MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1303

2005 HOUSE HUMAN SERVICES

HB 1303

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1303

House Human Services Committee

❑ Conference Committee

Hearing Date January 19, 2005

Tape Number	Side A	Side B	Meter #
#1		x	# 70- 857

Committee Clerk Signature Gelson

Minutes:

Chairman Price opened discussion on HB 1303. 10 members present, 2 absent.

Rep. Devlin: Move a Do Not Pass.

Rep. Pietsch: Second

Rep. Porter: The Insurance commissioner and Mr. St. Aubin testimony stressed that these issues are emotional issues, and emotionally charged. The insurance companies take their position and the individuals that want mandates take their position and this tool gives us an independent 3rd look at what the true cost benefit analyses is, and that is something that concerns us as we make policy. We have to take the emotional side and the _____? insurance side aside and look at it from an independent tool, and I appreciate it, so we have that side that is not involved to help us make our decisions. There is a PSA mandate, and there are instituions that are saying that it is not needed, so we have to be able to look at these and make a decisiion that is of benefit to our citizens of ND.

Rep. Sandvig: I was just trying to save the Ins. Comm. some money. I feel that we have enough information to make a informed judgement with out the CBA. I think we are capable of that as legislators.

Rep. Kaldor: This is new ground for me. I remember the debates the mandates, it was challenging. You had the insurance comp/advocacy groups. I am concerned about the contracting. The language says that the LC shall contract with the third party. I don't know if this is a right solution, and the cost involved, depending upon the type of mandate. The cost of the CBA ranged from $5,000/$8,000. I am not incinuating that they should be suspect, I just have some concern of how the process works.

Chairman Price: This is the 3rd or 4th forum on how to make this work, because it is not the way it started at all. The information from the 3rd party concerning the analys, was based on how extensive, as is it new ground or is it something they have done for other states, or mandates before. If they done this 4 or 5 times, the cost should be less. The first couple we recieved, we had a ton of questions, and tried to find our way thru it.

Rep. Sandvig: I think the analys looks more at the current situations rather that long term.

Chairman Price: It is hard to determine as it hasn't happened yet.

Vote: Do Not Pass 8-2-2.

Carrier: Rep. Weisz

FISCAL NOTE

Requested by Legislative Council
01/12/2005

Bill/Resolution No.: HB 1303

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures		$0		($25,000)		($25,000)
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2003-2005 Biennium			2005-2007 Biennium			2007-2009 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

HB 1303 removes the requirement that a cost benefit analysis be prepared before a measure mandating health insurance coverage may be acted on by any committee of the Legislative Assembly.

During the 58th Legislative Assembly, three health benefit mandates were introduced and cost benefit analyses were prepared by Milliman and Associates. The costs of the analyses were:

$ 7,867.33 - SB 2210 - Coverage for substance abuse treatment

$16,448.64 - HB 1247 and 1349 - Outpatient prescription drugs and services (HB 1247) and colorectal cancer screening (HB 1349)

$24,315.97 - Total

The cost of the analyses was paid for with moneys from the Insurance Regulatory Trust Fund.

This fiscal note presumes that future Legislative Assemblies will introduce three health insurance mandates and that the cost of the analyses will approximate the cost of the analyses prepared during the 58th Legislative Assembly. This may or may not be the case.

The Legislative Assembly may study more or fewer than three mandates and the cost of the mandates may be more or less, depending on the mandate.

The estimated impact on expenses of approximately $25,000 per biennium is the Insurance Department's best estimate of the impact of this bill on the Insurance Regulatory Trust Fund expenses.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

It is estimated that the proposed bill will reduce expenses by $25,000 per biennium for the Insurance Regulatory Trust Fund.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

Name:	Charles E. Johnson	**Agency:**	Insurance Department
Phone Number:	328-4984	**Date Prepared:**	01/14/2005

Date: 1/19/05

Roll Call Vote #:
1.
2.

