NORTH DAKOTA LEGISLATIVE COUNCIL

Minutes of the

EMPLOYEE BENEFITS PROGRAMS COMMITTEE

Thursday, January 15, 2004
Harvest Room, State Capitol
Bismarck, North Dakota

Senator Karen K. Krebsbach, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Karen K. Krebsbach, Richard Brown, Ralph L. Kilzer, Carolyn Nelson; Representatives Bill Amerman, Al Carlson, Mike Grosz

Member absent: Representative Francis J. Wald

Others present: See Appendix A

It was moved by Senator Brown, seconded by Senator Kilzer, and carried on a voice vote that the minutes of the November 3-4, 2003, meeting be approved as distributed.

At the request of Chairman Krebsbach, committee counsel distributed a copy of the January 2004 *Report Card* and the January 2004 *Retirement Today* newsletters published by the Teachers' Fund for Retirement and a copy of the *2003 Comprehensive Annual Financial Report* of the Retirement and Investment Office. Copies of the newsletters and the report are on file in the Legislative Council office.

Chairman Krebsbach called on Mr. Rick Johnson, Senior Vice President, The Segal Company, Washington, D.C., who reviewed the *2003 Segal State Health Benefits Survey: Medical Benefits for Employees and Retirees*. A copy of the slides Mr. Johnson used in his PowerPoint presentation is attached as Appendix B and a copy of the report is attached as Appendix C. Among the key findings of the *2003 Segal State Health Benefits Survey*, he said, was that the average health expense in 2002 was $5,571 per employee, or 16 percent of wages; that 36 percent of participating states do not require an employee contribution for employee-only coverage; that states subsidize an average of 82 percent of total medical plan expenses for employee coverage; that preferred provider organizations are the most prevalent medical plan type; that health maintenance organizations are most prevalent in the Midwest and West; that regions with similar medical plan enrollment patterns do not have similar health care cost-trend rates; and that states are adopting more aggressive cost-management tactics but are not considering reducing or eliminating retiree health coverage. He said more than 60 percent of participating states' indemnity, point of service, and preferred provider organization plans are self-funded. After wages and salaries, he said, health benefits are viewed by employees as their most important benefit. For the first time in the history of the survey, he said, health benefits have passed retirement benefits in importance to employees.

Concerning 2004 projected medical cost trends, Mr. Johnson said Segal is projecting an annual percentage increase of 15.6 percent for nonnetwork plans, 14.4 percent for preferred provider organizations, 14 percent for point of service plans, and 13.7 percent for health maintenance organizations. For retirees age 65 and older, he said, Segal is projecting an annual percentage increase of 12.4 percent for Medicare and supplement indemnity plans and 13 percent for Medicare Plus Choice health maintenance organization plans. Concerning 2004 projected prescription drug cost trends, he said, the projected annual percentage increase is 18.2 percent for retail drugs and 17.6 percent for mail-order drugs for actives and retirees less than 65 years of age and an increase in retail prescription drugs of 16.2 percent and 17.3 percent in mail-order drugs for retirees older than 65 years of age. He said the survey results show that some employers have shifted a portion of the cost of health insurance to their employees and in some cases the increase absorbed by employees is larger than their pay increase for the same period. He said annual medical premium costs for employees increased from $5,609 in 2002 to $6,125 in 2003 with the employer share remaining at 88 percent and the employee share at 12 percent. He said the employee premium cost-sharing for the most prevalent plan is 10 percent for employee-only plans and 22 percent for employee and family plans. For retirees, he said, the average retiree share is 43 percent for retiree-only plans for retirees under 65 years of age and 53 percent for the retiree and spouse when the retiree is under 65 years of age. He said the cost-share for retirees under a retiree-only plan for retirees 65 years of age and over is 43 percent and 56 percent for retiree and spouses for retirees 65 years of age and over.

Concerning deductibles, Mr. Johnson said the average deductible has increased by 30 percent since 1999 with the average deductible for indemnity plans $310, $360 for in-network services in a preferred provider organization, and $671 for out-of-network services in a preferred provider organization. He said

55 percent of plans have doctor office visit copayments of $15 or higher and the Public Employees Retirement System plan has a preferred provider organization doctor office visit copayment of $20. He said 25 percent of plans have individual out-of-pocket maximums of zero to $1,000; 17 percent of plans have individual out-of-pocket maximums of $1,001 to $1,500; 13 percent of plans have individual out-of-pocket maximums of $1,501 to $2,000; and 46 percent of plans have individual out-of-pocket maximums of more than $2,000. He said the composite annual premium cost and trend rates for employee coverage by plan type for 2002 and 2003 indicates that indemnity plan premiums increased from $6,832 to $7,696, a trend rate of 12.7 percent; preferred provider organization plan premiums increased from $5,334 to $6,138, an increase of 15.1 percent; point of service plan premiums increased from $5,911 to $6,795, an increase of 14.9 percent; and health maintenance organization plan premiums increased from $5,486 to $6,280, an increase of 14.5 percent.

