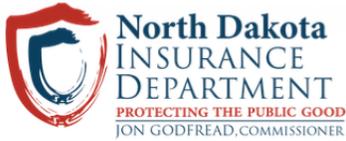


North Dakota
66th Legislative Assembly
Interim Health Care Study

Executive Summary and
Legislative Proposal Summary



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



Committee Summary

Interim Final Report August 2020

ND Legislative Management Interim Healthcare Study

- Data Summary
- Conclusion
- Policy Alternatives: In-Depth

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Dated: August 18, 2020

Summary, Interim Final Report August 2020

ND Legislative Management Interim Healthcare Study

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Background:

Below please find a summary of the 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. The focus was 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.

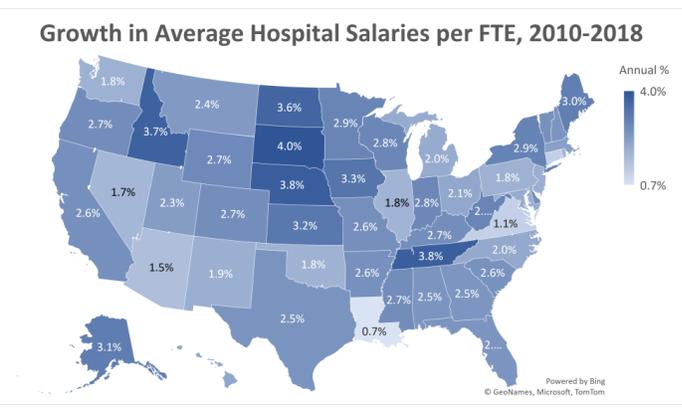
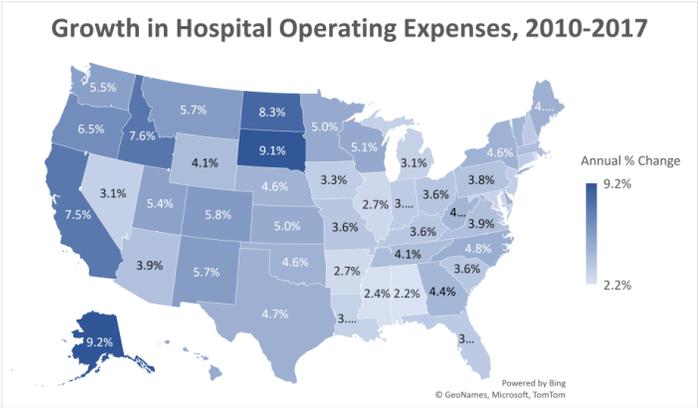
We gathered data on hospitals' overall costs and revenues in all the states from the Medicare cost reports. This was compared with data provided from the largest nine hospitals in North Dakota. The collected data and 50-state comparisons drove our analysis and informed our policy alternatives. We believe that North Dakota is well situated to have some of the lowest premiums in the nation; however, there is much work to be done to better manage hospital costs, coordinate patient care and improve health outcomes, and limit unnecessary growth of administrative costs. Changes in health insurance premiums are directly tied to the underlying growth in health care costs. According to the American Academy of Actuaries, premium drivers are "based on not only the increase in per-unit costs of services, but also changes in health care utilization and changes in the mix of services."¹

The underlying medical cost drivers in North Dakota include rapid growth in hospital operating expenses as well as growth in average length of stay for patients (increased utilization) and admissions (discharges). Insurers' administrative costs also grew rapidly in recent years, although they remain near national averages.

Findings of Note in Hospital Costs:

- On a per-capita basis, hospital expenses in North Dakota were highest in the nation in 2017, and their growth rate of about 8% per year since 2010 was among the fastest in the U.S. Specific hospital information in full report.
- 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.
- The hospitals' largest expense is wages and benefits. 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 \$90,000 in 2018, and wage growth was also among the fastest in the nation between 2010 and 2018.
- Importantly, several North Dakotan hospitals are near the Minnesota border, which indicates they may be a net importer of patients. This has the potential to increase measures of North Dakota "per resident" costs.

¹ American Academy of Actuaries, *Issue Brief: Drivers of 2017 Health Insurance Premium Changes*.
<https://www.actuary.org/sites/default/files/files/publications/IB.Drivers5.15.pdf>.



Source: Horizon Government Affairs based on data from CMS.

North Dakota Hospital Rankings vs. Other States, 2010-2018*	Rank (highest to lowest)	
	Level	Growth
Inpatient Discharges		14
Inpatient Days		5
Inpatient Days per 1,000 People	4	12
Average Length of Stay	4	3
Occupancy Rate	39	23
Beds Per Person	5	12
Operating Expenses		3
Operating Expenses per Person	1	4
Operating Revenues		2
Operating Revenues per Person	2	3
Average Salaries per FTE	4	5
Inpatient Revenue per Discharge	7	2
Commercial to Medicare Rate Ratio	12	9
Medicare Case Mix Index	30	16
Medicare Revenues per Enrollee	2	2
Medicare Inpatient Revenues		4
Medicare Inpatient Revenue per Discharge +	30	3
Medicare Outpatient Revenues		3
Medicare Outpatient Revenues per Enrollee	1	2
Medicaid Revenues		3
Medicaid Inpatient Discharges		7
Medicaid Inpatient Days		6
Medicaid Revenues per Enrollee	1	1
Private Patient Revenues per Private Insurance Enrollee	6	9
Patient Financial Assistance	38	3

Source. HGA based on data from the Medicare Hospital Cost Reports.
 Level Rankings are based on 2017 or 2018, and Growth Rankings are based on 2010 or 2011 to 2017 or 2018, depending on data availability.

