250**	2,496	26%	2.9%	26
OR	2,277	2,049	2,712	2,892	2,644	2,488	3,272	3,055	**3,249**	1,744	43%	4.5%	27
LA	2,325	2,508	2,667	2,649	2,686	2,752	3,025	3,039	**3,235**	1,888	39%	4.2%	28
IA	2,632	2,677	2,715	2,713	2,810	2,926	3,052	3,112	**3,171**	2,828	20%	2.4%	29
AK	2,453	2,476	2,431	2,499	2,624	2,756	2,859	2,914	**3,164**	1,089	29%	3.2%	30
NC	2,280	2,347	2,520	2,523	2,515	2,757	2,852	3,003	**3,087**	2,345	35%	3.9%	31
WY	2,397	2,375	2,466	2,517	2,600	2,838	2,905	2,992	**3,066**	2,990	28%	3.1%	32
WA	2,302	2,362	2,425	2,618	2,707	2,794	2,841	2,956	**3,055**	1,595	33%	3.6%	33
CO	2,135	2,154	2,201	2,289	2,430	2,593	2,729	2,982	**3,031**	1,667	42%	4.5%	34
TN	2,233	2,367	2,756	2,507	2,527	2,502	2,693	2,897	**2,981**	2,478	33%	3.7%	35
MS	2,551	2,516	2,877	2,702	2,795	2,749	2,869	2,821	**2,925**	2,516	15%	1.7%	36
SC	2,453	2,378	2,529	2,553	2,646	2,652	2,871	2,845	**2,908**	2,551	19%	2.1%	37
NJ	2,238	2,306	2,358	2,397	2,412	2,612	2,717	2,786	**2,862**	411	28%	3.1%	38
OK	2,289	2,299	2,471	2,462	2,510	2,581	2,707	2,780	**2,847**	2,275	24%	2.8%	39
NM	2,166	2,059	2,226	2,192	2,312	2,469	2,748	2,766	**2,817**	1,782	30%	3.3%	40
MD	2,320	2,436	2,485	2,456	2,566	2,572	2,657	2,753	**2,802**	2,809	21%	2.4%	41
VA	2,114	2,178	2,309	2,265	2,358	2,447	2,681	2,594	**2,756**	1,716	30%	3.4%	42
FL	2,213	2,313	2,242	2,242	2,332	2,424	2,520	2,615	**2,678**	1,897	21%	2.4%	43
GA	2,004	2,099	2,039	2,082	2,091	2,217	2,401	2,478	**2,597**	2,301	30%	3.3%	44
UT	1,877	2,084	2,037	2,043	2,163	2,196	2,482	2,489	**2,578**	2,530	37%	4.0%	45
HI	1,868	1,663	1,644	1,810	1,838	1,998	2,164	2,213	**2,460**	2,087	32%	3.5%	46
AR	1,990	1,901	2,089	2,003	2,030	2,095	2,294	2,317	**2,408**	1,666	21%	2.4%	47
TX	1,999	2,026	2,049	2,054	2,133	2,246	2,358	2,337	**2,387**	1,692	19%	2.2%	48
AZ	2,076	1,687	2,124	2,038	2,219	2,030	2,323	2,359	**2,375**	1,086	14%	1.7%	49
AL	1,972	1,853	2,232	2,129	2,121	1,958	2,419	2,253	**2,356**	2,132	19%	2.2%	50
NV	1,778	1,793	1,835	1,974	1,839	1,953	1,996	2,143	**2,266**	872	27%	3.1%	51

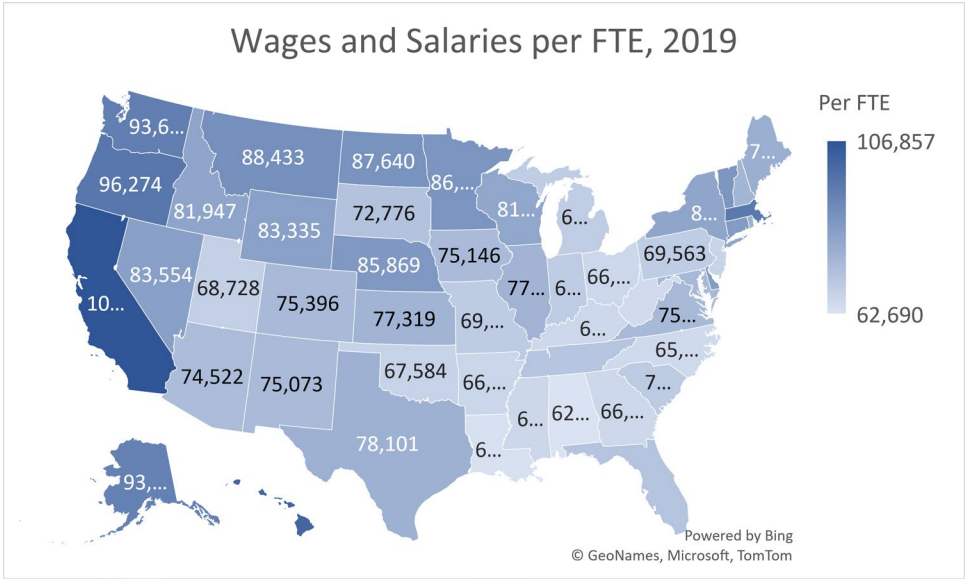
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

15. Average Salaries per FTE. Among the states, North Dakota had the 8th highest average salaries in 2019 at $87,640 per FTE, and about $10,000 higher than the national average (see Figure 8 and Table 22). From 2010 to 2019, average salaries in North Dakota grew by 2.9 percent per year; the national average growth rate in that period was 2.1 percent.

Figure 8.



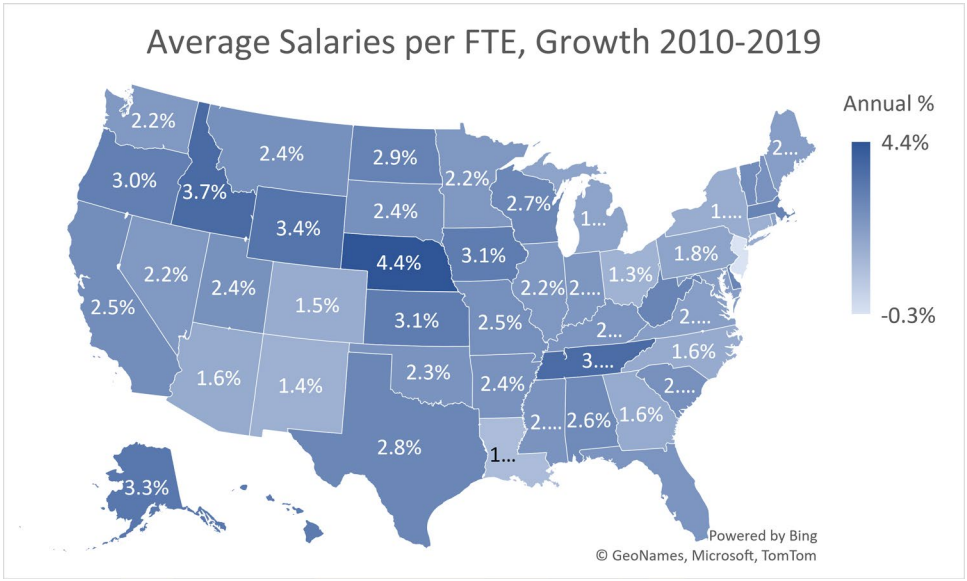


Table 22.

Average Salary per Full-Time Equivalent (FTE) Employee, Ranked by 2019 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Pct Growth 2010-2019	Avg Annual Growth	Rank
US	**64,269**	**65,722**	**67,299**	**68,502**	**70,122**	**71,944**	**73,382**	**75,589**	**77,549**	**77,494**	**21%**	**2.1%**	
CA	85,342	87,462	88,168	91,449	93,509	96,217	100,792	103,736	106,015	**106,857**	25%	2.5%	1
HI	76,669	78,693	81,208	81,480	82,796	86,086	91,390	94,600	91,095	**101,450**	32%	3.2%	2
OR	73,818	77,031	81,816	82,026	86,050	88,509	94,944	92,210	94,811	**96,274**	30%	3.0%	3
MA	74,132	77,438	80,014	77,769	83,545	85,690	86,024	84,241	88,767	**95,379**	29%	2.8%	4
WA	77,240	73,833	77,846	77,106	81,929	83,627	87,427	89,541	90,434	**93,666**	21%	2.2%	5
AK	69,630	72,562	73,308	96,538	78,699	74,443	70,007	76,296	85,392	**93,009**	34%	3.3%	6
MT	71,213	73,440	66,366	72,433	71,982	71,502	78,750	81,060	83,193	**88,433**	24%	2.4%	7
ND	67,765	66,493	67,672	65,387	79,756	81,258	82,891	86,792	90,678	**87,640**	29%	2.9%	8
MN	71,372	73,221	74,534	77,215	81,348	83,285	84,840	86,400	88,930	**86,858**	22%	2.2%	9
VT	69,010	73,118	72,006	74,639	77,064	79,480	81,232	83,842	84,724	**86,614**	26%	2.6%	10
NE	58,149	59,082	58,010	58,131	58,684	57,587	69,799	76,161	77,812	**85,869**	48%	4.4%	11
DC	70,572	67,838	71,857	73,869	77,063	79,323	78,489	80,851	84,022	**84,958**	20%	2.1%	12
CT	74,765	76,358	76,446	78,956	78,337	81,612	80,299	77,720	81,457	**84,817**	13%	1.4%	13
DE	66,035	67,562	67,961	72,716	73,880	75,631	77,580	79,621	81,332	**84,604**	28%	2.8%	14
NV	68,881	65,010	71,844	74,790	73,752	76,356	77,464	79,718	80,123	**83,554**	21%	2.2%	15
WY	61,848	64,376	62,994	65,822	69,539	73,540	75,347	78,922	76,559	**83,335**	35%	3.4%	16
ID	59,118	61,344	63,453	65,112	67,464	69,624	72,412	74,871	78,769	**81,947**	39%	3.7%	17
NY	71,422	72,990	75,850	76,860	79,841	79,109	82,998	86,182	89,700	**81,779**	15%	1.5%	18
WI	63,852	65,457	67,555	68,062	70,236	70,003	72,022	73,106	78,384	**81,483**	28%	2.7%	19
ME	66,019	68,435	70,999	73,419	65,419	72,564	74,856	78,881	81,116	**78,835**	19%	2.0%	20
RI	65,812	68,302	69,376	71,790	65,902	70,373	73,996	76,540	75,692	**78,107**	19%	1.9%	21
TX	61,011	61,893	64,056	65,687	67,717	69,177	70,111	72,294	73,910	**78,101**	28%	2.8%	22
KS	58,765	60,288	60,131	62,398	65,432	68,079	69,744	70,682	74,905	**77,319**	32%	3.1%	23
IL	63,523	66,626	65,360	66,165	66,877	71,224	71,133	72,160	72,582	**77,205**	22%	2.2%	24
NH	62,104	64,128	64,045	69,258	68,347	69,599	74,615	68,297	75,624	**76,807**	24%	2.4%	25
MD	63,472	64,158	64,838	66,677	67,081	68,428	69,999	73,481	74,227	**75,875**	20%	2.0%	26
VA	63,262	64,730	65,689	66,921	69,004	69,614	70,695	67,915	69,794	**75,534**	19%	2.0%	27
CO	65,751	67,157	66,423	72,194	73,004	75,266	76,662	77,274	80,554	**75,396**	15%	1.5%	28
IA	57,065	61,618	62,323	66,137	66,682	68,912	66,399	70,404	72,992	**75,146**	32%	3.1%	29
NM	66,211	66,705	67,502	69,102	68,410	69,936	70,736	72,252	75,479	**75,073**	13%	1.4%	30
AZ	64,658	66,835	67,775	70,170	69,682	67,533	72,442	72,718	75,852	**74,522**	15%	1.6%	31
SD	58,556	57,961	64,632	61,958	69,614	73,162	72,629	76,924	78,498	**72,776**	24%	2.4%	32
FL	58,903	59,773	60,203	58,645	62,807	66,790	66,945	69,498	71,252	**72,261**	23%	2.3%	33
TN	52,074	52,949	66,266	69,498	63,069	65,060	62,952	70,247	69,830	**71,976**	38%	3.7%	34
SC	56,550	57,009	58,878	57,953	61,397	62,855	63,029	66,990	69,290	**70,168**	24%	2.4%	35
MO	56,066	57,220	59,190	60,045	61,747	62,949	65,719	68,817	69,361	**69,882**	25%	2.5%	36
IN	57,054	58,118	59,529	62,511	61,516	64,214	65,639	68,903	71,379	**69,703**	22%	2.2%	37
PA	59,202	60,375	60,960	61,402	62,135	64,095	65,713	66,468	68,381	**69,563**	18%	1.8%	38
MI	59,081	61,556	61,422	63,539	64,758	67,066	68,671	71,962	69,611	**69,383**	17%	1.8%	39
UT	55,468	56,580	57,010	57,703	58,733	60,856	61,984	64,516	66,751	**68,728**	24%	2.4%	40
OK	54,942	57,809	58,183	61,849	64,145	63,239	66,899	64,461	64,051	**67,584**	23%	2.3%	41
NJ	69,112	69,343	71,007	71,257	73,133	75,430	75,236	78,622	80,462	**67,390**	-2%	-0.3%	42
AR	53,988	53,917	56,490	57,676	55,707	59,078	61,643	63,499	65,080	**66,818**	24%	2.4%	43
MS	53,902	55,217	55,068	56,078	55,916	58,469	59,248	62,926	66,230	**66,292**	23%	2.3%	44
OH	58,847	59,650	61,912	63,158	62,713	63,303	65,455	66,872	68,523	**66,185**	12%	1.3%	45
GA	57,342	58,910	59,056	61,162	63,531	65,075	64,868	67,775	68,882	**66,025**	15%	1.6%	46
KY	53,794	56,003	54,751	56,419	58,012	60,625	62,272	64,112	66,061	**66,010**	23%	2.3%	47
NC	56,944	58,384	59,685	59,719	60,093	61,300	63,536	65,385	66,916	**65,457**	15%	1.6%	48
WV	50,605	53,683	54,253	55,001	55,352	56,799	59,619	59,255	63,541	**65,092**	29%	2.8%	49
LA	57,945	59,089	63,723	59,073	63,467	64,047	62,703	66,449	61,570	**63,459**	10%	1.0%	50
AL	49,582	49,025	54,187	52,402	54,102	54,702	56,102	58,424	60,869	**62,690**	26%	2.6%	51

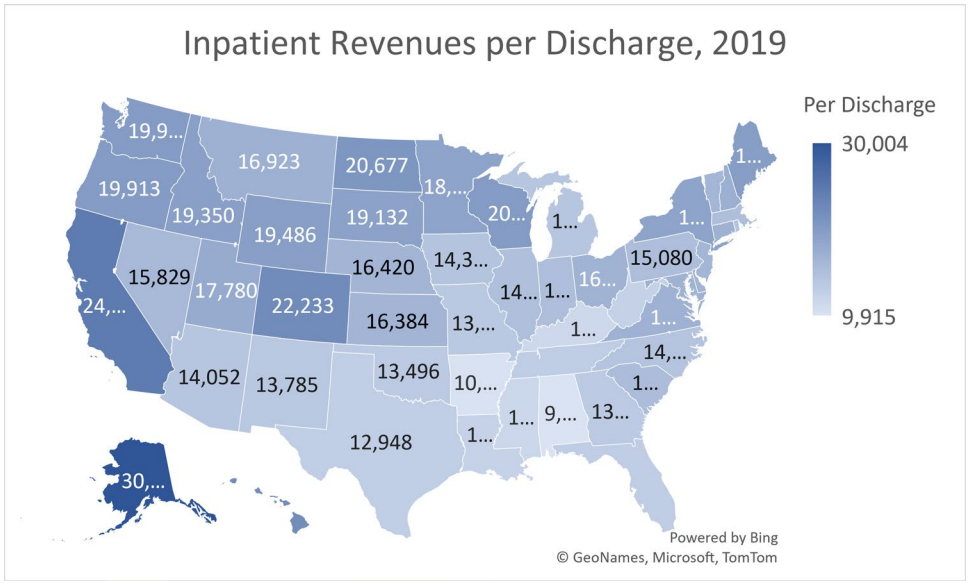
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

16. ***Inpatient Revenue Per Discharge.*** Although revenue or cost allocations are inherently uncertain, it has become customary to use charges as a tool to divide resource use among hospital units or services. To estimate hospital costs per discharge, we use inpatient vs. outpatient charges to allocate revenues to inpatient care, and then divide by the number of discharges.

    At over $20,000, North Dakota's inpatient revenue per discharge was 6th highest among states in 2019. Inpatient revenue per discharge grew by 5.7 percent per year, nearly double the national average of 3.0% (see Table 23 and Figure 9). In 2010, North Dakota's rank was 21st on this measure.

Figure 9.



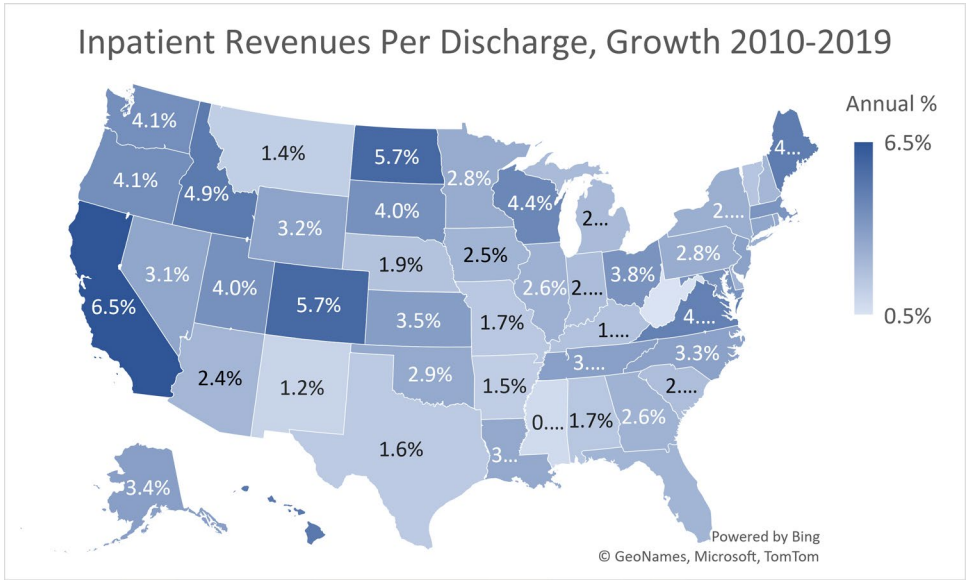


Table 23.

Inpatient Revenue per Discharge (approximated using charge ratios), Ranked by 2019 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019	Growth	Rank
US	**12,210**	**12,648**	**12,772**	**13,234**	**13,684**	**14,160**	**14,402**	**14,781**	**15,837**	**15,905**	**30%**	**3.0%**	
AK	22,253	22,725	22,085	19,430	21,176	22,829	23,489	23,530	25,043	**30,004**	35%	3.4%	1
DC	16,533	16,556	16,023	20,722	16,741	17,800	18,989	20,264	22,314	**25,172**	52%	4.8%	2
CA	13,879	14,957	15,060	16,908	16,875	17,059	17,721	17,961	25,008	**24,435**	76%	6.5%	3
CO	13,545	14,332	14,627	15,870	16,286	17,071	17,933	18,470	19,511	**22,233**	64%	5.7%	4
HI	14,231	12,241	13,004	13,197	14,387	15,222	16,185	16,339	17,583	**22,033**	55%	5.0%	5
ND	12,587	12,319	14,867	15,109	15,889	16,718	18,186	17,310	18,329	**20,677**	64%	5.7%	6
WI	13,645	13,997	15,093	15,913	16,692	17,429	17,618	17,828	17,978	**20,020**	47%	4.4%	7
WA	13,948	14,643	14,592	15,791	16,437	17,489	17,015	18,958	19,058	**19,949**	43%	4.1%	8
OR	13,893	14,204	15,190	18,387	16,050	16,118	17,426	17,057	18,252	**19,913**	43%	4.1%	9
ME	12,889	13,631	14,015	13,817	15,175	15,722	17,255	18,410	18,463	**19,686**	53%	4.8%	10
WY	14,701	15,390	16,131	16,444	16,703	17,820	18,260	18,074	18,990	**19,486**	33%	3.2%	11
ID	12,562	13,187	14,299	15,214	16,186	16,657	16,908	17,169	18,258	**19,350**	54%	4.9%	12
SD	13,446	15,654	15,995	16,705	16,714	18,147	18,956	18,591	18,522	**19,132**	42%	4.0%	13
NY	14,817	15,004	15,213	16,233	17,016	17,940	18,699	19,024	19,914	**18,896**	28%	2.7%	14
MN	14,603	15,350	16,043	16,359	18,056	18,370	19,301	19,159	19,866	**18,801**	29%	2.8%	15
UT	12,519	14,452	13,163	13,795	14,961	15,377	15,971	16,813	17,225	**17,780**	42%	4.0%	16
NH	13,874	14,285	14,158	14,822	15,081	15,194	15,511	16,620	17,075	**17,144**	24%	2.4%	17
MT	14,928	15,716	15,744	15,782	16,333	17,208	16,516	17,042	16,469	**16,923**	13%	1.4%	18
CT	12,828	13,797	13,627	14,176	14,464	14,632	14,439	14,840	16,058	**16,839**	31%	3.1%	19
VA	11,166	11,456	11,656	12,021	13,004	13,593	13,911	13,448	14,298	**16,792**	50%	4.6%	20
OH	11,922	12,270	12,522	12,677	13,132	13,714	14,370	14,372	14,807	**16,739**	40%	3.8%	21
MD	11,831	11,820	12,063	12,180	13,060	14,239	14,268	14,846	15,248	**16,709**	41%	3.9%	22
DE	13,091	13,110	13,992	13,011	13,959	15,679	15,807	15,746	16,111	**16,443**	26%	2.6%	23
NE	13,882	14,445	14,309	14,557	14,915	15,848	16,108	15,899	14,732	**16,420**	18%	1.9%	24
KS	12,072	11,388	12,711	13,022	13,328	13,744	13,746	14,520	14,975	**16,384**	36%	3.5%	25
VT	13,892	13,295	13,925	14,994	16,134	17,097	15,379	16,902	16,377	**16,310**	17%	1.8%	26
NJ	12,193	12,468	13,040	13,349	13,919	14,764	14,448	15,847	16,589	**16,294**	34%	3.3%	27
NV	12,053	12,322	13,163	13,376	13,035	13,681	13,515	14,012	14,417	**15,829**	31%	3.1%	28
SC	12,670	12,691	12,295	12,942	13,424	14,030	13,917	14,029	14,301	**15,251**	20%	2.1%	29
IN	12,495	12,988	13,936	13,791	14,850	14,525	14,688	15,096	15,845	**15,102**	21%	2.1%	30
PA	11,773	12,176	12,607	12,897	13,109	13,474	13,913	14,156	14,794	**15,080**	28%	2.8%	31
MA	10,764	11,331	11,881	12,100	12,625	12,796	13,560	13,722	14,856	**15,063**	40%	3.8%	32
IL	11,797	11,892	11,661	12,077	12,514	13,095	13,487	13,670	14,248	**14,921**	26%	2.6%	33
IA	11,500	11,484	11,604	11,617	12,069	12,039	12,491	12,762	12,945	**14,330**	25%	2.5%	34
RI	11,033	12,549	12,952	13,470	13,679	13,602	14,004	13,753	14,473	**14,301**	30%	2.9%	35
NC	10,663	10,855	11,593	11,529	11,675	12,604	12,824	13,357	13,691	**14,240**	34%	3.3%	36
AZ	11,327	11,729	11,654	11,582	12,117	11,364	12,603	13,898	14,019	**14,052**	24%	2.4%	37
MI	11,498	11,620	11,514	11,700	12,089	12,437	12,882	13,544	13,515	**13,995**	22%	2.2%	38
NM	12,399	12,046	12,182	11,713	12,184	13,399	13,566	13,012	14,495	**13,785**	11%	1.2%	39
MO	11,754	12,758	12,216	12,313	12,583	12,769	13,475	13,671	13,655	**13,643**	16%	1.7%	40
OK	10,397	10,213	10,701	10,149	10,972	11,688	11,904	12,363	12,523	**13,496**	30%	2.9%	41
GA	10,672	11,416	10,845	11,028	10,947	11,745	12,241	12,424	13,013	**13,405**	26%	2.6%	42
TN	9,689	10,667	11,161	10,557	10,740	10,687	10,822	11,502	12,209	**13,033**	35%	3.3%	43
FL	10,431	10,981	10,366	10,488	10,975	11,376	11,587	12,080	12,570	**13,000**	25%	2.5%	44
TX	11,229	11,490	11,269	11,536	12,320	12,677	12,829	12,828	13,152	**12,948**	15%	1.6%	45
WV	11,756	9,831	10,638	11,281	11,778	12,396	12,923	13,268	14,020	**12,348**	5%	0.5%	46
LA	9,403	10,235	10,574	10,911	11,538	12,342	12,232	12,304	12,540	**12,251**	30%	3.0%	47
MS	10,736	10,883	10,763	10,864	11,403	11,009	10,832	10,864	10,632	**11,623**	8%	0.9%	48
KY	9,656	9,974	9,745	10,040	10,234	10,587	10,917	11,199	11,409	**11,467**	19%	1.9%	49
AR	8,861	8,930	8,919	8,804	8,932	9,200	9,316	9,709	9,989	**10,094**	14%	1.5%	50
AL	8,493	8,509	8,671	8,892	8,947	9,110	8,912	9,050	9,331	**9,915**	17%	1.7%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

17. ***Commercial to Medicare Rate Ratio.*** We used a proxy measure of average commercial rates compared with Medicare rates. Among all hospitals in North Dakota, the average ratio in 2019 was 213 percent of Medicare rates, or more than twice Medicare payment rates (see Table 24 and Figure 10). For comparison, the commercial to Medicare rate ratio in 2018 ranged from a high of 247 percent in Colorado to 150 percent or below in New York, Texas, Maryland, Massachusetts, and a handful of other states. Over the 2010-2018 period, North Dakota's rank on this measure jumped from 30th to 7th.

Figure 10.

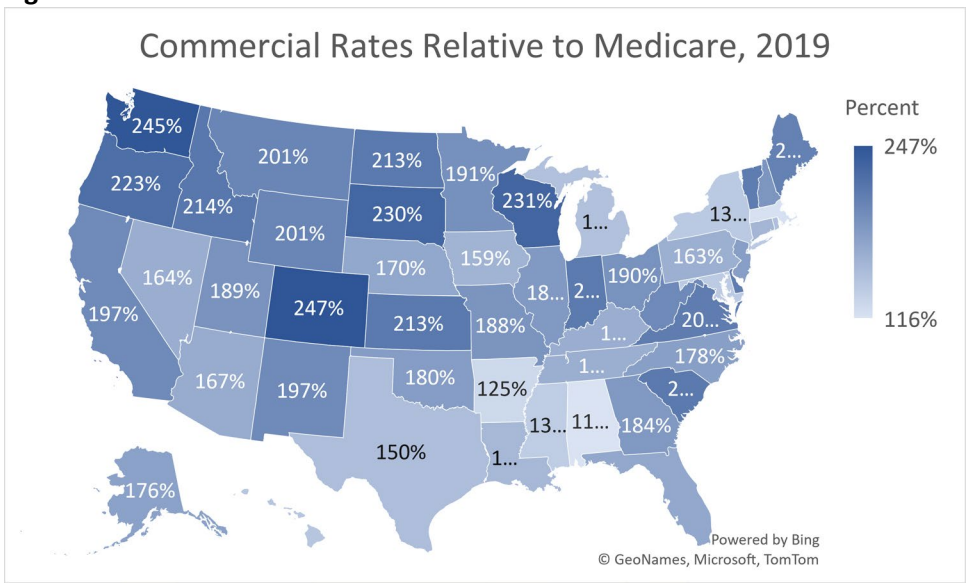


Table 24.

Commercial Rates Relative to Medicare, Ranked by 2019 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Pct Growth 2011-2019	Avg Annual Growth	Rank
US		**167%**	**168%**	**162%**	**167%**	**174%**	**172%**	**173%**	**173%**	**172%**	**3%**	**0.4%**	
CO		198%	218%	213%	212%	231%	239%	244%	244%	**247%**	24%	2.8%	1
WA		191%	194%	182%	196%	215%	203%	216%	216%	**245%**	28%	3.1%	2
WI		196%	212%	217%	223%	233%	236%	235%	227%	**231%**	17%	2.0%	3
SD		225%	230%	216%	203%	222%	221%	224%	230%	**230%**	2%	0.3%	4
OR		196%	205%	182%	206%	211%	218%	208%	205%	**223%**	14%	1.6%	5
ID		213%	218%	222%	224%	225%	216%	226%	226%	**214%**	0%	0.1%	6
ND		170%	177%	166%	180%	190%	202%	191%	205%	**213%**	26%	2.9%	7
KS		170%	189%	184%	189%	195%	200%	200%	197%	**213%**	25%	2.9%	8
SC		202%	200%	211%	217%	224%	223%	218%	211%	**212%**	5%	0.6%	9
IN		210%	232%	221%	234%	225%	225%	229%	239%	**212%**	1%	0.1%	10
VT		191%	198%	220%	229%	238%	228%	228%	214%	**209%**	10%	1.2%	11
VA		186%	184%	177%	185%	196%	200%	187%	193%	**209%**	12%	1.5%	12
DE		187%	201%	199%	203%	214%	207%	206%	211%	**209%**	12%	1.4%	13
ME		230%	234%	201%	216%	221%	219%	229%	220%	**205%**	-11%	-1.4%	14
MT		215%	211%	196%	207%	209%	187%	198%	204%	**201%**	-6%	-0.8%	15
WY		300%	213%	219%	221%	225%	213%	212%	209%	**201%**	-33%	-4.9%	16
WV		165%	195%	181%	186%	199%	209%	211%	204%	**197%**	19%	2.2%	17
CA		154%	166%	162%	159%	184%	182%	178%	194%	**197%**	28%	3.1%	18
NM		186%	193%	173%	190%	192%	198%	169%	207%	**197%**	6%	0.7%	19
DC		154%	156%	150%	151%	161%	162%	169%	180%	**196%**	27%	3.1%	20
MN		169%	173%	174%	178%	185%	190%	189%	194%	**191%**	13%	1.6%	21
OH		181%	175%	170%	168%	172%	179%	177%	176%	**190%**	5%	0.6%	22
UT		162%	177%	180%	181%	185%	198%	196%	196%	**189%**	17%	2.0%	23
MO		178%	177%	167%	173%	180%	184%	184%	176%	**188%**	6%	0.7%	24
NH		208%	207%	200%	198%	205%	197%	201%	190%	**187%**	-10%	-1.3%	25
GA		175%	164%	157%	161%	168%	172%	178%	177%	**184%**	5%	0.6%	26
IL		184%	177%	175%	179%	187%	181%	187%	178%	**183%**	0%	-0.1%	27
OK		168%	177%	155%	169%	177%	173%	179%	176%	**180%**	7%	0.9%	28
NJ		182%	181%	182%	173%	176%	180%	196%	187%	**178%**	-2%	-0.2%	29
NC		173%	181%	170%	169%	182%	182%	187%	185%	**178%**	3%	0.3%	30
AK		207%	199%	160%	175%	185%	185%	175%	180%	**176%**	-15%	-2.0%	31
NE		219%	214%	212%	213%	206%	206%	206%	174%	**170%**	-22%	-3.1%	32
FL		180%	162%	159%	176%	179%	174%	179%	180%	**170%**	-5%	-0.7%	33
AZ		167%	171%	151%	170%	161%	162%	172%	170%	**167%**	0%	0.0%	34
NV		153%	117%	159%	153%	163%	146%	160%	162%	**164%**	7%	0.9%	35
KY		179%	172%	167%	164%	173%	171%	174%	173%	**164%**	-8%	-1.1%	36
TN		164%	177%	142%	154%	155%	152%	159%	163%	**164%**	0%	0.0%	37
PA		153%	157%	155%	154%	161%	164%	160%	163%	**163%**	6%	0.8%	38
IA		180%	177%	162%	162%	166%	164%	160%	158%	**159%**	-11%	-1.5%	39
CT		157%	167%	165%	161%	157%	163%	156%	166%	**157%**	0%	0.0%	40
LA		161%	148%	151%	146%	156%	156%	147%	144%	**155%**	-4%	-0.5%	41
TX		163%	159%	153%	165%	175%	168%	173%	160%	**150%**	-8%	-1.0%	42
RI		157%	166%	160%	148%	142%	140%	144%	134%	**148%**	-6%	-0.7%	43
MI		145%	145%	139%	140%	141%	143%	145%	147%	**147%**	1%	0.1%	44
HI		112%	122%	109%	110%	127%	123%	121%	126%	**143%**	27%	3.1%	45
NY		127%	128%	125%	133%	134%	141%	137%	140%	**139%**	9%	1.1%	46
MD		127%	128%	121%	122%	124%	124%	130%	135%	**138%**	9%	1.0%	47
MS		192%	186%	169%	187%	172%	154%	153%	137%	**136%**	-29%	-4.2%	48
AR		148%	145%	128%	134%	133%	132%	133%	127%	**125%**	-15%	-2.0%	49
MA		120%	115%	112%	115%	116%	135%	123%	136%	**118%**	-2%	-0.2%	50
AL		122%	130%	126%	118%	128%	121%	116%	116%	**116%**	-5%	-0.7%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete.

18. ***Medicare Case Mix Index.*** The average Medicare case mix index gives an idea of the intensity or complexity of the inpatient services provided in a state. North Dakota's 2019 measure of 1.74 is very close to the national average of 1.79, and has remained close to the national average since 2010 (see Figure 11 and Table 25).

Figure 11.

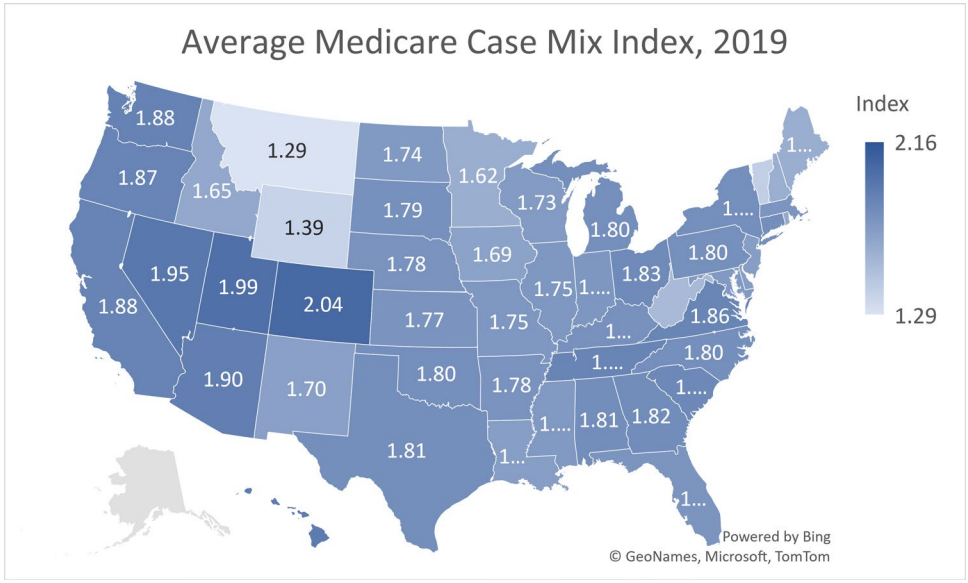


Table 25.

Average Medicare Case Mix Index, Ranked by 2019 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2019	Growth	Rank
US	**1.56**	**1.57**	**1.59**	**1.62**	**1.65**	**1.67**	**1.69**	**1.72**	**1.75**	**1.79**	**14%**	**1.6%**	
DC	1.76	1.81	1.76	1.72	1.83	1.88	1.95	2.02	2.09	**2.16**	19%	2.2%	1
CO	1.61	1.63	1.66	1.75	1.78	1.80	1.84	1.89	1.92	**2.04**	25%	2.9%	2
UT	1.71	1.76	1.77	1.78	1.86	1.86	1.90	1.93	1.98	**1.99**	13%	1.6%	3
NV	1.60	1.66	1.69	1.72	1.77	1.80	1.83	1.79	1.81	**1.95**	17%	2.0%	4
HI	1.61	1.61	1.67	1.66	1.68	1.70	1.78	1.83	1.85	**1.92**	19%	2.2%	5
AZ	1.68	1.67	1.74	1.74	1.78	1.81	1.89	1.90	1.94	**1.90**	14%	1.6%	6
WA	1.56	1.58	1.62	1.66	1.70	1.73	1.76	1.78	1.80	**1.88**	19%	2.2%	7
CA	1.60	1.63	1.67	1.68	1.71	1.72	1.76	1.79	1.82	**1.88**	15%	1.8%	8
OR	1.62	1.61	1.68	1.70	1.73	1.73	1.79	1.79	1.82	**1.87**	16%	1.9%	9
TN	1.62	1.65	1.68	1.72	1.74	1.75	1.77	1.83	1.85	**1.87**	13%	1.6%	10
VA	1.60	1.59	1.61	1.64	1.68	1.69	1.74	1.76	1.79	**1.86**	17%	2.0%	11
SC	1.61	1.62	1.65	1.69	1.71	1.70	1.75	1.78	1.80	**1.84**	14%	1.6%	12
OH	1.56	1.56	1.58	1.62	1.65	1.67	1.70	1.73	1.76	**1.83**	17%	2.0%	13
GA	1.59	1.60	1.64	1.67	1.69	1.70	1.74	1.77	1.78	**1.82**	14%	1.6%	14
AL	1.56	1.58	1.60	1.63	1.66	1.66	1.68	1.73	1.76	**1.81**	15%	1.7%	15
TX	1.60	1.61	1.61	1.64	1.67	1.69	1.73	1.74	1.79	**1.81**	12%	1.5%	16
CT	1.57	1.56	1.58	1.60	1.63	1.64	1.69	1.71	1.76	**1.81**	16%	1.8%	17
NY	1.53	1.54	1.55	1.59	1.64	1.66	1.70	1.72	1.75	**1.80**	17%	2.0%	18
OK	1.52	1.55	1.55	1.60	1.67	1.69	1.75	1.80	1.80	**1.80**	16%	1.9%	19
NC	1.58	1.60	1.64	1.67	1.69	1.70	1.76	1.77	1.78	**1.80**	12%	1.5%	20
MI	1.56	1.58	1.58	1.61	1.64	1.66	1.69	1.72	1.77	**1.80**	14%	1.7%	21
PA	1.58	1.59	1.60	1.64	1.67	1.68	1.72	1.74	1.78	**1.80**	13%	1.5%	22
SD	1.51	1.51	1.54	1.59	1.63	1.62	1.66	1.68	1.71	**1.79**	19%	2.2%	23
KY	1.49	1.50	1.50	1.56	1.59	1.62	1.67	1.70	1.73	**1.79**	19%	2.2%	24
NE	1.46	1.50	1.53	1.56	1.61	1.62	1.67	1.70	1.76	**1.78**	19%	2.2%	25
AR	1.46	1.49	1.48	1.53	1.56	1.60	1.64	1.69	1.73	**1.78**	20%	2.3%	26
KS	1.48	1.52	1.52	1.56	1.57	1.60	1.61	1.66	1.69	**1.77**	16%	1.9%	27
FL	1.57	1.58	1.59	1.61	1.62	1.63	1.68	1.71	1.75	**1.77**	12%	1.4%	28
MA	1.47	1.49	1.53	1.58	1.61	1.62	1.66	1.68	1.71	**1.77**	18%	2.1%	29
IN	1.52	1.52	1.52	1.56	1.61	1.62	1.67	1.70	1.72	**1.76**	16%	1.9%	30
MO	1.57	1.60	1.62	1.66	1.69	1.69	1.73	1.77	1.79	**1.75**	10%	1.2%	31
IL	1.49	1.51	1.51	1.56	1.60	1.62	1.65	1.68	1.72	**1.75**	16%	1.9%	32
MS	1.45	1.46	1.48	1.52	1.54	1.56	1.60	1.64	1.65	**1.74**	19%	2.2%	33
MD	1.49	1.52	1.55	1.56	1.58	1.61	1.63	1.68	1.70	**1.74**	15%	1.7%	34
ND	1.54	1.53	1.53	1.61	1.67	1.65	1.67	1.72	1.73	**1.74**	14%	1.6%	35
WI	1.49	1.50	1.51	1.54	1.59	1.59	1.63	1.65	1.67	**1.73**	15%	1.8%	36
LA	1.50	1.52	1.55	1.60	1.62	1.66	1.70	1.73	1.75	**1.71**	13%	1.5%	37
DE	1.52	1.54	1.63	1.64	1.68	1.70	1.74	1.74	1.74	**1.71**	11%	1.3%	38
NJ	1.55	1.56	1.58	1.60	1.65	1.66	1.71	1.74	1.75	**1.71**	10%	1.2%	39
NM	1.50	1.52	1.55	1.53	1.56	1.59	1.69	1.69	1.72	**1.70**	12%	1.4%	40
IA	1.40	1.42	1.45	1.47	1.50	1.51	1.55	1.57	1.61	**1.69**	19%	2.2%	41
ID	1.48	1.47	1.53	1.56	1.60	1.60	1.64	1.64	1.66	**1.65**	12%	1.4%	42
RI	1.45	1.49	1.52	1.55	1.55	1.54	1.57	1.62	1.62	**1.64**	10%	1.2%	43
MN	1.51	1.53	1.56	1.62	1.64	1.68	1.72	1.77	1.78	**1.62**	5%	0.7%	44
ME	1.37	1.38	1.43	1.44	1.44	1.45	1.51	1.56	1.58	**1.62**	17%	2.0%	45
NH	1.40	1.42	1.42	1.48	1.49	1.48	1.53	1.58	1.60	**1.61**	13%	1.5%	46
WV	1.46	1.44	1.45	1.51	1.54	1.54	1.58	1.63	1.68	**1.54**	7%	0.8%	47
VT	1.28	1.27	1.32	1.33	1.34	1.30	1.33	1.34	1.33	**1.41**	11%	1.3%	48
WY	1.18	1.21	1.25	1.25	1.27	1.30	1.35	1.35	1.35	**1.39**	14%	1.7%	49
MT	1.33	1.35	1.43	1.44	1.46	1.46	1.53	1.55	1.60	**1.29**	-4%	-0.5%	50
AK	1.49	1.52	1.52	1.52	1.61	1.65	1.66	1.66	1.67		12%	1.4%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Alaska growth rate is 2010-2018.

19. ***Medicare Revenues Per Enrollee.*** Medicare patient revenues per enrollee in North Dakota were 2nd highest in the nation in 2018. Figure 12 and Table 26 show the measure based on gross Medicare enrollment in the state (anyone with any Medicare enrollment). We also tested the concept using a "net" or much reduced enrollment measure (only Parts A and B, excluding dual Medicare-Medicaid eligible people). Under both measures, Medicare patient revenues per enrollee in North Dakota ranked number 2, behind only DC.

Figure 12.

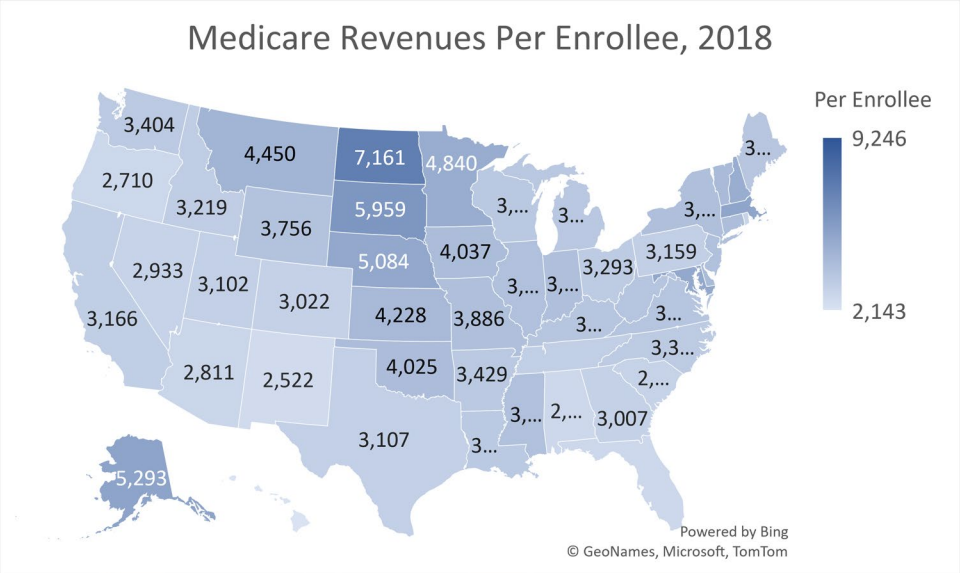


Table 26.

Annual Medicare Patient Revenues Per (Gross) Medicare Enrollee, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**3,397**	**3,344**	**3,366**	**3,331**	**3,345**	**3,314**	**3,433**	**3,429**	**3,433**	**2,216**	**1%**	**0.1%**	
DC	8,687	8,545	8,547	8,429	8,397	8,713	8,800	9,214	**9,246**	7,584	6%	0.8%	1
ND	4,866	5,056	5,839	5,542	6,240	6,489	6,856	7,002	**7,161**	5,501	47%	4.9%	2
SD	4,425	4,400	4,492	4,788	5,119	5,365	5,672	5,896	**5,959**	6,194	35%	3.8%	3
AK	3,443	3,576	3,603	4,602	4,626	4,623	4,948	5,070	**5,293**	1,480	54%	5.5%	4
MA	4,446	4,440	4,744	4,844	4,787	4,954	5,047	5,058	**5,198**	4,922	17%	2.0%	5
NE	4,415	4,483	4,513	4,643	4,558	4,659	4,874	4,962	**5,084**	3,195	15%	1.8%	6
MD	5,265	5,254	5,211	5,023	5,238	5,184	5,310	5,239	**5,068**	4,821	-4%	-0.5%	7
MN	3,682	3,816	3,899	3,963	4,144	4,342	4,509	4,740	**4,840**	1,429	31%	3.5%	8
NH	3,957	4,123	3,858	4,238	4,334	4,461	4,573	4,700	**4,803**	4,243	21%	2.4%	9
MT	3,152	2,973	3,804	3,721	3,779	3,499	4,339	4,258	**4,450**	1,716	41%	4.4%	10
KS	3,830	3,767	3,774	3,886	4,021	3,964	4,284	4,249	**4,228**	2,881	10%	1.2%	11
VT	3,833	3,846	3,896	3,799	3,834	3,926	4,074	4,188	**4,124**	4,047	8%	0.9%	12
DE	3,818	3,948	3,905	3,886	4,100	4,168	4,183	4,188	**4,117**	4,123	8%	0.9%	13
IA	3,732	3,763	3,732	3,784	3,829	3,952	3,947	4,040	**4,037**	3,473	8%	1.0%	14
OK	3,368	3,388	3,383	3,453	3,555	3,625	3,780	3,863	**4,025**	2,962	20%	2.3%	15
CT	4,137	4,118	3,945	4,086	4,184	4,155	4,199	4,250	**4,007**	3,758	-3%	-0.4%	16
IN	3,925	3,845	3,815	3,820	3,862	3,886	3,858	3,888	**3,887**	1,493	-1%	-0.1%	17
NY	3,882	3,811	3,726	3,649	3,673	3,593	3,800	3,824	**3,887**	785	0%	0.0%	18
MO	3,918	3,783	4,060	3,820	3,829	3,726	4,036	3,807	**3,886**	1,830	-1%	-0.1%	19
MS	3,768	3,595	3,893	3,682	3,656	3,649	3,825	3,821	**3,857**	3,408	2%	0.3%	20
IL	4,193	4,106	4,165	4,173	3,986	3,704	3,914	3,801	**3,850**	2,889	-8%	-1.1%	21
NJ	3,943	3,915	3,691	3,641	3,844	4,037	3,941	3,848	**3,826**	473	-3%	-0.4%	22
WY	3,248	3,068	3,221	3,318	3,345	3,529	3,703	3,742	**3,756**	3,696	16%	1.8%	23
WV	3,414	3,344	3,451	3,324	3,293	3,367	3,393	3,547	**3,640**	2,360	7%	0.8%	24
VA	3,221	3,149	3,355	3,317	3,409	3,319	3,512	3,531	**3,636**	2,045	13%	1.5%	25
KY	3,937	3,740	3,847	3,613	3,526	3,422	3,714	3,624	**3,587**	2,513	-9%	-1.2%	26
ME	3,742	3,701	3,684	3,713	3,661	3,790	3,749	3,787	**3,575**	3,148	-4%	-0.6%	27
MI	4,137	3,995	3,936	3,815	3,786	3,702	3,762	3,682	**3,472**	2,778	-16%	-2.2%	28
WI	3,283	3,274	3,276	3,245	3,333	3,307	3,300	3,370	**3,463**	2,056	5%	0.7%	29
AR	3,330	3,203	3,312	3,208	3,173	3,167	3,361	3,369	**3,429**	2,335	3%	0.4%	30
LA	3,466	3,342	3,494	3,406	3,414	3,266	3,513	3,418	**3,416**	1,997	-1%	-0.2%	31
WA	2,950	2,912	2,993	3,127	3,178	3,232	3,350	3,361	**3,404**	1,639	15%	1.8%	32
NC	3,566	3,603	3,556	3,581	3,347	3,332	3,275	3,347	**3,344**	2,508	-6%	-0.8%	33
OH	3,337	3,283	3,197	3,129	3,164	3,046	3,242	3,310	**3,293**	1,155	-1%	-0.2%	34
ID	2,447	2,480	2,669	2,780	2,907	2,957	3,030	3,076	**3,219**	2,338	32%	3.5%	35
CA	2,958	2,965	2,971	2,999	2,976	3,002	3,071	3,115	**3,166**	2,168	7%	0.9%	36
PA	3,032	3,020	2,966	2,887	2,991	3,081	3,133	3,232	**3,159**	3,162	4%	0.5%	37
TN	3,417	3,229	3,398	3,222	3,189	3,098	3,160	3,248	**3,145**	2,533	-8%	-1.0%	38
TX	3,477	3,419	3,373	3,237	3,176	3,120	3,204	3,122	**3,107**	2,133	-11%	-1.4%	39
UT	2,476	2,433	2,549	2,647	2,806	2,818	2,970	2,993	**3,102**	2,971	25%	2.9%	40
CO	2,601	2,563	2,476	2,622	2,724	2,745	2,836	3,051	**3,022**	1,784	16%	1.9%	41
GA	3,267	3,129	3,104	3,118	3,101	3,007	3,000	2,991	**3,007**	2,585	-8%	-1.0%	42
SC	3,112	2,969	3,130	3,062	3,010	2,861	3,018	2,931	**2,965**	2,515	-5%	-0.6%	43
NV	2,586	2,641	2,562	2,720	2,703	2,774	2,780	2,886	**2,933**	1,009	13%	1.6%	44
RI	2,975	2,932	2,816	2,923	3,228	3,226	3,287	2,952	**2,887**	2,385	-3%	-0.4%	45
AZ	2,602	2,493	2,604	2,600	2,738	2,716	2,871	2,881	**2,811**	1,352	8%	1.0%	46
OR	2,222	2,093	2,514	2,395	2,456	2,295	2,756	2,643	**2,710**	1,602	22%	2.5%	47
FL	2,955	2,898	2,816	2,760	2,757	2,732	2,730	2,707	**2,679**	1,781	-9%	-1.2%	48
AL	3,049	2,961	3,240	3,026	3,199	2,725	3,265	2,795	**2,676**	2,239	-12%	-1.6%	49
NM	2,232	2,102	2,266	2,278	2,344	2,290	2,588	2,510	**2,522**	1,659	13%	1.5%	50
HI	1,999	1,950	1,813	1,891	1,837	1,921	1,989	2,058	**2,143**	1,699	7%	0.9%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

20. Medicare Inpatient Revenues. Medicare inpatient revenues in North Dakota grew by 4.5 percent annually between 2010 and 2018, several orders of magnitude higher than the national average of 1.2 percent per year (see Table 27).