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1303

House **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken 1. DO NOT PASS -

Motion Made By 1. Devlin Seconded By 2. Pietsch

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S.**Price**	x		Rep.L. **Kaldor**	x	
V Chrm.G. **Kreidt**	x		Rep.L. **Potter**	AB	
Rep. V. **Pietsch**	x		Rep.S. **Sandvig**	x	
Rep.J.O. **Nelson**	AB				
Rep.W.R. **Devlin**	x				
Rep.T. **Porter**	x				
Rep.G. **Uglem**	x				
Rep C. **Damschen**	x				
Rep.R. **Weisz**	x				

Total ( ) 8 yes **No** 2

Absent 2 AB

Floor Assignment Carrier: Rep Weisz

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1303: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (8 YEAS, 2 NAYS, 2 ABSENT AND NOT VOTING). HB 1303 was placed on the Eleventh order on the calendar.

2005 TESTIMONY

HB 1303

Test: 1303

How 2003 session

FISCAL NOTE

Requested by Legislative Council
02/10/2003

Amendment to: HB 1349

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$322,845	$720,410	$322,845	$720,410
Appropriations			$322,845	$299,800	$322,845	$299,800

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
			$132,400	$65,750	$82,100	$132,400	$65,750	$82,100

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The PSA and fecal occult blood test screenings are already covered by the NDPERS benefit, so would not have an added cost to NDPERS.
The additional cost to NDPERS to cover the flexible sigmoidoscopy, colonoscopy, and double contrast barium enema as screenings is estimated at $3.20 per contract per month (spread over ALL contracts) for the 7-03/6-05 biennium. This assumes that the colonoscopy would be allowed once every 10 years, beginning at age 50, as recommended by the AMA. The flexible sigmoidoscopy and double contrast barium enema would be allowed once every 5 years, beginning at age 50, as recommended by the AMA.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The expenditures are the cost of the additional premium that will be necessary to pay for the new benefits proposed in this bill. The expenditures are for all state contracts.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The appropriation is the additional appropriation needed for the state agencies to pay the higher premium needed to support the proposed new benefits in this bill. The premium included in the Governors budget did not provide for this benefit. Higher Education is not included in the appropriation since they have a continuing appropriation.

Name:	Sparb Collins	**Agency:**	Public Employees Retirement System

TESTIMONY OF SPARB COLLINS ON HB 1349

from 2003

Madame Chair, members of the committee good morning, my name is Sparb Collins and I am with the Public Employees Retirement System (PERS). I appear before you today neither in favor nor opposed to HB 1349, but rather to discuss with you the effect the provisions of this bill will have on the PERS health plan and to request an amendment. Since this bill would require that we renegotiate our plan design with BCBS we asked them to provide us with the additional cost of adding these provisions. They have indicated that our premium would need to go up $3.20 to pay for these benefit enhancements. Since this is not anticipated in the proposed premium recommended by the Governor and presently being considered by the legislature I have attached a proposed amendment to this bill to pay the cost of the enhancements. If this bill was to pass and the premium would not be increased then the PERS Board would have to increase member's deductibles and co insurance to offset the cost of the enhancement. Under the alternate plan design that is presently being considered where the deductible for state employees in the PPO plan may already be increasing to a $250 across the board deductible if we had to add to that the cost of this bill it could increase that amount by about $50.

HB 1349 requires that certain benefits be added to the PERS health plan. Specifically the benefits proposed relate to colorectal cancer screening. The PSA and fecal occult blood test screenings are already covered by the NDPERS benefit so would not have an added cost to NDPERS. The additional cost to NDPERS to cover the flexible sigmoidoscopy, colonoscopy, and double contrast barium enema as screenings is estimated at $3.20 per contract per month (spread over ALL contracts) for the 7-03/6-05 biennium. This assumes that the colonoscopy would be allowed once every 10 years, beginning at age 50, as recommended by the AMA. The flexible sigmoidoscopy and double contrast barium enema would be allowed once every 5 years, beginning at age 50, as recommended by the AMA. This also assumes that these screenings would be subject to copays and coinsurance.