Findings of Note in Insurance Costs:

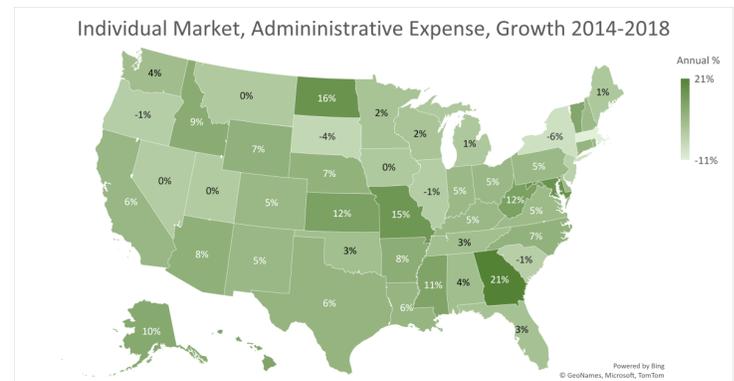
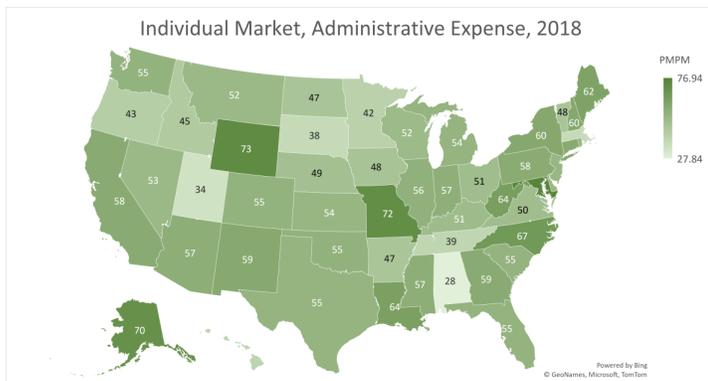
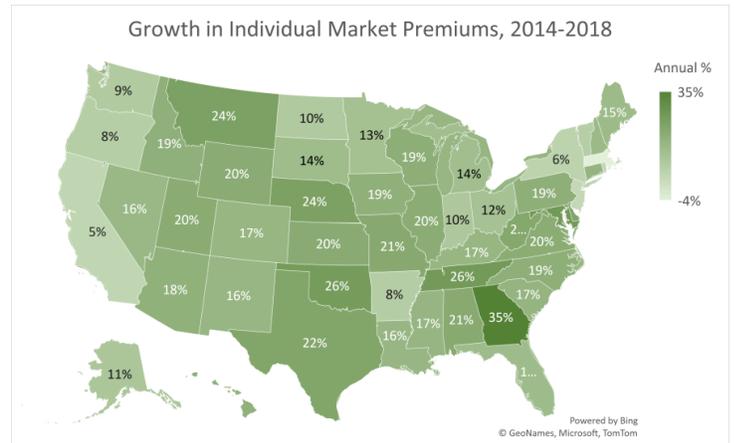
- Individual market premiums rose by about 10 percent in 2018, and we estimate they jumped by another 15 percent in 2019. However, premiums fell in 2020 by about 9 percent due to the establishment of North Dakota’s reinsurance program. Premiums in the small group and large group markets have been a bit 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 2018, 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.
 - 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 2014-2018 period.
 - 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.²
 - 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.

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	42,367
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	58,635	56,688
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	156,612	152,106
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 2010 by HGA.							
Note: Large group market does not include coverage by self-funded firms.							

² CMS 2017 Marketplace Open Enrollment Period Public Use File.

Comparisons of Insurance Measures:

Source: HGA based on data from the NAIC.



Insurance Measures Compared	North Dakota Rank (highest to lowest)	
	Level	Growth
Individual Market Premiums (PMPM)	40	41
Individual Market Claims	30	36
Individual Market Admin. Costs	40	3
Small Group Market Premiums	25	15
Small Group Market Claims	13	10
Small Group Market Admin. Costs	19	1
Large Group Market Premiums	20	9
Large Group Market Claims	16	8
Large Group Market Admin. Costs	41	2

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

Note: Level Rankings are based on 2018, and Growth Rankings are based on 2014 to 2018.

Covid-19 and Baseline Projections:

It is almost impossible to overstate the near-term impact Covid-19 has had on the U.S. health care system. For some medical providers, it has 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.³ Early reports indicate that treatment of heart attacks and strokes fell considerably at the onset of the pandemic – which could be a reflection of individuals forgoing needed care.⁴ By late 2020 or 2021, both providers and insurers could be facing sizable pent-up demand, as well as a continuing pandemic, which could lead to increasing utilization. The impact of these changes is likely significant and impossible to fully predict. A more complete analysis is available in the full Report.

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. 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.⁵ BCBS was recently fined following a market conduct exam, based on findings of improper payments for telehealth, mental health, and other services.⁶

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 interviews, the state seems mostly stuck in a fee-for-service reimbursement regime, in which providers compete to offer lucrative elective surgeries and insurers concentrate on holding down reimbursement rates across the board, with little regard for value of specific providers or patient outcomes from various care patterns.

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?

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.

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 Dakota policy makers 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 ND Insurance Commission, legislature, and Governor, to make informed decisions on a path forward to lowering health insurance premiums, lowering health care costs, and providing better population health

³ <https://www.houstonchronicle.com/business/article/Insurer-Anthem-s-2Q-profit-swells-helped-by-drop-15442284.php>

⁴ <https://medicalxpress.com/news/2020-07-decline-emergent-hospitalizations-early-phase.html>

⁵ 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).

⁶ 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>.

for North Dakotans.⁷ Full summaries of policy alternatives available under separate cover and in the full Report.

Utilization & Care Management. Medication nonadherence and the related hospital admissions and emergency department visits are significant health care cost drivers. Aligning the interests of the insurer, consumer and medical provider are key to driving down costs and moving consumers to better health. Focusing on driving down utilization (as identified as a major health care cost driver), while getting patients well, should be the focus.

1. **Benchmark Plan Revisions – Mandate Optimized Medication Plans**
2. **Private Insurance (Group) Mandate - Optimized Medication Plans**
3. **Medicaid Integrated Health Homes**
4. **Medicaid Strict Managed Care/Value-based Benefit Design**
5. **Other Options: (1) Limit Medicaid expansion to 100% of poverty, (2) Re-form Medicaid expansion as an exclusively managed care model**

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**
7. **Private Reinsurance – 1332 Amendment**
8. **Telehealth Improvements**

Transparency. 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.

