17.0790.01000

FISCAL NOTE

Requested by Legislative Council
01/17/2017

Bill/Resolution No.: HB 1406

1 A. **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.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$130,000	$0	$731,472	$0	$688,139
Appropriations	$0	$0	$0	$428,139	$0	$428,139

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

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill would require the PERS Health plan to go out for a full bid every 2 years instead of 6 years. The first contract would be January 2018. NDPERS would need additional support in the bid process every 2 years and contingency authority for staffing in case the plan became self-insured.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of the bill creates the fiscal impact. Pursuant to NDCC if the plan goes to bid the request for proposal (RFP) is for a bundled (Medical & Rx) and unbundled fully insured proposal and self-insured proposal. Consequently PERS bids the plan for actives, retirees and Part-D plan services. Pursuant to statute PERS may only select a self-insured proposal if it is lower cost that a fully insured plan.

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.*

N/A

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 are associated with consulting services to assist with the preparation, distribution, analysis, actuarial and other work efforts associated with a full bid process identified in the NDCC. Last time PERS used an actuarial/ technical consultant and Pharmacy consultant. The cost for the actuarial/technical consultant was about $200,000 and the pharmacy consultant approximately $60,000. This cost is for a complex bid review. A less complex review could cost less.

PERS would request contingent appropriation authority and 2 FTE so a self-funded plan could be fully considered. PERS has included this in its budget request for the last full bid and the renewal in case the plan moved from fully insured to self insured. Requested dollars needed for this is $428,139 per biennium.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The appropriations are not included in the executive budget. PERS would request contingent appropriation authority and 2 FTE so a self-funded plan could be fully considered. PERS has included this in its budget request for the last full bid and the renewal in case the plan moved from fully insured to self-insured. Requested dollars needed for this is $428,139 per biennium.

Name: Bryan Reinhardt

Agency: NDPERS

Telephone: 701-328-3919

Date Prepared: 01/23/2017

2017 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1406

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1406
1/25/2017
27372

☐ Subcommittee
☐ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee uniform group health insurance benefits.

Minutes: Attachment 1, 2, 3, 4, 5

Chairman Keiser: Opens the hearing of HB 1406. Rep Carlson will present for both bills because they are interrelated.

Rep Carlson~District 41-Fargo:

Attachment 1~Summary of HB 1406.
Attachment 2~Sheet of the cost.
Attachment 3~The health plan & a summary of his testimony.

9:30

The governor has asked for a 5% co-pay of the premium cost from each & every employee, including us, which is about $60 a month. We didn't have much to say about the whole big picture but we are the bad guys that is going to say that we are making you pay 5%. This is the year we should be self-insured. Continues on attachment 3. The purpose of HB 1406 is to change that date & makes it subject to our appropriations. We appropriate the money, then they have to go & live within it.

We should have introduced a bill to be self-insured. With the large volume of dollars that we are spending, as some point in time, continue to do that because we are the largest in the state in terms of value. This information is in your budget book.

13:00

Rep Boschee: If the change goes into effect, currently the health insurance premiums philosophy is a plan designs form to the budget. So this would change that the budget would form the plan design, theoretically, correct?

Rep Carlson: It would also require some communication between the two sides. We see this when everyone else see it in the governor's budget & we have no involvement in the process. Reads the PERS board composition.

14:42

Rep Laning: I'm assuming the changes you are proposing will get us out of any grandfathering in the affordable care act?

Rep Carlson: Every plan changes that was put in place falls within the guidelines to keep our grandfather status.

Vice Chairman Sukut: The legislature, we would come up with an appropriation dollar amount that they would have to stay within when they put the bid out. Can you give me an idea how we would come up with that number?

Rep Carlson: There is an employee' standing committee that meets all during the interim. Logically, that would be the place this would be funneled through. They could end up with making the same recommendation but the point is that we appropriate. But if they didn't, we have the authority like we do on every other budget to adjust it.

Rep Kasper: The process of the renewable of the health insurance plan under this bill, when will the final decision be made with the plan & cost if this bill were enacted?

Rep Carlson: It would have to be completed as to what that design would be, so we would have some parameters for funding by the time we leave at the end of our session.

Rep Kasper: The final decision of the plan design, would be made during the legislative session.

Rep Carlson: The dollars would be decided but the plan would still fall through PERS. They may have to adjust the plan to fit the numbers. My point is in what point in time do we have control of $21 million?

Chairman Keiser: Other than amending a bill, there are no bills in this session, we will be paying 100% of the premium, which is in statue.

Rep Carlson: You are absolutely correct. Unless someone brings an amendment, there will not be any changes for the 5% co-pay.

Chairman Keiser: Anyone here to testify in opposition HB 1406.

Sparb Collins~Executive Director of the ND Public Employees Retirement System (NDPERS): Attachment 4.

Rep Boschee: The change in this design, would it increase claims in the final (inaudible)?

Collins: It's not so much the claims in the design, it the claims in moving the bidding period. Because of trends, costs go up month by month & year over year, here were budgeting for two years. Our 1st year is cheaper than our 2nd year, etc.

Rep Kasper: I understand the trend but that would be only a onetime event, which would be the first 6 months. You are supposing the trend would be there but you don't know for a fact. Once the 6 months' period is over, then everything is back to being the same as far as trend & costs. Correct?

Collins: Yes.

Rep Lefor: Last legislation, we asked you hold off until we had an opportunity to address what you are doing. When I look at these issues, there is miscommunication, we deal with the dollars & that is what frustrates us. Do you or your board bear any responsibility of where we are today?

Collins: With changing this period, there will be a change in that process. We came up last fall the estimated cost for the existing plan design. The PERS board provide those numbers to you & the governor so you can make the decisions that you want to make. This time we gave those numbers to the governor. The governor looks at this & said that it's not the PERS board decision to use these reserve & make benefit reductions.

We have given this information to the executive budget office, they have looked at that information & they have given to you, what they think their recommendations should be going in terms of that 10.5.

Rep Lefor: But it's our job to spend the dollars & we have no say in that what so ever. In my opinion, no effort by the PERS board to the legislature in terms of working through this process. We have no say in the increase, that is what is frustrating & that is what you need to take back to your board.

Collins: We think you do.

Rep Kasper: I heard that you talk about your actuary & they give you a guess of what it will cost for next 2 years. Then the board decided to renew with the proposal with Sanford. It's substantially high, why did the board decide to take the guess of the actuary instead of going to the market & getting some competitive bids to see what the market could give as far as costs for the next 2 years?

Collins: It was pasted in the last special session, the process we showed you for renewal. There are 6 steps.

Rep Kasper: The board has the option to ask for bids. Why did they choose not to?

Collins: One of the steps in that piece of legislation is that the board should take a look & judge a reasonable renewal based upon information it received from its actuary. We sent a report by email to legislature last September & Sen Dever sent a whole renewable report to the legislature.

The board asked Deloitte to take projections at 3 different levels. Talks about the different levels.

