NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

ND Legislative Council

Industry, Business, and Labor Committee

August 6, 2009

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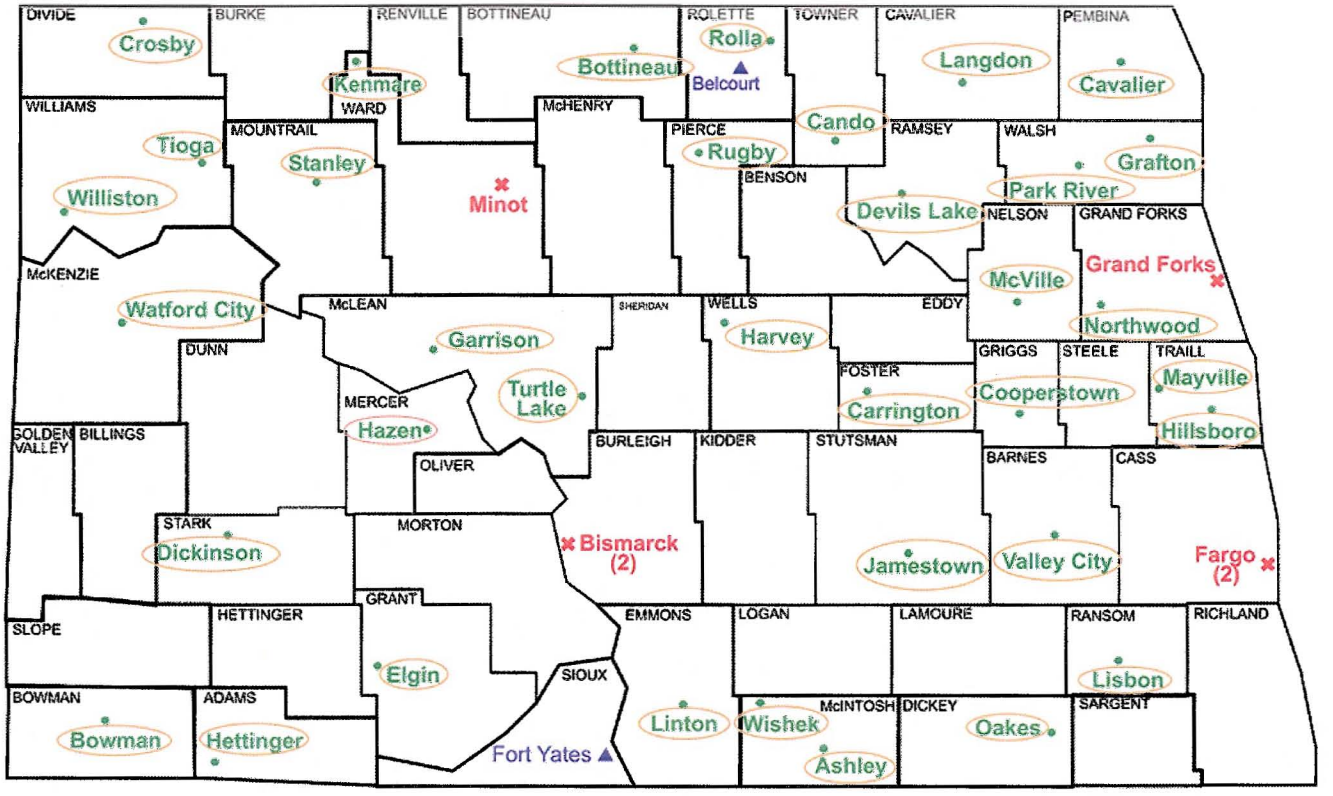
TABLE OF CONTENTS

1

North Dakota Hospitals and Critical Access Hospitals



Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

- Rural Hospital
- Indian Health Service Hospital
- Tertiary Hospital-CAH Network
- Critical Access Hospital

7/09

6 PPS Hospitals
36 CAH Hospitals
2 IHS Hospital

2

GLOSSARY

Bad Debt – An account that is uncollectible from a patient, although the patient has or may have the ability to pay. This results I a credit loss for the health care facility. These losses may be reflected as an allowance from revenue or as an expense of doing business of the entity.

CAH (Critical Access Hospitals) – A rural hospital designation established by the Medicare rural Hospital Flexibility Program (MRHFP) enacted as part of the 1997 Balanced Budget Act. Rural hospitals meeting criteria established by their State may apply for critical access hospital status. Designated hospitals are reimbursed based on cost (rather than prospective payment), must comply with Federal and State regulations for CAHs, and are exempt from certain hospital staffing requirements.

Case Mix – Categories of patients, classified by disease, procedure, method of payment or other characteristics, in an institution at a given time, usually measured by counting or aggregating groups of patients sharing one or more characteristics.

Case Mix Adjustment – A method of accounting for the difference in the severity of illness or resource intensity between patients at different hospitals. For instance, the average payment and cost is greater at a hospital that performs many heart surgeries tan at a hospital that primarily delivers babies. To account for these differences, Medicare assigns a relative value to each type of case. When adding up all the Medicare cases at each hospital, an average case mix index can be calculated and used to adjust the overall payment and cost figures so they are comparable.

Charge – The dollar amount charged by a hospital, physician or other health care provider for a unit of service, such as a day's stay in an inpatient unit or a specific medical procedure.

Charity Care – Generally refers to physician and hospital services provided to persons who are unable to pay for the cost of services, especially those who are low-income, uninsured, and underinsured.

Commercial Plan – The benefit package an insurance company/HMO/PPO offers to employers. This is distinguished from a senior plan which is offered to Medicare beneficiaries.

Cost: -

- Provider – expenses incurred in providing services.
- Payer – expenses incurred for receipt of services.

Cost Shift – The practice of charging certain patients higher rates to recoup losses sustained when a third party payer reimburses for other patients at an inadequate rate.

Emergency Room – The department or unit of a hospital organized to provide medical services necessary to sustain life or to prevent critical consequences. This department sometimes provides non-urgent, walk-ion care.

IHS (Indian Health Services) – A Federal health program for American Indians and Alaska Natives.

Inpatient – An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.

Insurance Major Medical – Insurance that protects the insured against all or a percentage of loss incurred as a the result of severe or prolonged illness or disability whose costs exceed a specified dollar amount

Insured – A traditional term for a party receiving benefits under a commercial insurance product.

Medicaid – A federally aided, State operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to brood Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medicare – A Federal program which provides health insurance benefits primarily to persons over the age of 65 and others eligible for social Security benefits. The program has two parts: hospital insurance (Part A) and medical insurance (Part B). Part B is also known as supplementary medical insurance.

Outpatient – A patient receiving ambulatory care at a hospital or other health facility without being admitted as an inpatient.

PPS (Prospective Payment System) – A method of payment to providers in which rates for services are established in advance based on a DRG system or some other methodology.

Payment Rate – The total amount paid for each unit of service rendered by a health care provider, including both the amount covered by the insurer and the consumer's cost sharing: sometimes referred to as payment level. Also used to refer to capitation payments to health plans. For Medicare payments to physicians, this is the same as the allowed charge.

Prepaid Health Plan – A prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis.

Self-Pay – Individuals, institutions or corporations assuming the entire responsibility for payment of hospital and medical bills which otherwise might be covered by an insurance policy.

TRICARE – The health care program for active duty members of the military, military retirees, and their eligible dependents. TRICARE was called the CHAMPUS program in the past.

Uncompensated Care – The sum of bad debts an charity care absorbed by a hospital in providing medical care to patients who are uninsured or are unable to pay.

Uninsured – Individuals who do not have health insurance coverage of any type. Over 80% of the uninsured are working adults and their family members, of which over 25% are children under 18. People on Medicare, Medicaid, Veterans Administration or other public programs are insured. Fewer than 20% of the uninsured do not work. The uninsured usually earn too much to qualify for public assistance, but too little to afford coverage.

WSI (Workforce Safety & Insurance) – Workforce Safety & Insurance, formerly called Worker's Compensation Bureau, is the program that covers by an employer, if verified by that employer.

3

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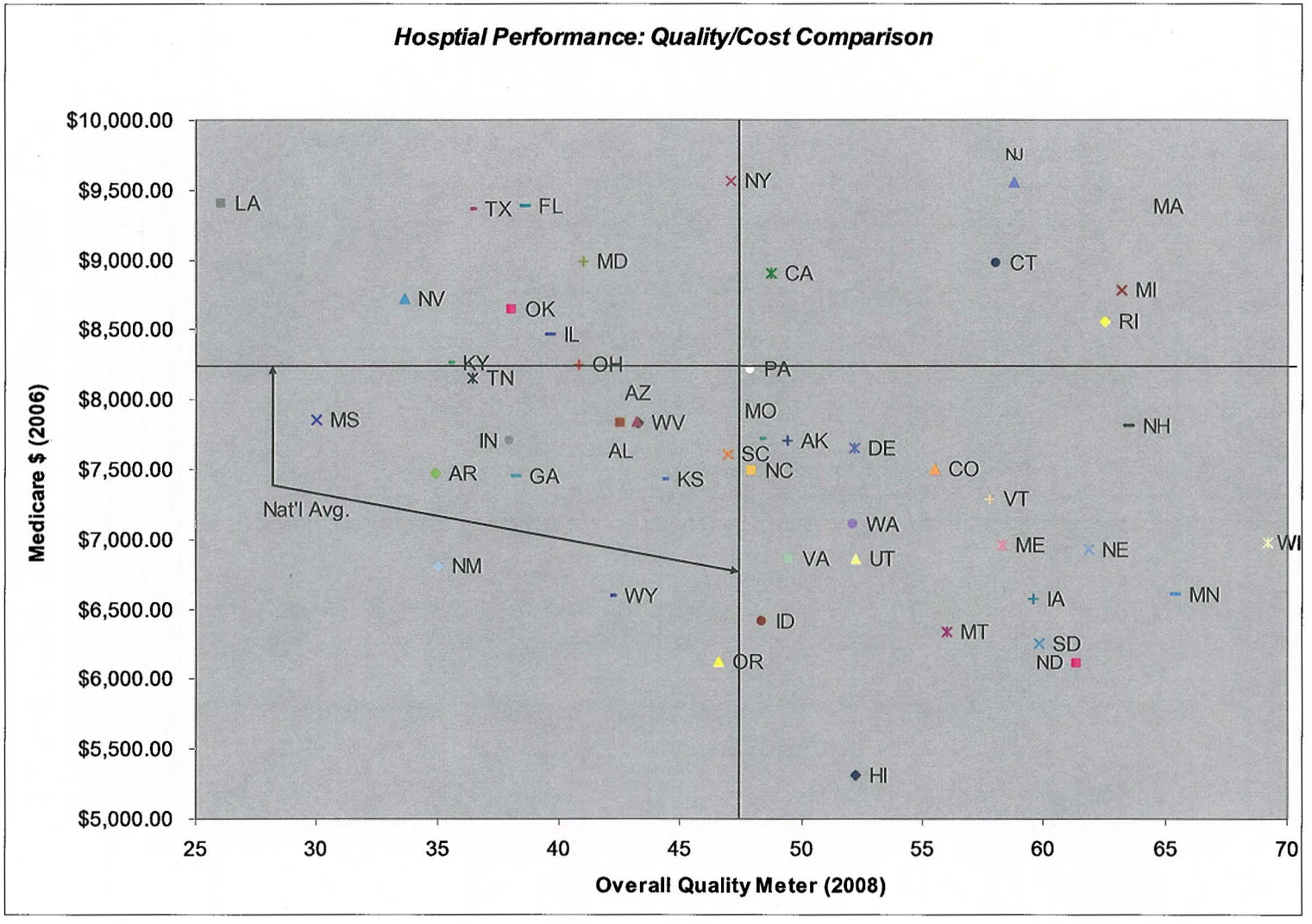

Source: Dartmouth Institute for Health Policy
2008 NHQR State Snapshots and 2006 Medicare Reimbursements by State

4

HOSPITAL ECONOMIC IMPACT

Executive Summary

A total of 43 community hospitals provide North Dakota residents with a comprehensive array of health services. These health care providers contribute significantly to the overall stability and viability of the state. Community hospitals provide positive impacts relating to financial, employment and patient care indicators. The research study which follows is titled "The Economic Pulse of North Dakota." It was conducted in 2008 to assess the contributions made by community hospitals to the economy of North Dakota. Key research findings include:

- According to the 2008 Pulse Survey, community hospitals contribute an estimated $1.8 billion dollars in direct impacts to North Dakota's economy, an increase of about $435 million dollars from the 2006 report. This represents a 32% increase in the contribution of community hospitals to the state's economy.

- The vast majority of dollars spent by community hospitals remain in North Dakota. On average, 76% of the dollars remain in the state, while the remaining 24% go to out-of-state sources for equipment, supplies and other resources.

- According to the 2008 Pulse Survey, community hospitals in North Dakota employ an estimated 11,784 full-time employees and 7,019 part-time employees. Thus, over 18,800 people are employed by community hospitals. This represents an estimated 15,398 full-time equivalent jobs.

- According to Job Service North Dakota, community hospitals paid their employees an average wage of $41,964 per year as of the first quarter of 2008. This average wage is considerably higher (24%) than the statewide worker average of $33,904 per year.

- According to Job Service North Dakota, the annual average employment for all business sectors in North Dakota as of the first quarter of 2008 was 340,910 workers. Health care and social assistance represents the state's largest non-government employment sector. Roughly14% of all workers in North Dakota are employed by a health care organization. About 5.5% are employed by community hospitals. Furthermore, seven of the top ten largest employers in the state are health care providers.

- Community hospitals provided care during 2007 for approximately 90,000 inpatients, 276,000 emergency room patients and over one and a half million outpatients. Based on these figures, each year roughly one out of every seven residents is admitted to a community hospital, and one out of every three residents requires a visit to a hospital emergency room. Moreover, every North Dakota resident had an average of approximately two outpatient visits with community hospitals in 2007.

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Findings

This research study documents the contribution of hospitals to North Dakota's economy from three distinct perspectives: financial, employment and patient care impacts.

Financial Impacts

Financial impacts were determined using information provided through the survey questionnaire that was completed by hospital administrators and/or their designated representative. Of the 43 community hospitals surveyed, 40 facilities responded to the survey by providing complete data, whereas the other three facilities provided partial data. Hospital administrators were also asked to estimate the amount of in-state and out-of-state expenditure for their most recently completed fiscal year.

Additional financial information was gleaned from each hospital's tax report to the Inter Revenue Service (Form 990 for non-profit hospitals). In the majority of cases, the most recent financial report on file covered the 2007 calendar year.

Gross Revenue and Deductions

According to the 2008 Pulse Survey, community hospitals in North Dakota generated over $3.1 billion dollars in gross revenue. This is the amount of money that hospitals billed to patients, insurance companies and other payers for services rendered.

Findings (continued)

Like other industries, not all bills that are submitted by hospitals to their customers are paid in full. The health care industry is hit especially hard by this phenomenon. Third party payers, such as the federal government and insurance companies, typically pay hospitals based on pre-established, fixed rates of reimbursement.

These reimbursement rates are considerably lower than the actual amount billed by hospitals to the third party payers. As a matter of fact, the deductions from revenue reported in the 2008 Pulse Survey totaled over $1.3 billion dollars, an astounding 42% less than actual billed charges. In other words, community hospitals in North Dakota were paid fifty eight cents on every dollar billed for serviced rendered.