9. **Direct to Consumer Pricing: Disclosure of Consumer Prices**
10. **Right to Shop:** We found that a consumer's ability to retrieve pricing information for hospital services can be difficult in North Dakota. The table below represents a secret shopper effort that took place during the data collection period of the Report. Each hospital was asked for consumer pricing, using the same script. We asked for the "cash price" for a patient that "didn't have insurance," for three common procedures: a "normal" colonoscopy, vaginal delivery and Caesarian-section. Some hospitals were more responsive than other. For example, both Sanford hospitals only replied after many attempts and even then only sent answers via postal "snail" mail.

⁷ 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 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 an Illinois based law and consulting firm that serves clients in multiple industries and states, including clients that may or may not be able to provide services mentioned and respond to the North Dakota's future requests for proposals as a result of this Report. 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 clients. Additional information regarding J W Hammer, LLC is available at www.jwhammerllc.com or upon request at jennifer@jwhammerllc.com

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

12. State Group Health Integrity Audit

13. State Group Health Waiver or "Opt-Out"

14. Coordination of Benefits/Identifying TPL (Third Party Liability)

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 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.

15. 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. Based on initial feedback from state policymakers, we would refine or expand this analysis for the final report. A complex implementation plan would also be provided. Preliminary cost estimates and discussion can be found in the full Report.

Conclusion:

As a result of the study and analysis of hospital and insurer data for the past ten years, it can be concluded that the underlying medical cost drivers in North Dakota include rapid growth in hospital operating expenses, as well as, growth in average length of stay for patients (increased utilization) and admissions (discharges). Insurers' administrative costs also grew rapidly in recent years, although they remain near national averages. Consideration shall be given to policy alternatives in (A) Utilization and Care Management, (B) Prices, Coverage and Insurance Initiatives, (C) Transparency, (D) Program Integrity, and (E) Crisis and Pandemic Planning. Following this summary, please find In depth analyses of the policy alternatives.

Policy Alternatives

Responding to the Data:
An In-Depth Look at Viable Solutions to
North Dakota's High Health Care Costs
Driving Health Insurance Premiums

- Utilization & Care Management
- Prices, Coverage, and Insurance Initiatives
 - Transparency
 - Program Integrity
- Crisis & Pandemic Planning

Utilization & Care Management

Care management has long been a buzz word in public policy circles. It holds the promise of delivering better care and better health outcomes, at a lower cost. Too often, the programs haven't delivered on that outcome. In some cases, consumers rebelled against tightly managed care protocols. In other cases, we simply did not have the information or ability to properly manage patient care on a population basis.

With provider consolidation, hospital system owned health plans, electronic health records and other healthcare changes, we are seeing increasing interest in finding new ways to better manage care. One of the key potential wins is in the area of medication optimization. While most estimates cite approximately \$300 billion as how much medication non-adherence costs the health care system in the United States annually, a more recent study found the potential impact of optimization to be more than \$500 billion dollars:¹

However, the cost associated with drug use reaches beyond the purchase of prescribed medications to encompass additional medical costs of morbidity and mortality resulting from medication regimens that are not optimized to effectively treat the indication resulting in a treatment failure (TF), where the resolvable medical problem is not adequately treated, a new medical problem (NMP), where a newly prescribed medication causes or contributes to an incident clinical symptom or syndrome, or both a TF and NMP. This cost has most recently been estimated as \$290 billion equating to 13% of total annual US medical costs in 2008. Although widely misdescribed in the published literature and policy documents as the cost associated with "patient nonadherence to medications," this estimate and the preceding estimates (\$76.6 billion in 1995 and \$177.4 billion in 2000) actually reflect medical resource utilization caused by TFs and NMPs that arising from nonoptimized medication use. Nonadherence to the indicated medication regimen is just one of multiple potential causal factors leading to a TF, resulting in downstream health services use.

A 2016 Chicago Tribune study² highlighted concerns with patients who were prescribed multiple medications and filled the prescriptions at their local pharmacy:

The Tribune reporter walked into an Evanston CVS pharmacy carrying two prescriptions: one for a common antibiotic, the other for a popular anti-cholesterol drug.

Taken alone, these two drugs, clarithromycin and simvastatin, are relatively safe. But taken together they can cause a severe breakdown in muscle tissue and lead to kidney failure and death.

When the reporter tried to fill the prescriptions, the pharmacist should have warned him of the dangers. But that's not what happened. The two medications were packaged, labeled and sold within minutes, without a word of caution.

Certainly, this raises public health concerns. The problem is that multiple drug interactions are common for individuals with chronic health conditions. One chronic condition may lead to co-morbid conditions – diabetes

¹ Watanabe JH, Mcinnis T, Hirsch JD. Cost of prescription drug-related morbidity and mortality. *Ann Pharmacother*. 2018;1060028018765159. doi: 10.1177/1060028018765159.

² <https://www.chicagotribune.com/investigations/ct-drug-interactions-pharmacy-met-20161214-story.html>

and heart disease for example. Managing these conditions and their medications together is important for the consumer to manage their own health. The article goes on to say:

Dangerous drug combinations are a major public health problem, hospitalizing tens of thousands of people each year. Pharmacists are the last line of defense, and their role is growing as Americans use more prescription drugs than ever. One in 10 people take five or more drugs — twice the percentage seen in 1994.

Some pharmacists who were tested got it right, coming to the counter to issue stern warnings. "You'll be on the floor. You can't have the two together," said one pharmacist at a Walgreens on Chicago's Northwest Side. Said a Kmart pharmacist in Rockford: "I've seen people go to the hospital on this combination."

But in test after test, other pharmacists dispensed dangerous drug pairs at a fast-food pace, with little attention paid to customers. They failed to catch combinations that could trigger a stroke, result in kidney failure, deprive the body of oxygen or lead to unexpected pregnancy with a risk of birth defects.