Table 27.

Medicare Inpatient Revenues (millions)						DRAFT					Pct Growth	Avg Annual	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**120,821**	**119,631**	**121,801**	**122,785**	**123,238**	**123,388**	**129,866**	**130,958**	**132,449**	**85,023**	**10%**	**1.2%**	
AK	165	175	180	233	244	250	278	289	306	58	86%	**8.0%**	1
NV	781	803	787	863	884	951	1,001	1,089	1,146	391	47%	**4.9%**	2
UT	491	494	525	560	602	615	668	680	706	695	44%	**4.6%**	3
MT	328	306	378	386	381	370	453	454	471	166	44%	**4.6%**	4
MN	2,007	2,095	2,167	2,256	2,327	2,464	2,612	2,778	2,869	762	43%	**4.6%**	5
ND	309	325	354	343	376	395	416	429	440	338	43%	**4.5%**	6
NH	523	561	522	595	616	648	682	722	744	649	42%	**4.5%**	7
ID	353	355	386	410	429	441	463	476	500	378	42%	**4.5%**	8
OR	980	918	1,147	1,101	1,153	1,078	1,364	1,307	1,346	770	37%	**4.0%**	9
CO	1,204	1,187	1,158	1,264	1,343	1,397	1,463	1,622	1,619	980	35%	**3.8%**	10
WA	2,083	2,042	2,160	2,301	2,329	2,422	2,581	2,608	2,633	1,314	26%	**3.0%**	11
SD	397	392	394	422	428	444	468	498	499	535	26%	**2.9%**	12
VA	2,768	2,743	2,977	2,995	3,060	3,003	3,278	3,304	3,456	1,957	25%	**2.8%**	13
NE	798	814	827	872	844	886	945	969	989	591	24%	**2.7%**	14
HI	319	316	301	327	318	338	360	377	394	304	23%	**2.7%**	15
MA	3,426	3,442	3,718	3,853	3,764	3,961	4,059	4,078	4,222	3,997	23%	**2.6%**	16
AZ	1,955	1,868	1,957	1,963	2,115	2,130	2,351	2,368	2,374	1,162	21%	**2.5%**	17
DE	441	455	454	467	505	515	529	542	531	533	20%	**2.4%**	18
NM	509	476	523	528	546	529	617	602	610	378	20%	**2.3%**	19
CA	11,382	11,533	11,822	12,185	12,113	12,358	12,944	13,307	13,615	9,137	20%	**2.3%**	20
DC	533	536	547	557	556	584	598	644	635	510	19%	**2.2%**	21
WY	186	168	179	187	187	201	217	217	219	224	18%	**2.0%**	22
VT	261	263	269	265	264	277	293	306	305	305	17%	**2.0%**	23
MD	3,156	3,211	3,264	3,218	3,444	3,442	3,585	3,580	3,677	3,482	17%	**1.9%**	24
KS	1,101	1,084	1,077	1,140	1,171	1,168	1,258	1,266	1,276	871	16%	**1.9%**	25
OK	1,484	1,483	1,465	1,491	1,507	1,531	1,614	1,657	1,716	1,351	16%	**1.8%**	26
IA	1,174	1,189	1,193	1,231	1,229	1,277	1,280	1,317	1,303	1,100	11%	**1.3%**	27
FL	7,942	7,875	7,815	7,881	8,007	8,158	8,354	8,436	8,488	5,620	7%	**0.8%**	28
PA	5,269	5,269	5,215	5,148	5,301	5,425	5,528	5,748	5,623	5,619	7%	**0.8%**	29
RI	408	403	391	414	459	469	481	439	434	356	6%	**0.8%**	30
SC	1,860	1,766	1,890	1,877	1,867	1,806	1,982	1,936	1,977	1,712	6%	**0.8%**	31
NY	9,307	9,279	9,190	9,182	9,137	9,007	9,514	9,639	9,862	1,981	6%	**0.7%**	32
WV	897	891	930	902	872	880	890	919	945	573	5%	**0.7%**	33
GA	3,127	3,018	3,032	3,070	3,079	3,029	3,111	3,173	3,287	2,831	5%	**0.6%**	34
WI	2,007	2,022	2,022	2,029	2,055	2,055	2,049	2,097	2,110	1,283	5%	**0.6%**	35
TX	8,055	7,942	8,008	7,895	7,835	7,820	8,222	8,202	8,464	5,825	5%	**0.6%**	36
IN	2,794	2,745	2,764	2,814	2,825	2,867	2,892	2,899	2,917	1,151	4%	**0.5%**	37
AR	1,266	1,226	1,252	1,240	1,207	1,207	1,282	1,300	1,318	859	4%	**0.5%**	38
LA	1,751	1,673	1,762	1,729	1,733	1,664	1,813	1,782	1,816	1,067	4%	**0.5%**	39
NJ	4,126	4,100	3,941	3,953	4,137	4,392	4,365	4,279	4,262	559	3%	**0.4%**	40
MO	2,835	2,732	2,938	2,821	2,824	2,772	2,993	2,852	2,916	1,292	3%	**0.4%**	41
MS	1,339	1,265	1,389	1,341	1,307	1,298	1,361	1,345	1,367	1,208	2%	**0.3%**	42
NC	3,970	4,006	4,000	4,113	3,845	3,861	3,882	3,968	4,035	3,131	2%	**0.2%**	43
OH	4,634	4,600	4,550	4,507	4,480	4,331	4,625	4,733	4,708	1,632	2%	**0.2%**	44
CT	1,802	1,810	1,728	1,841	1,840	1,807	1,835	1,877	1,800	1,696	0%	**0.0%**	45
TN	2,809	2,661	2,798	2,700	2,676	2,621	2,746	2,837	2,802	2,318	0%	**0.0%**	46
ME	615	596	590	609	593	619	616	634	599	542	-3%	**-0.3%**	47
IL	5,687	5,610	5,715	5,817	5,486	5,101	5,421	5,271	5,377	3,990	-5%	**-0.7%**	48
AL	1,936	1,876	2,075	1,959	2,095	1,754	2,179	1,884	1,829	1,531	-6%	**-0.7%**	49
KY	2,183	2,062	2,147	2,048	1,994	1,945	2,141	2,071	2,029	1,412	-7%	**-0.9%**	50
MI	5,090	4,969	4,931	4,880	4,848	4,822	4,929	4,903	4,623	3,769	-9%	**-1.2%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

21. ***Medicare Inpatient Revenue Per Discharge.*** On a per-discharge basis, Medicare inpatient revenue per discharge in North Dakota grew by 3.8 percent per year between 2010 and 2019, nearly a percentage point faster than the national average rate of 2.9 percent. However, the estimated level of Medicare inpatient revenues per discharge in North Dakota ($13,353) remained slightly below the national average ($14,448) in 2019 (see Table 28).

Figure 13.

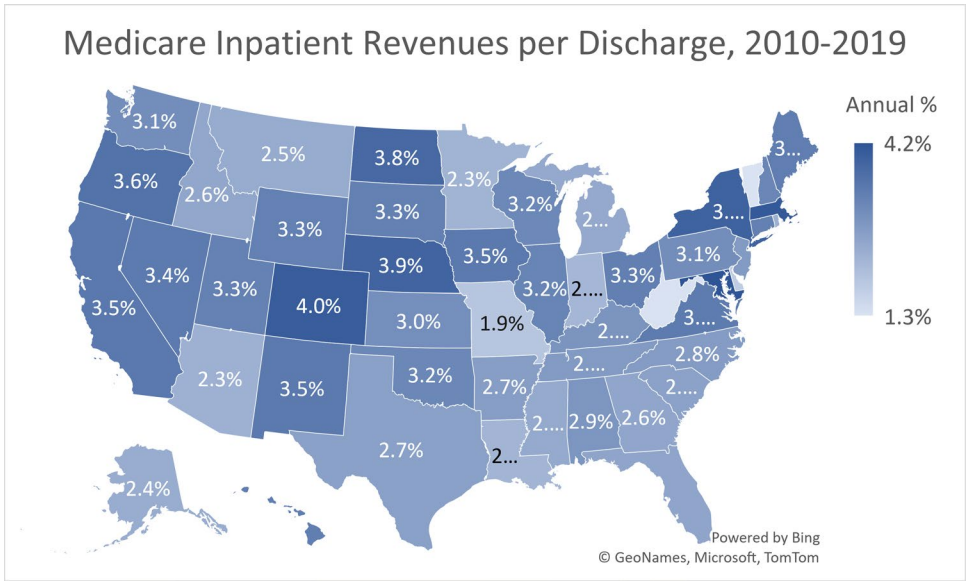


Table 28.

Medicare Inpatient Revenues Per Discharge DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Pct Growth 2010-2019	Avg Annual Growth	Rank
US	**11,144**	**11,270**	**11,539**	**12,072**	**12,530**	**12,729**	**13,089**	**13,371**	**13,871**	**14,448**	**30%**	**2.9%**	
MD	12,126	12,548	13,141	13,769	14,604	14,908	15,543	15,822	16,740	17,573	45%	**4.2%**	1
MA	11,963	12,057	13,623	14,126	14,488	14,805	15,105	15,002	15,638	17,184	44%	**4.1%**	2
CO	11,302	11,385	11,751	12,533	13,013	13,265	13,584	14,196	14,735	16,149	43%	**4.0%**	3
NY	14,222	14,296	14,876	15,874	16,685	17,064	17,652	17,832	18,226	20,130	42%	**3.9%**	4
NE	10,644	10,893	11,321	11,572	12,140	12,337	12,784	13,068	13,367	15,017	41%	**3.9%**	5
ND	9,548	11,165	10,504	11,197	11,971	12,175	12,374	12,602	12,900	13,353	40%	**3.8%**	6
OR	12,545	12,675	13,206	13,989	14,613	14,677	15,517	15,679	16,142	17,260	38%	**3.6%**	7
CA	14,795	15,147	15,741	16,387	16,919	17,264	17,912	18,022	18,467	20,122	36%	**3.5%**	8
IA	9,343	9,501	9,996	10,296	10,619	10,740	11,252	11,463	11,789	12,689	36%	**3.5%**	9
NM	10,666	10,869	11,129	11,426	12,086	12,705	12,695	12,843	13,556	14,482	36%	**3.5%**	10
NV	11,879	12,088	12,392	12,809	13,446	13,965	14,283	14,161	14,680	16,098	36%	**3.4%**	11
VA	10,273	10,240	10,427	10,891	11,223	11,398	11,777	12,067	12,291	13,908	35%	**3.4%**	12
ME	10,276	10,149	10,491	10,858	10,953	11,177	11,785	12,288	12,747	13,850	35%	**3.4%**	13
HI	14,899	14,951	15,064	16,296	17,073	17,565	18,359	18,659	19,794	20,047	35%	**3.4%**	14
OH	10,347	10,377	10,641	11,168	11,587	11,919	12,159	12,293	12,777	13,915	34%	**3.3%**	15
SD	9,949	10,300	10,638	11,253	11,569	11,677	12,135	12,327	12,551	13,352	34%	**3.3%**	16
CT	13,096	13,117	13,312	14,096	14,895	14,665	15,352	15,475	16,063	17,574	34%	**3.3%**	17
WY	11,162	11,324	11,830	11,860	12,271	12,702	13,477	13,624	13,783	14,967	34%	**3.3%**	18
UT	11,852	11,965	11,933	12,405	13,578	13,830	13,861	14,199	14,969	15,869	34%	**3.3%**	19
IL	10,403	10,544	10,753	11,253	11,687	11,918	12,205	12,531	13,045	13,871	33%	**3.2%**	20
NH	10,965	11,303	11,187	12,026	12,220	12,421	12,644	12,953	13,768	14,569	33%	**3.2%**	21
OK	9,234	9,592	9,647	10,017	10,727	10,847	11,064	11,439	11,740	12,242	33%	**3.2%**	22
DC	15,550	16,501	15,862	16,117	16,800	17,254	18,331	19,028	19,878	20,605	33%	**3.2%**	23
WI	11,073	11,140	11,144	11,735	12,134	12,376	12,569	12,934	13,260	14,653	32%	**3.2%**	24
PA	10,899	10,991	11,213	11,585	12,296	12,512	12,929	13,236	13,801	14,286	31%	**3.1%**	25
WA	12,186	12,293	12,749	13,541	14,046	14,436	14,794	15,007	15,211	15,972	31%	**3.1%**	26
KS	9,529	9,685	9,830	10,205	10,515	10,625	10,673	11,060	11,428	12,467	31%	**3.0%**	27
KY	9,468	9,409	9,544	10,119	10,497	10,626	10,961	11,248	11,500	12,264	30%	**2.9%**	28
AL	9,018	9,239	9,169	9,595	10,542	9,955	9,876	10,304	10,818	11,664	29%	**2.9%**	29
NJ	11,525	11,635	11,953	12,451	13,032	13,503	13,926	14,244	14,802	14,783	28%	**2.8%**	30
TN	9,732	9,821	10,035	10,483	10,756	10,795	11,062	11,472	11,916	12,474	28%	**2.8%**	31
NC	10,607	10,653	10,843	11,324	11,611	11,642	12,053	12,238	12,731	13,561	28%	**2.8%**	32
AR	8,883	9,029	9,070	9,413	9,676	9,823	10,066	10,358	10,730	11,324	27%	**2.7%**	33
TX	10,577	10,598	10,790	11,225	11,629	11,629	11,987	12,094	12,945	13,415	27%	**2.7%**	34
SC	10,451	10,425	10,538	11,006	11,283	11,182	11,329	11,644	12,310	13,229	27%	**2.7%**	35
FL	10,095	10,175	10,221	10,588	10,769	10,906	11,250	11,514	11,978	12,701	26%	**2.6%**	36
GA	10,526	10,466	10,790	11,117	11,416	11,499	11,841	12,038	12,538	13,225	26%	**2.6%**	37
ID	10,504	10,660	11,120	11,533	12,250	12,080	12,261	12,317	12,541	13,178	25%	**2.6%**	38
MI	11,362	11,486	11,486	11,909	12,286	12,547	12,987	13,437	13,822	14,195	25%	**2.5%**	39
MS	8,957	9,047	9,259	9,645	9,807	9,717	9,862	10,003	10,094	11,183	25%	**2.5%**	40
MT	9,516	10,043	10,499	11,067	11,010	11,392	11,865	12,413	12,927	11,845	24%	**2.5%**	41
AK	15,453	15,777	16,046	17,968	18,939	19,059	19,734	20,159	20,103	19,176	24%	**2.4%**	42
RI	12,157	12,165	12,563	13,310	13,611	13,584	14,190	14,379	15,016	14,981	23%	**2.3%**	43
AZ	12,034	11,814	12,150	12,669	13,228	13,651	14,417	14,829	15,035	14,829	23%	**2.3%**	44
MN	11,680	12,054	12,480	13,192	13,751	14,110	14,605	14,898	15,045	14,329	23%	**2.3%**	45
LA	9,695	9,871	10,143	10,431	10,820	10,959	11,223	11,522	12,090	11,860	22%	**2.3%**	46
IN	10,029	9,843	10,140	10,677	11,156	11,271	11,646	11,849	12,313	12,227	22%	**2.2%**	47
MO	10,315	10,572	10,769	11,215	11,430	11,655	11,857	12,157	12,650	12,252	19%	**1.9%**	48
DE	11,736	11,787	11,953	12,152	12,630	12,583	13,333	13,509	13,685	13,760	17%	**1.8%**	49
WV	9,190	9,043	9,315	9,878	10,082	10,282	10,733	10,833	11,316	10,383	13%	**1.4%**	50
VT	12,674	12,484	12,813	12,724	13,126	13,035	13,281	13,620	13,685	14,292	13%	**1.3%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

22. ***Medicare Outpatient Revenues.*** North Dakota's outpatient revenues from Medicare grew by 11.8 percent per year in the 2010-2018 period, higher than the national average growth rate of 7.7 percent a year (see Table 29 and Figure 14).

Figure 14.

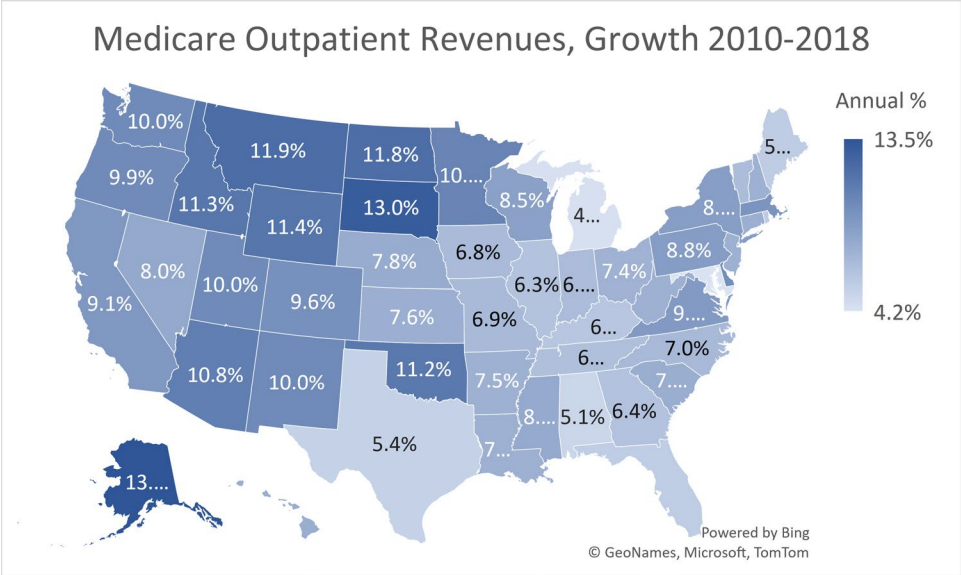


Table 29.

Medicare Outpatient Revenues (millions), Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**39,759**	**42,534**	**47,673**	**50,377**	**55,966**	**59,014**	**64,094**	**67,807**	**71,771**	**49,856**	**81%**	**7.7%**	
AK	619	668	816	830	931	883	1,047	932	921	808	175%	**13.5%**	1
SD	74	79	86	117	126	137	156	177	204	90	166%	**13.0%**	2
MT	530	574	691	768	881	961	1,037	1,167	1,200	627	146%	**11.9%**	3
ND	468	485	585	598	650	679	755	776	834	627	145%	**11.8%**	4
WY	2,869	3,125	3,427	3,711	4,202	4,615	4,913	5,274	5,773	4,442	137%	**11.4%**	5
ID	501	536	571	627	711	759	851	964	1,043	642	135%	**11.3%**	6
OK	487	527	597	646	755	813	860	906	876	854	133%	**11.2%**	7
AZ	141	163	181	185	210	237	253	269	297	324	126%	**10.8%**	8
MN	130	134	148	151	166	182	190	195	220	202	121%	**10.4%**	9
NM	2,140	2,268	2,419	2,479	2,728	2,860	3,015	3,189	3,334	2,480	115%	**10.0%**	10
UT	1,070	1,105	1,215	1,334	1,481	1,550	1,610	1,684	1,754	1,626	114%	**10.0%**	11
WA	98	101	102	107	118	132	141	157	178	160	114%	**10.0%**	12
OR	226	246	287	313	358	393	428	467	531	402	113%	**9.9%**	13
DE	1,877	1,987	2,288	2,462	2,597	2,553	2,831	2,899	3,070	2,451	110%	**9.7%**	14
CO	1,111	1,179	1,279	1,366	1,516	1,604	1,653	1,785	1,879	728	108%	**9.6%**	15
MA	689	738	792	846	919	982	1,028	1,100	1,169	1,068	104%	**9.3%**	16
CA	521	553	626	670	748	763	877	901	936	667	101%	**9.1%**	17
VA	775	820	932	937	989	1,007	1,125	1,176	1,244	918	99%	**9.0%**	18
PA	605	657	767	817	890	912	1,032	1,051	1,084	667	96%	**8.8%**	19
NY	375	409	449	472	504	543	562	587	585	524	95%	**8.7%**	20
WI	1,039	1,083	1,159	1,184	1,296	1,382	1,502	1,576	1,449	1,505	93%	**8.5%**	21
NV	1,254	1,353	1,602	1,757	1,926	2,067	2,230	2,374	2,560	2,537	85%	**8.0%**	22
MS	1,704	1,759	1,952	2,010	2,167	2,193	2,364	2,393	2,406	1,957	85%	**8.0%**	23
NE	883	978	1,093	1,165	1,356	1,503	1,629	1,807	1,953	695	82%	**7.8%**	24
HI	494	529	628	629	695	740	816	871	912	839	81%	**7.7%**	25
SC	1,036	1,101	1,334	1,329	1,437	1,461	1,690	1,652	1,766	951	81%	**7.7%**	26
KS	212	216	316	314	355	335	451	464	522	229	80%	**7.6%**	27
CT	400	433	478	513	550	575	624	666	729	512	80%	**7.6%**	28
LA	191	216	239	262	288	307	311	332	355	144	79%	**7.6%**	29
AR	364	387	399	450	493	528	564	598	649	615	78%	**7.5%**	30
NH	1,012	1,134	1,182	1,266	1,495	1,637	1,638	1,698	1,801	203	78%	**7.5%**	31
WV	197	207	241	265	299	323	378	394	424	320	78%	**7.5%**	32
NJ	2,034	2,143	2,405	2,544	2,918	3,009	3,443	3,678	3,972	863	78%	**7.5%**	33
OH	1,417	1,578	1,722	1,838	1,906	2,040	2,089	2,315	2,426	1,839	77%	**7.4%**	34
NC	194	211	289	287	348	371	413	440	474	381	71%	**7.0%**	35
MO	1,610	1,702	1,822	1,932	2,194	2,234	2,515	2,710	2,850	1,065	70%	**6.9%**	36
IA	511	576	670	758	859	932	1,005	1,071	1,192	833	70%	**6.8%**	37
DC	432	447	555	574	633	655	792	828	923	610	69%	**6.8%**	38
IN	1,454	1,601	1,790	1,894	2,147	2,383	2,560	2,752	2,853	3,006	69%	**6.8%**	39
VT	121	132	142	158	185	187	200	186	191	169	68%	**6.7%**	40
TN	611	652	758	797	866	888	957	1,014	1,108	987	66%	**6.5%**	41
GA	196	212	247	283	349	394	443	477	520	550	64%	**6.4%**	42
IL	825	861	1,050	1,069	1,168	1,207	1,253	1,369	1,366	1,112	64%	**6.3%**	43
KY	2,649	2,856	3,051	3,066	3,322	3,520	3,816	3,922	4,023	3,025	61%	**6.1%**	44
RI	230	233	265	288	332	360	398	433	493	493	57%	**5.8%**	45
ME	170	182	198	206	226	238	258	277	287	289	56%	**5.7%**	46
FL	950	985	1,147	1,217	1,411	1,479	1,601	1,737	1,888	1,123	56%	**5.7%**	47
TX	870	948	1,030	1,142	1,313	1,429	1,557	1,685	1,861	914	52%	**5.4%**	48
AL	356	369	420	440	481	522	542	599	634	461	49%	**5.1%**	49
MI	959	1,014	1,132	1,197	1,354	1,417	1,515	1,644	1,847	1,121	41%	**4.4%**	50
MD	76	86	98	107	120	133	147	164	180	182	39%	**4.2%**	51

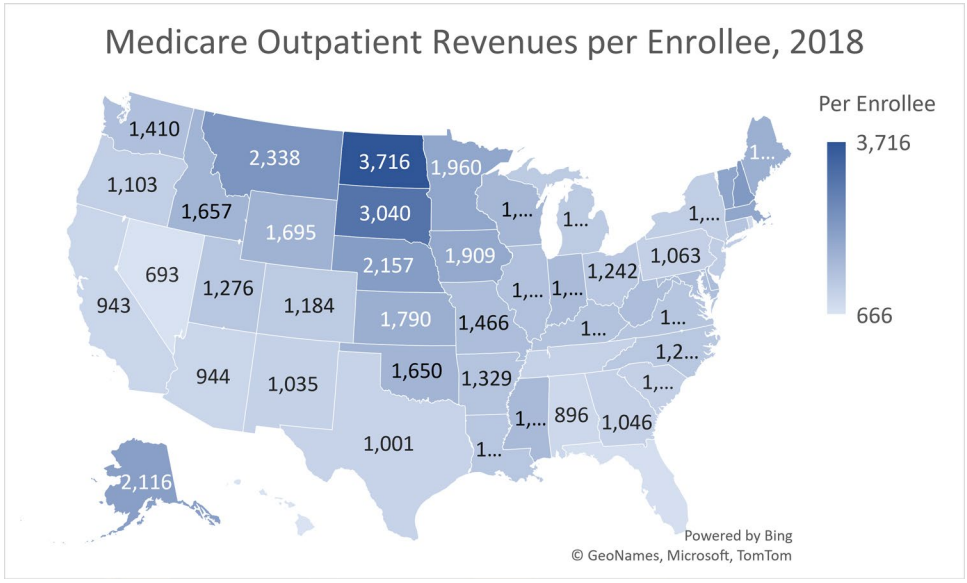
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

23. **Medicare Outpatient Revenues Per Enrollee.** On a per enrollee basis, Medicare reimbursements to North Dakota hospitals for outpatient care were highest in the nation in both 2010 and 2018, and were tied for the 2nd fastest growing in the 2010-2018 period (see Figure 15 and Table 30).

Figure 15.



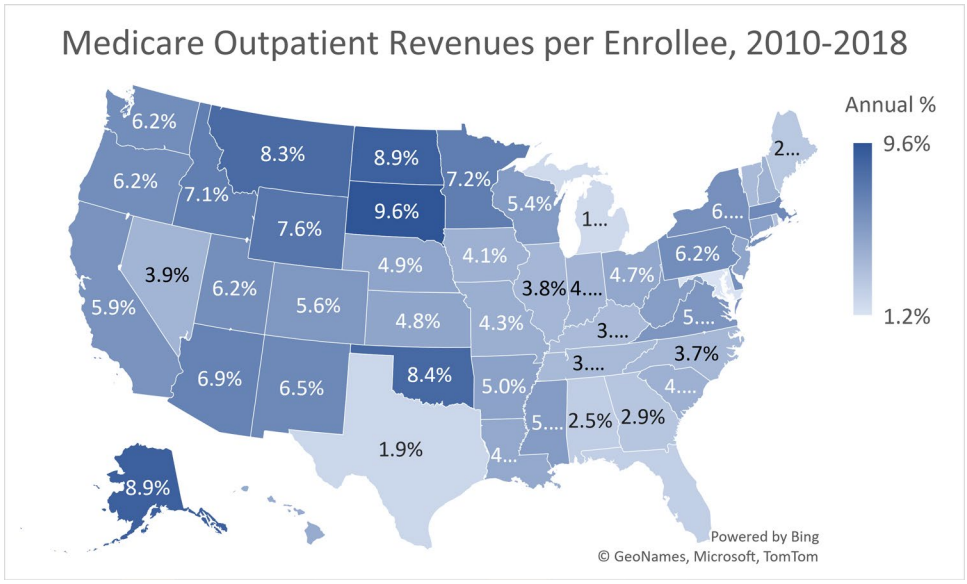


Table 30.

Medicare Outpatient Revenues Per (Gross) Medicare Enrollee, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2018	Growth	Rank
US	**841**	**877**	**947**	**969**	**1,045**	**1,072**	**1,134**	**1,170**	**1,207**	**819**	**43%**	**4.6%**	
ND	1,877	1,989	2,624	2,523	2,999	3,143	3,413	3,544	**3,716**	2,916	98%	8.9%	1
SD	1,460	1,544	1,728	1,921	2,301	2,521	2,759	2,886	**3,040**	3,142	108%	9.6%	2
DC	1,705	1,706	1,816	1,798	1,935	2,069	2,121	2,137	**2,380**	2,151	40%	4.3%	3
MT	1,237	1,230	1,731	1,670	1,824	1,663	2,165	2,152	**2,338**	996	89%	8.3%	4
NH	1,623	1,682	1,671	1,825	1,925	2,003	2,070	2,128	**2,238**	2,064	38%	4.1%	5
NE	1,474	1,557	1,652	1,720	1,797	1,834	1,940	2,023	**2,157**	1,483	46%	4.9%	6
AK	1,067	1,109	1,171	1,541	1,574	1,639	1,780	1,928	**2,116**	896	98%	8.9%	7
VT	1,513	1,574	1,653	1,659	1,769	1,814	1,910	1,987	**1,997**	1,970	32%	3.5%	8
MA	1,191	1,253	1,428	1,517	1,620	1,699	1,790	1,861	**1,962**	1,911	65%	6.4%	9
MN	1,125	1,214	1,307	1,350	1,526	1,645	1,731	1,868	**1,960**	682	74%	7.2%	10
IA	1,380	1,441	1,489	1,541	1,638	1,717	1,758	1,839	**1,909**	1,711	38%	4.1%	11
KS	1,230	1,272	1,388	1,438	1,568	1,567	1,760	1,766	**1,790**	1,249	46%	4.8%	12
ME	1,418	1,507	1,592	1,622	1,683	1,771	1,790	1,821	**1,767**	1,547	25%	2.8%	13
WY	942	1,033	1,140	1,208	1,306	1,407	1,492	1,608	**1,695**	1,658	80%	7.6%	14
ID	956	1,016	1,138	1,204	1,322	1,392	1,456	1,523	**1,657**	1,204	73%	7.1%	15
OK	863	947	1,062	1,164	1,291	1,371	1,451	1,517	**1,650**	1,130	91%	8.4%	16
WI	1,062	1,093	1,176	1,204	1,324	1,350	1,403	1,481	**1,617**	959	52%	5.4%	17
MS	1,016	1,060	1,212	1,176	1,270	1,325	1,434	1,501	**1,543**	1,396	52%	5.4%	18
IN	1,117	1,155	1,207	1,249	1,349	1,395	1,404	1,482	**1,523**	579	36%	4.0%	19
DE	927	1,042	1,112	1,102	1,202	1,314	1,353	1,388	**1,477**	1,558	59%	6.0%	20
MO	1,049	1,086	1,267	1,223	1,291	1,286	1,457	1,396	**1,466**	776	40%	4.3%	21
WV	970	978	1,074	1,090	1,170	1,254	1,284	1,399	**1,462**	1,052	51%	5.3%	22
MD	1,304	1,325	1,365	1,352	1,432	1,485	1,568	1,601	**1,432**	1,455	10%	1.2%	23
WA	869	923	966	1,037	1,146	1,199	1,261	1,319	**1,410**	673	62%	6.2%	24
IL	1,040	1,074	1,191	1,241	1,281	1,235	1,343	1,349	**1,399**	1,099	34%	3.8%	25
KY	1,031	1,064	1,165	1,134	1,169	1,167	1,279	1,312	**1,363**	990	32%	3.6%	26
AR	898	907	1,054	1,044	1,111	1,141	1,245	1,260	**1,329**	985	48%	5.0%	27
CT	880	929	1,013	1,061	1,218	1,289	1,340	1,383	**1,311**	1,259	49%	5.1%	28
VA	823	832	933	959	1,076	1,095	1,152	1,217	**1,284**	746	56%	5.7%	29
LA	890	942	1,059	1,093	1,158	1,156	1,274	1,269	**1,277**	768	43%	4.6%	30
UT	790	780	854	899	997	1,040	1,108	1,165	**1,276**	1,232	61%	6.2%	31
NC	938	1,018	1,070	1,106	1,109	1,152	1,146	1,233	**1,256**	928	34%	3.7%	32
OH	860	887	914	939	1,040	1,037	1,142	1,205	**1,242**	456	44%	4.7%	33
MI	1,038	1,045	1,116	1,113	1,169	1,157	1,220	1,208	**1,189**	949	15%	1.7%	34
CO	765	797	818	870	943	966	1,043	1,138	**1,184**	706	55%	5.6%	35
NJ	777	848	852	883	1,020	1,096	1,075	1,093	**1,136**	126	46%	4.9%	36
NY	696	715	773	792	889	900	1,010	1,056	**1,116**	238	60%	6.1%	37
OR	680	685	820	821	870	867	1,012	1,025	**1,103**	708	62%	6.2%	38
SC	770	801	896	913	954	943	983	1,007	**1,065**	920	38%	4.1%	39
PA	656	704	758	776	862	940	992	1,047	**1,063**	1,102	62%	6.2%	40
GA	833	838	888	944	1,007	1,018	1,023	1,037	**1,046**	943	26%	2.9%	41
NM	624	636	715	761	829	869	983	993	**1,035**	761	66%	6.5%	42
TN	775	790	927	914	969	976	990	1,057	**1,031**	821	33%	3.6%	43
TX	860	904	931	905	946	968	1,016	1,010	**1,001**	729	16%	1.9%	44
AZ	555	586	680	731	805	844	879	951	**944**	474	70%	6.9%	45
CA	595	632	668	700	767	816	845	884	**943**	709	58%	5.9%	46
AL	738	778	915	901	984	913	1,060	925	**896**	774	21%	2.5%	47
RI	682	721	752	806	927	921	965	880	**881**	767	29%	3.3%	48
FL	627	648	666	660	701	709	724	743	**755**	545	20%	2.4%	49
NV	509	559	597	634	665	676	658	674	**693**	272	36%	3.9%	50
HI	470	473	460	468	496	541	558	606	**666**	586	42%	4.5%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2010-2018.

24. Medicaid Total Revenues. Table 31 shows HCRIS Medicaid revenues, with North Dakota showing much higher than average growth (13.3% average annual growth in 2011-2018 vs. 5.0% nationally).

Table 31.

Medicaid Revenues (millions), Ranked by 2011-2018 Growth					DRAFT					Pct Growth	Avg Annual	
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2011-2018	Growth	Rank
US		**74,935**	**78,875**	**78,302**	**85,871**	**92,857**	**100,149**	**102,540**	**105,171**	**68,841**	**40%**	**5.0%**	
MT		150	196	178	207	197	362	446	429	178	185%	**16.2%**	1
CO		584	592	612	868	1,306	1,472	1,550	1,603	768	175%	**15.5%**	2
ND		129	152	141	192	225	302	313	310	260	140%	**13.3%**	3
HI		199	195	257	296	336	325	343	420	327	111%	**11.2%**	4
MD		1,588	1,776	1,816	2,215	2,728	2,903	3,205	3,256	3,111	105%	**10.8%**	5
NJ		1,574	1,670	1,685	2,313	2,763	2,706	3,218	3,216	482	104%	**10.7%**	6
KY		1,240	1,304	1,280	1,552	2,077	2,499	2,460	2,512	1,740	103%	**10.6%**	7
AK		188	196	198	221	248	316	368	374	134	99%	**10.3%**	8
OR		736	934	952	1,200	1,385	1,739	1,560	1,463	936	99%	**10.3%**	9
NV		384	304	382	518	586	785	744	758	216	98%	**10.2%**	10
CA		9,831	10,311	10,956	12,721	14,181	15,035	15,975	17,436	13,103	77%	**8.5%**	11
NH		146	130	142	151	214	263	259	258	260	76%	**8.4%**	12
NM		664	676	659	794	1,114	1,200	1,214	1,159	859	75%	**8.3%**	13
WA		1,318	1,424	1,642	2,041	2,118	2,397	2,235	2,270	1,145	72%	**8.1%**	14
IA		621	659	670	790	895	950	1,004	1,064	892	71%	**8.0%**	15
AR		267	456	297	408	475	527	504	439	374	64%	**7.3%**	16
IN		1,550	1,877	1,660	1,716	1,508	1,677	2,204	2,395	765	55%	**6.4%**	17
RI		344	356	351	426	473	486	541	530	488	54%	**6.4%**	18
DE		285	311	315	341	394	394	391	435	460	53%	**6.2%**	19
WV		553	614	595	698	753	763	820	818	445	48%	**5.8%**	20
PA		2,788	2,938	2,775	3,118	3,255	3,828	4,106	4,114	4,219	48%	**5.7%**	21
OH		2,763	2,808	2,841	3,353	3,861	3,999	4,085	4,011	1,423	45%	**5.5%**	22
MI		2,157	2,133	2,080	2,324	2,863	3,141	3,152	3,059	2,580	42%	**5.1%**	23
WI		953	1,019	948	1,166	1,400	1,316	1,305	1,340	957	41%	**5.0%**	24
MN		1,299	1,334	1,356	1,405	1,656	1,743	1,747	1,799	673	38%	**4.8%**	25
LA		1,528	1,504	1,175	1,465	1,229	1,454	1,854	2,111	1,323	38%	**4.7%**	26
IL		3,119	3,401	3,449	3,631	4,029	4,422	4,209	4,206	3,319	35%	**4.4%**	27
GA		1,636	1,897	1,841	1,919	1,923	2,082	1,988	2,180	1,632	33%	**4.2%**	28
CT		1,031	1,126	1,095	1,111	1,228	1,248	1,284	1,352	1,488	31%	**3.9%**	29
UT		417	434	430	497	511	535	533	538	606	29%	**3.7%**	30
MS		919	1,061	1,004	1,020	1,058	1,168	1,162	1,184	1,016	29%	**3.7%**	31
DC		477	460	468	540	644	614	631	610	464	28%	**3.6%**	32
AL		560	662	632	611	625	789	752	713	709	27%	**3.5%**	33
MA		2,433	2,425	2,497	2,880	2,932	3,097	3,178	3,092	2,682	27%	**3.5%**	34
NY		9,999	10,160	10,040	10,551	11,047	12,477	12,403	12,478	2,857	25%	**3.2%**	35
TN		1,400	1,678	1,725	1,439	1,412	1,652	1,711	1,700	1,312	21%	**2.8%**	36
ID		367	342	366	434	419	417	419	431	352	18%	**2.3%**	37
MO		1,588	1,693	1,721	1,649	1,655	1,843	1,731	1,864	853	17%	**2.3%**	38
KS		496	510	490	499	533	563	530	581	458	17%	**2.3%**	39
VA		1,362	1,520	1,554	1,500	1,607	1,449	1,508	1,547	1,457	14%	**1.8%**	40
SD		185	157	158	163	178	195	222	199	206	7%	**1.0%**	41
AZ		1,828	1,509	1,355	1,477	1,705	1,948	1,901	1,944	1,000	6%	**0.9%**	42
NC		1,972	2,087	2,128	2,021	2,118	2,160	2,160	2,096	1,811	6%	**0.9%**	43
TX		4,213	4,578	4,282	4,127	4,225	3,968	3,927	4,454	3,432	6%	**0.8%**	44
WY		85	83	87	83	82	83	84	86	75	1%	**0.1%**	45
NE		338	362	279	310	337	347	338	336	223	-1%	**-0.1%**	46
ME		422	456	442	393	406	392	394	410	410	-3%	**-0.4%**	47
SC		1,164	1,020	1,056	1,101	1,028	1,151	1,062	1,084	1,011	-7%	**-1.0%**	48
OK		757	795	819	820	782	795	803	684	614	-10%	**-1.4%**	49
VT		161	174	170	182	192	201	155	142	117	-12%	**-1.8%**	50
FL		4,166	4,416	4,252	4,418	3,944	3,959	3,840	3,638	2,604	-13%	**-1.9%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Average annual growth from 2011-2018.

25. ***Medicaid Inpatient Discharges and Days.*** North Dakota's growth in Medicaid inpatient discharges averaged 1.4 percent over the 2010-2018 period (see Table 32) and the number of inpatient days rose by 2.5 percent per year (see Table 33). These growth rates for overall Medicaid utilization are similar to those reported above from the AHA-style data, giving us confidence in their accuracy. However, Tables 31 and 32 also show that the HCRIS Medicaid utilization data for many other states shows very large declines in inpatient discharges and days over the 2010-2018 period. In some states, the reductions in Medicaid utilization were well over 10 percent *per year* during this period. These states showing huge reductions include large states like Florida, Illinois, and Texas, as well as many smaller and medium-sized states. For example, the percentage of Medicaid discharges as a share of total discharges in Kentucky is reported to have fallen from 17 percent in 2010 to 2 percent in 2018, which seems unlikely.

    There could be several reasons for the apparent decline in Medicaid inpatient use in these other states, including shifts from inpatient to outpatient care or mischaracterization of Medicaid managed care coverage as private or commercial coverage instead of Medicaid. HCRIS does not provide data on outpatient utilization, and we are investigating the labelling of Medicaid vs. Medicaid managed care data, but , at this point, we do not have a good reason why these other states are showing such precipitous apparent declines in Medicaid hospital utilization and (sometimes) hospital revenues.

Table 32.

Medicaid Inpatient Discharges, Ranked by 2011-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**4,765,032**	**4,525,821**	**4,344,378**	**4,085,608**	**3,870,595**	**3,501,682**	**3,428,371**	**3,103,971**	**2,884,663**	**1,800,895**	**-39%**	**-6.1%**	
MT	11,526	11,338	13,765	13,398	13,735	13,631	19,200	21,309	23,191	9,168	101%	**9.1%**	1
AK	9,521	8,194	8,068	12,744	12,650	12,843	16,443	16,690	17,628	2,616	85%	**8.0%**	2
CT	45,862	60,549	71,121	69,840	82,573	85,083	79,628	76,319	77,249	73,576	68%	**6.7%**	3
CO	62,610	59,695	58,283	58,495	75,282	87,383	92,574	93,947	89,568	44,458	43%	**4.6%**	4
NV	28,666	30,208	28,233	27,805	33,445	36,608	34,582	35,204	34,544	11,984	21%	**2.4%**	5
DE	16,473	17,918	17,505	16,648	17,157	20,441	19,220	19,006	19,278	19,840	17%	**2.0%**	6
ND	10,883	10,996	10,682	9,422	9,635	9,852	11,016	12,021	12,136	8,396	12%	**1.4%**	7
VT	8,381	8,913	8,405	8,517	8,798	9,236	9,407	8,973	9,075	9,201	8%	**1.0%**	8
ID	22,363	21,185	22,921	25,705	23,463	24,553	23,488	24,557	23,161	17,234	4%	**0.4%**	9
OR	61,880	50,541	73,590	56,409	65,718	43,943	71,627	64,452	63,336	31,704	2%	**0.3%**	10
AL	103,878	97,974	104,309	97,139	94,724	95,693	113,882	108,176	101,955	91,787	-2%	**-0.2%**	11
AR	48,751	45,828	47,184	45,552	47,735	42,923	45,532	47,043	45,511	33,072	-7%	**-0.9%**	12
NJ	59,127	57,282	47,888	42,009	55,857	63,550	61,714	63,880	53,216	11,641	-10%	**-1.3%**	13
NC	235,083	236,158	227,187	214,715	204,603	213,451	210,603	211,821	208,716	148,307	-11%	**-1.5%**	14
NM	18,684	16,454	18,126	19,248	18,539	16,568	19,842	14,713	16,171	11,223	-13%	**-1.8%**	15
SD	16,929	15,834	17,037	17,252	18,177	15,803	15,292	14,751	14,282	14,292	-16%	**-2.1%**	16
OK	92,783	91,143	89,287	95,497	91,532	87,606	81,354	80,113	77,052	64,782	-17%	**-2.3%**	17
GA	106,208	104,387	107,696	97,009	99,544	92,284	86,740	88,326	87,792	67,439	-17%	**-2.4%**	18
ME	27,006	25,471	26,797	25,183	20,672	21,288	18,231	20,979	20,614	18,697	-24%	**-3.3%**	19
MA	108,239	105,111	104,988	101,861	99,298	92,071	84,089	90,689	82,431	69,797	-24%	**-3.3%**	20
IA	56,524	53,692	56,933	56,127	56,138	57,243	53,987	32,561	41,823	29,440	-26%	**-3.7%**	21
HI	7,769	5,734	5,891	5,696	5,157	12,381	7,759	7,769	5,676	2,392	-27%	**-3.8%**	22
MS	85,972	76,296	86,126	83,674	76,202	76,954	64,687	59,024	60,618	47,317	-29%	**-4.3%**	23
MO	99,111	91,415	97,183	80,359	85,106	83,632	87,709	73,740	68,521	32,436	-31%	**-4.5%**	24
MD	98,505	96,726	96,020	97,920	88,976	84,727	72,850	69,000	67,181	54,264	-32%	**-4.7%**	25
AZ	186,267	164,353	144,943	134,149	150,762	153,523	132,149	124,945	124,699	30,486	-33%	**-4.9%**	26
MI	75,805	72,862	65,996	64,858	76,411	59,483	59,515	49,267	49,673	34,558	-34%	**-5.1%**	27
WI	53,224	54,693	48,992	59,287	46,948	50,403	39,088	39,203	33,779	16,198	-37%	**-5.5%**	28
VA	86,928	88,513	78,434	65,636	57,407	48,611	50,951	46,959	52,348	24,283	-40%	**-6.1%**	29
WY	7,146	6,265	6,380	5,669	5,364	5,115	4,716	4,839	4,257	3,830	-40%	**-6.3%**	30
WV	45,293	46,160	43,945	40,600	44,370	44,657	35,035	29,311	25,931	16,438	-43%	**-6.7%**	31
TX	305,819	248,797	254,521	247,063	244,319	201,712	217,935	174,870	161,568	109,598	-47%	**-7.7%**	32
NY	261,311	258,741	212,445	171,897	171,108	168,927	159,621	147,993	131,912	40,458	-50%	**-8.2%**	33
CA	539,446	508,613	433,573	364,295	382,111	389,776	344,986	294,077	269,903	165,636	-50%	**-8.3%**	34
DC	24,269	27,599	23,671	20,365	14,514	16,051	15,722	15,182	11,425	7,754	-53%	**-9.0%**	35
SC	60,548	51,497	46,949	48,673	34,156	26,711	30,529	28,325	28,133	28,399	-54%	**-9.1%**	36
MN	76,785	72,523	73,354	71,397	57,973	57,744	63,201	48,739	34,692	10,258	-55%	**-9.5%**	37
IL	309,231	295,244	291,925	280,864	264,388	219,044	192,368	150,536	134,176	67,114	-57%	**-9.9%**	38
OH	111,842	95,021	94,332	96,332	98,924	74,134	68,677	62,425	48,070	21,348	-57%	**-10.0%**	39
UT	33,877	33,282	32,645	33,834	23,072	19,226	15,724	15,259	14,293	14,763	-58%	**-10.2%**	40
PA	129,466	127,420	124,542	112,163	77,197	65,835	61,414	65,119	52,797	53,276	-59%	**-10.6%**	41
TN	129,618	123,280	133,730	137,574	79,946	80,634	80,323	75,687	48,380	39,384	-63%	**-11.6%**	42
IN	97,530	94,989	90,937	99,674	84,637	63,730	52,538	37,471	35,554	13,588	-64%	**-11.9%**	43
FL	337,346	337,275	336,749	341,453	317,532	173,538	137,969	125,412	118,641	90,606	-65%	**-12.2%**	44
NE	27,654	28,023	26,791	27,534	25,267	19,650	16,878	12,566	9,685	7,949	-65%	**-12.3%**	45
WA	109,613	107,125	96,617	92,292	67,720	61,508	57,258	41,118	37,078	11,804	-66%	**-12.7%**	46
RI	14,619	11,660	11,360	9,600	10,818	10,133	8,940	4,162	4,487	4,178	-69%	**-13.7%**	47
NH	14,210	13,251	12,132	12,655	8,877	7,177	5,755	4,300	3,763	3,568	-74%	**-15.3%**	48
KS	32,676	34,212	33,222	24,853	14,027	6,314	13,712	6,226	6,175	3,388	-81%	**-18.8%**	49
LA	153,627	136,473	119,113	91,286	72,063	41,773	27,782	37,081	28,713	20,481	-81%	**-18.9%**	50
KY	98,148	88,908	61,856	53,381	35,968	36,526	28,854	24,395	7,985	5,320	-92%	**-26.9%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Growth rates from 2010-2018.

Table 33.