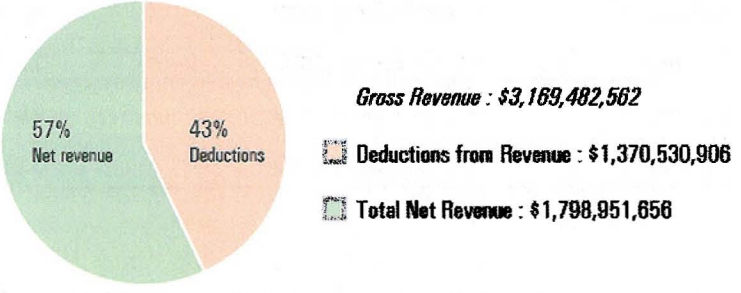
North Dakota hospitals receive 58 cents on every dollar billed.

42 cents on every dollar billed by North Dakota hospitals is unpaid by third party payers and patients.

Net Revenue

With gross revenues totaling over $3.1 billion dollars and deductions from revenue totaling over $1.3 billion dollars, the (actual) net revenue generated by community hospitals in North Dakota as reported in the 2008 Pulse Survey was an estimated $1.8 billion dollars.

Figure 1 : Hospitals Generate $1.8 Billion Annually



2008 Pulse Survey	Amount
Gross Revenue	$3,169,482,562
Deductions from Revenue	(-$1,370,530,906)
Net Revenue	$1,798,951,656

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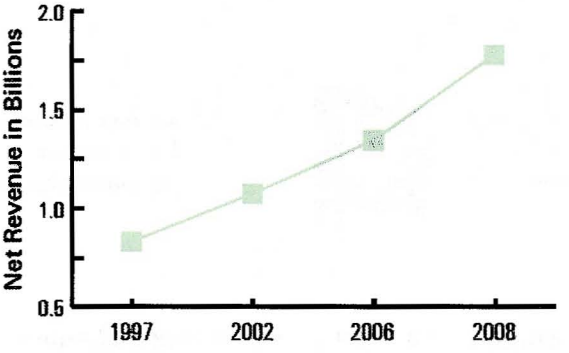
Findings (continued)

Total net revenues for community hospitals in North Dakota have grown substantially when compared to the results of prior economic impact surveys conducted by NDHA. Since 1997, the net revenue generated by community hospitals in North Dakota has more than doubled. In the past two years alone, total revenues have increased by $435 million dollars, a growth in revenue of thirty-two percent (32%).

Figure 2 : Hospital Revenues Have Doubled in Past Decade



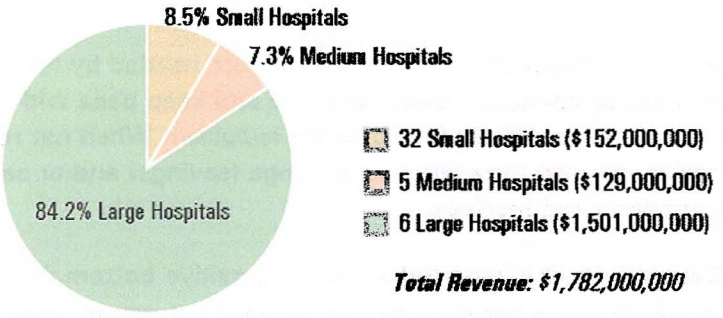
	Total Annual Net Revenues	% Of Growth From One Survey To The Next
1997 Survey	$832,000,000	N/A
2002 Survey	$1,076,000,000	29%
2006 Survey	$1,347,000,000	25%
2008 Survey	$1,782,000,000	32%

These numbers are consistent with statistics that are tracked and reported by the American Hospital Association on an annual basis. The 2007 AHA Hospital Statistics publication reports that community hospitals in North Dakota generated $1.2 to $1.5 billion annually in net revenues between 2002 – 2005.

Findings (continued)

The vast majority of net revenues were generated by facilities located in larger communities throughout the state. The 6 largest hospitals in four major cities (Fargo, Grand Forks, Minot and Bismarck) accounted for 84.2% of total revenue. The 5 medium-sized hospitals in the state (Jamestown, Williston, Dickinson, Devils Lake and Hettinger) accounted for 7.3% of total revenue. The remaining 32 hospitals located in rural communities throughout the state accounted for 8.5% of total annual revenue.

Figure 3 : Six Largest Hospitals Account for 84% of Total Revenues



Source: NDHA Survey. 2008.

Much of the revenue generated by North Dakota hospitals represents new wealth to the state. New wealth associated with community hospitals comes from federal transfer payments for medical services (e.g., Medicare and Medicaid) and revenues for medical services provided to out-of-state residents (e.g., Minnesota or South Dakota residents seeking treatment in North Dakota).

For most North Dakota hospitals, the percentage of Medicare and Medicaid reimbursement ranges from 60-80% of total revenue. This means that of the $1.8 billion dollars that are generated annually by community hospitals, over a billion dollars in new money is brought into the State each year from out-of-state residents and federal programs.

Total Expenses and Net Returns

According to the 2008 Pulse Survey, community hospitals in North Dakota spent nearly the same amount of money as they generated in net revenue. Total annual expenditures amounted to $1.78 billion dollars. Such expenses are used to pay for personnel, supplies, equipment and facilities needed to operate community hospitals.

Findings (continued)

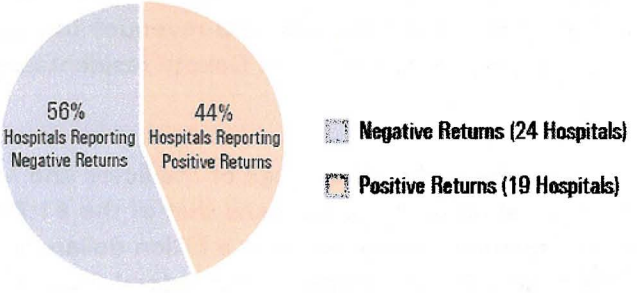
With revenues and expenses nearly identical to one another, the net return for hospitals as reported in the 2008 Pulse survey totaled an estimated $16.2 million dollars. Even though this figure represents a significant amount of money, the percentage is less than a 1% (.009) of the total net revenue generated by community hospitals.

North Dakota hospitals typically experience lower net returns than other hospitals across the nation. According to the American Hospital Association 2007 annual statistics report, U.S. hospitals averaged a positive net return of 3% during the most recent five-year reporting period (2002-2006).

The net return represents the bottom line dollars that are needed by hospitals to improve their facilities, purchase new equipment, expand services and keep pace with inflationary factors (e.g., raises for employees and increased costs for supplies). When net returns are inadequate, hospitals are forced to tap into their retained earnings (savings) and/or seek additional financing to sustain their operations and facilities.

Although North Dakota hospitals reported an overall positive bottom line on a cumulative basis, many individual hospitals had a negative net return. In other words, they spent more money than they generated in annual revenue. Of the 43 hospitals surveyed in 2008, a total of 24 facilities (56%) reported negative net returns.

Figure 4 : 24 Individual Hospitals Report Negative Returns



The number of hospitals reporting negative net returns has remained relatively consistent with the prior report (2006). At that time, 23 of the 43 hospitals surveyed (53%) reported having negative net returns. The difference in financial performance between the various hospitals may be attributed to many factors including, but not limited to, reimbursement from Medicare and other third party payers, scope of services offered, market share, capital improvements and operational costs. Negative net returns affected all types of hospitals regardless of size or geographic location.

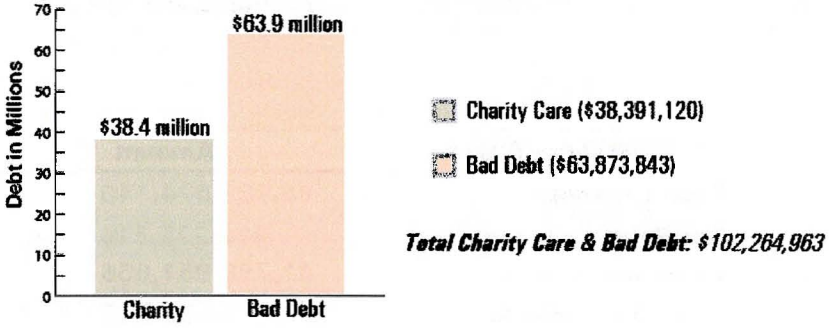
Findings (continued)

Charity Care and Bad Debt

As socially-responsible organizations, community hospitals provide needed services to patients, such as emergency and trauma care, regardless of an individual's financial standing or ability to pay. With this in mind, according to the 2008 Pulse Survey, community hospitals provided over $38 million dollars in charity care during 2007 to people who were unable to pay for services rendered.

Additionally, community hospitals had an estimated $64 million dollars in bad debt during 2007. Bad debt is defined as a bill to a payer that is deemed to be uncollectible. This determination is made after all attempts have been pursued to collect on the debt. The debt, once considered to be bad, is written off by the hospital as an expense.

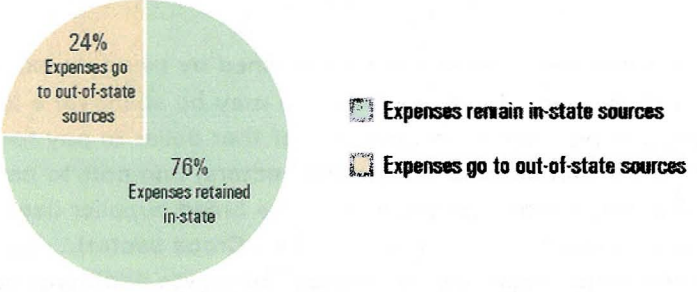
Figure 5 : Charity Care & Bad Debt Expenses



Dollars Spent in North Dakota

According to the 2008 Pulse survey, the vast majority of all expenses incurred by community hospitals are spent in North Dakota. On average, 76% of the dollars remain in the state, while the remaining 24% of dollars go to out-of-state sources for supplies, equipment and other items needed to operate community hospitals.

Figure 6 : Hospitals Spend Majority Of Dollars In-State



Source: NDHA Survey. 2008.

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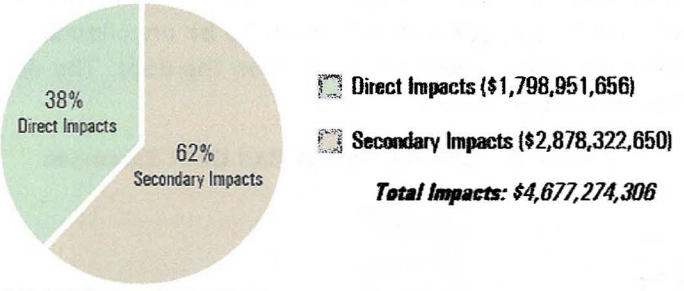
Findings (continued)

Direct and Secondary Economic Impacts

Direct economic impacts to a region are typically defined as the amount of dollars spent by a particular industry, plus the retained earning (net return). Therefore, when it comes to quantifying the impact of community hospitals on the state's economy, the direct impact based on the 2008 Pulse Survey is estimated to be $1.8 billion dollars.

Figure 7 : Direct and Secondary Impacts Total Over $4.6 Billion



2008 Pulse Survey	Amount
Total Expenses	$1,782,674,140
Net Return	$16,277,516
Direct Impacts	$1,798,951,656
Secondary Impacts	$2,878,322,650
Total Impacts	$4,677,274,306

In keeping with other economic impact studies conducted in North Dakota, this report will utilize input/output analysis (e.g., the amount of spending and re-spending in an economy) to estimate the secondary effects of community hospitals on North Dakota's economy. Secondary impacts are often referred to as the "multiplier or ripple effect". This takes into account the total business activity resulting from subsequent rounds of re-spending that occur within an economy (Coon et al. 1985).

This process of spending and re-spending can be explained by using an example. A single dollar paid by a hospital to an employee (Households sector) may be spent for a loaf of bread at the local store (Retail Trade sector). The store uses part of that dollar to pay for the next shipment of bread (Transportation and Agricultural Processing sectors) and part to pay the store employee (Households sector) who shelved or sold the bread. The bread supplier uses part of that dollar to pay for the grain used to make the bread (Agriculture-Crops sector)... and so on (Hamm et al. 1993). The impact of the initial dollar has "multiplied" to create additional economic impacts.

Findings (continued)

This is considered to be the secondary impact attributable to the original industry. *(Dean A. Bangsund and F. Larry Leistritz, Economic Contribution of the Petroleum Industry to North Dakota, 2007).*

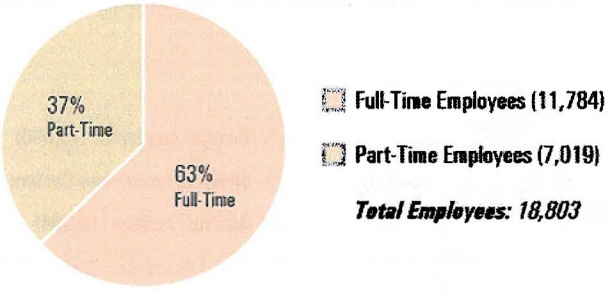
In order to determine the secondary impact on North Dakota's economy, a multiplier of 1.6 will be used to estimate the additional business volume generated by the hospital industry. *(Note: this is a typical output multiplier as identified and determined by the U.S. Bureau of Economic Analysis, and the Kansas Long-Term Model (or KLTM), a dynamic input-output model under development at the Institute for Public Policy and Business Research).*

As previously stated, direct impacts for community hospitals as documented in the 2008 Pulse Study totaled $1.79 billion dollars. When multiplied times 1.6, the secondary impacts are estimated to generate an additional $2.87 billion dollars in economic activity. Thus, gross business volume (direct and secondary effects) attributable to community hospitals in the 2008 report is estimated to be nearly $4.7 billion annually.

Employment Impacts

According to the 2008 Pulse Survey results, community hospitals in North Dakota directly employed 11,784 full-time employees and 7,019 part-time employees. Thus, a total of over 18,800 people were directly employed by community hospitals in 2007. This represented an estimated 15,379 full-time equivalent (FTE) hours.

Figure 8 : Hospital Employees



Employment Statistics Are Consistent with Other Data Sources

These figures are consistent with the most recent employment information reported in the 2007 AHA Hospital Statistics publication. For 2005, the AHA reports a total of 11,072 full-time and 7,274 part-time employees work at community hospitals in North Dakota. Thus, the total combined employment reported by AHA for 2005 is 18,346 workers.

Findings (continued)

Furthermore, when comparing these numbers to statistics collected by Job Service North Dakota, the employment figures are also quite similar. For the most recent reporting year (2006), Job Service North Dakota reports the total employment (full and part time) for hospitals in North Dakota is 17,132 workers. Within the next 10 years, Job Service estimates the need for hospital employees to grow by approximately 1% annually.

Hospital Salaries are 24% Higher than the Statewide Average

Job Service reports the average annual wage for hospital workers to be $41,964 as of the first quarter of 2008. This average wage is considerably higher (24%) than the statewide worker average of $33,904/year.

An Estimated 5.5% of All Workers in North Dakota are Employed by Hospitals

Job Service of North Dakota reports the total average level of employment in North Dakota to be 340,910 workers as of the first quarter of 2008. Using statistics from the 2008 Pulse Report, an estimated 5.5% of all workers in North Dakota are directly employed by community hospitals.

