HEALTH CARE REFORM REVIEW COMMITTEE

The Health Care Reform Review Committee was assigned three studies.

Section 1 of 2015 House Bill No. 1035 directed the committee to consider continuing the study of the needs and challenges of the North Dakota health care delivery system.

Section 1 of 2015 House Bill No. 1378 directed a study of the proposed and final federal rules issued by the federal Health and Human Services Department relating to the essential health benefits under the federal Affordable Care Act (ACA).

House Concurrent Resolution No. 3003 (2015) directed a study of state contributions for state employee health insurance premiums.

Committee members were Representatives George Keiser (Chairman), Rick C. Becker, Alan Fehr, Robert Frantsvog, Eliot Glassheim, Mary C. Johnson, Jim Kasper, Mike Lefor, Alex Looysen, Alisa Mitskog, and Karen M. Rohr and Senators Tom Campbell, Gary A. Lee, Tim Mathern, David O'Connell, and Ronald Sorvaag.

HEALTH CARE DELIVERY SYSTEM STUDY

Background

The study may include monitoring the implementation of the ACA, examining Medicaid Expansion and Medicaid reform, reviewing any impact on rural access to primary health care and emergency services, making recommendations to maintain and enhance rural primary health care and emergency services, and considering the feasibility of developing a state-based plan for a health care model that will comply with federal health care reform in a manner that will provide high-quality access and affordable care for North Dakota citizens. As part of the study, the University of North Dakota School of Medicine and Health Sciences Advisory Council was required to make periodic reports on the status of the biennial report developed pursuant to North Dakota Century Code Section 15-52-04.

2013-15 Interim Health Care Reform Review Committee

During the 2013-14 interim, the Health Care Reform Review Committee was assigned three studies:

- Section 15 of 2013 House Bill No. 1012 directed the committee to study the immediate needs and challenges of the North Dakota health care delivery system, implementing the Healthy North Dakota initiative, examining Medicaid reform, and the feasibility of developing a plan for a private health care model that will comply with federal health care reform in a manner that will provide high-quality, accessible, and affordable care for North Dakota. The committee considered population shifts, facility needs, personnel needs, rural access, regulatory public health functions, and vulnerable populations.
- Section 1 of 2013 House Bill No. 1034 directed the committee to study health care reform options, including the implementation of the ACA and state alternatives for state-based health care reform. The Insurance Commissioner, State Department of Health, and Department of Human Services were directed to provide status reports on the state of health insurance and health-related public assistance.
- Section 3 of 2013 House Bill No. 1362 directed the committee to consider studying the effects of the ACA.

The committee's recommendations included:

- House Bill No. 1035 (2015), which resulted in the 2015-16 study.
- House Bill No. 1036 (2015), which directed the State Department of Health to evaluate state programs to assist health professionals, with a focus on state loan repayment programs for health professionals, and make periodic reports to the Legislative Management on the outcome of the study. The Health Services Committee received these reports during the 2015-16 interim.
- House Bill No. 1037 (2015), which directed the Department of Human Services to study options for implementing income-based cost-sharing provisions for the Medicaid and Medicaid Expansion programs and report by July 1, 2016, to the Legislative Management on the outcome of the study. The Human Services Committee received this report during the 2015-16 interim.
- House Bill No. 1038 (2015), which required the Public Employees Retirement System (PERS) Board provide health benefits coverage under a policy that provides coverage for health services delivered by means of telehealth, which is the same as the policy coverage for health services delivered by in-person means. The mandate was limited to the PERS Board and expires in 2 years.

- House Bill No. 1039 (2015), which would have amended the group health policy mandate for substance abuse coverage. The bill would have applied the substance abuse coverage requirements to all health insurance policies, removed the coverage requirement formulas for different types of substance abuse services, and clarified required coverage must include inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment. The bill failed.
- House Bill No. 1040 (2015), which revised the involuntary commitment proceeding law to update the language and to expand the statutory authority of physician assistants and advanced practice registered nurses to authorize physician assistants and advanced practice registered nurses to act as independent expert examiners in involuntary commitment proceedings.
- House Bill No. 1041 (2015), which provided when implementing medical assistance expansion under the ACA, the contract between the Department of Human Services and a private carrier must provide a reimbursement methodology for all medications and dispensing fees which identifies the minimum amount paid to pharmacy providers for each medication, provides full transparency of all costs and all rebates in aggregate, allows an individual to obtain medication from a pharmacy that provides mail order service, ensures pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification, and ensures the payments to pharmacy providers do not include a required payback amount to the private carrier or one of the private carrier's contractors or subcontractors, which is not representative of the amounts allowed under the reimbursement methodology.

Affordable Care Act

In March 2010 President Barack Obama signed into law two pieces of legislation that laid the foundation for a multiyear effort to implement health care reform in the United States--the Patient Protection and Affordable Care Act (H.R. 3590) and the Health Care and Education Reconciliation Act of 2010 (H.R. 4872)--which together are referred to as the Affordable Care Act or ACA. The Affordable Care Act crafted new structural models to increase access and affordability of health care coverage, to improve operational governance of the health insurance industry, to provide consumers protection, and to provide new tools for the improvement of the health care delivery system and patient outcomes.

Since enactment of the ACA, North Dakota has made several decisions regarding implementation, including whether to administer the health benefit exchange, whether to select the state's essential health benefits or instead allow the essential health benefits to be selected through the default method, and whether to participate in Medicaid Expansion.

Health Benefit Exchanges

During the November 2011 special legislative session, the Legislative Assembly considered legislation that would have provided for a state-administered health benefit exchange. The legislation failed and the state is allowing the federal government to administer its health benefit exchange. Guidelines issued by the federal Department of Health and Human Services indicate in the future, states will be allowed to transition from one exchange model to another. A state may alter its exchange structure and administration model by submitting an exchange blueprint and having it approved by the Department of Health and Human Services.

Medicaid Expansion

As enacted, the ACA provided for all states to expand Medicaid coverage to eligible state residents with incomes below 138 percent of the federal poverty line. Failure to comply with this Medicaid Expansion requirement could result in penalties. However, the June 28, 2012, ruling of the United States Supreme Court in *NFIB v. Sebelius*, found the ACA's Medicaid Expansion provision is unconstitutionally coercive on states and that this situation is remedied by limiting Department of Health and Human Service's enforcement authority. The practical effect of the ruling is states have the option of expanding Medicaid under ACA. A state that does not expand Medicaid is not subject to penalties under the ACA.