In addition to medication optimization, North Dakota should consider components of an integrated medical home model, in the Medicaid population. Below please find several vehicles to implementing medication optimization in North Dakotan payer populations.

- 1. ACA Benchmark Plan Revisions - Optimized Medication Plans:** The continued release of academic studies regarding medication nonadherence, drug-drug interactions, and non-optimized medication plans highlights the need to focus on medication optimization 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 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.³ 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.

Pro: The proposed changes to the benchmark plan would allow North Dakota to lead on this issue. It would put in place a medication optimization program that would help better serve consumers, improve health, and save money. Payers would see decreased claims. Consumers would see lower premiums and wellness. Little investment by the state. High likelihood of success in approval of the EHB Benchmark Plan revisions.

³<https://www.pharmacytimes.com/contributor/timothy-aungst-pharmd/2018/06/does-nonadherence-really-cost-the-health-care-system-300-billion-annually>; and 2. Watanabe JH, Mcinnis T, Hirsch JD. Cost of prescription drug-related morbidity and mortality. *Ann Pharmacother.* 2018;1060028018765159. doi: 10.1177/1060028018765159. !

Con: Today, insurers are free to craft these programs as part of their plans, but most often fail to implement programs unless specifically required by regulators, regardless of return on investment and wellness improvements of the consumer. This only applies to individual and small group market. Implementation timeline is more than a year.

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

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.”⁴ 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.

Pro: If done successfully, the program should provide a return on investment for insurers, and better health outcomes for consumers. It is not dissimilar to coverage for nutritional counseling – it could be done periodically and based on the medication or the on the medical condition. With the utilization of clinical pharmacists, a majority of a successful program can be conducted at low cost and remotely.

Con: This creates a new mandated provider group. The benefit and payment structures may be difficult for insurers to implement. There are concerns about cost. New mandate cost defrayals are required in certain markets, as such legislation is insufficient to add to individual and small group. EHB Benchmark revisions are necessary.

- 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 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,

⁴ <https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf>

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 systematically 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 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.

Pro: Integrated health homes can provide a great benefit to those on Medicaid who are unable to work due to their medical status. An integrated health home can help an aid a recipient to progress from dependence to independence. In the long run, the state will save money by better managing the condition. The funding for an IHH model program is 90% federal for the first eight quarters (and possibly beyond).

Con: Medicaid recipient eligibility is inconsistent, even with the state's expansion. Staff resources are needed at the Medicaid Department.

- 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. There is some question as to whether or not a traditional Medicaid program with robust managed care would be more successful. Additionally, there have been some political questions on the impact of Medicaid expansion.

Pro: Value based design in Medicaid and the state employee plan can help North Dakota by paying more for high value care, and less for lower value and less effective care. This can lead to more effective outcomes, and fewer resources wasted on low value care.

Con: These programs need a great deal of management both by members and administrators. Medicaid's low cost sharing makes it difficult to design a program.

5. Other Issues

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 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.⁵

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 an exclusively managed care model. The importance of a medical home is highlighted above, 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 would also require the Medicaid population to adjust to considerable changes with new requirements, and new provider networks.

It is important to note that under the current program, Sanford Health Plan operates as a managed care organization or MCO. In this model, the program would move exclusively to an MCO model with an RFP that transfers all risk to the MCO or MCOs.

Pro: Both of these changes would lead to the state paying fewer dollars for Medicaid.

Con: While North Dakota would save money, it would only lower program costs by the state share, about 10% in program costs. In other words, cutting \$1 million dollars from the program would save the state \$100,000 and the federal government would save \$900,000 due to the federal match.

⁵ <https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/>

Prices, Coverage, and Insurance Initiatives

Though the three policy items in this document do not have any direct relationship with one another, together they reflect important issues for all states, including North Dakota, to consider. The policies reflect the issues surrounding competition, the intersection between public and private business, and the relationship between public policy and market interference.

Based on our "Secret Shopper" survey, we found wide variation in prices for similar hospital services. These findings are consistent with a national RAND Corporation survey¹ that also found wide variation in hospital service prices. In order to help better understand hospital pricing, the RAND study suggested that policymakers compare hospital rates to those of Medicare, which is the nation's most common health insurance payer. As the study states:

Large price discrepancies exist between what private health plans pay for hospital services and what Medicare pays. RAND Corporation researchers used data from three sources — self-insured employers, state-based all-payer claims databases, and health plans — to assess \$13 billion in hospital spending in terms of hospital price levels, variation, and trends from 2015 through 2017 in 25 states. In this report, prices reflect the negotiated allowed amount paid per service, including amounts from both the health plan and the patient, with adjustments for the intensity of services provided. These negotiated prices are then compared with Medicare reimbursement rates for the same procedures and facilities to determine relative prices.

Key audiences for this report are (1) self-insured employers that have participated in the study and that are assessing the reasonableness of the prices they are paying for hospital care, (2) other employers that are struggling with high and rising health care costs and that want to better understand patterns and trends in hospital prices, and (3) policymakers and researchers who are concerned with hospital pricing and price transparency. Employers can use this report to become better-informed purchasers, and this report illustrates for policymakers that it is feasible and worthwhile to use claims data from private health plans to measure and compare hospital prices at a high level of detail.

Ultimately, it's a question of whether hospital markets are competitive, or do they operate in a more monopolistic manner? Network adequacy requirements — the requirement that insurers have a sufficient number and type of in-network providers to meet consumer needs — exacerbate this problem. In a rural state like North Dakota, it is unlikely state or federal regulators would approve an insurer for an area without the local hospital. In many cases there may be no effective competition because of the regional nature of hospitals, the lack of competition for services locally, and network adequacy.

Hospitals in North Dakota have consistently claimed that their costs have no impact on insurer rates, and the dominance of Blue Cross Blue Shield of North Dakota means hospitals must accept whatever rates are offered. In states that have more competitive hospital markets, plans vary based on which hospital system is in-network. In those states, hospitals left out-of-network claim that the only offer they have received is based on Medicaid, not Medicare rates. In contrast, North Dakota rates appear to be rising as a percentage of Medicare, according to the data in the report.