Healthcare Industry Comprised of Four Main Sectors

The annual 2007 employment estimates from Job Service of North Dakota indicate that the health care and social assistance sector employs 47,600 workers. Hospital employees account for 35.5% of this sector, whereas the remaining workers are employed at nursing facilities (29.4%), clinics and ambulatory centers (22.5%) and social assistance centers (12.6%).

Figure 9 : 4 Main Sectors of Healthcare Industry

Source: Job Service of North Dakota website. 2008.

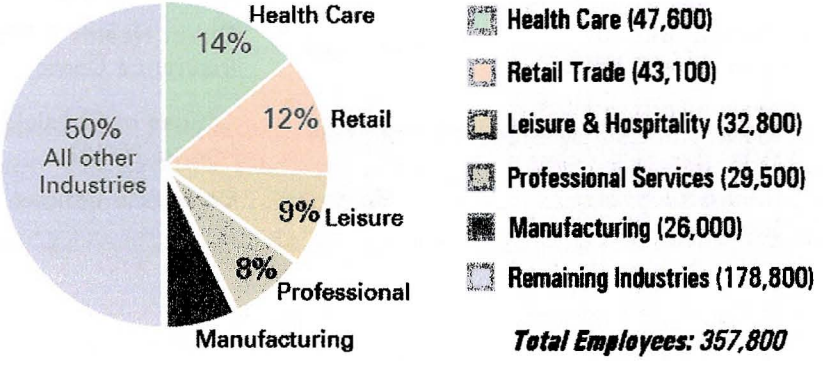
Findings (continued)

Note: The health care and social assistance sector is composed of the following: ambulatory health care services (offices of physicians, dentists, other health practitioners, outpatient care centers, medical and diagnostic laboratories, home health care services and other ambulatory health care services): Hospitals (general medical and surgical hospitals and psychiatric and substance abuse hospitals/other hospitals); nursing and residential care facilities (nursing care facilities, residential mental health facilities, community care facilities for the elderly, other residential care facilities) and social assistance (individual and family services, emergency and other relief services, vocational rehabilitation services and child day care services).

Health Care Is North Dakota's Largest Non-Government Employer

According to Job Service of North Dakota, the annual average employment for all business sectors in North Dakota during 2007 was 357,800 workers. Health care and social assistance represents the state's largest employment sector. Roughly 14% of all workers in North Dakota are employed by a health care organization.

Figure 10 : Health Care and Social Assistance - State's Largest Employing Industry



Source: Job Service of North Dakota website. 2008.

Furthermore, Job Service of North Dakota reports that 7 of the top 10 largest employers in the state are health care providers.

Figure 11 : Majority Of North Dakota's Largest Employers Are Health Providers (Shaded in Blue)

Rank	Firm/Organization	Location	Industry
1	Non-disclosed	Non-disclosed	Non-disclosed
2	Altru Health Systems	Grand Forks	General Medical & Surgical Hospitals
3	Meritcare Hospital	Fargo	General Medical & Surgical Hospitals
4	Trinity Health	Multiple	General Medical & Surgical Hospitals
5	Medcenter One	Multiple	General Medical & Surgical Hospitals
6	St. Alexius Medical Center	Bismarck	General Medical & Surgical Hospitals Health Care
7	Bobcat	Multiple	Construction Machinery Manufacturing
8	Nordian Mutual Insurance Company	Multiple	Direct Health & Medical Insurance Carriers
9	Meritcare Medical Group	Multiple	Offices of Physicians, Except Mental Health
10	Meritcare Health Systems	Fargo	Corporate Offices

Source: Job Service of North Dakota website. 2008. ND's largest employers based on First Quarter of 2008 numbers reported to the Quarterly Census of Employment and Wages program.

Findings (continued)

Hospitals Especially Critical in Rural Areas

In rural areas, hospitals are often either the largest or second largest employer, behind the school system. Rural hospitals provide a source of high-tech jobs for young people who might otherwise leave communities heavily dependent upon agriculture. Rural hospitals also provide an anchor for other health care jobs, such as physicians and pharmacists, which, in the absence of the hospital, may not be available.

Direct and Secondary Employment Impacts

By all accounts, whether one uses the 2008 Pulse Survey, 2007 AHA Statistics Guide, or Job Service North Dakota website, the hospital industry directly employs approximately 18,000 workers. The hospital industry also has a secondary employment impact on other related industries.

Secondary employment is a term used to describe jobs that are created and supported by the volume of business activity generated by an industry, but does not include jobs that are part of that industry. Direct employment and secondary employment are two distinctly different measures. Productivity ratios were used with estimates of business activity in various sectors of the North Dakota economy to obtain estimates of secondary employment.* As previously stated, the hospital industry in North Dakota was estimated to generate an additional $2.9 billion in secondary business activity, which was sufficient to support 24,952 FTE jobs. *(Dean A. Bangsund and F. Larry Leistritz, Economic Contribution of the Petroleum Industry to North Dakota, 2007).*

Another method to determine the secondary employment impact of North Dakota's hospitals is to use multiplier of 1.9. Using this formula, the estimated secondary employment impact of the hospital industry is 34,200 additional jobs. *(Note: this is a typical employment multiplier as identified and determined by the U.S. Bureau of Economic Analysis, and the Kansas Long-Term Model (or KLTM), a dynamic input-output model under development at the Institute for Public Policy and Business Research).*

* A measure of the amount of business activity needed in an economic sector to support one full-time equivalent (FTE) job.

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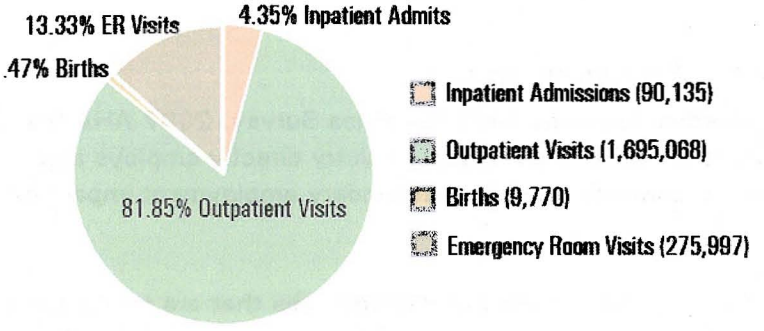
Patient Care Impacts

As part of the 2008 Pulse Survey, hospital administrators were asked to provide utilization statistics pertaining to key service offerings. They estimated the number of total inpatient admissions, outpatient visits, emergency room visits and births for 2007.

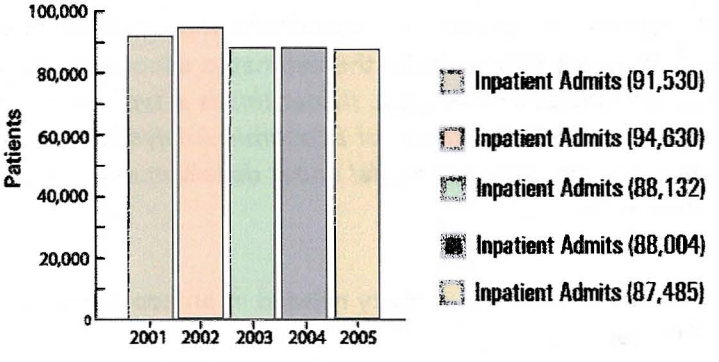
Figure 12 : Key Service Offerings



Inpatient Admissions

According to the 2008 Pulse Survey, a total of 90,135 inpatients were admitted to community hospitals in North Dakota. This level of activity is consistent with inpatient utilization that is tracked and reported annually by the American Hospital Association.

Figure 13 : Hospitals Care For Approximately 90,000 Inpatients Annually



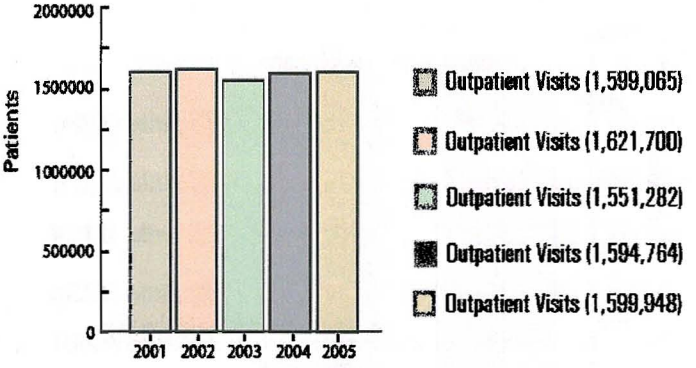
Source: AHA Hospital Statistics, 2007.

Findings (continued)

Outpatient Visits

According to the 2008 Pulse Survey, a total of 1,695,068 million outpatient visits were received at community hospitals in North Dakota. This level of activity is consistent with outpatient utilization that is tracked and reported annually by the American Hospital Association.

Figure 14 : Hospitals Care For Over 1.5 Million Outpatients Annually

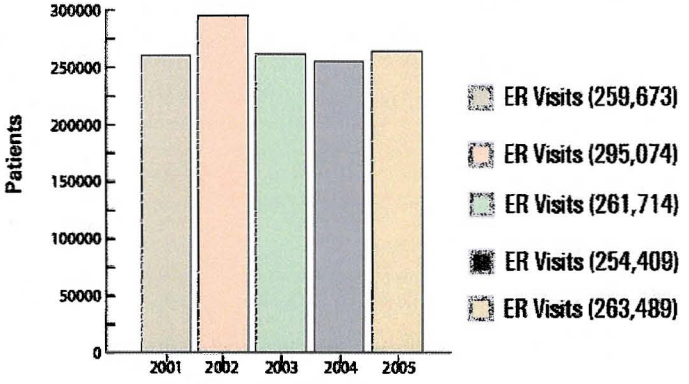


Source: AHA Hospital Statistics, 2007.

Emergency Room Visits

According to the 2008 Pulse Survey, a total of 275,997 emergency room visits were received at community hospitals in North Dakota. This level of activity is consistent with emergency room utilization that is tracked and reported annually by the American Hospital Association.

Figure 15 : Hospitals Care For Nearly 276,000 ER Patients Annually

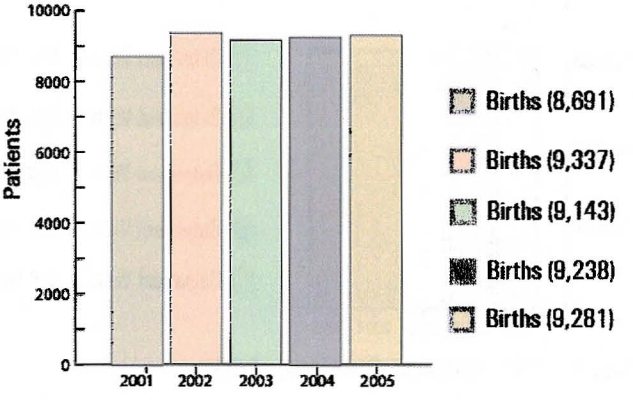


Source: AHA Hospital Statistics, 2007.

Births

According to the 2008 Pulse Survey, a total of 9,770 births were delivered at community hospitals in North Dakota. This level of activity is consistent with the total number of births that are tracked and reported annually by the American Hospital Association.

Figure 16 : Hospitals Host The Delivery Of Nearly 10,000 Births Annually

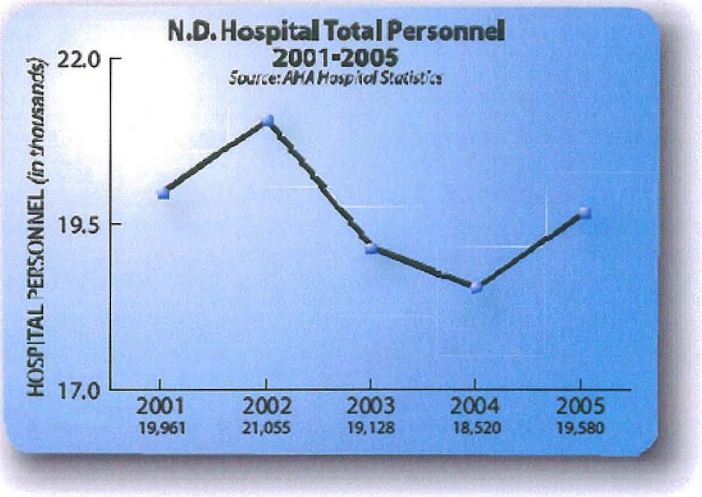


Source: AHA Hospital Statistics, 2007.

Based on the preceding figures, roughly one out of every seven residents was admitted to a community hospital, and one out of every three residents required a visit to a hospital emergency room. Moreover, every North Dakota resident had an average of approximately two and a half outpatient encounters with community hospitals in 2007.

5

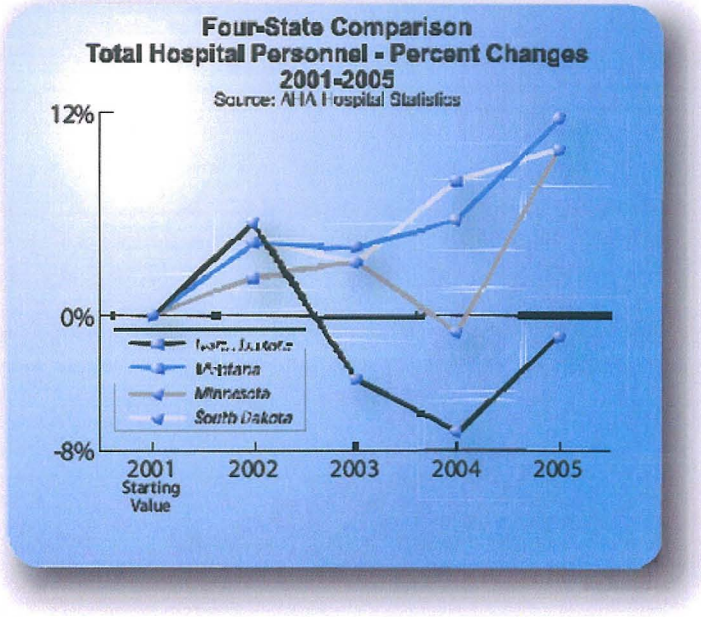
TOTAL PERSONNEL
2001-2005



Total Personnel (Total Facility)

During the five year period, the number of personnel employed by North Dakota hospitals decreased 1.9 percent, peaking in 2002 due to increases in inpatient service intensity and outpatient utilization.

From 2002 to 2004 the number of hospital personnel decreased substantially due to consolidations and mergers. Hospital personnel increased again between 2004-2005.