Rep Kasper: Everything you said was all guesses & the only way to find out what the market is going to offer & that is if you have competitive bids. That's the frustration we have. Why do you continue to use the guesses of an actuary as opposed to what the market has to bear?

Collins: We are following what is provided in statute & use the best information we can.

Rep Kasper: It's not better than the market.

Rep Louser: I don't know anywhere, even the governor, who has the authority to spend without the legislature. In this case it looks like PERS board have ability to approve spending before it's appropriated. Doe the PERS board recognize that?

Collins: No, we are giving you a proposed premium. You are going to make the decision in the next couple of months whether that's the premium in there.

Rep Louser: That's a function of timing & we are not a full time legislature.

Collins: We would do that right now. If you give us an 8.55% increase, we would make the change. It's up to you what to give us & that drives the plan size. That's the same thing you would be telling us months out front. Now, with the 2 together, you tell us what it is & we will tell you the plan size is.

Rep Kasper: You mentions the loss of grandfather status would cost of 3%. Can you provide the back of data?

Collins: The actuary can.

Collins: Continues with his testimony.

42:30

Rep Kasper: Aren't your concerns covered finally in the appropriations process where they determine how much money is appropriated where for the various plans you just mentioned?

Collins: The state appropriates their dollars to us. Those plans come from other sources.

Rep Kasper: Some of those would not have any impact on appropriations?

Collins: No, but it seems that this bill implies that we are limited to spending, we may not be able to spend those.

Rep Kasper: There is an easy fix?

Collins: Unintended but an easy fix.

Rep Louser: I can't get my head around the idea that the PERS board can spend money, that even the governor can't. If a contract is signed & then it falls on the legislature to fund that the contract. We could breach the contract if we choose not to take money out of reserves.

Collins: The contract that we have in place is with the carrier. One of the things that is always left open in that contract is what the actual plan design may be, you can adjust the plan higher or lower in terms of cost. The only thing that the contract argues is that we have already establish that relationship with that carrier to carry that contract forward.

We cannot legally obligate your spending.

Chairman Keiser: This is frustrating, the entire rational for going to Sanford was that we would have competition in the market place. Then we don't want completion in the market place for 6 year & you make the argument that could in less aggressive bids going forward.

We don't know, it is clear that the premium rate increase was 17.4% for the premium & that was over a 2-year period. In the interim, my understanding that Sanford has lost about 60 million to the PERS program to date. Obviously there either was a problem in understanding the plan or an issue of underwriting the risk.

My question is if they need 17.4% to basically cover the half of what the loss was to the breakeven point. Going to the market would have been a great idea.

We can improve the communication between the board. When we send a letter to the board says "may we talk to you?" & then they denied that. Then they voted for the plan, that's not the kind of relationship that you were suggesting.

How many members voted to rebid?

Collins: None. The renewal decision was a unanimous decision of the board but I'll verify that with the board.

Chairman Keiser: You indicated that there may be concerns with section 18 of article one, relating to impairment of contracts. Do you have any suggestions to correct that if this bill passes?

Collins: That's a legal concern & would have to have legal counsel to answer that?

Chairman Keiser: Your next point was; this proposal would add 6 months of high claims after the end of the projection period. Those projections would be known by any bidderer or current contract holder. Is that not correct, we would have that information?

Collins: What we shared here would be known now, yes.

Chairman Keiser: The board recommended, I guess that we have to approve it through the rates we have, that you use a signification portion of the reserves to reduce the transfers of the cost to the state. Did the transfer of that reserve, was there any discussion at the board level that pretty much eliminate the possibility of self-insuring & ND is the only state that is not self-insured.

When we took out that big chunk of reserve, that would have been pretty close to the concept of self-insuring?

Collins: It's the governor's recommendation to use the reserves.

Chairman Keiser: Did the board support it?

Collins: The board didn't take a position.

Chairman Keiser: The board didn't object, they didn't have you go talk to the governor, don't do this?

Collins: We provide options in the executive budget process. We are not an executive agency under the governor. The only way we can balance that out is to do benefit cuts is to go to reserves to keep the same plan. What we are trying to do now is get all of that upfront so that you talk not only the increase but plan design you want.

Those are not our recommendations, it's the governor's recommendations & we are waiting for you to tell us what to do.

Rep Beadle: When we look at the open bids & sought out competition on the market. In the past, had the actuarial projections in terms of what the costs will be going forward, were they fairly accurate with how the bids were coming back or have the bids from existing provider, is now rebidding, tended to be higher, lower or right on what the projections were?

Collins: When we do a renewal, we know, that is a locked in rate, there is no variance. When we do bids, then we have to estimate because the bids come in until January of the session. So we have to provide the governor an estimate. Then we go to market, we get the bid back & the bid is higher, we have to come back to it.

Rep Beadle: So you are saying, from here going forward, you can't tell us what is going to happen. 90% of what we are doing from here is shooting from the hip & hope it works. In the past when it has happened, where did it fall based on the projections where everyone thought they would come in versus where it came in at.

Collins: We've been pretty ok.

Rep Beadle: The renewal versus market, so based on history our actuarial projections have always been pretty much lock step where the market is?

Collins: I didn't mean it that way. What I meant to say, every time we had to do a projection of what a bid might turn out to be when we go to market, they have been generally within that. We never get the opportunity to check the market, so I can't tell you.

Rep Beadle: If you knew what the renewal fix cost was & now you go to market, how does that compare what the renewal fix cost was in actuarial projections. How accurate do the actuarial end up being as we are making the projection & have they been proven to predict where the market is at.

Chairman Keiser: It's almost unanswerable if you renew it because you don't have anything from the market.

Rep Kasper: The data, those are the actual claims & cost, is that correct?

Collins: Yes

Rep Kasper: That data had to be complied from someplace to give to insurance company to do their bidding.

Collins: Yes, our history.

Rep Kasper: So it's actual claims history that they are compiling for you.

Collins: They want to know what our history is.

Chairman Keiser: Is there anyone else here to testify in opposition to HB 1406?

Lisa Carlson~ Senior Marketing of Sanford Plan: Attachment 5.

1:10

Rep Kasper: You indicated, a fully insured plan, going to a 2 year bid compare to a 6 year bid, would stifle competition & increase pricing. I under the impression that the PERS board could bid a fully insured plan every 2 years & that you don't have a 6-year contract in place. Therefore, you are at risk every 2 years or not?

Carlson: You are correct. We have a 6-year contract, with a 2-year renewal. There is an assumption built in at the initial bid that we will be able to retain it because we are competent in our service & performance level. You are correct.

Rep Kasper: Provider contracting, do you already have those provider contracts in place & it's standard practice that every year the insurance company negotiating the providers for renewal? You are going to be negotiating provider contracts anyway?

Carlson: Yes, PERS has a unique PPO plan design versus the basic plan. Providers in the PPO plan must be maintained & is unique to the PERS. Any new bidder would have to actually replicate something.