Mr. Johnson said states have implemented several cost management programs with 81 percent of states utilizing hospital inpatient precertification requirements, 75 percent of states utilizing disease management programs, 72 percent of states utilizing prescription drug prior authorization requirements, 69 percent of states utilizing claims payer auditors, 50 percent of states utilizing outpatient precertification requirements, 50 percent of states utilizing hospital bill audits, 47 percent of states utilizing prescription drug clinical intervention requirements, 44 percent of states utilizing centers of excellence, 28 percent of states utilizing utilization review vendor audits, 25 percent of states utilizing employee self-audits, and 6 percent of states utilizing health reimbursement accounts.

Concerning cost management programs, Mr. Johnson said 87 percent of states are considering higher member copayments, 60 percent of states are considering disease management programs, 84 percent of states are considering increasing employee contributions for dependent coverage, 78 percent of states are considering increasing employee contributions for employee coverage, 67 percent of states are considering implementing group purchasing coalitions, 53 percent of states are considering reducing plan offerings, 51 percent of states are considering implementing consumer-driven health plans, 27 percent of states are considering the elimination of certain providers, 15 percent of states are considering reducing retiree health benefits, 30 percent of states are considering implementation of three-tier hospital networks to control costs, 24 percent of states are considering implementing retiree medical accounts, 24 percent of states are considering raising eligibility requirements, 3 percent of states are considering eliminating Medicare Plus Choice offerings. However, he said, no state is considering eliminating retiree health benefits at this time.

Concerning prescription drug plan design features, Mr. Johnson said very few states offered three-tier prescription drug programs in 1999 while now 66 percent of states offer three-tier drug prescription programs. He said the three tiers are generic drugs, formulary prescription drugs, and nonformulary prescription drugs. He said 8 percent of prescription drug plans now have deductibles, 18 percent have copayments, and 26 percent have out-of-pocket maximums. He said 71 percent of states encourage the use of formulary drugs for employees and 70 percent for retirees but states do not maintain tightly controlled formulary designs, prohibiting reimbursement for nonformulary drugs.

In response to a question from Representative Carlson, Mr. Johnson said steps other states are taking to address the increase in health care costs are increasing premiums, changing plan designs to shift or balance the cost from employer to employee with increases in copayments and coinsurance, not providing pay increases and designating any pay increase as an increase in health insurance premiums and communicating this to the employees, and educating employees as to what their total compensation is including benefits.

Chairman Krebsbach called on Mr. Sparb Collins, Executive Director, Public Employees Retirement System, who discussed existing health insurance plan designs and the impact of implementing several plan design changes. A copy of the slides used by Mr. Collins in his PowerPoint presentation is attached as Appendix D. He said the public employee health insurance plan design is a consumer-driven plan design with different levels of coverage provided to encourage members to use providers that are the most cost-effective for the plan, including exclusive provider organizations and preferred provider organizations. He said the plan design rewards those who do not use services and the plan design provides a fee for usage of services through copayments and deductibles. He said the deductible for nonphysician services is $250 for individuals in the basic and preferred provider organization plans and $100 for the exclusive provider organization plan. He said the deductible for a family plan is $750 for the basic and preferred provider organization plans and $300 for the exclusive provider organization plan. In 2003, he said, the employer paid 63 percent of prescription drug claims while the employee paid 37 percent of prescription drug claims. He said if deductibles are eliminated, there would be a 3.3 percent increase in premiums and if all cost-share is eliminated, he said, there would be a 25.4 percent increase in premiums. Thus, he said, essentially the employer is paying 75 percent of an employee's health insurance costs while the employee is paying 25 percent.

In response to a question from Senator Brown, Mr. Collins said there was no general salary increase provided to state employees this biennium and the $79.61 increase in health insurance premiums was characterized by some as in lieu of a salary increase. He said the employer is still paying the entire cost of the premium.

Chairman Krebsbach called on Mr. Tom Christensen, Blue Cross Blue Shield of North Dakota, Fargo. A copy of his presentation is attached as Appendix E. Mr. Christensen reviewed state health plan drug discounts and out-of-pocket expenses incurred by members of the state health plan. Concerning the long-term growth in costs per member per month for the prescription drug program, he said, the change in the allowed and paid per member per month for the third quarter of 2003 increased 8 to 10 percent over the same period in 2002. As the cost of prescription drugs increases, he said, the cost also increases for employees because of the corresponding increase in coinsurance and deductibles. He said Blue Cross Blue Shield works with its pharmacy benefit manager to control the rate of pharmacy spending through contracted pharmacy network discounts, benefit design, drug manufacturer discounts or rebates, utilization management, and accurate claim adjudication. He said pharmaceutical manufacturers may provide retrospective discounts or rebates on brand-name drugs based on formulary status, benefit design, or utilization of the drug. He said the Public Employees Retirement System pharmacy benefit design employs a tiered-benefit design using differential copayment and coinsurance amounts to encourage generic and formulary drug use.