Section 1 of 2013 House Bill No. 1362 directed the Department of Human Services to expand the state's Medicaid program coverage as authorized under the ACA. The department was directed to implement the expansion by bidding through private carriers or utilizing the health insurance exchange. The Department of Human Services implemented Medicaid Expansion through a contract with a private carrier--Sanford Health Plan. Section 1 of the bill has an expiration date of August 1, 2017.

State Innovation Waivers

Section 1332 of ACA authorizes states to submit applications for state innovation waivers. The final rules for these waivers were published March 14, 2011, providing that beginning in 2017, a state may qualify for a state innovation waiver to allow the state to pursue its own innovative strategies to ensure residents have access to high-quality affordable health insurance. To qualify for a waiver, the state's plan must provide affordable insurance coverage to at least as many residents as the ACA and may not increase the federal deficit.

Medicaid Waivers

The federal government provides four primary types of waivers and demonstration projects to allow states to test new or existing ways to deliver and pay for health care services through Medicaid and the children's health insurance program.

1. Section 1115 research and demonstration projects waiver - Allows states to apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and the children's health insurance program. Typically, Section 1115 demonstrations are approved for a 5-year period and may be renewed, for an additional 3 years. Demonstrations must be budget neutral to the federal government, so during the course of the project federal Medicaid expenditures will not be more than federal spending without the waiver.
2. Section 1915(b) managed care waiver - Allows states to apply for waivers to provide services through managed care delivery systems or otherwise limit a person's choice of providers. Within this waiver, there are four options:
    a. Section 1915(b)(1) allows an applicant to implement a managed care delivery system that restricts the types of providers people may use to get benefits;
    b. Section 1915(b)(2) allows a county or local government to act as a choice counselor or enrollment broker to help people pick a managed care plan;
    c. Section 1915(b)(3) allows the use of savings the state gets from a managed care delivery system to provide additional services; and
    d. Section 1915(b)(4) allows a state to restrict the number or type of providers that may provide specific services, such as disease management or transportation.
3. Section 1915(c) home- and community-based services waiver - Allows states to apply for waivers to provide long-term care services in home and community settings rather than in institutional settings.
4. Concurrent Sections 1915(b) and 1915(c) waiver - Allows states to apply to simultaneously implement two types of waivers to provide a continuum of services to elderly people with disabilities.

Testimony

Affordable Care Act

The committee received status reports from a representative of the Insurance Department on the implementation of the ACA, including data on the number of North Dakotans covered under grandfathered and nongrandfathered health plans, the phasing out of the reinsurance and risk corridor measures to spread risks among insurers, and rates and open enrollment.

The committee conducted several panel discussions of representatives of insurers in the state to gather information regarding the implementation of and upcoming changes to the ACA as well as regarding concerns related to the ACA. Topics addressed by the panel participants included:

- The ACA provisions that impact premium, such as transitional reinsurance, risk corridors, and health insurance provider fees.
- Upcoming ACA changes, such as changes in the tool used to determine the actuarial value and the identification of the metallic plans, the 2018 Cadillac plan tax, and employer reporting requirements.
- The distribution of the carriers' plans in high-deductible plans, platinum plans, gold plans, silver plans, and bronze plans.
- The trend of employers moving towards high-deductible plans.

The committee received status reports on the implementation of the ACA from representatives of the Department of Human Services, including updates on Medicaid Expansion, the children's health insurance program, the eligibility modernization project, and hospital presumptive eligibility for Medicaid Expansion.

Medicaid Expansion

The committee tracked the implementation of Medicaid Expansion and considered options to the Medicaid Expansion program. The committee considered five options:

1. Continue with the state's Medicaid Expansion contract;
2. Continue with a revised version of the state's Medicaid Expansion contract;
3. Allow the Medicaid Expansion law to sunset on August 1, 2017;

4. Provide Medicaid Expansion through a Department of Human Services administered program, similar to traditional Medicaid; and
5. Provide Medicaid Expansion through an alternative model, such as what Arkansas and Tennessee have done or have considered.

The committee received reports from representatives of Sanford Health Plan, the carrier administering Medicaid Expansion in the state, regarding membership enrollment figures and demographics, utilization and utilization of emergency rooms, preventative care and preventative screenings, the coordinated service program, case management opportunities, quality improvement projects, the provider network, the pharmacy network, the status of the Pharmacy Engagement Program for the North Dakota Medicaid Expansion Pharmacies, and utilization data.

The committee was informed Medicaid Expansion enrollment has plateaued, retention is very important, and the longer a member is continually enrolled, the more likely that member is to comply with a treatment plan and seek preventative care.

The committee considered the federal funding levels for Medicaid Expansion.

Calendar Year	Federal Funding
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020	90%

A representative of the Department of Human Services testified:

- The Medicaid Expansion contract with Sanford Health Plan is able to be renewed annually and the contract period is each calendar year.
- The 2013 request for proposal included six renewal options and one 12-month extension option.
- If Sanford Health Plan wants to terminate the contract without cause, it must provide a minimum of 90 days' notice to the department.
- If the department wants to terminate the contract without cause, it must provide Sanford Health Plan a minimum of 60 days' notice.

A representative of the Department of Human Services reported on efforts the department is taking to decrease costs associated with Medicaid and Medicaid Expansion to comply with the decreasing funds resulting from the allotment.

The committee received a report on the covered benefits under Medicaid and under Medicaid Expansion, Medicaid Expansion income eligibility levels, and Medicaid Expansion premium rates. Medicaid Expansion does not provide adults age 21 and older coverage for dental and vision services. The anticipated cost of adding dental and vision coverage for these uncovered adults ranges from $36.57 to $52.10 per month.

The committee considered the cost of administering Medicaid Expansion as a managed care product versus administering it in the same way traditional Medicaid is administered.

Managed Care	Traditional Medicaid
The administrative costs are part of the per member per month payment made to Sanford Health Plan.	The current traditional Medicaid enrollment is approximately 68,000. Increasing the enrollment by one-third would increase administrative staffing needs, such as: • Utilization review • Care management • Claims processing
Because the administrative costs are part of the per member per month payment, the federal match is at Medicaid Expansion match rates.	Administrative costs would be at the traditional Medicaid administrative match rates.
Sanford Health Plan has a member center as part of its administrative services. North Dakota Medicaid does not have this.	Would no longer need actuarial services or external quality review. Would increase transaction contracts, such as ID cards, third-party liability, prior authorization, and certificate of need.

If the Department of Human Services took over administration of Medicaid Expansion as a managed care program, the department would need to make changes to the Medicaid management information system. The estimated cost to change the system is $3.4 million, which would be eligible for 90/10 federal/state funding.

The committee received testimony from a representative of the Health Policy Consortium regarding the positive impact Medicaid Expansion has had on decreasing bad debt of hospitals, patient care, and on health care facilities in the state.