A MILLIMAN GLOBAL FIRM

Milliman USA
Consultants and Actuaries

8500 Normandale Lake Blvd., Suite 1850
Minneapolis, MN 55437
Tel +1 952 897.5300
Fax +1 952 897.5301
www.milliman.com

February 4, 2003

Mr. John D. Olsrud
Director
North Dakota Legislative Council
600 E Boulevard
Bismarck, ND 58505-0360

Re: Analysis of House Bills 1247 and 1349

Dear Mr. Olsrud:

Thank you for your letter of January 29 requesting a cost-benefit analysis of the mandates included in House Bill Nos. 1247 and 1349. In accordance with NDCC 54-03-28, you asked that we provide information to help determine the following:

a. the extent to which the proposed mandate would increase or decrease the cost of the service;
b. the extent to which the proposed mandate would increase the appropriate use of the service;
c. the extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and
d. the impact of the proposed mandate on the total cost of health care.

Given the short turn around time you requested, we are providing this letter which summarizes the information we have gathered to date. If you have questions regarding this information or would like additional detail on any point, we would be happy to continue our review on a more comprehensive basis.

This letter is intended for use by North Dakota legislators and officials for the purpose of considering this proposed legislation. It should not be used for other purposes and was not prepared for the benefit of any third party. In doing our work, we have relied on the data and information cited in this letter. This information includes the House Bills attached to your letter. If there are changes to these bills, the comments here may no longer be appropriate.

We discuss each of the bills separately below. In general, these mandates will introduce some added administrative costs. These include updating contracts and other policyholder communications, changes in claims processing systems to allow payment of these claims, and additional agent or broker commissions where they apply. However, we would not expect any extraordinary administrative expenses due to these mandates.

Bill No. 1247 – Outpatient Prescription Drugs and Devices

This bill would provide coverage for certain outpatient prescription drugs and devices, including osteoporosis treatment and therapy (including hormone replacement therapy), contraceptives, and infertility therapy. We will address each of these coverages individually.

In general, we do not believe that mandating coverage for these particular drugs will materially impact the unit price that carriers pay for them. (However, there may be some impact on the rebates that drug companies sometimes pay, depending on the change in volume.)

Osteoporosis Treatment and Therapy (Including Hormone Replacement Therapy)

We researched the drugs used to treat this condition, primarily using the *Milliman Care Guidelines 8th Edition (CGs)*. The *CGs* describe the best practices for treating common conditions in a variety of care settings. The *CGs* are designed to assist physicians and other healthcare professionals in providing optimal care. They show what is currently being done by providers and hospitals across the United States, as supported by the latest research in risk and medical management.

According to the CGs, the following are the drugs most commonly used to treat osteoporosis:

- Calcium and Vitamin D: These drugs are generally available over the counter, and so may not be covered by the mandate. The typical price of these drugs ranges from $0.63 to $6.44 per month.

- Estrogens: The typical price of these drugs ranges from $7 to $33 per month, depending on the drug. Insurance carriers often pay something less than these prices for drugs—discounts in the range of 10 – 20% are common.

  According to the *CGs:* "Hormone replacement therapy (HRT) has been recommended for most postmenopausal women not only for its ability to preserve BMD but also for help with menopausal symptoms and for a presumed cardio-protective effect."(1) In a report on a related mandate, the Pennsylvania Health Care Cost Containment Council cites research by Katalinic showing that when estrogen is used for at least 10 years, the risk of heart attack is significantly reduced. (2)

  However, thinking about the appropriate use of these treatments has been changing in recent years. According to the *CGs:* "Recent studies have shown less encouraging data regarding advantages of hormone replacement therapy."(3) The *CGs* also indicate that: "Recent randomized controlled trials indicate that the cardio-protective effect of hormone replacement therapy is now a point of controversy. Data from some of the same trials also revealed no fracture protection with estrogens."(4)

  From the *CGs:* "A well-designed, recent study has supported prior work on the association of hormone replacement therapy (HRT) with an increased risk of breast

cancer. While estrogen alone increases risk, the combination of estrogen and progesterone appears to increase the risk even further." (5)

- Anti-Resorptive Drugs: These drugs serve as a protective coating for the bones and prevent disintegration. The typical price of these drugs ranges from $10 to $500 per month.

- Selective Estrogen Receptor Modulators: These are used as an alternative to estrogen replacement. The typical price ranges from $73 to $214 for a one month supply.