Medicaid Inpatient Days, Ranked by 2010-2018 Growth DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth 2010-2018	Avg Annual Growth	Rank
US	**21,959,788**	**20,986,536**	**20,114,574**	**18,550,884**	**18,600,168**	**16,958,588**	**16,615,756**	**15,619,890**	**15,039,721**	**9,351,985**	**-32%**	**-4.6%**	
CT	161,137	166,882	272,393	343,082	331,792	313,969	313,553	335,481	334,630	324,680	108%	**9.6%**	1
AK	46,515	48,945	44,816	61,848	67,097	67,544	85,728	90,134	90,774	9,869	95%	**8.7%**	2
MT	69,298	66,215	86,451	84,838	82,258	83,083	112,611	120,889	117,650	55,461	70%	**6.8%**	3
CO	303,427	289,183	285,357	283,980	371,559	423,989	447,275	471,510	481,960	274,099	59%	**6.0%**	4
DE	73,925	66,719	71,728	68,394	89,821	102,227	34,519	107,563	109,257	112,109	48%	**5.0%**	5
MA	375,723	320,639	349,606	335,895	374,309	454,928	454,609	478,181	477,327	404,302	27%	**3.0%**	6
ND	60,051	57,003	62,029	63,316	67,748	72,874	76,411	77,097	73,003	55,676	22%	**2.5%**	7
AR	159,763	161,808	169,106	177,300	200,362	153,178	170,555	180,590	185,734	134,463	16%	**1.9%**	8
NV	180,855	157,248	153,323	193,138	213,694	208,526	205,338	206,774	209,654	68,808	16%	**1.9%**	9
VT	35,542	39,277	35,637	37,144	37,107	39,677	39,337	38,733	40,431	46,256	14%	**1.6%**	10
NJ	306,790	333,251	312,306	250,805	323,473	365,709	343,348	375,097	339,281	49,116	11%	**1.3%**	11
ID	93,939	92,226	98,289	104,364	95,232	98,787	103,819	102,001	101,121	77,056	8%	**0.9%**	12
AL	496,250	493,069	544,364	517,891	504,196	454,203	571,667	529,803	522,641	443,915	5%	**0.6%**	13
OR	210,305	184,973	228,330	206,769	246,680	188,562	240,174	215,187	208,610	119,773	-1%	**-0.1%**	14
ME	112,822	119,868	118,441	111,356	97,504	105,475	96,343	114,301	110,644	81,998	-2%	**-0.2%**	15
OK	411,505	499,490	478,165	509,738	495,675	421,804	415,813	405,006	400,103	386,177	-3%	**-0.4%**	16
NC	965,375	964,707	955,312	817,306	900,093	880,273	894,991	911,061	919,307	670,669	-5%	**-0.6%**	17
GA	535,162	525,704	547,257	511,578	509,740	477,989	465,521	463,747	488,222	372,598	-9%	**-1.1%**	18
SD	86,747	84,941	87,645	89,575	86,245	78,202	83,110	81,145	78,493	85,408	-10%	**-1.2%**	19
WI	232,791	218,473	200,827	169,739	193,335	202,965	200,505	210,434	206,222	110,427	-11%	**-1.5%**	20
MN	237,208	274,345	250,284	264,461	254,266	236,822	271,233	231,037	207,616	62,989	-12%	**-1.7%**	21
MO	451,364	430,415	476,142	411,411	428,809	412,221	462,601	411,600	389,551	178,587	-14%	**-1.8%**	22
HI	35,640	32,043	31,139	26,436	30,130	34,800	32,161	31,465	29,134	16,267	-18%	**-2.5%**	23
AZ	762,198	684,816	488,267	487,930	604,659	649,911	619,991	602,344	607,446	163,238	-20%	**-2.8%**	24
MD	336,947	349,005	325,936	282,024	260,525	275,455	292,467	258,527	243,878	191,777	-28%	**-4.0%**	25
MS	408,067	377,547	432,674	399,580	379,317	371,911	354,895	312,097	293,437	255,424	-28%	**-4.0%**	26
DC	126,474	119,534	106,508	106,935	101,148	105,156	108,806	95,106	89,031	68,288	-30%	**-4.3%**	27
IA	261,691	271,083	270,251	259,346	265,571	266,414	243,035	144,005	179,136	124,219	-32%	**-4.6%**	28
MI	382,302	401,636	370,540	340,211	338,656	354,514	300,655	281,723	252,317	196,811	-34%	**-5.1%**	29
WY	24,292	21,587	26,892	25,258	22,841	22,394	22,079	20,025	15,856	14,094	-35%	**-5.2%**	30
WV	183,614	166,680	181,394	165,004	191,926	177,765	136,863	109,592	119,518	44,676	-35%	**-5.2%**	31
OH	445,640	412,720	439,304	416,532	467,605	373,312	321,832	323,953	277,568	106,459	-38%	**-5.7%**	32
TX	1,265,441	1,081,530	1,090,371	1,024,232	1,066,841	933,927	927,679	804,794	766,427	525,465	-39%	**-6.1%**	33
NM	76,827	72,619	56,359	69,015	64,319	59,094	47,913	44,124	46,191	31,874	-40%	**-6.2%**	34
NE	128,825	134,476	136,924	127,318	101,440	101,139	91,195	83,126	76,445	50,257	-41%	**-6.3%**	35
VA	433,795	406,134	401,637	320,324	310,083	298,595	277,513	279,996	248,909	136,431	-43%	**-6.7%**	36
UT	168,924	161,149	157,939	116,952	109,501	107,540	112,218	99,314	94,650	102,065	-44%	**-7.0%**	37
PA	532,613	512,380	525,445	393,321	386,669	357,541	345,486	307,262	295,647	285,490	-44%	**-7.1%**	38
RI	62,362	56,757	62,836	47,926	52,962	38,572	46,176	29,353	34,275	28,416	-45%	**-7.2%**	39
NY	1,633,178	1,559,374	1,285,166	1,058,164	1,076,549	1,034,258	1,067,800	952,183	883,019	290,753	-46%	**-7.4%**	40
CA	3,049,326	2,859,902	2,528,709	2,258,253	2,283,083	2,314,925	1,945,968	1,826,449	1,638,580	978,789	-46%	**-7.5%**	41
SC	308,556	244,246	228,699	231,285	170,877	159,922	159,190	168,768	164,051	154,721	-47%	**-7.6%**	42
TN	420,186	434,619	391,798	391,045	387,451	269,933	294,092	277,751	206,904	139,528	-51%	**-8.5%**	43
NH	54,770	55,536	51,647	55,319	35,906	35,413	23,918	26,909	26,149	15,924	-52%	**-8.8%**	44
FL	1,747,087	1,734,299	1,769,401	1,780,630	1,647,953	991,982	857,540	756,781	786,553	560,053	-55%	**-9.5%**	45
WA	421,906	387,630	386,165	350,501	303,335	283,146	236,233	197,927	188,497	78,331	-55%	**-9.6%**	46
IL	1,378,152	1,314,547	1,330,411	1,229,502	1,230,176	913,017	723,969	611,137	554,576	286,076	-60%	**-10.8%**	47
IN	394,132	327,187	342,448	361,507	321,910	286,026	201,592	170,006	153,603	61,351	-61%	**-11.1%**	48
KS	154,087	168,437	166,357	120,079	32,513	30,870	44,668	38,912	32,251	15,124	-79%	**-17.8%**	49
LA	713,055	628,808	530,005	388,577	291,031	193,409	120,047	97,953	128,419	74,417	-82%	**-19.3%**	50
KY	443,207	414,874	171,549	103,750	94,196	74,640	63,642	67,530	59,164	36,740	-87%	**-22.3%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports

*2019 Data may be incomplete. Growth Rates from 2010-2018.

26. Medicaid Revenues Per Enrollee. Table 34 shows rankings of Medicaid revenues per enrollee. By this measure, North Dakota had the highest Medicaid hospital cost per enrollee in 2018.

However, it is fair to note that North Dakota hospitals' Medicaid revenues by this measure fluctuated widely from year to year, and state-to-state comparisons may be more uncertain than other measures.

Table 34.

Medicaid Revenues per Medicaid Enrollee, Ranked by 2018 Level DRAFT

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Pct Growth Avg Annual 2011-2018	Growth	Rank
US		**1,883**	**1,951**	**1,925**	**1,903**	**1,880**	**1,978**	**2,051**	**2,134**	**1,358**	**13%**	**1.8%**	
ND		2,696	4,884	3,591	3,905	4,206	5,589	6,441	**5,776**	4,358	114%	11.5%	1
DC		4,060	3,672	3,563	3,885	4,970	4,312	4,364	**4,123**	3,055	2%	0.2%	2
MD		2,673	2,804	2,815	2,844	3,482	3,641	4,013	**3,982**	3,692	49%	5.9%	3
NY		3,029	3,086	2,996	2,932	2,855	3,157	3,131	**3,240**	761	7%	1.0%	4
RI		2,755	3,100	3,195	2,633	2,824	3,068	3,202	**3,195**	2,972	16%	2.1%	5
NJ		1,907	1,973	1,999	2,408	2,466	2,408	2,898	**3,102**	497	63%	7.2%	6
ME		2,234	2,217	2,307	2,200	2,595	2,741	3,019	**3,098**	3,012	39%	4.8%	7
AK		2,183	2,462	2,707	2,606	2,269	2,946	2,884	**3,072**	1,147	41%	5.0%	8
MO		2,556	2,581	2,801	2,797	2,669	3,028	2,677	**2,924**	1,354	14%	1.9%	9
SD		2,421	2,065	1,923	2,245	2,478	2,617	3,183	**2,897**	2,981	20%	2.6%	10
MA		2,469	2,409	2,558	2,703	2,593	2,757	2,848	**2,852**	2,533	15%	2.1%	11
KY		2,091	2,377	2,377	2,059	2,396	2,756	2,674	**2,813**	2,004	34%	4.3%	12
IN		2,119	2,580	2,281	2,252	1,805	1,910	2,495	**2,805**	921	32%	4.1%	13
DE		2,097	2,143	2,160	2,603	2,615	2,910	3,032	**2,738**	2,340	31%	3.9%	14
CT		2,463	2,570	2,491	2,219	2,447	2,405	2,443	**2,547**	2,762	3%	0.5%	15
HI		1,419	1,113	1,562	1,681	1,855	1,828	1,932	**2,490**	2,035	75%	8.4%	16
WY		2,120	1,684	2,079	1,937	1,733	1,749	1,699	**2,447**	3,092	15%	2.1%	17
MT		1,787	1,865	1,629	1,885	1,716	2,249	2,974	**2,432**	862	36%	4.5%	18
IA		1,938	1,909	1,874	2,016	2,187	2,137	2,505	**2,431**	1,853	25%	3.3%	19
MS		1,805	2,016	1,961	1,955	1,895	2,199	2,271	**2,416**	2,152	34%	4.3%	20
MN		2,330	2,382	2,455	2,110	2,187	2,276	2,334	**2,364**	862	1%	0.2%	21
PA		1,839	2,017	1,996	2,197	1,994	2,140	2,279	**2,304**	2,371	25%	3.3%	22
IL		1,728	1,949	1,979	1,935	1,968	2,188	2,118	**2,279**	1,929	32%	4.0%	23
WV		2,097	2,763	2,312	2,012	2,009	1,843	2,107	**2,278**	1,338	9%	1.2%	24
UT		1,639	1,759	1,706	2,030	2,034	1,973	2,052	**2,263**	2,757	38%	4.7%	25
VA		2,387	2,605	2,502	2,405	2,328	2,217	2,251	**2,253**	2,046	-6%	-0.8%	26
OH		1,952	1,921	1,976	2,005	2,084	2,107	2,188	**2,213**	806	13%	1.8%	27
NH		1,956	1,523	1,735	2,177	2,243	2,463	2,242	**2,163**	2,089	11%	1.4%	28
KS		1,952	1,931	1,867	1,716	2,043	2,078	2,018	**2,152**	1,633	10%	1.4%	29
CA		1,737	1,777	1,839	1,782	1,671	1,726	1,889	**2,098**	1,600	21%	2.7%	30
OR		1,573	1,883	1,958	1,679	1,803	2,287	2,111	**2,055**	1,354	31%	3.9%	31
NM		1,660	1,751	1,566	1,667	1,989	2,139	2,110	**2,034**	1,515	22%	2.9%	32
WI		1,266	1,507	1,315	1,674	1,993	1,860	1,939	**2,033**	1,470	61%	7.0%	33
ID		2,208	1,857	2,034	2,333	2,000	1,970	1,885	**2,003**	1,678	-9%	-1.4%	34
NE		2,199	2,421	1,736	1,946	2,042	2,263	2,233	**1,956**	1,141	-11%	-1.7%	35
LA		2,093	1,951	1,627	2,003	1,556	1,593	1,797	**1,950**	1,163	-7%	-1.0%	36
CO		1,147	1,055	1,060	1,200	1,523	1,678	1,741	**1,912**	967	67%	7.6%	37
WA		1,715	1,888	2,134	2,078	1,791	1,991	1,880	**1,877**	926	9%	1.3%	38
MI		1,469	1,499	1,477	1,539	1,668	1,860	1,893	**1,823**	1,519	24%	3.1%	39
TN		1,557	1,908	1,895	1,496	1,457	1,590	1,710	**1,684**	1,286	8%	1.1%	40
GA		1,386	1,485	1,450	1,384	1,402	1,489	1,494	**1,612**	1,182	16%	2.2%	41
NV		1,653	1,278	1,526	1,394	1,301	1,691	1,593	**1,609**	452	-3%	-0.4%	42
NC		1,605	1,655	1,611	1,474	1,524	1,509	1,537	**1,511**	1,317	-6%	-0.9%	43
VT		1,582	1,605	1,464	1,588	1,704	1,751	1,247	**1,502**	1,653	-5%	-0.7%	44
SC		1,978	1,643	1,651	1,567	1,452	1,564	1,514	**1,490**	1,337	-25%	-4.0%	45
AZ		1,599	1,401	1,279	1,233	1,296	1,368	1,412	**1,399**	700	-12%	-1.9%	46
OK		1,555	1,596	1,661	1,653	1,516	1,445	1,491	**1,338**	1,263	-14%	-2.1%	47
FL		1,716	1,688	1,607	1,543	1,303	1,268	1,255	**1,224**	908	-29%	-4.7%	48
TX		1,241	1,303	1,225	1,144	1,134	1,053	1,073	**1,223**	945	-1%	-0.2%	49
AL		921	1,039	988	937	907	1,164	1,050	**1,087**	1,180	18%	2.4%	50
AR		599	1,037	653	773	830	878	813	**702**	590	17%	2.3%	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2011-2018.

27. ***Private Patient Revenues Per Private Insurance Enrollee.*** We ranked states by non-Medicare and non-Medicaid (essentially private insurance) patient revenues per insured enrollee (employer plus non-group). By this measure, North Dakota ranked 3rd among the states in 2018 (see Figure 16 and Table 35).

Figure 16.

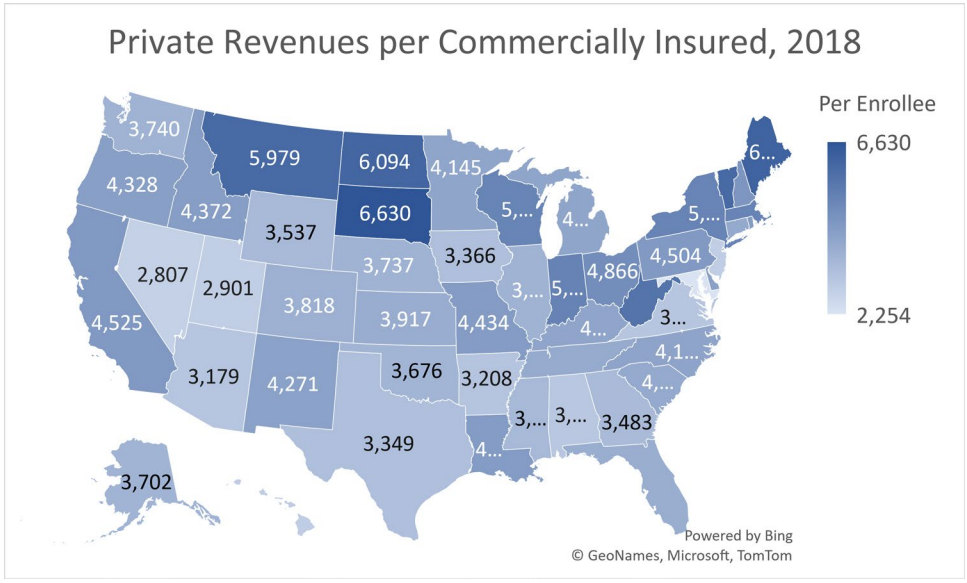


Table 35.

Private Revenues per Private Insurance Enrollee, Ranked by 2018 Level DRAFT **Pct Growth Avg Annual**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2011-2018	Growth	Rank
US		**3,084**	**3,262**	**3,338**	**3,297**	**3,360**	**3,642**	**3,737**	**4,088**	**2,627**	**33%**	**4.1%**	
SD		4,572	4,797	5,544	5,369	5,926	5,878	6,230	**6,630**	7,497	45%	5.5%	1
ME		4,586	4,945	5,103	5,007	5,197	5,536	6,050	**6,185**	5,592	35%	4.4%	2
ND		4,180	5,134	4,728	5,132	5,674	5,830	5,646	**6,094**	5,328	46%	5.5%	3
VT		3,889	4,196	4,988	4,824	4,994	4,792	5,932	**5,982**	5,610	54%	6.3%	4
MT		4,119	5,343	5,069	4,965	4,583	5,553	5,697	**5,979**	2,457	45%	5.5%	5
DC		5,197	5,276	5,599	5,027	4,954	5,550	5,670	**5,944**	5,066	14%	1.9%	6
WV		3,607	3,929	4,109	4,100	4,358	5,025	5,424	**5,680**	3,703	57%	6.7%	7
IN		4,105	4,609	4,464	4,466	4,620	4,783	4,920	**5,204**	1,654	27%	3.4%	8
NY		3,545	3,645	3,826	3,955	4,086	4,591	4,714	**5,172**	1,464	46%	5.5%	9
MA		3,327	3,535	3,560	3,544	3,899	4,423	4,593	**5,169**	4,568	55%	6.5%	10
WI		3,813	4,169	4,458	4,486	4,545	4,803	5,006	**5,162**	3,535	35%	4.4%	11
OH		3,778	4,132	4,214	4,129	4,265	4,597	4,742	**4,866**	1,816	29%	3.7%	12
NH		3,709	3,578	3,764	3,785	3,752	4,035	4,443	**4,616**	4,402	24%	3.2%	13
CA		2,592	2,692	2,955	2,721	2,761	2,933	2,941	**4,525**	2,453	75%	8.3%	14
PA		3,607	3,678	3,782	3,761	3,899	4,145	4,332	**4,504**	4,591	25%	3.2%	15
LA		3,375	3,664	3,721	3,512	3,728	4,127	4,076	**4,449**	2,605	32%	4.0%	16
MO		3,539	3,907	3,681	3,610	3,596	4,199	4,226	**4,434**	2,394	25%	3.3%	17
RI		3,872	4,043	3,923	3,997	3,743	3,876	4,199	**4,391**	3,935	13%	1.8%	18
ID		2,758	3,227	3,427	3,377	3,658	3,824	4,051	**4,372**	3,565	58%	6.8%	19
OR		2,783	3,777	4,151	3,599	3,187	4,228	3,958	**4,328**	2,198	56%	6.5%	20
NM		3,310	3,460	3,642	3,596	3,643	3,974	4,095	**4,271**	2,514	29%	3.7%	21
DE		3,150	3,091	3,233	3,417	3,282	3,361	3,803	**4,249**	4,620	35%	4.4%	22
NC		3,018	3,368	3,330	3,288	3,615	3,773	4,025	**4,184**	3,140	39%	4.8%	23
KY		3,489	3,411	3,427	3,375	3,484	3,843	3,983	**4,158**	2,977	19%	2.5%	24
MI		3,355	3,529	3,519	3,543	3,583	3,909	4,112	**4,148**	3,609	24%	3.1%	25
MN		3,134	3,301	3,389	3,531	3,621	3,785	3,978	**4,145**	1,239	32%	4.1%	26
SC		3,212	3,543	3,564	3,705	3,593	3,878	3,928	**4,016**	3,528	25%	3.2%	27
CT		2,884	3,211	3,346	3,327	3,266	3,488	3,583	**4,009**	4,109	39%	4.8%	28
TN		3,075	3,598	3,208	3,262	3,156	3,409	3,719	**3,990**	3,443	30%	3.8%	29
KS		2,357	3,010	3,115	3,097	3,070	3,543	3,763	**3,917**	2,844	66%	7.5%	30
FL		3,396	3,260	3,332	3,328	3,412	3,564	3,769	**3,900**	2,786	15%	2.0%	31
CO		2,888	3,014	3,113	3,196	3,319	3,457	3,818	**3,818**	2,060	32%	4.1%	32
WA		3,051	3,077	3,343	3,281	3,384	3,354	3,549	**3,740**	2,028	23%	3.0%	33
NE		3,476	3,364	3,692	3,594	3,413	3,921	3,989	**3,737**	2,795	8%	1.0%	34
IL		3,000	3,098	3,250	3,351	3,344	3,661	3,610	**3,731**	2,831	24%	3.2%	35
AK		3,574	3,419	3,107	3,418	3,534	3,511	3,596	**3,702**	1,244	4%	0.5%	36
OK		3,124	3,429	3,322	3,213	3,309	3,503	3,618	**3,676**	2,938	18%	2.4%	37
MS		3,470	4,033	3,754	3,754	3,580	3,549	3,438	**3,547**	2,940	2%	0.3%	38
WY		2,937	3,171	3,003	3,117	3,386	3,488	3,686	**3,537**	3,224	20%	2.7%	39
GA		2,895	2,722	2,819	2,716	2,864	3,134	3,268	**3,483**	3,198	20%	2.7%	40
IA		2,930	2,984	2,982	2,967	3,045	3,231	3,208	**3,366**	3,160	15%	2.0%	41
TX		2,916	2,925	2,960	2,981	3,097	3,281	3,277	**3,349**	2,383	15%	2.0%	42
AR		2,570	2,742	2,739	2,599	2,631	2,888	2,991	**3,208**	2,189	25%	3.2%	43
AZ		2,127	3,072	2,909	3,100	2,598	3,070	3,084	**3,179**	1,420	49%	5.9%	44
VA		2,530	2,656	2,607	2,680	2,782	3,100	2,953	**3,162**	1,923	25%	3.2%	45
AL		2,278	2,835	2,741	2,585	2,405	2,930	2,877	**3,107**	2,830	36%	4.5%	46
HI		1,991	2,093	2,246	2,197	2,357	2,599	2,657	**2,919**	2,527	47%	5.6%	47
UT		2,611	2,471	2,449	2,511	2,488	2,809	2,821	**2,901**	2,800	11%	1.5%	48
NJ		2,467	2,581	2,677	2,472	2,641	2,795	2,829	**2,896**	427	17%	2.3%	49
NV		2,405	2,563	2,682	2,287	2,407	2,324	2,581	**2,807**	1,178	17%	2.2%	50
MD		2,216	2,272	2,246	2,241	2,058	2,085	2,160	**2,254**	2,365	2%	0.2%	51

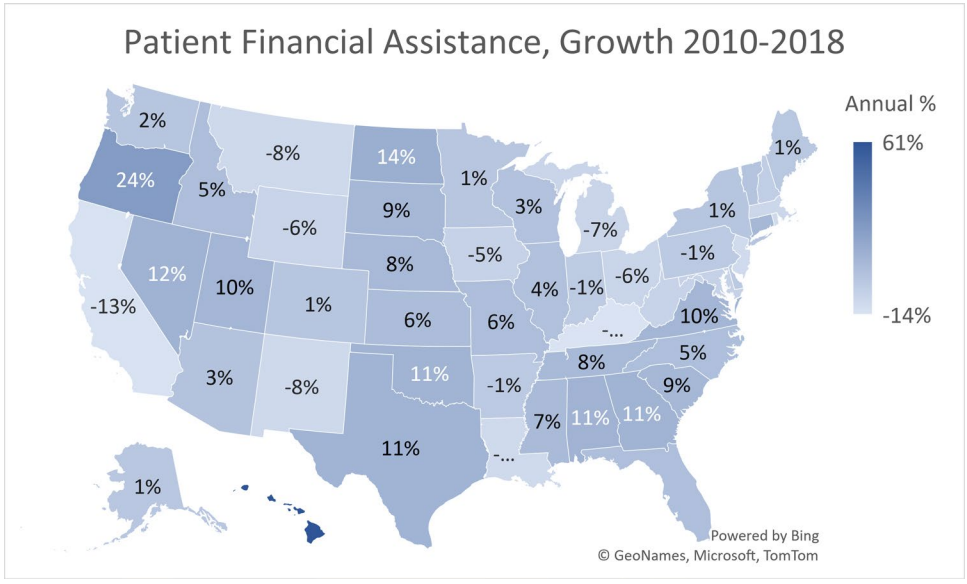
Source: Horizon Government Affairs. HCRIS Data RAND vintage 8-1-20

Note: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. Population/enrollment data by HGA via KFF and CMS.

*2019 Data may be incomplete -- Average Annual Growth from 2011-2018.

28. ***Patient Financial Assistance.*** HCRIS reported charity care is based on both uninsured and insured patients qualifying for hospitals' financial assistance programs, less partial payments received. The valuation of the assistance is adjusted to a cost basis using cost-to-charge ratios. As noted above, North Dakota hospitals' financial assistance has increased rapidly (see Table 36 and Figure 17). However, at 1.3 percent of net patient revenues, the level of assistance is low compared with most other states, and well below the national average of nearly 3 percent (see Table 37). Importantly, the valuation of patient financial assistance in the HCRIS data is quite volatile from year to year, and therefore may be more uncertain than other measures.

Figure 17.



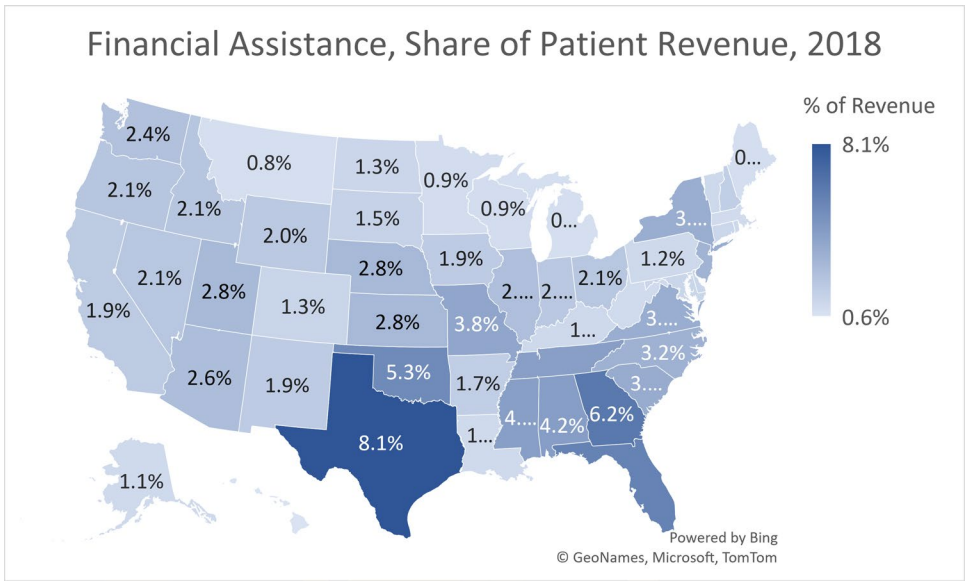


Table 36.

Patient Financial Assistance (Uninsured and Insured Patients), Ranked by 2011-2018 Growth DRAFT

State	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Average Annual Growth	Rank
		Raw HCRIS Data (by calendar year, millions of dollars)										
US		**23,780**	**25,686**	**26,440**	**25,453**	**21,367**	**23,531**	**24,875**	**27,901**	**11,242**	**2%**	
HI		8	14	7	79	15	15	243	222	8	**61%**	1
OR		350	341	301	749	175	771	1,200	1,554	99	**24%**	2
ND		19	29	36	38	34	35	37	46	27	**14%**	3
NV		59	62	141	119	104	73	116	128	29	**12%**	4
AL		185	215	233	261	269	298	352	392	283	**11%**	5
OK		236	254	266	339	366	376	417	494	242	**11%**	6
GA		787	797	860	1,071	1,135	1,240	1,461	1,645	854	**11%**	7
TX		2,403	2,846	3,664	3,918	3,988	4,312	4,490	4,998	2,202	**11%**	8
VA		501	541	566	621	714	875	900	979	332	**10%**	9
UT		116	131	133	152	162	199	211	222	173	**10%**	10
CT		143	176	131	119	137	158	177	264	109	**9%**	11
SD		38	47	51	53	51	51	61	69	39	**9%**	12
SC		317	345	418	451	501	568	486	574	301	**9%**	13
NE		96	93	117	147	143	168	159	168	62	**8%**	14
TN		466	533	510	607	624	638	716	796	399	**8%**	15
MS		204	226	202	255	249	270	320	331	210	**7%**	16
KS		135	143	126	193	192	201	202	207	112	**6%**	17
MO		500	533	571	660	658	656	699	735	233	**6%**	18
ID		71	38	52	76	82	110	98	104	66	**5%**	19
NC		715	750	755	793	805	847	909	1,025	450	**5%**	20
FL		2,049	1,875	2,040	2,416	2,219	2,290	2,528	2,877	1,392	**5%**	21
IL		902	1,275	1,240	974	830	1,022	925	1,214	433	**4%**	22
WI		193	207	248	198	147	212	236	243	81	**3%**	23
AZ		221	348	440	374	253	247	217	273	130	**3%**	24
DC		26	31	28	38	36	30	32	31	14	**3%**	25
VT		22	20	18	22	20	19	24	26	19	**2%**	26
WA		359	419	487	304	233	280	342	405	176	**2%**	27
NY		1,439	1,389	1,410	1,653	1,542	1,513	1,524	1,595	390	**1%**	28
CO		226	251	261	199	216	214	204	249	67	**1%**	29
MN		191	169	148	111	99	119	177	209	36	**1%**	30
AK		36	46	48	61	58	26	37	38	4	**1%**	31
ME		73	76	78	99	84	84	88	77	30	**1%**	32
DE		45	55	54	42	37	32	37	44	20	**0%**	33
PA		481	579	573	549	507	449	411	462	249	**-1%**	34
AR		135	152	161	170	106	88	100	129	50	**-1%**	35
IN		577	697	701	714	440	549	494	532	111	**-1%**	36
NH		94	85	96	98	69	60	66	77	52	**-3%**	37
IA		213	260	225	164	98	110	129	151	84	**-5%**	38
MD		279	308	310	235	175	172	177	196	98	**-5%**	39
WV		115	127	127	77	62	85	76	78	34	**-5%**	40
WY		52	28	30	35	33	36	37	33	15	**-6%**	41
OH		1,113	1,148	1,138	797	485	651	647	700	173	**-6%**	42
MI		404	432	472	330	162	184	221	251	137	**-7%**	43
MA		452	444	463	366	336	356	254	263	179	**-7%**	44
MT		68	70	81	97	69	54	40	37	8	**-8%**	45
NM		158	169	167	127	89	81	78	85	39	**-8%**	46
LA		390	378	400	551	527	519	201	202	53	**-9%**	47
NJ		1,272	1,268	1,371	784	637	688	677	641	63	**-9%**	48
RI		68	97	97	60	40	40	33	34	25	**-9%**	49
CA		4,327	4,751	4,018	2,921	1,226	1,325	1,463	1,635	779	**-13%**	50
KY		451	418	371	185	128	134	145	160	69	**-14%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 2-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports.
Average annual growth rates from 2011-2018.

* 2019 data may be incomplete.

Table 37.

Patient Financial Assistance As a Percentage of Net Patient Revenues, Ranked by 2019 Level DRAFT

State	2011	2012	2013	2014	2015	2016	2017	2018	2019	Rank
	Raw HCRIS Data (by calendar year)									
US	**3.3%**	**3.5%**	**3.5%**	**3.2%**	**2.6%**	**2.7%**	**2.7%**	**2.8%**	**2.9%**	
TX	5.0%	5.9%	7.3%	7.3%	7.0%	7.3%	7.5%	8.0%	**8.1%**	1
GA	4.1%	4.3%	4.5%	5.3%	5.2%	5.4%	6.1%	6.4%	**6.2%**	2
FL	5.0%	4.7%	5.0%	5.4%	4.7%	4.6%	4.8%	5.2%	**5.7%**	3
OK	2.9%	3.0%	3.1%	3.7%	3.8%	3.8%	4.1%	4.6%	**5.3%**	4
AL	2.1%	2.3%	2.5%	2.7%	2.8%	3.0%	3.4%	3.6%	**4.2%**	5
MS	2.8%	3.0%	2.7%	3.3%	3.2%	3.5%	4.1%	4.2%	**4.2%**	6
TN	3.0%	3.4%	3.3%	3.9%	3.8%	3.7%	3.9%	4.1%	**4.2%**	7
MO	3.0%	3.2%	3.4%	3.8%	3.6%	3.4%	3.5%	3.5%	**3.8%**	8
SC	2.9%	3.1%	3.7%	3.7%	4.0%	4.4%	3.6%	4.1%	**3.5%**	9
NY	2.7%	2.6%	2.5%	2.8%	2.4%	2.3%	2.2%	2.2%	**3.4%**	10
VA	3.0%	3.2%	3.2%	3.3%	3.6%	4.3%	4.4%	4.5%	**3.4%**	11
NC	3.3%	3.3%	3.3%	3.3%	3.1%	3.1%	3.1%	3.4%	**3.2%**	12
NJ	6.7%	6.6%	6.9%	3.9%	3.0%	3.0%	2.9%	2.6%	**3.1%**	13
KS	2.2%	2.1%	1.8%	2.6%	2.5%	2.4%	2.3%	2.3%	**2.8%**	14
NE	1.9%	1.8%	2.2%	2.8%	2.5%	2.8%	2.7%	2.8%	**2.8%**	15
UT	2.1%	2.4%	2.3%	2.4%	2.4%	2.8%	2.8%	2.8%	**2.8%**	16
AZ	1.7%	2.7%	3.4%	2.9%	1.9%	1.7%	1.4%	1.7%	**2.6%**	17
IL	3.0%	4.1%	4.0%	3.0%	2.4%	2.8%	2.5%	3.1%	**2.5%**	18
WA	2.3%	2.7%	2.8%	1.7%	1.2%	1.5%	1.7%	1.9%	**2.4%**	19
OR	4.0%	3.8%	2.9%	7.2%	1.6%	6.8%	10.2%	12.1%	**2.1%**	20
ID	2.1%	1.0%	1.3%	1.8%	1.8%	2.3%	1.9%	1.9%	**2.1%**	21
NV	1.2%	1.3%	2.7%	2.3%	1.9%	1.3%	1.9%	1.9%	**2.1%**	22
OH	3.5%	3.5%	3.4%	2.3%	1.3%	1.7%	1.6%	1.7%	**2.1%**	23
IN	3.0%	3.4%	3.5%	3.4%	2.1%	2.5%	2.2%	2.2%	**2.0%**	24
WY	4.0%	2.0%	2.1%	2.4%	2.1%	2.3%	2.3%	2.0%	**2.0%**	25
CA	6.2%	6.6%	5.1%	3.6%	1.5%	1.5%	1.6%	1.3%	**1.9%**	26
IA	2.8%	3.4%	3.0%	2.0%	1.2%	1.3%	1.5%	1.6%	**1.9%**	27
NM	3.8%	4.0%	3.8%	2.7%	1.8%	1.5%	1.6%	1.5%	**1.9%**	28
AR	2.5%	2.7%	2.9%	3.0%	1.7%	1.4%	1.5%	1.9%	**1.7%**	29
NH	2.4%	2.1%	2.4%	2.4%	1.6%	1.3%	1.3%	1.5%	**1.7%**	30
SD	1.3%	1.5%	1.5%	1.5%	1.3%	1.3%	1.5%	1.6%	**1.5%**	31
CO	2.2%	2.3%	2.3%	1.6%	1.6%	1.5%	1.4%	1.5%	**1.3%**	32
MD	2.1%	2.3%	2.3%	1.7%	1.2%	1.1%	1.2%	1.3%	**1.3%**	33
DE	2.0%	2.3%	2.2%	1.6%	1.3%	1.1%	1.3%	1.4%	**1.3%**	34
ND	0.7%	1.0%	1.2%	1.2%	1.0%	0.9%	1.0%	1.2%	**1.3%**	35
CT	1.5%	1.8%	1.3%	1.2%	1.3%	1.5%	1.6%	2.3%	**1.3%**	36
RI	2.4%	3.3%	3.3%	2.0%	1.3%	1.3%	1.0%	1.0%	**1.2%**	37
VT	1.2%	1.0%	0.9%	1.0%	0.9%	0.9%	1.0%	1.2%	**1.2%**	38
PA	1.4%	1.6%	1.6%	1.5%	1.3%	1.1%	1.0%	1.1%	**1.2%**	39
KY	4.0%	3.7%	3.3%	1.6%	1.0%	1.0%	1.1%	1.1%	**1.2%**	40
LA	3.7%	3.6%	3.7%	4.8%	4.4%	4.2%	1.6%	1.5%	**1.1%**	41
AK	2.2%	2.8%	2.9%	3.4%	3.0%	1.3%	1.8%	1.7%	**1.1%**	42
WV	2.4%	2.4%	2.4%	1.4%	1.1%	1.4%	1.2%	1.2%	**1.0%**	43
MA	2.3%	2.2%	2.3%	1.7%	1.5%	1.5%	1.0%	1.0%	**1.0%**	44
DC	0.9%	1.1%	1.0%	1.3%	1.1%	0.9%	0.9%	0.8%	**0.9%**	45
MN	1.3%	1.1%	1.0%	0.7%	0.6%	0.7%	0.9%	1.0%	**0.9%**	46
WI	1.2%	1.2%	1.3%	1.0%	0.7%	1.0%	1.1%	1.1%	**0.9%**	47
ME	1.7%	1.7%	1.8%	2.2%	1.7%	1.6%	1.6%	1.4%	**0.9%**	48
MI	1.6%	1.7%	1.8%	1.2%	0.6%	0.6%	0.7%	0.8%	**0.8%**	49
MT	2.3%	2.4%	2.7%	3.0%	2.0%	1.5%	1.0%	0.9%	**0.8%**	50
HI	0.4%	0.7%	0.3%	3.2%	0.6%	0.5%	8.5%	7.4%	**0.6%**	51

Source: Horizon Government Affairs. HCRIS Data RAND vintage 2-1-20

Notes: All Hospitals (including federal, critical access etc.) from Medicare Cost Reports. 2019 data may be incomplete.

III. Insurers – Historical Data 2010-2019

Key Findings and Illustrations

30. Individual Market Premiums – The NDID, NAIC, and CMS Data are in Rough Agreement on Overall Market Sizes and Trends
31. Premiums per Member Grew Rapidly in the Individual Market; Slower in Group Markets
32. Administrative Costs Grew Rapidly in the 2010-2018 Period
33. Pharmaceutical Benefit Claims, Net of Rebates, Grew Rapidly
34. Individual Market Baseline Reconstruction for 2019 and 2020

We gathered data on insurance benefits and claims from several sources: the CMS rate review data for 2020 (experience data through 2018), the NAIC supplemental exhibit (2010-2019), the NDID insurance market report (2014 through 2018), a data request to state insurers (through 2019 with some projections for 2020 and beyond; data request shown in Appendix D), and information from the state's 1332 reinsurance waiver request.

The following tables show our preliminary tabulations and estimates of statewide North Dakota premiums and benefits.

29. Individual Market Premiums – The NDID, NAIC, and CMS Data are in Rough Agreement on Overall Market Sizes and Trends. Table 38 indicates that the NDID Market Report, the NAIC supplemental exhibit, and the CMS rate review data are in reasonably good agreement for concepts they measure in common. ACA coverage has gradually expanded since its introduction in 2014 as a share of total individual market coverage. Individual market premiums grew very rapidly in 2014 and 2015 mostly due to the added benefits required for ACA coverage.

Table 38.

North Dakota Individual Market Aggregate Premiums, by Data Source (millions) **DRAFT**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Individual Market										
NDID Market Report					186	232	255	248	265	
NAIC Supplemental Exhibit	121	132	142	152	194	242	244	240	255	256
NDID/NovaRest 1332 Reinsurance Actuarial Report \a								227	259	
ACA Coverage										
CMS Rate Review Public Use File					94	157	202	200	219	
NDID Market Report					80	159	206	204	223	
NDID/NovaRest 1332 Reinsurance Actuarial Report \a								189	224	236

Source: Horizon Government Affairs.
\a 2018 is based on May 31

30. ***Premiums per Member Grew Rapidly in the Individual Market; Slower in Group Markets.*** Premiums per-member per-month (PMPM) in the individual market grew by about 8-9 percent annually in the 2014-2018 period, and about 4-5 percent per year in the small group and large group markets (see Table 39). A key reason for the difference was probably an influx of relatively older and sicker enrollees in the individual market during that period, as the individual market switched to guaranteed issue coverage (no coverage denials or limitations due to preexisting medical conditions).

Table 39.

North Dakota Premiums, by Market					**DRAFT**						Average Annual
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Growth*
					NDID Market Summary						
Premiums (millions)											
Individual Market					186	232	255	248	265		9.1%
Small Group Market					362	370	369	378	375		0.9%
Member Months											
Individual Market					571,655	627,815	631,775	608,929	567,055		-0.2%
Small Group Market					967,648	912,400	883,940	884,349	848,472		-3.2%
Premiums PMPM											
Individual Market					326	369	404	407	467		9.4%
Small Group Market					375	405	417	427	442		4.2%
					NAIC Supplemental Exhibit						
Premiums (millions)											
Individual Market	121	132	142	152	194	242	244	240	255	256	5.7%
Small Group Market	290	243	266	282	291	303	295	300	319	340	3.1%
Large Group Market	453	557	603	650	702	722	735	753	806	851	3.9%
Member Months											
Individual Market	535,780	530,932	544,927	756,912	582,131	667,548	620,560	594,515	549,367	518,591	-2.3%
Small Group Market	995,164	776,463	810,831	845,028	788,308	757,106	741,852	710,767	713,623	732,478	-1.5%
Large Group Market	1,437,007	1,706,714	1,786,130	1,860,455	1,913,878	1,857,512	1,828,600	1,795,950	1,832,387	1,874,147	-0.4%
Premiums PMPM											
Individual Market	226	249	260	201	333	363	393	404	465	493	8.1%
Small Group Market	291	313	328	334	369	401	397	422	447	464	4.7%
Large Group Market	315	326	338	349	367	388	402	419	440	454	4.4%
Covered Lives											
Individual Market	47,687	44,416	47,038	66,023	49,075	54,151	49,718	47,192	43,333	40,957	-3.6%
Small Group Market	79,378	65,789	69,893	73,909	64,497	64,424	62,179	60,381	60,028	61,351	-1.0%
Large Group Market	120,348	142,944	149,561	158,836	160,820	149,872	151,322	149,111	154,872	156,685	-0.5%
					NDID/NovaRest 1332 Reinsurance Actuarial Report (ACA only) \a						
Individual Market											
Premiums								189	224	237	
Member Months								467,822	474,576	469,583	
Premiums PMPM								404	472	504	
Covered Lives								39,068	39,545	39,103	
Memorandum:											
CMS Individual Market PMPM (ACA Coverage)			225	230	318	362	401	404	468	516	471

Source: Horizon Government Affairs.

* Growth rate may be 2014-2018 or 2014-2019 depending on data availability for 2019.

31. Administrative Costs Grew Rapidly in the 2010-2019 Period. In the individual market, general and administrative costs (including claims processing) grew by about 5.6 percent per year in the 2010-2019 period, more slowly than benefit costs (7.0%) and premiums (8.7%). However, administrative costs grew much more rapidly than claims costs in the group markets, according to preliminary data from the NAIC (see Table 40).

Table 40.

Insurance Premiums vs. Benefits and Administrative Costs, by Market, NAIC Data **DRAFT**
(costs in millions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	Average Annual Growth 2010-2019
Premiums											
Individual Market	121	132	142	152	194	242	244	240	255	256	8.7%
Small Group Market	290	243	266	282	291	303	295	300	319	340	1.8%
Large Group Market	453	557	603	650	702	722	735	753	806	851	7.3%
Benefits											
Individual Market	121	120	133	138	175	213	227	226	223	222	7.0%
Small Group Market	254	192	225	259	239	245	251	247	281	290	1.5%
Large Group Market	416	512	555	597	635	667	680	689	739	791	7.4%
General and Administrative Costs, Claims Processing											
Individual Market	14	13	15	13	14	19	21	20	25	23	5.6%
Small Group Market	19	16	19	22	21	21	24	27	42	41	8.9%
Large Group Market	20	28	33	42	40	42	42	43	57	64	14.0%
Taxes and Assessments											
Individual Market	2	1	0	2	8	18	12	9	9	10	18.4%
Small Group Market	6	11	7	3	18	20	13	9	3	2	-10.4%
Large Group Market	4	7	6	5	18	31	23	11	16	-5	
Defined Expenses for Health Quality											
Individual Market	1	1	1	1	1	1	1	1	1	1	2.8%
Small Group Market	1	1	1	1	1	1	1	1	1	1	-0.1%
Large Group Market	2	3	4	3	3	6	7	5	5	5	10.8%
Other and Reinsurance (net)											
Individual Market	-4	0	0	1	-8	-14	-2	-6	-2	1	
Small Group Market	3	0	0	0	5	-1	-2	-1	0	0	
Large Group Market	2	-1	-2	9	-1	29	-23	-11	-7	-6	
Net Underwriting Gain (+) or Loss (-)											
Individual Market	-12	-2	-7	-2	4	5	-15	-9	-1	-2	
Small Group Market	7	23	14	-4	7	16	6	16	-9	6	
Large Group Market	9	8	6	-7	8	-53	8	17	-4	2	

Source: Horizon Government Affairs, based on data from NAIC.
* Preliminary

32. Pharmaceutical Benefit Claims, Net of Rebates, Grew Faster Than Non-Pharmacy Costs. Based on the NAIC data, net pharmacy claims grew more rapidly than non-pharmacy costs in all markets. For example, in the individual market, net pharmacy claims grew by 11.8 percent per year, compared with average annual growth of 6.0 percent for non-pharmacy claims over the 2010-2019 period (see Table 41).

Table 41.

Benefits Costs, By Type, NAIC Data (costs in millions)						**DRAFT**					Average Annual Growth
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2010-2019
Non-Pharmaceutical Claims											
Individual Market	107	105	117	120	148	181	188	183	179	181	6.0%
Small Group Market	222	168	199	230	209	212	216	207	238	243	1.0%
Large Group Market	361	447	483	517	540	563	577	582	620	672	7.1%
Pharmaceutical Claims											
Individual Market	15	16	17	20	28	37	45	47	50	51	14.7%
Small Group Market	33	26	27	31	31	40	42	43	47	55	5.8%
Large Group Market	57	68	78	87	104	119	122	124	141	152	11.5%
Rebates											
Individual Market	1	1	1	2	1	5	5	7	10	13	35.2%
Small Group Market	2	2	2	2	2	6	6	7	10	14	25.7%
Large Group Market	2	3	6	7	8	15	20	22	28	39	37.0%
Net, Pharmaceutical Claims											
Individual Market	14	15	16	18	27	32	40	40	39	38	11.8%
Small Group Market	32	24	25	29	29	34	35	36	37	42	3.1%
Large Group Market	55	65	72	80	96	104	103	102	113	113	8.4%
Total, Incurred Claims											
Individual Market	121	120	133	138	175	213	227	226	223	222	7.0%
Small Group Market	254	192	225	259	239	245	251	247	281	290	1.5%
Large Group Market	416	512	555	597	635	667	680	689	739	791	7.4%

Source: Horizon Government Affairs, data from NAIC.
Note: Claims costs do not sum exactly to totals for 2017-2019.
* Preliminary

33. Individual Market Baseline Reconstruction for 2019 and 2020. Table 42 shows our baseline reconstruction for the Individual Market in 2019 and 2020. This table is particularly uncertain and subject to change. It assumes 2020 premiums will be about 9 percent lower than 2019, due to the state's new reinsurance program. The reduction in enrollment is due mostly to the Covid-19 recession, based in preliminary data submitted by the state's health plans. Absent the recession, we had expected enrollment in the individual market to increase, based on preliminary data from CMS on 2020 plan selections, and due to the reinsurance and resulting premium reduction.

Table 42.

Individual Coverage Baseline Estimates (HGA)				DRAFT			
	2014	2015	2016	2017	2018	2019	2020e
On Exchange		**Covered Lives**					
APTC Only		7,223	7,731	7,360	7,798	9,964	10,123
APTC/CSR		7,021	8,234	9,039	9,095	8,604	7,867
No Subsidy		2,407	2,726	2,948	2,749	2,693	2,559
Total, On Exchange		16,651	18,691	19,347	19,642	21,261	20,549
Off Exchange		19,678	21,736	21,023	17,750	15,224	14,324
Total, ACA	19,738	36,329	40,427	40,370	37,392	36,485	34,873
Transitional and Grandfathered	28,619	16,905	10,756	8,598	7,902	7,262	6,674
Total, Individual	48,356	53,234	51,183	48,968	45,294	43,747	41,547
Individual Market		**Premiums PMPM**					
On Exchange (CMS)	334	363	403	398	450	496	453
Total ACA (NDID/Novarest)	342	371	412	407	476	523	478
Total, Individual Market	326	369	404	407	467	512	468
Individual Market		**Growth**					
On Exchange (CMS)		9%	11%	-1%	13%	10%	-9%
Total ACA (NDID/Novarest)		9%	11%	-1%	17%	10%	-9%
Total, Individual Market		13%	9%	1%	15%	10%	-9%
Individual Market		**Aggregate Premiums (millions)**					
On Exchange (CMS)		72	90	92	106	127	112
Total ACA (NDID/Novarest)		162	200	197	214	229	200
Total, Individual Market	189	236	248	239	254	269	233
Memorandum							
Average Deductible, Individual Market		2,300	2,500	2,900	3,600	4,000	4,500
Loss Ratio, Individual Market		89%	89%	97%	95%	90%	87%

Source: Preliminary HGA estimates based on data from the NAIC, NDID/Novarest, CMS.