The committee received information on how some states have implemented or considered implementing alternative Medicaid Expansion programs through federal waivers. Arkansas received a federal Section 1115 demonstration waiver to implement Medicaid Expansion by using Medicaid funds as premium assistance to purchase coverage through the health insurance exchange. Tennessee considered multiple proposals to implement an alternative Medicaid Expansion proposal that would include premium assistance; however, these proposals have not passed the state legislature.

The committee received a report from a representative of the Department of Human Services regarding the feasibility of Medicaid Expansion cost-sharing. Cost-sharing may relate to copayments and premium. The report included a list of copayments applicable to Medicaid Expansion, identification of services exempt from cost-sharing, populations exempt from cost-sharing, the allowable consequences if a client fails to pay the patient's share, the maximum Medicaid cost-sharing limits, aggregate limits on premium cost-sharing, required tracking and sharing of cost-sharing, and the possibility of being granted a 1115 waiver for a cost-sharing demonstration project and premium cost-sharing limitations if the waiver is not granted.

The committee reviewed summaries of cost-sharing programs in Arkansas, Iowa, Indiana, Michigan, and Montana. The committee was informed if premium cost-sharing, that requires tracking, is implemented for the Medicaid Expansion program, the Department of Human Services, Sanford Health Plan, and actuaries would need to determine if there would be an impact on the per member per month payments, including the administrative component of the payment.

As part of the committee consideration of cost-sharing, the committee received testimony from health facilities, insurers, and consumer advocates regarding copayment and premium cost-sharing.

Indian Country

The committee received overviews of how health services are provided in Indian Country as well as the multiple ways American Indians may receive health care services. The committee learned about the history of Indian Health Services, how the ACA affects Indian Health Services and the American Indian consumer, opportunities and activities to improve health care being provided to American Indians, and challenges American Indians face in addressing health disparities.

The committee received testimony in support of Medicaid Expansion and its positive impact on the health of American Indians. The committee was informed the ACA is the largest expansion of Indian health care in our generation. Not only does the ACA cover American Indians through Medicaid Expansion and health insurance subsidies, the ACA permanently reauthorizes the Indian Health Care Improvement Act, which is the legal authority for provision of health care to American Indians. Although the provision of health care to American Indians is a federal obligation, there are implications for the North Dakota Medicaid system.

The committee received a report on federal guidance issued February 26, 2016, regarding increased state funding opportunities for services a Medicaid-eligible American Indian receives through Indian Health Services or a tribal facility. The report indicated:

- Indian Health Services and tribal facilities may enter care coordination agreements with non-Indian Health Services providers and non-tribal providers to furnish certain services for patients who are American Indian Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent.
- At a minimum, care coordination will involve:

  The Indian Health Services or tribal facility practitioner providing a request for specific services by electronic or other verifiable means and relevant information about the practitioner's patient to the non-Indian Health Services provider or non-tribal provider;

  The non-Indian Health Services provider or non-tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic, or treatment procedures, to the Indian Health Services or non-tribal facility practitioner;

The Indian Health Services or tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and

The Indian Health Services or tribal facility incorporating the patient's information in the medical record through the health information exchange or other agreed-upon means.

To ensure accountability for program expenditures in states where Indian Health Services or tribal facilities elect to implement the policy described in the guidance letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services received through an Indian Health Services or tribal facility.

The documentation must be sufficient to establish:

- The item or service was furnished to an American Indian patient of an Indian Health Services or tribal facility practitioner pursuant to a request for services from the practitioner;
- The requested service was within the scope of a written care coordination agreement under which the Indian Health Services or tribal facility practitioner maintains responsibility for the patient's care;
- The rate of payment is authorized under the state plan and is consistent with the requirements set forth in the guidance letter; and
- There is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

The benefits under this federal care coordination include:

- American Indians can be eligible for both Indian Health Services and Medicaid;
- When care for Medicaid-eligible American Indians meets the four-part test, Indian Health Services bills Medicaid and the federal government pays 100 percent of these services; and
- When Medicaid-eligible American Indians receive services outside Indian Health Services, the non-Indian Health Services provider bills Medicaid and the federal government pays at the state's regular rate.

Waivers

The Department of Human Services in October 2015 submitted renewal requests to the Centers of Medicare and Medicaid Services for both the 1915(b) waiver and 1115 waivers. These waivers were approved by the Centers of Medicare and Medicaid Services. The Medicaid 1915(b) waiver authorizes the department to provide Medicaid Expansion as a managed care organization program allowing mandatory enrollment of individuals, including American Indians, eligible for Medicaid Expansion into the plan offered by a private carrier (managed care organization). The Medicaid 1115 waiver authorized North Dakota to operate a single managed care plan in urban areas.

The committee was informed the Section 1332 innovation waiver has a fairly lengthy approval process by the federal government; however, although the rules are final, the specifics of the process are not yet known. If the state were to pursue this waiver, neither the Insurance Department nor Department of Human Services would have the data necessary to do the state analysis requirement. Thus, pursuit of this waiver would require third-party experts.

Health-Related Surveys

The committee received reports on the Behavioral Risk Factor Surveillance System program and the related survey, which is the world's largest random-digit-dialed survey that reaches adults in private residences, and on the Youth Behavior Risk Survey, which is completed by students in grades 7 through 12.

University of North Dakota School of Medicine and Health Sciences Advisory Council Biennial Report

The committee received a report on the status of the University of North Dakota School of Medicine and Health Sciences Advisory Council biennial report required by Section 15-52-04. The committee received a brief history of the biennial report and the outcomes of previous reports.

The 2015 biennial report will be completed in late 2016, and will be available for the 65th Legislative Assembly. This report will focus on mental health and behavioral issues, provide data on nonphysician providers, provide greater assessment of the impact of the ACA, and provide a preliminary analysis of the impact of the University of North Dakota School of Medicine and Health Sciences and Healthcare Workforce Initiative. The committee received an overview of the ongoing activities of the initiative.

Considerations

The committee considered the impact Medicaid Expansion has had on North Dakotans and health care facilities, providers, and insurers, and generally expressed support for continuation of the program. However, in considering benefit design and how the program is administered, the Department of Human Services was unable to provide the committee the financial information the committee needed to make specific recommendations. The committee was informed this financial data will be available in time for the 2017 legislative session. The committee members generally supported removing the statutory requirement directing the Department of Human Services to implement Medicaid Expansion through a private carrier or through the health insurance exchange to provide the flexibility to administer a program that is well designed for North Dakota and is fiscally responsible. The committee supported consideration of provider reimbursement rates, premium cost-sharing, and transparency.