Total Personnel - Percent Changes

The graph at the left compares the percent changes in hospital personnel between North Dakota, Montana, Minnesota and South Dakota. The following are overall percent changes in personnel from 2001 to 2005:

- North Dakota = 1.2% decrease
- Montana = 11.6% increase
- Minnesota = 9.9% increase
- South Dakota = 9.9% increase

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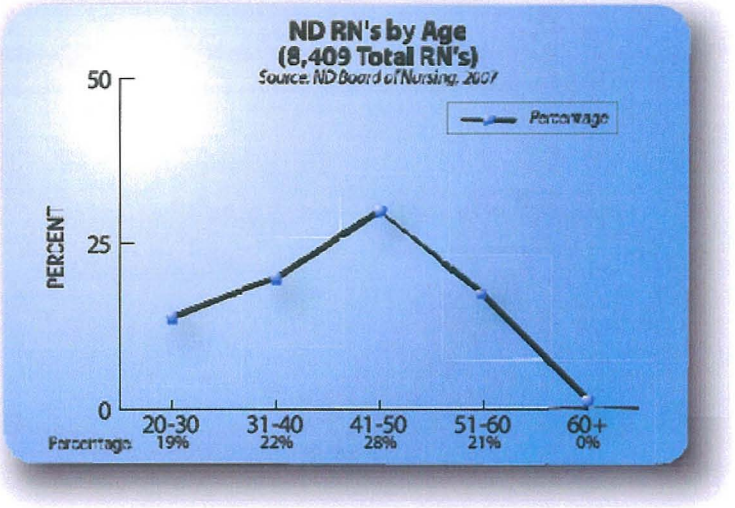
NORTH DAKOTA REGISTERED NURSES BY AGE
2007

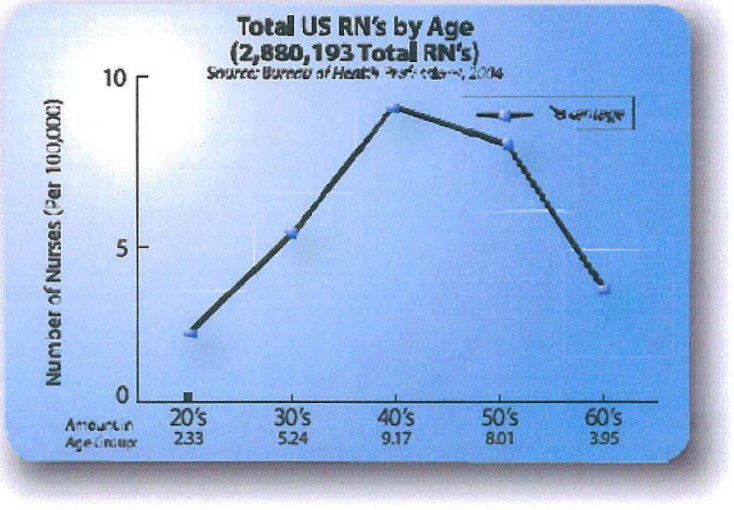


North Dakota Registered Nurses by Age

Source: ND Board of Nursing, 2007

Age	Number	Percent of Total RN's
20-30	1,561	19%
31-40	1,866	22%
41-50	2,371	28%
51-60	2,611	31%
60+	0	0%
TOTAL	8,409	

**Increase in number due to new legislation requiring only 2 year certification.*



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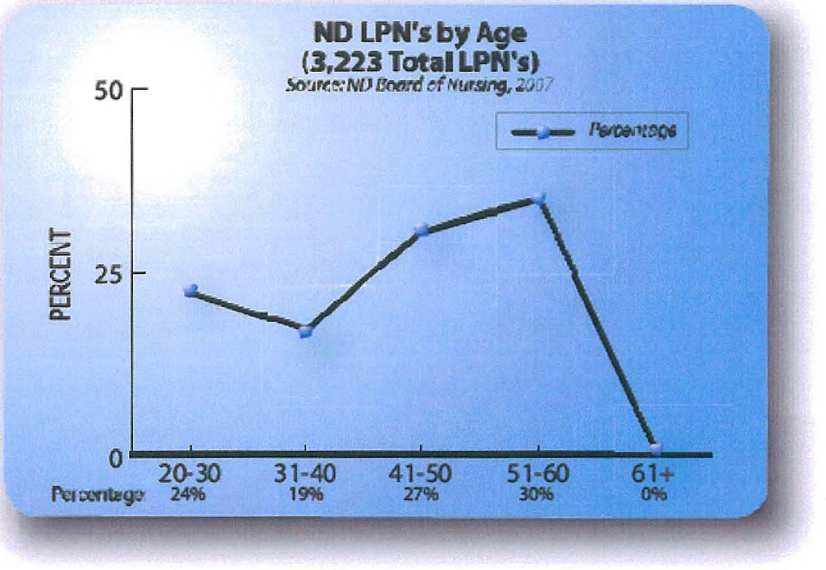
NORTH DAKOTA LICENSED PRACTICAL NURSES BY AGE
2007



North Dakota Licensed Practical Nurses by Age

Source: ND Board of Nursing, 2007

Age	Number	Percent of Total LPN's
20-30	761	24%
31-40	619	19%
41-50	872	27%
51-60	971	30%
61+	0	0%
TOTAL	3,223	

**Increase in numbers due to new legislation requiring only 1 year certification.*

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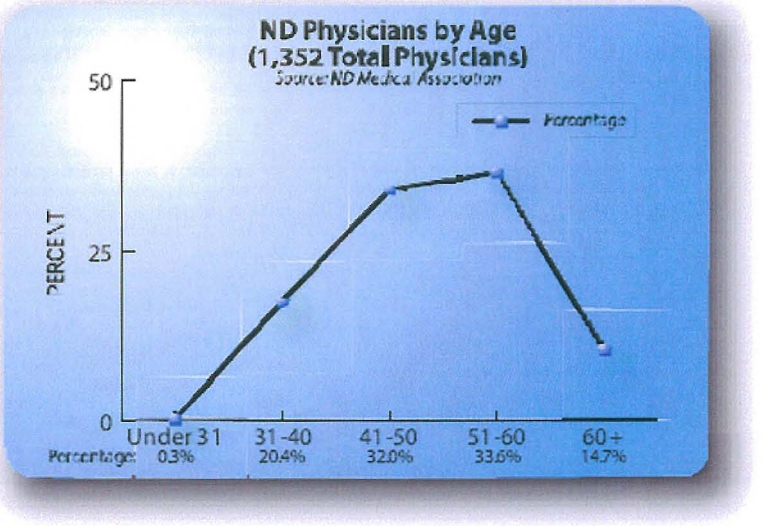
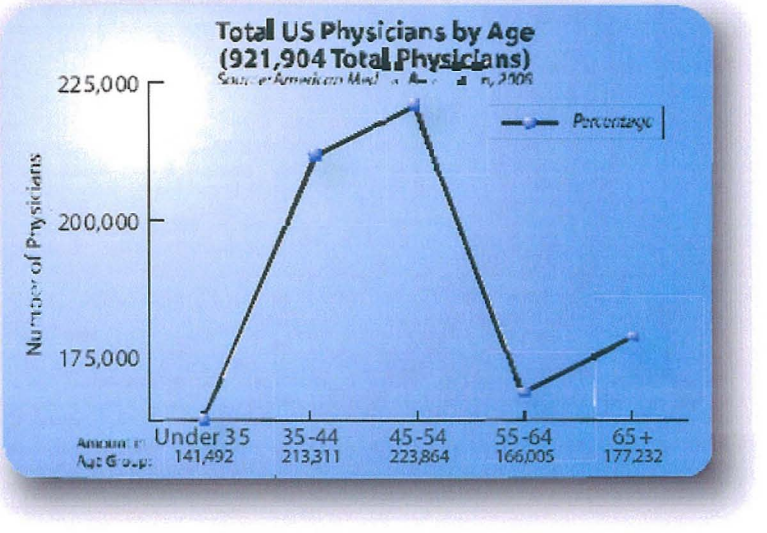
NORTH DAKOTA PHYSICIANS BY AGE
2007



North Dakota Physicians by Age
Source: ND Medical Association, 2007

Age	Number	% of Total
Under 31	4	0.3%
31-40	276	20.4%
41-50	434	32.1%
51-60	455	33.6%
Over 60	183	13.5%
TOTAL	1,352	



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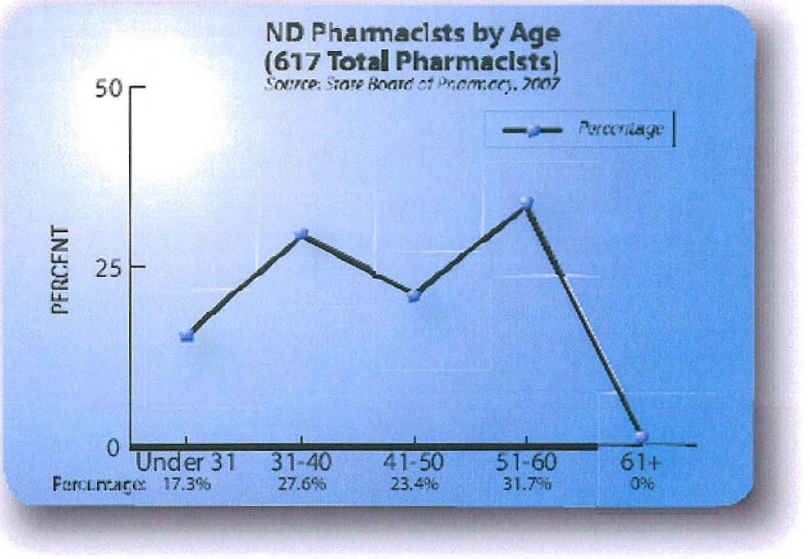
NORTH DAKOTA PHARMACISTS BY AGE
2007



North Dakota Pharmacists by Age

Source: State Board of Pharmacy, 2007

Age	Number	% of Total
Under 31	116	17.3%
31-40	185	27.6%
41-50	157	23.4%
51-60	213	31.7%
Over 60	0	0%
TOTAL	671	

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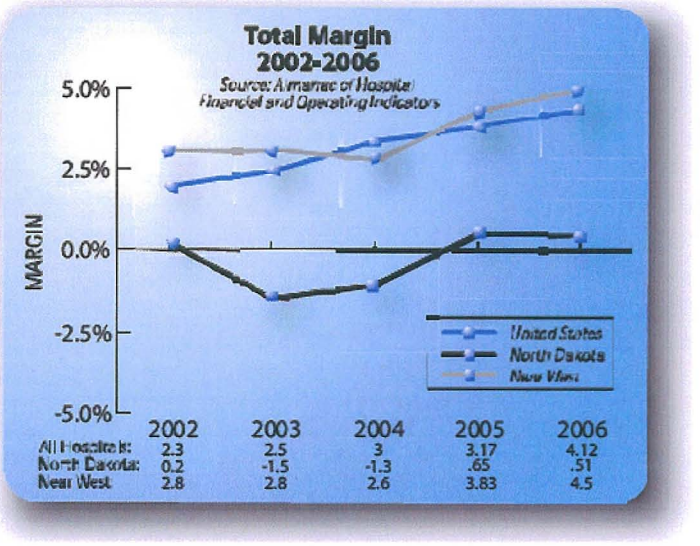
TOTAL MARGIN
2002-2006

Total Margin

North Dakota hospitals experience lower margins than all other hospitals in the nation. From 2002 through 2006, North Dakota hospitals averaged a margin of negative 0.29 percent, whereas U.S. hospitals overall averaged a positive margin of 3 percent during the same time period. Hospitals in Near West states* averaged a positive margin of 3.3 percent over the five-year period.



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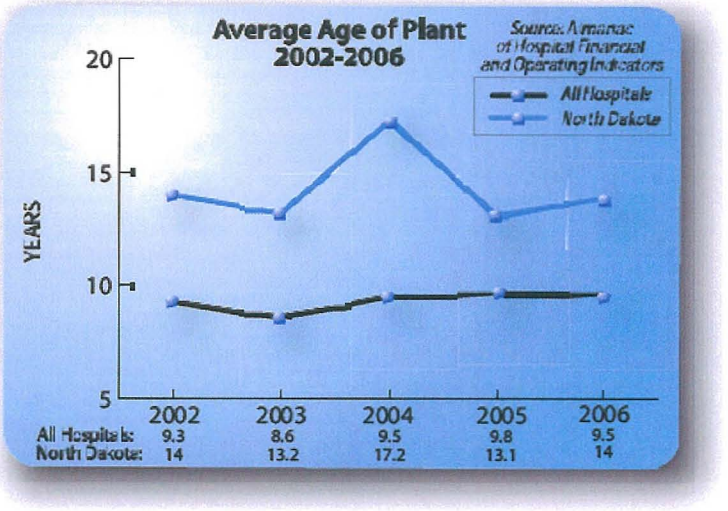
AVERAGE AGE OF PLANT
2002-2006

Average Age of Plant

The average age of plant for North Dakota hospitals runs almost five years higher than that of all other hospitals in the nation. From 2002 to 2006, U.S. hospitals had an average age of plant of 9.34 years, whereas North Dakota hospitals had an average age of plant of 14.3 years during the same time period.



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PAYROLL AND BENEFITS EXPENSE

Payroll and Benefits Expense as a Percent of Total Expense

In North Dakota, payroll and benefits account for 53.6% of total hospital expenses. This is higher than in West North Central states and the total U.S, where payroll and benefits are 43% and 50% of total expenses, respectively.

Payroll and Benefits Expense as Percent of Total Expense

SOURCE: Health Forum, 2007 AHA Annual Survey of Hospitals

North Dakota	53.6%
West North Central	43.0%
US Total	50.0%

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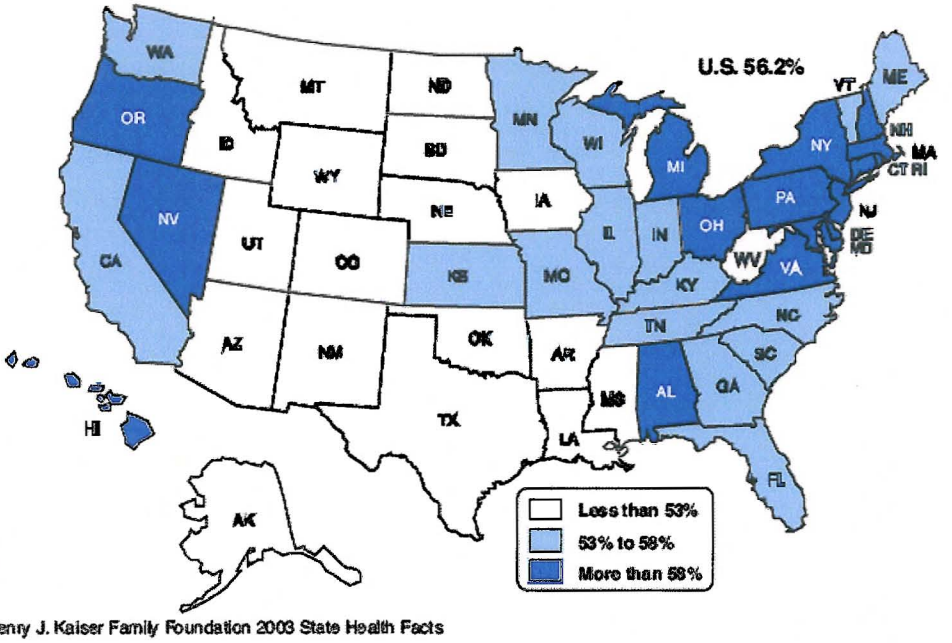
EMPLOYER SPONSORED HEALTH INSURANCE: 2003

The percent of employers that offer health insurance to employees by state is shown below. 44.7 percent of North Dakota employers (private sector) offer health insurance, which is 11.6 percent below the U.S. average of 56.2 percent. North Dakota is tied at 47th nationally.