Concerning the reimportation of drugs from foreign sources, including Canada, Mr. Christensen said Blue Cross Blue Shield of North Dakota takes the position that the importation of drugs violates the federal Food, Drug, and Cosmetic Act in almost all instances. He said the Food and Drug Administration has made it clear that pharmacies in the United States that aid in the importation of drugs from foreign sources are in violation of the Act. He said Blue Cross Blue Shield of North Dakota has now taken the position that it will not reimburse for drugs purchased from a foreign source. In summary, Mr. Christensen said, reimportation of prescription drugs from Canada is a violation of the federal Food, Drug, and Cosmetic Act and personal reimportation is also in violation of the Act. He said any drug shipped in interstate commerce without Food and Drug Administration approval violates the Act. He said approval means manufacturing, distribution, and labeling as well as a determination that the drug is safe. He said anyone participating in the reimportation process is at risk of prosecution.

Chairman Krebsbach called on Mr. Duane Houdek, Governor's Counsel, who addressed developments in other states concerning the reimportation of Canadian prescription drugs. He said states and municipalities have developed several types of drug reimportation methods or models. He said one model is known as the city model and is being used by Springfield, Massachusetts, and explored by Boston, Massachusetts. Under this model, he said, the city pays for and processes individual employee or member orders for prescription drugs. He said this model is opposed by the Food and Drug Administration. He said the Food and Drug Administration is trying to dissuade the City of Boston from pursuing this model and may sue the City of Springfield to halt its drug reimportation efforts. The second model, he said, is the state seek permission model to reimport drugs for all purposes. He said the states of Illinois and Iowa have pursued this method and the Food and Drug Administration has refused to grant permission. The third model is the medicine assist model first utilized by the United Health Alliance of Vermont. He said Minnesota is following this model and the Governor's office is also exploring this model. He said this model provides a web site with access to Canadian pharmacies that the United Health Alliance has inspected for safety and compliance with Canadian laws. Under this model, he said, the individual voluntarily participates and processes his or her drug orders and only the link is provided by a governmental entity. Mr. Houdek said New Hampshire, West Virginia, Minnesota, Massachusetts, Michigan, Vermont, Utah, and Oregon are exploring this model.

In response to a question from Senator Krebsbach, Mr. Houdek said the medicine assist program is similar to the current practice of individuals traveling to Canada, mailing orders to Canada, or ordering prescription drugs over the Internet that the Food and Drug Administration has declined to enforce to date.

Mr. Houdek said there are a number of factors that are driving the debate in the direction of the medicine assist program. First, he said, it has been the policy of the Food and Drug Administration to allow individuals to import prescription drugs for their own use. In addition, he said, Health Canada has taken the position that Canadian pharmacies may continue to supply individuals, but if they go beyond that and supply groups, such as employee groups, Health Canada will intervene because of concerns about maintaining an adequate supply of prescription drugs in Canada. Finally, he said, United States pharmaceutical groups have started to discuss limiting supplies of drugs to Canada which has cost concerns in Canada.

Chairman Krebsbach called on Mr. Howard C. Anderson, Jr., Executive Director, Board of Pharmacy, who discussed the reimportation of Canadian prescription drugs. A copy of his written materials is attached as Appendix F. He said the responsibility of the Board of Pharmacy is to regulate and license

pharmacies in North Dakota to ensure that North Dakota consumers are receiving their prescription drugs from a licensed pharmacist. He said the importation of prescription drugs from Canada is illegal if it is done through the mail or common carriers are used. In addition, he said, if an individual travels to Canada and purchases prescription drugs for reimportation into the United States it is also illegal, but the Food and Drug Administration has declined to enforce or prosecute this practice.

In response to a question from Senator Nelson, Mr. Anderson said approximately 30 to 35 percent of the cost of a prescription drug is for research and development of the drug, 30 to 40 percent is for marketing of the drug, with the remainder of the cost for production of the drug, distribution, and profit for the drug company.

Senator Krebsbach called on Mr. Larry Brooks, Blue Cross Blue Shield of North Dakota, who reviewed the implementation of the case management program and the smoking cessation program. A copy of Mr. Brooks' written comments concerning the case management program is attached as Appendix G.