Rep Kasper: Isn't the fact, in our market place, there is only 4 or 5 players in ND?

Carlson: The state will attract more bidders if it were self-funded.

Chairman Keiser: You made an interesting point, the information available to providers that had the contract for 16 years, they have 16 years' worth of information, but bidders can only get the last 2 years, they are at a distinct disadvantage. That would make the argument that it should be bid every 2 years so that we make it a level playing field for all bidders? Is that true?

Carlson: The conviction & motivation to be aggressive in a bid, is going to be tied the period of which in the fully insured environment would have to either hit the mark or miss the mark. If you miss the mark, you may never recover again. It can set the tone that you want to create an environment that welcomes competition.

Rep Kasper: The claims experience date, if I request 3 years' experience, I can get that from prior carrier & that's really immaterial because things have changed so much.

Carlson: I can't speak to that.

Jack McDonald~Behalf of America's Health Insurance Plans-AHIP: Attachment 6.

Rep Kasper: How many other members that do AHIP?

McDonald: Medica & United.

Chairman Keiser: The first bill is just a budgeting & timing & the second is to limit or not limit the contract to a 2-year period. One of my frustrations is the bidding process for the state, we have complicated bids for the state, maybe they should be put on a 6-year cycle because it takes so much work to do one.

McDonald: Health care is unique & has more variables.

Chairman Keiser: Without the law of large numbers, in making estimates, there isn't much risk, we have actuaries that can make projections, what makes health different?

McDonald: I can't answer with any specificity health care faces but more variables.

Rep Kasper: With the changes in the market place, wouldn't that be an argument for having shorter contract periods?

McDonald: Yes, you could say that, at the same time, there is a benefit to plan out.

Chairman Keiser: Is there anyone else here to testify in the opposition, neutral position?

Chairman Keiser: Closes the hearing on HB 1406.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1406
1/25/2017
27398

☐ Subcommittee
☐ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee uniform group health insurance benefits.

Minutes:

Chairman Keiser: Reopens the hearing of HB 1406. This bill is the changing of the time table & making the appropriations apply to the new contract.

Rep Laning: Rep Kasper had a good point. Six months, after listening to testimony, sounds like it really short but the 2 ½ year would be a very doable thing.

Chairman Keiser: This does have an emergency clause on it but it does require a change in the time table.

Rep Kasper: Moves a Do Pass rereferal to Appropriations.

Vice Chairman Sukut: Second.

Chairman Keiser: Further discussion?

Rep Kasper: I do a lot of group insurance. There are ways for the insurance company to get creative. It gives time for the funding.

Chairman Keiser: The motion with be with a rereferal to appropriations.

Rep Kasper: We are dealing, right now, after the fact, but they don't have the power to appropriate dollars. It's the Legislative responsibility, this gets us back to doing the function that we were elected to do.

Roll call was taken on HB 1406 for a Do Pass & rereferal to Appropriations with 11 yes, 2 no, 1 absent & Vice Chairman Sukut is the carrier.

Date: Jan 25, 2017

Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1406

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description:

Recommendation

☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐

Motion Made By Rep Kasper **Seconded By** Rep Sukut

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	X		Rep Laning	X	
Vice Chairman Sukut	X		Rep Lefor	X	
Rep Beadle		X	Rep Louser	X	
Rep R Becker	Ab		Rep O'Brien		X
Rep Bosch	X		Rep Ruby	X	
Rep C Johnson	X		Rep Boschee	X	
Rep Kasper	X		Rep Dobervich	X	

Total (Yes) 11 No 2

Absent 1

Floor Assignment Rep Sukut

REPORT OF STANDING COMMITTEE

HB 1406: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (11 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). HB 1406 was rereferred to the **Appropriations Committee**.

2017 HOUSE APPROPRIATIONS

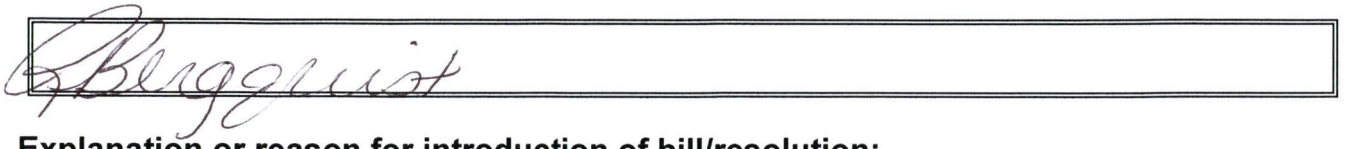
HB 1406

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1406
2/8/2017
28067

☐ Subcommittee
☐ Conference Committee



Explanation or reason for introduction of bill/resolution:

Relating to public employee uniform group health insurance benefits; to provide for application; and to declare an emergency.

Minutes:

Representative Keiser: This is a PERS insurance bill. Relatively simple bill, simply states that the contract negotiated by the PERS Board would be consistent with the appropriation an acted in the most recent legislative session and that the term of the contract is January 1st of even numbered years. The additional feature is that it would be a two-year contract and then would be rebid. Reason for this, you're all facing it right now, has the contract for the coming biennium been signed? It has not been signed, however it has been approved in concept, they sat down with Sanford, current health insurance, and they negotiated the deals. It's as the point now that you are building into the budgets the projected cost of the contract. We felt that we needed to offset that time period of the contracts being bid to give the legislature the opportunity to address the funding rather than react to it and plug it into you budget and work around it. Beginning on January 1 of even years is when the contract would begin, about 12 months after we approved the budget. The most recent legislation would drive the contract in the next two-year period instead of the contract guiding the appropriation.

5:20 It was testified that it would be too difficult, too costly, that the insurance companies would not benefit from the opportunity of the managed care provisions that we have consistently had in our contract. Two years ago, the boards where excited that we finally have some competition, Blue Cross and Blue Shield and Sanford Health, both bidding. The contract is a two-year contract with 2 two-year renewal options. The board has the authority to go in and negotiate a contract, sign the contract, it is our understanding that the board has not yet but will be doing it at the next meeting.

They are going to sign the contract despite the fact that they said they wanted competition, they agreed with the argument but said it would limit the providers. BC&BS has expressed an interest in bidding. We heard the argument that Sanford Health has worked really hard this first two years in managing the health care, a managed care system, and therefor sometimes when you manage a system you really don't see the benefits for two maybe three years. That is correct but then we could argue that BC&BS could have made that very same

argument two years ago. Managed care could help some and it won't help others but we now have two providers that have both benefited from the same system. If we renew this current contract Sanford Health has also had a really significate benefit of the all the work the BC&BS. We have a reserve that has been built up, about 35 million dollars, the current bid that is about to be signed transfers about 18 million into the fund to reduce the premium. That money was created by that previous provider. So with the argument that it's too hard to bed every two years, then we should have never changed because BC&BS worked really hard to build up this surplus that could be used for the buy down.

The argument was made that doing every two years is too difficult, did any of you see that bid from two years ago? I could have cut and pasted it from the last twenty RFPs that have been put out. Many companies bid the insurance every year, large or small.