¹ https://www.rand.org/pubs/research_reports/RR3033.html

The proposal is to limit the out-of-network rates that hospitals charge patients to a percentage of Medicare rates. The proposal suggests charging patients approximately 220% of Medicare. Setting this relatively high percentage should have two effects. First, setting a cap on out-of-network rates facilitates the start of the negotiation for in-network rates. The out-of-network rate cap also may make the North Dakota market more attractive for new insurers currently not offering coverage. The rate cap allows insurers a benchmark to negotiate in-network rates.

The second issue relates to the state's reinsurance pool. Under the current structure, the state is responsible for covering 75% of all claims between \$100,000 and \$1,000,000 for the covered products. By the nature of the reinsurance pool, the cost of coverage will vary from year to year depending on claims, as well as the size of the market. Similar to unemployment insurance, it is likely that the state will see some relative growth in the individual market as a result of downturns into the economy as consumers lose job-based insurance coverage.

For the state, there are also administrative costs in running the program. Thus, year to year estimates are required, eligible claims must be reviewed periodic audit procedures are necessary, as well as a host of other issues.

While state workers can successfully run these programs, the privately run reinsurance may be an advantageous option. Depending on the design of the program, private reinsurance can provide price certainty. Here, North Dakota would pay an actuarially determined premium that could cover the entire risk. Similar to any other insurance plan, the state could pay lower annual premiums by retaining some portion of the risk. The biggest advantage to the state is that the reinsurer can take on most administrative tasks, and because it is a part of their normal operations, reinsurers offer economies of scale that state governments just can't meet. Reinsurers estimate that North Dakota can save considerable dollars in the long run.

The last issue concerns telehealth. In the midst of the pandemic, there has been explosive growth in the use of telehealth. FAIR Health estimates year-over-year use in the Midwest in April reflects an increase of over 6,000 %. Such growth has been fueled by a number of issues. Noticeably, the pandemic has had a profound impact both in consumer use and in provider adoption. The pandemic has also impacted the regulatory structure by making it easier for providers to practice telemedicine, and easier for consumers to use. We would highlight a number of specific telehealth issues:

- 1. 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 NCSBN compacts, among others), as well as other flexibilities that may enhance providers ability to practice telemedicine.
- 2. Payment.** Currently, many states are mandating that telehealth providers be paid on par for the same services. There should be no mandates. These requirements, often referred to as "payment parity" or "reimbursement parity" laws effectively drive up costs, mitigating the likelihood that a robust telehealth infrastructure will lead to meaningful cost savings.

3. **Software.** Consumers and medical providers should be allowed to agree on the use of any software service. States shouldn't pick winner and losers.
4. **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.
5. **Insurance.** States should create a legal framework that would allow business and consumers to purchase an insurance product providing telehealth services.
6. **Broadband.** North Dakota has been a leader in rural access to high speed internet. Telehealth services are offered in many different forms, (i.e., audio-only, audio-visual real-time, audio-visual asynchronous, etc.) and some platforms operate better on enhanced networks. While audio-only telehealth may be offered on an existing infrastructure that supports telephone calls, access to other types of telehealth services may be limited for populations where there is little or no broadband connectivity. North Dakota should continue its leadership on this issue.

There are three substantive issues in the telehealth proposal. First, we believe that the telehealth market is competitive, and that the legislature should consider easing licensing and scope of practice requirements to make it easier for both in-state and out-of-state providers to practice. Second, we do not believe the legislature should mandate how physicians are paid for their services. It is possible the federal government payment parity requirements will be widely adopted, but there is no reason to imbed the requirement in state law – let the market determine payment. Finally, we believe a number of insurers and employers will seek to create telehealth insurance products.

We urge the legislature to consider legal framework that allow this to happen:

1. **Cap on Out-of-Network Payment:** 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.

Pro: There is some question whether or not hospital markets can be competitive. This proposal effectively regulates the hospital prices by limiting their out-of-network charges. This may lead to less expensive hospital rates and potential more competitive insurance market.

Con: North Dakota will be setting rate caps for hospital services, and effectively regulating prices.

2. **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 driving down and stabilizing rates while preventing spikes by providing consistency for taxpayers and users.

Pro: Private reinsurance can provide cost certainty, and administrative simplicity. Reinsurers can better track trends, and provide more consistent data than the state can. Private reinsurance can provide significant loss mitigation and subsequent savings, reductions in premiums to consumers. In theory, it

should create significant “smoothing” of risk from year to year. North Dakota should procure a vendor, which should result in little NDID staff resource needs.

Con: Reinsurance programs are designed to pay out a set benefit, and while private reinsurance provides certainty, it may also mean North Dakota may overpay in some years, while underpaying in others. The program may need to be offered out as an RFP on a consistent basis, which may mean cost fluctuations and administrative complications.

3. **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 2020.² Consumers are increasingly becoming accustomed to telehealth, and states should consider whether existing regulatory barriers are necessary.

Pro: Telehealth is growing. It provides consumers with an easy way to access healthcare that will expand availability across North Dakota. By providing simplification of the licensing process, consumers will be able to access a broad variety of medical providers from easy-to-access locations, like their own homes.

Con: The main issue is requiring payment parity. Providers believe mandating payment parity is both fair, and needed to ensure access to a broad choice of providers.

² <https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/apr-2020-midwest-telehealth.pdf>

Transparency

If you ask, everyone is in favor of price transparency but with caveats. It is in those caveats that the problems form, and where true transparency dies a quiet death. In crafting solutions to transparency, it is important to remember that there are just two customers.

The first customer is the individual consumer. Individual consumers should be able to understand the cost of necessary services beforehand, and what percentage of the bill they'll have to pay. This means that the consumer should have information from both the medical providers and the insurer. The information needs to be delivered in a timely manner and, in the platonic ideal, allow the consumer to shop for less expensive alternatives.