Source: The Henry J. Kaiser Family Foundation 2003 State Health Facts

Rank	State	Percent of Firms Offering Coverage	Rank	State	Percent of Firms Offering Coverage
	U.S. Average	56.2%	26	Vermont	54.9%
1	Hawaii	86.2%	27	Georgia	54.6%
2	District of Columbia	79.3%	27	South Carolina	54.6%
3	New Hampshire	68.8%	29	Kansas	54.5%
4	Massachusetts	65.6%	30	Maine	53.5%
5	Pennsylvania	65.4%	31	Indiana	53.4%
6	Connecticut	65.3%	32	Missouri	53.3%
7	Rhode Island	63.6%	33	Tennessee	53.0%
8	Delaware	61.1%	34	West Virginia	52.8%
8	Michigan	61.1%	35	Colorado	52.6%
10	New Jersey	60.8%	36	Arizona	52.4%
11	Maryland	59.9%	37	Idaho	51.0%
12	New York	59.7%	38	Iowa	50.8%
13	Ohio	59.6%	39	New Mexico	50.5%
14	Virginia	59.4%	40	Louisiana	50.0%
15	Nevada	58.7%	41	Texas	48.7%
16	Alabama	58.3%	42	Utah	48.6%
16	Oregon	58.3%	43	Alaska	47.0%
18	Kentucky	57.5%	44	Oklahoma	46.4%
19	Washington	57.1%	45	Mississippi	45.9%
20	North Carolina	56.5%	46	Montana	45.1%
21	California	55.9%	47	Nebraska	44.7%
21	Minnesota	55.9%	**47**	**North Dakota**	**44.7%**
23	Wisconsin	55.7%	49	South Dakota	44.2%
24	Florida	55.3%	50	Wyoming	42.5%
25	Illinois	55.0%	51	Arkansas	42.2%

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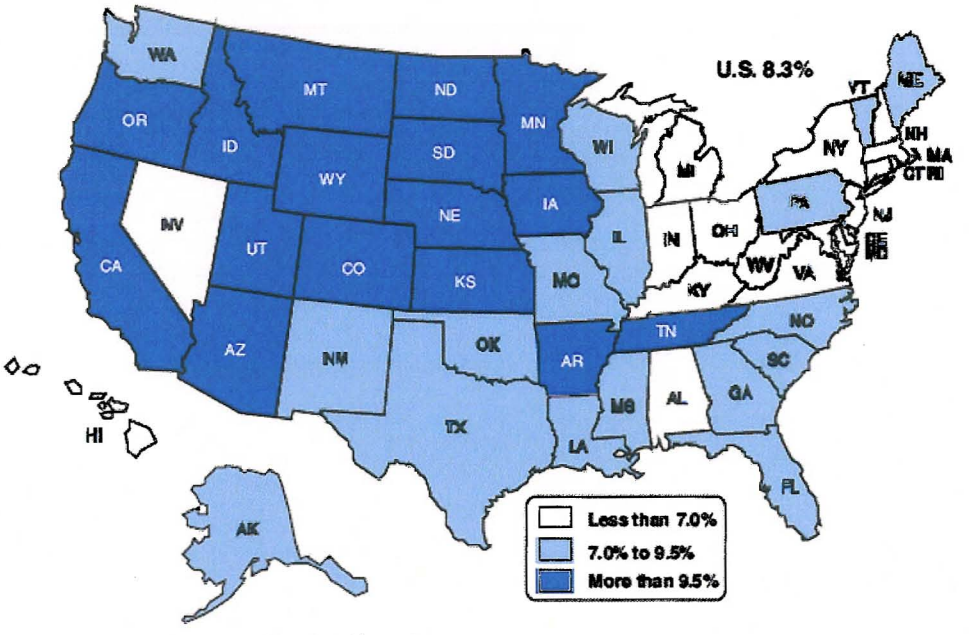
EMPLOYEE CONTRIBUTION TO HEALTH INSURANCE BY STATE: 2005

The percent of employee and employer contribution to employment-based health insurance by state is shown below. Employees contribute 14.5 percent in North Dakota, which is 6.2 percent above the U.S. average of 8.3 percent. North Dakota tied for 3rd nationally in 2005 ranked from high to low in employee contribution.



Source: The Henry J. Kaiser Family Foundation 2005 State Health Facts

Rank	State	Employee Contribution	Employer Contribution	Rank	State	Employee Contribution	Employer Contribution
	U.S. Average	8.3%	91.7%	26	Mississippi	8.1%	91.9%
1	South Dakota	15.5%	84.5%	27	Texas	7.9%	92.1%
2	Montana	14.6%	85.4%	28	Vermont	7.7%	92.3%
3	**North Dakota**	**14.5%**	**85.5%**	29	Oklahoma	7.6%	92.4%
4	California	12.4%	87.6%	30	Maine	7.5%	92.5%
5	Idaho	12.2%	87.8%	31	Georgia	7.4%	92.6%
6	Wyoming	11.8%	88.2%	32	South Carolina	7.3%	92.7%
7	Utah	11.3%	88.7%	32	Alaska	7.3%	92.7%
8	Nebraska	11.1%	88.9%	34	Illinois	7.0%	93.0%
9	Colorado	10.8%	89.2%	35	New York	6.8%	93.2%
10	Iowa	10.7%	89.3%	36	Nevada	6.6%	93.4%
10	Arkansas	10.7%	89.3%	37	Virginia	6.5%	93.5%
12	Oregon	10.4%	89.6%	37	Rhode Island	6.5%	93.5%
13	Minnesota	10.3%	89.7%	37	Indiana	6.5%	93.5%
14	District of Columbia	9.9%	90.1%	37	Maryland	6.5%	93.5%
15	Arizona	9.8%	90.2%	41	Michigan	6.3%	93.7%
16	Tennessee	9.7%	90.3%	41	Kentucky	6.3%	93.7%
17	Kansas	9.6%	90.4%	43	Massachusetts	6.2%	93.8%
18	Florida	9.5%	90.5%	44	Connecticut	6.1%	93.9%
19	Louisiana	9.2%	90.8%	45	New Hampshire	5.8%	94.2%
20	New Mexico	9.1%	90.9%	45	Ohio	5.8%	94.2%
21	Washington	8.9%	91.1%	47	Alabama	5.6%	94.4%
22	Wisconsin	8.6%	91.4%	48	Delaware	5.0%	95.0%
22	Missouri	8.6%	91.4%	49	Hawaii	4.7%	95.3%
24	North Carolina	8.5%	91.5%	50	New Jersey	4.2%	95.8%
25	Pennsylvania	8.3%	91.7%	50	West Virginia	4.2%	95.8%

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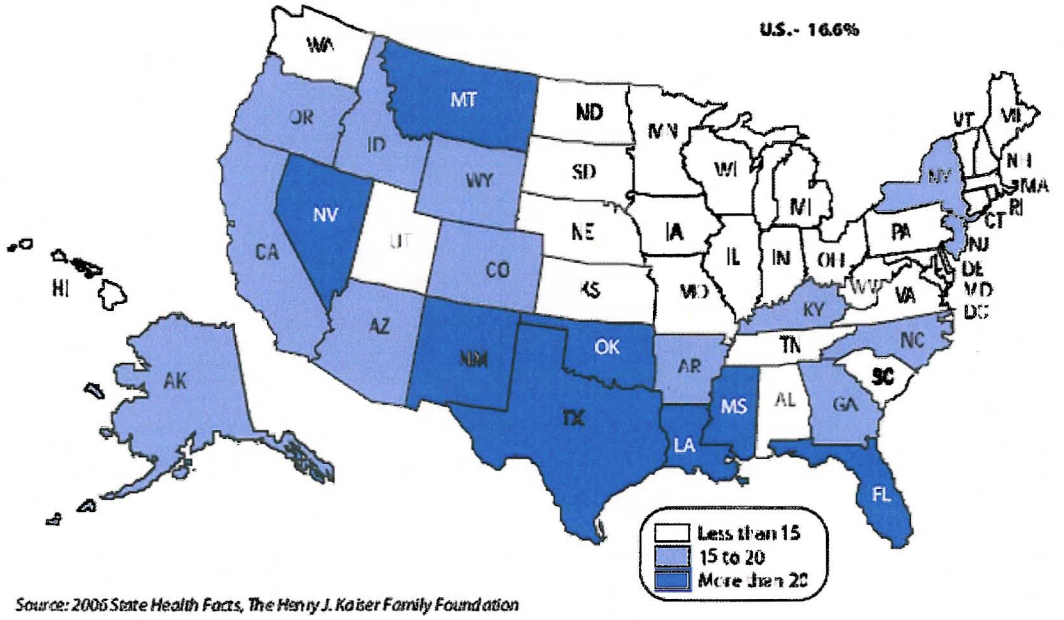
HEALTH INSURANCE COVERAGE: 2006

According to data from the U.S. Census Bureau, 12.2 percent of North Dakota's population was not covered by health insurance in 2006, the 12th lowest nationally. This compares to 16.6 percent of the total U.S. population not covered by health insurance in 2006.



Source: 2006 State Health Facts, The Henry J. Kaiser Family Foundation

Rank	State	Percent Uninsured
	United States	16.6%
1	Texas	26
2	New Mexico	24.8
3	Louisiana	23.6
4	Mississippi	21.9
5	Nevada	21.9
6	Oklahoma	21.2
7	Montana	20.3
8	Florida	20.1
9	Oregon	19.5
10	California	18.9
11	Arkansas	18.4
12	Arizona	18.1
13	Idaho	18
14	Colorado	17.7
15	Alaska	17.5
16	Kentucky	17.5
17	New Jersey	16.3
18	Georgia	16.2
19	New York	16.2
20	North Carolina	15.6
21	Wyoming	15.3
22	Alabama	14.7
23	Virginia	14.7
24	Maryland	14.6
25	Tennessee	14.3

Rank	State	Percent Uninsured
26	Utah	14.3
27	Illinios	14.2
28	Missouri	13.9
29	South Carolina	13.5
30	Kansas	13.3
31	Nebraska	13.2
32	Delaware	13.1
33	New Hampshire	13
34	Iowa	12.7
35	West Virginia	12.6
36	Massachusetts	12.4
37	Washington	12.4
38	South Dakota	12.3
39	District of Colomubia	12.2
40	**North Dakota**	**12.2**
41	Indiana	12.1
42	Pennsylvania	12.1
43	Michigan	11.3
44	Ohio	10.6
45	Minnesota	10.4
46	Wisconsin	10.2
47	Hawaii	10.1
48	Connecticut	9.2
49	Maine	9
50	Vermont	8.6
51	Rhode Island	7.851

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HEALTHIEST STATES RANKINGS, 2003-2006

SOURCE: United Health Foundation State Health Ratings, 2006.

State	2006 Rank	2005 Rank	2004 Rank	2003 Rank	State	2006 Rank	2005 Rank	2004 Rank	2003 Rank
Minnesota	1	1	1	1	Ohio	25	26	26	26
Vermont	2	2	3	4	New York	29	27	31	31
New Hampshire	3	3	2	1	Illinois	25	28	29	30
Utah	6	4	5	3	Michigan	27	29	29	28
Hawaii	4	5	4	10	Alaska	31	30	24	38
North Dakota	**8**	**6**	**7**	**12**	Arizona	34	31	23	32
Connecticut	5	7	8	6	Indiana	33	32	32	27
Maine	9	8	10	8	Delaware	30	33	32	34
Massachusetts	7	9	6	5	Maryland	32	34	34	29
Iowa	11	10	11	7	Missouri	35	35	36	33
Nebraska	12	11	12	16	North Carolina	36	36	41	36
Rhode Island	13	12	14	13	Nevada	38	37	37	36
Wisconsin	10	13	9	14	New Mexico	40	38	38	40
Washington	15	14	15	11	Texas	37	39	35	35
New Jersey	14	15	17	18	Florida	41	40	42	42
Idaho	19	16	18	17	West Virginia	43	41	43	44
Colorado	16	17	13	9	Kentucky	39	42	39	39
Oregon	19	18	21	19	Georgia	42	43	45	41
*South Dakota	18	19	19	15	Oklahoma	44	44	40	45
*Wyoming	23	19	28	23	Alabama	45	45	43	43
Montana	22	21	26	25	South Carolina	48	46	47	48
California	23	22	22	22	Arkansas	46	47	46	47
Kansas	17	23	16	20	Tennessee	47	48	48	46
Virginia	21	24	20	21	Louisiana	50	49	50	49
Pennsylvania	28	25	25	24	Mississippi	49	50	49	50

Seventeen factors were chosen that reflect basic health care and access to health care. The 17 factors were divided into two groups: those that are "negative", where a high ranking would be considered bad for a state, and those that are "positive", for which a high ranking would be considered good for a state.

In the years prior to 2005, rankings were determined based on a simple average of the state's rankings for these factors. Rates for each of the 17 factors were processed through a formula that measures how a state compares to the national average for a given category.

The positive factors then were weighted (factors were weighted equally). These weighted scores were then added together to get a state's final score. This way, states are assessed based on how they compare with the national average. The end result is that the farther below the national average a state's health ranking is, the lower (and less healthy) it ranks. The farther above the national average, the higher (and healthier) a state ranks.

Caution is advised in comparing the four year's rankings because of the change in methodology.

*ranked equally

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2006 U.S. HOSPITAL INPATIENT CHARGES PER DAY AND OUTPATIENT CHARGES PER VISIT

Hospital Unit Charges

- Charges per day is defined as billing for services rendered at full established rates.

- In 2006, North Dakota's 2006 hospital charges per inpatient day of $1,649 are 44.8 percent lower than the Midwest average and 62.3 percent lower than the U.S. average. North Dakota hospitals are the second lowest nationally.

- In 2006, outpatient charges per outpatient visit of $758 in North Dakota hospitals are 0.4 percent higher than the Midwest average and 13.2 percent lower than the U.S. average. North Dakota ranks 31st nationally.