They are putting the legislature back in control of the money. The plan would have a full bid every two years instead of six. It isn't a six-year contract, it's a two-year contract with the option of two two-year renewals. I really don't agree with the numbers on this fiscal note, there might be some differential. I think if this was the law they would set the system up so the bid could occur reasonably. It's not a simple thing to switch but it should not be a barrier to competitive bidding within our state for our health plan. Committee did a Do pass 11-2-1

11:45 Chairman Delzer: What is the timing on the bids? Was there any discussion? I think that's out almost a year as well.

Representative Keiser: There wasn't a lot of time other than to say, if this new time table went into effect they would have to initiate all the same activities at the previous time period that they were using.

Chairman Delzer: Do you see the legislature having any kind of a bid in front of it or do you see them coming up with a dollar figure and then tell them to try to fit it?

Representative Keiser: This would go into effect January 1 of 2018.

Representative Boehning: How long does it take to get a bid back?

Representative Keiser: Companies do this all the time, insurance companies do this all the time, it's takes about two weeks but I have a small company.

Representative Boehning: How do you work with the money or the plans? Do you say this is what we are going to spend?

Representative Keiser: We decide which plan we want, there is a discussion between what is affordable and what we want out of the plan, so our employees have kind of a range that they know they have to operate it. In all honesty, our plan hasn't significantly changed over the years.

15:25 Representative Brabandt: The previous provider, did they sign two year contracts?

Representative Keiser: It was the same as it is now, two years with two two-year renewals

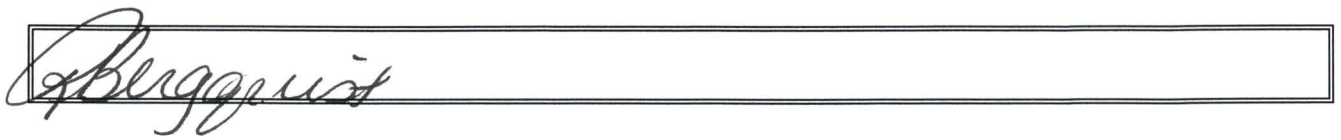
Chairman Delzer: We will close this hearing

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1406 B
2/9/2017
28172

☐ Subcommittee
☐ Conference Committee



Explanation or reason for introduction of bill/resolution:

Relating to public employee uniform group health insurance benefits; to provide for application; and to declare an emergency.

Minutes:

Recording 28172 Starting 18:00

Chairman Delzer: We dealt with these two bill yesterday, they deal with PERS, came out of committee 11-2 Do Pass. HB 1406 is the one that say the two year forced bid for PERS health insurance. What are your wishes?

Representative Streyle: Motion to Do Pass

Representative Schatz: Seconded the motion

Chairman Delzer: frankly I think it should be bid every two years, when you had Representative Keiser up here, he talked about how quick and how often they do theirs. I think most business do that, I'm a little disappointed that we didn't do it this year. I know two or three schools in my district that stayed with the Blues when we switched and they have gone up very little.

Representative Vigesaa: I absolutely agree this should go forward, when you take half the reserve fund and you raise the deductibles when you raise the co-pay and I can almost bet that if there had been a bid that would not have happened.

A Roll Call vote was taken. Yea: 17 Nay: 0 Absent: 4

Motion passed Representative Sukut will carry the bill

Date: 2/9/2017
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1406

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Representative Streyle Seconded By Representative Schatz

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X				
Representative Kempenich	X		Representative Streyle	X	
Representative: Boehning	X		Representative Vigesaa	X	
Representative: Brabandt	X				
Representative Brandenburg	X				
Representative Kading	X		Representative Boe	X	
Representative Kreidt	A		Representative Delmore	A	
Representative Martinson	X		Representative Holman	X	
Representative Meier	A				
Representative Monson	X				
Representative Nathe	X				
Representative J. Nelson	X				
Representative Pollert	X				
Representative Sanford	X				
Representative Schatz	X				
Representative Schmidt	A				

Total (Yes) 17 No 0

Absent 4

Floor Assignment Representative Sukut

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

REPORT OF STANDING COMMITTEE

HB 1406: Appropriations Committee (Rep. Delzer, Chairman) recommends **DO PASS** (17 YEAS, 0 NAYS, 4 ABSENT AND NOT VOTING). HB 1406 was placed on the Eleventh order on the calendar.

2017 SENATE GOVERNMENT AND VETERANS AFFAIRS

HB 1406

2017 SENATE STANDING COMMITTEE MINUTES

Government and Veterans Affairs Committee
Sheyenne River Room, State Capitol

HB 1406
3/2/2017
Job Number 28609

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee uniform group health insurance benefits; to provide for application; and to declare an emergency.

Minutes:

Attachments: 1-3

Chairman Poolman: Opened the hearing on HB 1406.

Representative Carlson, District 41: See Attachment #1 for information provided to the committee. Gave the history of the PERS board. There is a contract ready to be renewed for the health insurance that requires a $21 million increase from general fund dollars, and we have basically no input on that other than the two people that are on the board that are outnumbered 9 to 2. Neither one of those people are on the appropriations committee. You are encumbering us to something that we have to do without any input in it. We do not do any other budget this way in the system. We have to be able to fit the money into what we have available for appropriations. This allows the contract to be done on Jan 1 of even years. The logic to that is that it allows us to appropriate the money before the contract is signed. It is important to get this right for the future of how our legislature handles the health care plan. It does not change anyone's health care plan. It just tells us how to make a change. Some do not like the two-year time frame. They think it will eliminate competition because no one will bid. It is a six-year contract with two year options to renew. We need the capability to look at the contract before it is signed. This is not about BCBSND versus Sanford. This is a fight about how legislators manage the money that we take from our tax payers and provide benefits to our employees. It does not say they are any more or less valuable. This time, in order to keep the raise down, they had to take $18 million out of our reserves to keep the premium so that we can afford the $21 million. We took years to build the reserves. That was money that was given back to us when our claims were less than our premiums. Those reserves were built by the prior carrier. It was $36 million in reserves. We are taking $16 million to $18 million out just to hold the premium down which would have been much higher if we would have not done that. We had nothing to say about the spending of the reserves. The board determined that in order to make this affordable, they would have to spend that amount from the reserves. This is all about the time line.

(7:15) Senator Bekkedahl: As I understand, Subsection 2 of Section1, would mean that if the appropriation level was not sufficient to cover the current standard of benefits that is there now, there would have to be a look at a change to the benefits program to come into the budget number you are talking about. Is that correct?