Recommendations

The committee recommends a bill to remove the July 31, 2017, sunset for the Medicaid Expansion program; to provide Medicaid Expansion provider reimbursement rates are the same as the provider reimbursement rates set for traditional Medicaid; and to remove the requirement Medicaid Expansion be provided through a private carrier or by utilizing the health insurance exchange.

The committee also recommends a bill to remove the July 31, 2017, sunset for the Medicaid Expansion program; to remove the requirement Medicaid Expansion be provided through a private carrier or by utilizing the health insurance exchange; to direct the Department of Human Services to pursue a federal Medicaid waiver to allow the department to implement premium cost-sharing for individuals enrolled in Medicaid Expansion if the cost-sharing program does not have a negative fiscal effect for the state; and to direct the department to pursue care coordination agreements to increase federal reimbursement for Medicaid-eligible American Indians.

The committee also recommends a bill to remove the July 31, 2017, sunset for the Medicaid Expansion program; to remove the requirement Medicaid Expansion be provided through a private carrier or by utilizing the health insurance exchange; to provide if the Department of Humans Services contracts with a private carrier, the contract must provide the department with full access to provider reimbursement rates and the department is directed to consider these rates in selecting a private carrier; and to direct the department to report to the Legislative Management regarding provider reimbursement rates under the Medicaid Expansion program.

ESSENTIAL HEALTH BENEFITS STUDY

This study was to include a review of the rules relating to the state's ability to participate in defining the state-based essential health benefits package under the ACA for plan years 2017 and beyond, how the state may be authorized to select a benchmark plan for plan years 2017 and beyond, and the deadlines related to these rules and related decisions.

Background

Under the ACA, a health insurance issuer that offers health insurance coverage in the individual or small group market must ensure coverage includes the essential health benefits package required under the ACA. Initially, it was assumed the federal government would issue a single set of essential health benefits package requirements for all states. On December 16, 2011, the United States Department of Health and Human Services released a bulletin that each state's essential health benefits package will be based upon a benchmark plan selected by that state. Each state may choose a benchmark plan from one of the following four benchmark plan types:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
2. Any of the three largest state employee health benefit plans by enrollment;
3. Any of the three largest national Federal Employees Health Benefits Plan options by enrollment; or
4. The largest insured commercial non-Medicaid health maintenance organization operating in the state.

In addition to the services covered by the state's selected benchmark plan, the state's essential health benefits package must include the following 10 categories of services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;

6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

If a state failed to choose a benchmark plan by September 30, 2012, the default plan was the nongrandfathered small group plan with the largest enrollment in the state. For this initial essential health benefits package selection, North Dakota chose to use the largest insured commercial non-Medicaid health maintenance organization operating in the state as the state's benchmark plan for 2014 through 2016 plan years.

The federal government directed the states to select, by June 1, 2015, their essential health benefits benchmark plans for plan years 2017 and beyond. If a state would fail to choose a benchmark plan by the federal deadline, the default plan would be the nongrandfathered small group plan with the largest enrollment in the state.

Unlike the first time North Dakota was faced with selecting a benchmark plan, the 64th Legislative Assembly passed House Bill No. 1378, which established a process for an interim committee to study the state's options and report to the Legislative Management. The Legislative Management may issue a directive to the Governor to notify the federal government of North Dakota's selection.

In studying the federal rules, the committee was to:

- Consider the state's ability to participate in defining the state's essential health benefits package for plan years 2017 and beyond;
- Consider how the state may be authorized to select an essential health benefits benchmark plan;
- Consider the federal deadlines related to these federal rules and related decisions; and
- Make findings and report the findings to the Legislative Management, which may issue a directive to the Governor to notify the federal government of the state's decisions relating to the state's benchmark plan and essential health benefits package for plan years 2017 and beyond.

If the Legislative Management were to issue a directive under this bill, the directive was to not direct the federal government to modify the state's existing essential health benefits package for plan year 2017 in a way that adds benefits to the essential health benefits package, unless the added benefits:

- Were in one or more of the state's benchmark plan options considered for plan year 2014;
- Were in the benchmark plan options for plan year 2014; or
- Are in at least one of the 10 benchmark plan options for plan years 2017 and beyond.

A Legislative Management directive under this bill may not result in state liability due to the state reimbursement requirements under the ACA.

Additionally, if over the course of the interim, all or a portion of the ACA is repealed, the committee was directed to consider whether the repeal impacts the state's decision regarding the state's benchmark plan and essential health benefits package for the 2017 plan year and beyond.

Testimony

The committee at its July 22, 2015, meeting focused on the essential health benefits study and:

- Received an overview of the history of this study and the selection process in place for the essential health benefits package for plan years 2017 and beyond;
- Received a copy of the Insurance Department's *Analysis of Essential Health Benefits Under the Patient Protection and Affordable Care Act*, dated August 2012, which was prepared for the initial selection of the state's essential health benefits package effective with the plan year 2014;
- Received a table comparing the 10 benchmark plan choices for the essential health benefits package selection for plan years 2017 and beyond; and

- Assembled a panel of health insurers to provide the committee information relevant to the selection of a benchmark plan to establish the state's essential health benefits package.

The committee learned the deadline for a state to report that state's essential health benefits selection to the United States Department of Health and Human Services was June 1, 2015, with some states being granted an extension to July 1, 2015. The United States Department of Health and Human Services was informed of North Dakota's selection procedure and timeline established through 2015 House Bill No. 1378.

A representative of the Insurance Department reported although North Dakota did not meet the federal deadline, and is therefore considered to have selected the default essential health benefits benchmark plan, if North Dakota were to make an affirmative selection before the publication of the final federal rules, it is likely the state's selection would be valid and included and published in the final rule.

A representative of the Insurance Department testified once a state informs the federal government of the state's essential health benefits benchmark plan, the selection will be incorporated into federal rules, health insurance carriers will design health plans, the designed plans will be submitted for rate and form approval, the plans will be placed on the state's health benefit exchange in time for the 2017 open enrollment period, and the plan will be effective plan year 2017.

The committee was informed North Dakota's default essential health benefits benchmark plan is the state's largest plan by enrollment in the small group insurance product, which is Blue Cross Blue Shield's small group exchange plan, which as of March 31, 2014, had an enrollment of 3,222.

In reviewing the selection process, the committee was reminded if a state chooses to add mandated benefits, the state would be required to pay for any benefits in addition to the essential health benefits required; however, if the state chooses a benchmark plan from the 10 identified benchmark plans which has more benefits than the existing essential health benefits benchmark plan, there would not be additional costs to the state.