The impact of this mandate on the total cost of care is unknown because of the uncertainty regarding the appropriate use and the side effects of the treatment. If the medication truly increases the risk of cancer, both economic and social costs could increase. Whether or not these costs would be financially offset by the benefits of the treatment is currently unclear.

The extent to which mandating coverage for these drugs would impact their appropriate use in aggregate is highly dependent on the degree to which the benefits are already covered. Generally, insurance plans do provide coverage for these drugs, except where they are available on an "over the counter" basis. A survey of the top carriers in the state would help to ascertain the extent of existing coverage in North Dakota. Also, since most of these drugs are relatively inexpensive, insureds are more likely to be paying for them out-of-pocket than they might be for a more expensive drug. In that case, insuring them may not significantly increase their use.

We expect that even if this benefit was not previously covered, the mandate would have a relatively small impact on premium. This is due to the low cost and the low utilization of the drugs by the insured population. We prefer not to quantify this impact without additional research, which we would probably be able to complete within another week if you would like us to.

Contraceptives

According to the Milliman *Health Cost Guidelines (HCGs)*, oral contraceptives (the most common type of prescription contraceptives) make up about 4% of prescription drug costs, when covered. This is about 0.5% of total claim costs for a comprehensive major medical plan before cost sharing. The HCGs also indicate that, in a typical commercially insured population with coverage for contraceptives, there are 459 prescriptions filled for oral contraceptives per year per 1,000 insureds.

According to the *CGs*, the price for prescription oral contraceptives ranges from $33 to $45 per month. The typical price of Norplant, a single dose alternative which protects against pregnancy for up to five years, is slightly over $500 per dose.

The impact the mandate would have on appropriate use is a point of debate. Some sources say that because of the cost of contraceptives, some people either go without contraception or use less effective (but also less expensive) forms of contraception. Others contend that

the majority of those who would use contraceptives currently have access to them, and they would use them regardless of whether or not they are covered. In a report prepared by Milliman for the State of Texas, we estimated that 25% to 75% of gross healthcare costs for oral contraceptives will be recovered through reduced pregnancy and delivery costs. (6) These estimates may be somewhat different if adjusted to reflect the North Dakota population, although we did not have time to do this for this analysis.

Infertility

According to the CDC, 3% of women have ever used ovulation drugs, the most common form of treatment for infertility. Based on research we performed in developing our Milliman *Health Cost Guidelines*, the per member per month cost of infertility drugs and supplies ranges from $0.22 to $0.45. This would equate to less than 0.25% of premium for a comprehensive major medical plan covering a typical commercial population.

Of course, fertility treatment would presumably lead to an increase in other costs related to pregnancy and childbirth. We could probably quantify this increase given additional time.

Bill No. 1349 – Colorectal Cancer Screening

This bill mandates coverage for prostate-specific antigen (PSA) testing and for colorectal cancer screening. PSA testing is currently a mandate in North Dakota, and our analysis of this benefit appears in our report dated September 18, 2002.

This bill adds coverage for colorectal cancer screening and requires carriers to cover the cost of screenings for individuals who are fifty years of age or more who do not have personal or family history risk factors, and for individuals who are less than fifty years of age if they have personal or family history risk factors. This screening may include a fecal occult blood test, flexible sigmoidoscopy, double contrast barium enema, colonoscopy, or other procedure as determined appropriate by a medical provider.

The American Cancer Society estimates that in North Dakota there will be 300 new cases of colon and rectal cancer and 100 deaths due to these cancers in 2003. (7) The Agency for Healthcare Research and Quality of the US Department of Health and Human Services reports that colorectal cancer is the 4th most common cancer in the US and the 2nd leading cause of cancer death.

The American Cancer Society recommends the following screening schedule for men and women beginning at age 50:

- Annual fecal occult blood test and flexible sigmoidoscopy every five years, or
- A double-contrast barium enema every five years, or
- A colonoscopy every 10 years.

Therefore, we expect that this benefit would be used by a significant portion of the population.

According to information from the Centers for Disease Control and Prevention (CDC), the following costs are a typical range of rates for colorectal cancer screening tests.