Rank	State	Inpatient Charges Per Day
	U.S. Average	**$4,408**
	Midwest Average	**$2,985**
1	New Jersey	$7,418
2	California	$7,174
3	Arizona	$5,942
4	Nevada	$5,691
5	Pennsylvania	$5,614
6	Colorado	$5,530
7	Florida	$5,182
8	Texas	$5,007
9	Washington	$4,994
10	Alaska	$4,914
11	DC	$4,674
12	New Mexico	$4,634
13	Illinois	$4,394
14	Ohio	$4,209
15	Utah	$4,188
16	Oregon	$4,144
17	Alabama	$4,141
18	South Carolina	$4,094
19	Missouri	$4,092
20	Rhode Island	$4,067
21	Virginia	$3,806
22	Michigan	$3,804
23	Connecticut	$3,794
24	New Hampshire	$3,751
25	Indiana	$3,744
26	Tennessee	$3,734
27	Louisiana	$3,668
28	Massachusetts	$3,662
29	Oklahoma	$3,655
30	New York	$3,615
31	Arkansas	$3,477
32	Minnesota	$3,449
33	Wisconsin	$3,392
34	Kentucky	$3,290
35	Georgia	$3,245
36	Hawaii	$3,157
37	Kansas	$3,135
38	Delaware	$3,119
39	North Carolina	$3,051
40	Maine	$2,995
41	Mississippi	$2,858
42	Idaho	$2,856
43	Nebraska	$2,608
44	Iowa	$2,450
45	West Virginia	$2,423
46	Maryland	$2,299
47	Vermont	$2,139
48	Wyoming	$1,744
49	South Dakota	$1,695
50	**North Dakota**	**$1,649**
51	Montana	$1,531

Rank	State	Outpatient Charges Per Visit
	U.S. Average	**$873**
	Midwest Average	**$755**
1	Florida	$1,429
2	DC	$1,325
3	South Carolina	$1,223
4	Arizona	$1,205
5	Mississipoi	$1,160
6	Alabama	$1,115
7	Nevada	$1,110
8	Texas	$1,109
9	California	$1,083
10	Colorado	$997
11	Georgia	$987
12	Rhode Island	$980
13	Tennessee	$974
14	Minnesota	$969
15	New Jersey	$938
16	Washington	$936
17	Kentucky	$927
18	Hawaii	$922
19	Pennsylvania	$910
20	Oklahoma	$909
21	Virginia	$862
22	Massachusetts	$862
23	Arkansas	$853
24	North Carolina	$822
25	Illinois	$822
26	Ohio	$819
27	Connecticut	$816
28	New Hampshire	$789
29	Nebraska	$780
30	Kansas	$770
31	**North Dakota**	**$758**
32	Michigan	$753
33	Wisconsin	$751
34	Missouri	$736
35	South Dakota	$721
36	Louisiana	$720
37	Indiana	$697
38	Alaska	$694
39	New York	$641
40	Delaware	$620
41	Oregon	$589
42	New Mexico	$584
43	Maine	$579
44	Utah	$569
45	West Virginia	$565
46	Maryland	$564
47	Idaho	$563
48	Vermont	$560
49	Wyoming	$556
50	Iowa	$509
51	Montana	$460

Source: Annual Survey of Hospitals (2006) American Hospital Association (AHA) - Trend Analysis Group

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6

NORTH DAKOTA HOPITALS
PPS AND CRITICAL ACCESS ONLY

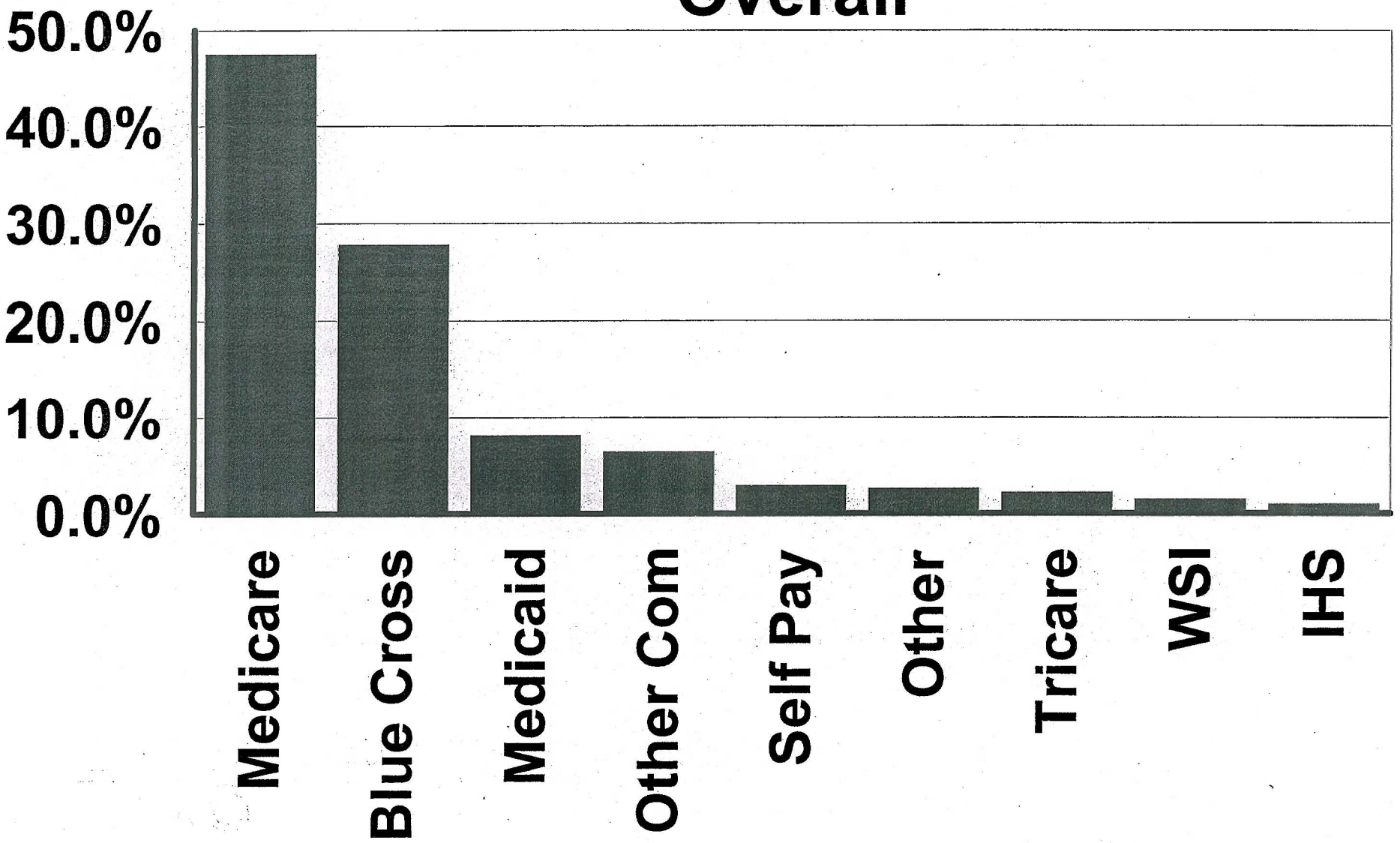
NAME	CATEGORY	CITY
PPS Hospitals		
St. Alexius Medical Center	PPS	Bismarck
Medcenter One	PPS	Bismarck
Meritcare Medical Center	PPS	Fargo
Innovis Health	PPS	Fargo
Altru Health System	PPS	Grand Forks
Trinity Health	PPS	Minot
NAME	CATEGORY	CITY
Critical Access Hospitals		
Total Revenue > $15 million		
Jamestown Hospital	Large	Jamestown
Mercy Hospital	Large	Devils Lake
Mercy Medical Center	Large	Williston
St. Joseph's Hospital	Large	Dickinson
Total Revenue $8 - $15 million		
Carrington Health Center	Medium	Carrington
Cavalier County Memorial Hospital	Medium	Langdon
First Care Health Center	Medium	Park River
Heart of America Medical Center	Medium	Rugby
Lisbon Medical Center	Medium	Lisbon
Mercy Hospital of Valley City	Medium	Valley City
Northwood Deaconess Health Center	Medium	Northwood
Oakes Community Hospital - CAH	Medium	Oakes
Pembina Count Memorial Hospital	Medium	Cavalier
Presentation Medical Center	Medium	Rolla
Sakakawea Medical Center	Medium	Hazen
St. Aloisius Medical Center	Medium	Harvey
Towner County Medical Center	Medium	Cando
West River Regional Medical Center	Medium	Hettinger
Wishek Community Hospital and Clinics	Medium	Wishek
Total Revenue < $8 million		
Ashley Medical Center - CAH	Small	Ashley
Community Memorial Hospital	Small	Turtle Lake
Cooperstown Medical Center	Small	Cooperstown
Garrison Memorial Hospital	Small	Garrison
Hillsboro Medical Center	Small	Hillsboro
Jacobson memorial Hospital	Small	Elgin
Kenmare Community Hospital	Small	Kenmare
Linton Hospital	Small	Linton
McKenzie County Memorial Hospital	Small	Watford City
Mountrail County Medical Center	Small	Stanley
Nelson County Health System	Small	McVille
Southwest HC Services	Small	Bowman
St. Andrews Health Center	Small	Bottineau
St. Luke's Hospital	Small	Crosby
Tioga Medical Center	Small	Tioga
Union Hospital	Small	Mayville
Unity Medical Center	Small	Grafton