IV. Insurers – 50 State Data

Contents: Measures Compared	Figure	Table	Rank (highest to lowest)		
			Level		
			2014	2019	Growth
35. Individual Market Premiums (PMPM)	18	43	15	35	43
36. Individual Market Claims	19	44	21	26	38
37. Individual Market Admin. Costs	20	45	50	38	5
38. Small Group Market Premiums		46	30	30	22
39. Small Group Market Claims		47	22	27	25
40. Small Group Market Admin. Costs	21	48	50	24	1
41. Large Group Market Premiums		49	32	18	12
42. Large Group Market Claims		50	30	16	13
43. Large Group Market Admin. Costs		51	49	41	3

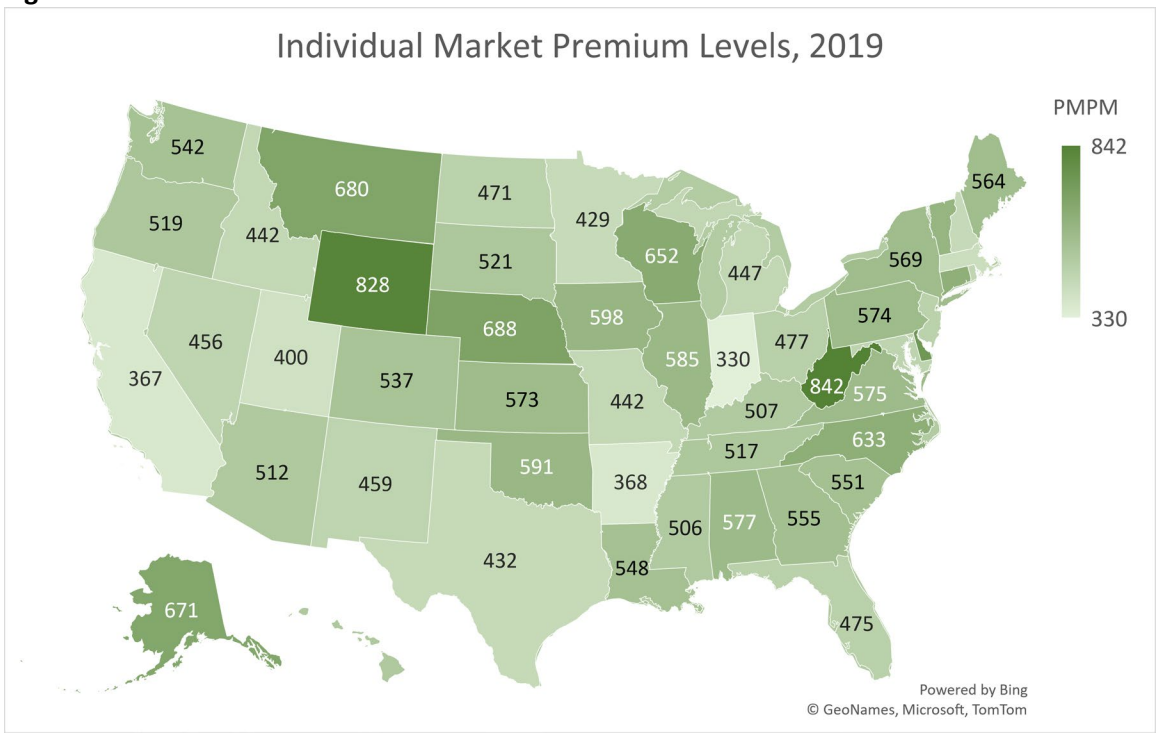
Source. HGA based on data from the National Association of Insurance Commissioners.
Notes: Growth is based on 2014 to 2019, except as noted in tables. All measures are based on PMPM (per-member per-month).

The data below show overall premiums and claims and other measures from the NAIC supplemental exhibit. These data are much more stable and comprehensive than the CMS Rate Review data, and we believe they are most appropriate for state-to-state market comparisons. However, there is still the possibility that the NAIC data could have volatility due to carriers entering or departing state markets. Importantly, the NAIC's "large group" category does not include self-funded (ERISA) benefit plans.

Despite North Dakota's relatively high and rapidly growing hospital and pharmaceutical costs, North Dakota's statewide premiums and claims per member month are about average, in the individual, small group, and large group markets.

34. **Individual Market Premiums.**

Figure 18.



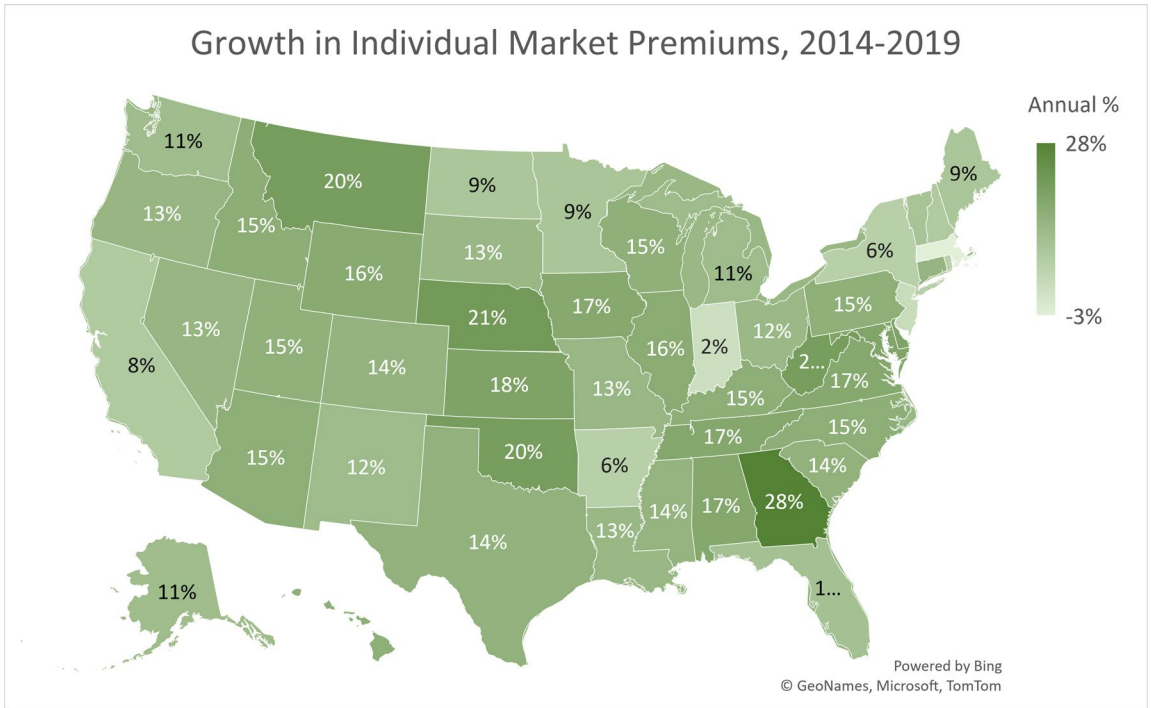


Table 43.

NAIC Supplemental Exhibit DRAFT

Net Adjusted Premiums After Assessments and Reinsurance, Per Member Month, Ranked by 2019 Level

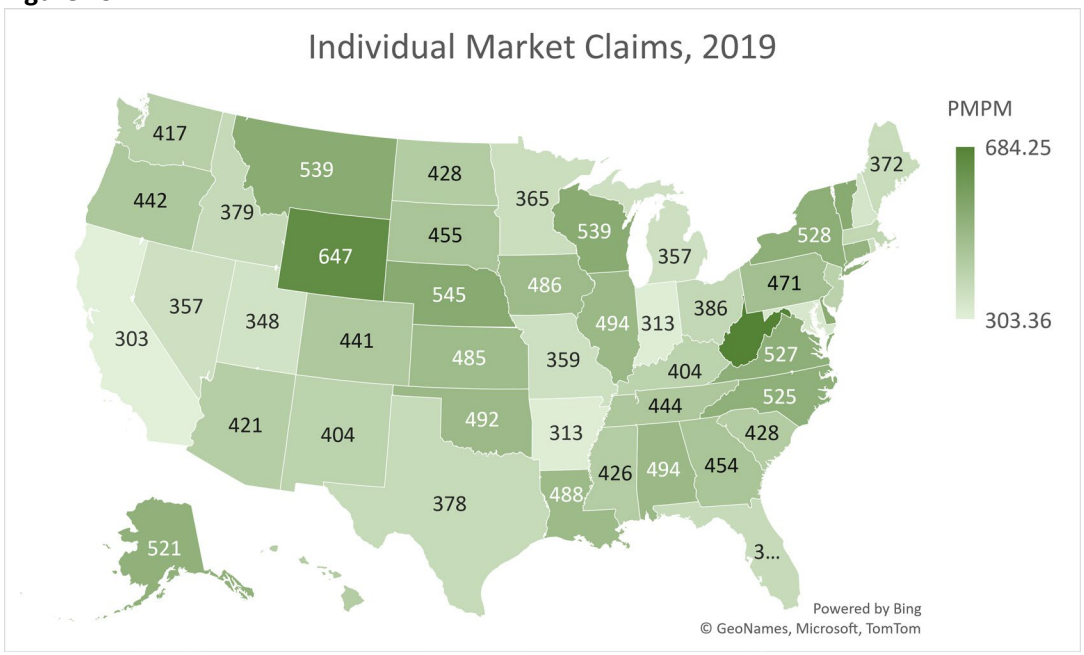
Individual Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**203**	**212**	**221**	**195**	**275**	**309**	**348**	**413**	**508**	**499**	**13%**	
WV	245	254	270	199	338	424	482	609	740	**842**	20%	1
WY	254	255	260	263	388	467	503	582	813	**828**	16%	2
DE	228	247	284	224	320	361	450	591	729	**740**	18%	3
NE	222	217	226	223	265	317	351	479	628	**688**	21%	4
MT	187	203	217	217	272	317	368	530	643	**680**	20%	5
AK	280	306	318	316	391	493	727	800	590	**671**	11%	6
WI	211	216	226	221	327	370	409	463	663	**652**	15%	7
NC	201	224	224	148	313	332	399	531	632	**633**	15%	8
CT	255	252	260	264	334	376	377	431	628	**626**	13%	9
VT	371	321	381	405	385	443	458	501	522	**601**	9%	10
IA	217	231	240	243	275	335	344	413	544	**598**	17%	11
OK	185	184	196	173	236	282	331	510	594	**591**	20%	12
IL	215	219	236	220	280	323	353	455	576	**585**	16%	13
AL	153	163	178	144	261	299	369	490	554	**577**	17%	14
VA	216	244	223	205	264	276	327	370	545	**575**	17%	15
PA	215	224	241	221	285	340	379	552	569	**574**	15%	16
KS	184	198	216	136	247	270	320	411	518	**573**	18%	17
NY	442	314	407	397	423	454	503	495	536	**569**	6%	18
ME	289	300	299	265	369	391	388	473	642	**564**	9%	19
GA	199	190	182	192	163	214	285	402	545	**555**	28%	20
SC	204	203	214	169	281	267	371	443	529	**551**	14%	21
LA	219	221	234	218	300	352	404	474	553	**548**	13%	22
WA	213	238	251	254	318	339	347	382	454	**542**	11%	23
CO	173	198	207	202	279	286	352	396	517	**537**	14%	24
SD	207	219	224	238	288	250	349	425	494	**521**	13%	25
OR	205	219	215	203	280	270	354	408	382	**519**	13%	26
TN	193	198	203	166	234	269	336	450	598	**517**	17%	27
AZ	202	199	204	183	253	271	283	467	495	**512**	15%	28
HI	220	241	251	262	254	256	327	412	501	**511**	15%	29
KY	202	210	212	200	249	275	327	363	462	**507**	15%	30
DC	248	232	240	261	238	242	323	361	434	**506**	16%	31
MS	193	191	192	155	266	306	326	376	494	**506**	14%	32
OH	167	189	211	181	266	298	339	366	424	**477**	12%	33
FL	216	217	222	211	293	329	351	408	504	**475**	10%	34
ND	221	245	257	196	310	332	373	388	447	**471**	9%	35
NJ	361	347	406	386	413	410	453	467	489	**470**	3%	36
MD	183	185	193	194	203	230	277	340	524	**460**	18%	37
NM	185	207	198	168	264	426	310	358	485	**459**	12%	38
NV	197	200	193	183	246	301	326	338	441	**456**	13%	39
RI	182	355	355	338	347	313	344	347	415	**450**	5%	40
MI	193	204	200	187	260	297	338	351	432	**447**	11%	41
MO	180	180	188	170	242	283	334	392	519	**442**	13%	42
ID	142	167	176	174	216	265	303	374	429	**442**	15%	43
TX	183	202	206	130	222	302	314	359	499	**432**	14%	44
NH	244	265	276	244	298	333	346	431	527	**431**	8%	45
MN	201	221	226	229	278	275	357	495	450	**429**	9%	46
MA	347	353	448	403	480	384	355	360	404	**414**	-3%	47
UT	154	159	159	158	202	214	259	298	422	**400**	15%	48
AR	163	172	181	117	274	291	321	357	376	**368**	6%	49
CA	164	179	191	197	252	338	350	357	307	**367**	8%	50
IN	195	177	224	208	303	364	369	397	449	**330**	2%	51

Source: HGA calculations, based on data from the NAIC.

35. Individual Market Claims

Figure 19.



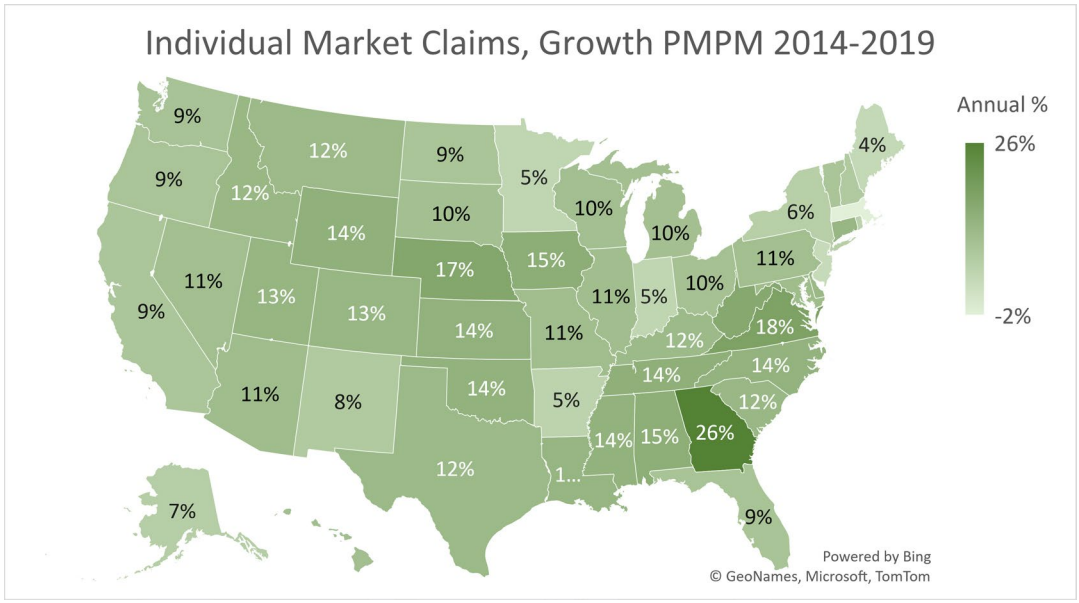


Table 44.

NAIC Supplemental Exhibit DRAFT

Net Incurred Claims After Reinsurance, Per Member Month, Ranked by 2019 Level

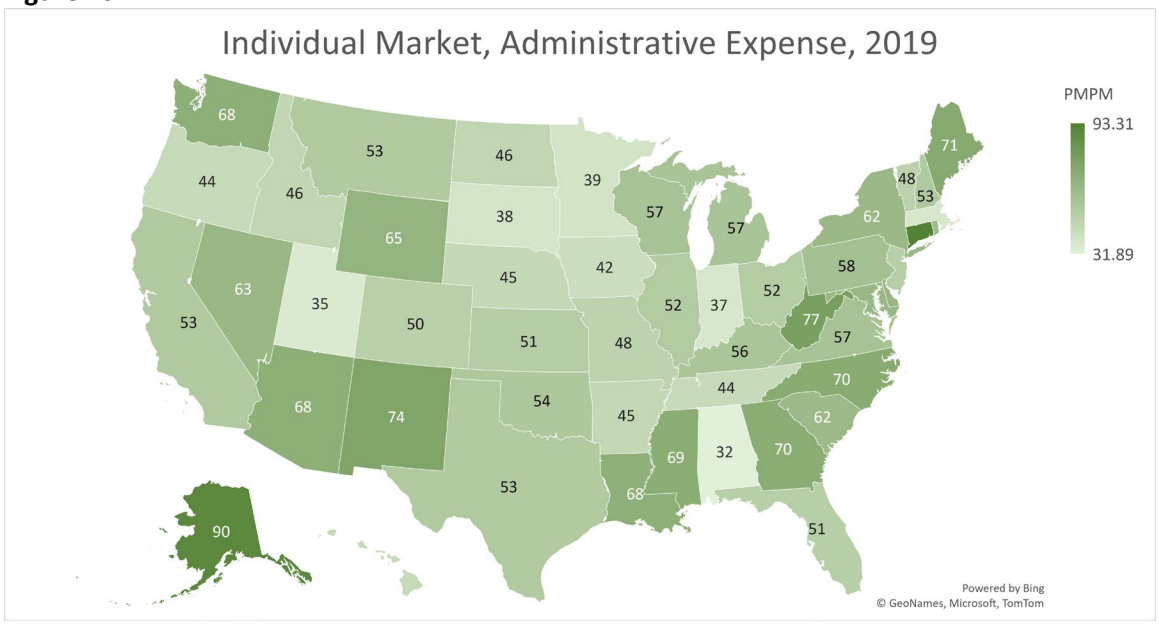
Individual Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**163**	**178**	**188**	**167**	**250**	**295**	**326**	**352**	**398**	**415**	**11%**	
WV	163	198	236	178	323	451	475	509	622	**684**	16%	1
WY	207	198	202	211	334	426	549	525	618	**647**	14%	2
NE	178	188	201	197	251	329	336	414	516	**545**	17%	3
VT	332	292	377	372	353	371	429	453	508	**543**	9%	4
WI	162	181	195	189	328	377	387	432	514	**539**	10%	5
MT	149	168	195	192	309	364	382	430	405	**539**	12%	6
DE	175	187	238	180	302	408	452	530	522	**535**	12%	7
NY	409	282	401	382	388	414	501	480	491	**528**	6%	8
VA	159	203	186	171	230	251	308	350	423	**527**	18%	9
NC	186	187	192	126	277	333	341	402	482	**525**	14%	10
AK	225	249	239	231	378	512	613	604	554	**521**	7%	11
DC	201	315	239	254	253	240	339	416	494	**518**	15%	12
CT	192	209	224	224	281	345	425	400	333	**511**	13%	13
IL	161	176	193	187	296	300	342	364	406	**494**	11%	14
AL	139	150	165	141	249	318	362	400	457	**494**	15%	15
OK	134	143	154	150	259	269	323	379	431	**492**	14%	16
LA	173	176	192	176	267	329	360	379	429	**488**	13%	17
IA	190	201	214	208	242	288	328	353	443	**486**	15%	18
KS	147	164	183	115	253	274	328	379	449	**485**	14%	19
PA	186	203	226	202	285	354	369	445	438	**471**	11%	20
SD	178	185	224	218	279	317	333	373	438	**455**	10%	21
GA	154	157	151	142	140	215	270	349	427	**454**	26%	22
TN	145	166	162	140	226	271	327	361	404	**444**	14%	23
OR	179	200	195	192	285	286	356	388	405	**442**	9%	24
CO	137	166	177	171	242	304	344	365	428	**441**	13%	25
ND	217	225	242	181	277	294	362	369	402	**428**	9%	26
SC	138	158	172	130	239	239	353	383	408	**428**	12%	27
MS	140	151	160	123	224	264	293	306	386	**426**	14%	28
HI	207	217	241	252	258	308	426	378	420	**425**	10%	29
AZ	148	159	159	146	249	265	286	339	379	**421**	11%	30
WA	179	207	211	210	265	289	332	350	362	**417**	9%	31
NJ	341	295	358	363	345	350	407	415	418	**407**	3%	32
NM	155	208	173	178	278	352	299	313	370	**404**	8%	33
KY	155	161	170	153	233	246	298	313	386	**404**	12%	34
MA	369	365	462	409	436	348	373	351	371	**391**	-2%	35
OH	123	154	186	148	239	286	308	319	348	**386**	10%	36
ID	106	138	144	141	211	337	304	312	358	**379**	12%	37
TX	127	161	170	116	215	296	304	302	355	**378**	12%	38
FL	165	178	179	170	240	285	292	346	396	**375**	9%	39
ME	231	267	255	206	308	351	381	421	494	**372**	4%	40
MN	189	192	213	190	290	334	381	367	303	**365**	5%	41
RI	163	287	341	327	278	253	279	323	319	**364**	6%	42
MO	126	144	155	135	214	252	292	301	397	**359**	11%	43
NV	141	159	156	150	216	271	296	300	325	**357**	11%	44
MI	166	184	166	161	219	243	302	297	318	**357**	10%	45
UT	125	129	127	134	189	308	287	265	359	**348**	13%	46
NH	171	194	200	176	235	280	332	361	386	**340**	8%	47
MD	143	154	158	162	196	209	256	320	443	**333**	11%	48
IN	143	143	190	171	249	348	315	336	385	**313**	5%	49
AR	123	145	146	96	241	260	305	315	306	**313**	5%	50
CA	132	142	157	174	200	331	326	310	277	**303**	9%	51

Source: HGA calculations, based on data from the NAIC.

36. Individual Market Administrative Costs

Figure 20.



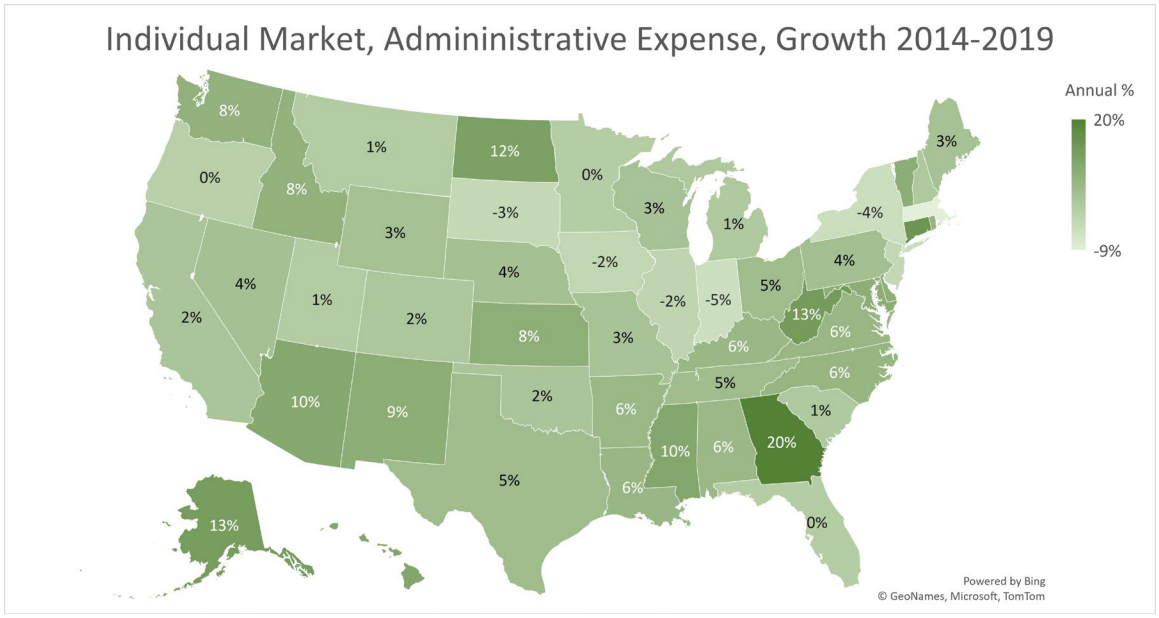


Table 45.

NAIC Supplemental Exhibit DRAFT

General Administrative, Claims Adjustment, Defined Quality Costs, Per Member Per Month, Ranked by 2019 Level

Individual Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**40**	**37**	**38**	**36**	**46**	**46**	**47**	**50**	**53**	**54**	**3%**	
CT	41	36	35	38	46	53	55	41	59	**93**	15%	1
AK	47	48	49	56	49	39	47	67	70	**90**	13%	2
DC	54	64	49	58	52	46	66	59	77	**81**	9%	3
WV	44	42	37	31	41	43	49	59	64	**77**	13%	4
NM	37	32	36	36	49	71	46	60	59	**74**	9%	5
ME	42	40	41	41	60	15	18	55	62	**71**	3%	6
NC	37	32	34	29	51	49	59	58	67	**70**	6%	7
GA	40	35	34	35	27	32	36	44	59	**70**	20%	8
MS	37	38	37	29	42	48	45	57		**69**	10%	9
AZ	42	39	38	35	43	47	43	66	57	**68**	10%	10
WA	39	42	43	48	48	45	45	50	55	**68**	8%	11
LA	42	33	35	36	50	51	52	66	64	**68**	6%	12
WY	44	37	37	45	55	53	42	42	73	**65**	3%	13
DE	45	34	37	35	43	45	44	55	52	**64**	8%	14
MD	38	36	37	40	42	46	55	61	76	**63**	9%	15
NV	47	40	37	36	53	51	46	36	53	**63**	4%	16
NY	37	33	38	42	77	63	66	71	60	**62**	-4%	17
SC	53	42	43	41	58	44	43	46	55	**62**	1%	18
RI	27	53	56	47	44	47	62	53	53	**61**	7%	19
PA	36	33	35	39	48	50	47	58	58	**58**	4%	20
VA	35	24	34	35	42	44	43	49	50	**57**	6%	21
WI	46	43	46	47	48	55	55	58	52	**57**	3%	22
MI	38	38	40	41	53	55	56	50	54	**57**	1%	23
KY	39	37	37	39	42	39	38	38	51	**56**	6%	24
OK	42	34	36	37	48	42	53	58	55	**54**	2%	25
NH	46	44	46	44	50	74	57	53	60	**53**	1%	26
MT	44	40	37	43	52	51	56	54	52	**53**	1%	27
TX	46	38	40	29	42	45	48	52	55	**53**	5%	28
CA	40	39	39	36	47	54	53	52	58	**53**	2%	29
IL	48	41	42	48	58	48	51	55	56	**52**	-2%	30
OH	43	39	35	30	41	44	41	48	51	**52**	5%	31
KS	36	35	36	25	34	32	38	40	54	**51**	8%	32
FL	47	44	43	47	50	52	51	52	55	**51**	0%	33
NJ	50	53	45	40	57	63	62	61	53	**50**	-3%	34
CO	40	38	38	39	45	40	53	53	55	**50**	2%	35
VT	40	36	32	33	32	38	40	40	48	**48**	9%	36
MO	42	38	37	35	41	40	49	49	72	**48**	3%	37
ND	28	25	28	18	26	30	35	35	47	**46**	12%	38
ID	32	34	37	36	32	38	39	42	45	**46**	8%	39
AR	34	37	36	23	34	31	33	39	47	**45**	6%	40
NE	41	33	34	34	37	44	48	48	49	**45**	4%	41
OR	40	37	39	37	45	49	43	42	43	**44**	0%	42
HI	22	23	22	25	27	30	35	41	40	**44**	10%	43
TN	41	37	35	31	35	38	39	50	39	**44**	5%	44
IA	38	35	36	44	47	36	40	45	48	**42**	-2%	45
MN	31	30	32	38	38	43	47	44	42	**39**	0%	46
SD	36	34	35	35	44	39	37	40	38	**38**	-3%	47
IN	43	31	35	35	47	53	52	50	57	**37**	-5%	48
MA	44	55	44	40	59	44	39	38	37	**37**	-9%	49
UT	28	32	32	37	34	35	32	35	34	**35**	1%	50
AL	17	17	18	18	24	28	29	26	28	**32**	6%	51

Source: HGA calculations, based on data from the NAIC.

37. Small Group Market Premiums

Table 46.

NAIC Supplemental Exhibit DRAFT

Net Adjusted Premiums After Assessments and Reinsurance, Per Member Month, Ranked by 2019 Level

Small Group Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**318**	**321**	**329**	**341**	**347**	**365**	**384**	**418**	**447**	**473**	**6%**	
AK	370	502	533	538	544	547	622	642	219	**762**	7%	1
NY	363	350	365	396	400	431	465	512	552	**591**	8%	2
DE	356	364	342	369	386	426	483	468	522	**577**	8%	3
NJ	338	350	361	380	371	426	378	471	538	**574**	9%	4
CT	377	402	427	443	396	402	421	441	502	**567**	7%	5
WY	355	336	392	398	392	402	447	470	510	**553**	7%	6
WV	353	356	351	369	403	402	415	475	508	**551**	6%	7
MA	379	412	411	420	414	428	461	479	497	**516**	5%	8
IL	337	352	372	382	390	398	432	459	495	**515**	6%	9
RI	372	377	402	418	437	440	450	473	492	**515**	3%	10
FL	350	359	365	373	380	393	416	450	478	**507**	6%	11
TX	293	300	298	307	321	340	361	415	456	**506**	10%	12
MO	290	297	310	339	334	368	401	419	468	**504**	9%	13
IN	302	315	329	356	358	380	403	438	453	**504**	7%	14
NH	388	401	409	422	424	435	440	443	474	**498**	3%	15
PA	342	309	322	320	356	438	445	498	460	**495**	7%	16
WI	319	338	336	350	368	365	402	435	458	**495**	6%	17
OH	279	297	309	326	333	344	372	397	441	**494**	8%	18
VT	305	320	352	379	379	392	420	473	487	**494**	5%	19
CA	274	278	292	309	320	312	314	375	429	**490**	9%	20
DC	346	351	310	378	357	333	363	372	464	**489**	6%	21
KY	299	300	310	315	313	337	362	398	435	**488**	9%	22
NE	309	322	336	346	312	360	363	404	447	**485**	9%	23
NM	333	347	363	333	382	457	410	414	446	**478**	5%	24
LA	318	340	351	377	378	390	409	432	453	**476**	5%	25
KS	239	290	294	301	311	331	364	412	495	**474**	9%	26
VA	320	319	319	335	344	327	365	390	451	**464**	6%	27
SD	310	329	343	348	363	359	341	420	445	**462**	5%	28
HI	306	299	311	339	343	365	388	418	432	**461**	6%	29
ND	285	299	320	330	341	373	379	409	442	**459**	6%	30
ME	306	294	298	322	325	332	347	362	396	**458**	7%	31
MN	336	331	335	348	340	362	379	407	438	**444**	5%	32
CO	332	333	344	351	357	348	369	399	403	**436**	4%	33
MT	303	324	340	317	347	354	350	413	413	**431**	4%	34
WA	330	315	326	340	341	363	364	391	415	**430**	5%	35
OR	318	334	342	346	361	368	389	393	407	**430**	4%	36
OK	302	306	318	322	335	355	369	402	413	**420**	5%	37
IA	274	290	299	315	322	333	348	377	400	**419**	5%	38
SC	304	316	328	343	338	399	360	368	392	**418**	4%	39
MD	326	330	316	349	346	325	330	334	422	**415**	4%	40
AL	297	315	324	333	349	359	374	412	401	**408**	3%	41
AZ	250	250	251	247	258	272	286	299	365	**400**	9%	42
MI	336	321	330	345	329	365	380	394	399	**399**	4%	43
NV	298	269	290	280	295	312	324	344	384	**390**	6%	44
TN	283	283	298	311	302	316	352	373	381	**390**	5%	45
NC	319	334	341	346	343	375	367	376	375	**389**	3%	46
MS	283	297	297	276	319	321	343	360	362	**382**	4%	47
GA	261	268	270	265	281	279	270	298	339	**378**	6%	48
AR	278	287	280	291	292	324	346	392	363	**377**	5%	49
ID	241	258	271	276	275	297	324	347	344	**359**	5%	50
UT	237	244	253	264	260	264	275	312	333	**341**	6%	51

Source: HGA calculations, based on data from the NAIC.

38. Small Group Market Claims

Table 47.

NAIC Supplemental Exhibit DRAFT

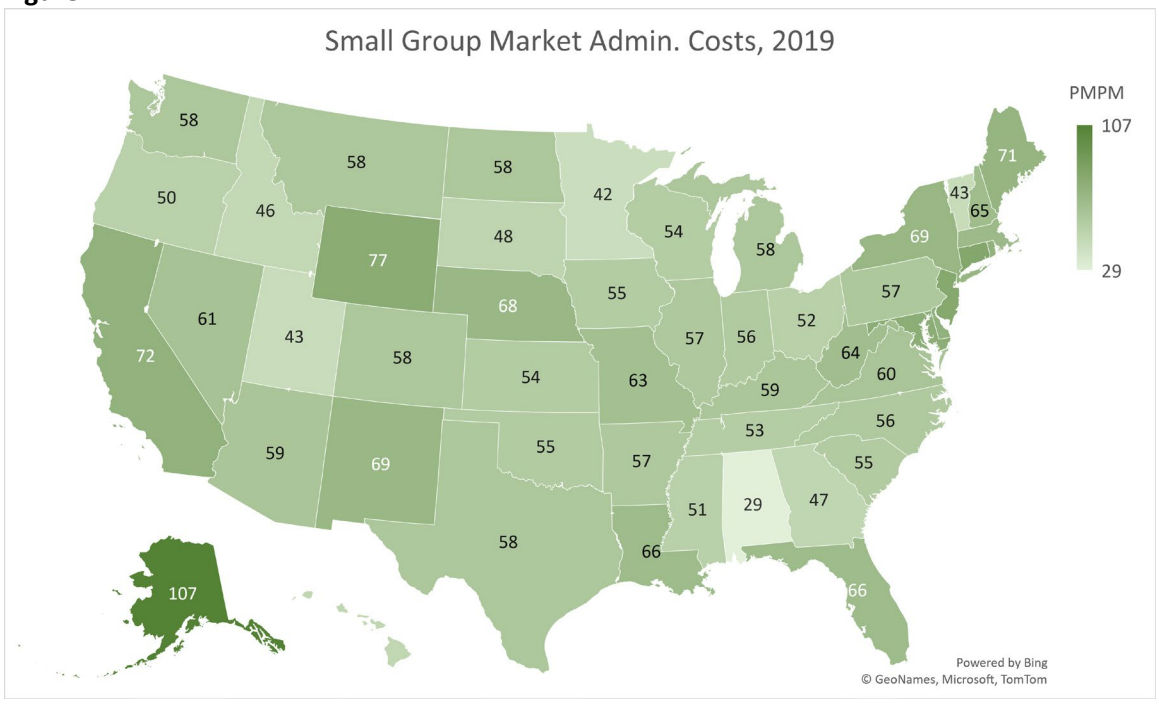
Net Incurred Claims After Reinsurance, Per Member Month, Ranked by 2019 Level

Small Group Market	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**264**	**266**	**275**	**285**	**295**	**310**	**327**	**348**	**370**	**393**	**6%**	
NY	323	311	324	346	354	373	403	444	477	**511**	8%	1
CT	308	324	348	361	335	340	372	397	402	**483**	8%	2
WV	280	289	300	304	336	345	356	383	427	**475**	7%	3
NJ	285	289	299	314	313	354	323	384	422	**470**	8%	4
WY	285	259	287	329	327	342	386	390	399	**469**	7%	5
VT	272	276	313	348	344	379	409	425	439	**467**	6%	6
AK	308	397	434	434	459	492	552	505	439	**467**	0%	7
DE	280	300	278	291	324	333	387	391	431	**453**	7%	8
MA	335	348	360	367	380	394	396	420	424	**443**	3%	9
KS	197	244	257	253	280	308	326	351	427	**416**	8%	10
KY	235	245	255	260	268	284	306	340	348	**415**	9%	11
IN	236	250	264	283	293	314	339	360	370	**415**	7%	12
OH	231	246	255	267	279	288	312	327	360	**414**	8%	13
IL	268	285	308	313	326	343	366	378	398	**414**	5%	14
RI	350	277	345	356	363	351	389	400	402	**413**	3%	15
MO	223	234	248	272	276	303	335	340	378	**412**	8%	16
NH	355	337	345	359	350	361	387	391	410	**411**	3%	17
WI	263	290	291	299	324	316	337	354	371	**411**	5%	18
PA	287	259	280	282	318	372	371	431	380	**410**	5%	19
FL	275	289	291	298	311	313	331	357	386	**408**	6%	20
TX	235	240	246	255	272	300	317	337	374	**407**	8%	21
NM	268	290	307	291	323	386	365	378	369	**404**	5%	22
HI	264	259	275	301	299	316	339	366	387	**402**	6%	23
LA	260	283	286	306	317	338	351	354	370	**400**	5%	24
NE	236	263	277	284	261	307	318	341	383	**397**	9%	25
DC	271	278	256	316	286	272	298	296	388	**396**	7%	26
ND	258	247	277	306	303	322	336	346	394	**393**	5%	27
CA	227	231	245	253	264	252	272	311	338	**388**	8%	28
ME	262	253	249	271	279	282	304	318	347	**382**	6%	29
MN	286	281	295	311	303	317	344	369	391	**379**	5%	30
VA	246	256	259	275	283	269	300	320	358	**378**	6%	31
OR	270	287	285	294	300	305	344	344	351	**377**	5%	32
AL	264	270	292	299	313	336	338	342	352	**372**	3%	33
SD	275	287	293	293	323	303	313	354	374	**368**	3%	34
WA	281	266	278	287	299	308	317	319	339	**363**	4%	35
MT	243	256	284	270	303	331	320	349	337	**359**	3%	36
CO	276	278	285	293	295	285	295	323	345	**355**	4%	37
OK	234	241	254	261	284	319	322	317	333	**348**	4%	38
SC	246	254	263	269	271	325	305	303	316	**344**	5%	39
MD	255	265	259	282	269	251	267	270	339	**339**	5%	40
MS	251	260	271	242	270	277	303	299	314	**332**	4%	41
MI	283	268	272	276	255	291	310	314	326	**332**	5%	42
GA	209	217	217	222	233	233	225	244	281	**332**	7%	43
IA	225	232	243	258	270	285	301	308	330	**330**	4%	44
NC	263	275	280	287	294	310	305	302	307	**319**	2%	45
TN	225	225	236	245	240	258	289	283	295	**317**	6%	46
AZ	191	198	203	199	215	222	242	240	285	**314**	8%	47
NV	230	208	226	223	253	263	271	282	307	**313**	4%	48
ID	196	214	226	230	244	243	282	284	291	**303**	4%	49
AR	215	225	228	240	247	273	286	322	300	**302**	4%	50
UT	187	200	200	216	224	254	235	256	273	**289**	5%	51

Source: HGA calculations, based on data from the NAIC.

39. Small Group Market Administrative Costs

Figure 21.



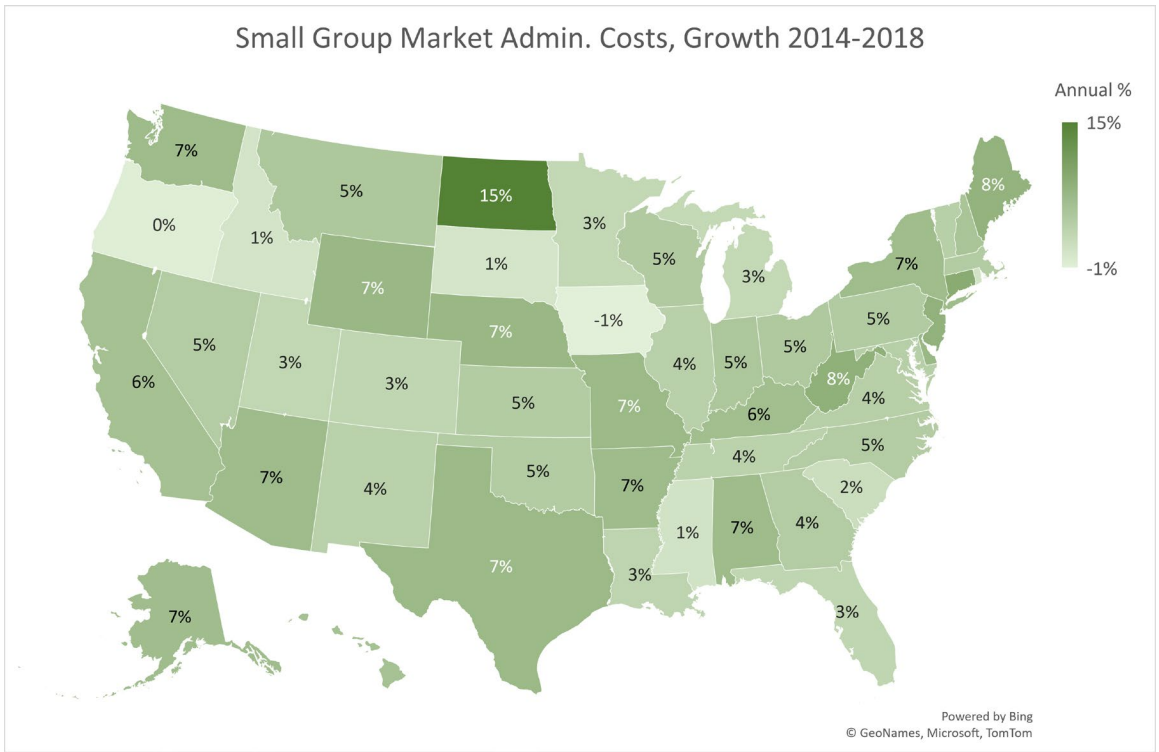


Table 48.

NAIC Supplemental Exhibit DRAFT

General Administrative, Claims Adjustment, Defined Quality Costs, Per Member Per Month, Ranked by 2019 Level

Small Group Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**44**	**44**	**44**	**45**	**46**	**49**	**50**	**55**	**58**	**59**	**5%**	
AK	53	67	73	78	77	76	73	95	29	**107**	7%	1
CT	44	54	52	54	52	63	97	68	76	**80**	9%	2
NJ	52	60	55	55	53	71	62	77	74	**79**	8%	3
WY	58	54	61	61	54	51	45	46	74	**77**	7%	4
DC	49	52	48	60	65	60	69	62	76	**76**	3%	5
MD	51	58	54	60	62	60	68	64	78	**75**	4%	6
DE	49	42	45	54	51	54	58	61	60	**73**	7%	7
RI	47	50	53	58	68	64	70	69	70	**73**	1%	8
CA	43	48	53	53	54	54	41	67	72	**72**	6%	9
ME	34	35	40	45	48	45	37	54	63	**71**	8%	10
NY	37	46	44	47	50	52	52	61	65	**69**	7%	11
NM	50	52	57	51	57	68	60	59	70	**69**	4%	12
NE	53	42	44	45	48	51	51	55	70	**68**	7%	13
MA	40	53	49	52	53	54	53	55	64	**67**	5%	14
FL	51	54	54	50	56	57	59	62	62	**66**	3%	15
LA	52	45	48	54	56	59	70	62	63	**66**	3%	16
NH	43	46	45	47	50	50	48	55	61	**65**	6%	17
WV	47	44	37	39	43	38	39	56	51	**64**	8%	18
MO	42	41	39	43	44	48	51	53	60	**63**	7%	19
NV	62	47	48	49	49	51	48	54	58	**61**	5%	20
VA	40	40	41	44	49	48	50	55	64	**60**	4%	21
AZ	43	43	42	43	42	44	42	53	64	**59**	7%	22
KY	47	42	41	40	43	42	46	50	56	**59**	6%	23
ND	21	22	25	28	29	30	35	40	61	**58**	15%	24
MI	49	45	48	54	51	58	56	56	57	**58**	3%	25
CO	46	43	43	46	49	51	55	55	59	**58**	3%	26
WA	48	40	40	40	41	47	49	55	54	**58**	7%	27
TX	46	42	41	45	41	42	46	52	56	**58**	7%	28
MT	52	52	46	43	45	47	51	51	55	**58**	5%	29
PA	41	38	41	41	45	62	55	61	60	**57**	5%	30
AR	49	46	39	39	41	44	48	57	55	**57**	7%	31
IL	52	48	45	47	47	45	47	53	57	**57**	4%	32
NC	48	43	42	44	45	48	51	57	54	**56**	5%	33
IN	44	39	39	43	43	48	45	50	52	**56**	5%	34
OK	47	45	45	48	44	44	44	53	52	**55**	5%	35
SC	48	45	44	49	50	55	50	48	54	**55**	2%	36
IA	43	41	42	50	56	50	51	50	51	**55**	-1%	37
KS	34	38	40	45	43	46	48	48	58	**54**	5%	38
WI	43	39	39	40	43	44	46	51	51	**54**	5%	39
TN	46	44	47	45	44	46	51	73	70	**53**	4%	40
OH	43	40	38	40	40	41	45	52	49	**52**	5%	41
MS	36	42	43	41	48	49	47	50	47	**51**	1%	42
OR	43	40	41	42	51	55	51	47	49	**50**	0%	43
SD	34	36	36	36	46	41	39	47	47	**48**	1%	44
GA	43	41	39	37	38	38	35	42	47	**47**	4%	45
HI	36	32	31	36	35	37	40	45	42	**47**	6%	46
ID	38	39	41	41	43	39	38	40	41	**46**	1%	47
VT	47	43	43	45	35	33	34	36	43	**43**	4%	48
UT	40	39	39	39	37	41	41	41	42	**43**	3%	49
MN	34	35	37	40	36	40	44	43	43	**42**	3%	50
AL	17	17	17	19	21	23	22	29	28	**29**	7%	51

Source: HGA calculations, based on data from the NAIC.

40. Large Group Premiums

Table 49.

NAIC Supplemental Exhibit DRAFT

Net Adjusted Premiums After Assessments and Reinsurance, Per Member Month, Ranked by 2019 Level

Large Group (Insured) Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**317**	**320**	**326**	**333**	**358**	**368**	**381**	**388**	**406**	**426**	**4%**	
AK	541	470	508	509	563	582	599	638	711	**739**	6%	1
NH	416	438	438	443	464	476	502	538	555	**594**	5%	2
VT	360	370	380	398	395	425	445	488	483	**546**	7%	3
MA	403	423	430	430	437	450	473	502	516	**545**	5%	4
NJ	364	381	392	414	459	462	433	482	504	**532**	3%	5
ME	392	406	413	427	427	437	455	483	498	**528**	4%	6
WY	351	386	422	436	388	401	424	421	492	**527**	6%	7
DE	327	351	375	350	371	342	408	396	436	**524**	7%	8
WV	370	377	400	418	399	417	417	453	487	**516**	5%	9
CT	392	400	410	409	405	417	463	-89	460	**512**	5%	10
MT	314	329	333	362	375	397	413	441	478	**490**	5%	11
MD	312	373	378	385	385	402	428	447	457	**490**	5%	12
NY	260	269	275	274	387	432	442	460	470	**487**	5%	13
NM	321	347	356	372	374	399	446	413	444	**483**	5%	14
OR	346	367	380	394	395	404	426	442	454	**480**	4%	15
RI	371	377	385	388	409	408	413	439	440	**461**	2%	16
NC	337	344	361	363	387	392	391	387	422	**459**	3%	17
ND	312	322	334	346	352	370	387	412	430	**455**	5%	18
WI	373	397	397	407	410	413	415	416	436	**454**	2%	19
SD	325	343	354	363	368	395	382	418	434	**452**	4%	20
LA	341	363	349	363	372	393	405	419	428	**448**	4%	21
NE	335	374	377	379	401	372	392	395	430	**447**	2%	22
CO	334	370	377	388	394	407	417	430	416	**446**	2%	23
IN	357	389	362	355	437	396	404	419	417	**444**	0%	24
PA	316	335	334	336	331	359	373	368	422	**444**	6%	25
IL	333	336	331	364	363	351	385	409	426	**439**	4%	26
OK	333	332	339	343	360	370	374	391	408	**435**	4%	27
MI	310	314	316	320	309	330	344	365	376	**429**	7%	28
WA	332	343	355	369	373	384	392	404	410	**427**	3%	29
SC	289	270	271	329	340	337	362	383	399	**425**	5%	30
FL	352	358	367	372	383	392	380	391	404	**423**	2%	31
DC	315	251	283	326	329	342	365	377	400	**423**	5%	32
VA	339	358	355	314	377	297	414	424	409	**422**	2%	33
GA	311	324	343	351	378	391	398	386	392	**422**	2%	34
IA	314	328	339	346	352	353	380	388	404	**418**	4%	35
ID	290	290	302	311	316	337	347	363	393	**417**	6%	36
TN	274	334	331	335	355	368	365	373	390	**414**	3%	37
OH	312	337	345	354	365	388	398	401	393	**414**	3%	38
AL	308	314	323	328	339	351	374	385	389	**411**	4%	39
KY	315	333	336	341	350	368	380	399	386	**407**	3%	40
UT	272	297	304	317	333	343	354	365	374	**398**	4%	41
AZ	323	261	286	285	287	296	297	299	378	**391**	6%	42
MO	384	345	349	344	349	366	334	352	356	**382**	2%	43
MN	251	290	306	316	318	334	344	346	331	**377**	4%	44
MS	307	305	311	331	328	344	348	357	362	**374**	3%	45
HI	243	273	280	284	297	304	322	341	359	**374**	5%	46
TX	295	291	299	310	319	336	342	342	359	**367**	3%	47
NV	271	230	279	288	293	305	320	335	332	**352**	4%	48
AR	271	278	290	311	310	318	327	368	327	**351**	2%	49
KS	273	308	329	328	328	331	267	284	290	**313**	-1%	50
CA	291	249	204	220	240	256	235	295	256	**301**	5%	51

Source: HGA calculations, based on data from the NAIC.

41. Large Group Claims

Table 50.