- Flexible occult blood test (FOBT) - $10-$25
- Flexible Sigmoidoscopy - $150-$300
- Double contrast barium enema - $250-$500
- Colonoscopy - $800-$1,600 (8)

You should also be aware that there are potentially more expensive procedures that may be used for these screenings, such as nuclear magnetic resonance, although this is uncommon and not currently recommended by the CDC.

We estimated that this mandate might increase insurance premiums in the range of 0.1% to 0.3%, where coverage is not currently provided. In calculating this estimate, we used the mandate pricing model we developed last year for North Dakota, along with some relatively conservative assumptions regarding the compliance with the recommendations outlined above. In particular, we assumed that each year: (1) 25 percent of adults between the ages of 50 – 65 received a FOBT and (2) either 10% received a sigmoidoscopy or 5% received a colonoscopy. We have not included the cost of any office visits or other services that may be incurred along with the actual colorectal screening test. This compares to our estimates of 0.1% for PSA testing (including an office visit) and 0.5% for mammography testing in our September 2002 report.

The actual increase will depend on a number of factors, including the demographics of the covered population, out of pocket costs (such as deductibles, coinsurance, and copays), and the degree of compliance with screening recommendations. Also, costs may be higher the first year the mandate is in place, since many insureds may be behind schedule and may be incented to undergo screening after it becomes an insured benefit.

There could also be offsetting benefits related to the early detection and treatment of colorectal cancer. The state of Pennsylvania recently considered a similar mandate and issued a report in which the American Cancer Society is cited as reporting offsetting benefits. In particular, they report that a precancerous polyp can be removed during screening for about $1,100. They go on to say that if that polyp goes undetected and develops into stage four colorectal cancer, treatment costs can reach up to $58,000. They also stated that "the initial cost of treating rectal cancer that is detected early is about $5,700. This is approximately 75% less than the estimated $30,000 - $40,000 that it costs to initially treat rectal cancer that is detected further in its development." (9)

On the other hand, the FOBT is reported to have a significant rate of false positives, which would introduce added follow up costs. The follow up test is typically a colonoscopy. We are not able to quantify this cost without additional research.

Additional expenses to insureds may include health insurance cost sharing and time taken off work to go to the exam. On the other hand, insureds may realize some savings in disability and life insurance costs over the long run, if morbidity and mortality costs decline due to these screenings.

❖❖❖

This letter contains estimates of future experience, based on the assumptions described here. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. If actual experience is different from the assumptions used in the calculations, the actual amounts will also deviate from the projected amounts.

John, I hope this letter is helpful to you as you consider these bills. If you have questions regarding this letter, or would like us to do additional analysis, please feel free to contact me at (952) 820-2481 or leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim

Leigh M. Wachenheim, FSA, MAAA
Principal

cc: Jim Poolman, Insurance Commissioner

Bibliography:

(1) Milliman Care Guidelines 8th Edition. Ambulatory Care. Milliman USA, Inc, 8th Edition
(2) *Findings of the Pennsylvania Health Care Cost Containment Council: Mandated Benefits Review of Senate Bill 1057*. The Pennsylvania Health Care Cost Containment Council, 1998
(3) Milliman Care Guidelines 8th Edition. Ambulatory Care. Milliman USA, Inc, 8th Edition
(4) Milliman Care Guidelines 8th Edition. Ambulatory Care. Milliman USA, Inc, 8th Edition
(5) Milliman Care Guidelines 8th Edition. Ambulatory Care. Milliman USA, Inc, 8th Edition
(6) Susan K. Albee, FSA; Esther Blount, FSA; Mulloy G. Hansen, MD; Tim D. Lee, FSA; Mark Litow, FSA; Mike Sturm, FSA. "Cost Impact Study of Mandated Benefits in Texas." Milliman USA. September 28, 2000
(7) "Estimated New Cancer Cases by Site and State, US, 2003". *Cancer Facts and Figures 2003*. American Cancer Society. pp. 5-6
(8) "Colorectal Cancer: Health Professionals Facts on Screening". Center for Disease Control and Prevention. Pub #099-6487. July 2000
(9) *Mandated Benefits Review by the Pennsylvania Health Care Cost Containment Council: Senate Bill 636: Colorectal Cancer Screening Mandate*, The Pennsylvania Health Care Cost Containment Council, 2002