Representative Carlson: That could happen, yes. By the way, we have the same plan the public employees have, so we are not picking on the public employees. Governor Burgum asked for two things and we have not done either one. The first one was to pass the provider tax to fund the shortfall on our providers for nursing homes, and instead we decided to backfill that with general fund dollars. The second this was that there should be a 5% copay or participation by each and every public employee towards their premium. Which is about $11 million that would have been saved had we done that. The Senate does not want to do that at this time, and the House did not want to send budgets over that were different so we did not do it either. One of the major reasons to save legislative days is to react to the changes that could be made to the Affordable Care Act. These bills do not affect our ACA, grandfather, but they do say you have to bid after we appropriate instead of before we appropriate. It does not say we cannot sign contract; it just says the timeline has to be different. (Lists some changes that were made by the board.) There are additional changes that were made that will cost the state and the employee more this year and we were not made aware of that until we got here. It is our job to appropriate money and pass policy so we need to be aware. I have trouble with turning that over as a legislator to someone else. It is what we are elected to do. In this case, I believe we have designated that money too far away from us. Others will tell you this is too complicated and can't be done, but I think competition is a good thing. With the Affordable Care Act potentially changing I think there will be more bidders in the market place.

Chairman Poolman: So the short version of the answer to his question is that we are already cutting benefits?

Representative Carlson: Yes, that was already determined in the plan designed that went out for bid. That was not done by us, it was done by a board.

Chairman Poolman: If we enact this bill and we change it to 2 years, the issue that continues to come up is that we are in the middle of a six-year contract and that puts us in breach of contract. What is your response to that argument – that you can't change the game in the middle of a six-year contract?

Representative Carlson: You can because we have the option of 2 year renewals. We do not have to exercise that option. We can not take that option. The rates are not locked in for those six years. You should have the opportunity to seek other bids to make sure that is a fair competitive bid. After many conversations with the Governor, he will always revert back to the 80/20 plan that he had at Great Plains. He thinks we should do something different and that is why we started with 5%. I am not asking for anyone to pay more and I am not promoting that because they are already paying more because of the plan changes, but we are not re-bidding the plan changes. We are just changing them.

(14:37) Representative Kasper, District 46: Testified in favor of HB 1406. I am in the insurance business, and have been there for 25 years. I understand all sides of the issue. I

do self-funded insurance plans, and I do fully insured health insurance plans. I understand the market and I understand how the insurance companies do their business. I understand how the employer has concerns. I understand what is and isn't the truth on how the market works. With my private clients, and I do not have any public clients, if we have a group of 100 or more employees, we will re-bid that group for their health insurance at least every two years, and in many cases every year. The competition is good and it is the obligation of the employer and mine as a consultant to find the best pricing that we can for that business. You may hear after I am done from those against the bill that this is difficult and onerous on the insurance companies and that they really don't want to bid every year because it is too costly and time consuming. It is not true. When a plan goes out to bid, the first thing that we do as brokers is we get the information from the current insurance company that is in place and we provide it to the bidding companies. We give the plan documents to them to show them what plan they need to duplicate or come up with a better plan etc. It is done easily behind the scenes. I have looked at the fiscal note and I have talked with Sparb about this. The fact that PERS indicates that you would have to hire a consultant for over $400,000 to analyze the bids is preposterous. That is a number that I can't imagine why we would pay anywhere near those dollars because the numbers speak for themselves. The insurance companies and their people who are providing the proposals can be there to answer any technical questions about their plans and how they adjudicate claims for the benefit of the board who makes the decision. The current method of how PERS operates is to hire a consultant for an RFP from the bidders. You don't have to have an RFP. It is the plan document. You already have it. You don't need to duplicate it and pay $400,000 for that. Then once the bids come in they have to be given to the consultant to analyze; thereby having to pay them for their consultant fees. The recommendation that they would give is the numbers. The premium determines the effectiveness of the new proposal. The process that PERS has been using all these years is expensive and it is preposterous. You can analyze the numbers from each proposal and what you are getting for the amount and decide which one is better. The fact of the matter is that the process is simple. The data that goes behind scenes from an insurance company to all the other insurance companies that are bidding is already there and it is done every day. There is no need to analyze that. I think if Obamacare goes away I suspect we will have even more competition. We are just asking for the two year bid because it is just the best thing for the people of North Dakota. The taxpayers and the employees covered under the plan. I believe we as a legislative body have a fiduciary responsibility because we spend taxpayers' money to try and get absolutely the best plan that we can for our state employees because we pay for it.

(22:30) Sparb Collins, Executive Director, PERS: See Attachment #2 for testimony in opposition to the bill. Made it clear to the committee that the cost could be more with the moving of the six months to the January date.

(34:10) Senator Bekkedahl: You kept talking about the grandfather status, is that a provision under the Affordable Care Act?

Sparb Collins: Yes, the Affordable Care Act it was said that you could keep the plan you had if you liked it. It was grandfathered in. Then you did not have to make the changes that were in the Affordable Care Act. PERS actually runs two plans. The state is not our only client. There are a lot of political subdivisions. The state is about 52% of the membership in our plan. We run a grandfathered and a non-grandfathered plan. In the grandfathered plan,

the question came up as to whether it could be changed, and it was determined that it could be changed slightly but only so much or the grandfathered status would be lost. When we lose that status those things that have to be added in equate to about 3%.

Senator Bekkedahl: It may change depending on what Congress does.

Sparb Collins: Yes, if they repeal the grandfather status, that is gone.

Senator Bekkedahl: Is North Dakota unique among the states, or does everyone kind of do it this way? Mainly I am talking about the six-year contract and the two year revisions to the cycle.

Sparb Collins: That I cannot tell you.

Senator Davison: The impact of moving the biennium is a one-time charge correct?

Sparb Collins: Yes, once we get cycled in it would be there. Your budget is based on a July 1st start date and now this would move it to January creating that initial cost.

Chairman Poolman: Can your office look up what other states do?

Sparb Collins: We can check on that.

(39:00) Lisa Carlson, Senior Director of Market Strategy, Sanford Health Plan: See Attachment #3 for testimony in opposition to the bill.

(55:04) Senator Bekkedahl: In looking at the difficulties of moving around the 68,000 employees and changing contracts, I am hearing that it is disruptive to those covered and that it is not impossible for you to do.

Lisa Carlson: Yes.

Senator Bekkedahl: You talked about the fully insured contract and Sanford Health would lose $3 million and the state could lose $6 million under self-funded; isn't it a case of pay me now or pay me later in either of those cases? I am guessing Sanford Health does not exist to lose money. If it is costing $3 million and we have a two-year adjustment period, isn't there some recapture for Sanford in here? It isn't a not for profit designed to lose money.

Lisa Carlson: Sanford Health Plan is a non-profit taxable entity, however to answer your question, Sanford Health Plan tries very hard to be on target because it upsets our clients when we miss the mark and give them a high increase to try and make up for it. It works against us in the long run because clients will chose to do business elsewhere if they feel those spikes. Every insurance company can say that they have lost clients when that happens. It is not intentional and it is not a game to try and recover it late. The point of us retaining actuaries is because it is such a critical part of hitting the mark. Your ability of being accurate comes down to your clients to being able to trust you. They appreciate, understand, and expect predictability in their premiums. All clients know that premiums go up over the

years. It usually goes down when clients dip into their reserves. Competition is always a driving force in our business.

