MEDICARE TO COMMERCIAL RATE FAQ

Because additional questions arose in the hearing regarding the comparison of commercial rates to Medicare rates and what drives the differential, we are providing additional information for the Committee's consideration.

1. **Are providers "rate takers" or is there actual negotiation of rates[1]?**
    a. State agencies traditionally do not interact or opine on contractual relationships between providers and insurers.
    b. The fact that there is a significant differential in rates between different providers suggests some level of negotiation has happened.
    c. "The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the rate review provisions imposing tighter limits on health insurance rate increases."[2]
    d. Insurers must also meet state and federal network adequacy standards. This means, in some cases, certain providers have significant negotiating leverage while others may not have any leverage.
    e. "At the first stage of competition, healthcare providers and commercial insurers negotiate reimbursement rates and non-monetary reimbursement terms . . ."[3]

2. **Is BCBSND a "powerful buyer"?**
    a. "There is no question that BCBSND is a powerful buyer in the Bismarck-Mandan area and throughout the state."[4]
    b. "Generally, BCBSND uses a statewide uniform base fee schedule, though its reimbursement rates are higher for some of the more rural facilities with which its contracts. BCBSND has deviated from the statewide fee schedule in response to "provider-specific" requests and providers' demonstrated need."[5]
    c. "BCBSND endeavors to set reimbursement rates adequate to 'make sure the providers can continue to offer services in North Dakota.'"[6]
    d. Of course, the BCBSND is also required to meet network adequacy requirements which may mean some providers – especially hospitals – have more leverage.

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[1] As part of the potential acquisition of Mid Dakota, the United States District Court for the District of North Dakota and then later the 8th Circuit Court of Appeals, the providers provided some insight into the negotiation process between Sanford/Mid Dakota and Blue Cross. For the remainder of this document, we will reference factual assertions in the lower court case, because the appeals court affirmed. This is not a legal analysis but statements of fact that were delivered in the opinion. (Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017.)

[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio

[3] Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017, pg. 12.

[4] Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017, pg. 35.

[5] Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017, pg. 36-37.

[6] Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017, pg. 37.

3. **Do providers (such as Sanford) negotiate?**
   a. "[A] provider offering the only 'super specialist that many [BCBSND] members need' has greater leverage in establishment of the fee schedule."[7]
   b. "Though [Sanford and Mid Dakota] contend that BCBSND does not truly negotiate with provider, in various documents in the record, [Sanford and Mid Dakota] have characterized their interactions with BCBSND as 'negotiation'. . . BCBSND moved to a different methodology for inpatient reimbursement."[8]
   c. "BCBSND . . . analyzes certain quality-based metrics of patient care. Dependent on the results of that analysis, a provider may receive "shared savings" payment from BCBSND."[9] This evidences that increased quality care, could be one reason for higher rates at certain providers.

4. **Are the Medicare to Commercial comparisons noted in the Study inclusive of just North Dakota insurance plans such as BC/BS-ND, excluding Blue BC/BS-MN OR are they inclusive of all commercial payors having their enrollees seen by providers in the state?**
   a. The Medicare to Commercial comparisons are inclusive of all commercial payors, not solely ND insurance plans. Figure 12 and Table 26 were developed from the data in HCRIS Medicare Cost Reports. The same data was used for every state, making the table a decent 50 state comparison. This data is self-reported by the hospitals and was then cross referenced with AHA reported data from the hospitals as well, that evidenced consistent reporting in both reports from the hospitals. If you have concerns about migration, the appropriate charts to reference are Figure 13 and Table 28 on pages 57 and 58 of the Report. These are Medicare Revenues per Discharge which would take into account in and out of state migration. The growth illustrated in Table 28 is significant, but the actual revenues seem average. The Medicare Outpatient Revenues Per Enrollee is also high on page 61 and 62. The hospitals do not report outpatient "discharge" which means we do not have a denominator to create a similar chart for Outpatient Revenues Per Discharge. This could be something that is researched further in the future, but this would require providers to collect and then report additional data. Throughout this study, we attempted to prevent additional "work" for the providers, especially during the pandemic.

5. **Are there unusual anomalies in the comparison that would explain differences in Medicare reimbursement among the noted providers, for example, Medicare add-ons (DSH, Medical Education, SCP) given Altru (1.67 in 2018), Essentia (3.01 in 2018) or the overall state average (2.11 in 2018) demonstrate dramatic variation?**
   a. There may be unusual anomalies that create the dramatic variation in Table 9 (page 25), but a simple explanation could very well be difference negotiated reimbursement rates paid by insurers to providers. However, we don't have extensive depth of data to explain the differences between providers. Obviously, there is significant growth in some providers over the term of the study. This data is HCRIS data for commercial

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[7] Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017, pg. 37.
[8] Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017, pg. 38.
[9] Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Case 1:17-cv-133, Dec. 15. 2017, pg. 7.

revenues which means it includes all insurer payments (in state and out of state insurers). This is also self-reported data from the hospitals. An additional study would need to occur to understand the differences in private rates provided to the hospitals and why the variance exists between providers. We do not have visibility into the rates themselves, rather total revenues by source of revenue, as provided by each hospital. As illustrated in Table 9, Altru didn't report 2019 data, as of the time of the final report data pull. However, the available data illustrates that Altru private payment rates were 136% of Medicare in 2011, fluctuated dramatically year-to-year and ended the cycle in 2018 at 167% of Medicare rates in the same year. Other hospitals, such as Essentia began in 2011 at 207% of Medicare and ended in 2018 at 301% of Medicare. Sanford Fargo was 145% in 2011 and 211% in 2018. In conclusion, the weighted average of private rates to Medicare rates grew from 170% to 211% between 2011 and 2018 for all six large acute care hospitals. This means that all large acute care hospitals saw growth during the term, but some hospitals saw more significant growth than others. When we added in the three critical access hospitals, they all three saw declines. Therefore, the weighted average for all nine hospitals began 2011 at 170% of Medicare and ended 2018 at 207% of Medicare. I hope this is helpful and I am happy to provide further analysis of Table 9 if needed.

Approximate Ratio of 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		195%	194%	188%	190%	227%	223%	199%	201%	153%
Sanford Bismarck		193%	151%	192%	182%	208%	217%	203%	195%	219%
Essentia		207%	187%	205%	254%	242%	247%	206%	301%	322%
Sanford Fargo		145%	199%	193%	197%	194%	218%	207%	211%	203%
Altru		136%	139%	137%	137%	145%	150%	151%	167%	/a
Trinity		217%	218%	118%	192%	253%	273%	266%	253%	248%
Weighted Average		170%	180%	172%	185%	200%	211%	199%	211%	/a
3 Critical Access Hospitals										
Jamestown		148%	125%	134%	121%	117%	132%	135%	146%	145%
Dickinson		176%	148%	141%	118%	106%	113%	110%	121%	124%
Williston		205%	167%	160%	115%	107%	136%	143%	177%	193%
Weighted Average		170%	148%	147%	117%	113%	115%	129%	149%	/a
All Reporting Hospitals		170%	178%	170%	181%	194%	205%	194%	207%	/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.

\a Data missing for 2019.