HB
Test: 1303

from 2003 session

FISCAL NOTE

Requested by Legislative Council
02/10/2003

Amendment to: HB 1247

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$364,000	$810,500	$364,000	$810,000
Appropriations			$364,000	$337,000	$364,000	$337,500

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
			$149,000	$74,000	$93,000	$149,000	$74,000	$93,000

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The outpatient prescription drugs for hormone replacement therapy and for osteoporosis treatment and management are already covered by the NDPERS benefit, so would not have an added cost to NDPERS. The additional cost to NDPERS to cover outpatient prescription drugs for contraceptives and for infertility therapy through their regular drug benefit is estimated at $3.60 per contract per month (spread over all contracts) for the 7-03/6-05 biennium. The infertility drugs are covered under the current benefit, but this assumes that the infertility drugs would be processed under the drug benefit rather than the infertility benefit and they would no longer accumulate toward the $20,000 lifetime infertility maximum.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Expenditures refect the additional premium of $3.60 that would be necessary for the 13,584 state contracts to pay the cost of this additional benefit.
The cost for political subdivisions is for those entities that participate in the PERS health plan. Shown above is the cost for counties, school districts and cities. Also thier are 385 additional governmental units in PERS and the additional cost to them for the upcoming biennium is $33,264. The above estimates are based upon 24 months of coverage.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The appropriated amount reflects the actual additional appropriation that will be necessary for state contracts (8,107).

The 5,477 higher education contracts are covered as part of their continuing appropriation.

Name:	Sparb Collins	**Agency:**	Public Employees Retirement System
Phone Number:	328-3901	**Date Prepared:**	02/10/2003

TESTIMONY OF SPARB COLLINS
ON HB 1247

Madame Chair, members of the committee good morning, my name is Sparb Collins and I am with the Public Employees Retirement System (PERS). I appear before you today neither in favor nor opposed to HB 1247, but rather to discuss with you the effect the provisions of this bill will have on the PERS health plan and to request an amendment.

HB 1247 requires that certain benefits be added to the PERS health plan. Of the provisions required PERS already covers outpatient prescription drugs for hormone replacement therapy and for osteoporosis treatment. Infertility drugs are also covered under the current plan as well. However the requirement relating to covering contraceptives and for infertility therapy are not presently covered and would have a cost to the PERS plan. Since this would require that we renegotiate our plan design with BCBS we asked them to provide us with the additional cost of adding these provisions. They have indicated that our premium would need to go up $3.60 to pay for these benefit enhancements. Since this is not anticipated in the proposed premium recommended by the Governor and presently being considered by the legislature I have attached a proposed amendment to this bill to pay the cost of the enhancements. If this bill was to pass and the premium would not be increased then the PERS Board would have to increase member's deductibles and co insurance to offset the cost of the enhancement. Under the alternate plan design that is presently being considered where the deductible for state employees in the PPO plan may already be increasing to a $250 across the board deductible if we had to add to that the cost of this bill it could increase that amount by approximately $50.

Madame Chair, members of the committee I would request that the attached amendment be added to the bill and be a part of its consideration. Thank you for providing me this opportunity.

from 2003

PROPOSED AMENDMENT TO HOUSE BILL 1247

Page 1, line 4, remove "and"

Page 1, line 4, after "application" add "; and to provide an appropriation"

from 2003

Page 2, after line 4, insert the following:

SECTION 4. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from other funds derived from federal funds and other income, to the following departments for the purpose of defraying the cost of the additional health insurance premiums necessary to pay the cost of the provisions of this bill, for the biennium beginning July 1, 2003, and ending June 30, 2005, as follows:

	General	Other
Office of the Governor	$1,468.80	$0.00
Office of the Secretary of State	$2,073.60	$0.00
Office of Management and Budget	$7,163.52	$3,031.68
Information Technology Department	$3,143.03	$16,642.57
Office of the State Auditor	$2,809.83	$1,337.37
Office of the State Treasurer	$518.40	$0.00
Office of the Attorney General	$8,978.41	$2,944.79
Office of the Sate Tax Commissioner	$10,627.20	$0.00
Office of Administrative Hearings	$0.00	$432.00
Legislative Assembly	$10,713.60	$0.00
Legislative Council	$3,110.40	$0.00
Judicial Branch	$28,049.47	$30.53
Retirement and Investment Office	$0.00	$1,296.00
Public Employees Retirement System	$0.00	$2,246.40
Department of Public Instruction	$2,202.54	$4,882.26
North Dakota University System	$1,432.45	$122.75
State Land Department	$0.00	$1,468.80
Forest Service	$1,555.20	$0.00
State Library	$2,160.00	$0.00
School for the Deaf	$4,472.15	$107.05
School for the Blind	$0.00	$2,419.20
State Board for Vocational and Technical Ed	$1,300.19	$687.01
North Dakota Department of Health	$7,879.88	$16,916.92
Veterans Home	$8,121.60	$0.00
Indian Affairs Commission	$259.20	$0.00
Department of Veterans Affairs	$486.83	$31.57
Childrens Services Coordinating Committee	$0.00	$86.40
Department of Human Services	$133,196.31	$45,997.29
Protection and Advocacy Project	$1,389.31	$684.29
Job Service North Dakota	$6.38	$30,838.42
Office of the Insurance Commissioner	$0.00	$3,283.20
Industrial Commission	$4,406.01	$432.39
Office of the Labor Commissioner	$599.04	$178.56
Public Service Commission	$3,122.06	$333.94
Aeronautics Commission	$0.00	$432.00
Department of Financial Institutions	$0.00	$1,814.40
Office of the Securities Commissioner	$691.20	$0.00

purview of Section 54-03-28; the chairman sets aside the bill for committee discussion when the committee meets on the following Monday.

3. On Monday, February 3, the committee discusses the bill and votes to request a cost-benefit analysis; this request is immediately taken to the Legislative Council office.
4. By Tuesday, February 4, the Legislative Council staff refers the request for a cost-benefit analysis to the entity under contract to provide the cost-benefit analysis.
5. On Thursday, February 6, Senate Rule 329 would need to be suspended if the bill would otherwise be rereferred to the Senate Appropriations Committee, because the committee cannot take "action" on the bill and rerefer it to the Appropriations Committee (the deadline for rereferral of bills to the Appropriations Committee is the 23rd legislative day--February 6).
6. By Wednesday, February 12, the chairman must schedule the bill for hearing.
7. By Tuesday, February 18 (the 31st legislative day), the bill must be reported out of committee.

Under this scenario, the actuary has 12 calendar days to prepare and deliver the cost-benefit analysis to the committee--assuming the actuary receives the request on midday on Tuesday, February 4, and returns the cost-benefit analysis midday on Monday, February 17, for a hearing on the 18th, on which day the bill must be reported out of committee.

Possible Legislative Rule

The timeframe described in the preceding section illustrates the limited time available for requesting, preparing, and receiving a cost-benefit analysis, as well as for scheduling a hearing on the measure, if the analysis is not requested until the committee has reviewed the bill. Presumably, a hearing would not be held until after the cost-benefit analysis is received. This time factor may be addressed during the 2003 session through a joint legislative rule to establish a procedure similar to that for measures requiring fiscal notes. The rule could provide that every measure mandating health insurance coverage of services or payment for specified providers of services must have a cost-benefit analysis attached. Every committee to which such a measure would be referred would be deemed to have requested a cost-benefit analysis on the measures that the Legislative Council staff determine should have cost-benefit analyses. If the cost-benefit analysis has not been provided by the Legislative Council, the committee, acting through the chairman, could determine whether a legislative measure mandates coverage and then request a cost-benefit analysis. This would at least allow additional time for preparation of the cost-benefit analysis because the initial request to the entity preparing the analysis would be when the measure is prefiled or is introduced. This procedure would require the Legislative Council staff to review all measures introduced to determine which ones would appear to mandate health insurance benefits, and this procedure would require expertise in an area in which the staff has not previously had experience. The proposed joint rule could read:

> **HEALTH COVERAGE MANDATE ANALYSIS.** The committee to which a measure mandating health insurance coverage of services or payment for specified providers of services will be referred upon introduction is deemed to have requested preparation of a cost-benefit analysis as determined by the Legislative Council. The committee, through the chairman, to which a bill has been referred shall determine whether a cost-benefit analysis is to be prepared for a bill not having a cost-benefit analysis provided by the Legislative Council. The committee, through the chairman, shall determine whether a cost-benefit analysis must be prepared for an amendment mandating health insurance coverage of services. The committee shall determine whether the cost-benefit analysis must be prepared before final action on the amendment by the committee, before consideration of the amendment on sixth order, or before second reading of the amended bill. If the cost-benefit analysis is not prepared before final action on the amendment by the committee, the Secretary of the Senate or the Chief Clerk of the House, whichever the case may be, shall read the analysis at the time of consideration of the amendment or the reading of the title of the bill to be voted on.

Possible Statutory Change

The procedure for determining actuarial impact on the workers' compensation fund appears to have worked well since 1995. The Workers Compensation Bureau has the expertise to know which measures affect workers' compensation, to determine which measures could have an actuarial impact on the workers' compensation fund, to contract with its actuary to provide actuarial services, and to provide the actuarial report on measures that would have an actuarial impact on the workers' compensation fund.

Section 54-03-28 could be amended to provide a similar procedure, except that the Insurance

Commissioner would appear to be the appropriate official with expertise over health insurance issues. A proposed amendment is:

54-03-28. Health insurance mandated coverage of services - Cost-benefit analysis requirement.

1. ~~A~~ The insurance commissioner shall review any legislative measure mandating health insurance coverage of services or payment for specified providers of services may not be acted on by any committee of the legislative assembly unless the measure is to determine whether the measure should be accompanied by a cost-benefit analysis ~~provided by~~ the legislative council. Factors to consider in this analysis include:

a. The extent to which the proposed mandate would increase or decrease the cost of the service.

b. The extent to which the proposed mandate would increase the appropriate use of the service.

c. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds.

d. The impact of the proposed mandate on the total cost of health care.

2. A majority of the members of the committee, acting through the chairman, has sole authority to determine whether a legislative measure mandates coverage of services under this section.

~~3. Any~~ The commissioner shall review any amendment made during a legislative session to a measure which mandates health insurance coverage of services ~~may~~ not be acted on by a committee of the legislative assembly unless the amendment ~~is~~ to determine whether the amendment should be accompanied by a cost-benefit analysis provided by the legislative ~~council~~ that includes the considerations listed in subsection 1.

3. If the commissioner determines that a measure or an amendment should be accompanied by a cost-benefit analysis, the commissioner shall submit, before the measure or amendment is acted upon, the cost-benefit analysis to the appropriate legislative committee.

4. The legislative council commissioner shall contract with a private entity, ~~after~~ receiving one or more recommendations from the insurance commissioner, to provide the cost-benefit analysis required by this section. The insurance commissioner shall pay the cost of the contracted services to the entity providing the services.

SUMMARY AND CONCLUSION

Section 54-03-28 places the burden of determining which bills mandate health insurance coverage on standing committees and chairmen of those committees. Under current rules and deadlines during legislative sessions, there may not be sufficient time for preparation of appropriate cost-benefit analyses.

A legislative rule could be adopted creating a procedure similar to the current joint rule requiring fiscal notes. A disadvantage to that procedure is that it would require the Legislative Council staff to review all measures to identify which ones appear to mandate health insurance coverage, and that procedure would require expertise in an area in which the staff has not previously had experience.

Another option would be to enact legislation amending Section 54-03-28 to establish a procedure similar to that followed under current law on bills affecting workers' compensation legislation. Under this option, the Insurance Commissioner would be required to determine which measures mandate health insurance coverage. However, if the option of changing the law is selected, procedures will be required during the 2003 legislative session to handle this subject until the bill amending Section 54-03-28 is enacted.