7

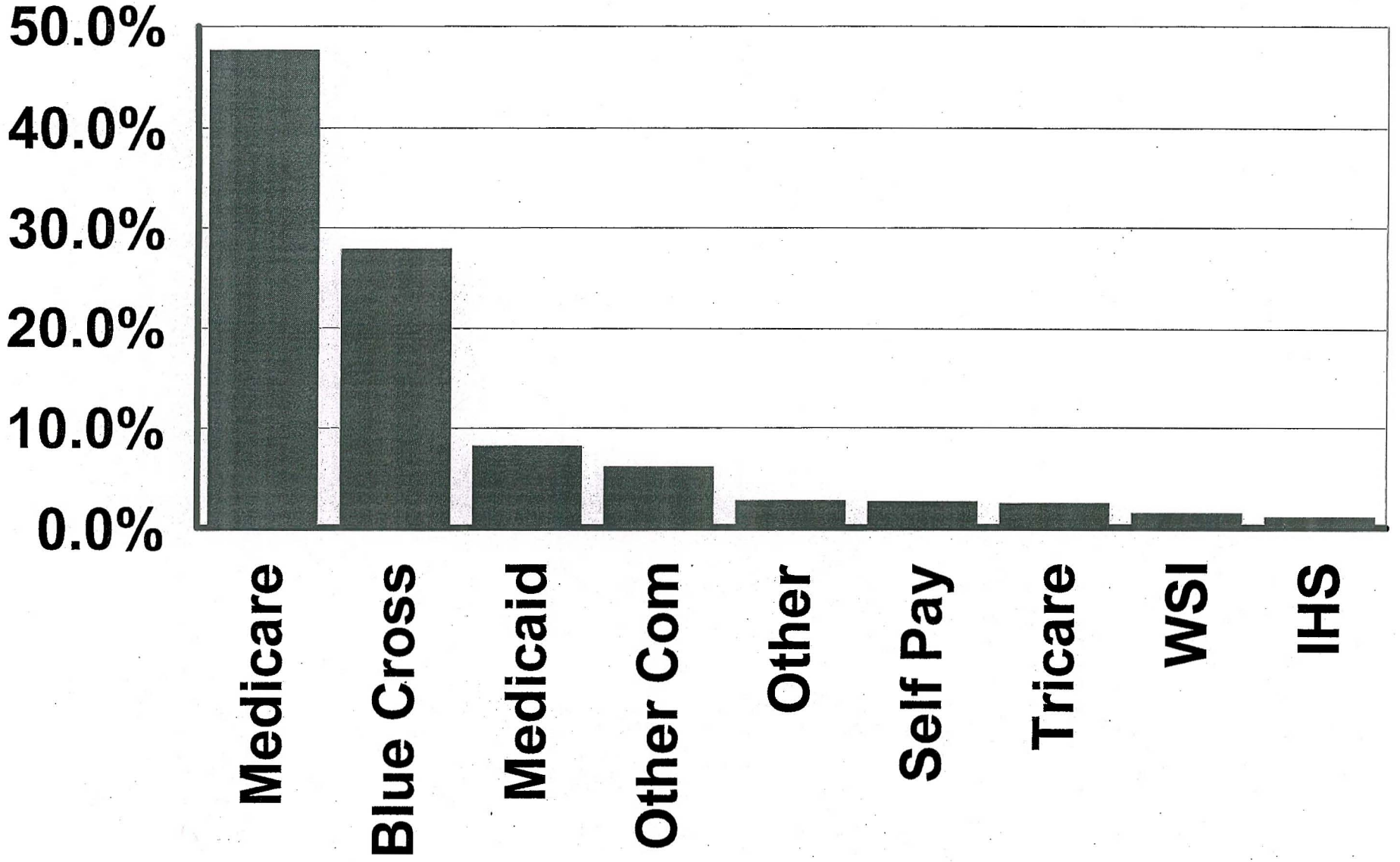
North Dakota Hospitals

Payer Mix

Overall



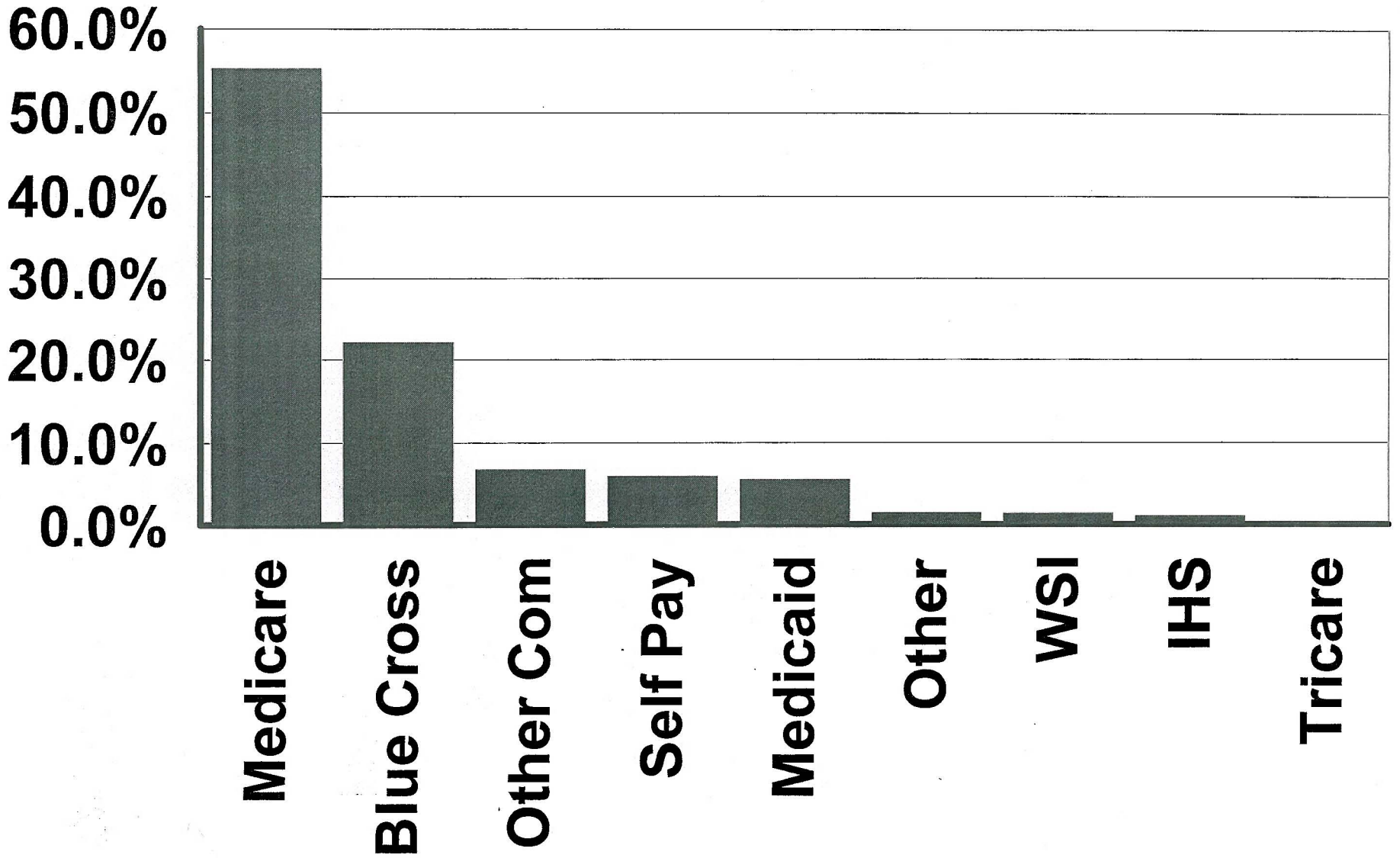
North Dakota PPS Hospital
Payer Mix



North Dakota CAH Hospital - Small

Payer Mix

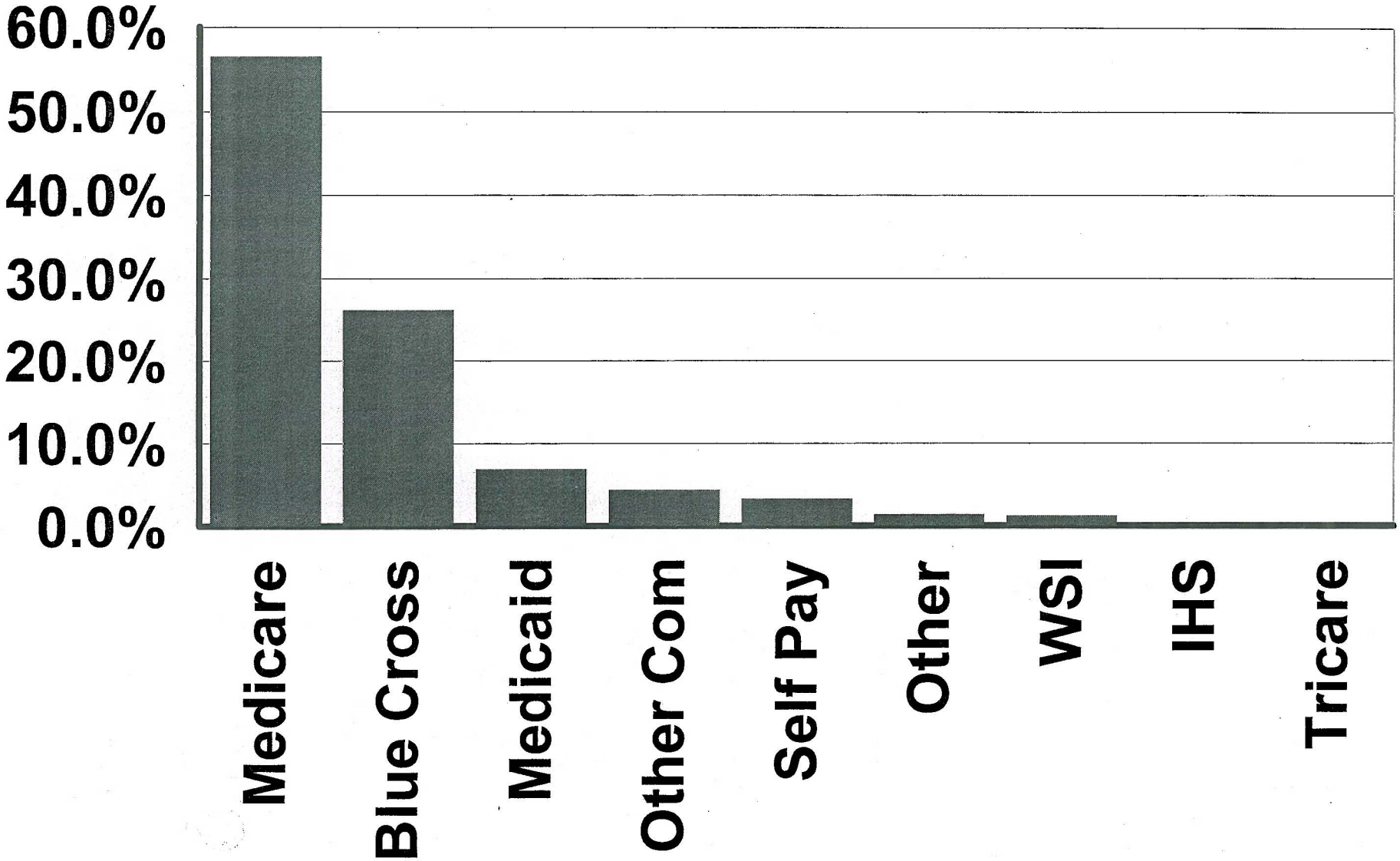
Revenue < $8 million



North Dakota CAH Hospital - Medium

Payer Mix

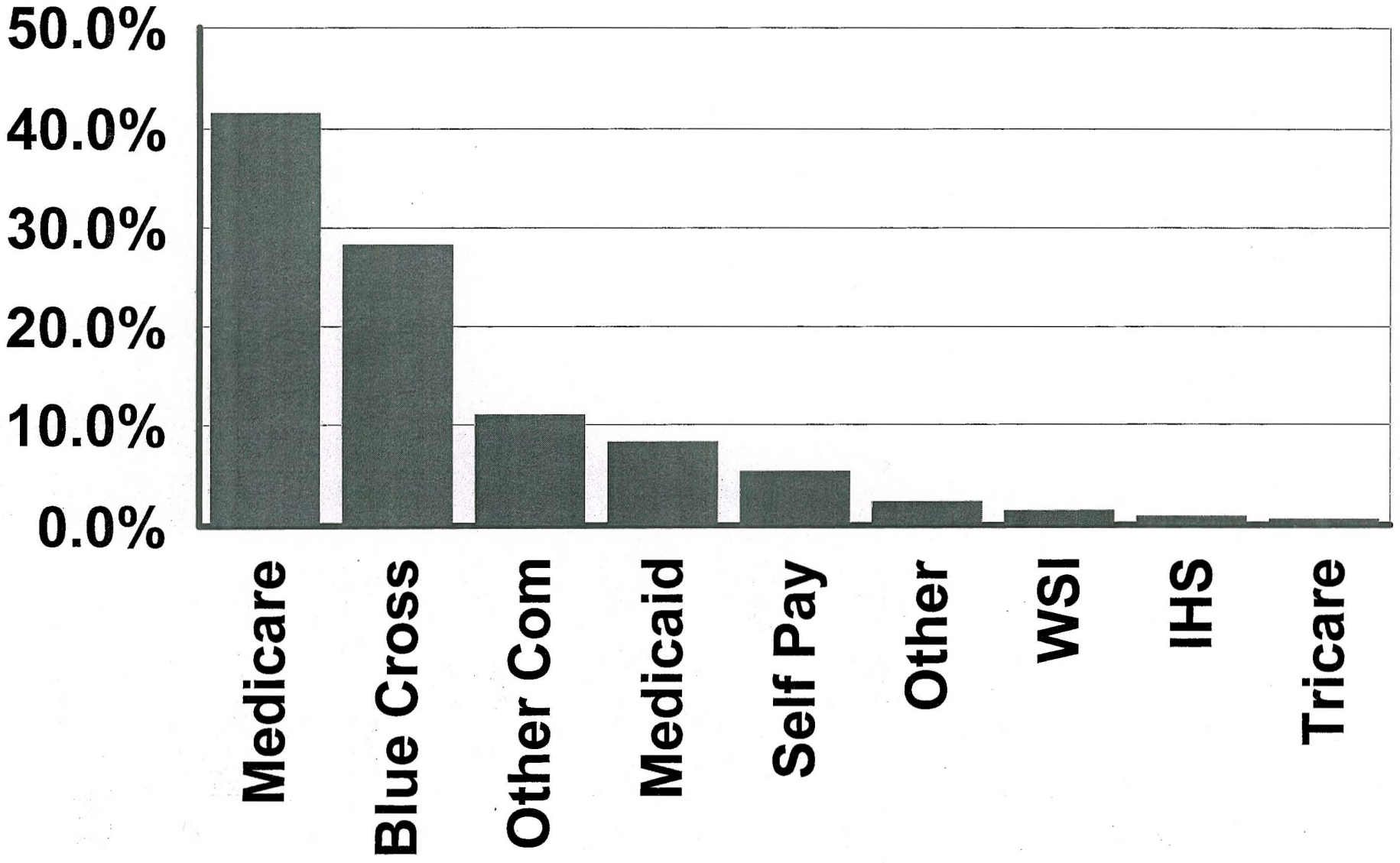
Revenue $8 - $15 million



North Dakota CAH Hospital - Large

Payer Mix

Revenue > $15 million

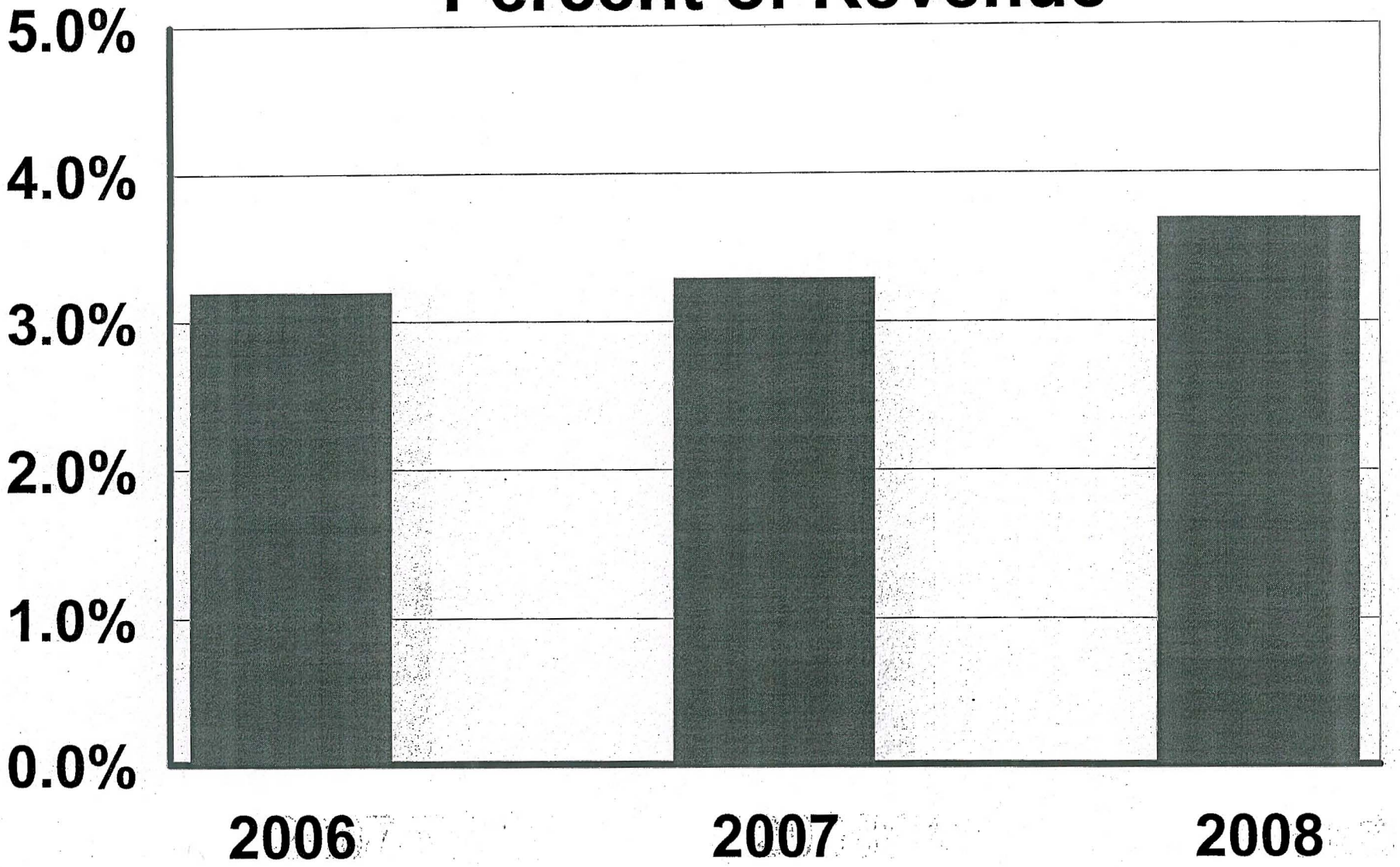


8

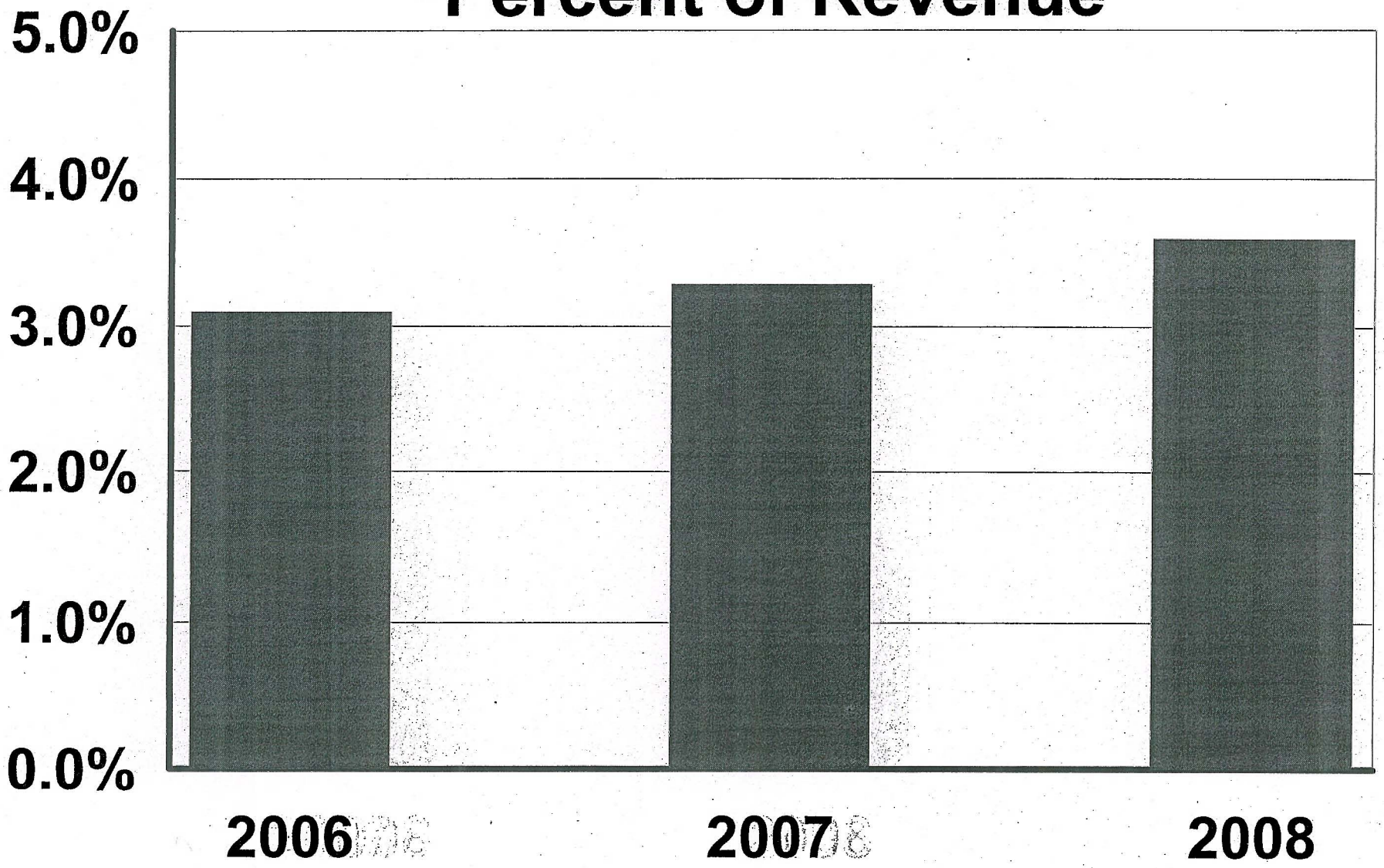
North Dakota Hospital - Overall

Bad Debt/Charity

Percent of Revenue



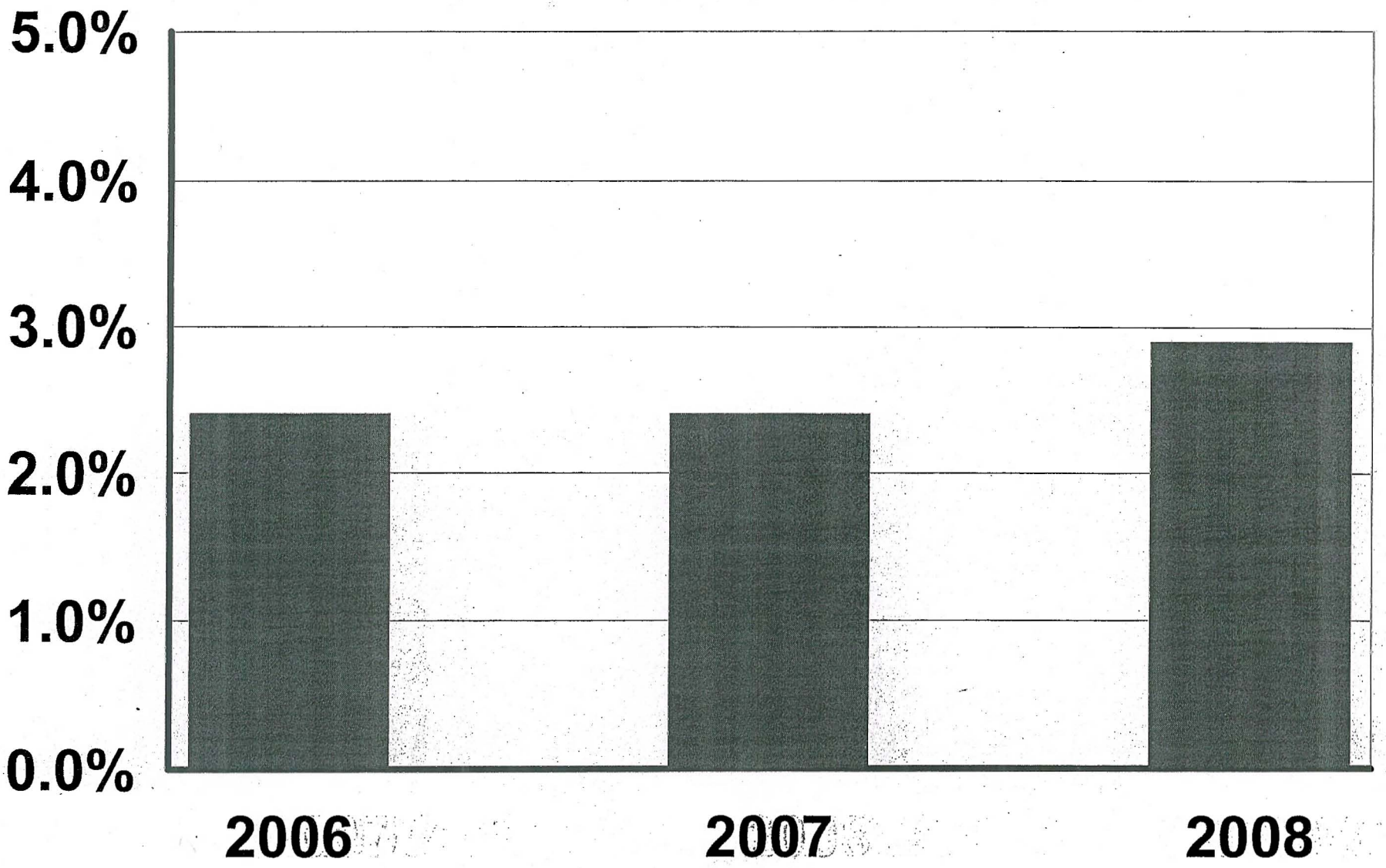
North Dakota PPS Hospital
Bad Debt/Charity
Percent of Revenue



North Dakota CAH Hospital - Small

Bad Debt/Charity

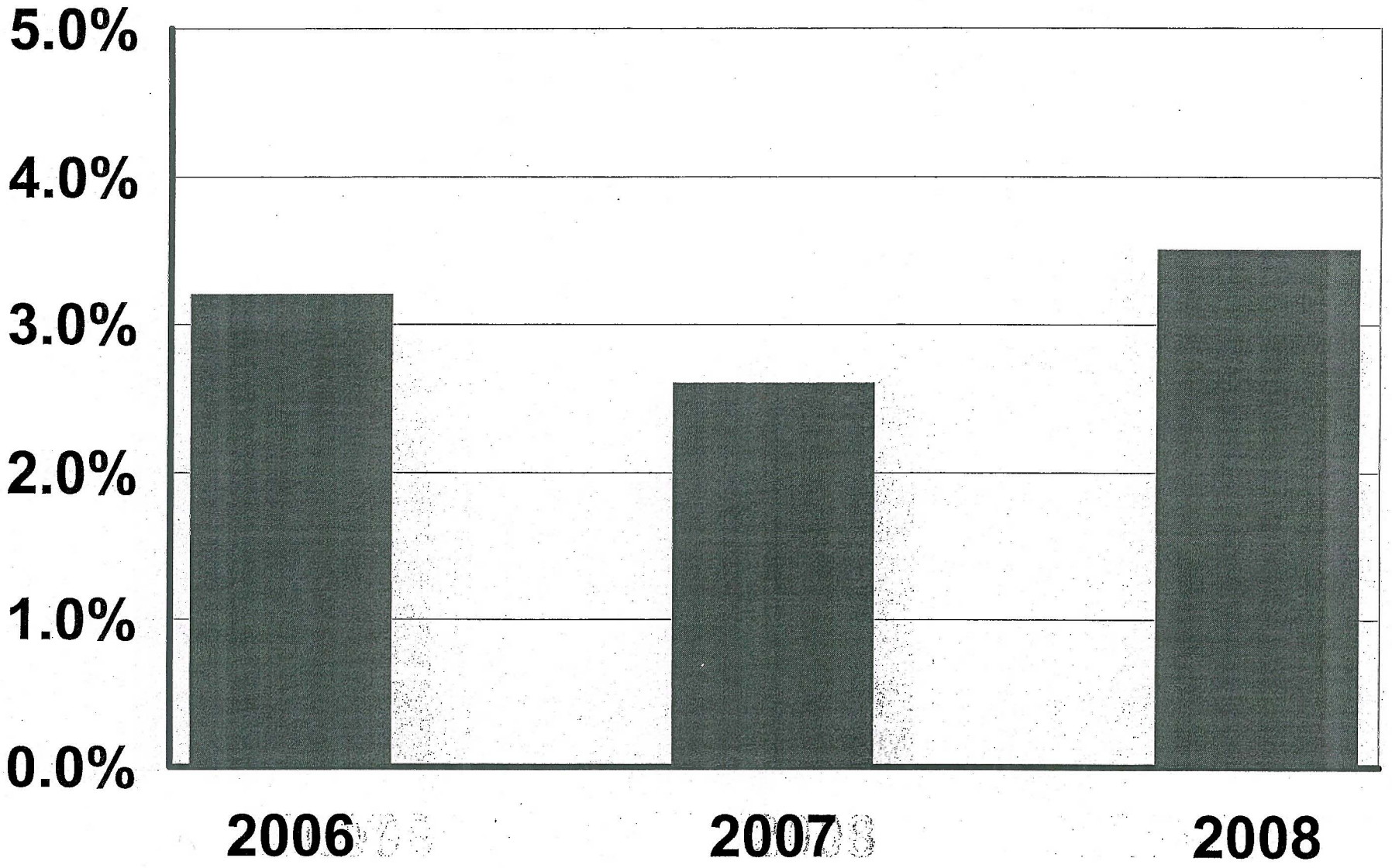
Percent of Revenue



North Dakota CAH Hospital - Medium

Bad Debt/Charity

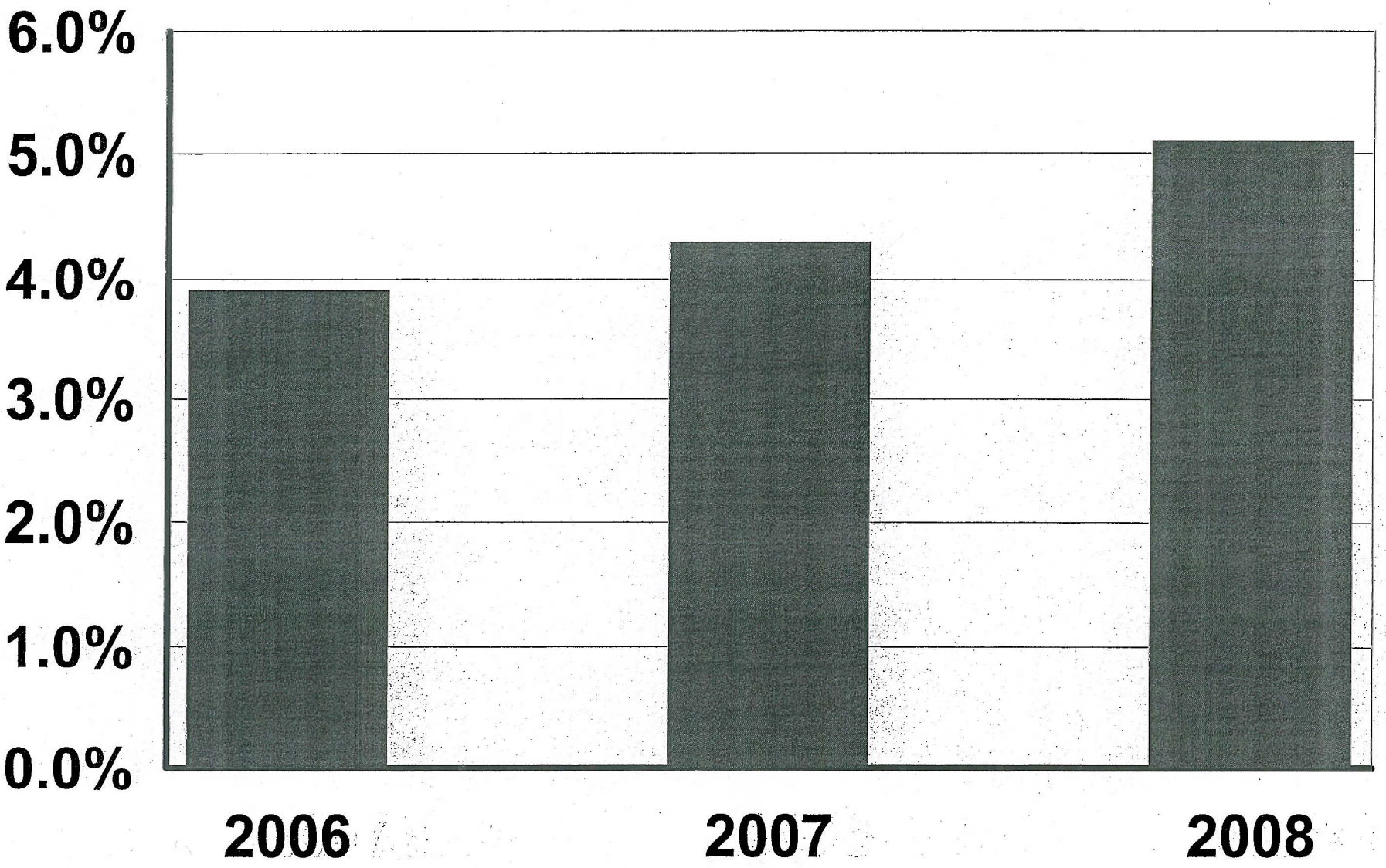
Percent of Revenue



North Dakota CAH Hospital - Large

Bad Debt/Charity

Percent of Revenue



9

NDHA

North Dakota Healthcare Association

Hospital Pricing Principles Were Applied at Ole's Café[1]

Ole's Cafe is going to include a new item - Lutefisk. Ole knows it will cost him $10 to produce the meal and, at the suggestion of his bank, he should have a five percent rate of return. You would think the price should be $10.50.

However, not everybody who comes into the diner for the Lutefisk is going to pay the $10.50. In fact, 5 out of every 10 people will present Ole with a government payment card (Medicaid/Medicare) that says Ole, in serving them the Lutefisk, can only charge them $8.00.

In addition, Ole already knows from experience that 1 out of every 10 people will eat the Lutefisk and not pay for it. (Bad debt)

Four out of 10 will have private meal cards (Blue Cross) or pay cash and those 4 will have to pay much more than the $10.50 in order to make up for the other 6 who aren't paying enough to cover Ole's costs or who aren't paying at all.

So what should the Lutefisk price be?

Ole's cost	$10.00
Ole's rate of return	$ .50
Menu Price	$10.50

Let's assume that 10 of Ole's diners want Lutefisk each day --
$10.50 x 10 diners per day = $105.00

5 diners with $8.00 government cards (Medicare/Medicaid):	$40.00
1 diner who leaves without paying (Bad Debt):	$00.00
4 diners @ $10.50 (Private/BC):	$42.00
	$82.00

Ole isn't even getting enough to pay for his cost of producing the Lutefisk.