The committee was informed by a representative of the Insurance Department it is unlikely selection of any of the 10 benchmark plans would decrease premiums; however, some plans may increase premiums. Although the benchmark selected will impact covered benefits, since the benchmark plans reflect a point in time, some of those benchmark plans have later changed covered benefits. Therefore, it is challenging to know the exact impact the selection of a benchmark plan will have on existing policies.

The committee was informed the nature of essential health benefits is that the health plans in the state have become more alike and therefore the 10 benchmark plans are very similar to each other, with the largest difference being the grandfathered state employee health plan, which offers fertility benefits. There is still a large portion of the state's insureds who have a grandfathered plan, and under ACA these grandfathered plans are not required to provide the essential health benefits. In addition, a representative of the Insurance Department testified there have been some shifts in the state from fully funded insurance products to self-funded plans, which also are not required to provide essential health benefits. As premiums increase over the years, consumers tend to shop for perceived bargains and move to higher deductible plans, resulting in an increase in the incidence of unpaid medical bills which leads to providers increasing the cost of services and increased premiums. The committee was informed implementation of the ACA is too recent to determine whether the ACA will help stem this trend.

The committee was informed there is a value to standardization of health plan benefits. As benefits become more standardized, price becomes more similar and the consumer tends to focus more on the quality of services.

The committee considered the pros and cons of selecting different essential health benefits benchmark plans and the benefits covered and not covered in each of the 10 benchmark plans. As the health insurance plans in the state become more alike, the consequence of the essential health benefits benchmark decision may be minimal. Because of adverse selection, essential health benefits set both a ceiling and a floor and all the plans migrate to the essential health benefits.

Recommendation

The committee recommended North Dakota select the Blue Cross Blue Shield of North Dakota small group benchmark plan as the state's essential health benefits package for plan years 2017 and beyond, the nongrandfathered small group plan with the largest enrollment. This selected plan also was the default plan the United States Department of Health and Human Services would use if North Dakota did not notify the department of a selected benchmark plan. The committee notified the Chairman of the Legislative Management in July 2015 of its recommendation. The result is for plan years 2017 and beyond the state's essential health benefits are based on this benchmark plan.

STATE EMPLOYEE HEALTH INSURANCE PREMIUMS STUDY

Background

The study was to include the feasibility and desirability of establishing a maximum state contribution for state employee health insurance premiums and the effect of losing the state's grandfathered status under the ACA.

Previous Legislative Study

The 2013-14 interim Government Finance Committee studied the state contribution to the cost of state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution for state employee health insurance premiums. The state health plan is exempt from certain provisions of the ACA as long as the plan's grandfathered status is continued. The committee learned the plan's grandfathered status may be lost if certain existing plan benefits are not maintained or if an employee is required to pay more than 5 percent of a single or family premium rate. The Government Finance Committee recommended House Concurrent Resolution No. 3003, which was approved by the 2015 Legislative Assembly and resulted in additional study.

Plan History

Chapter 54-52.1 provides group medical insurance is available to an employee who meets the eligibility requirements of being a permanent employee of the state. To be eligible, an employee must be at least 18 years of age, occupy a regularly funded position, work at least 20 hours per week, and work at least 20 weeks each year. A temporary employee who works at least 20 hours per week and 20 weeks per year may purchase health insurance at that employee's own expense or the employing agency may pay the premium.

The 1963 Legislative Assembly enacted Chapter 52-12, authorizing state agencies, either individually or jointly with other agencies, to enter a group hospitalization and medical care plan and group life insurance plan for each agency's employees. The agencies were required to pay $5 per month for each participating employee's insurance premium. An employee could elect to participate in a single or family plan.

The 1971 Legislative Assembly repealed Chapter 52-12 and enacted Chapter 54-52.1, establishing the uniform group insurance program. The program was placed under the authority of the Public Employees Retirement Board. The board was directed to solicit bids and contract for the provision of insurance benefits coverage with an insurance carrier determined by the board.

From 1971 to 1983, Blue Cross Blue Shield of North Dakota provided and administered the health insurance benefits plan for public employees. In 1983 the Public Employees Retirement Board was authorized by Section 54-52.1-04.2 to establish a plan of self-insurance for providing health benefits coverage under an administrative services-only contract or a third-party administrator contract if the board determined during any biennium a self-insured plan is less costly than the lowest bid submitted by an insurance carrier. The board exercised the option to implement a self-insurance health benefits plan and administered the program in that manner from July 1, 1983, through June 30, 1989.

Although the Public Employees Retirement Board began its administration of the self-insured health benefits plan on July 1, 1983, with reserves of $2,143,880, claim expenditures and other expenses of the program exceeded premium income and other revenue in 1984. By June 1987 the fund balance was a negative $4,759,963 with estimated outstanding claims payable of $4,600,000.

In 1987 the Public Employees Retirement Board incorporated various cost-containment components into the health benefits plan which included:

1. Implementation of a program of concurrent review of inpatient hospitalizations designed to eliminate unnecessary treatment or prolonged hospital stays and to allow consideration of less expensive appropriate treatment for long-term medical care.
2. Implementation of a program of mandatory second surgical opinions for certain elective surgeries. This program did not generate anticipated results, and after a 1-year trial period, was discontinued.
3. Expansion of contract deductibles to include all inpatient, outpatient, and physician services.
4. Increase of the coinsurance base from the first $2,000 in charges to the first $4,000 in charges.
5. Implementation of a preferred pharmacy program.
6. Establishment of a separate premium rate for retirees, based on retiree claims experience.
7. Introduction of a $25 copayment for each hospital emergency room visit.
8. Adjustment of the Medicare coordination of benefits formula applied to retiree members of the plan.

Due to the introduction of these cost-containment initiatives and the availability to public employees of a number of attractive health maintenance organization plans, approximately 3,350 membership contracts, constituting 23 percent of the total contracts of the health benefits plan, were lost during the 1987 open enrollment period, resulting in a decrease of approximately $563,000 per month in premium income.

The decision by the Medcenter One Health Maintenance Organization, the health maintenance organization with the largest PERS eligible enrollment, to discontinue its participation agreement with PERS as of July 1, 1988, and substantial increases in premiums charged by other health maintenance organizations, resulted in a substantial number of public employees choosing the PERS health benefits plan during the 1988 open enrollment period.

In January 1989 the Public Employees Retirement Board voted to end the state-funded health insurance program and buy the coverage from Blue Cross Blue Shield of North Dakota. Officials of PERS predicted the state would end the 1987-89 biennium with a $3.5 million deficit and would need to increase premium rates by 65 percent in the 1989-91 biennium. The Blue Cross Blue Shield of North Dakota bid of approximately $35 million to fund state employees' health insurance for the 1989-91 biennium included provisions the company would absorb approximately $5 million in unpaid claims when the company took over in July 1989.