Chairman Poolman: You talked about the fact that many other states are self-funded rather than fully insured, and then you went on to talk about how disastrous it would be for us if we would be self-funded. There has to be a reason why those other states are choosing to be self-funded, right?

Lisa Carlson: I did not mean to say that it would be a disastrous move. Yes, there is a reason. They are large enough and their assumptions are actuarially meaningful because you have a block that is predictable and you do not have a lot of turnover. Employees tend to keep their jobs with the state. It is a good block for actuaries to build their assumptions off of and project. States are self-funded because it becomes a control. They are paying a TPA a fee to process and pay claims. A lot of times states will wrap around and complement their self-funded by hiring different vendors to care management (Gave examples). They have to build a reserve. All states use their reserves. If you build it up to an amount where it is a reliable source to dip into in order to prevent buying down benefits or cutting benefits. That is great. Some states may do that because they are large enough. It is about control and you have to have the dollars and a mechanism to reserve with responsibility.

Chairman Poolman: So, we are fully insured because we are much smaller?

Lisa Carlson: No, I think that is a question better reserved for Sparb to answer from a historical perspective.

Chairman Poolman: Closed the hearing on HB 1406.

2017 SENATE STANDING COMMITTEE MINUTES

Government and Veterans Affairs Committee
Sheyenne River Room, State Capitol

HB 1406
3/30/2017
Job Number 29824

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee uniform group health insurance benefits; to provide for application; and to declare an emergency.

Minutes: No Attachments

Chairman Poolman: Opened HB 1406 for committee discussion. This bill states that we would have a contract term of only 2 years and that it must begin on January 1st of an even numbered year and that the board may not sign a contract unless the terms of the plan designed are consistent with the appropriation. It certainly brings about contractual complications, because, if you notice at the bottom, the application of this bill will start January 1st of 2018, and we have already renewed our contract. It may not be signed yet, but they have gone through all of the processes to renew that. I suppose it is up for debate. The bill, in that sense, is problematic.

Senator Bekkedahl: The area that I have highlighted is Line 13, Subsection 2, that is basically telling the PERS board that they may not sign a contract unless the plan design is consistent with the appropriation for uniform group and health insurance program benefits coverage enacted by the most recent legislative assembly. I see that as a lot of stuff being written into statue that I do not think we currently need. We have the PERS Board doing this right now.

Senator Bekkedahl: Moved a Do Not Pass.

Senator Meyer: Seconded.

Chairman Poolman: Is there any discussion? I would agree that we have not set up a system to do it this way, and to try to completely transform and reverse that system with one small bill seems pretty difficult.

A Roll Call Vote Was Taken: 6 yeas, 0 nays, 0 absent.

Motion Carried.

Senator Bekkedahl will carry the bill.

Date: 3/3
Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1406

Senate Government and Veterans Affairs Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Bekkedahl Seconded By Meyer

Senators	Yes	No	Senators	Yes	No
Chairman Poolman	✓		Senator Marcellais	✓	
Vice Chairman Davison	✓				
Senator Bekkedahl	✓				
Senator Meyer	✓				
Senator Vedaa	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Bekkedahl

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

REPORT OF STANDING COMMITTEE

HB 1406: Government and Veterans Affairs Committee (Sen. Poolman, Chairman) recommends **DO NOT PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1406 was placed on the Fourteenth order on the calendar.

2017 TESTIMONY

HB 1406

Jan 25, 2017

1

HOUSE BILL NO. 1406 (2017) - SUMMARY

This memorandum provides a summary of 2017 House Bill No. 1406 (attached). The bill creates a new section to North Dakota Century Code Chapter 54-52.1, the law providing for the Public Employees Retirement System (PERS) uniform group insurance program. The PERS health benefits plans are among several types of group insurance plans addressed in this chapter, which includes life insurance plans, dental insurance plans, vision insurance plans, long-term care plans, and employee assistance plans.

The PERS health benefits plans may be provided through a private carrier (Section 54-52.1-04), through a health maintenance organization (Section 54-52.1-04.1), or through a self-insurance plan (Section 54-52.1-04.2). The term of a health benefits plan contract may not exceed 2 years, and there are statutory requirements that need to be followed if the contract is renewed (Section 54-52.1-05). The current PERS health benefits plans are provided through a private carrier, and the 2-year contract corresponds with the state's biennium--July 1 of an odd-numbered year through June 30 of the next odd-numbered year. The following table reflects the contract renewal and bidding schedule PERS follows for health benefits contracts and the schedule that would likely result under the bill:

Current Schedule	Typical PERS Health Benefits Plan Contract Timeline PERS Activities		House Bill No. 1406 Schedule
	Renewal Activities	**Bid Activities**	
May		Prepare request for proposal (RFP)	November
June		Prepare RFP	December
July	Conduct renewal estimate	Prepare RFP	**January***
August	Consider proposed renewal	Prepare RFP	**February***
September	Make renewal decision - If not renewed, go to bid		**March***
October		If goes to bid, issue RFP	**April***
November*		Receive bids	May
December		Review bids	June
January*		Review bids	July
February*		Review bids	August
March*	Sign contract	Make award and sign contract	September
April*			October
May			November
June			December
July	Contract begins	Contract begins	January
***Legislative session**			

House Bill No. 1406 applies to PERS health benefits plans, regardless of type. The changes in law would provide a 2-year health benefits plan contract must begin on January 1 of an even-numbered year, resulting in the plan year beginning the January immediately following the completion of a regular legislative session. Additionally, the bill provides the terms of the health benefits plan must be consistent with the appropriation for the uniform group health insurance program benefits coverage enacted by the most recent Legislative Assembly.

The application clause in the bill would allow for the transition from the current fiscal biennium contract term to the new calendar year contract term. Additionally, the bill includes an emergency clause.

Jan 25, 2017

HB 1406

2

Biennium	Monthly Premium	Percentage Change from Previous Biennium
2001-03	$409	16.9%
2003-05	$489	19.6%
2005-07	$554	13.3%
2007-09	$658	18.8%
2009-11	$826	25.5%
2011-13	$887	7.4%
2013-15	$982	10.7%
2015-17	$1,130	15.1%
2017-19 executive recommendation	$1,249	10.6%

The percentage increase to maintain the existing health insurance plan benefits is 17.4 percent for the 2017-19 biennium. To reduce this percentage increase, the Governor is recommending increasing member out-of-pocket expenses to reduce plan costs by $49.61 per contract, per month, which would reduce the overall increase by 4.4 percent.

The Governor is also recommending using Public Employees Retirement System (PERS) health insurance reserves to pay an additional $27.31 of premiums per contract, per month, which would reduce the overall increase by 2.45 percent. The Governor is using approximately $18.0 million of the estimated $35.0 million in health insurance reserve funds to reduce the premium rate increase. Of the $18.0 million utilized, $10.5 million relates to state employee health insurance plans, $4.4 million relates to political subdivisions, and $3.1 million relates to retiree health plans.