The second customer is the market. Price transparency should be designed to encourage competition. It should drive consumers to low-cost high-quality providers and away from high-cost low quality providers. It should drive innovation in the delivery of health care to find better, cheaper ways to deliver high quality outcomes.

In response to concerns about price transparency President Trump issued an executive order, and the Tri-agencies (the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury) have issued a rule on price transparency¹:

In response to the Executive Order, the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (collectively, the Departments) are issuing a proposed rule, "Transparency in Coverage" that would require most employer-based group health plans and health insurance issuers offering group and individual coverage to disclose price and cost-sharing information to participants, beneficiaries, and enrollees up front. With this information, patients will have accurate estimates of any out-of-pocket costs they must pay to meet their plan's deductible, co-pay, or co-insurance requirements. This will make previously unavailable price information accessible to patients and other stakeholders in a standardized way, allowing for easy comparisons.

If finalized, the proposed Transparency in Coverage rule would require health plans to:

- Give consumers real-time, personalized access to cost-sharing information, including an estimate of their cost-sharing liability for all covered healthcare items and services, through an online tool that most group health plans and health insurance issuers would be required to make available to all of their members, and in paper form, at the consumer's request. This requirement would empower consumers to shop and compare costs between specific providers before receiving care.
- Disclose on a public website their negotiated rates for in-network providers and allowed amounts paid for out-of-network providers. Making this information available to the public is intended to drive innovation, support informed, price-conscious decision-making, and promote competition in the healthcare industry. Making this information public directly helps the consumer, but, more

¹ <https://www.hhs.gov/about/news/2019/11/15/trump-administration-announces-historic-price-transparency-and-lower-healthcare-costs-for-all-americans.html>

importantly, creates new opportunities for researchers, employers and other developers to build new tools to help consumers.

The proposed rule would also encourage health insurance issuers to offer new or different plan designs that incentivize consumers to shop for services from lower-cost, higher-value providers by allowing issuers to take credit for "shared savings" payments in their medical loss ratio (MLR) calculations.

In addition, the Administration is finalizing a rule that will require hospitals to provide patients with clear, accessible information about their "standard charges" for the items and services they provide, including through the use of standardized data elements, making it easier to shop and compare across hospitals, as well as mitigating surprises. The final rule will require hospitals to make their standard charges public in two ways beginning in 2021:

- *Comprehensive Machine-Readable File*: Hospitals will be required to make public all hospital standard charges (including the gross charges, payer-specific negotiated charges, the amount the hospital is willing to accept in cash from a patient, and the minimum and maximum negotiated charges) for all items and services on the Internet in a single data file that can be read by other computer systems. The file must include additional information such as common billing or accounting codes used by the hospital (such as Healthcare Common Procedure Coding System (HCPCS) codes) and a description of the item or service to provide common elements for consumers to compare standard charges from hospital to hospital.
- *Display of Shoppable Services in a Consumer-Friendly Manner*: Hospitals will be required to make public payer-specific negotiated charges, the amount the hospital is willing to accept in cash from a patient for an item or service, and the minimum and maximum negotiated charges for 300 common shoppable services in a manner that is consumer-friendly and update the information at least annually.
 - Shoppable services are services that can be scheduled by a healthcare consumer in advance such as x-rays, outpatient visits, imaging and laboratory tests or bundled services like a cesarean delivery, including pre- and post-delivery care.
 - The requirements for the consumer-friendly file are that the information must be made public in a prominent location online that is easily accessible, without barriers, and it must also be searchable. Item and service descriptions must be in 'plain language' and the shoppable service charges must be displayed and grouped with charges for any ancillary services the hospital customarily provides with the primary shoppable service.

The American Hospital Association has filed suit against the hospital transparency final rule but have lost the in the DC district court.² The issue remains an important one. As part of this project, a secret shopper program was completed. We examined several common procedures that allow consumers to shop prices, including a colonoscopy, a normal birth, and a birth by c-section. As you can see below, the prices quoted varied widely.

² https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv3619-35

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.

Understanding what something costs is important to both customers – the consumers and the market. The Trump administrations’ transparency rules, assuming the American Hospital Association lawsuit ongoing challenge is unsuccessful –provides an important movement in transparency. The requirements allow consumers to understand their health plan liabilities and understand the potential costs of services. North Dakota should consider efforts to include these changes in state law to ensure consumers can take advantage of the changes.

While the federal rules provide important changes, they aren’t enough. Medical procedures are generally billed based on either Diagnostic Related Groups (DRG) which are typical for most hospital services or based on a Common Procedural Terminology (CPT) code usually for most physician-based services. The Trump administration’s rules, if fully implemented, allow consumers the opportunity to understand the costs of services the consumer is expected to receive. They do not provide a comprehensive understanding of the costs of the services relative to other providers for a range of services.

We are suggesting two changes that are intended to be additive to the federal transparency rules. First, we suggest that hospitals and perhaps other medical providers disclose their prices based on a percentage of Medicare. This provides the market with a benchmark to judge a hospital’s pricing. We believe that this is the easiest, most transparent way for consumers to compare costs across a range of services.

The second initiative is the Right to Shop.³ The Right to Shop extends price transparency requirements by allowing insurers to reward consumers who shop for low-cost, high value providers of a service. When a consumer receives a referral for a medical service, the consumer can contact their insurer to see if any medical providers meet the criteria to be low-cost, high value provider. If the consumer uses those services, the insurer is allowed to provide a reward – including a cash payment – to incentivize the consumer.

³ <https://thefga.org/research/right-to-shop/>

8. Direct to Consumer Pricing: Disclosure of Consumer Prices⁴. 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 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.

Pro: Hospitals will be not only required to disclose the price of a service to consumers but also a benchmark against Medicare charges. This provides the consumer with a simple metric to judge the relative cost of the full range of services. It also allows a common metric for policymakers to judge against.

Con: In some cases, consumers may have no other choice of provider and the comparison can provide little value. Medicare rates vary by region, making the comparison difficult compared to real costs.

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. 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.