[1]*Source: Larry Sartoris, President, Virginia Hospital and Healthcare Association*

Ole has no choice but to charge the 4 diners who have either private meal cards (Blue Cross) or who are paying cash, more than the $10.50.
In fact, to make everything work out, Ole has to charge those 4 diners $16.25 for their Lutefisk.

5 diners with $8.00 government cards (Medicare/Medicaid):	$ 40.00
1 diner who leaves without paying (Bad Debt):	$ 00.00
4 diners @ $16.25 (Private/BC):	$ 65.00
	$105.00

This is not a treatise on hospital finance. It is just a short story to illustrate how hospitals have to price their services in order to accommodate the different payment rates that exist for the same services.

Some may suggest that these pricing practices are hidden cost shifts or hidden taxes on people with private means of payment, for the purpose of offsetting government payment policies. Regardless of how one views hospital pricing and payment practices, there are four basic premises to keep in mind:

1. The financial principles that apply to business also apply to hospitals. (i.e. Hospitals have to pay their bills.)
2. Without a reasonable rate of return, hospitals run the risk of first having to eliminate services and ultimately having to close. (Problem of accessibility to healthcare for local communities.)
3. Expecting a minority of private insurers to offset flawed government payment policies increases the pressure on private insurers to transfer more financial risk to their insured. (i.e. Higher co-payments and deductibles.)
4. Requiring the insured to assume more financial risk (higher co-payments and deductibles) decreases the desirability and availability of health insurance coverage. (The problem continues to increase.)

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- For illustrative purposes:
  - governmental programs (Medicare and Medicaid) are portrayed paying the same reduced rate on the published charge. This is not the case in any state, including ND. The ND Medicaid program pays hospitals approximately 25% less for similar services than Medicare.
  - privately insured individuals are portrayed paying rates equal to published prices. This is not true in all cases. Some insurance companies, like government payers, pay less than the hospitals' established price. These discounts however are not as great as that of government payers.