EMPLOYEE ASSISTANCE PROGRAM

The monthly rate for the employee assistance program remains at $1.54 per month, or $18.48 annually.

LIFE INSURANCE

The monthly rate for life insurance provided to state employees remains at $0.28 per month, or $3.36 annually.

UNEMPLOYMENT INSURANCE

Funding is included for unemployment insurance for state employees at a rate of 1 percent of the first $6,000 of an employee's annual salary ($60 per year or $120 per biennium maximum). No unemployment insurance was collected on state employee salaries during the 2013-15 and 2015-17 bienniums.

TOTAL COMPENSATION CHANGES COS

The schedule below provides the total cost of major compensation changes recommended in the 2017-19 executive budget.

	General Fund	Special Funds	Total
Salary increase of 1 percent, effective July 1, 2018	$5,447,422	$6,411,108	$11,858,530
Health insurance premium increases	20,924,659	24,626,376	45,551,035
Total	$26,372,081	$31,037,484	$57,409,565

FULL-TIME EQUIVALENT POSITIONS

The 2017-19 executive budget includes a total of 15,937.69 FTE positions, an increase of 4,100.12 FTE positions from the 2015-17 authorized level of 11,837.57 FTE positions. The total number of FTE positions for the 2017-19 biennium now reflects certain higher education positions that were previously not reflected in the budget.

The 2017-19 executive budget recommended FTE level of 15,937.69 is an overall decrease of 551.56 FTE positions compared to the adjusted 2015-17 biennium total, including a decrease of 315.27 FTE positions in higher education and a decrease of 215.61 FTE positions in all other state agencies.

The reduction of 215.61 FTE positions resulted in a decrease of $29.0 million, of which $15.9 million is from the general fund.

Major changes in FTE positions, excluding higher education, are as follows:

Agency Increases	2015-17 Authorized FTE Positions	2017-19 Executive Budget	Increase
301 - State Department of Health	365.00	381.00	16.00
530 - Department of Corrections and Rehabilitation	836.29	846.29	10.00
475 - Mill and Elevator Association	147.00	153.00	6.00

Agency Decreases	2015-17 Authorized FTE Positions	2017-19 Executive Budget	(Decrease)
380 - Job Service North Dakota	237.76	181.61	(56.15)
180 - Judicial branch	391.00	354.50	(36.50)
640 - Main Research Center	361.12	336.12	(25.00)
405 - Industrial Commission	121.75	105.25	(16.50)
125 - Attorney General	250.00	234.00	(16.00)
630 - North Dakota State University Extension Service	265.98	252.98	(13.00)
627 - Upper Great Plains Transportation Institute	54.98	43.88	(11.10)
628 - Branch research centers	120.29	110.29	(10.00)

2

Jan 25, 2017

3

HB 1406

PERS Health Plan

Summary:

The cost increase to maintain the existing plan of benefits is 17.4%. The executive budget proposes:

1. To fund an increase in employer premiums of $119.25 per month per contract which is a 10.55% increase for two years which would be about 5.3% per year
2. To change the plan design by increasing member out of pocket expenses which reduces plan costs by $49.61 per contract per month and reduces the over all increase by 4.4%
3. To use PERS Health Insurance Reserves to pay the remaining cost of the premium which is $27.31 per contract per month which is equal to approximately 2.45% of premium costs

Estimated Existing PERS Health Reserves:

The estimated balance of the existing PERS health reserves is $35 million. This takes into consideration the following assumptions:

1. Nothing is being retained in-house to cover any ACA fee settlement with Sanford Health Plan, in the event the actual ACA fees are greater that what was projected.
2. The $35 million estimated balance includes the $3 million risk deposit currently held at BCBS. We are expecting that the full $3 million will be returned to PERS in July 2017 when the contract with BCBS is closed out, however, it should be noted that this amount is still at risk until June 30, 2017.
3. The $35 million estimated balance does not include $2.5 million of life insurance reserves.

Executive Budget Plan Design:

Plan design changes	Approximate Potential % savings or (loss)	Effect on Grandfathered status
1. Change Deductible from $400 to $500	.6%	None
2. Increase the single co-insurance maximum for the PPO plan from $750 to $1,000 and for the basic plan from $1,250 to $1,500. Increase the family co-insurance max from $1,500 for the PPO plan to $2,000 and for the Basic plan from $2,500 to $3,000	1.8%	None

3. Increase office call co-payment for the single PPO plan from $25 to $30 and for the basic plan from $30 to $35. Increase the Emergency room co-payment fro $50 to $60.	.9%	None
4. Increase the co-payment for generic Rx from $5 to $10 Increase the co-payment for Brand Rx from $20 to $25 Increase the co-payment for Non-formulary Rx from $25 to $30	1.1%	None
TOTAL	4.4%	

Executive Budget Buydown of State Premiums:

The Executive Budget proposes to buydown state premiums by 2.45% by using PERS health insurance reserves. This amounts to $27.31 per month for each state contract.

$27.31 x 15,938 (budgeted state FTE) x 24 months = **$10,446,403** (estimated state buydown of premiums from PERS health reserves)

Effect on other Plan Members (non state):

To maintain equity with other PERS plan members, if the state uses PERS reserves to buydown premiums, then the same amount should be used to offset other member's premiums. This results in the following estimated buydown for other PERS plan members.

$4.4 million Political Subdivision Buydown

$3.1 million Retiree Buydown

Projected Reserves if Executive Budget Recommendation accepted for state employees and other plan members:

Estimated Health Reserve Balance	$35.0 million
Less Premium Buydown for 17-19 biennium	(18.0) million
Remaining Balance	$17.0 million

Jan 25, 2017

4

TESTIMONY OF NDPERS
HOUSE BILL 1406

Mr. Chairman, members of the committee my name is Sparb Collins. I am the Executive Director of the North Dakota Public Employees Retirement System (NDPERS). I appear before you today on behalf of the PERS Board and in opposition to this bill. House Bill 1406 would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that the term of a uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage (insured or self-insured) may not exceed two years and must begin on January 1st of an even-numbered year. Further, the board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly. I've had the opportunity to review this information with the PERS Board and would like to share with you today some observations. I have also attached a review of this bill conducted by our consultant which will be shared with the Legislative Employee Benefits Committee for its review tomorrow as required in the NDCC.

OVERALL CONCLUSIONS AND OBSERVATIONS

- This bill could have a material impact on the Health Plan resulting in significant reductions in the plan design or requiring additional appropriations if the existing plan design is to be maintained (as funded in the executive budget).
- This bill could affect the willingness of new carriers to bid on the plan and could have the unintentional effect of reducing future competition for the NDPERS plan.
- Having a required two year bid process versus a six year process could result in carriers being less aggressive in the bids knowing that they would face another bid in two years. A six year process may encourage carriers to invest in the relationship by being more aggressive in pricing and other guarantees.
- There may be concerns with Section 18 of Article I of the North Dakota Constitution relating to impairment of contract.
- If the emergency provision is passed, it will require an abbreviated bid process.
- This proposal would add in six months of higher claims after the end of the projection period which are generally more expensive and drop 6 months of claims at the beginning of the projection period which are generally lower cost. Deloitte has projected that this will increase costs about 3.1% based upon current factors which would result in plan design reductions or the need for higher premiums.