Senate Bill No. 2026 (1989) appropriated $1.2 million from the fund for unemployment compensation claims to PERS for the state group health program for the period beginning January 1, 1989, and ending June 30, 1991.

Until 1993 the health insurance program charged premiums based on each employee's election of a single or family plan. Beginning with the 1993-95 biennium, the Public Employees Retirement Board began to charge a combination rate that is a blended rate per employee, whether a single or family plan is chosen. The blended rate enables agencies to budget the same premium rate for all employees; therefore, an agency's budget is not adversely affected if an employee electing to receive single health insurance coverage quits and is replaced by an employee electing to receive family coverage.

The following schedule reflects the monthly premiums charged since the program began in 1963.

Biennium	Single Plan	Percentage Change	Family Plan	Percentage Change	Combination Rate	Percentage Change
1963-65	$5.00		$21.00			
1965-67	$8.55	71.0%	$21.50	2.4%		
1967-69	$10.75	25.7%	$25.00	16.3%		
1969-71	$14.45	34.4%	$34.90	39.6%		
1971-73	$15.95	10.4%	$41.90	20.1%		
1973-75	$14.46	(9.3%)	$41.90	0.0%		
1975-77	$19.50	34.9%	$59.95	43.1%		
1977-79	$25.50	30.8%	$67.42	12.5%		
1979-81	$34.84	36.6%	$87.40	29.6%		
1981-83	$42.68	22.5%	$107.07	22.5%		
1983-85	$50.28	17.8%	$140.28	31.0%		
1985-87	$60.00	19.3%	$168.00	19.8%		
1987-89	$68.28	13.8%	$191.28	13.9%		
1989-91	$99.82	46.2%	$280.39	46.6%		
1991-93	$108.00	8.2%	$304.00	8.4%		
1993-95					$254.00	
1995-97					$265.00	4.3%
1997-99					$301.00	13.6%
1999-2001					$349.72	16.2%
2001-03					$409.09	17.0%
2003-05					$488.70	19.5%
2005-07					$553.95	13.4%
2007-09					$658.08	18.8%
2009-11					$825.66	25.5%
2011-13					$886.62	7.4%
2013-15					$981.69	10.7%
2015-17					$1,130.22	15.1%

From 1963 through 1969, the state contributed $5 per month toward the cost of health insurance for state employees. State employees paid any additional amount for single or family coverage. During the 1969-71 biennium, the state contributed $7.50 per month. For the period 1973 through 1979, the state paid the cost of a single health insurance plan and employees choosing a family plan paid any additional cost. Since 1979 the state has paid the full cost of a single or family plan for eligible state employees.

The following schedule provides information on health insurance premiums and the cost of health insurance increases since the 1997-99 biennium.

State Employee Health Insurance Increases (Excluding Higher Education)						
Biennium	Monthly Premium	Increase From Previous Biennium	Percentage Increase	General Fund	Special Funds	Total
1997-99	$301	$36	13.6%	$7,026,674	$3,619,802	$10,646,476
1999-2001	$350	$49	16.2%	$6,989,537	$3,858,174	$10,847,711
2001-03	$409	$59	17.0%	$11,182,551	$6,001,252	$17,183,803
2003-05	$489	$80	19.5%	$8,027,122	$8,258,216	$16,285,338
2005-07	$554	$65	13.4%	$5,335,798	$7,903,870	$13,239,668
2007-09	$658	$104	18.8%	$9,115,817	$12,346,031	$21,461,848
2009-11	$826	$168	25.5%	$15,889,790	$20,215,824	$36,105,614
2011-13	$887	$61	7.4%	$7,179,809	$5,995,847	$13,175,656
2013-15	$982	$95	10.7%	$11,127,312	$9,700,989	$20,828,301
2015-17	$1,130	$148	15.1%	$19,877,362	$14,316,411	$34,193,773

As of July 2015, there were approximately 15,177 active state health contracts, including higher education employees. Based on this number, total funding required for a biennium for health insurance premiums is $411,680,375.

Excluding higher education, state agencies budgeted for 9,627 state health contracts for the 2015-17 biennium. Based on this number, total funding for health insurance premiums for the 2015-17 biennium was $261,135,071, of which $151,766,345 was from the general fund.

High-Deductible Plan

Section 54-52.1-18, as enacted by the 2011 Legislative Assembly, directs the Public Employees Retirement Board to develop and implement a high-deductible health plan with a savings account as an alternative to the regular health insurance plan. The difference between the cost of the high-deductible health plan premium and the regular health plan premium for single and family health plans is deposited in a health savings account for the benefit of the participating employee. The high-deductible health plan has higher annual deductibles and larger out-of-pocket costs, which are partially offset by the employer contribution to the health savings account. The health savings account is not subject to federal income tax at the time of deposit and funds may be carried over and used in subsequent years. The account is owned by the participant, the state makes contributions to the account, there is no fund balance limit, funds in the account continue into subsequent years if not used, and the account is portable if the employee discontinues employment with the state. The state currently contributes $60.74 per month into the account for employees with a single plan and contributes $147 per month into the account for employees covered under a family plan. As of May 2015, there were 164 employees enrolled in the high-deductible health plan.

Calculation of Health Insurance Premiums

During the spring and summer of even-numbered years, PERS begins the process to renew the existing contract or obtain bids for state employee health insurance policies for the following biennium. The cost of renewal is normally returned in August, reviewed by the Public Employees Retirement Board, and if accepted the data is then submitted to the Office of Management and Budget for inclusion in the executive budget. Renewals received for health insurance premiums generally include several options that may affect the amount of the premium. Options include changes in deductible amounts, coinsurance amounts, copayment amounts, and prescription drug benefits. The health insurance plan also may have reserves that can be used to buy down the cost of premiums. If a policy is not renewed, a request for proposal is issued.

Affordable Care Act

The state health plan is exempt from certain provisions of the ACA as long as the plan's grandfathered status is continued. The plan's grandfathered status may be lost if certain existing plan benefits are not maintained or if the employer contribution to employees' health insurance premiums is reduced by more than 5 percent from the contribution rate in effect on March 23, 2010. If an employee is required to pay more than 5 percent of a single or family premium rate the state plan also may lose its grandfathered status.

Estimated Employee Cost Based on Percentage Contributions for Premiums

For the 2015-17 biennium, state agencies are charged a blended rate of $1,130.22 per month for a state employee's health insurance premium. The blended rate is based on a single health insurance plan rate of $543.28 per month and a family health insurance plan rate of $1,311.74. As of March 2014, there were 3,433 employees with a single plan and 11,744 employees with a family plan. The following schedule details the monthly cost to state employees if they were required to pay a percentage of their health insurance premiums.