NAIC Supplemental Exhibit DRAFT

Net Incurred Claims After Reinsurance, Per Member Month, Ranked by 2019 Level

Large Group (Insured) Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**280**	**283**	**290**	**295**	**321**	**331**	**342**	**346**	**361**	**380**	**3%**	
AK	485	435	475	474	533	563	575	594	669	**662**	4%	1
NH	379	393	393	394	412	419	457	465	483	**512**	4%	2
VT	312	327	343	362	361	395	407	459	456	**492**	6%	3
MA	364	369	383	384	396	411	431	446	454	**482**	4%	4
WV	336	332	361	392	364	395	391	408	451	**471**	5%	5
NJ	313	324	334	356	410	412	388	423	448	**468**	3%	6
ME	354	366	373	386	394	404	417	439	444	**475**	4%	7
MT	288	305	307	330	334	368	376	394	441	**443**	6%	8
WY	330	352	385	400	356	373	404	392	429	**485**	6%	9
NY	228	240	245	242	345	380	393	401	412	**427**	4%	10
NM	290	316	323	339	344	356	419	383	409	**442**	5%	11
MD	273	332	341	342	344	356	378	398	405	**442**	5%	12
OR	313	328	340	349	344	354	375	390	405	**425**	4%	13
WI	338	364	365	375	373	378	382	379	401	**417**	2%	14
CO	296	329	338	345	350	362	381	396	398	**400**	3%	15
ND	291	299	310	326	326	373	357	376	398	**417**	5%	16
SD	298	310	323	336	337	343	364	379	397	**413**	4%	17
CT	340	342	362	354	370	381	413	218	397	**461**	5%	18
NE	297	340	338	337	359	336	357	347	392	**393**	2%	19
DE	290	311	333	304	334	310	356	342	389	**462**	7%	20
RI	318	310	345	341	357	358	375	389	387	**407**	3%	21
NC	292	301	322	325	347	355	354	339	380	**414**	4%	22
IL	300	298	294	323	332	325	347	361	379	**392**	3%	23
PA	276	294	295	300	297	326	335	321	372	**402**	6%	24
LA	305	323	316	319	330	354	357	360	370	**398**	4%	25
IA	279	290	298	298	316	332	340	348	370	**368**	3%	26
IN	314	352	327	320	396	361	364	377	369	**389**	0%	27
VA	300	318	320	281	341	266	374	380	368	**380**	2%	28
FL	304	312	322	327	344	350	336	342	366	**375**	2%	29
AL	280	286	300	301	319	336	351	350	365	**388**	4%	30
GA	280	288	313	324	352	355	359	350	359	**392**	2%	31
WA	289	301	315	323	333	342	347	352	358	**376**	3%	32
OK	298	292	300	303	323	335	337	350	357	**388**	4%	33
SC	262	240	244	297	302	302	321	339	354	**370**	4%	34
ID	264	260	275	280	286	312	316	319	353	**371**	5%	35
OH	274	299	317	320	333	350	359	356	351	**364**	2%	36
DC	268	220	248	281	288	295	314	333	347	**367**	5%	37
TN	239	291	289	293	318	329	327	325	339	**358**	2%	38
KY	272	294	293	295	307	332	342	349	338	**355**	3%	39
UT	243	270	274	283	302	310	319	325	333	**356**	3%	40
MS	277	278	285	309	295	308	318	318	331	**349**	3%	41
AZ	281	226	244	246	255	264	265	262	329	**331**	5%	42
MI	279	277	277	281	270	294	305	313	327	**373**	7%	43
MO	335	298	307	300	308	329	293	315	319	**336**	2%	44
HI	231	252	258	264	272	282	291	315	318	**337**	4%	45
TX	262	257	266	278	287	306	314	304	312	**337**	3%	46
AR	238	245	258	274	279	290	297	327	292	**313**	2%	47
MN	222	254	280	284	287	297	310	313	287	**334**	3%	48
NV	229	198	235	250	263	270	287	285	285	**303**	3%	49
KS	244	274	296	290	296	302	235	250	259	**275**	-1%	50
CA	249	213	173	187	208	225	205	259	228	**269**	5%	51

Source: HGA calculations, based on data from the NAIC.

42. Large Group Administrative Costs

Table 51.

NAIC Supplemental Exhibit DRAFT

General Administrative, Claims Adjustment, Defined Quality Costs, Per Member Per Month, Ranked by 2019 Level

Large Group (Insured) Market

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Annual Growth 2014-2019	Rank
US	**31**	**29**	**30**	**31**	**33**	**34**	**35**	**35**	**38**	**41**	**4%**	
WY	27	29	29	32	29	25	22	25	55	**51**	12%	1
LA	35	31	29	36	38	39	40	50	51	**51**	6%	2
NJ	46	38	42	41	40	39	40	46	48	**56**	7%	3
SC	33	24	25	34	34	34	34	42	47	**48**	7%	4
AZ	40	31	32	32	28	29	32	33	47	**46**	11%	5
NY	26	24	23	25	39	42	40	45	46	**50**	5%	6
NH	37	37	37	39	38	39	41	43	46	**51**	6%	7
MA	36	39	39	39	41	40	41	41	46	**52**	5%	8
RI	48	43	41	44	55	46	42	45	45	**47**	-3%	9
VT	42	39	35	34	35	39	39	42	45	**47**	6%	10
KY	34	30	31	33	34	37	38	41	44	**45**	6%	11
NC	36	34	33	33	34	36	37	43	43	**47**	7%	12
NE	34	34	35	35	38	35	34	36	43	**54**	8%	13
MT	31	29	28	38	30	32	34	40	42	**44**	8%	14
AK	45	34	29	28	30	28	35	43	42	**55**	13%	15
MD	26	34	34	37	39	40	44	41	42	**43**	2%	16
MI	29	31	33	38	37	41	40	40	41	**49**	6%	17
DE	36	36	33	38	33	29	31	29	41	**41**	4%	18
PA	32	31	31	32	34	33	32	34	41	**40**	3%	19
NM	33	37	38	42	36	34	41	37	39	**47**	5%	20
OR	29	29	32	34	33	34	36	35	38	**40**	4%	21
MO	41	35	33	33	34	33	35	35	38	**40**	4%	22
WA	31	33	35	36	35	36	34	40	38	**44**	5%	23
CT	37	36	40	41	38	99	112	-152	38	**56**	8%	24
WI	31	32	33	35	37	37	37	38	37	**41**	2%	25
ID	28	29	29	29	28	31	33	34	37	**41**	8%	26
AR	27	32	30	31	32	33	34	41	37	**39**	4%	27
OK	34	31	31	31	33	32	33	36	37	**40**	4%	28
OH	36	29	29	30	29	33	34	39	37	**38**	5%	29
IN	29	26	26	25	31	32	34	33	36	**40**	5%	30
NV	51	27	31	30	29	31	32	34	36	**40**	7%	31
TN	31	37	38	34	36	36	36	35	36	**47**	5%	32
WV	33	31	31	33	35	30	27	29	36	**36**	1%	33
ME	29	28	31	32	30	31	31	35	36	**39**	6%	34
MS	27	29	30	33	36	40	38	39	36	**39**	1%	35
FL	37	36	37	32	37	33	33	35	36	**39**	1%	36
GA	32	31	31	32	30	31	35	34	35	**37**	5%	37
VA	27	27	27	25	31	23	34	34	35	**37**	3%	38
DC	42	24	27	32	28	29	32	45	35	**38**	6%	39
CO	30	33	31	33	36	35	35	36	35	**35**	-1%	40
ND	15	18	21	24	22	26	26	27	34	**37**	11%	41
IL	28	25	25	28	26	25	29	30	34	**35**	6%	42
SD	23	26	25	25	34	25	29	32	34	**37**	2%	43
MN	23	24	26	29	26	31	33	31	33	**33**	5%	44
IA	31	31	32	28	33	31	36	33	33	**35**	1%	45
TX	29	29	28	27	27	27	29	33	33	**34**	4%	46
KS	25	31	35	33	32	31	27	30	30	**33**	0%	47
UT	27	26	25	26	26	27	29	31	30	**32**	5%	48
HI	21	19	21	22	22	24	26	30	29	**34**	9%	49
CA	35	30	24	26	25	26	23	33	27	**34**	6%	50
AL	16	16	17	18	18	20	20	22	24	**26**	7%	51

Source: HGA calculations, based on data from the NAIC.

V. Current Market Status, Covid-19 Update, Baseline Projections to 2024

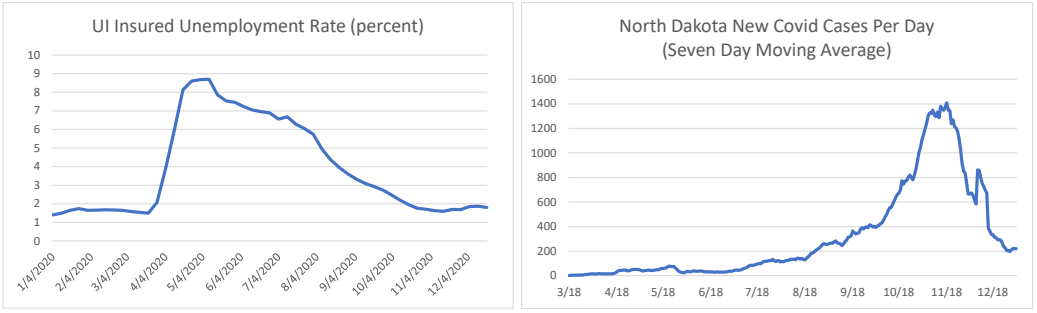
To estimate the impact of alternative policies, we begin by creating a benchmark or "baseline" estimate of the status quo. These baseline projections are not necessarily intended to be forecasts of the future. In light of the Covid-19 pandemic, any projections at this time are particularly uncertain. Nevertheless, working out a coherent set of projections is a key first step toward evaluating the impact of policy changes.

For North Dakota's hospital and insurance claims baselines we started by looking at the impact of the Covid-19 pandemic and the national recession on the state's overall economy and the state budget. 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.

Covid-19 and Impact on Unemployment. As of late July, North Dakota's total active caseload was about 1,000 cases and the number of new cases diagnosed over the prior week was about 120 per day. Statewide, only 42 patients were hospitalized. However, the number of cases rose steadily in July and the test positivity rate increased to nearly 7 percent.[23] The July 26 federal report to the states showed North Dakota in the "Red Zone" (highest risk) for outbreak.[24]

Between March 14th and July 11th, more than 80,000 North Dakota residents filed initial unemployment insurance (UI) claims.[25] For perspective, during the full year 2019 only 25,000 initial claims were filed. The state's insured unemployment rate (the ratio of people receiving unemployment benefits to those covered by the unemployment compensation system) rose to nearly 9 percent in April before returning to less than 2 percent in November (see Figure 22). However, the return to full employment corresponded with a large increase in the number of Covid cases.

Figure 22.



Sources: U.S. Dept. of Labor. https://oui.doleta.gov/unemploy/wkclaims/report.asp and NYTimes Covid Database https://raw.githubusercontent.com/nytimes/covid-19-data/master/us-states.csv (accessed Jan 3, 2021).

[23] https://www.health.nd.gov/diseases-conditions/coronavirus/north-dakota-coronavirus-cases (accessed July 25, 2020) and https://coronavirus.jhu.edu/testing/individual-states/north-dakota (accessed July 25, 2020).
[24] https://www.nytimes.com/interactive/2020/07/28/us/states-report-virus-response-july-26.html
[25] US Dept of Labor, https://oui.doleta.gov/unemploy/claims.asp (accessed July 27, 2020).

State Budget Impact of the Covid-19 Recession and Oil Price Changes. Table 52 shows our rough approximated model of the state's main expenditure and revenue categories. We used data from the National Association of State Budget Officers (NASBO)[26], supplemented with some data from the state's biennial reports.[27] Although this budgetary model is highly simplified, one relationship sort of jumps off the page: the correlation between the annual percent change in state oil and gas revenues and that of total state expenditures (see Figure 23).

Table 52.

Approximated North Dakota Main Sources and Uses of State Funds (for modeling only) DRAFT

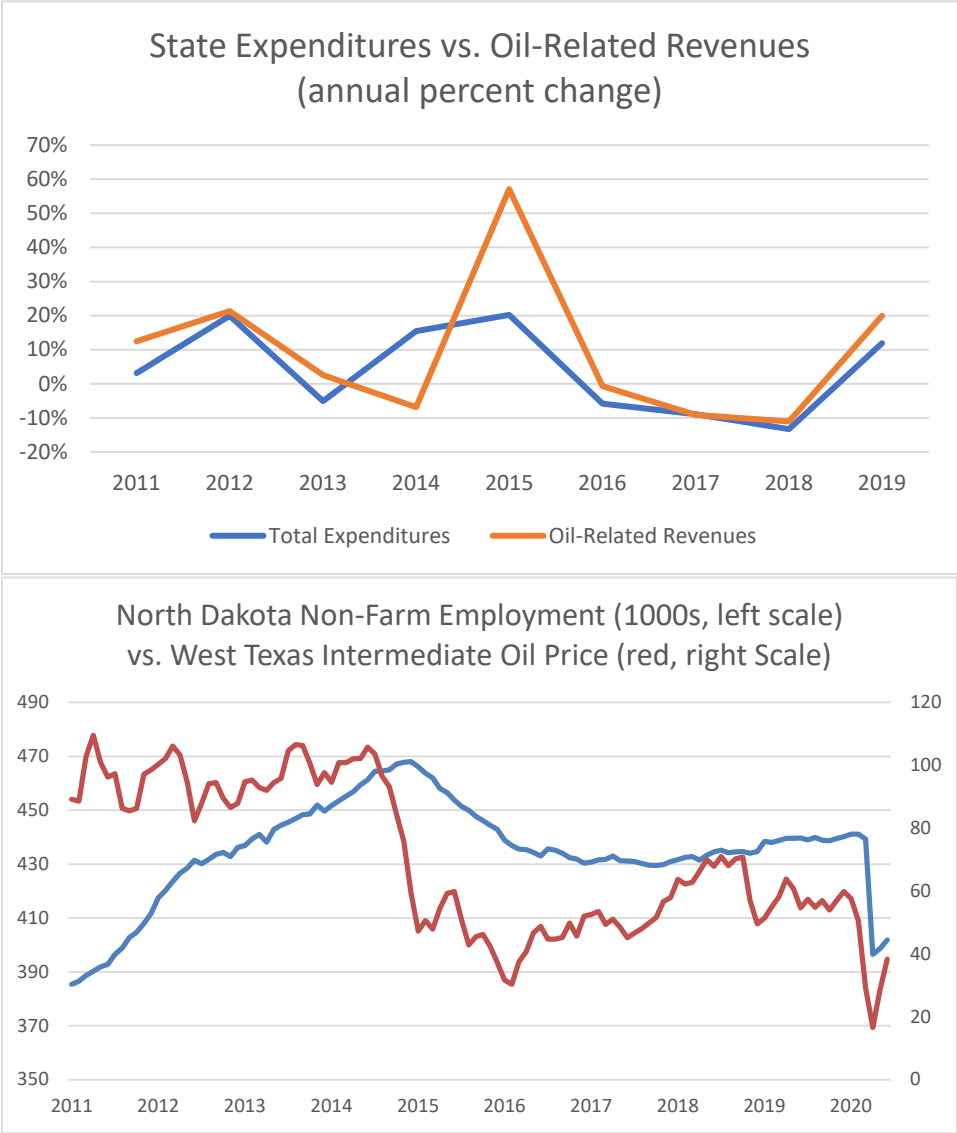
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Main State Expenditures					**Million of Dollars**					
Education	1,831	1,825	1,898	1,943	2,180	2,256	2,430	2,395	2,330	2,793
Medicaid	662	716	730	782	849	1,110	1,146	1,112	1,220	1,199
Transportation	546	620	987	918	1,252	1,668	1,826	969	679	645
Capital Expenditures	579	580	928	749	957	1,062	1,015	860	534	673
Other Expenditures	1,248	1,277	1,477	1,320	1,354	1,827	1,042	1,456	1,126	1,281
Total	4,866	5,018	6,020	5,712	6,592	7,923	7,459	6,792	5,889	6,591
Main Sources of State Revenues										
Oil Related Revenues	1,394	1,568	1,902	1,950	1,816	2,853	2,832	2,574	2,289	2,746
General Tax Revenues										
Sales Taxes	610	782	1,154	1,296	1,350	1,405	1,031	908	944	1,079
Income Taxes	302	428	430	616	514	536	354	313	364	414
Corporate Income Tax	88	147	199	187	239	196	98	69	92	148
Other Revenues	1,441	1,561	2,321	2,449	2,688	2,679	2,444	2,337	2,258	2,411
Total, General Fund	1,529	1,708	2,520	2,636	2,927	2,875	2,542	2,406	2,350	2,559
Federal Medicaid Spending	467	493	419	421	455	672	730	689	754	726
Federal Transport Spending	328	360	533	353	306	295	246	303	255	318
Federal Education Spending	388	308	294	259	245	142	257	257	258	355
Other Federal Funding	674	653	638	503	517	604	374	367	205	240
Total	4,780	5,090	6,306	6,122	6,266	7,441	6,981	6,596	6,111	6,944
Surplus (+) or Deficit (-)	-86	72	286	410	-326	-482	-478	-196	222	353
Main State Expenditures					**Annual Percent Change**					
Education		0%	4%	2%	12%	3%	8%	-1%	-3%	20%
Medicaid		8%	2%	7%	9%	31%	3%	-3%	10%	-2%
Transportation		14%	59%	-7%	36%	33%	9%	-47%	-30%	-5%
Capital Expenditures		0%	60%	-19%	28%	11%	-4%	-15%	-38%	26%
Other Expenditures		2%	16%	-11%	3%	35%	-43%	40%	-23%	14%
Total		3%	20%	-5%	15%	20%	-6%	-9%	-13%	12%
Main Sources of State Revenues										
Oil Related Revenues		12%	21%	3%	-7%	57%	-1%	-9%	-11%	20%
General Tax Revenues										
Sales Taxes		28%	48%	12%	4%	4%	-27%	-12%	4%	14%
Income Taxes		42%	0%	43%	-17%	4%	-34%	-12%	16%	14%
Corporate Income Tax		67%	35%	-6%	28%	-18%	-50%	-30%	33%	61%
Other Revenues		8%	49%	6%	10%	0%	-9%	-4%	-3%	7%
Total, General Tax Revenues		12%	48%	5%	11%	-2%	-12%	-5%	-2%	9%
Federal Medicaid Spending		6%	-15%	0%	8%	48%	9%	-6%	9%	-4%
Federal Transport Spending		10%	48%	-34%	-13%	-4%	-17%	23%	-16%	25%
Federal Education Spending		-21%	-5%	-12%	-5%	-42%	81%	0%	0%	38%
Other Federal Funding		-3%	-2%	-21%	3%	17%	-38%	-2%	-44%	17%
Total		6%	24%	-3%	2%	19%	-6%	-6%	-7%	14%

Source: HGA based on data from NASBO -- DRAFT for modeling only

[26] https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives

[27] https://www.legis.nd.gov/files/fiscal/2019-21/docs/2019-21_state_budget_actions.pdf

Figure 23.



Source: HGA based on data from NASBO, St. Louis Fed, BLS.

Hospital Financial Status Pre- and Post- Covid-19. Nationally, estimates of the potential costs of Covid-19 care over the course of the pandemic are as high as $160 billion.[28] However, when other analyses accounted for the possibility of reduced or deferred elective or unrelated care, they estimated a net health expenditure *savings* of $75 to $575 billion in 2020 alone.[29]

Of course, this huge range of costs and savings illustrate the uncertainty. Much will depend on whether a cure or vaccine is found, and whether the cost would be borne by government or private payers.

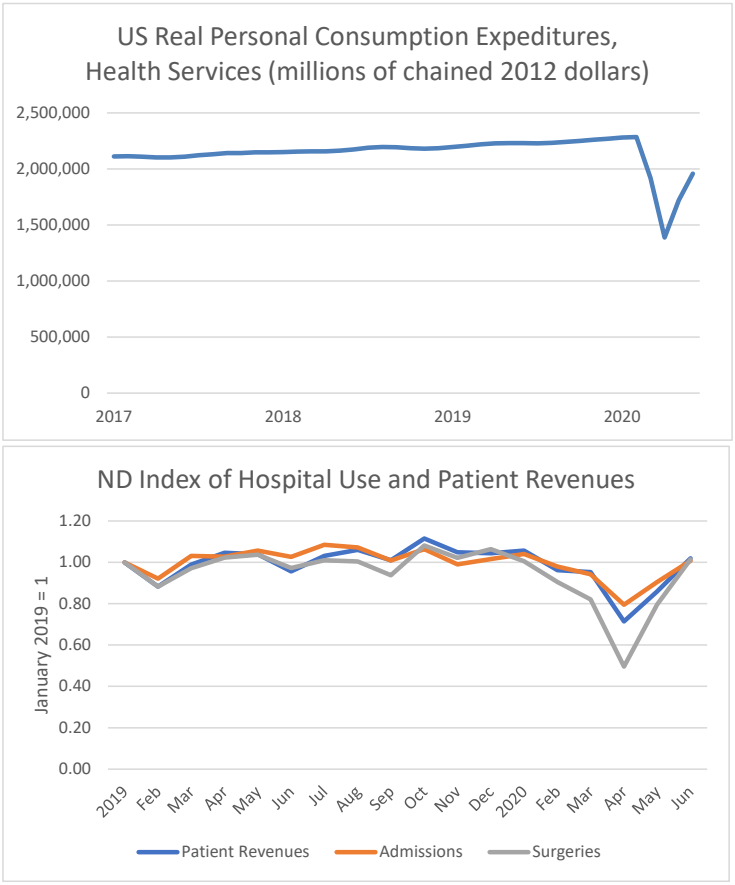
[28] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00426
[29] https://us.milliman.com/en/insight/estimating-the-impact-of-covid19-on-healthcare-costs-in-2020

In the first quarter of 2020, the nationwide reductions in health spending from reduced or deferred care were much larger than the cost of Covid-19 care. Based on initial GDP estimates, U.S. personal consumption expenditures for health care fell by about 15 percent between February 2020 and June 2020 (see Figure 24).[30]

The pandemic and recession have also hurt total payrolls, including the health sector. Nationwide, hospitals and outpatient centers shed 2 percent of payrolls between June 2019 and June 2020, with larger percentage losses for other types of health services. Among all industries, jobs were down 9 percent during that period (see Table 53).

However, in North Dakota, hospital admissions and patient revenues had mostly bounced back to prior levels by June 2020. And during the state's surge in Covid cases in September through November 2020, HGA estimates that claims costs in the state were likely running about 5-10 percent higher than in those same months in 2019.

Figure 24.



Sources: US: Bureau of Economic Analysis; ND Horizon Government Affairs.
Note: ND index of patient revenues does not include federal emergency funding or other sources of non-patient revenues.

[30] https://apps.bea.gov/iTable/iTable.cfm?reqid=19&step=3&isuri=1&1910=x&0=-99&1921=underlying&1903=2015&1904=2016&1905=2018&1906=m&1911=0 (accessed July 30, 2020).

Table 53.

U.S. Totals, Change in Jobs, June 2019 to June 2020

Millions of payroll jobs

	June 2019	June 2020	Job Loss	Percent
Total Nonfarm Payrolls (all industries)	**150,759**	**137,802**	**-12,957**	**-9%**
Health Care	16,250	15,603	-647	-4%
Ambulatory Health Care Services	7,681	7,295	-386	-5%
Offices of Physicians	2,670	2,570	-100	-4%
Offices of Dentists	967	875	-92	-10%
Offices of Other Health Practitioners	966	866	-100	-10%
Outpatient Care Centers	961	937	-24	-2%
Medical and Diagnostic Laboratories	282	266	-16	-6%
Home Health Care Services	1,523	1,483	-40	-3%
Other Ambulatory Health Care Services	312	299	-13	-4%
Hospitals	5,192	5,112	-80	-2%
Nursing and Residential Care Facilities	3,378	3,197	-182	-5%

Source: Bureau of Labor Statistics.

At this point, our assumption is that the state's Covid-19 costs and the short-term savings from deferred or delayed care approximately netted out in 2020, and that final year-end results will likely show that claims costs for the year came close to pre-Covid expectations. The outlook for 2021 remains uncertain, but for this report, we have not changed our assumptions about future hospital costs compared with the September interim report. Likewise, we have only adjusted our assumptions on future insurance costs slightly, based on the latest approved rates for 2021.

Table 54 shows our baseline reconstruction of the state's 9 largest hospitals' aggregated results from 2015-2019 and our preliminary pre-Covid-19 baselines to 2024. We assumed some slowing in hospital wage and benefit growth, and a slowing of the growth of non-patient revenues (including philanthropy) that had been propping up the hospital sector's margins in 2018 and 2019. Note we are assuming a somewhat lower total margin for the sector (3-4%) than had been achieved in the mid-2010s (5-6%).

Table 54.

Baseline Hospital Cost and Revenue Projections -- Large ND Hospitals
Aggregate Revenues and Expenses (AHA Data vs. HCRIS), All Nine Reporting Hospitals

(by calendar year, in millions)	2015	2016	2017	2018	2019	2020	2021	DRAFT PROJECTED 2022	2023	2024
AHA Data					**AHA-Style Data**					
Payroll	1,360	1,467	1,561	1,631	1,681	1,756	1,835	1,917	2,002	2,092
Benefits	242	271	288	298	309	325	343	361	380	401
Total, Wages and Benefits	1,602	1,739	1,850	1,929	1,990	2,082	2,177	2,278	2,382	2,492
Interest Expense	42	43	46	49	47	50	52	54	56	59
Other Expenses	1,395	1,459	1,532	1,649	1,747	1,813	1,900	2,010	2,127	2,250
Total, Expenses	3,038	3,240	3,428	3,627	3,784	3,944	4,129	4,342	4,565	4,801
Patient Revenues	3,072	3,221	3,360	3,495	3,598	3,669	3,854	4,048	4,252	4,466
Non-Patient, Non-Oper. Rev.	170	183	203	256	327	387	424	464	507	555
Total, Revenues	3,241	3,404	3,563	3,751	3,925	4,057	4,278	4,512	4,759	5,021
Margin	203	164	135	124	140	112	149	170	194	220
Margin %	6%	5%	4%	3%	4%	3%	3%	4%	4%	4%
					Growth Rate					
Payroll	8%	8%	6%	4%	3%	4%	4%	4%	4%	4%
Benefits	10%	12%	6%	3%	4%	5%	5%	5%	5%	5%
Total, Wages and Benefits	8%	9%	6%	4%	3%	5%	5%	5%	5%	5%
Interest Expense	8%	2%	9%	6%	-4%	4%	4%	4%	4%	4%
Other Expenses	6%	5%	5%	8%	6%	4%	5%	6%	6%	6%
Total, Expenses	7%	7%	6%	6%	4%	4%	5%	5%	5%	5%
Patient Revenues	9%	5%	4%	4%	3%	2%	5%	5%	5%	5%
Non-Patient, Non-Oper. Rev.	-15%	8%	11%	26%	27%	19%	9%	9%	9%	9%
Total, Revenues	7%	5%	5%	5%	5%	3%	5%	5%	5%	5%
Margin	8%	-19%	-17%	-9%	13%	-20%	32%	14%	14%	14%
Medicare Cost Reports					**HCRIS Data**					
Total Wages and Benefits	1,572	1,650	1,711	1,744	1,800	1,882	1,969	2,059	2,154	2,253
Interest Expense	42	43	48	52	50	53	55	57	60	62
Other Expenses	1,537	1,667	1,766	1,851	1,960	2,035	2,132	2,256	2,387	2,525
Operating Expenses	3,152	3,361	3,526	3,647	3,810	3,970	4,156	4,373	4,601	4,841
Patient Revenues	3,190	3,323	3,419	3,532	3,636	3,708	3,895	4,091	4,297	4,514
Non-Patient, Non-Oper. Rev.	155	192	230	239	305	361	395	432	473	517
Total, Revenues	3,344	3,514	3,649	3,771	3,941	4,070	4,290	4,523	4,770	5,031
Margin	155	192	230	239	131	100	134	151	169	190
Margin %	5%	5%	6%	6%	3%	2%	3%	3%	4%	4%

Source: Tabulations and calculations by Horizon Government Affairs. HCRIS data as processed by RAND vintage 11-4-2019.

Table 55 below shows the underlying utilization assumptions behind the revenues and expenses projected in Table 56. We followed recent trends in North Dakota's expected hospital utilization, with very slow growth in admissions, approximately zero growth in inpatient days, and a slow downward trend in average length of stay. Medicare utilization will likely grow faster than that of Medicaid and private insurance enrollees.

Currently, we estimate that hospital patient revenues are growing more slowly than expenses in North Dakota. To re-balance revenues and expenses within the projection period from 2020 to 2024, we lowered the recent average growth of wages and benefits by one percentage point per year, to about 4.5 percent per year, and reduced the growth of "other" expenses considerably in 2020 and 2021. On the other hand, we assumed the growth of interest expenses would be about 1 percentage point higher per year during the projection period, reflecting current capital expenditure trends (but also assuming very low interest rates). Finally, we lowered the growth of non-patient revenues from its recent extraordinary growth rate of over 25 percent per year to 18 percent in 2020 and about 10 percent in 2021-2024.

The bottom line is that recent revenue growth has been lower than recent expense growth, particularly if we assume the growth of non-patient revenues slows from recent extremely high rates. Thus, to maintain margins, we expect North Dakota hospitals will be required to lower their rate of growth in expenses. We reflect this in the projections.

As a group, the state's hospitals seem to be in good financial condition. However, the hospital sector's financial outlook likely worsened in 2019, and several individual hospitals seem to be in precarious financial situation. Moreover, there are large construction projects in place or in the pipeline that could further squeeze hospital's finances in coming years, with an uncertain payoff down the road.

Table 55.

Baseline Hospital Cost and Revenue Projections -- Large ND Hospitals
Aggregate Utilization Measures (AHA Data vs. HCRIS)

Nine Responding Plans									DRAFT PROJECTED	
(by calendar year)	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Admissions					**AHA Historical Data**					
Medicare	32,892	33,266	34,081	34,850	35,016	35,569	36,131	36,702	37,282	37,871
Medicaid	13,287	15,540	15,659	16,227	16,447	17,381	18,367	19,410	20,511	21,676
Private/Other	34,288	29,914	30,295	30,009	31,147	31,575	32,009	32,449	32,895	33,347
Total	80,467	78,719	80,034	81,085	82,610	83,166	83,726	84,289	84,857	85,428
Days										
Medicare	179,089	175,646	172,764	175,152	173,370	173,687	174,004	174,321	174,640	174,959
Medicaid	73,616	83,832	84,841	86,288	86,551	90,250	94,106	98,127	102,321	106,693
Private/Other	125,119	119,596	113,605	114,437	120,147	119,035	117,933	116,842	115,761	114,690
Total	379,124	379,073	371,210	375,877	380,068	380,338	380,609	380,880	381,151	381,422
Inpatient Surgeries	24,696	24,635	24,718	24,202	24,156	24,156	24,156	24,156	24,156	24,156
ED Visits	256,880	253,005	246,322	244,994	247,200	247,200	247,200	247,200	247,200	247,200
Outpatient Visits	2,156,467	2,171,771	2,109,200	2,061,083	2,013,684	2,013,684	2,013,684	2,013,684	2,013,684	2,013,684
Outpatient Surgeries	68,218	68,734	69,183	69,905	69,564	69,564	69,564	69,564	69,564	69,564
Beds	1,638	1,631	1,668	1,700	1,675	1,675	1,675	1,675	1,675	1,675
Occupancy Rate	63.4%	63.7%	61.0%	60.6%	62.2%	62.2%	62.3%	62.3%	62.3%	62.4%
Average Length of Stay (days per admission)										
Medicare	5.4	5.3	5.1	5.0	5.0	4.9	4.8	4.7	4.7	4.6
Medicaid	5.5	5.4	5.4	5.3	5.3	5.2	5.1	5.1	5.0	4.9
Private/Other	3.6	4.0	3.8	3.8	3.9	3.8	3.7	3.6	3.5	3.4
Weighted Average	4.7	4.8	4.6	4.6	4.6	4.6	4.5	4.5	4.5	4.5
Overall Utilization Index, 2010	1.15	1.14	1.13	1.13	1.13	1.14	1.14	1.14	1.14	1.14
Admissions					**HCRIS Data**					
Medicare	28,782	29,288	30,106	30,354	30,499	30,981	31,470	31,968	32,473	32,986
Medicaid	10,145	11,133	10,850	11,555	11,712	12,377	13,079	13,822	14,606	15,435
Private/Other	35,500	35,670	36,442	35,008	36,336	36,836	37,342	37,855	38,375	38,903
Total	74,428	76,092	77,398	76,917	78,364	78,892	79,422	79,957	80,495	81,037
Days										
Medicare	147,385	149,090	148,579	148,875	147,360	147,629	147,899	148,169	148,439	148,711
Medicaid	70,929	73,126	71,768	69,828	70,042	73,035	76,156	79,410	82,803	86,341
Private/Other	130,901	130,184	130,771	132,611	139,228	137,939	136,663	135,398	134,145	132,904
Total	349,215	352,400	351,118	351,315	355,232	355,485	355,738	355,991	356,244	356,497
Beds	1,436	1,452	1,475	1,475	1,472	1,472	1,472	1,472	1,472	1,472
Occupancy Rate	66.6%	66.5%	65.2%	65.2%	66.1%	66.1%	66.2%	66.2%	66.3%	66.3%
Average Length of Stay (days per admission)										
Medicare	5.1	5.1	4.9	4.9	4.8	4.8	4.7	4.6	4.6	4.5
Medicaid	7.0	6.6	6.6	6.0	6.0	5.9	5.8	5.7	5.7	5.6
Private/Other	3.7	3.6	3.6	3.8	3.8	3.7	3.7	3.6	3.5	3.4
Weighted Average	4.7	4.6	4.5	4.6	4.5	4.5	4.5	4.5	4.4	4.4

Source: Horizon Government Affairs. HCRIS data via RAND, vintage 11-4-19.
Note: Average annual growth rate is 2010-2019 for AHA data; 2010-2018 for HCRIS data.
\a Overall utilization composite index is calculated by HGA using data from the AHA survey responses. It is not an AHA calculation.

Preliminary Individual Insurance Market Projections. Tables 56-59 below show how these projections of hospital spending fold into our projections of insurance coverage and individual market claims and premiums. Tables 56 and 57 summarize the individual, small group, and large group (non-ERISA) markets. These are the markets regulated by the state. Table 58 and 59 show additional detail on the individual market.

Our baseline projects that premiums will increase by about 5 percent per year beginning in 2021. Note that in the individual market we account for North Dakota's state-led reinsurance program within the claims account – that program is the primary reason premiums are expected to be about 9 percent lower in 2020 than in 2019. We estimate that the Covid-19 recession will reduce private coverage in all markets in 2020, but that the magnitude of the coverage losses in North Dakota will be relatively small, less than 5 percent. Based on CMS data from 2020 open enrollment, we had assumed an increase in individual market coverage in 2020, due to the reductions in premiums associated with North Dakota's reinsurance program. However, we now expect slightly declining enrollment due to affordability issues, particularly among unsubsidized enrollees with ACA coverage.

HGA conducted an interview with a pandemic modeling expert at a large health insurer outside the state. They also expected considerable deferrals of care, but were cautious about the 2021 outlook, particularly regarding the cost of possible Covid-19 vaccines and treatments. In general, her expectation was that about half of delayed care would be simply deferred, and would resume in 2021. However, in her model some deferred or delayed care would result in worse outcomes; other patients would simply decide not to get their previously anticipated care.

On balance, we have made only slight adjustments to premiums for 2021 and later years, compared with the September report. In particular, we slightly reduced expected premium growth in the small group market for 2021, based on the latest approved rates from NDID.[31]

Table 56.

Baseline Enrollment Model			DRAFT							
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
					Number of Covered Lives					
Individual	53,234	51,183	48,968	45,294	43,747	41,547	41,538	41,581	41,673	41,810
Small Group Employer	64,424	62,179	60,381	60,028	61,351	59,314	58,531	57,173	55,846	54,550
Large Group Employer	149,872	151,322	149,111	154,872	156,685	152,178	152,365	152,553	153,504	154,461
Large Group ERISA	190,304	189,799	211,608	200,800	201,187	197,551	195,957	196,335	196,713	197,093
Medicaid	65,540	67,264	63,206	68,963	73,767	75,170	76,599	78,056	79,540	81,053
Medicare	105,960	107,637	109,495	112,338	114,549	116,803	119,102	121,447	123,837	126,274
Military	18,200	18,600	11,700	16,500	15,100	15,100	15,100	15,100	15,100	15,100
Other Coverage	18,866	20,917	17,032	15,506	14,645	13,832	13,064	12,339	11,654	11,006
Uninsured	60,000	57,000	54,500	56,300	49,969	60,915	61,565	60,654	58,788	56,728
Total Population	726,400	725,900	726,000	730,600	731,000	732,410	733,822	735,237	736,655	738,076
Memorandum:										
Estimated Medicaid Expansion Population				21,100	22,570	26,373	24,576	25,044	25,520	26,005

Source: Horizon Government Affairs.

[31] https://www.insurance.nd.gov/news/godfread-announces-approved-2021-health-insurance-rates.

Table 57.

Baseline State Premiums Model DRAFT

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
					Covered Lives					
Individual Market	53,234	51,183	48,968	45,294	43,747	41,547	41,538	41,581	41,673	41,810
Small Group	64,424	62,179	60,381	60,028	61,351	59,314	58,531	57,173	55,846	54,550
Large Group	149,872	151,322	149,111	154,872	156,685	152,178	152,365	152,553	153,504	154,461
					Premiums (millions)					
Individual Market	236	248	239	254	269	233	240	255	272	290
Small Group	303	295	300	319	344	354	355	363	375	387
Large Group	722	735	753	806	848	889	935	984	1,041	1,101
					Premiums PMPM					
Individual Market	369	404	407	467	512	468	481	511	543	577
Small Group	401	397	422	447	467	498	506	529	559	591
Large Group	388	402	419	440	451	487	511	538	565	594
					Growth PMPM					
Individual Market	13.1%	9.5%	0.8%	14.6%	9.9%	-8.7%	2.8%	6.3%	6.2%	6.2%
Small Group	8.4%	-0.8%	6.3%	5.9%	4.4%	6.6%	1.6%	4.6%	5.6%	5.6%
Large Group	5.9%	3.4%	4.4%	4.8%	2.5%	7.9%	5.1%	5.1%	5.1%	5.1%

Source: Horizon Government Affairs.

Table 58.

Individual Coverage Baseline Estimates (HGA) DRAFT

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Individual Market										
ACA										
On Exchange					**Covered Lives**					
APTC Only	7,223	7,731	7,360	7,798	9,964	10,123	10,285	10,449	10,615	10,785
APTC/CSR	7,021	8,234	9,039	9,095	8,604	7,867	7,993	8,120	8,250	8,381
No Subsidy	2,407	2,726	2,948	2,749	2,693	2,559	2,585	2,611	2,638	2,665
Total, On Exchange	16,651	18,691	19,347	19,642	21,261	20,549	20,862	21,180	21,503	21,831
Off Exchange	19,678	21,736	21,023	17,750	15,224	14,324	14,542	14,764	14,989	15,218
Total, ACA	36,329	40,427	40,370	37,392	36,485	34,873	35,404	35,944	36,492	37,049
Transitional and Grandfathei	16,905	10,756	8,598	7,902	7,262	6,674	6,134	5,637	5,181	4,761
Total, Individual	53,234	51,183	48,968	45,294	43,747	41,547	41,538	41,581	41,673	41,810
Individual Market					**Premiums PMPM**					
On Exchange (CMS)	363	403	398	450	496	453	466	495	526	559
Total ACA (NDID/Novarest)	371	412	407	476	523	478	491	522	555	589
Total, Individual Market	369	404	407	467	512	468	481	511	543	577
Individual Market					**Growth**					
On Exchange (CMS)	9%	11%	-1%	13%	10%	-9%	3%	6%	6%	6%
Total ACA (NDID/Novarest)	9%	11%	-1%	17%	10%	-9%	3%	6%	6%	6%
Total, Individual Market	13%	9%	1%	15%	10%	-9%	3%	6%	6%	6%
Individual Market					**Aggregate Premiums (millions)**					
On Exchange (CMS)	72	90	92	106	127	112	117	126	136	146
Total ACA (NDID/Novarest)	162	200	197	214	229	200	209	225	243	262
Total, Individual Market	236	248	239	254	269	233	240	255	272	290
Memorandum -- Individual Market Model Parameters										
Average Deductible, Individu	2,300	2,500	2,900	3,600	4,000	4,500	4,800	5,100	5,400	5,700
Loss Ratio, Individual Market	89%	89%	97%	95%	90%	87%	87%	87%	87%	87%

Source: Horizon Government Affairs Baseline for modeling only -- not a prediction.

Table 59.

Individual Market Accounting Model DRAFT
(millions of dollars)

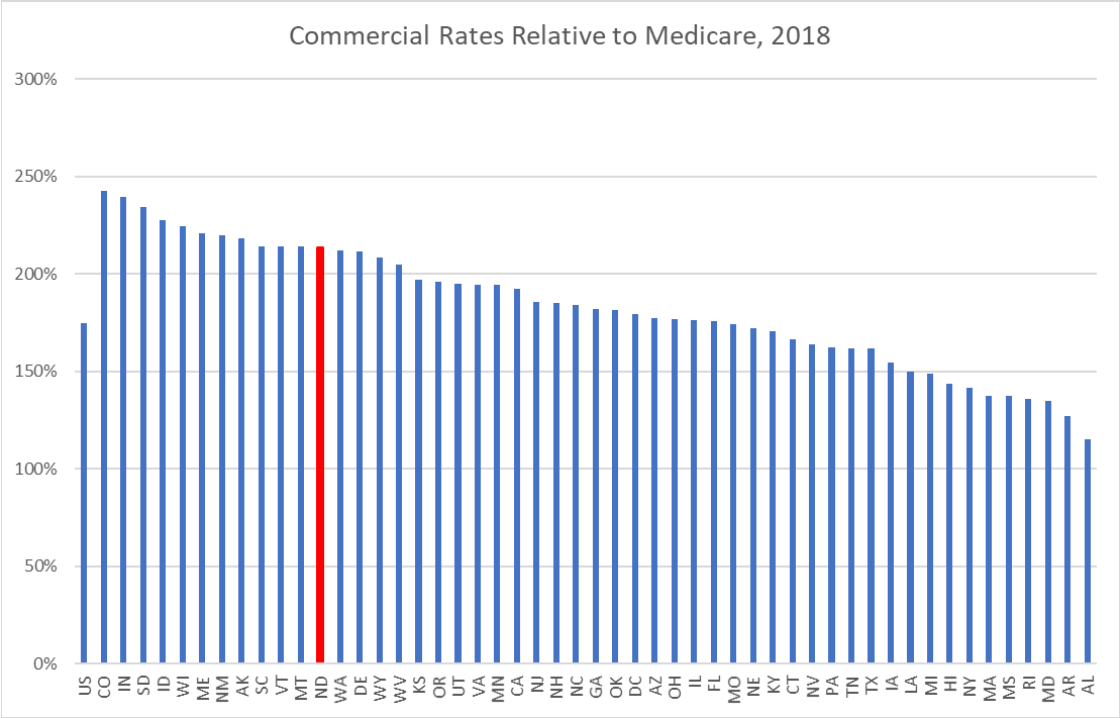
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Premiums	236	248	239	254	269	233	240	255	272	290
Claims										
Non-Pharmaceutical	181	188	183	179	193	155	164	174	185	196
Pharmaceutical Claims	37	45	47	50						
Rebates	5	5	7	10						
Net, Pharmaceutical Claims	32	40	40	39	41	42	45	48	52	56
Total, Incurred Claims	213	227	226	223	234	197	209	222	237	252
General and Administrative Costs, Claims Processing	19	21	20	25	26	27	28	28	29	30
Taxes and Assessments	18	12	9	9	9	9	9	9	9	9
Defined Expenses for Health Quality	1	1	1	1	1	1	1	1	1	1
Other and Reinsurance (net)	-14	-2	-6	-2	-2	-2	-2	-2	-2	-2
Net Underwriting Gain (+) or Loss (-)	5	-15	-9	-1	1	2	-5	-3	-2	-1
Memo										
Loss Ratio	90%	92%	95%	88%	87%	84%	87%	87%	87%	87%
Private/Medicare Rate Ratio	1.94	2.05	1.94	2.07	2.12	2.16	2.21	2.26	2.31	2.37

Source: Horizon Government Affairs, based on data from NAIC.

National Policy Outlook. Post-Covid-19, federal health policy remains extremely uncertain. Our preliminary baseline projections of North Dakota health costs will assume no major policy changes at the federal level that would affect the state's health markets before 2024.

However, in the longer run, the mismatch between Medicare and commercial rates is unstable, and likely unsustainable. North Dakota's rates are among the highest in the country (see Figure 25). Under Democratic control of the White House and Congress, we would expect legislation expanding subsidies for ACA coverage, and regulations rolling back some of the Trump Administration's relaxations of rules on state-based 1332 waivers. Less likely policy changes could include allowing commercial plans to use some multiple of Medicare rates, and/or allowing health plans to offer Medicare or MA-type coverage to broader populations, again using some multiple of Medicare rates. Even less likely would be a more direct Medicare "buy-in" for some of the population (perhaps for people aged 55+ or in the individual market).

Figure 25.



Source: HGA based on HCRIS/Rand data.

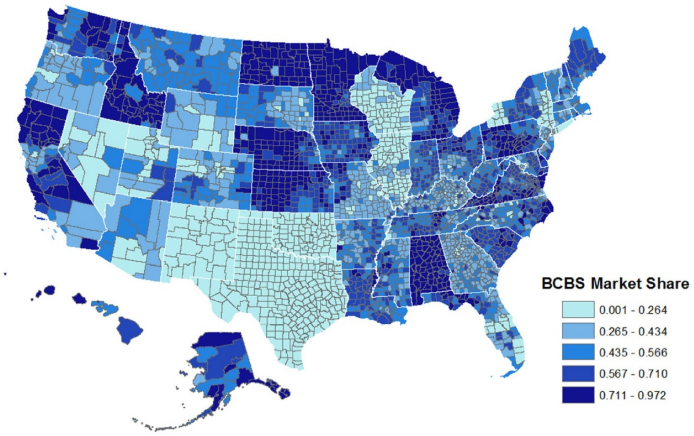
Competition and Markets. Although several insurers serve the North Dakota market, the dominant presence is Blue Cross Blue Shield of North Dakota (see Figure 26), particularly in the individual market. Two metro areas (Bismarck and Fargo) host two hospitals; other cities and towns in North Dakota have at most one. Sanford Health Group owns the state's two fastest-growing hospitals, and accounts for more than 50 percent of the state's hospital expenses among the state's 6 large acute care facilities (see Figure 27).

From an outsider's perspective at least, there may be some areas of concern in the state's health care markets. Sanford Health 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.[32] BCBS was recently fined following a market conduct exam, based on findings of improper payments for telehealth, mental health, and other services.[33]

[32] 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).

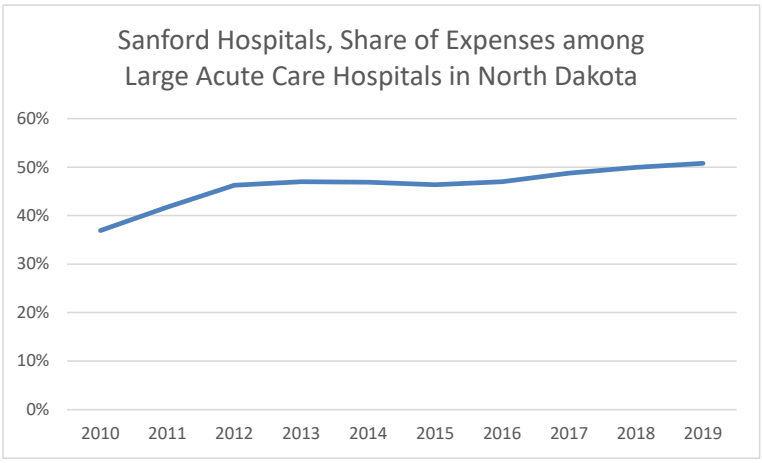
[33] See https://www.insurance.nd.gov/news/insurance-commissioner-fines-blue-cross-blue-shield-north-dakota-125000-result-market-conduct and https://www.nd.gov/ndins/sites/www/files/documents/Enforcement/Market%20Conduct%20Exams/2018-19%20BCBSND%20Exam%20Report%20-%20Signed%20-%20FINAL.pdf.

Figure 26.
Estimated Blue Cross Blue Shield Market Share, by County



Source: 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.

Figure 27.



Source: Horizon Government Affairs.

North Dakota has a limited managed care footprint and relatively low use of value-based payment methods, population health efforts or care coordination programs. Based on our interviews, the state seems mostly stuck in 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.

Certainly, North Dakota is not unique in this regard. On a nationwide basis, the Covid-19

pandemic has exposed problems with existing markets for health care delivery and financing. For example, the lack of telehealth infrastructure and financing may be a symptom of broader market dysfunction – call it market "lethargy" or market "stagnation" – the inability of existing markets to produce the sort of dynamism we expect from competitive systems.

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.

So 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.

The Covid-19 crisis might be a very good spur to revisit those efforts. 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.

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. 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.

VI. Policy Alternatives and Options

In this section, we describe several policy alternatives for consideration by North Dakota policymakers. For some of the policies, we have also provided preliminary cost and impact modeling in the subsequent section below.

Some of the policy alternatives suggested are mutually exclusive. Ultimately, policy choices reflect value judgements, and it is not our job to substitute our judgment for that of the North Dakota's Legislature, the Governor or Insurance Commissioner. We have provided, what we hope, is sufficient information for policymakers and stakeholders to start charting a path forward toward lowering health insurance premiums, lowering overall health care costs, and providing better population health for North Dakotans. Below you will find 15 policy alternatives in five themes, as shown below**.**

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 noted in the footnote.[34]

Utilization & Care Management

1. **Benchmark Plan Revisions - Optimized Medication Plans**
2. **Private Insurance (Group) Mandate - Optimized Medication Plans**
3. **Integrated Health Homes**
4. **Strict Managed Care/Value-Based Benefit Design**

Prices, Coverage and Insurance Initiatives

5. **Caps on Out-of Network Rates**
6. **Telehealth**
7. **Private Reinsurance**

Transparency

8. **Direct To Consumer Pricing**

[34] 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 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 horizondc.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.

9. **Public Policy Price Disclosures**
10. **Right To Shop**

Program Integrity

11. **Medicaid Integrity Audit**
12. **State Group Health Integrity Audit**
13. **State Group Health Waiver**
14. **Coordination Of Benefits**

Crisis & Pandemic Planning

15. **Risk Assessments**

Utilization and Care Management. Health care policy analysts have long touted the potential for wellness and preventive care to help Americans avoid disease. But gaps in coverage remain for many individuals managing a chronic health condition or conditions. While preventive care is provided at no cost on almost all health plans, those managing chronic medical conditions may have significant medical expenses. For example, a colonoscopy for someone who is 50 and healthy will be provided at no cost, but for an individual with ulcerative colitis they may be facing up to a $5,500 bill in North Dakota, if they have not yet met their deductible. But in some cases, chronic care management may be one area with the greatest return on investment. Medication and diet adherence for a diabetic, for example, leads to a longer, healthier life. For an insurer, it means fewer expensive complications.