Pro: The proposal rewards consumers for making the right choice. Psychologically, cash rewards seem to have a larger effect on consumer behavior than the lower prices.

Con: In implementation, consumers usually have to contact an administrator to help shop for alternative providers. In a rural state like North Dakota, some services may not be shoppable due to driving distances.

⁴ #9 Public Policy Price Disclosure is predominately synonymous with “Direct to Consumer Pricing” and therefore has not been provided additional attention in this summary document.

Program Integrity

The Centers for Medicare and Medicaid Services defines program integrity as “pay it right,” that is, “paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking aggressive actions to eliminate fraud, waste and abuse.”¹

It may be an oversimplification to state that program integrity is an effort to ensure that taxpayer resources are spent appropriately. But it is not far off the mark. With the growth of the Medicaid program, the Trump administration has made new efforts to ensure the integrity of the program and ensure that states are administering the program effectively while maximizing taxpayer spending. In a 2019 press release, Administrator Verma stated²:

The Medicaid program has grown from \$456 billion in 2013 to an estimated \$576 billion in 2016, largely fueled by a mostly federally financed expansion of the program to more than 15 million new working age adults. For these adults, the estimated cost per enrollee grew about 7 percent from FY2017 to 2018, compared to about 0.9 percent for other enrollees. With this historic growth comes a commensurate and urgent responsibility by CMS on behalf of the American taxpayers to ensure sound stewardship and oversight of our program resources. While the primary responsibility for ensuring proper payments in Medicaid lies with states, CMS plays a significant role in supporting states’ efforts and holding them accountable through appropriate oversight and increased transparency.

While Medicaid is administered and operated by the states, the federal government finances a large proportion of Medicaid costs. As Administrator Verma expressed, the federal government has an expectation that states will appropriately manage the taxpayer dollars allocated by the federal government to their Medicaid programs. CMS expanded on its understanding of and priorities for program integrity responsibility in a June 2019 Bulletin³:

While fiscal integrity is imperative for every aspect of the Medicaid program, we particularly want to highlight these responsibilities with respect to coverage of the Medicaid adult expansion group authorized under section 1902(a)(10)(A)(i)(VIII) of the Act and for other expenditures that are claimed at an enhanced federal matching rate. CMS needs to ensure the fiscal integrity of the overall program. As part of CMS’ ongoing program integrity efforts, any aspect of a state’s Medicaid program may be subject to future program oversight reviews or audits as provided by 42 CFR 430.32. This guidance is critical in light of recent audits conducted by the U.S. Department of Health and Human Services Office of Inspector General and others that found that some states did not always determine Medicaid eligibility in accordance with Federal and state requirements, potentially resulting in States inappropriately claiming significant Federal funds. Beyond this guidance, CMS is developing other regulatory or sub-regulatory efforts to strengthen Medicaid fiscal integrity.

¹ <https://www.cms.gov/blog/future-medicare-program-integrity#:~:text=CMS%20defines%20program%20integrity%20very,eliminate%20fraud%2C%20waste%20and%20abuse.>

² <https://www.cms.gov/blog/medicaid-program-integrity-shared-and-urgent-responsibility>

³ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf>

Listed below, are the main four areas that a state should prioritize to ensure proper claiming federal match for their Medicaid program.

1. Development of necessary program integrity protections,
2. Implementation of appropriate system and financial oversight controls,
3. Monitoring the program effectively, and;
4. Documentation and evidence to support these activities.

This information is important for those states that may be considering adopting the Medicaid expansion, it should also help those states that have already adopted the Medicaid expansion and operational oversight of their program. The state should provide assurances of compliance with applicable program requirements to ensure appropriate expenditure categorization and claiming.

Program Integrity is important in order to ensure that North Dakotans receiving health benefits are covered by the correct payer and funds are being used appropriately. For example, a Medicaid recipient shouldn't be covered by Medicaid if he or she is eligible for a group health plan. Whether it is due to mission creep, shifting priorities or just loss of focus, states often stray away from dedicating time and resources to guaranteeing program integrity and associated cost savings.

While program integrity can provide savings, it is also important to note the potential risks to North Dakota is the state does not fully meet the federal guidelines.

There are a number of options, with unique benefits and drawbacks, that the state can consider in order to ensure program integrity and find cost savings.

11. Medicaid Integrity Audit: It is imperative to audit the entire Medicaid population to ensure that beneficiaries are not otherwise covered by a primary payer, such as Medicare. A more intense audit would evaluate the beneficiaries to determine whether they should be receiving disability benefits, and therefore Medicare shall be the primary payer. This is accomplished through third party vendors, namely patient advocates, and has long been a practice of Fortune 100 companies. 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, such as premises liability coverage. Contingency fee contracts provide vendors the opportunity to find savings for the state through Medicaid Integrity Audits. The state also has an opportunity to build program integrity requirements into the RFP for the Medicaid expansion.

Pro: By contracting with full contingency fee vendors, North Dakota can use outside resources to recover significant dollars. The vendors have experience in auditing Medicaid files to find other payers. Further, arguably the consumer (beneficiaries) would receive more comprehensive coverage and disability benefits, if eligible. These are likely the high utilizer populations. Savings are inevitable but each beneficiary could take as long as two years to convert.

Con: Staff resources are necessary. The state would be responsible for the beneficiaries identified, and therefore would be responsible for costs upon discovery and conversion.

12.State Group Health Integrity Audit: This effort is similar to the Medicaid audit but would be applied to the state employee health plan.

Pro: Like all employers, the state has employees and dependents that may have other forms of coverage. This is particularly important to uncover when an employer provides 100% family coverage. An audit may identify other sources of coverage, especially for dependents.

Con: This audit would apply to a relatively small population and the single source of coverage may mean the audit is unlikely to find significant savings.

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.

Pro: State employees may be eligible for coverage under their spouses, however North Dakota’s no-cost benefit may encourage them to stay on state coverage. This waiver would provide an opt-out payment option for state employees and may lead to lower costs.