Monthly Premium[1]	1 Percent of Premium	2 Percent of Premium	3 Percent of Premium	4 Percent of Premium	5 Percent of Premium
Single plan - $543.28	$5.43	$10.87	$16.30	$21.73	$27.16
Family plan - $1,311.74	$13.12	$26.23	$39.35	$52.47	$65.59

[1]Reflects monthly premiums for the 2015-17 biennium.

The following table details the estimated biennial amounts that would be paid by state employees if they were required to pay a percentage of health insurance premiums.

Estimated Total Biennial Amounts to Be Paid by State Employees for Health Insurance Based on Percentage of Premium Paid						
	Number of Plans	1 Percent	2 Percent	3 Percent	4 Percent	5 Percent
Single plan	3,433	$447,619	$895,239	$1,342,858	$1,790,477	$2,238,096
Family plan	11,744	3,697,218	7,394,436	11,091,654	14,788,872	18,486,089
Total	15,177	$4,144,837	$8,289,675	$12,434,512	$16,579,349	$20,724,185

Testimony and Committee Considerations

The committee received testimony from representatives of PERS, insurers, the Human Resource Management Services Division, public employee representatives, and an employer.

Representatives of PERS and Sanford Health Plan provided detailed overviews of the current PERS health plan, focusing on plan demographics, plan participation, plan history, plan design, the ACA, and state premiums. This overview provided the following information:

- As of September 2015, there were 16,087 active state employees, 15,142 of whom were covered under the health plan and 945 of whom were not covered due to dual coverage or waived coverage.
- As of January 2015, there were 45 counties, 38 school districts, 50 cities, and 64 other political subdivisions participating in the state health plan.
- Coverage provided to pre-Medicare and Medicare retirees.
- The history of the state's experience with self-insured health coverage.
- The premium history of the health plan, out-of-pocket cost history under the health plan, the history of the budget appropriation for the health plan, and state employee salary history.
- The history of the high-deductible health plan option.
- The history of PERS using reserve funds to buy down premium.

  2003-05 - $6 million

  2005-07 - $14.3 million

  2013-15 - $11 million
- A review of the wellness initiatives available under the health plan and the history of the wellness plan, including the collaborative drug therapy program, healthy pregnancy program, tobacco cessation benefits, preventative cancer screenings benefits, and fitness center reimbursements.
- A comparison of the benefits and premiums for the state's health plan grandfathered under the ACA and the health plan not grandfathered under the ACA.
- An overview of the percentage of total spending by disease category for the top 10 diseases and an overview of spending distribution by disease.

The committee received information regarding the feasibility of providing health insurance premium discounts for wellness.

- The federal Health Information Portability and Accountability Act provides an individual may not be denied eligibility for benefits or charged more for coverage because of a health factor.
- The federal Public Health Services Act and federal Employee Retirement Income Security Act provide group health plans and health insurance issuers in the group and individual market are generally prohibited from discriminating against participants, beneficiaries, and individuals when establishing eligibility, benefits, and premiums based on a health factor. An exception to this general prohibition allows premium discounts, rebates, or modification of otherwise applicable cost-sharing in return for adherence to certain programs of health promotion and disease prevention, commonly referred to as wellness programs.

Affordable Care Act Grandfathered Status

A representative of PERS provided the committee a consultant's analysis of the changes that can be made to the grandfathered health plan without causing the plan to lose its grandfathered status under the ACA. The analysis provided:

- All changes are measured against or compared with the terms of the plan in effect on March 23, 2010, the date the ACA was enacted, and all changes to the relevant health plan terms occurring after March 23, 2010, must be aggregated for purposes of determining if a particular change will result in a loss of grandfathered status.
- A health plan will lose its grandfathered status if:

  The health plan eliminates all or substantially all benefits to diagnose or treat a particular condition. This includes eliminating benefits for any necessary element for diagnosing or treating a condition.

  There is any increase to an individual's coinsurance percentage requirement or other percentage cost-sharing requirement measured from March 23, 2010. Other cost-sharing increases may cause a plan to lose grandfathered status if the increase exceeds certain specific thresholds.

    In the case of fixed-amount cost-sharing requirements other than copayments, such as deductibles or out-of-pocket maximums, grandfathered status will be lost if the total percentage increase exceeds the "maximum percentage increase."

    In the case of copayments, grandfathered status will be lost if the total increase in the copayment exceeds the greater of $5, increased by medical inflation, or the "maximum percentage increase."

  The employer's contribution is based on the cost of coverage, and the employer decreases its contribution rate for any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage.

  The employer's contribution is based on a formula and the employer decreases its contribution rate for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period.

  The health plan did not impose an overall annual or lifetime limit on the dollar value of benefits on March 23, 2010, but subsequently imposes an overall annual limit on the dollar value of benefits.

  The health plan imposed an overall lifetime limit, but no overall annual limit, on the dollar value of benefits on March 23, 2010, and subsequently imposes an overall annual limit at a dollar limit that is below the lifetime limit on March 23, 2010.

  The health plan imposed an overall annual limit on the dollar value of benefits on March 23, 2010, and subsequently decreases the dollar value of the annual limit.
- In addition to the potential consequences for grandfathered status, any changes with respect to overall lifetime or annual limits also must comply with the ACA's new restrictions on such limits. These restrictions apply to all group health plans, including grandfathered plans.
- A health plan also can lose grandfathered status pursuant to certain anti-abuse rules.

The committee received testimony regarding possible pros and cons of keeping or losing the ACA grandfathered status.

- Pros of a health plan losing grandfathered status:

  Expands preventative services which may decrease the cost of a health plan in the long run.

  Allows health plans to shift more cost of the coverage to members.

  Ends the need to monitor compliance of maintaining grandfathered status.

  Increases employee goodwill due to adding preventative services.
- Cons of a health plan losing grandfathered status:

  Prohibits retaining an out-of-plan limit above current ACA limits.

  Requires contraception coverage, regardless of religious objections.

  Prohibits retaining carve out plans for executives.

  A small group is required to comply with the insurance market changes under the ACA, including:

    Essential health benefits;

Cost-sharing limits;

Metallic levels; and

Modified community rating.

The committee compared the services offered in the grandfathered state health plan to the services offered in the nongrandfathered state health plan.

Self-Insurance

The committee considered the pros and cons of staying with the current fully insured health plan versus changing to a self-insured health plan.

The committee received information from a private employer regarding his experience with self-funding and incentives.