Consumers with chronic medical conditions should be incentivized to manage their own care. It is well known that medication nonadherence and the related hospital admissions and emergency department visits are a significant cost driver of health care costs, particularly under fee-for-service insurance arrangements. For example, a comprehensive population study of Medicare beneficiaries in the fee-for-service program with diabetes, heart failure, hypertension, or hyperlipidemia found that avoidable healthcare costs due to medication nonadherence totaled nearly $30 billion.[35] Aligning the interests of the insurer, consumer and medical provider are key to this effort. North Dakota should (1) mitigate risk, (2) analyze and deploy a medication adherence and disease management strategy of investing targeted resources in the comorbid populations (two or more disease states and six or more medications), and (3) re-evaluate pricing structures. These efforts will lead to a measurable return on investment and measurably better health outcomes for North Dakotans.

1. **ACA Benchmark Plan Revisions - Optimized Medication Plans:** The continued release of academic studies regarding medication nonadherence highlights the need to focus on medication adherence as the greatest cost driver to utilization. The Lloyd et. al. report cited above specifically identified medication nonadherence as costing "billions of . . .expenditures, millions in hospital days and thousands of emergency department visits, that could have been avoided." She further goes on to state that "medication is a cornerstone of disease management. . . However, adherence to medications for most chronic conditions remains suboptimal – an

[35] Lloyd JT, Maresh S, Powers CA, Shrank WH, Alley DE. How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program?. Med Care. 2019;57(3):218-224. doi:10.1097/MLR.0000000000001067

important gap in care that represents a ***major opportunity for cost savings and health improvement*** for the 150 million American adults, 60% of the population, living with a chronic illness." (*emphasis added).* The estimated annual cost of prescription drug-related morbidity and mortality resulting from nonoptimized medication therapy has ranged as high as $528.4 billion in 2016 US dollars.[36] If addressed appropriately, the state can reasonably expect to see lower hospital-related utilization and substantial cost savings. The state would be the first in the nation to seriously address this issue if it was implemented across all payers.

Implementation:
Insurers. In the individual and small group market, North Dakota should consider revising their ACA Benchmark Plan to include a robust "medication optimization program" as a new mandate AND specifically enumerate that home delivery or mail order dose-packaged medication are proactively offered though the ACA-qualified health plans or QHPs. The medication optimization program would allow consumers to have a comprehensive review of all their prescription drugs to assure that the consumer is on the correct dosages the correct medication and to review any unfavorable drug interactions.

CMS has indicated that once approval is received for essential health benefit changes, there is a presumption that the "generosity test" has been met. The new "mandate" is then an EHB (essential health benefit), which indicates that it is not a "mandate". After passage of the ACA, new mandates require cost defrayal by the state. This is the only vehicle to expand coverage for North Dakotans purchasing health insurance in the individual market, without financial obligation by the state. Once the Benchmark Plan includes the new mandate, insurers will reap a 3:1 ROI and North Dakota consumers will see lower premiums and increased health.

Additionally, the state should work with CMS to ensure medication optimization is treated as a preventive health service. This will ensure that access is affordable, and that plans – especially high deductible plans – can cover the service without requiring a deductible be met.

Action Item: File Revised Benchmark Plan for Individual Market
Time to Completion: 12-24 months

2. **Private Insurance (Group) Mandate - Optimized Medication Plans:** Similar to the ACA Benchmark Plan revisions discussed above, North Dakota could pass legislation requiring all small and large group, including non-ACA plans, to offer an optimization program.

Insurers. North Dakota should require the same mandate for inclusion of "clinical pharmacist driven medication optimization coupled with dose-packaged

[36] https://www.pharmacytimes.com/contributor/timothy-aungst-pharmd/2018/06/does-nonadherence-really-cost-the-health-care-system-300-billion-annually; and Watanabe JH, Mcinnis T, Hirsch JD. Cost of prescription drug-related morbidity and mortality. Ann Pharmacother. 2018;1060028018765159. doi: 10.1177/1060028018765159.

medication" by all small and large group plans as well. According to one source, "[t]he data from the delivery of this service are positive, with a demonstrated ROI as high as 12:1 with an average of 3:1–5:1. ROI reflects an ability to decrease hospital admissions, physician visits, and emergency department admissions and reduce the use of unnecessary and inappropriate medications."[37] There is no reason insurers shouldn't be deploying these resources to the comorbid populations. Prior to passage of a requirement, the insurance department could issue a bulletin requiring all insurers to address medication adherence and medication optimization in their plan filings.

State Government. North Dakota should also consider revising their state employee benefits to include a robust "medication optimization program" as a new inclusion in the plans offered to state employees. A well-designed, clinical pharmacist-led medication optimization plan and follow-up can reduce total medical cost by a third. In subsequent years, the state would reap the benefits of a state employee population that is using fewer sick days and driving down health care costs, which drive premiums.

Action Item: Legislation or Commissioner Bulletin to implement the mandate. Revise the fully insured employee benefit plan or bargain through negotiations AND pass legislation or issue a Bulletin for the non-Erisa group market

Time to Completion: 18-24 months for passage and implementation of optimization requirements. Less than 12 months to issue bulletin, and receive reports.

Medical Community. Medication optimization should become a priority in the medical community. Hospital systems, physicians, and pharmacists should routinely discuss medication optimization with their patients. Patients with multiple conditions should regularly have their medication reviewed in order to ensure patient compliance, drug interactions, and changing medical history. Medical and pharmacy schools should develop courses to educate medical providers on medication optimization.

Action Item: Legislation to require North Dakota Pharmacy and Medical School to offer medication optimization courses. Hospital systems and pharmacies should be encouraged to require their employees to routinely discuss the issue with their patients.

Time to Completion: 18-24 months for passage and creation of courses. Less than 12 months to issue guidance to medical providers.

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. In most cases requiring treatment of acute care conditions, this administrative difficulty

[37] https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf

does not lead to significantly poorer health outcomes. For the chronically ill, the issue is very different.

The chronically ill face many issues. Many have a number of medical issues, and these co-morbidities mean that managing the conditions separately creates problems. Multiple medications mean managing potential adverse drug interactions. The issue is even more severe for consumers with rarer medical conditions whose interactions may not be understood by most medical providers.

CMS has approved integrated health homes that have a component of medication adherence. This provides a sizable match to the state if efficacy is shown. The Medicaid population needs to be engaged in the process for outcomes to improve. Success means not only a lower budget line item, but better health for Medicaid recipients. If health has been an impediment for maintaining a job (as it sometimes is), it also means the potential for a better life.

One of the policy solutions is to create integrated health homes that will work systemically with the chronically ill Medicaid population to develop a medication regimen that is error and contraindication free, and then support the patients to adherence. The most effective model is to include a clinical pharmacist team. North Dakota should look at a narrower Illinois integrated health homes (IHH) model (which was developed based upon the Oklahoma model). It is a model of engagement and adherence to behavioral/physical health and medication regimens. Most importantly, quality metrics can be set, such as reduction of ED visits, claims etc. for the IHHs. The state should procure a vendor to assist in crafting a medication adherence program through the IHH model. The program should include collection of data to verify that Medicaid recipients are filling needed prescriptions, follow-up to ensure prescriptions are taken appropriately, and a review of all medications for the most chronically ill to ensure the prescriptions are in the right amount and if more than one that there are no negative interactions. If the program works correctly, it could ensure that Medicaid patients have fewer increases in severity for their chronic illness, and in some cases may allow ill patients to recover enough to re-join the workforce.

Implementation: The state should file a State Plan Amendment (SPA) with the federal government to seek 90%/10% match funds for an eight-quarter program to provide medication optimization services. In addition to medication optimization, the integrated health homes should connect Medicaid beneficiaries with social services and accountability services with their current providers. North Dakota should reference Illinois or Oklahoma's integrated health home models for reference. North Dakota should also procure an integrated health home project manager or director.

Action Item: State Plan Amendment & Approp Funding to Medicaid Dept
Time to Completion: 18-48 months

4. **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. In addition, the state should consider hiring a vendor to assist state workers in managing their prescriptions and helping with adherence. In the long run, the program should reduce claims, and lead to a healthier workforce with less absenteeism.

   The State of North Dakota originally passed Medicaid expansion in 2013, providing coverage to residents up to 138% of poverty. The program is administered by Sanford Health Plan which won the RFP to administer the program. Despite lower than expected enrollment, the costs have been significantly higher than expected.

   The program created a two-tiered system. Those under 100% of poverty receive a traditional Medicaid managed care program. Those over 100% of poverty receive a program that pays commercial rates to medical providers.

   While strongly supported by the hospitals, there have been some significant concerns raised about the program. It requires Medicaid to run two separate programs which increases administrative costs. By splitting the pool, it makes it more difficult to manage the underlying claims costs both by making each pool less credible (since they are both small pools) and ensuring the larger pool is potentially attractive to managed care organizations. The differing benefit levels also create a sense of unfairness – it is hard to defend providing better benefits to those making more money.

   Two options exist:

   Limit Medicaid expansion to 100% of poverty. Currently North Dakota has expanded eligibility to Medicaid to 138% of poverty. However, the Affordable Care Act provides subsidies to all individuals over 100% of poverty.

   By limiting expansion to 100% of poverty, North Dakota would still be providing coverage to everyone in poverty, but allowing those over 100% of poverty to enroll in private market health insurance. For those enrolling in the exchange between 100% -138% of poverty it is very likely that in addition to enhanced cost sharing in silver plans, the consumers would be eligible to enroll in a bronze plan at no cost.[38]

   However, the savings to North Dakota is limited. The expansion population is effectively covered at less than 90 percent federal matching rate, which means $1 million savings to North Dakota requires more than $10 million in cuts.

   Re-form Medicaid expansion as a single combined pool in an exclusively managed care model. The importance of a medical home is highlighted above,

[38] https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/

but several states have begun using a similar managed care model in Medicaid. The idea is to eliminate a fee-for-service program in its entirety and require insurers to fully manage the health of Medicaid recipients. For some areas, a managed care program has led to extensive efforts to investigate social determinants of health, such as addressing food deserts or transportation limitations among patients.

This proposal could also require the Medicaid population to adjust to considerable changes with new requirements, and new provider networks. But the program could be offered to all Medicaid enrollees making it simpler to understand.

Implementation: The proposed program will require significant changes. By creating a single Medicaid program, the agency will be able to better manage care, offer better contracts to quality providers, and have economies of that do not come from divided pools. It also creates a more equitable program by treating all Medicaid recipients the same – regardless of income. This includes better use of value-based design inside Medicaid. The current program has a 90 percent federal match, which means state savings will be less.

Value based benefit design isn't just about waiving co-pays or deductibles. It is about determining the services that provide the best value and provide consumers with better health outcomes at lower overall costs. For example, a benefit design that ensures diabetics can afford the right dose of insulin and regards high value care will find that the cost of their diabetic population will fall.

***State Government*.** This is an area in which the state can lead. North Dakota state employees typically work with the state for a long period of time and are a large stable population. Implementing value-based design will allow the state employee health plan to assist state employee with managing their cost and care. The rewards for the state are not just in lower health care cost. If done correctly, it should also lead to a more productive, healthier workforce. For North Dakota employers and insurers, the state's leadership can provide concrete examples for success.

***Medicaid*.** Combining Medicaid into a single pool just makes logical sense. There will be resistance because of the loss of some federal revenue, but the program will be easier and less costly to manage, be fair for all recipients, and by pooling the risks together make it easier for Medicaid recipients. The Medicaid program can still use its limited levers to encourage the use of high value services. For example, one option would be removing fee-for-service as an option and requiring Medicaid recipients to receive care through an MCO with a required medical home. A number of states have used the MCO model to improve the costs in the program over time. However, with a small population, a strong rural component and a significant Native American population, the population may be too diverse to successfully implement a full managed care model statewide. Therefore, Medicaid could attempt to break the state into sections and try to attract MCOs to bid for care of local populations.

***Insurers*.** Insurers have begun to experiment with value-based design. However, in the highly regulated individual and small group markets, the rules are more complicated. State mandated benefits may favor low-value care or require lower cost sharing for some low value services. There is also a balancing act between providing additional incentives for high value care and concern that insurers are creating discriminatory benefit designs.

Action Item: Legislation, Major project planning across multiple state agencies
Time to Completion: 12-48 months

Prices, Coverage, and Insurance Initiatives. The following sections address pricing reforms that have the potential to restrain the ever-upward push of commercial rates, improve coverage for tele-health 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.[39] Preliminary estimates of the potential savings are shown below in the cost estimates section.

5. **Caps on Out of Network Rates for Private Coverage and the Uninsured.** Medicare's payment rates are commonly used as a benchmark for insurers. As shown above, commercial payment rates relative to Medicare have been rising in North Dakota. 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.
This policy would not directly affect rates for in-network providers. However, it would 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. (Of course, there are other benefits to in-network status, such as data disclosures and quality measures, so some insurers may have an incentive to pay in-network providers more than the out-of-network cap in order to retain high-quality providers in their networks.)

   Setting the initial rate cap quite high, such as at 220 percent of Medicare, would not severely disrupt provider payments. (For context, we estimate that state average was 207 percent in 2018 (see Table 9 above) and we estimate that the statewide average would be about 220 by 2021, when the policy would take effect. If applied at the provider level, setting an out-of-network rate cap may also have a positive effect on surprise billing by limiting rates charged by out-of-network providers operating in a hospital setting. As we suggest below under the transparency section, we recommend that the state monitor prices regularly and issue regular reports.

   Implementation:
   ***State Government*.** Setting a rate cap for out-of-network services could allow the state employee plan (NDPERS) to bid for lower-cost coverage, by letting the state

[39] 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

offer coverage without any required network. Because the state would have access to detailed data about claims patterns and trends, it would allow a direct way to monitor the impact of the cap on premiums and healthcare providers in various parts of the state.

***Private Insurance Market*.** Rate caps are intended to help new insurers enter markets and create networks. Likewise, policymakers can use rate caps to ensure competitive rates even in areas without a competitive market for providers. Therefore, rate caps, could be viewed as alternative to more rigid price setting regulations when competitive outcomes are difficult to achieve. The ACA's network adequacy rules can make hospital negotiations difficult. Setting maximum hospital rates provides a benchmark for negotiations with insurers. If done right, it could lower the barrier to entry for insurers to compete in the North Dakota health insurance market currently dominated by one insurer.

Action Item: Legislation with set benchmarks.
Time to Completion: 12 months with implementation.

6. **Telehealth:** If structured properly, telehealth services may increase access to needed care while also controlling costs. In a rural state like North Dakota, telehealth can provide the opportunity to access medical specialists without time consuming travel. For those with mental health issues, telehealth can be an important lifeline. With more frequent visits and early interventions available, telehealth can help avoid costly delays in care (such as undiagnosed conditions that become worse with time) and, in situations where an in-person visit may not be required, virtual encounters may be priced at a lower rate than in-person care (if there is no state mandate requiring payment parity).

   For North Dakota, proper utilization of telehealth could have an overwhelming impact considering the 6,000+ percent increase in telehealth visits in the midwestern U.S. between April 2019 and April 2020.[40] Consumers are increasingly becoming accustomed to telehealth, but the current increase in availability of telehealth services is largely based on temporary regulatory waivers.

   Implementation:
   ***State Government & Insurers*.** There are a number of issues that states should examine to create a permanent infrastructure that supports widespread adoption and utilization of telehealth:

   Licensure. Many states have significant licensing barriers that control providers' ability to use telehealth. Provider licensing boards should be encouraged to embrace telehealth, allowing providers to establish relationships remotely as long as necessary conditions are met and the standard of care is upheld. State boards should consider the interstate compacts available (e.g., FSMB and

[40] https://www.fairhealth.org/states-by-the-numbers/telehealth

NCSBN compacts, among others), as well as other flexibilities that may enhance providers ability to practice telemedicine.

Payment. Currently, many states are mandating that telehealth providers be paid on par for the same services. These requirements, often referred to as "payment parity" or "reimbursement parity" laws effectively drive up the price insurers are required to pay by limiting their ability to freely contract for services. These laws stifle competition by not allowing insurers and providers to set different rates based on the delivery of service.

Software. Consumers and medical providers should be allowed to agree on the use of any software service. States shouldn't pick winner and losers.

Scope of practice. The pandemic has allowed many new types of service to be delivered by telehealth. States should look closely at their telehealth practice requirements and permanently modernize the statutes.

Insurance. States should create a legal framework that would allow businesses and consumers to purchase an insurance product providing telehealth services.

Action Item: Legislative and regulatory study, legislation.

Time to Completion: 6-18 months

7. **Private Reinsurance:** The Governor signed HB 1106 enabling North Dakota's Reinsurance Association of North Dakota (RAND) to implement a non-private reinsurance program to reduce healthcare costs for individual taxpayers participating in the State's healthcare marketplace. 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 driving down/stabilizing rates and preventing spikes providing consistency for taxpayers/users. For example, Aon, a private reinsurer, has proposed such a system, which is shown in Appendix E.

   Using reinsurance to transfer the budgetary/program volatility, creates immediate opportunities for the State of North Dakota including:
   - Transferring volatility away from the existing RAND program into the private market
   - Reducing the future "known, unknowns", thereby allowing greater funding flexibility with the safety and security of knowing that protection is in place in the event of a higher-than-normal claims year
   - Providing stability in rates from payers as a pre-arranged amount of funding is known
   - Predictable cash flows for insurers and the state as there is no need, once coverage is purchased, to adjust the reimbursement levels to carriers based on higher-than-expected claim numbers and amounts

- Adjudication and claims processing is handled by the reinsurer, removing some of the operations of running the program in house

In addition, given the current Covid-19 health crisis there is likely to be further pressure on the individual health market. According to a recent Kaiser Family Foundation report, "It is likely that the most significant impacts of the coronavirus outbreak and economic crisis on the individual market will not be evident nationally until data from the second and third quarters of 2020 become available." These solutions can help mitigate impacts stemming from the global pandemic.

Action Item: Legislation & Outside Resources for Data and Reinsurance Management
Time to Completion: 6-18 months

Transparency. Too often, price transparency is seen as a panacea to our health system and blame for our opaque pricing system 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. Competition is the ultimate consumer protection because it allows a consumer to walk away from a transaction to find a better partner. Without competition, the alternative to competition is and should be, increased government oversight. When entities act like a monopoly, it may be necessary for government to regulate it like a monopoly.

The Trump administration had a number of initiatives that if implemented will significantly increase transparency for patients. These include availability of hospital and insurer information on pricing. The recent Covid-19 legislation also requires new disclosures which will help many patients with one of the biggest problems, surprise billing. While these changes are an important first step, we believe North Dakota can build on the approach to ensure consumers have access to the information they need before receiving care.

8. **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 Table 60). What we found was drastically different estimates. For colonoscopy, the prices quoted ranged from a high of $5,509 to a low of $1,775, a difference of more than 300 percent. For vaginal childbirth, the range from highest quoted price to lowest was nearly 350 percent, and for delivery by Caesarian Section, prices ranged from about $5,000 to more than $31,000, a difference of more than 600 percent.

Table 60.

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.

In general, consumer-facing price disclosures by hospitals are too complicated or obscure to be useful, particularly if the prices disclosed are full charges or so-called "chargemaster" amounts or if the price quotes are based on discrete (often obscure) technical codes instead of commonly known procedures, such as hip replacement or appendectomy. These amounts often have little resemblance to actual reimbursements by insurers. In order for a price disclosure to be useful to a consumer, it must meet certain criteria:

1. The disclosure must be **actionable**. Disclosures that are delivered at the time of service don't allow the consumer to shop.
2. The disclosure must be **personal**. General pricing disclosures don't reflect the likely costs based on the consumer's insurance plan or other service variables. This may mean that the referring or treating physician be required to provide billing codes.
3. The disclosure must be **understandable**. The consumer needs to understand what is covered by the price disclosure. Since most hospital-based physicians bills separately, the consumer should be made aware of other possible bills that may accompany the disclosed amount.

Implementation:

Hospital and Clinics. Rather than disclosing chargemaster amounts or prices based on inscrutable procedure costs, we recommend that hospitals and other large health care providers, including clinics and outpatient surgery centers, ***disclose their prices to uninsured patients as a function of Medicare rates***. For example, a hospital could simply state that its walk-up rates for patients without insurance were "100% of Medicare rates" or "200% of Medicare" or whatever amount they wished to charge. However, patients could then shop based on one number, a simple percentage, and could be confident that they would only be charged what Medicare would pay plus the stated markup. Note, that we would not require providers to disclose their reimbursement rates with insurers, which could be higher or lower than the function of Medicare rates quoted to uninsured patients. However, it is clear that insured patients with high

deductibles might not be happy if their carrier's negotiated rates were higher than the walk-up rates charged to the uninsured. This dynamic would help drive intramarket competition and prices down over time.

Action Item: Legislation
Time to Completion: 12 months

State Government. We recommend that the state health or insurance departments publish and ***publicize lists of Medicare rates for common bundles of services, starting with the most common procedures that patients may face, such as childbirth, knee or hip replacement***, and so on. For example, consumers with a choice of hospital could look at the hospitals stated rates relative to Medicare, and then compute their costs based on the Medicare reimbursement rates. For example, if the state's analysis of certain procedure showed an average Medicare reimbursement rate of $1,000, a patient would have a better idea what to expect in absolute costs from a hospital that charged 150 percent of Medicare ($1,500) vs. one that charged 200 percent of Medicare ($2,000).

Another recommendation is that the state ***operate a price disclosure website***, similar to the website offered by the Wisconsin Hospital Association (https://www.wipricepoint.org/Home.aspx) The website allows consumers to shop prices at any time and uses a series of questions to drill down on the procedure and the consumer's insurance coverage. The Wisconsin website uses chargemaster prices – in line with our recommendations above, we would ideally recommend that an analogous North Dakota use prices for the uninsured based on a stated percentage of Medicare rates.
Action Item: Internal Project Plans
Time to Completion: 12-24 Months

Insurers. Consumers will be unable to meaningfully shop until real-time benefit tools become more widely available. We encourage North Dakota policymakers to ***require the state's health plans to expand their out-of-pocket calculators to include real-time benefit information***, so that patients would know exactly where they stand on their deductibles and could assess their out-of-pocket costs while still at the doctor's office, pharmacy, or hospital. Real-time benefit tools are especially important for consumer and medical providers evaluating their prescription drug options including cash payment prices. We recommend that state law and insurance regulations clarify that health plans would be allowed to give patients financial rewards for using real-time out-of-pocket benefit calculators. We acknowledge that providing real-time cost calculators can be particularly difficult in cases where providers are not in insurers' networks, and estimated payments on unadjudicated claims from out-of-network providers may be more difficult to estimate in advance. This work is hard and complex, but it is also necessary in an era where most patients have substantial deductibles. In summary, insurers should have a similar

responsibility as providers for educating consumers on their possible costs, what their insurance will cover, and reviewing options that will help save the consumer money.

Action Item: Bulletin or Legislation
Time to Completion: 6-12 months

9. **Public Policy Price Disclosures:** Another key element of transparency is disclosure to taxpayers and state policymakers. Most health care providers benefit from tax advantages, municipal bond funding for construction, and receive direct subsidies and reimbursements from federal, state, and local governments. They are essentially public/private entities, and it is certainly in the public's interest to balance private-led innovation against public health and financial responsibilities. In general, we do not recommend all-payer claims databases (APCDs) for North Dakota. For one, with such a dominant insurer, the price and reimbursement data in those databases could be very sensitive. But even more importantly, we believe that states that have mandated APCDs have produced relatively little actionable information relative to the investment.

   Implementation:

   State Government*.** We recommend that ***North Dakota staff a position (or otherwise contract for) dedicated to tracking the state's health care costs, using data collected from insurers, hospitals, and other health care providers. Best case scenario would require a continuous transmission of information similar to the data compiled in this report. The data could be gathered from providers and insurers in the same formats as disclosures those entities already make to the AHA and the NAIC. Further, it could be supplemented or cross-checked against publicly available data. The state's providers and insurers would be required to provide to the Insurance Commissioner. Legislative action may be required to continue to require providers to supply same.

   Action Item: Internal Project Plan & Legislation
   Time to Completion: 6 months

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 medical provider to the most convenient care delivery center – often the local hospital. There may be cheaper alternatives with equal or even better quality outcomes, especially for services like colonoscopies or MRIs. 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.

    For consumers there is a trade-off. In some cases, the less expensive service may require some travel or other care coordination. However, many find the cash payment incentive enough to spend the time and energy finding the best quality

and cost-effective treatment. New Hampshire implemented the program in their state employee program and has saved an estimated $11 million in 3 years[41].

Implementation:

Insurers. A number of states have passed "Right to Shop" legislation. Insurers should be allowed the option of encouraging consumer shopping by providing direct consumer incentives.

***State Government*.** The New Hampshire program for state employees appears to have been a success. The state of North Dakota could consider a similar program in an effort to lead on the issue and provide data to the private industry.

Action Item: Legislation
Time to Completion: 6-12 months

Program Integrity. State governments are often the largest purchasers of health care in any given state. The state provides health care coverage to both its state employees and those on Medicaid. This provides an opportunity for the state to lead on a number of health care issues, help change the dynamics for the private market, and to provide data on success or failure. But there are landmines for the state to consider. Often, those eligible to be covered under state programs may also be eligible for other coverage, leading to confusion on the correct payer. Poorly designed state-run benefit programs can replace existing private dollars, leading to private market crowd-out and an inefficient use of taxpayer dollars. In implementing benefit programs, North Dakota should endeavor to cover only those intended to be eligible for the program.

Program integrity does just that. Program Integrity focuses on ensuring that consumers have coverage for their health needs from the correct payer and is an important tool to maximize taxpayer resources. Program integrity issues are almost unavoidable without a consistent outside focus. 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. Through the use of risk-based contracts, states have the option to outsource program integrity initiatives. Because private companies do not get paid unless there are recoveries, there is very little downside to the state.

Market-wide, it is imperative that consumers are covered by the correct payer. Program integrity issues exist in Medicaid, the commercial market and the state group health population. For example, we understand that Pennsylvania is currently addressing their state employee population, and we believe a majority of Fortune 100 companies have done this for their employees. This is the perfect opportunity for high utilizers to be transitioned to the correct payer, rather than the state. Any savings accrued in the state employee health plan and

[41] Josh Archambault and Nic Horton. Right To Shop: The Next Big Thing In Health Care. Forbes. Aug 5, 2016. Available from: https://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/#31bda24b4f60.

Medicaid could result in a substantial return back to the state. Savings in the commercial population would drive down health insurance rates for all private consumers.

11. **Medicaid Integrity Audit:** When a consumer receives financial assistance, North Dakota law allows for full assignment of benefits with no time limit.[42] It is important for the state to periodically audit Medicaid enrollees receiving benefits for other options to receive benefits. 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 another 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.
    Action Item: Legislation and completion of an RFP process.
    Time to Completion: 12-18 months

12. **State Group Health Integrity Audit:** North Dakota's health insurance benefits are generous and encourage full family coverage. However, State employees and their families may be covered by a variety of health insurance plans including private health insurance coverage, Medicare, and rarely Medicaid. North Dakota could consider a similar audit and consider what – if any – ongoing procedural changes are necessary to ensure program integrity.
    Action Item:
    Time to Completion:

13. **State Group Health Waiver**: The state currently provides no-cost health insurance to state employees and their families.[43] In some cases, the employee may also be covered under their spouse's plan. The offer of "free" health insurance can and does lead to double coverage. One option is to provide a small bonus to state employees who choose to opt entirely out of coverage. It provides an option to avoid double coverage, provides the employee an additional benefit, and reduces costs**.**
    Action Item: Legislation
    Time to Completion: Less than 12 months**.**

14. **Coordination of Benefits:** Coordination of Benefits rules in health insurance clarify which insurer is responsible to pay for certain benefits. The rules work entirely automatically and are a great example of program integrity. The NAIC adopted changes to the model coordination of benefits rule in 2013 but North Dakota's rule dates to 2006. North Dakota should consider the merits of updating the rule.
    Action Item: Updated Regulation.
    Time to Completion: 12 months**.**

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[42] https://www.legis.nd.gov/information/acdata/pdf/75-02-02.1.pdf

[43] https://www.ndhealth.gov/HumanResources/Benefits.htm#:~:text=The%20State%20of%20North%20Dakota%20offers%20state%20employees,medical%20and%20child%20care%20expenses%29%20Employee%20Assistance%20Program.

Employer Coverage. The focus on insurance costs at the state and national level has primarily been on individual market ACA coverage which is a small percentage of the population. The vast majority of consumers receive coverage through their employer. As employer coverage continues to erode because of 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.

    Implementation:

    State: A one-year study would need to be completed with all stakeholders including insurers, employers, agents, and others. The study would have to consider the impact on the individual and small group markets separately and together.

    Action Item: Legislation
    Time to Completion: 12-24 months

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 complete surprise, based on our 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:**
    Insurer Own Risk Solvency Assessment. Domestic insurers are required to file a highly confidential report that details the risks to their solvency called the Own Risk Solvency Assessment or ORSA. This board level report is expected to detail all of the potential risks facing an insurer. One option for future pandemic planning is to recommend that health insurers include discussions of pandemic risks.

    Implementation:

    Insurers: ORSA reports are required to be filed with insurers domiciled in the state. It is likely most insurers will include pandemic issues in their ORSA reports in the immediate aftermath of this pandemic. The important issue will be maintaining pandemic planning in the coming years. The insurance department should add the issue in their ORSA reviews and in any 5-year financial exams.

    Action Item: Insurance Department Bulletin
    Time to Completion: 24-36 months

Hospital Own Risk Assessment. Hospitals and hospital systems have been forced to lead throughout this pandemic. In many ways, hospitals have become the main point of contact for public health initiatives. Nationally, it has been clear that public health officials have needed to develop new reporting mechanisms to understand the availability of hospital beds, ICU's, and important equipment. We hope and expect those efforts will be made permanent. But public health issues need more attention and planning, especially at the local level. We are suggesting that the state mandate that hospitals and hospital systems conduct their own version of a risk assessment. These critical reports should be reviewed at the board level. The analysis should be highly confidential, and should consider financial, health, and disaster issues that could negatively impact the hospital and public health in the community.

Implementation:

Hospital: Insurer required ORSA reports were developed to ensure all insurers – from the smallest town mutual to the largest multinational insurer – had a framework to critically evaluate all possible risks facing the insurer. The report must be reviewed by the insurer's board. We are proposing a similar structure here that would require an evaluation by the hospital and its board. Over time, this annual evaluation will impact hospital operations and will foster ongoing discussions regarding hospital's public health obligations.

Action Item: Legislation, legislative study.
Time to Completion: 18-36 months

VII. Cost and Impact Discussion

For some of the policy alternatives noted above we have prepared preliminary cost estimates and discussion. Based on initial feedback from state policymakers, we would refine or expand this analysis for the final report.

Historically, public and private efforts to contain health costs have followed recessions. This makes sense, because a large share of health costs is paid directly by governments, whose revenues are constrained during recessions, and indirectly (via private insurers) by employers and employees, whose profits and wages are also squeezed in bad times. After the recession of the early 1980s, Congress enacted the PPS program, which cut Medicare's hospital payments, particularly for extended stays. Following the recession of the early 1990s, managed care programs flourished with strong employer support, with the goal of restraining private health costs. After the Great Recession of 2008, the growth of Medicare fees was constrained via sequestration.

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 RAND published a report demonstrating the savings and impact of capping hospitals rates for out-of-network services.[44] Medicare's payment rates are commonly used as a benchmark for insurers. 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.

This policy would not directly affect rates for in-network providers. However, it would 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. (Of course, there are other benefits to in-network status, such as data disclosures and quality measures, so some insurers may have an incentive to pay in-network providers more than the out-of-network cap in order to retain high-quality providers in their networks.)

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. We would recommend that the initial out-of-network rate cap be set quite high, such as at 220 percent of Medicare, so that provider payments would not be severely

[44] 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

disrupted. For context, we estimate that state average was 207 percent in 2018 (see Table 9 above), and we estimate that the statewide average would be about 220 percent by 2021, when the policy would take effect. The cap could be held constant or gradually lowered over time to give healthcare providers time to adjust.

Table 61 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 by 2024.

Table 62 shows an option where the cap was gradually lowered from 220 percent in 2021 to 190 percent in 2024. Under this option, claims costs and premium reductions would be larger, with premiums falling by approximately $500 per year or about $40 PMPM by 2024.

Table 61.

Cost Impact -- Cap Out-of-Network Rates				DRAFT			
	2018	2019	2020	2021	2022	2023	2024
				Option 1 -- Flat Cap			
Cap Level				220%	220%	220%	220%
Reduction in Claims Cost (millions)							
Individual Market				-1	-2	-5	-7
Small Group Market				-1	-4	-7	-10
Large Group Insured Market				-2	-10	-19	-29
Percentage Reduction in Premiums							
Individual Market				0%	-1%	-2%	-2%
Small Group Market				0%	-1%	-2%	-2%
Large Group Insured Market				0%	-1%	-2%	-3%
Per-Capita Reduction in Premiums (annual)							
Individual Market				-12	-59	-110	-166
Small Group Market				-13	-65	-122	-184
Large Group Insured Market				-14	-67	-125	-187
Reduction in Premiums (PMPM)							
Individual Market				-1	-5	-9	-14
Small Group Market				-1	-5	-10	-15
Large Group Insured Market				-1	-6	-10	-16
Federal Tax/ACA Subsidy Savings (millions)							
Individual Market				0	-1	-1	-2
Small Group Market				0	-1	-2	-3
Large Group Insured Market				-1	-3	-6	-9
Total				**-1**	**-5**	**-9**	**-14**
Memorandum:							
Baseline Commercial Rates for Hospitals (% of Medicare)				221%	226%	231%	237%

Source: Horizon Government Affairs.
Note: Preliminary estimates, subject to change. PMPM = per member per month.

Table 62.

Cost Impact -- Cap Out-of-Network Rates				DRAFT			
	2018	2019	2020	2021	2022	2023	2024
					Option 2 -- Declining Cap		
Cap Level				220%	210%	200%	190%
Reduction in Claims Cost (millions)							
Individual Market				-1	-6	-13	-19
Small Group Market				-1	-10	-19	-28
Large Group Insured Market				-2	-26	-53	-81
Percentage Reduction in Premiums							
Individual Market				0%	-2%	-5%	-7%
Small Group Market				0%	-3%	-5%	-7%
Large Group Insured Market				0%	-3%	-5%	-7%
Per-Capita Reduction in Premiums (annual)							
Individual Market				-12	-151	-302	-463
Small Group Market				-13	-169	-335	-514
Large Group Insured Market				-14	-173	-342	-522
Reduction in Premiums (PMPM)							
Individual Market				-1	-13	-25	-39
Small Group Market				-1	-14	-28	-43
Large Group Insured Market				-1	-14	-29	-44
Federal Tax/ACA Subsidy Savings (millions)							
Individual Market				0	-2	-4	-6
Small Group Market				0	-3	-6	-8
Large Group Insured Market				-1	-8	-16	-24
Total				**-1**	**-13**	**-25**	**-38**
Memorandum:							
Baseline Commercial Rates for Hospitals (% of Medicare)				221%	226%	231%	237%

Source: Horizon Government Affairs.
Note: Preliminary estimates, subject to change. PMPM = per member per month.

The large group market in these estimates only includes “insured” health plans under state regulation, not so-called “self-funded” coverage operating under the federal ERISA program. The estimates also do not include NDPERS coverage.

Under both options, there would be federal savings as well, in both the individual market due to reduced ACA subsidies, and in the group markets due to revenue impacts. (When premiums are reduced for group coverage, federal tax analysts estimate that tax revenues increase, due to dollars being shifted from non-taxable employee benefits to taxable wages and profits.)

It would be a longshot, but it would be possible that North Dakota could apply via an ACA Section 1332 waiver to recoup the federal savings, at least from reduced ACA subsidies in the Individual market. Such a waiver application might have a more likely chance of success under a possible Biden Administration, which would be moving toward capping rates (or setting them) as a percent of Medicare as general policy.

Option: Re-Pricing Payment Rates for the Medicaid Expansion Population.
Medicaid expansion in 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.

We used two methods of approximating the estimate – one using per-capita costs, one using payment rate ratios. Each has advantages and disadvantages. A disadvantage to the per-capita method implicitly assumes that the expansion has the same morbidity profile as the regular Medicaid (non-institutionalized) population. The ratio method is limited by our lack of data on the ratios of hospital costs to the overall. Given the uncertainties, we show both methods as a range of possibilities.

Since the state share of costs for the Medicaid expansion population is very small, the savings from this proposal would mostly accrue to the federal government (see Table 63). We estimate a range of state savings from $5 to $8 million in 2021, growing to $6 to $9 million in 2024.

Table 63.

Re-Price Medicaid Expansion at Regular Medicaid Rates				DRAFT			
	2018	2019	2020	2021	2022	2023	2024
				Medicaid Expansion, Baseline Assumptions			
Expansion Enrollment	21,100	22,570	26,373	24,576	25,044	25,520	26,005
Cost per Enrollee (annual)	$14,107	$12,961	$14,530	$14,618	$15,062	$15,520	$15,992
Expansion Cost, Fed + State (n	298	293	383	359	377	396	416
State Share	8%	8%	10%	10%	10%	10%	10%
State Cost, Baseline	23	23	38	35	37	39	41
				Potential Savings in Millions			
Total Savings -- Per-capita Method				-81	-85	-89	-93
State Share				**-8**	**-8**	**-9**	**-9**
Total Savings -- Ratio Method				-53	-57	-61	-65
State Share				**-5**	**-6**	**-6**	**-6**
Memorandum:							
Baseline Commercial Rates for Hospitals (% of Medicare)				221%	226%	231%	237%

Source: Horizon Government Affairs.
Note: Preliminary estimates, subject to change.

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 Medicare[45] and Medicaid.[46] 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

[45] Congressional Budget Office, A Premium Support System for Medicare: Updated Analysis of Illustrative Options (October 5, 2017) https://www.cbo.gov/publication/53077
[46] Congressional Budget Office, Exploring the Growth of Medicaid Managed Care (August 7, 2018) https://www.cbo.gov/publication/54235

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 assumed a phase-in period of five years, and that the additional administrative and implementation costs for the more tightly managed MCO model in Medicaid would add $10 million in costs per year for the non-expansion population and $5 million for the expansion population. We also assumed that those costs would be effectively eligible for federal matching at the usual rates.

Table 64 illustrates these potential costs (+) and savings (-), both for the Medicaid program as a whole in North Dakota and the state's share of those costs. 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. Notably, by using overall savings estimates from Medicare bids and the experience of other state Medicaid managed care programs, we do not make explicit assumptions about exactly how these savings are achieved by MCOs. In theory, these savings estimates could be achieved by a variety of means, including improved Medicaid adherence, better access to primary care, and other methods.

Table 64.

Tighter Managed Care and Population Health Requirements in Medicaid		DRAFT		
	2021	2022	2023	2024
	Medicaid Claims Cost Savings (millions)			
Total Original Medicaid FFS (non-institutionalized enrollees) Fed	-12	-25	-39	-55
State Share	-5	-12	-19	-27
Expansion MCO	-4	-8	-12	-17
State Share	0	-1	-1	-2
	Health Plans' Implementation and Administrative Costs			
Total Original Medicaid FFS (non-institutionalized enrollees) Fed	10	10	10	10
State Share	3	3	3	3
Expansion MCO	5	5	5	5
State Share	0	0	0	0
	Net Cost (+) or Savings (-)			
Total Original Medicaid FFS (non-institutionalized enrollees) Fed	-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.

Note: Assumes administrative and care coordination costs of Medicaid health plans would qualify for federal match. FFS = fee for service. MCO = Managed Care Organization. Components may not sum to totals due to rounding.

Appendix A – Hospital Data Request for AHA-Style Data

General info and Q&A calls Nov 7, Nov 12, Nov 21, Nov 26, and Dec 5, 2019. Hospitals returned data in December 2019 and January 2020.

Hospital Name											
		Example:	ST ALEXIUS MEDICAL CENTER								
Point of Contact for Your Hospital's Data Response											
	Name	Example:	Jane Smith								
	Email		jsmith@emailaddress.org								
	Cell		701 000 0000								
	Office		701 000 9999								
Hospital Fiscal or Reporting Year for Current Year and Projected Years											
	Begin Date	End Date									
Example:	Jan 1 2019	Dec 31 2019									
Table 1.							Current Year				
North Dakota Hospitals, Beds and Utilization, Baseline Historical 2010 to 20				<==		Historical	Estimated	Projected	==>		
All Participating Hospitals	2018 AHA	2010	2011	2017	2018		2019	2020	2021	2022	2023	2024
Hospital Fiscal Years as Reported to AHA	Definition						(or current year)					
Total licensed Beds	E.1.a.						Yr over Yr % Chg					
Beds set up and staffed for use (eoy)	E.1.b.						Yr over Yr % Chg					
Admissions (exclude newborns, etc.	E.1.e.						Yr over Yr % Chg					
Inpatient Days	E.1.f.						Yr over Yr % Chg					
ED visits	E.1.g.						Yr over Yr % Chg					
Total outpatient visits	E.1.h.						Yr over Yr % Chg					
Inpatient surgical operations	E.1.i.						Yr over Yr % Chg					
Outpatient surgical operations	E.1.k.						Yr over Yr % Chg					
Medicare inpatient discharges	E.2.a1.						Yr over Yr % Chg					
Medicare inpatient days	E.2.b1.						Yr over Yr % Chg					
Medicaid discharges (total)	E.2.c1						Yr over Yr % Chg					
Medicaid inpatient days	E.2.d1						Yr over Yr % Chg					
Source: Horizon Government Affairs.												
Notes:												
Estimated data for current year should be based on observed growth over same months in prior fiscal year.												
Projected data under baseline are approx consistent with hospitals' 5-year or long-term capacity plans.												
Data exclude federal (IHS, VA) hospitals, Long-Term hospitals.												
Data exclude nursing home units/facilities.												

Table 2.									
North Dakota Hospitals, Key Financial Indicators, Baseline Historical 2010 to 2024 (projected, curre						Current Year			
				<==	Historical	Estimated	Projected	==>	
Hospital Fiscal Years as Reported to AHA	2018 AHA	2010	2011	2017	2018	2019	2020	2021	2022
	Definition					(current year)			
Net Patient Revenue	E.3.a.	As Reported to AHA				Yr over Yr % Chg	Projected		
Tax Appropriations	E.3.b.					Yr over Yr % Chg			
Other Operating Revenue	E.3.c.					Yr over Yr % Chg			
Nonoperating Revenue	E.3.d.					Yr over Yr % Chg			
Total Revenue	E.3.e.					Yr over Yr % Chg			
Payroll Expense	E.3.f.					Yr over Yr % Chg			
Employee Benefits	E.3.g.					Yr over Yr % Chg			
Depreciation	E.3.h.					Yr over Yr % Chg			
Interest Expense	E.3.i.					Yr over Yr % Chg			
Pharmacy Expense	E.3.j.					Yr over Yr % Chg			
Supply Expense (other than pharmacy)	E.3.k.					Yr over Yr % Chg			
All Other Expenses	E.3.l.					Yr over Yr % Chg			
Total Expenses	E.3.m.					Yr over Yr % Chg			
Total Gross Inpatient Revenue	E.4.a.					Yr over Yr % Chg			
Total Gross Outpatient Revenue	E.4.c.					Yr over Yr % Chg			
Total Gross Patient Revenue	E.4.b.					Yr over Yr % Chg			
Bad Debt	E.5.a.					Yr over Yr % Chg			
Financial Assistance	E.5.b.					Yr over Yr % Chg			
Medicare Gross Revenue	E.6.a.(1)(c)(1)					Yr over Yr % Chg			
Medicare Net Revenue	E.6.a.(1)(c)(2)					Yr over Yr % Chg			
Medicaid Gross Revenue	E.6.a.(2)(g)(1)					Yr over Yr % Chg			
Medicaid Net Revenue	E.6.a.(2)(g)(2)					Yr over Yr % Chg			
Self Pay Gross Revenue	E.6.b.(1)(1)					Yr over Yr % Chg			
Self Pay Net Revenue	E.6.b.(1)(2)					Yr over Yr % Chg			
Third Party Payers Gross Revenue	E.6.b.(2)(c)(1)					Yr over Yr % Chg			
Third Party Payers Net Revenue	E.6.b.(2)(c)(2)					Yr over Yr % Chg			
All Other Non-Government Gross Reven	E.6.b.(3)(1)					Yr over Yr % Chg			
All Other Non-Government Net Revenue	E.6.b.(3)(2)					Yr over Yr % Chg			
Total Margin	E.7.a.					Year to Date			
Operating Margin	E.7.b.					Year to Date			
Medicare Margin	E.7.d.					Year to Date			
Medicaid Margin	E.7.e.					Year to Date			
Total Capital Expenses	E.9.					Yr over Yr % Chg			
Source: Horizon Government Affairs.									
Notes:									
Estimated data for current year should be based on observed growth over same months in prior fiscal year (Yr over Yr % Chg) or Year to Date as marked									
Projected data under baseline are approx consistent with hospitals' 5-year or long-term capacity plans.									
Data exclude federal (IHS, VA) hospitals, Long-Term hospitals.									
Data exclude nursing home units/facilities.									

Table 3.						
North Dakota Hospitals, Privileged Physicians, Baseline Historical 2010 to 2018						
				<==	Historical	
Hospital Fiscal Years as Reported to AHA	2018 AHA	2010	2011	2017	2018	
	Definition				(or most recent year)	
		Total Employed				
Primary Care	E.12.a.(1)	As Reported to AHA				
Emergency Medicine	E.12.b.(1)					
Hospitalist	E.12.c.(1)					
Intensivist	E.12.d.(1)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(1)					
Other Specialist	E.12.f.(1)					
Total	E.12.g.(1)					
		Total Individual Contract				
Primary Care	E.12.a.(2)					
Emergency Medicine	E.12.b.(2)					
Hospitalist	E.12.c.(2)					
Intensivist	E.12.d.(2)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(2)					
Other Specialist	E.12.f.(2)					
Total	E.12.g.(2)					
		Total Group Contract				
Primary Care	E.12.a.(3)					
Emergency Medicine	E.12.b.(3)					
Hospitalist	E.12.c.(3)					
Intensivist	E.12.d.(3)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(3)					
Other Specialist	E.12.f.(3)					
Total	E.12.g.(3)					
		Not Employed or Under Contract				
Primary Care	E.12.a.(4)					
Emergency Medicine	E.12.b.(4)					
Hospitalist	E.12.c.(4)					
Intensivist	E.12.d.(4)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(4)					
Other Specialist	E.12.f.(4)					
Total	E.12.g.(4)					
		Total, Privileged				
Primary Care	E.12.a.(5)					
Emergency Medicine	E.12.b.(5)					
Hospitalist	E.12.c.(5)					
Intensivist	E.12.d.(5)					
Radiologist/Pathologist/Anesthesiologist	E.12.e.(5)					
Other Specialist	E.12.f.(5)					
Total	E.12.g.(5)					
Source: Horizon Government Affairs.						
Notes:						
Estimated data for current year should be based on observed growth over same months in prior fiscal year.						
Projected data under baseline are approx consistent with hospitals' 5-year or long-term capacity plans.						
Data exclude federal (IHS, VA) hospitals, Long-Term hospitals.						
Data exclude nursing home units/facilities.						

Appendix B – Information from IRS Form 990s and Financial Statements/Prospectuses

We looked at both form 990s and other financial statements to cross-check our data. Note, this is not a complete analysis. However, here are some preliminary notes on the data gathering process from these sources:

- **Financial Statements:** We found a fair share of financial statements, but there will be several years that has no information for some hospitals as there was no publicly available documentation for those respective years. As discussed previously, for the hospitals that are doing business under the Catholic Health Initiatives, this section is left unfilled.

- **Schedule H:** For Schedule H, which provides information of hospitals' bad debt, financial assistance and community benefits, it appears that submission of this document began in FY2013. Thus, there will be no data entries for 2010-2012.

- **Municipal Revenue Bonds:** For this section, there is still work to do based on differences in issued prices reported in the Schedule K (990) and on the Electronic Municipal Market Access (EMMA) platform—next step includes understanding the differences in reporting requirements for both sources. Additionally, as in the case with Trinity, a revenue bond reported on the Schedule K couldn't be found on EMMA when entering the CUSIP# considering that it was a recently issued revenue bond. Moreover, some hospitals did not have Schedule K submissions and/or other type of revenue bond information, so this section will be unfilled for those hospitals. Further fact-checking is required for this section before deriving any conclusions.

- **Public Benefits:** We are studying public benefits and will add a section describing those and presenting data from hospitals in future progress reports. A section highlighting major hospitals' Financial Assistance Programs under IRS 501(r)(4) is included below.