Con: Providing the additional benefit may have a crowd-out effect i.e. paying out an additional benefit to those already waiving coverage.

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.

Pro: The newer NAIC model provides a more consistent framework for coordination of benefits across the country. It provides the insurers with a more consistent national framework.

Con: The savings from this change would likely be fairly small.

Crisis & Pandemic Planning

We are facing an unprecedented crisis in the pandemic surrounding COVID-19. We have faced other concerning issues including the very similar SARS and Zika viruses. Unlike in those cases, COVID-19 spread quickly and dangerously. Medical professionals were ill-equipped, at the outset, to deal with rapidly growing crisis. For many public health officials, it was worse. Information was scarce, especially on the number of available beds, number of available ICU beds, and equipment like ventilators.

As the pandemic worsened, information gathering came to be increasingly important to estimate the resources available to fight the pandemic. Hospitals, which have always operated privately, were required to be part of the very public fight against COVID-19. Hospital resources, in essence, became public resources.

While the situation in New York was concerning, it looks like currently we have a better handle on the resources needed to fight COVID-19 and the resources available. 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.

Based on prior pandemics, the COVID-19 crisis appears to be a black swan event i.e. a rare occurrence. But as the issues in Italy and even New York demonstrated, the pandemic has the possibility of being devastating. Planning for the next pandemic means that we need to understand the intersection of public health concerns with private health care resources.

Similarly, the 2008 financial crisis was another black swan event for the insurance industry. The repercussions for the economy were serious, and state insurance regulators had concerns about both insurer solvency and monitoring insurance solvency. One of the key tools the National Association of Insurance Commissioners created was the Own Risk and Solvency Assessment. (ORSA)The concept was to require insurers to review their own risk. From the NAIC website¹:

ORSA: WHAT IS IT?

An ORSA is an internal process undertaken by an insurer or insurance group to assess the adequacy of its risk management and current and prospective solvency positions under normal and severe stress scenarios. An ORSA will require insurers to analyze all reasonably foreseeable and relevant material risks (i.e., underwriting, credit, market, operational, liquidity risks, etc.) that could have an impact on an insurer's ability to meet its policyholder obligations.

The "O&" in ORSA represents the insurer's "own" assessment of their current and future risks. Insurers and/or insurance groups are required to articulate their own judgment about risk management and the adequacy of their capital position. This is meant to encourage management to anticipate potential capital needs and to take proactive steps to reduce solvency risks. ORSA is not a one-off exercise-it is a continuous evolving process and should be a component of an insurer's enterprise risk-management (ERM) framework. Moreover, there is no mechanical way of conducting an ORSA; how to conduct the

1

https://content.naic.org/cipr_topics/topic_own_risk_and_solvency_assessment_orisa.htm#:~:text=The%20NAIC%20ORSA%20Implementation%20%28E%29%20Subgroup%20is%20charged,ORSA%20Guidance%20Manual%20and%20consider%20revisions%20as%20necessary.

ORSA is left to each insurer to decide, and actual results and contents of an ORSA report will vary from company to company. The output will be a set of documents that demonstrate the results of management's self-assessment.

North Dakota passed their own ORSA law several years ago. From a policy perspective, ORSA reports provide valuable insight into how an individual insurer views its own risks. The framework is scalable – smaller insurers have less complicated reports than larger insurers who may, for example, also have an international component. Most importantly, it requires an insurer to regularly examine the risks on the horizon and document any action taken to mitigate that risk.

This policy proposal seeks to put the same framework in place for pandemic planning for both hospitals and insurers. For health insurers, it is likely that the ORSA framework would already require pandemic planning through a bulletin, rules or both but it may be necessary to permanently enshrine the requirement in state practice. This will be important as the memory of issues tends to fade over time.

For hospitals, the issue is different. Certainly, most hospitals do extensive planning and conduct a variety of drills and planning sessions for catastrophic scenarios. But ORSA planning is different. It would require a board-level examination of the risks facing the hospital with a focus on public health risks. Specifically, an evaluation of likely and unlikely public health risks, the impact on the hospital, and the availability of equipment, personnel, and beds to help fight the risk.

As an example, early in the COVID-19 crisis, it appeared we had a shortage of ventilators. There were anecdotal reports that some hospitals had increased their supply during and after the SARS pandemic, and when they were little used, sold the units out of storage. The sales were done with good reason and good intention and presumably provided for other critical needs.

This is not to suggest the decision was wrong, and indeed ventilators have proven less necessary as the treatment of COVID-19 has evolved. What we are suggesting is that the state should require hospitals establish a consistent framework for review of possible risks to the hospital, risks to its financial viability, and public health risks. Similar to the ORSA report, this is intended to be formal, self-critical analysis of risks that is reviewed by the hospital board. It is intended not just to raise issues but analyze solutions that will mitigate risks. These reports should be kept highly confidential as the analysis of the risks could lead to understanding of non-public risks faced by the hospital. One option to consider is a review by the North Dakota health department to help the department understand the hospital assessment of risk.

It is also important to note that while the report will produce a better assessment of a region and the state's medical risks, it may mean higher costs. As this pandemic has started to demonstrate, hospitals are centers for public health. For a hospital in a region to mitigate certain risks, it may need to request to be paid by the state for those services or pass higher costs on to local consumers. A hospital that stores hundreds of ventilators will need to provide storage space, maintenance, and the initial capital required to purchase the ventilators. These costs may exist outside the hospital's core mission.

15. 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 (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.

Pro: An ORSA-style report for hospitals would be a first in the nation requirement. The proposal can be right-sized based on the size of the hospital or the hospital system. It creates a common framework for analysis of the health risks facing the hospital and the community. With an annual review, the hospital Board and executives can use the ORSA report to analyze the any investments and their impact on reducing or increasing hospital risk.

Con: Many hospitals conduct similar risk processes and have risk managers that examine systemic risks on a regular basis. An ORSA analysis will require additional administrative resources. Insurance ORSA reports have strict confidentiality protections because of the sensitive nature of the information, and the report provides detailed information on weaknesses of the organization.