The committee considered possible advantages to having a self-insured health plan, including:

- Reduction in taxes;
- Avoidance of ACA fees;
- Reduction in administrative fees due to the elimination of built-in risk charges is possible;
- Benefit of reserves being held by the employer and any investment income generated is retained by the employer;
- Gain flexibility in plan design;
- Benefits from passthrough savings to the employer, such as provider discounts and rebates; and
- Exempt from state health mandates, unless Century Code specifically directs PERS to provide that health mandate.

The committee considered possible disadvantages to having a self-insured health plan, including:

- The employer is at risk for financial losses;
- The employer is liable for incurred but not reported claims on the balance sheet;
- The employer must maintain and fund a reserve account;
- The employer is required to maintain cashflow; and
- The employer is directly responsible for some administrative responsibilities.

The committee was informed although the current public employee health plan is technically a fully insured plan, it is a hybrid fully insured plan. Due to the group's large size, PERS has been able to negotiate a fully insured plan that incorporates many of the advantages of a self-insured plan and avoids many of the disadvantages of a fully insured plan. The plan is modified to allow PERS to share in gains and limited losses. Benefits of the PERS health plan being designed as a hybrid plan include:

Advantages of self-insurance (Disadvantage of being fully-insured)	**PERS hybrid fully-insured health plan**
Reduction in taxes No ACA tax	Century Code exempts PERS from insurance premium tax
Administrative costs and risk	This is offset to a certain extent by having to pay for stop-loss insurance when self-insured
Reserves	PERS gets interest on cash flow as part of the settlement process if the plan has a gain and PERS gets all earnings reserves
Flexibility	PERS determines plan design based upon funding
Passthrough savings	PERS gets savings less than $1.5 million
Mandates	Century Code provides PERS does not have to comply with state health mandates unless specifically addressed

Disadvantages of self-insurance (Advantages of being fully insured)	**PERS hybrid fully-insured health plan**
Financial risk	PERS health plan limits employer loss to 50 percent of first $6 million or a total of $3 million
Employer must retain incurred but not reported claims	Insurance company is responsible and at risk for incurred but not reported claims
Employer needs a reserve account	Insurance company is responsible for maintaining and at risk for reserve account
Must maintain cashflow	Insurance company is responsible for cashflow
Employer is directly responsible for some administrative responsibilities	Insurance company is directly responsible

The committee was informed if PERS moves from the primary health benefit plan, which is a grandfathered plan, to the PERS nongrandfathered plan, there would be a 3 percent increase in premium. This 3 percent reflects the immediate financial impact of building the wellness provisions into the plan, but does not reflect the anticipated savings in the long term--with the PERS grandfathered plan costing $1,085 and the nongrandfathered plan costing $1,300 per month.

Additionally, the committee was informed if PERS changes to a self-insured plan, unlike most other states, North Dakota does not have an annual budget. With biennial budgets and legislative sessions, there is a greater likelihood PERS would have to appear before the Emergency Commission if costs exceeded the appropriation. The Public Employees Retirement System currently has a 2-year reserve and if that fund is exhausted, there would be financial concerns.

Systemic Changes to the Health Plan

The committee received testimony regarding shifting reimbursement methods from a fee-for-service model to a value-based program model, received testimony regarding patient-centered medical homes, and received testimony regarding coordination of care.

State Employees

A representative of state employees encouraged the committee to consider the impact the health plan has on the ability of the state to recruit employees as well as retain employees. A change in the health plan may impact the decision of some employees who are eligible to retire regarding whether to remain in state employment.

The committee received testimony from a representative of the Human Resources Management Services Division, which provided an overview of state employee data, state employee turnover data, data regarding state employee estimated retirements, temporary and permanent employees' eligibility for health insurance, and a summary of the Hay Group *State Employee Evaluation of Classified Employee Compensation System Fund Report* completed October 2010 and the general follow up performed in 2014.

As of December 2014, the average age of a classified state employee was 46.3 years, average years of services was 12.9, and the average annual salary was $53,297. In 2010 classified employee turnover was 8 percent and it has increased to 12.5 percent in 2015.

The Hay Group report found the state provided a comprehensive and cost-effective benefits program with a competitive health care and retirement program. Although the state's health plan was above market due to it being 100 percent employer funded and having low out-of-pocket contributions, this offset other plan design features that were below market, ultimately putting the health plan at market.

Health Plan Status and Renewal

The committee received periodic updates on the status of the health plan's new carrier's performance and on the status of PERS's activities in reviewing the carrier's performance measures and considering whether to renew the contract or put the contract out for bid.

A representative of PERS provided the following timeline:

- May through August 2016 - Prepare request for proposals in case the decision is to go out to bid;
- July through August 2016 - Conduct renewal estimate;
- August through September 2016 - Receive and consider the proposed renewal and other information required under Section 54-52.1-05;
- September 2016 - If the renewal is not approved, PERS would go to bid immediately with the following timeline:

  September 2016 - Issue request for proposal;

  November 2016 - Receive bids; and

  December 2016 through February 2017 - Review bids; and
- February 2017 - Award plan for 2017-19 biennium.

A representative of PERS reported the contract carrier submitted a proposal for a 17.4 percent increase for the 2017-19 biennium.

	17.4% Increase
2015-17 biennium rate	$1,130.22
2017-19 percent annual trend	8.35%
Projected 2017-19 biennium rate	$1,326.39
2017-19 biennium dollar increase	$196.17
2017-19 biennium percent increase	17.40%
Total state additional funds	$55,658,922
Total additional general fund	$30,612,407
Total current premium	$320,675,060
Total projected premium	$376,333,982

A representative of the carrier, Sanford Health Plan, presented its renewal proposal for the 2017-19 biennium, including alternative options for the health plan, such as:

- Increasing the deductible, decreasing the coinsurance percentage, and increasing the out-of-pocket maximum for out-of-state services.
- Pharmaceutical changes to the plan.
- Increasing office visit and emergency room copayment amounts.
- Increasing the deductible.
- Increasing the coinsurance maximum.

The committee reviewed a bill draft that would have removed the current requirement the state pay the entire premium amount for state employees' health benefit plans. In considering this bill draft the committee received testimony indicating state employees earn 7 to 10 percent less than private sector employees, and the state's benefit package helps overcome this shortfall.

Conclusion

The committee makes no recommendations with respect to this study.

After the committee concluded its work for the interim, the PERS Board announced a temporary suspension of the PERS health plan's wellness program, effective January 1, 2017, due to a recently issued federal Internal Revenue Service memorandum advising cash payments made to employees for gym membership and other cash equivalent incentives for participation in a wellness program are taxable income to the employee. Additionally, after the conclusion of the committee's work, the PERS Board announced its plan to renew the health plan contract with the current carrier and not put the contract out for bid.