ALTRU HEALTH SYSTEM

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As N/A

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**404,376,500**	**431,707,747**	**468,848,735**	**479,576,615**	**498,703,511**	**522,975,652**	**541,032,394**	**563,948,218**
Contributions and grants	1,769,870	2,217,753	2,240,058	2,714,445	3,676,190	4,371,202	3,111,765	2,878,464
Program service revenue	398,290,568	424,145,122	463,961,841	467,457,435	489,329,541	516,692,202	542,028,176	555,999,359
Investment income	3,874,572	4,921,726	2,230,007	9,018,944	5,382,811	1,754,115	(4,271,017)	4,914,964
Other revenue	441,490	423,146	416,829	385,791	314,969	158,133	163,470	155,431
Expenses	**381,071,295**	**414,810,580**	**453,809,727**	**471,698,614**	**477,657,709**	**504,285,525**	**535,095,068**	**565,165,343**
Grants	68,673	106,934	267,360	244,179	288,959	31,740	1,023,468	1,062,049
Salaries/Emp. Benefits	235,908,618	249,507,009	273,143,881	285,707,820	296,361,790	307,765,281	323,595,510	338,818,207
Other expenses	145,094,004	165,196,637	180,398,486	185,746,615	181,006,960	196,488,504	210,476,090	225,285,087
Revenue less expenses	23,305,205	16,897,167	15,039,008	7,878,001	21,045,802	18,690,127	5,937,326	(1,217,125)
Total Assets	371,999,674	380,667,327	453,496,991	455,613,013	470,129,714	480,240,011	478,270,432	548,207,089
Total Liabilities	227,020,666	235,692,188	290,811,356	269,648,753	274,517,289	268,918,642	262,658,959	282,364,561
Net assets or fund balances	144,979,008	144,975,139	162,685,635	185,964,260	195,612,425	211,321,369	215,611,473	265,842,528
Bad Debt Expense				23,893,645	16,447,811	11,511,135	9,148,528	9,480,521
Medicare								
Revenue Received (incl. DSH & IME)				104,577,110	110,421,745	123,534,578	124,341,171	130,670,289
Allowable Cost of Care re: payments				307,658,779	330,642,790	349,787,424	375,910,924	394,057,285
Surplus (Shortfall)	0	0	0	(203,081,669)	(220,221,045)	(226,252,846)	(251,569,753)	(263,386,996)

Source: Altru Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Orthopedics	21,812,238	22,086,073	22,977,684	20,328,051	18,649,827	19,766,131	33,267,692	34,412,616
Cardiology	18,032,640	18,626,589	16,608,949	16,291,841	12,727,072	15,469,228	16,200,213	16,480,769
General Surgery	14,066,914	14,155,204	14,245,444	14,998,322	15,407,955	17,470,919	17,401,971	16,511,963
Other program services	340,903,727	366,084,337	403,083,516	415,694,194	440,998,320	457,919,380	462,967,410	484,206,695
Total	**394,815,519**	**420,952,203**	**456,915,593**	**467,312,408**	**487,783,174**	**510,625,658**	**529,837,286**	**551,612,043**
Expenses								
Orthopedics	17,555,778	18,652,584	16,961,112	14,464,727	12,495,038	11,641,749	17,176,606	19,028,382
Cardiology	13,608,082	16,539,952	12,212,587	12,807,551	9,722,848	11,849,885	10,714,406	10,567,623
General Surgery	9,242,009	10,324,126	9,821,228	10,809,208	10,412,263	11,872,371	10,688,470	8,016,521
Other program services	307,524,870	332,278,022	353,323,575	389,356,930	396,729,210	416,660,541	438,579,076	455,745,935
Total	**347,930,739**	**377,794,684**	**392,318,502**	**427,438,416**	**429,359,359**	**452,024,546**	**477,158,558**	**493,358,461**

Source: Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				5.72%	6.29%	4.39%	4.39%	3.98%
Financial Assistance at cost				3,566,208	3,354,429	2,773,818	2,445,008	2,119,706
Medicaid				22,016,320	25,804,508	18,314,583	20,016,397	19,447,748
Costs of other				1,376,658	887,259	1,055,047	1,017,567	896,723
Total	0	0	0	26,959,186	30,046,196	22,143,448	23,478,972	22,464,177
Other Benefits, net				0.33%	0.38%	0.43%	0.35%	0.36%
Community health improvement services and community benefit operations				834,664	1,053,906	1,041,072	907,359	1,159,720
Health professions education				475,189	460,451	631,029	663,027	608,719
Subsidized health services				0	0	0	0	0
Research				227,035	236,175	281,840	222,189	78,498
Cash and in-kind contributions for community benefit				8,707	41,530	133,052	107,375	147,000
Total, Other benefits	0	0	0	1,545,595	1,792,062	2,086,993	1,899,950	1,993,937
Total, Overall	0	0	0	28,504,781	31,838,258	24,230,441	25,378,922	24,458,114
%, Total Expense	0.00%	0.00%	0.00%	6.05%	6.67%	4.82%	4.74%	4.34%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bond

Issuer Name	CUSIP #	Date Issued	Principal Amount	Issue Price	Description of purpose
City of Grand Forks	38546WCC2	5/1/2012	37855000	117025978	Refund Bonds issued in 1997, amd 2010A/2010B
City of Grand Forks	38546WCR9	7/12/2017		65233846	Refund bonds issued in 2005; finance facilities, imfrastructure, equipment
City of Grand Forks		9/6/2017		21720835	Refund binds issued in 2007

Source: Schedule K, Form 990; EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Abdel Ahmed	1,647,335
Mickey Syrquin	1,096,754
Mohamed Chebaclo	1,050,573
Ikechukwu Onyeka	974,234
Ronald Brockman	901,315
Donald Debeltz MD	488,584
Casey Ryan MD	482,691
James Hargreaves DO	432,117
Matthew Roller MD	430,382
David Molmen	420,142

2011	
Name/Title	Compensation
Abdel Ahmed	1,772,882
Mickey Syrquin	1,084,630
Ikechukwu Onyeka	1,080,120
Srinivas Pulagam	991,465
Randall Smith	949,994
James Hargreaves DO	583,760
Bradley Belluk MD	528,424
Casey Ryan MD	523,082
David Molmen	496,947
Matthew Roller MD	452,907

2012	
Name/Title	Compensation
Abdel Ahmed, *Physician*	1,857,653
Mickey Syrquin, *Physician*	1,073,900
Ikechukwu Onyeka, *Physician*	1,044,641
Barry Bjorgaard, *Physician*	1,016,076
Randall Smith, *Physician*	887,745
Casey Ryan MD, *Board Member/Pre*	559,562
David Molmen, *Board Member/CEO*	540,235
Bradley Belluk MD, *Board Member/I*	521,348
Matthew Roller MD, *Baord Member/*	442,147
Dwight Thompson, *CFO/Treasurer*	392,025

2013	
Name/Title	Compensation
Abdel Ahmed, *Physician*	1,861,365
Ikechukwu Onyeka, *Physician*	1,137,914
Srinivas Pulagam, *Physician*	999,728
Charles Owens, *Physician*	887,777
Randall Smith, *Physician*	874,330
Casey Ryan MD, *Board Member/President/Physician*	580,384
David Molmen, *Board Member/CEO*	573,431
Scott Charette MD, *Medical Director Surgical Care*	572,715
Bradley Belluk MD, *Board Member/Physician*	515,048
Dwight Thompson, *CFO/Treasurer*	465,290

2014	
Name/Title Name/Title	Compensation
Ikechukwu Onyeka, *Phsyician*	1,187,870
Charles Wood, *Physician*	1,034,294
Srinivas Pulagam, *Physician*	1,033,191
Rabeea Aboufakher, *Physician*	944,870
Abdel Ahmed, *Physician*	921,341
Casey Ryan MD, *Board Member/President/Physician*	691,056
David Molmen, *Board Member/CEO*	645,753
Scott Charette, *Medical Director Surgical*	549,182
Matthew Roller MD, *Board Member/Physician*	523,041
Bradley Belluk MD, *Board Member/Physician*	520,951

2015	
Name/Title	Compensation
Ikechukwu Onyeka, *Physician*	1,216,893
David Molmen, *CEO*	1,081,280
Rabeea Aboufakher, *Physician*	988,595
Abdel Ahmed, *Physician*	911,630
Srinivas Pulagam, *Physician*	916,590
Charles Owens, *Physician*	887,114
Eric Lunn, *Board Member/Physician*	701,728
Bradley Wehe, *Board Member/COO*	658,672
Dwight Thompson, *CFO/Treasurer*	653,892
Scott Charette, *Medical Director Surgical*	633,204

2016	
Name/Title	Compensation
Ikechukwu Onyeka, *Physician*	1,365,472
David Molmen, *CEO*	1,090,019
Rabeea Aboufakher, *Physician*	997,739
Atilla Dalmi, *Physician*	971,018
Darin Leetun, *Physician*	936,051
Dwight Thompson, CFO/Treasurer	763,197
Eric Lunn, *Board Member/Physician*	758,465
Scott Charette, *Medical Director Surgical*	699,246
Bradley Wehe, *Board Member/COO*	678,098
Colleen Swank MD, *Chief Medical Officer*	589,528

2017	
Name/Title	Compensation
Ikechukwu Onyeka, *Physician*	1,426,413
Rabeea Aboufakher, *Physician*	1,187,637
Atilla Dalmi, *Physician*	1,014,939
Charles Owen, *Physician*	938,958
Sunil Kartham, *Physician*	923,415
Abdel Ahmed, *Physician*	911,630
David Molmen, *CEO*	846,935
Dwight Thompson, *CFO/Treasurer*	754,671
Jeremy Gardner, *Medical Director*	712,205
Scott Charette, *Medical Director Surgical*	657,869

Source: Altru Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?
Assets									
Current Assets		$ 320,178,922	$ 280,054,731	$ 270,730,636				$ 240,610,408	$ 226,672,418
Limited Use Assets		29,810,407	30,396,027	27,415,232				18,368,259	30,376,301
Property, Plant & Equipment		203,335,952	198,434,986	205,623,938				142,526,810	135,558,001
Other Assets		8,865,990	9,274,539	7,226,506				4,551,519	4,244,817
Total Assets	**-**	**562,191,271**	**518,160,283**	**510,996,312**	**-**	**-**	**-**	**406,056,996**	**396,851,537**
Liabilities and Net Assets									
Current Liabilities		55,746,269	63,662,106	58,623,991				54,300,051	52,487,196
Long-Term Liabilities		225,475,903	201,358,056	208,689,758				184,584,345	177,271,800
Total Liabilities		281,222,172	265,020,162	267,313,749	-	-	-	238,884,396	229,758,996
Net Assets		280,969,099	253,140,121	243,682,563				167,172,600	167,092,541
Total Liabilities & Net Assets	$ -	$ 562,191,271	$ 518,160,283	$ 510,996,312	$ -	$ -	$ -	$ 406,056,996	$ 396,851,537

Income Statement

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?
Unrestricted Operating Revenue									
Patient Service Revenue		$ 533,215,486	$ 522,763,865	$ 500,727,804				$ 414,545,592	$ 390,262,581
Provision for Bad Debts		(9,880,302)	(9,255,097)	(11,570,421)				(29,151,584)	(18,618,905)
Net Patient Revenue	-	523,335,184	513,508,768	489,157,383	-	-	-	385,394,008	371,643,676
Other Operating Revenue		41,401,503	37,804,757	37,598,553				22,001,873	19,734,977
Total Operating Revenue	-	564,736,687	551,313,525	526,755,936	-	-	-	407,395,881	391,378,653
Unrestricted Operating Expenses									
Patient care Services		85,070,813	86,168,011	79,906,192				55,609,884	51,332,616
Clinic Professional Services		186,666,225	177,825,264	158,737,640				123,798,591	113,260,706
Other Professional Services		92,495,448	92,121,844	89,858,055				79,307,432	79,538,883
Other Services		4,342,418	4,084,427	4,677,166				4,333,329	4,729,977
General Services		25,289,048	24,816,414	25,187,722				19,435,031	18,104,304
Administrtive Services		72,889,707	60,240,576	54,568,811				35,961,439	32,119,365
Amoritization of Other Costs		141,713	146,752	123,135				609,858	687,734
Real Estate Taxes		881,513	945,225	926,935				673,660	602,360
Interest		8,602,086	8,719,051	8,903,109				6,549,921	6,530,463
Depreciation		26,829,770	27,304,334	28,391,468				20,792,774	18,630,076
Insurance		2,495,461	2,651,344	2,702,743				2,082,579	2,941,450
Employee Benefits and Payroll Taxes		58,259,505	52,456,799	52,939,889				46,045,786	42,901,413
Total Operating Expense	-	563,963,707	537,480,041	506,922,865	-	-	-	395,200,284	371,379,347
Net Income from Operations		**772,980**	**13,833,484**	**19,833,071**	**-**	**-**	**-**	**12,195,597**	**19,999,306**
Other Income - Primary Investments		7,355,366	3,591,792	2,124,815				5,899,511	4,615,985
Other Expense - Impairment		-	(7,071,248)	-				-	-
Other Expense		(269,688)	(269,688)	(269,688)				(1,086)	(44,531)
Cash Balance Settlement Expense		(3,463,026)	-	-				-	-
Loss on Advance Bond Refunding		(1,408,850)	-	-				-	-
Total Other Income (Expense)		2,213,802	(3,749,144)	1,855,127	-	-	-	5,898,425	4,571,454
Excess Revnue over Expense		**2,986,782**	**10,084,340**	**21,688,198**	**-**	**-**	**-**	**18,094,022**	**24,570,760**
Unrealized Gain/(Loss) on Investments		13,724,411	5,855,499	(2,344,648)				(1,908,999)	6,666,992
Increase in Unrestricted Net Assets	$ -	$ 16,711,193	$ 15,939,839	$ 19,343,550	$ -	$ -	$ -	$ 16,185,023	$ 31,237,752

Source: Altru Audited Financial Statements, 2010-2017

INNOVIS HEALTH LLC

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As: Essentia Health West

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**259,370,424**	**272,859,742**	**300,121,459**	**333,821,248**	**356,239,221**	**363,725,628**	**373,471,417**	**370,391,230**
Contributions and grants	37,133	45,813	272,147	296,483	197,882	367,535	166,865	156,981
Program service revenue	259,134,360	270,973,139	297,713,532	330,732,484	351,579,702	359,254,512	371,245,879	368,689,895
Investment income	(2,182,423)	(704,791)	(359,139)	(1,796,536)	(96,797)	(753,709)	162,661	(682,038)
Other revenue	2,381,354	2,545,581	2,494,919	4,588,817	4,558,434	4,857,290	1,896,012	2,226,392
Expenses	**260,636,475**	**285,329,352**	**303,482,084**	**325,006,503**	**333,859,123**	**362,753,939**	**376,194,458**	**378,942,827**
Grants	250,000	577,502	527,425	580,046	567,432	446,638	402,654	388,694
Salaries/Emp. Benefits	144,171,719	151,490,833	157,665,642	163,270,817	167,140,007	182,217,515	194,258,048	199,752,589
Other expenses	116,214,756	133,261,017	145,289,017	161,155,640	166,151,684	180,089,786	181,533,756	178,801,544
Revenue less expenses	(1,266,051)	(12,469,610)	(3,360,625)	8,814,745	22,380,098	971,689	(2,723,041)	(8,551,597)
Total Assets	206,182,462	220,177,623	202,614,626	220,061,557	294,543,640	303,736,083	287,530,202	280,506,448
Total Liabilities	201,905,639	230,886,064	215,571,832	224,983,615	277,168,617	289,568,679	276,854,758	277,532,422
Net assets or fund balances	4,276,823	(10,708,441)	(12,957,206)	(4,922,058)	17,375,023	14,167,404	10,675,444	2,974,026
Bad Debt Expense				26,536,766	20,695,964	12,002,754	12,093,910	8,803,788
Medicare								
Revenue Received (incl. DSH & IME)				68,203,119	71,182,090	73,859,989	78,229,343	83,132,595
Allowable Cost of Care re: payments				70,710,482	69,188,290	86,061,965	93,020,318	103,573,835
Surplus (Shortfall)	0	0	0	(2,507,363)	1,993,800	(12,201,976)	(14,790,975)	(20,441,240)

Source: Innovis Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Overall	259,134,360	270,973,139	297,713,532	330,732,484	351,579,702	359,254,512	371,245,879	368,689,895
Total	**259,134,360**	**270,973,139**	**297,713,532**	**330,732,484**	**351,579,702**	**359,254,512**	**371,245,879**	**368,689,895**
Expenses								
Overall	203,073,962	205,275,235	228,102,956	266,993,571	272,849,081	304,828,012	330,236,114	337,757,025
Total	**203,073,962**	**205,275,235**	**228,102,956**	**266,993,571**	**272,849,081**	**304,828,012**	**330,236,114**	**337,757,025**

Source: Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				3.93%	2.20%	2.58%	3.51%	3.68%
Financial Assistance at cost				2,880,985	3,252,865	3,558,757	4,204,613	4,958,133
Medicaid				8,826,766	3,640,169	5,523,278	8,601,379	8,671,851
Costs of other				0	0	0	0	0
Total	0	0	0	11,707,751	6,893,034	9,082,035	12,805,992	13,629,984
Other Benefits, net				0.35%	0.34%	0.40%	0.48%	0.52%
Community health improvement services and community benefit operations				112,109	170,840	283,980	477,500	204,586
Health professions education				935,927	905,859	1,114,965	1,123,161	1,622,873
Subsidized health services				0	0	0	1,071	0
Research				0	0	0	0	0
Cash and in-kind contributions for community benefit				0	0	4,175	130,227	78,360
Total, Other benefits	0	0	0	1,048,036	1,076,699	1,403,120	1,731,959	1,905,819
Total, Overall	0	0	0	12,755,787	7,969,733	10,485,155	14,537,951	15,535,803
%, Total Expense	0.00%	0.00%	0.00%	4.28%	2.54%	2.98%	3.99%	4.20%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bond

Issuer Name	CUSIP #	Date Issued	Maturity Date	Coupon	Principal Amount at Issuance	Issue Price	Description of Purpose
MN AG & ECON DEVEL BRD	604920Z43	2008-05-02	2/15/2038	4.75%	4,410,000	42,909,274	SRS 2008E Bonds
CASS COUNTY ND	148047AU7	7/12/2017	2/15/2037	5.125%	61,100,000	59,573,111	SRS 2008A REOFF
WI HEALTH AND EDUCATION FACILITI	97710BSD5	2/25/2010	2/15/2030	5.125%	12,975,000	12,854,722	SRS 2008B REOFF
MN AG & ECON DEVEL BRD	6049202H0	2/25/2010	2/15/2030	5.000%	52,860,000	165,717,405	SRS 2008C REOFF
CASS COUNTY ND	148047AX1	6/3/2014	2/15/2044	4.790%	45,000,000	45,000,000	SRS 2014-ND Bonds

Source: Schedule K (Form 990); EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Daniel Smith MD, *Surgeon*	1,333,094
Jerome Sampson MD, *Radiologist*	1,163,114
Aaron Wright MD, *Radiologist*	1,075,630
Marc Eichler MD, *Neurosurgeon*	1,021,337
Francis Cormier MD, *Orthopedic Surgeon*	994,342
Timothy Mahoney MD, *Clinical Services C*	879,821
Gregory Glasner MD, *President*	786,910
Kevin Pitzer, *Chief Administrative Officer*	583,363
Richard Vetter MD, *Clinical Services Chie*	566,434
Michael Briggs MD, *Clinical Services Chie*	391,355

2011	
Name/Title	Compensation
Bradford Selland MD	1,091,597
Daniel Smith MD	1,048,431
Jerome Sampson MD	915,887
Aaron Wright MD	913,766
Francis Comier MD	897,042
Timothy Mahoney	Timothy Mahoney	732,287
Gregory Glasner I	Gregory Glasner I	709,258
Kevin Pitzer	556,994
Richard Vetter MD	490,604
Robert Wroblewski MD	392,583

2012	
Name/Title	Compensation
Bradford Selland MD	1,368,964
Daniel Smith MD	1,217,613
Francis Comier MD	1,048,221
Jerome Sampson MD	907,524
Aaron Wright MD	819,831
Timothy Mahoney MD	641,513
Gregory Glasner MD	606,533
Kevin Pitzer	487,418
Richard Vetter MD	480,101
Robert Wroblewski MD	408,083

2013	
Name/Title	Compensation
Michael Hill MD, *Physician*	1,289,918
Daniel Smith MD, *Physician*	1,128,453
Francis Cornier MD, *Physician*	1,024,015
Jerome Sampson MD, *Physician*	981,513
Bradford Selland MD, *Physician*	873,536
Gregory Glasner MD, *President & CMO*	713,333
Timothy Mahoney MD, *Clinical Services C*	706,836
Richard Vetter MD, *Clinical Services Chie*	537,639
Peter Jacobson, *West SVP/Pres EH St M*	456,531
Michael Briggs MD, *Clinical Services Chie*	429,205

2014	
Name/Title	Compensation
Michael Hill MD, *Physician*	1,195,989
Daniel Smith MD, *Physician*	1,128,521
Abdul Baker MD, *Physician*	1,084,725
Saeed Ally MD, *Physician*	1,034,325
Jerome Sampson MD, *Physician*	1,004,529
Gregory Glasner MD, *President & C*	694,700
Timothy Mahoney MD, *Clinical Serv*	651,180
Richard Vetter MD, *Clinical Services*	488,650
Doug Vang, *SVP Hospital OPS Thru*	486,377
Peter Jacobson, *West SVP/Pres EH*	450,949

2015	
Name/Title	Compensation
Abdul Baker MD, *Physician*	1,503,276
Daniel Smith MD, *Physician*	1,219,301
Saeed Ally MD, *Physician*	1,107,273
Jerome Sampson MD, *Physician*	1,061,399
Mickey Syrquin MD, *Physician*	1,013,848
Gregory Glasner MD, *President & C*	674,665
Timothy Sayler, *Chief Operating Offi*	671,509
Robert Wroblewski MD, *Board Direc*	589,013
Peter Jacobson, *SVP Regional & Pr*	501,365
Richard Vetter MD, *Primary Care Cl*	495,036

2016	
Name/Title	Compensation
Abdul Baker MD, *Physician*	2,037,310
Daniel Smith MD, *Physician*	1,276,615
Benjamin Smith MD, *Physician*	1,142,473
Mitchell Crider MD, *Physician*	1,076,262
Jerome Sampson MD, *Physician*	1,001,146
Gregory Glasner MD, *President*	824,161
Robert Wroblewski MD, *Board Director*	565,547
Timothy Sayler, *Chief Operating Officer*	562,514
Richard Vetter MD, *Physician Chief, Primary Care Services,*	495,633
Stefanie Gefroh Ellison MD, *Physician Chief, Hospital Base*	461,981

2017	
Name/Title	Compensation
Daniel Smith MD, *Physician*	1,225,020
Abdul Baker MD, *Physician*	1,150,604
Mitchel Crider MD, *Physician Leade*	1,039,185
Benjamin Smith MD, *Physician*	990,603
Sumit Tiwari MD, *Physician*	986,901
Gregory Glasner MD, *President*	740,185
Timothy Sayler, *Chief Operating Off*	581,894
Robert Wroblewski MD, *Board Direc*	544,076
Scott Johnson MD, *Chief Medical O*	541,023
Richard Vetter MD, *Physician Leade*	536,160

Source: Innovis Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2019	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Assets										
Current Assets	$ 419,422	$ 401,767		$ 418,945	$ 397,664					
Limited Use Assets	1,810,901	1,113,331		654,605	514,292					
Property, Plant & Equipment	739,073	714,760		619,867	591,094					
Other Assets	109,846	109,932		121,942	126,735					
Total Assets	**3,079,242**	**2,339,790**	**-**	**1,815,359**	**1,629,785**	**-**	**-**	**-**	**-**	**-**
Liabilities and Net Assets										
Current Liabilities	277,666	251,730		235,192	214,458					
Long-Term Liabilities										
Total Liabilities	1,732,172	1,076,602		1,014,017	931,586	-	-	-	-	-
Net Assets	1,347,070	1,263,188		801,342	698,199					
Total Liabilities & Net Assets	$ 3,079,242	$ 2,339,790	$ -	$ 1,815,359	$ 1,629,785	$ -	$ -	$ -	$ -	$ -

Income Statement

Period ending date	6/29/2018	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Operating Revenue										
Patient Service Revenue	$ 2,102,254	$ 2,010,148		$ 1,894,389	$ 1,817,193					
Provision for Bad Debts	-	-		61,176	62,792					
Net Patient Revenue	2,102,254	2,010,148	-	1,955,565	1,879,985	-	-	-	-	-
Other Operating Revenue	65,933	56,128		-	-					
Total Operating Revenue	2,168,187	2,066,276	-	1,955,565	1,879,985	-	-	-	-	-
Unrestricted Operating Expenses										
Salaries, wages and related benefits	1,346,976	1,299,906		1,205,914	1,156,448					
Supplies	358,651	336,662		312,897	292,713					
Purchased services and professional fees	83,247	83,946		71,987	70,828					
Utilities and maintenance	72,891	71,059		-	-					
Professional liability and general insuranc	15,960	23,039		-	-					
Depreciation and amortization	91,068	91,462		86,664	80,323					
Interest	25,725	25,456		-	-					
Provider and other taxes	34,914	31,928		-	-					
Other	78,354	79,868		218,636	214,335					
Campus replacement and other costs	6,931	11,986		-	-					
Total Operating Expense	2,114,717	2,055,312	-	1,896,098	1,814,647	-	-	-	-	-
Net Income from Operations	**53,470**	**10,964**	**-**	**59,467**	**65,338**	**-**	**-**	**-**	**-**	**-**
Investment income on funds	19,510	15,299								
Net realized gains on investments	35,066	19,724							-	-
Net change in unrealized gains and losse	(3,066)	53,092								
(Loss) Gains on swap agreements	(2,680)	3,457		-	-				-	-
Other, net	(4,013)	(1,383)		(50,792)	16,948				-	-
Total nonoperating gains, net	44,817	90,189	-	(50,792)	16,948	-	-	-	-	-
Excess Revnue over Expense	**98,287**	**101,153**	**-**	**8,675**	**82,286**	**-**	**-**	**-**	**-**	**-**
Pension and other postretirment liability a	(16,977)	18,380								
Other, net	1,236	876								
Increase in Net Assets	$ 82,546	$ 120,409	$ -	$ 8,675	$ 82,286	$ -	$ -	$ -	$ -	$ -

Source: Essentia Audited Financial Statements, 2010-2017

SANFORD (Group, includes other states)

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As N/A

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**2,379,772,843**	**2,820,513,337**	**3,405,373,090**	**3,652,696,559**	**3,411,016,895**	**3,621,661,130**	**3,741,477,877**	**3,924,093,992**
Contributions and grants	50,707,291	59,295,812	68,966,991	55,758,028	59,401,173	55,386,334	70,015,308	72,701,349
Program service revenue	2,316,427,369	2,755,702,179	3,329,759,934	3,589,720,396	3,338,667,965	3,553,249,301	3,669,768,613	3,844,742,598
Investment income	10,847,236	3,651,009	4,594,569	2,764,588	8,788,377	8,700,289	(1,365,155)	3,638,552
Other revenue	1,790,947	1,864,337	2,051,596	4,453,547	4,159,380	4,325,206	3,059,111	3,011,493
Expenses	**2,323,983,967**	**2,747,993,308**	**3,362,393,616**	**3,550,243,043**	**3,207,510,050**	**3,409,148,116**	**3,602,772,824**	**3,811,087,565**
Grants	15,705,354	18,934,965	19,010,601	10,658,800	11,403,756	14,409,710	22,990,888	29,331,220
Salaries/Emp. Benefits	1,263,960,872	1,440,771,373	1,829,378,640	1,888,740,884	1,981,169,107	2,090,504,437	2,181,401,280	2,285,593,789
Other expenses	1,044,317,741	1,288,286,970	1,514,004,375	1,650,843,359	1,214,937,187	1,304,233,969	1,398,380,656	1,496,162,556
Revenue less expenses	55,788,876	72,520,029	42,979,474	102,453,516	203,506,845	212,513,014	138,705,053	113,006,427
Total Assets	1,577,600,190	1,897,147,387	2,311,855,171	2,335,827,341	2,518,921,978	2,665,510,312	2,760,585,976	2,835,813,206
Total Liabilities	845,339,675	1,059,466,486	1,233,964,385	1,222,181,413	1,456,837,768	1,574,793,011	1,598,658,494	1,553,506,154
Net assets or fund balances	732,260,515	837,680,901	1,077,890,786	1,113,645,928	1,062,084,210	1,090,717,301	1,161,927,482	1,282,307,052
Bad Debt Expense				69,429,822	55,641,853	36,726,460	49,187,478	50,285,952
Medicare								
Revenue Received (incl. DSH & IME)				667,477,189	713,108,245	760,987,356	822,234,978	881,110,124
Allowable Cost of Care re: payments				673,131,137	702,648,689	774,759,500	848,058,095	936,620,572
Surplus (Shortfall)	0	0	0	(5,653,948)	10,459,556	(13,772,144)	(25,823,117)	(55,510,448)

Source: Sanford Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Sanford	-	2,754,593,768	3,326,970,820	3,586,460,338	3,336,037,044	3,548,886,392	3,666,072,736	3,769,499,749
Medical Education	-	0	0	0	0	0	0	3,873,734
Sanford Research	-	2,269,852	2,096,148	3,260,058	2,630,921	4,362,909	3,695,877	4,203,667
Sanford USD Medical Center	1,105,072,720	-	-	-	-	-	-	-
Sanford Clinic	739,677,830	-	-	-	-	-	-	-
Sanford Health Network	274,274,309	-	-	-	-	-	-	-
Other program services	198,549,869	-	-	-	-	-	-	-
Total	**2,317,574,728**	**2,756,863,620**	**3,329,066,968**	**3,589,720,396**	**3,338,667,965**	**3,553,249,301**	**3,669,768,613**	**3,777,577,150**
Expenses								
Sanford	-	2,314,517,695	2,840,430,011	2,922,714,702	2,760,546,120	2,904,255,181	3,126,592,371	3,244,372,653
Medical Education	-	5,293,670	6,281,978	6,808,460	7,517,291	8,684,420	11,696,380	24,181,248
Sanford Research	-	24,498,548	27,967,031	26,414,384	2,862,045	27,694,832	13,860,412	25,803,175
Sanford USD Medical Center	780,703,971	-	-	-	-	-	-	-
Sanford Clinic	747,128,357	-	-	-	-	-	-	-
Sanford Health Network	187,326,236	-	-	-	-	-	-	-
Other program services	257,549,591	-	-	-	-	-	-	-
Total	**1,972,708,155**	**2,344,309,913**	**2,874,679,020**	**2,955,937,546**	**2,770,925,456**	**2,940,634,433**	**3,152,149,163**	**3,294,357,076**

Source: Sanford Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				3.78%	4.84%	5.65%	7.14%	6.43%
Financial Assistance at cost				50,811,514	58,264,928	67,179,952	65,358,134	72,271,034
Medicaid				77,143,970	96,981,543	125,449,580	192,160,446	172,511,011
Costs of other				0	0	0	0	0
Total	0	0	0	127,955,484	155,246,471	192,629,532	257,518,580	244,782,045
Other Benefits, net				5.46%	6.21%	2.75%	4.04%	3.28%
Community health improvement services and community benefit operations				4,441,285	6,108,204	6,935,625	7,903,786	9,711,726
Health professions education				12,621,370	11,426,524	11,319,584	14,836,321	20,307,514
Subsidized health services				140,325,856	159,720,237	48,562,992	95,223,586	61,359,678
Research				18,131,505	13,458,712	16,547,656	15,549,489	14,101,052
Cash and in-kind contributions for community benefit				9,769,166	8,311,960	10,724,280	12,335,806	19,912,155
Total, Other benefits	0	0	0	185,289,182	199,025,637	94,090,137	145,848,988	125,392,125
Total, Overall	0	0	0	313,244,666	354,272,108	286,719,669	403,367,568	370,174,170
%, Total Expense	0.00%	0.00%	0.00%	9.24%	11.05%	8.40%	11.18%	9.71%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bond

Issuer Name	CUSIP #	Date Issued	Maturity Date	Coupon	Principal Amount at Issuance	Issue Price	Description of Purpose
South Dakota Health and Educational Facil	83755VHY3	9/14/2004	11/1/2034	5.25%	18,050,000	70,073,989	2004: New construction of healthcare facilities
South Dakota Health and Educational Facil	83755VNZ3	9/29/2009	11/1/2040	5.50%	39,965,000	71,015,042	2009:New construction and remodeling of healthcare facilities
City of Fargo	307479CK9	2/9/2011	11/1/2031	6.25%	56,935,000	134,069,821	2011: Refunding bonds issued 12/5/1996, 11/8/2000, and 6/18/2002
South Dakota Health and Educational Facil	83755VVM3	11/1/2012	11/1/2042	4.00%	20,000,000	128,733,641	2012E: New construction and remodeling of healthcare facilities
Affiliates:							
City of Chamberlain	83755VWA8	8/5/2014	11/1/2034	4.00%	52,000,000	52,083,720	2014A: Current refund 2004A issued 9/14/2004
South Dakota Health and Educational Fa	83755VXE9	10/28/2014	11/1/2044	4.00%	50,000,000	207,014,209	2014B: New construction and remodeling of healthcare facilities
South Dakota Health and Educational Fa	83755VZW7	10/21/2015	11/1/2045	5.00%	50,600,000	192,641,206	2015: New construction and advanced refunding of bonds issued 4/19/07, 5/22/07
South Dakota Health and Educational Fa	-	10/28/2016	-	-	-	50,000,000	2016: New construction, equipment and improvements

Source: Schedule K, Form 990; EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Tomasz P Stys	2,306,869
Scott Pham	2,306,488
Kelby K Krabbenhoft	1,859,865
Adam T Stys	1,831,798
Wilson T Asfora	1,808,633
Marian S Petrasko	1,699,080
John C Vanderwoude	1,215,261
Rebecca Nelson	1,087,793
David Link	1,000,871
Bill Marlette	825,817

2011	
Name/Title	Compensation
Tomasz P Stys	2,119,950
Scott Pham	2,083,575
Kelby K Krabbenhoft	2,071,070
William C Brunner	2,064,305
Wilson T Asfora	2,028,099
Adam T Stys	1,906,183
John C Vanderwoude	1,212,025
Rebecca Nelson	1,070,917
David Link	992,503
Bill Marlette	806,339

2012	
Name/Title	Compensation
William C Brunner, *Physician*	2,121,005
Kelby K Krabbenhoft, *Sanford Healt*	2,151,098
Tomasz P Stys, *Physician*	2,106,918
Scott Pham, *Physician*	2,096,690
Adam T Stys, *Physician*	1,953,062
Corey L Teigen, *Physician*	1,798,327
Rebecca Nelson, *Senior Vice Presi*	1,111,539
Craig Lambrecht, *President - Sanfo*	873,647
David Link, *Executive Vice Presider*	994,432
Bill Marlette, *Treasurer*	802,947

2013	
Name/Title	Compensation
Rebecca Nelson, *Senior VP & COO - HSD (Thru Nov 13)*	4,842,070
Rebecca Nelson Deferred Comp, *Senior VP & COO - HSD (t*	3,782,496
Tomasz P Stys, *Physician*	2,634,732
Scott Pham, *Physician*	2,438,552
Corey L Teigen	2,297,555
William C Brunner	2,249,392
Bruce Pitts MD, *Chief Medical Officer (thru July 13)*	2,102,001
Kelby K Krabbenhoft, *Sanford Health President & CEO*	1,951,933
Lisa Carlson, *Former Chief Financial Officer Corp*	1,636,216
Craig Lambrecht, *President - Sanford Bismarck*	893,909

2014	
Name/Title	Compensation
Scott Pham, *Phys*	3,420,899
Kelby K Krabbenh	2,500,619
Tomasz P Stys, P	2,496,113
Adam T Stys, Phy	2,307,590
William C Brunne	2,248,099
Corey L Teigen, P	2,106,758
Dennis Millirons, I	1,367,918
Michael LeBeau M	1,187,335
Mark Lundeen MD	1,085,290
David Link, *Execu*	1,019,822

2015	
Name/Title	Compensation
Kelby K Krabbenhoft, *Sanford Presi*	4,635,839
Scott Pham, *Physician*	2,919,505
Tomasz P Stys, *Physician*	2,689,915
Adam T Stys, *Physician*	2,496,823
William C Brunner, *Physician*	2,438,328
Wilson T Asfora, *Physician*	2,196,880
Michael LeBeau MD, *Trustee/Sanfo*	1,318,677
David Link, *Chief Strategy Officer (t*	1,187,684
Nate White, *Chief Operating Officer*	1,157,021
Bill Marlette, *Treasurer*	1,011,854

2016	
Name/Title	Compensation
David Link, *Frmr Chief Strategy Officer (thru 116)*	4,174,052
Kelby K Krabbenhoft, *Sanford President & CEO*	3,032,936
Scott Pham, *Physician*	2,934,430
William C Brunner, *Physician*	2,680,132
Tomasz P Stys, *Physician*	2,581,062
Adam T Stys, *Physician*	2,409,860
Timothy Lindley, *Physician*	2,362,351
Michael LeBeau MD, *Trustee/Sanford Physician*	1,438,533
Nate White, *Chief Operating Officer*	1,179,300
Bill Marlette, *Treasurer*	1,076,713

2017	
Name/Title	Compensation
Kelby K Krabbenhoft, *Sanford Preside*	3,166,316
Scott Pham, *Physician*	2,926,448
William Brunner, *Physician*	2,698,037
Tomasz P Stys, *Physician*	2,686,642
Adam T Stys, *Physician*	2,504,453
Larry Burris, *Physician*	2,298,310
Nate White, *COO/President Fargo*	1,484,074
Michael LeBeau MD, *Trustee/Senior V*	1,443,682
Randy Bury, *Chief Administrative Offic*	1,101,011
JoAnn L Krunkel, *CFO*	1,063,529

Source: Sanford Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2019	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Assets										
Current Assets					$ 800,903	$ 793,101	$ 721,821	$ 594,718		
Limited Use Assets					1,157,698	887,848	898,289	857,901		
Property, Plant & Equipment					1,513,739	1,369,400	1,319,718	1,141,047		
Other Assets					218,415	213,206	211,116	171,800		
Total Assets	-	-	-	-	**3,690,755**	**3,263,555**	**3,150,944**	**2,765,466**	-	-
Liabilities and Net Assets										
Current Liabilities					496,863	413,989	396,808	345,759		
Long-term Liabilities										
Total Liabilities					1,525,927	1,256,705	1,267,821	1,077,743		
Net Assets					2,164,828	2,006,850	1,883,123	1,687,723		
Total Liabilities & Net Assets	$ -	$ -	$ -	$ -	$ 3,690,755	$ 3,263,555	$ 3,150,944	$ 2,765,466	$ -	$ -

Income Statement

Period ending date	6/30/2019	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	11	12	12	12	12	12	12	12	12	12
Cost report status	?	?	?	?	?	?	?	?	?	?
Operating Revenue										
Patient Service Revenue					$ 3,086,517	$ 2,943,498	$ 2,799,279	$ 2,300,714		
Provision for Bad Debts					(145,574)	(165,461)	(130,467)	(99,782)		
Net patient revenue less provison for bad	-	-	-	-	2,940,943	2,778,037	2,668,812	2,200,932	-	-
Premium Revenue					425,830	192,427	144,308	136,702		
Other Operating Revenue				-	342,557	303,855	268,113	163,970		
Net assets released from restrictions for operations					11,780	16,353	24,669	15,141		
Total Operating Revenue	-	-	-	-	3,721,110	3,290,672	3,105,902	2,516,745	-	-
Unrestricted Operating Expenses										
Salaries, wages and related benefits					2,016,238	1,919,987	1,861,635	1,463,129		
Supplies					617,902	544,166	534,315	394,905		
Purchased services and other					453,092	431,012	428,010	362,166		
Medical claims					251,533	97,803	64,908	69,542		
Depreciation and amortization					157,420	157,555	154,722	119,431		
Interest					29,765	30,128	31,466	28,258		
Total Operating Expense	-	-	-	-	3,525,950	3,180,651	3,075,056	2,437,431	-	-
Net Income from Operations	-	-	-	-	**195,160**	**110,021**	**30,846**	**79,314**	-	-
Investment return					(8,495)	22,005	(5,379)	27,914		
Change in interest rate swap valuation					916	1,154	1,680	(677)	-	-
Loss on extinguishment of debt					-	-	-	(2,934)		
Other expenses and losses				-	(18,539)	(15,194)	(13,637)	(18,237)	-	-
Total nonoperating gains, net	-	-	-	-	(26,118)	7,965	(17,336)	6,066	-	-
Excess Revnue over Expense, before co	-	-	-	-	**169,042**	**117,986**	**13,510**	**85,380**	-	-
Contributions received in connection with	-	-	-	-	-		120,059	5,976		
Excess Revnue over Expense	-	-	-	-	**169,042**	**117,986**	**133,569**	**91,356**	-	-
Net assets released from restrictions for acquisitions of property and equipment					3,576	2,160	5,326	5,010		
Pension plan related changes other than net periodic plan expense					(15,347)	1,304	33,632	(22,499)		
Increase in Net Assets	$ -	$ -	$ -	$ -	$ 157,271	$ 121,450	$ 172,527	$ 73,867	$ -	$ -

Source: Sanford Audited Financial Statements

St Alexius

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Eric Belanger, *Neurosurgeon*	1,503,989
Steven Karljic, *Neurosurgeon*	1,442,692
John Windsor, *Interventional*	915,614
Leslie Rainwater, *Urologist*	796,803
Brent Herbel, *Interventional R*	761,060
Andrew Wilson, *President/CE*	615,921
Dr Syed Hyder, *VP Medical A*	485,097
Gary Miller, *President/CEO*	298,066
Rosanne Schmidt, *VP/CNO*	253,345
Duwayne Schlittenhard, *VP F*	234,250

2011	
Name/Title	Compensation
Steven Kraljic, *Neurosurgeon*	1,671,358
Eric Belanger, *Neurosurgeon*	1,652,421
Robert Oatfield, *Interventional Cardi*	805,029
Leslie Rainwater, *Urologist*	792,864
Brent Herbel, *Interventional Radiolo*	784,645
Gary Miller, *President/CEO*	508,519
Dr Syed Hyder, *VP Medical Affairs*	506,795
Rosanne Schmidt, *VP/CNO*	281,419
Wanda Pfaff, *VP Human Resources*	252,625
Duwayne Schlittenhard, *VP Profess*	247,713

2012	
Name/Title	Compensation
Eric Belanger, *Neurosurgeon*	1,984,929
Steven Kraljic, *Neurosurgeon*	1,600,858
Leslie Rainwater, *Urologist*	1,001,259
Brent Herbel, *Interventional Radiolo*	910,278
Robert Oatfield, *Interventional Cardi*	783,096
Gary Miller, *President/CEO*	709,115
Shiraz Hyder, *VP Medical Affairs*	559,831
Rosanne Schmidt, *VP & Chief Nursi*	305,775
Wanda Pfaff, *VP Human Resources*	275,265
Duwayne Schlittenhard, *VP Profess*	270,680

2013	
Name/Title	Compensation
Dr Eric Belanger, *Neurosurge*	1,959,608
Dr Steven Kraljic, *Neurosurge*	1,564,530
Dr Brent Herbel, *Interventiona*	768,762
Dr Christopher Fukuda, *Urolo*	766,238
Dr Allen Booth, *Cardiovascul*	718,728
Dr Michael Brown, *Director/C*	714,441
Gary Miller, *President/CEO*	561,699
Syed Hyder, *VP Medical Affa*	438,589
Rosanne Schmidt, *VP Chief I*	235,347
Duwayne Schlittenhard, *VP H*	205,501

2014	
Name/Title	Compensation
Dr Eric Belanger, *Neurosurgeon*	2,300,947
Dr Steven Kraljic, *Neurosurgeon*	2,144,056
Dr Christopher Fukuda, *Urologist*	1,040,711
Gary Miller, *President/CEO (Partial*	795,367
Brent Herbel, *Interventional Radiolo*	770,454
Dr Allen Booth, *Cardiovascular & Th*	762,161
Dr Michael Brown, *Director/Cardiova*	760,996
Shiraz Hyder, *VP Medical Affairs*	668,155
Joseph Messmer, *Interim President/*	377,986
Rosanne Schmidt, *VP & Chief Nursi*	321,102

2015	
Name/Title	Compensation
Dr Eric Belanger, *Neurosurgeon*	2,001,922
Dr Steven Kraljic, *Neurosurgeon*	1,984,671
Jeffrey Drop, *Director*	1,243,310
Dr Allen Booth, *Cardiovascular & Th*	775,057
Dr Michael Brown, *Cardiovascular S*	772,687
Boyd Marts, *Cardiovascular Surgeo*	769,954
Gary Miller, *Former President/CEO*	764,326
Shiraz Hyder, *VP Medical Affairs*	653,908
Kurt Schley, *CEO*	527,762
Joseph Messmer, *Interim President/*	392,534

2016	
Name/Title	Compensation
Dr Steven Kraljic, *Neurosurgeon*	2,094,642
Jeffrey Drop, *Director*	1,343,536
Dr Eric Belanger, *Neurosurgeon*	991,661
Dr Allen Booth, *Cardiovascular & Thoracic Surg*	805,075
Boyd Marts, *Cardiovascular Surgeon*	802,013
Dr Michael Brown, *Cardiovascular Surgeon*	794,165
Kurt Schley, *President/Market CEO*	606,189
Shiraz Hyder, *VP Medical Affairs*	574,250
Kevin Dahmen MD, *Director*	491,856
Todd Preszler MD, *Director*	481,091

2017	
Name/Title	Compensation
Dr Steven Kraljic, *Neurosurgeon*	1,741,860
Jeffrey Drop, *Director*	1,463,693
Kym Chandler, *Neurosurgeon*	1,048,960
Boyd Marts, *Cardiovascular Surgeo*	856,182
Dr Allen Booth, *Cardiovascular & Th*	855,352
Dr Michael Brown, *Cardiovascular S*	844,900
Kevin Dahmen MD, *Director*	628,352
Kurt Schley, *Director & CEO*	624,964
Shiraz Hyder, *VP Medical Affairs*	557,521
Todd Preszler MD, *Director*	519,177

Source: St. Alexius Form 990

TRINITY HEALTH & AFFILIATES

Summary of finanical information outlined in organizations 990 form, ranging from FY2010-2017

Doing Business As N/A

	2010	2011	2012	2013	2014	2015	2016	2017
Revenue	**245,993,420**	**299,355,451**	**289,016,536**	**354,555,120**	**304,581,894**	**320,274,641**	**326,909,495**	**343,256,289**
Contributions and grants	2,237,788	2,311,018	973,398	581,169	882,485	455,678	1,000,420	989,846
Program service revenue	242,014,918	289,982,315	285,352,213	288,652,040	303,832,376	319,236,043	324,534,819	339,392,091
Investment income	1,356,665	1,021,896	2,149,764	335,936	1,279,673	2,053,216	2,891,532	4,086,064
Other revenue	384,049	6,040,222	541,161	64,985,975	(1,412,640)	(1,470,296)	(1,517,276)	(1,211,712)
Expenses	**238,491,890**	**273,369,815**	**271,294,965**	**281,695,301**	**266,631,873**	**284,490,233**	**285,766,508**	**289,483,280**
Grants	417,699	574,274	109,150	265,140	65,700	42,695	305,181	328,506
Salaries/Emp. Benefits	112,977,763	119,323,020	121,387,830	118,973,490	117,749,092	128,847,856	130,308,766	130,124,828
Other expenses	125,096,428	153,472,521	149,797,985	162,456,671	148,817,081	155,599,682	155,152,561	159,029,946
Revenue less expenses	7,501,530	25,985,636	17,721,571	72,859,819	37,950,021	35,784,408	41,142,987	53,773,009
Total Assets	508,339,689	569,541,785	655,440,720	204,703,659	240,116,969	256,607,242	253,406,674	669,932,345
Total Liabilities	274,590,263	309,204,107	376,839,020	47,296,519	54,627,826	51,921,017	41,939,113	481,837,654
Net assets or fund balances	233,749,426	260,337,678	278,601,700	157,407,140	185,489,143	204,686,225	211,467,561	188,094,691
Bad Debt Expense				37,235,009	10,907,414	11,668,252	12,030,387	16,862,202
Medicare								
Revenue Received (incl. DSH & IME)				80,810,183	86,247,019	95,802,446	81,446,956	83,191,546
Allowable Cost of Care re: payments				88,001,604	96,552,067	113,625,298	11,180,140	98,825,791
Surplus (Shortfall)	0	0	0	(7,191,421)	(10,305,048)	(17,822,852)	70,266,816	(15,634,245)

Source: Trinity Form 990; Schedule H (990)

Program Service Financial Overview

Service Area	2010	2011	2012	2013	2014	2015	2016	2017
Revenue								
Trinity Health & Affiliates	-	142,286,571	122,979,923	268,161,318	282,919,529	298,898,528	303,428,741	318,371,603
Trinity Homes	20,488,003	17,825,049	18,443,698	20,490,722	20,912,847	20,337,515	21,106,078	21,020,488
Trinity Hospital Pharmacies	66,171,734	74,682,853	86,379,487	-	-	-	-	-
Trinity Hospital Laboratories	66,171,734	55,187,842	57,549,105	-	-	-	-	-
Other program services	49,685,576	-	-	-	-	-	-	-
Total	**202,517,047**	**289,982,315**	**285,352,213**	**288,652,040**	**303,832,376**	**319,236,043**	**324,534,819**	**339,392,091**
Expenses								
Trinity Health & Affiliates	-	145,199,097	182,724,467	227,345,207	198,714,242	217,077,460	219,738,142	226,221,316
Trinity Homes	21,613,913	20,229,749	19,992,813	23,715,544	20,467,431	21,568,696	20,965,868	20,593,824
Trinity Hospital Pharmacies	22,002,960	24,387,501	27,389,266	-	-	-	-	-
Trinity Hospital Laboratories	10,182,506	10,617,572	10,067,171	-	-	-	-	-
Other program services	143,774,071	-	-	-	-	-	-	-
Total	**197,573,450**	**200,433,919**	**240,173,717**	**251,060,751**	**219,181,673**	**238,646,156**	**240,704,010**	**246,815,140**

Source: Trinity Form 990

Financial Assistance and Certain Other Community Benefits at Cost

	2010	2011	2012	2013	2014	2015	2016	2017
Financial Assistance & Government Programs, net*				2.85%	0.85%	3.51%	0.49%	0.46%
Financial Assistance at cost				4,230,543	1,673,863	2,037,882	1,190,007	1,251,775
Medicaid				3,796,991	519,678	7,537,919	204,019	0
Costs of other				0	0	0	0	0
Total	0	0	0	8,027,534	2,193,541	9,575,801	1,394,026	1,251,775
Other Benefits, net				0.00%	0.00%	0.00%	0.08%	0.13%
Community health improvement services and community benefit operations				0	0	0	147,278	314,850
Health professions education				0	0	0	74,484	16,130
Subsidized health services				0	0	0	0	0
Research				0	0	0	0	0
Cash and in-kind contributions for community benefit				0	0	0	2,660	200
Total, Other benefits	0	0	0	0	0	0	224,422	331,180
Total, Overall	0	0	0	8,027,534	2,193,541	9,575,801	1,618,448	1,582,955
%, Total Expense	0.00%	0.00%	0.00%	2.85%	0.85%	3.51%	0.57%	0.59%