Mr. Brooks said his primary responsibility with Blue Cross Blue Shield of North Dakota is to act as a liaison between Blue Cross Blue Shield and the Public Employees Retirement System. He said the case management system is designed to slow the increase in health care costs. It has been shown, he said, that 20 percent of a plan's participants incur 80 percent of the expenses and if the costs of the 20 percent portion can be controlled or mitigated, it will help the financial status of the overall plan. He said the Medical Management Division was created in 1988-89 and now does prior approvals, referrals, psychiatric and substance abuse review, disease management, chiropractic review, pharmacy review, and case management. He said the mission of the Case Management Department is to have a positive impact on the health care needs of the members of Blue Cross Blue Shield by ensuring quality, cost-effective health care across the continuum of care. He said case management is important in coordinating and ensuring that the members of Blue Cross Blue Shield receive the most appropriate and cost-effective health care possible. He said the case management program also allows for benefits outside the scope of coverage, when these benefits are medically appropriate and cost-effective. In recognition of ever-increasing health care costs, particularly in light of new technology and complex treatment methods, he said, additional case management was deemed necessary. He said based on a request for assistance by the Public Employees Retirement System in this area, Blue Cross Blue Shield has assigned a dedicated case manager to the Public Employees Retirement System group. For example, he said, during the period July 1, 2001, to June 30, 2002, 122 people, or .3 percent of the total members of the Public Employees Retirement System, had claims in excess of $50,000. He said the total benefit payments to this group was $11.8 million or 17 percent of the total claims experienced by the Public Employees Retirement System group. During the period July 1, 2002, to June 30, 2003, he said, 155 members had claims in excess of $50,000 for total benefit payments of $13.8 million. Again, he said, the percentage of members with claims in excess of $50,000 was only .3 percent of the total members but accounted for 17 percent of the total benefit payments. He said the case management program is designed to monitor heart disease, malignancies, respiratory conditions, congenital anomalies, cerebral vascular disease, musculoskeletal disease, blood disorders, mental disorders, and newborn complications. He said Blue Cross Blue Shield of North Dakota is estimating case management savings of $1.4 million for 2003. He said the case management savings were achieved by arranging for patient care in less-costly facilities, negotiating reduced pricing for durable medical equipment, extending outpatient visits to prevent inpatient stays, and reducing pricing for prescription medications. During the third quarter of 2003, he said, case management reviewed 90 cases, of which 22 are still active.

Concerning the prenatal plus program, Mr. Brooks said the program was developed to identify women at risk for premature delivery and to prevent incidents of preterm births. He said the program consists of assessment, intervention, and education for participants during their pregnancy, but stressed that participation in the prenatal plus program is strictly voluntary. He said the Public Employees Retirement System has implemented incentives for Public Employees Retirement System members to participate in the prenatal plus program, including waiver of the mother's deductible for claims and copayments waived for prenatal vitamins. He said participation in the prenatal plus program has increased from 131 or 30 percent of deliveries in 2001 to 207 or 38 percent of deliveries in 2003. He said Blue Cross Blue Shield of North Dakota and the Public Employees Retirement System are working to enhance prenatal plus program participation by establishing an appropriate benchmark for participation, investigating incentives for providers, if appropriate, reviewing appropriate design changes, and researching what other carriers are doing in this area. In summary, he said, case management is necessary to promote quality, cost-effective medical outcomes, and Blue Cross Blue Shield of North Dakota is continuing to explore ways to enhance the system, always looking to make things better.

Mr. Brooks reviewed the Public Employees Retirement System tobacco cessation program. A copy of his written comments is attached as Appendix H. He also distributed a copy of an information sheet

concerning the program, which is attached as Appendix I, and a brochure describing the program, a copy of which is on file in the Legislative Council office. He said all state employees and their family members who are 18 years of age and over are eligible to participate in the tobacco cessation program. He said employees of political subdivisions, retirees, and people under COBRA coverage are not eligible. He said under the program the member decides when he or she is ready to quit and then contacts one of the providers participating with the program. He said the provider then verifies the member's eligibility as a state employee and an initial assessment is completed. He said most programs are eight weeks in duration. He said the program pays $200 for counseling, 75 percent of the cost of medications up to $375 with the participant paying 25 percent up to $125, and 75 percent of the cost of a physician's office visit up to $50 with the participant required to pay 25 percent up to $16.67.

In response to a question from Representative Amerman, Mr. Christensen said Blue Cross Blue Shield of North Dakota will not reimburse for drugs purchased in Canada.

Chairman Krebsbach called on Mr. Rod St. Aubyn, Blue Cross Blue Shield of North Dakota. He distributed an article from *USA TODAY* entitled "FDA head: States can cut drug costs without using imports," a copy of which is attached as Appendix J.

STAFF DIRECTIVES

Representative Carlson requested that the Legislative Council staff contact representatives of the Greater North Dakota Association to invite them to appear at a future meeting to describe member health insurance issues.

No further business appearing, Chairman Krebsbach adjourned the meeting at 3:00 p.m.

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Jeffrey N. Nelson
Committee Counsel

ATTACH:10