Source: Schedule H (990) *Note: * = Percent of Total Expense*

Municipal Revenue Bonds

Issuer Name	CUSIP #	Date Issued	Maturity Date	Coupon	Principal Amount	Issue Price	Description of Purpose
Ward County North Dakota		9/27/2017				56,875,000	Refund Series 2006 Bonds; Hospital Construction
Ward County North Dakota	394023EW8	12/28/2017				382,748,522	Hospital Construction

Source: Schedule K, Form 990; EMMA

Top 10 Highest Compensated Employees

2010	
Name/Title	Compensation
Martin Rothberg MD	992,473
Kevin Collins	707,661
Jeffrey Verhey	582,970
Jeffrey Sather	575,824
John Nelson	528,980
Scott Knudson	486,275
Danial R Padgett	467,427
John M Hutch	411,928
Asitha Dias	410,996
Kevin Seehafer	291,296

2011	
Name/Title	Compensation
Kevin Collins MD, *Director*	1,011,875
Martin Rothberg MD, *Director*	837,438
Jeffrey Verhey MD, *Former Director*	562,953
John Kutch, *President/CEO*	436,126
Paul Simonson, *VP*	255,570
Kevin Seehafer, *CFO*	242,845
Dave Kohlman, *VP*	186,877
Randy Schwan, *VP*	184,835
Thomas Warsocki, *VP*	177,846
John Sheenan MD, *Former Director*	174,545

2012	
Name/Title	Compensation
Kevin Collins MD, *Director*	823,845
Jeffrey Verhey, *Former Director*	547,422
John Kutch, *President/CEO*	488,981
Paul Simonson, *VP - HR*	255,950
Barbara Brown, *VP - CNO*	216,028
Dave Kohlman, *VP - Facilities*	196,065
Randy Schwan, *VP - Marketing*	186,889
Thomas Warsocki, *VP - Physician R*	173,635
Martin Rothberg MD, *Director*	125,531
Alison Fyre, *Assistant Secretary*	45,426

2013	
Name/Title	Compensation
Martin Rothberg MD, *Director*	1,086,385
Kevin Collins MD, *Director*	753,348
John Kutch, *President/CEO*	556,930
Paul Simonson, *VP - HR*	254,359
Barbara Brown, *VP - CNO*	209,394
Dave Kohlman, *VP - Facilities*	182,166
Randy Schwan, *VP - Marketing*	178,662
Thomas Warsocki, *VP - Physician Rela*	166,391
Dennis Empey, *VP & CFO*	80,537
Alison Fyre, *Assistant Secretary*	51,838

2014	
Name/Title	Compensation
John Kutch, *President/CEO*	681,937
Scott Knutson MD, *Director*	617,979
Dennis Empey, *VP & CFO*	302,755
Paul Simonson, *VP* - HR	251,366
Dave Wanner - *VP - CIO*	229,448
Randy Schwan, *VP - Marketing*	223,337
Thomas Warsocki, *VP - Physician R*	213,937
Barbara Brown, *VP - CNO*	208,905
Dave Kohlman, *VP - Facilities*	184,438
Rhonda Walter, *VP - Trinity Homes*	164,836

2015	
Name/Title	Compensation
John Kutch, *President/CEO*	832,465
Scott Knutson MD, *Director*	547,025
Dennis Empey, *VP & CFO*	352,983
Paul Simonson, *VP - HR*	280,279
Thomas Warsocki, *VP - Physician C*	208,423
Randy Schwan, *VP - Mission Integra*	208,226
Dave Kohlman, *VP - Facilities Mana*	208,012
Martin Rothberg MD, *Director*	204,753
Rhonda Walter, *VP - Trinity Homes*	186,169
Karen Zimmerman, *VP & CNO*	185,930

2016	
Name/Title	Compensation
Martin Rothberg MD, *Director*	850,441
John Kutch, *President & CEO*	761,112
Scott Knutson MD, *Director*	581,669
Dennis Empey, *VP & CFO*	370,898
Paul Simonson, *VP - HR*	278,138
Glen Taylor Wilson, *VP - Clinical Integration*	246,372
Randy Schwan, *VP - Mission Integration*	216,056
Thomas Warsocki, *VP - Physician Operations*	212,056
Dave Kohlman, *VP - Facilities Management*	207,437
Rhonda Walter, *VP - Trinity Homes Administrator*	187,200

2017	
Name/Title	Compensation
John Kutch, *President & CEO*	835,542
Martin Rothberg MD, *Director*	780,654
Scott Knutson MD, *Director*	603,937
Dennis Empey, *VP & CFO*	379,505
Paul Simonson, *VP - HR*	291,845
Glen Taylor Wilson, *VP - Clinical Int*	278,073
Philip Patterson, *VP & CAO*	263,048
Thomas Warsocki, *VP - Physician C*	228,846
Randy Schwan, *VP - Mission Integra*	222,187
Dave Kohlman, *VP - Facilities Mana*	216,179

Source: Trinity Form 990

FINANCIAL STATEMENT OVERVIEW

Balance Sheet

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted
Assets									
Current Assets	8,623,539	$ 8,141,733	$ 8,197,917	$ 7,826,812	$ 7,076,798	$ 4,417,936	$ 4,290,549	$ 3,700,454	$ 3,432,281
Limited Use Assets	5,252,706	5,000,824	4,154,117	4,137,245	3,925,260	3,006,064	2,754,001	2,623,633	2,293,700
Property, Plant & Equipment	8,025,580	7,853,456	7,676,734	6,773,283	6,566,958	4,548,908	4,221,827	3,374,103	3,349,524
Other Assets	4,293,875	3,743,070	3,350,103	3,037,979	2,864,173	476,585	409,538	331,467	246,075
Total Assets	**26,195,700**	**24,739,083**	**23,378,871**	**21,775,319**	**20,433,189**	**12,449,493**	**11,675,915**	**10,029,657**	**9,321,580**
Liabilities and Net Assets									
Current Liabilities	4,475,583	4,491,239	4,502,282	4,138,177	4,045,002	2,748,146	2,492,833	2,366,829	2,360,351
Long-Term Liabilities									
Total Liabilities	12,851,684	12,753,656	13,131,658	10,979,413	9,889,727	6,646,459	6,806,905	4,815,345	5,011,642
Net Assets	13,344,016	11,985,427	10,247,213	10,795,906	10,543,462	5,803,034	4,869,010	5,214,312	4,309,938
Total Liabilities & Net Assets	$ 26,195,700	$ 24,739,083	$ 23,378,871	$ 21,775,319	$ 20,433,189	$ 12,449,493	$ 11,675,915	$ 10,029,657	$ 9,321,580

Income Statement

Period ending date	6/30/2018	6/30/2017	6/30/2016	6/30/2015	6/30/2014	6/30/2013	6/30/2012	6/30/2011	6/30/2010
Number of months in period	12	12	12	12	12	12	12	12	12
Cost report status	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted	As submitted
Operating Revenue									
Patient Service Revenue	$ 16,406,252	$ 15,747,094	$ 14,718,528	$ 12,843,346	$ 12,206,460	$ 8,288,991	$ 7,849,161	$ 6,495,919	$ 5,966,053
Provision for Bad Debts	(574,954)	(548,965)	(489,558)	(358,820)	(605,596)	(480,302)	(431,457)	(323,275)	(306,079)
Net patient revenue less provision for	15,831,298	15,198,129	14,228,970	12,484,526	11,600,864	7,808,689	7,417,704	6,172,644	5,659,974
Premium and capitation revenue	1,067,582	1,039,749	869,030	790,948	687,581	467,093	422,493	378,568	359,441
Net assets releaed information	50,510	39,826	36,352	24,476	27,984	13,566	12,120	12,357	20,513
Other Operating Revenue	1,396,015	1,350,141	1,204,695	1,038,200	1,083,416	689,037	617,136	464,505	434,021
Total Operating Revenue	18,345,405	17,627,845	16,339,047	14,338,150	13,399,845	8,978,385	8,469,453	7,028,074	6,473,949
Unrestricted Operating Expenses									
Salaries, wages and related benefits	7,949,446	7,594,863	7,056,453	6,093,539	5,792,799	3,793,347	3,549,999	2,850,939	2,612,189
Employee benefits	1,525,511	1,510,144	1,457,253	1,211,902	1,182,036	841,318	831,816	729,746	657,147
Contract labor	296,611	242,018	205,916	117,471	101,384	86,365	82,903	56,471	43,937
Total labor expense	9,771,568	9,347,025	8,719,622	7,422,912	7,076,219	4,721,030	4,464,718	3,637,156	3,313,273
Supplies	2,983,635	2,880,802	2,676,637	2,293,317	2,124,452	1,468,953	1,430,933	1,190,255	1,127,789
Purchased services and professional fe	2,083,761	2,059,267	1,889,460	1,601,894	1,449,833	857,177	775,408	683,560	613,443
Depreciation and amortization	857,154	870,289	835,213	740,321	697,808	479,882	464,750	405,631	407,340
Occupancy	748,346	744,444	698,198	592,182	571,577	370,404	348,864	307,722	290,580
Medical Claims	406,330	417,054	414,648	362,848	284,449	238,209	210,245	198,355	191,531
Interest	224,882	207,152	195,829	163,060	156,985	110,533	102,781	84,071	70,651
Other	868,437	835,673	758,103	691,576	638,249	410,448	401,745	296,565	256,032
Total Operating Expense	17,944,113	17,361,706	16,187,710	13,868,110	12,999,572	8,656,636	8,199,444	6,803,315	6,270,639
Operating Income Before Other Item	**401,292**	**266,139**	**151,337**	**470,040**	**400,273**	**321,749**	**270,009**	**224,759**	**203,310**
Consolidation Costs	-	-	-	-	(42,857)	(16,950)	-	-	-
Pension curtailment gain	-	-	-	11,054	149,734	-	-	-	-
Pensions settlement loss	-	-	-	-	(195,987)	-	-	-	(48,986)
Litigation accrual	-	-	-	-	(36,448)	-	-	-	-
Asset impairment charges	(264,366)	(248,070)	(39,623)	(23,402)	(56,293)	-	-	-	-
Restructuring costs	-	(36,184)	-	-	(45,166)	-	-	-	-
Premium revenue adjustment	-	-	(65,335)	-	-	-	-	-	-
Net Income from Operations	**136,926**	**(18,115)**	**46,379**	**457,692**	**173,256**	**304,799**	**270,009**	**224,759**	**154,324**
Investment earnings (losses)	488,715	859,934	(199,326)	106,553	606,309	325,646	(19,159)	483,550	328,038
Equity in earnings of unconsolidated af	328,353	376,642	162,075	182,907	265,703	-	-	-	-
Change in market value and cash payn	25,671	52,955	(94,783)	(10,223)	(25,351)	45,818	(114,468)	13,554	(39,928)
(Loss) Gains from early extinguishment	(39,857)	792	(43,056)	(96,924)	(1,623)	-	(13,458)	(10,185)	(949)
Gain on controlling interest related to a	-	-	-	40,317	-			-	-
Inherent contributions related to acquis	1,903	65,103	133,355	-	-	-	216,796	-	-
Inherent contributions related to acquis	-	-	87,170	-	-	-	-	-	-
Other, including income taxes	7,419	(488)	(2,011)	(8,692)	(15,865)	(9,824)	27,333	(28,765)	(10,856)
Total nonoperating items	812,204	1,354,938	43,424	213,938	829,173	361,640	97,044	458,154	276,305
Excess Revenue over Expense	**949,130**	**1,336,823**	**89,803**	**671,630**	**1,002,429**	**666,439**	**367,053**	**682,913**	**430,629**
Excess Revenue over Expenses Attributable To Noncontrolling Interest	(47,619)	(45,599)	(48,460)	(34,836)	(14,032)	(10,566)	(8,312)	(6,580)	(4,133)
Increase in Net Assets	$ 901,511	$ 1,291,224	$ 41,343	$ 636,794	$ 988,397	$ 655,873	$ 358,741	$ 676,333	$ 426,496

Source: Trinity Health & Affiliates Audited Financial Statements

Appendix C – Financial Assistance, Raw HCRIS Detail, All North Dakota Hospitals

Column: 708
Concept: Cost of initial obligation of insured patients approved for charity care (charges * cost-to-charge ratio) (2552-10 only) [costs_insured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	15	23	12	23	18	9	12	15	15
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	56,390	266,142	240,204	44,283	127,852	51,261	199,929	222,994	246,247
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	1,992,069	317,074	0	0	1,190,751	615,280
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	363,251	375,616	1,196,630	7,051,228	10,038,768	4,125,739	5,177,296	4,736,772	7,682,396
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	10,639,080	20,511,691	9,443,562	11,337,504	5,083,112	1,813,717	1,762,297	2,355,158	1,715,206
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	0	0	0	0	0	0	0	1,694,004	
350070	INNOVIS HEALTH	FARGO	Short Term	0	1,188,806	394,744	314,457	553,855	1,734,644	1,111,062	2,191,436	2,569,392	2,041,894
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	0	0	198	4,438	12,714	245	59,644	13,784	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	46	41	0	0	0	13,839	6,191	33,245	36,595
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	2,804	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	2,846	2,537	2,613	6,204	17,065	0	27,479	18	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	0	0	25,764	2,647	464	134	2,225	13	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	0	0	0	0	55,121	0	0	5,000	1,838
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	15,300	2,508	6,182	24,817	13,639	6,294	4,694	11,485	29,417
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	0	0	61,814	31,157	126,798	167,707	47,239	400,078	728,985
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	0	90,960	185,174	147,834	9,166	139,519	3,276	18,771	41,160
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	0	0	0	0	0	36,154	27,298	43,687	36,726
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	0	0	102,878	35,581	27,182	129,599	43,499	18,518	12,797
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	2,796	14,010	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	0	0	0	0	0	7,029	19,475	46,855	26,006
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	0	41,334	0	0	133,725	34,479	61,916	42,640	52,287
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	4,623	985	3,257	12,227	20,879	34,671	31,974	46,220	16,151
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	17,285	13,145	13,521	17,398	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	57,291	32,628	80,301	62,499	130,346	36,312	7,775	5,207
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	0	2,291	2,483	3,258	0	0	3,456	255	2,395
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	0	0	0	130,293	41,390	99,844	0	0	23,771
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	40,024	8,223	0	0	0	10,121	149,042	28,521	14,201
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	0	0	0	0	0	0	909	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	12,151	15,514	23,757	8,570	22,271	28,998	44,311	50,845	76,346
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	114,608	21,530	15,574	3,217	4,447	2,686	1,935	1,168	1,408
351328	LINTON HOSPITAL	LINTON	Critical Access	0	114,608	27,196	0	0	4,447	0	0	24,893	7,479
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	21,468	33,161	18,913	33,077	96,402	54,819	175,081	411,403	382,985
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	21,468	164,668	119,308	306,320	96,402	231,946	279,118	54,216	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	15,892	14,785	7,966	6,753	17,423	909	23,897	18,716	7,544
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	15,892	16,373	94,463	96,677	17,423	168,849	623,006	0	104,322
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	203,576	0	0	0	23,219	36,154	106,149	203,913	138,982
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	2,305,656	588,545	198,544	505,695	35,364	149,396	168,987	332,240	496,166
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	0	0	0	0	0	95,706	110,737	92,971	100,600
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	0	0	0	97,844	20,051	153,790	187,696	233,542	447,332

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Column: 722
Concept: Cost of initial obligation of uninsured patients approved for charity care (charges * cost-to-charge ratio) (2552-10 only) [costs_uninsured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	11	13	18	20	19	25	27	26	25
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	805,940	1,466,367	1,410,810	612,633	3,300,568	3,990,361	3,384,882	1,694,721	2,035,621
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	802,437	871,688	5,214,596	5,757,152	582,777	1,027,742
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	3,257,232	5,130,742	8,204,332	10,632,040	7,341,888	8,224,134	8,527,808	11,005,264	10,751,936
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	1,012,363	728,409	544,423	2,218,930	2,897,774	3,272,744	3,048,692	3,270,166	2,648,273
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	1,589,557	1,295,960	1,908,805	1,739,464	1,434,792	1,396,594	1,177,534	2,154,704	
350070	INNOVIS HEALTH	FARGO	Short Term	0	1,435,573	933,461	1,737,491	1,029,306	1,722,150	1,386,405	2,002,493	3,986,536	3,698,852
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	5,528	5,226	2,958	7,166	37,561	6,177	4,372	41,779	6,010
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	46	41	2,639	20	20,969	14,971	5,794	15,058	18,690
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	22,954	10,767	7,287	7,198	513	7,050	40,138	73,349	117,457
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	18,548	12,882	3,346	35,122	4,352	12,081	0	38	38,527
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	16,162	8,452	19,341	18,516	4,890	0	0	24	14,276
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	10,329	18,146	39,296	26,182	32,382	23,094
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	3,691	7,584	663	50,568	14,507	0	0	371	3,472
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	68,053	40,620	85,012	78,312	1,126	21,514	150,318	1,969	6,511
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	51,801	0	0	0	612	4,248	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	365	950	48,751	43,721	57,591	36,936	46,705	89,521	123,100
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	196,997	89,903	133,507	44,895	20,433	10,746	4,266	28,761	38,286
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	71,458	129,409	40,342	36,632	57,237	61,975	31,884	63,311	71,637
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	11,440	34,709	12,773	24,764	28,803	52,059	43,027	43,109	53,119
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	64,913	34,830	40,737	66,899	24,577	47,936	70,314	38,378	44,541
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	10,147	18,941	3,110	34,376	12,902	3,835	3,646	28,703	12,998
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	194,791	129,594	72,917	135,039	93,402	3,847	57,457	130,019	131,703
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	114,049	108,480	158,407	33,894	69,078	89,695	92,811	88,845	94,784
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	162,880	134,011	574,577	358,420	14,771	14,358	54,048	92,218	129,658
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	65,833	30,267	6,574	0	0	0	19,497	22,239	9,437
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	33,569	14,011	20,706	14,706	0	0	0	13,412	16,372
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	34,048	21,664	18,896	5,960	14,680	3,036	16,921	44,285
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	9,105	27,848	30,173	1,974	10,946	1,425	1,815	8,857	187
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	122,819	142,620	36,966	0	0	16,800	13,053	0	408
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	40,024	119,075	0	154,725	42,898	14,926	22,588	117,206	181,765
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	120,375	0	0	0	0	0	6,095	156	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	46,991	48,891	37,655	51,399	38,971	21,805	2,938	31,053	1,306
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	33,342	33,035	34,070	3,547	3,268	0	1,896	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access	0	33,342	27,340	35,610	35,865	3,268	173	15,888	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	12,037	0	0	0	39,980	21,920	53,116	96,523	174,678
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	12,037	67,731	102,200	48,908	39,980	67,769	103,720	100,629	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	11,111	18,414	34,571	16,701	9,033	3,645	10,935	4,232	5,378
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	11,111	189,891	154,124	157,735	9,033	63,813	153,625	0	20,900
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	376,437	358,232	538,099	390,888	38,992	42,510	282,942	424,350	607,994
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	494,993	943,326	750,919	631,848	326,042	476,220	679,002	1,006,651	1,207,031
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	237,764	442,261	431,594	313,816	165,819	42,324	47,048	65,293	115,140
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	425,941	502,176	423,414	319,674	48,793	340,336	782,022	1,068,159	1,555,706

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Column: 747

Concept: Partial payment by uninsured patients approved for charity care (2552-10 only) [pymt_uninsured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	1	1	1	1	1	0	1	1	1
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	240,884	426,079	307,044	192,952	574,457	43,934	459,647	0	3,856
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	0	83,854	0	0	114,885	1,165
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	0	0	220,552	183,334	60,581	63,744	174,220	99,134	100,174
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	587,692	523,443	381,163	718,056	44,030	19,552	24,565	14,582	24,210
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	0	0	0	0	0	0	0	48,314	
350070	INNOVIS HEALTH	FARGO	Short Term	0	234,151	158,060	262,701	85,245	176,657	102,804	136,165	622,202	581,079
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	0	0	100	502	1,364	400	0	1,532	4,793
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	2	2	0	0	0	11,827	1,029	1,032	581
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	274	600	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	7,909	1,987	0	184	200	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	4,462	0	1,021	0	487	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	0	4,712	10,134	19,252	295	346	1,817	0	714
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	2,248	0	0	0	30	1,263	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	0	0	3,019	161	374	204	25	2,395	4,840
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	0	1,783	7,655	5,282	123	830	2,079	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	0	0	0	0	0	694	100	175	214
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	1,136	0	4,052	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	0	0	1,768	1,203	1,271	453	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	1,636	2,937	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	0	0	0	0	0	0	550	7,753	168
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	0	0	0	0	0	0	758	913	950
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	4,718	5,408	3,944	0	0	0	3,715	12,542	4,981
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	12,003	3,951	0	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	1,210	2,216	946	370	795	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	0	550	550	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	30,012	0	0	0	0	8,234	0	0	0
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	0	0	0	0	0	0	20	25	12,537
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	0	0	5,710	8,963	0	0	0	36,557	1,804
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	948	2,184	0	0	0	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access	0	948	2,076	0	0	0	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	0	0	0	0	361	48	205	1,527	2,409
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	0	3,545	2,110	3,171	361	13,834	13,335	17,680	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	725	171	0	85	675	1,515	100	20	0
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	725	230,095	27,915	27,915	675	14,377	21,229	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	0	0	0	0	0	694	155	945	1,070
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	0	0	0	0	0	775	2,398	7,395	9,819
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	0	0	0	0	0	1,501	3,253	16,862	31,784
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	0	0	0	0	0	7,189	6,603	15,122	13,272

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Column: 746

Concept: Partial payment by insured patients approved for charity care (2552-10 only) [pymt_insured_charity_only10]

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	7	8	3	1	1	1	1	1	1
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term	0	30,199	6,894	13,742	11,173	9,666	19,495	12,569	0	0
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term	0	0	0	0	0	30,597	0	0	53,841	5,979
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term	0	31,054	53,004	152,951	395,936	205,742	83,931	306,615	214,345	307,750
350015	SANFORD BISMARCK	BISMARCK	Short Term	0	6,430,284	7,434,056	2,937,796	263,606	87,541	120,682	104,482	88,000	50,668
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term	0	0	0	0	0	0	0	0	121,481	
350070	INNOVIS HEALTH	FARGO	Short Term	0	58,898	11,017	87,481	52,231	172,353	163,113	221,004	169,835	118,101
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access	0	0	0	94	600	387	0	167	206	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access	0	2	2	0	0	0	2,322	343	557	1
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access	0	1,582	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access	0	1,685	0	0	1,313	106	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access	0	0	0	229	1,921	178	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access	0	0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access	0	0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access	0	3,474	309	1,069	723	973	340	0	0	736
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access	0	0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access	0	0	0	40,426	825	1,015	1,352	781	6,526	13,253
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access	0	0	3,952	7,240	183,459	2,640	137,081	2,318	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access	0	0	0	0	0	0	1,502	941	271	1,070
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access	0	0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access	0	0	0	49,111	32,009	13,228	57,708	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access	0	585	1,293	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access	0	0	0	0	0	0	0	1,371	772	2,320
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access	0	0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access	0	0	0	0	0	0	0	1,150	903	106
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access	0	496	1,988	1,591	2,691	5,735	4,284	3,434	16,463	6,932
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access	0	0	16,085	200	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access	0	0	471	1,325	332	2,244	80,729	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access	0	0	2,039	2,039	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access	0	0	0	0	3,655	1,413	104,114	0	0	17,385
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access	0	474	474	0	0	0	0	251	53	1,446
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access	0	0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access	0	0	0	22,172	28,712	0	0	0	41,413	9,112
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access	0	2,406	4,623	5,248	0	135	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access	0	2,406	1,279	0	0	135	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access	0	18,438	21,201	488	0	53	213	1,436	5,437	3,381
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access	0	18,438	11,528	63,871	347,593	53	258,992	17,756	3,493	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access	0	145	94	141	0	373	0	152	354	243
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access	0	145	19,617	101,812	96,580	373	115,124	257,923	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access	0	0	0	0	0	0	1,502	3,677	400	1,945
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access	0	0	0	0	0	0	8,007	3,862	4,890	3,396
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access	0	0	0	0	0	0	5,647	9,860	8,072	13,080
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access	0	0	0	0	0	0	5,441	8,458	1,330	2,714

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Uncorrected HCRIS Data by Cost Report Year
Column: Uncompensated Care For Insured Pts Approved for Charity Care
Concept: Millions of Dollars

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	9	15	9	21	18	8	11	14	15
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term		0	0	0	0	0	0	0	0	0
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term		0	0	0	2	0	0	0	1	1
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term		0	0	1	7	10	4	5	5	7
350015	SANFORD BISMARCK	BISMARCK	Short Term		4	13	7	11	5	2	2	2	2
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term		0	0	0	0	0	0	0	2	
350070	INNOVIS HEALTH	FARGO	Short Term		1	0	0	1	2	1	2	2	2
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	1
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access Hospitals		0	0	0	0	0	0	0	0	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access Hospitals		2	1	0	1	0	0	0	0	0
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Uncorrected HCRIS Data by Cost Report Year
Column: Uncompensated Care For Uninsured Pts Approved for Charity Care
Concept: Millions of Dollars

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sum	(millions)			0	10	12	16	19	18	25	26	25	24
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term		1	1	1	0	3	4	3	2	2
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term		0	0	0	1	1	5	6	0	1
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term		3	5	8	10	7	8	8	11	11
350015	SANFORD BISMARCK	BISMARCK	Short Term		0	0	0	2	3	3	3	3	3
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term		2	1	2	2	1	1	1	2	
350070	INNOVIS HEALTH	FARGO	Short Term		1	1	1	1	2	1	2	3	3
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access Hospitals		0	1	0	0	0	0	0	0	0
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351328	LINTON HOSPITAL	LINTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access Hospitals		0	0	0	0	0	0	0	0	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access Hospitals		0	0	1	0	0	0	0	0	1
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access Hospitals		0	1	1	1	0	0	1	1	1
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access Hospitals		0	1	0	0	0	0	1	1	2

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Uncorrected HCRIS Data by Cost Report Year
Column: Uncompensated Care For Insured and Uninsured Pts Approved for Charity Care
Concept: Millions of Dollars

Medicare Provider #	Hospital Name	Town	Hospital Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Sum
	(millions)			0	19	27	25	40	36	32	36	40	39	
350002	ST ALEXIUS MEDICAL CENTER	BISMARCK	Short Term		1	1	1	0	3	4	3	2	2	
350006	TRINITY HOSPITALS/ST JOES	MINOT	Short Term		0	0	0	3	1	5	6	2	2	
350011	SANFORD MEDICAL CENTER - FARGO	FARGO	Short Term		4	5	9	17	17	12	13	15	18	
350015	SANFORD BISMARCK	BISMARCK	Short Term		5	13	7	13	8	5	5	6	4	
350019	ALTRU HEALTH SYSTEM-ALTRU HOSPI	GRAND FORKS	Short Term		2	1	2	2	1	1	1	4	0	
350070	INNOVIS HEALTH	FARGO	Short Term		2	1	2	1	3	2	4	6	5	
351300	TIOGA MEDICAL CENTER	TIOGA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351301	MOUNTRAIL COUNTY MEDICAL CENTE	STANLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351302	MCKENZIE COUNTY HEALTHCARE SYS	WATFORD CIT	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351303	GARRISON MEMORIAL HOSPITAL	GARRISON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351304	TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351305	KENMARE COMMUNITY HOSPITAL	KENMARE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351306	COOPERSTOWN MEDICAL CENTER	COOPERSTOW	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351307	ST ANDREWS HEALTH CENTER	BOTTINEAU	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351308	NELSON COUNTY HEALTH SYSTEM-HO	MCVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351309	SANFORD MAYVILLE	MAYVILLE	Critical Access Hospitals		0	0	0	0	0	0	0	0	1	
351310	SAKAKAWEA MEDICAL CENTER	HAZEN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351311	LISBON AREA HEALTH SERVICES	LISBON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351312	NORTHWOOD DEACONESS HEALTH CE	NORTHWOOD	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351313	SOUTHWEST HEALTHCARE SERVICES	BOWMAN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351314	JACOBSON MEMORIAL HOSPITAL	ELGIN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351315	OAKES COMMUNITY HOSPITAL	OAKES	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351316	PRESENTATION MEDICAL CENTER	ROLLA	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351318	CARRINGTON HEALTH CENTER	CARRINGTON	Critical Access Hospitals		0	0	1	0	0	0	0	0	0	
351319	PEMBINA COUNTY MEMORIAL HOSPI	CAVALIER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351320	UNITY MEDICAL CENTER	GRAFTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351321	WISHEK COMMUNITY HOSPITAL	WISHEK	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351322	ASHLEY MEDICAL CENTER	ASHLEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351323	CAVALIER COUNTY MEMORIAL HOSPI	LANGDON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351324	MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351325	ST. LUKES HOSPITAL	CROSBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351326	FIRST CARE HEALTH CENTER	PARK RIVER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351327	ST ALOISIUS MEDICAL CENTER	HARVEY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351328	LINTON HOSPITAL	LINTON	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351329	SANFORD HILLSBORO	HILLSBORO	Critical Access Hospitals		0	0	0	0	0	0	0	1	1	
351330	WEST RIVER REGIONAL MEDICAL CEN	HETTINGER	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351331	TOWNER COUNTY MEDICAL CENTER	CANDO	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351332	HEART OF AMERICA MEDICAL CENTER	RUGBY	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351333	MERCY HOSPITAL	DEVILS LAKE	Critical Access Hospitals		1	0	1	0	0	0	0	1	1	
351334	MERCY MEDICAL CENTER	WILLISTON	Critical Access Hospitals		3	2	1	1	0	1	1	1	2	
351335	JAMESTOWN REGIONAL MEDICAL CEN	JAMESTOWN	Critical Access Hospitals		0	0	0	0	0	0	0	0	0	
351336	ST JOSEPHS HOSPITAL & HEALTH CTR	DICKINSON	Critical Access Hospitals		0	1	0	0	0	0	1	1	2	

Source: Horizon Government Affairs, HCRIS data via RAND vintage 11-1-2020.

Appendix D – Insurer Data Request

Table Mockup for North Dakota Insurance Data DRAFT

Please replace the NAIC statewide numbers 2010-2018 with data for your company's results in North Dakota. The statewide data are simply shown as an example -- please replace.
Please estimate 2019 and project data for 2020-2022 using current policy and your most likely scenario for regulation. Assume the HIT is repealed as per Dec. 2019 federal law.
We know 2019 claims won't be fully complete and 2019 full-year expenses may not be fully tabulated by Feb 6, 2020 due date -- please estimate full year best possible.
Please note there are three additional data fields that are not on the NAIC supplemental: Average deductible, total allowed claims, Medicaid managed care.
Please try to estimate total allowed claims and average deductibles using a consistent method across time. Zero deductibles count towa Estimated Projected ==>

For your Company Only (not statewide)

Calendar Years	2010	2014	2015	2016	2017	2018	2019	2020	2021	2022
Health premiums earned (from Part 2, Line 1.11)		<========== ========== Most Important Years ==========>								
Individual	121,119,359	194,006,259	242,299,636	243,932,210	240,147,155	255,459,103				
Small Group Employer	289,890,522	291,271,574	303,224,993	294,678,443	300,037,906	319,110,613				
Large Group Employer	453,338,202	701,787,635	721,605,268	734,705,676	753,273,099	805,814,251				
Federal taxes and federal assessments										
Individual	389,693	4,419,871	14,008,439	7,754,117	4,829,644	4,976,710				
Small Group Employer	1,408,217	12,284,760	15,051,751	8,069,877	3,914,141	-2,338,904				
Large Group Employer	1,698,933	11,924,313	25,122,400	16,886,108	4,812,790	9,848,940				
State insurance, premium and other taxes										
Individual	1,784,177	3,410,588	4,263,017	4,211,239	4,096,250	4,307,029				
Small Group Employer	4,556,127	5,540,011	5,066,016	5,001,534	5,176,372	5,270,938				
Large Group Employer	2,519,902	5,592,193	6,035,708	5,688,432	6,072,118	6,300,227				
Net adjusted premiums earned after reinsurance (Lines 1.8+1.9+1.10+1.11)										
Individual	118,625,599	180,483,381	221,689,989	231,173,900	230,843,035	245,687,789				
Small Group Employer	283,529,085	268,618,302	282,474,587	280,867,290	290,533,736	315,608,626				
Large Group Employer	448,834,886	674,549,412	688,157,488	708,315,961	740,360,398	787,423,764				
Incurred claims excluding prescription drugs										
Individual	106,829,243	148,487,708	180,601,977	187,516,702	183,319,287	179,148,457				
Small Group Employer	222,125,579	209,399,147	211,589,042	216,002,439	207,384,054	238,357,221				
Large Group Employer	361,153,065	539,720,187	562,990,899	576,913,215	582,096,592	619,754,609				
Prescription drugs										
Individual	14,799,301	28,252,329	36,731,947	44,968,681	46,886,855	49,554,675				
Small Group Employer	33,376,507	30,850,258	39,815,104	41,773,320	42,910,875	46,739,430				
Large Group Employer	57,027,284	103,592,545	118,550,388	122,169,657	124,125,168	141,151,385				
Pharmaceutical rebates										
Individual	862,247	1,457,034	4,581,467	5,145,096	7,374,522	10,278,371				
Small Group Employer	1,748,208	1,578,952	5,911,494	6,362,406	7,258,729	9,958,422				
Large Group Employer	2,277,829	8,002,831	14,961,549	19,506,627	21,649,256	28,113,316				
Total incurred claims (Lines 2.1 + 2.2 - 2.3 - 2.4 + 3)										
Individual	120,766,298	175,309,995	212,802,990	227,353,507	226,139,001	223,374,636				
Small Group Employer	253,753,879	238,671,904	245,498,561	251,414,938	247,358,646	281,437,285				
Large Group Employer	415,902,519	635,310,074	666,583,912	679,577,490	688,743,106	738,866,156				
Net incurred claims after reinsurance (Lines 5.0+5.1+5.2+5.3-5.4+5.5-5.6)										
Individual	116,150,025	161,187,942	196,510,373	224,505,848	219,375,754	220,711,866				
Small Group Employer	256,331,485	238,829,187	243,602,439	248,971,517	246,224,789	281,126,478				
Large Group Employer	417,695,774	624,532,999	693,269,522	652,580,183	676,031,753	729,453,112				
Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1+6.2)										
Individual	620,331	816,538	1,027,285	1,137,634	780,430	749,911				
Small Group Employer	1,472,768	1,235,448	1,448,215	1,474,215	1,256,493	1,444,231				
Large Group Employer	2,117,631	2,570,204	5,828,574	6,526,118	4,696,741	4,990,356				
Total claims adjustment expenses (Lines 8.1 + 8.2)										
Individual	4,313,423	4,941,940	6,050,280	5,345,482	6,567,381	12,350,924				
Small Group Employer	7,296,616	8,180,548	8,842,148	9,016,706	11,604,647	24,602,808				
Large Group Employer	9,072,345	16,437,821	17,734,051	15,497,859	17,629,054	30,306,251				
Total general and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)										
Individual	9,881,216	9,524,911	12,937,241	15,470,295	13,404,881	12,933,467				
Small Group Employer	11,713,853	13,234,470	12,535,625	15,451,840	15,517,868	17,263,210				
Large Group Employer	10,676,805	23,223,697	24,333,194	26,170,451	25,344,505	27,169,830				
Underwriting Gain/(Loss)										
Individual	-12,339,396	4,012,050	5,164,810	-15,285,359	-9,285,411	-1,058,379				
Small Group Employer	6,714,363	7,138,649	16,046,160	5,953,012	15,929,939	-8,828,101				
Large Group Employer	9,272,331	7,784,691	-53,007,853	7,541,350	16,658,345	-4,495,785				
Number of Certificates/Policies										
Individual	33,896	26,776	29,811	28,121	26,612	24,539				
Small Group Employer	42,281	33,493	33,183	31,798	30,825	31,409				
Large Group Employer	57,198	76,340	71,191	71,033	70,733	73,404				
Number of Covered Lives										
Individual	47,687	49,075	54,151	49,718	47,192	43,333				
Small Group Employer	79,378	64,497	64,424	62,179	60,381	60,028				
Large Group Employer	120,348	160,820	149,872	151,322	149,111	154,872				
Number of Groups										
Individual	xxx	xxx	xxx	xxx	xxx	xxx				
Small Group Employer	5,193	4,805	4,841	4,883	4,845	3,144				
Large Group Employer	204	578	772	883	856	590				
Member Months										
Individual	535,780	582,131	667,548	620,560	594,515	549,367				
Small Group Employer	995,164	788,308	757,106	741,852	710,767	713,623				
Large Group Employer	1,437,007	1,913,878	1,857,512	1,828,600	1,795,950	1,832,387				
Health premiums earned (from Part 2, Line 1.11) per Covered Life										
Individual	2,540	3,953	4,475	4,906	5,089	5,895				
Small Group Employer	3,652	4,516	4,707	4,739	4,969	5,316				
Large Group Employer	3,767	4,364	4,815	4,855	5,052	5,203				
Total incurred claims (Lines 2.1 + 2.2 - 2.3 - 2.4 + 3) per Covered Life										
Individual	2,532	3,572	3,930	4,573	4,792	5,155				
Small Group Employer	3,197	3,701	3,811	4,043	4,097	4,688				
Large Group Employer	3,456	3,950	4,448	4,491	4,619	4,771				

Individual Market							
Improve Health Outcomes	130,184	280,351	395,947	488,305	329,900	275,357	
Activities to Prevent Hospital Re	22,318	28,352	68,270	72,321	27,138	11,023	
Improve Patient Safety and Red	50,205	137,675	221,653	182,619	123,300	135,446	
Wellness & Health Promotion A	152,741	322,717	276,989	251,939	176,367	190,033	
HIT Expenses	264,881	47,445	64,425	142,452	123,727	138,046	
Total (1 to 5)	620,329	816,539	1,027,285	1,137,636	780,431	749,908	
Cost Containment Expenses	1,548,748	1,659,859	1,824,261	1,293,399	1,423,895	1,501,258	
Other Claims Adjustment Expen	2,888,679	3,336,031	4,174,668	3,996,665	5,118,105	10,849,667	
General Administrative Expense	8,706,618	8,521,577	11,568,309	14,821,524	13,397,508	13,842,831	
Total Expenses (6 to 9)	13,877,140	14,334,005	18,594,521	21,249,225	20,709,941	26,943,666	
Small Group Market							
Improve Health Outcomes	284,394	493,294	539,060	485,596	428,845	513,804	
Activities to Prevent Hospital Re	64,811	29,618	19,536	15,099	23,016	31,954	
Improve Patient Safety and Red	200,030	216,234	251,067	212,574	200,093	289,906	
Wellness & Health Promotion A	445,068	430,599	529,634	599,730	452,417	443,251	
HIT Expenses	478,465	65,706	108,916	161,221	152,122	168,315	
Total (1 to 5)	1,472,767	1,235,450	1,448,215	1,474,218	1,256,493	1,444,230	
Cost Containment Expenses	1,978,326	2,702,661	2,025,084	2,042,356	2,202,695	2,557,631	
Other Claims Adjustment Expen	4,990,523	5,743,521	6,670,095	6,889,744	9,314,651	22,045,176	
General Administrative Expense	10,032,384	11,139,136	10,552,409	13,235,556	14,269,879	16,326,151	
Total Expenses (6 to 9)	18,507,076	20,820,767	20,695,800	23,641,874	27,043,715	42,373,188	
Large Group Market							
Improve Health Outcomes	200,539	893,366	3,123,724	2,428,962	1,334,717	1,266,505	
Activities to Prevent Hospital Re	59,915	18,487	22,446	16,430	30,912	38,326	
Improve Patient Safety and Red	170,310	397,754	417,673	261,935	256,213	337,946	
Wellness & Health Promotion A	762,588	1,065,796	1,515,413	2,424,792	1,611,511	1,973,663	
HIT Expenses	924,276	194,804	749,318	1,394,003	1,463,390	1,369,675	
Total (1 to 5)	2,117,628	2,570,206	5,828,574	6,526,121	4,696,742	4,990,359	
Cost Containment Expenses	2,098,748	4,871,907	3,771,893	4,092,641	5,243,523	6,082,937	
Other Claims Adjustment Expen	6,844,012	11,673,241	13,820,938	11,249,679	12,240,075	24,223,303	
General Administrative Expense	10,049,656	22,890,512	23,372,724	24,039,932	23,008,138	31,899,471	
Total Expenses (6 to 9)	21,138,872	42,005,866	46,794,131	45,908,373	45,188,480	67,196,067	

Questions not on the NAIC form:

Estimated Average Deductible ($ per policy)

Individual Market	
Small Group Market	
Large Group Market	

Total Allowed Claims ($)

Individual Market	
Small Group Market	
Large Group Market	

Medicaid Results (primary insured -- not including Medicare wraparound, duals, LTC for aged etc.)

Reimbursements	
Incurred Claims	
Non-Claim Benefit Expense (clinic overhead, member care management etc. not reflected in claims)	
Member Months	

Appendix E – Aon Private Reinsurance Proposal

Public Sector Partnership:

State Governments:

Financial solutions that transfer volatility away from the individual health market allowing for rate stability and taxpayer healthcare savings

Q4 2020

Opportunity Overview:

The Governor signed HB 1106 enabling North Dakota's Reinsurance Association of North Dakota (RAND) to implement a non-private reinsurance program to reduce healthcare costs for individual taxpayers participating in the State's healthcare marketplace. 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 driving down/stabilizing rates and preventing spikes providing consistency for taxpayers/users.

Using reinsurance to transfer the budgetary/program volatility, creates immediate opportunities for the State of North Dakota including:

- Transferring volatility away from the existing RAND program into the private market
- Reduces the future "known, unknowns", thereby allowing greater funding flexibility with the safety and security of knowing that protection is in place in the event of a higher than normal claims year
- Provides stability in rates from payers as a pre-arranged amount of funding is known
- Predictable cash flows for insurers and the state as there is no need, once coverage is purchased, to adjust the reimbursement levels to carriers based on higher than expected claim numbers and amounts
- Adjudication and claims processing is handled by the reinsurer, removing some of the operations of running the program in house

In addition, given the current Covid-19 health crisis there is likely to be further pressure on the individual health market. According to a recent Kaiser Family Foundation report, "…enrollment in the individual market was fairly steady from March to September 2020. In normal years, there is typically more attrition during these months as more people leave the market than come in during special enrollment periods (SEP). However, SEP enrollment was higher this year in healthcare.gov and state based exchanges." These solutions can help mitigate impacts stemming from the global pandemic.

The analysis that follows is based on 2017 RAND claims data provided by the State of North Dakota. The analysis can be updated based on more recent data, however the key points remain the same.

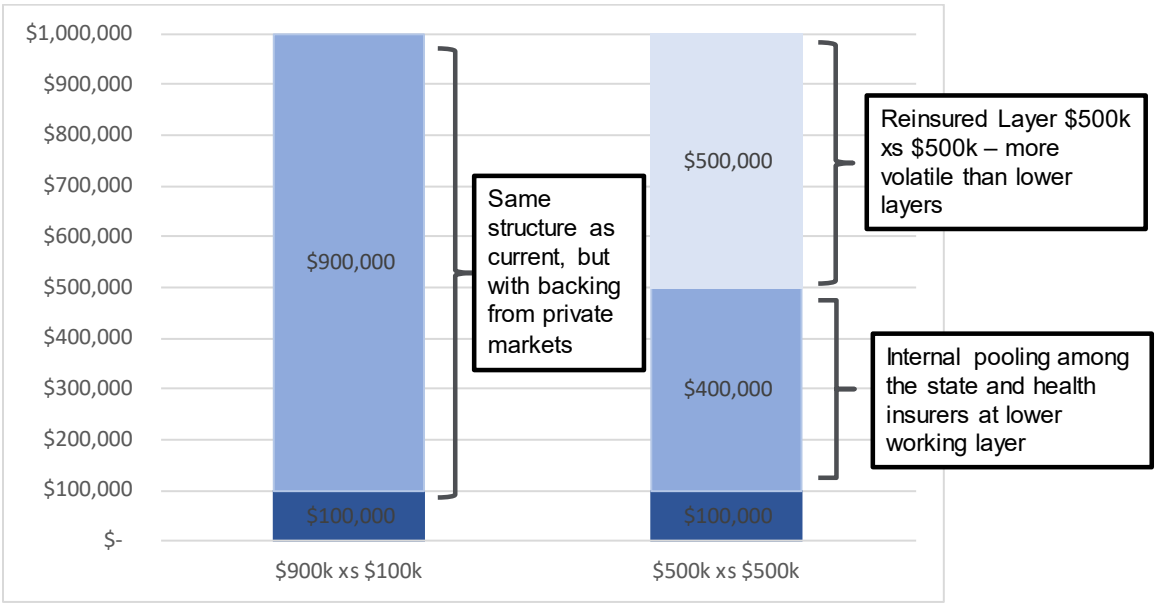
How would a private reinsurance program work?

The State of North Dakota in conjunction with RAND would purchase a transparent, reliable, and easily understood reinsurance policy that provides immediate recoveries based on predetermined attachment and exhaustion points.

When considering the existing Reinsurance Association of North Dakota (RAND) program, there are two main structural options to consider.

Excess of Loss

- Provides recoveries after a pre-determined amount of loss
- Smooths results in excess of pre-determined attachment point



Aggregate Stop Loss

- Provides recoveries after a pre-determined amount of loss in a defined/determined time period
- Coverage ensures the aggregation of numerous claims do not drain the financial reserves of the risk-bearer/entity

How much would this cost?

Aon modeled various scenarios using stochastic and deterministic models, we also used market data to derive pricing.

Aon used available data collected for the initial 1332 Waiver Process to illustrate a few structural and pricing options that would make sense given the current RAND structure. In evaluating solutions for North Dakota our overarching motivation is to maximize coverage, deliver fast payment, and provide clear benefit to the users of the RAND program.

Projected claims costs were derived from North Dakota's 2017 year. In order to secure pricing from the reinsurance markets, typically 3-5 years of data in required, however we believe this 12-month snapshot provides enough information to draw preliminary conclusions.

Pricing is provided on a 100% experience basis, and blended with national market data to provide more credibility to the block of business. It is illustrated on a per member per month basis.

Aon's analysis is based on following general market underwriting methodologies used across the reinsurance industry to develop a likely premium. Since North Dakota would be transferring the volatility to the market, the amount of money allocated to reinsurance claims in one particular year does not have to be as conservative as what may be traditionally allocated to a self-funded plan. Because RAND is a newly formed self-insured reinsurance program, it is not surprising that additional conservatism was included in the preliminary (NovaRest) actuarial analysis.

Claims Projections:

	75% Coinsurance	
Source	$900k xs $100k	$500k xs $500k
Nova Rest	$106.68	
Market	$67.27	$8.18
Aon - Deterministic	$58.53	$4.38
Aon - Stochastic	$58.82	$4.65

Pricing Options:

*XOL Pricing by layer	Premium
1. $900k xs $100k	$70.58
2. $500k xs $500k	$5.58
*Agg Pricing	
1. 110% of expected	$27.64
2. 120% of expected	$20.61
3. 130% of expected	$14.58

Key Takeaways:

- Based on the 2017 claims year costs there are indications that meaningful cost savings can be achieved by a private reinsurance purchase
- Claims costs can be shifted to the private market for less dollars than they are being funded for in the existing program, leaving additional funding to further stabilize rates and pay for the private purchase
- We can transfer claims to the private market for .65-.85 cents on the dollar (this is based on only one claims year and we would need 3-5 years to fully validate this with third party capital)
- The structures presented would provide more program certainty to payers allowing for greater flexibility in rate pricing
- While the premium payments for the State of North Dakota may be higher than the claims cost in some years, high claims years will counter balance the years where the state ends in a negative net position
- As an example, 1 in 20 years the reinsurer is projected to lose $20.57 per member per month, paying $1.30 to the state for every $1 the state pays in premium

Return Period (1 in X years)	**Losses (PMPM)**	**Reinsurer Position (PMPM)**
Average	$58.82	$11.76
5	$72.34	-$1.76
20	$91.14	-$20.57
40	$99.22	-$28.64

Considerations for Next Steps:

In order to procure formal pricing from the market, additional information is needed.

Reinsurance Parameters	Key Considerations
Data Required (last 3-5 years)	- Membership Data - Claims Triangles - Large Claim Loss Data - Plan Design Changes (Historical and Proposed)
Attachment Point	- Attachment points can allow for any corridor, both overlapping what is being offered or just covering a piece - To reduce total cost coinsurance can be included which will reduce the reimbursement by a percentage for each claim
How Much "Limit" to Purchase	- Often relatively small incremental premium to purchase higher limit - Markets will cap the limit they offer based on their risk tolerance
Contractual Considerations	- If the State of North Dakota does not cede the entire $900k xs $100k layer to the reinsurance market, arrangements will be needed to administer the pooling layer - Additional analysis will be required to confidently opine on the contractual structure between the State of North Dakota reinsurance program and the reinsurers

Who would provide this backstop?

Reinsurance companies are the providers of this protection and have been active participants in the health market for several years.

There is a significant market appetite for health exposure. There are several highly rated counterparties that will be interested in an excess of loss or aggregate structure as these are the main vehicles used to transfer volatility in the space.

All counterparties would be highly rated ("A" or better AM Best and/or S&P) entities with significant capital and strong track records of paying claims as agreed.

To learn more about potential structures, pricing and capacity please contact the team on the following page.

For Additional Information:

Knowing that our fiduciary commitment is always to our clients and prospects, Aon's Public Sector Partnership team focuses on developing innovative solutions to help governments and other public institutions reduce volatility and increase the resiliency of their mission. The PSP is a global team of talented colleagues that have deep experience serving in government, insurance, reinsurance, and the capital markets.

Joseph Monaghan
Chief Executive Officer
Aon Public Sector Partnership
t + (312) 560-5541
e: joseph.monaghan@aon.com

Danielle Iordanou
Managing Director
Aon Public Sector Partnership
t + (646) 573-5529
e: danielle.iordanou@aon.com

Bob Black
Executive Managing Director
Aon Reinsurance Solutions
t + (312) 381-5344
e: Robert.Black@aon.com

Jake Birchard
Senior Actuarial Analyst
Aon Reinsurance Solutions
t + (303) 639-4152
e: Jake.Birchard@aon.com