- If additional funding is not added to offset the increase noted above, the plan will lose its grandfathered status resulting in about 3% more in premium costs or benefit reductions.

- If the two items noted above occur, this will result in the need for about 6% in benefit cuts which would increase the single deductible to about $1,250 or require an increase in premiums.

- This bill will result in a compressed timeline for the bid and implementation.

- Section 1 item 2 limits the plan to the appropriation passed during the most recent session. If employees pay a part of the premium that is not counted in the appropriation and, therefore, pursuant to this legislation, the plan may need to be cut by 5% to balance as prescribed. Also, if the limitation is interpreted to be a total for the plan, then others such as retirees, political subdivisions and others may be required to leave the plan. Additionally, since use of reserves are not appropriated on a biennium to biennium basis, they may not be available to be used resulting in a 1.65% cost increase to premiums or reductions in plan design.

- Moving the plan to a January start date instead of a July date will mean that it will no longer be coordinated with the budgeting process. Today since it is coordinated, PERS is able to let the Legislature know the exact plan design it is purchasing. Under this bill it would no longer be coordinated so the Legislature would have to make decisions based on estimates. If the estimates do not match the resulting bid, the PERS Board would need to make plan design cuts to balance the plan or the Legislature would need to have a special session to address any shortfall.

- Additional contingent authority should be added in case the plan was to consider going self-insured.

- The effect on membership should be minimal as a result of bidding the plan more often. However, if the result is changes in the carrier every two years, this could have an effect on members since networks, formularies and other items may change even though there may not be any changes in the plan design. During the transfer to Sanford, even though the plan design did not change, some members experienced the above adjustments.

I stand before you today to request that you do not support House Bill 1406.

Mr. Chairman, members of the committee, thank you, and this concludes my testimony. If I can assist you with your considerations, please let me know.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000
Fax: 612 397 4450
www.deloitte.com

Memo

Date: January 24, 2017

To: Senator Krebsbach, Chair
Legislative Employee Benefits Programs Committee

From: Josh Johnson and Jon Herschbach, Deloitte Consulting LLP

Subject: ACTUARIAL REVIEW OF PROPOSED BILL 17.0790.01000 (HB1406) REGARDING THE CONTRACT TERM AND PLAN DESIGN FOR HEALTH BENEFITS COVERAGE

The following summarizes our review of the proposed legislation.

I. OVERVIEW OF PROPOSED BILL

The proposed bill would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that the term of a uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage (insured or self-insured) may not exceed two years and must begin on January 1st of an even-numbered year. Further, the board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly.

II. CURRENT STATE - JULY 1, 2017 PREMIUM AND FUNDING

The PERS board voted to renew with Sanford on a fully insured basis for the biennium beginning July 1, 2017. The rate increase from the biennium ending June 30, 2017 for the uniform group health insurance program was 17.4% assuming no changes to plan design. In order to reduce premiums, Sanford has identified all available plan design changes that would not trigger a loss of grandfathered status under PPACA. These changes reduced the premium increase to 12.2% and are as follows:

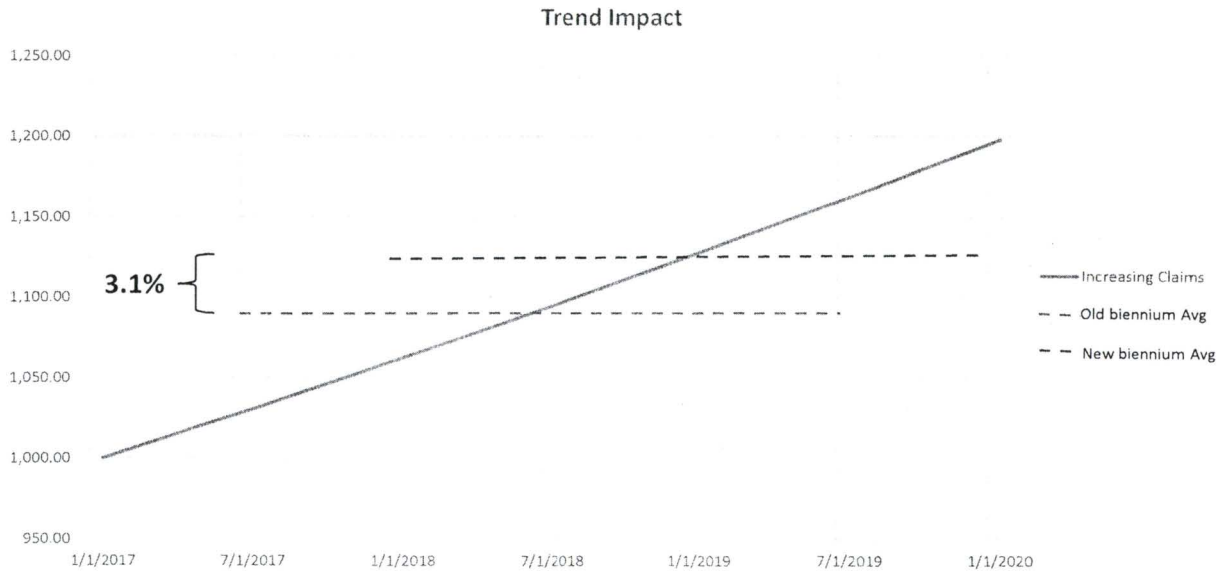
Plan design changes
1. Change Deductible from $400 to $500
2. Increase the single co-insurance maximum for the PPO plan from $750 to $1,000 and for the basic plan from $1,250 to $1,500. Increase the family co-insurance max from $1,500 for the PPO plan to $2,000 and for the Basic plan from $2,500 to $3,000.

3. Increase office call co-payment for the single PPO plan from $25 to $30 and for the basic plan from $30 to $35. Increase the Emergency room co-payment from $50 to $60.
4. Increase the co-payment for generic Rx from $5 to $10 Increase the co-payment for Brand Rx from $20 to $25 Increase the co-payment for Non-formulary Rx from $25 to $30

The governor appropriated funding equal to an increase of 10.55%. The difference between the appropriated funding and the rates quoted by Sanford (including the plan changes above) is 1.65% which is proposed to be paid from the uniform group insurance program's contingency reserves.

III. IMPACT OF MOVING BIENNIUM

Changing the start date of the 2-year coverage period from July 1, 2017 to January 1, 2018 will have a trend impact equal to six months of medical and pharmacy trend. Trend is the rate of increase in health care costs from one period of time to another (month to month; year over year, etc). The trend impact causes an increase in cost when changing from one period of time to another assuming all other variables remain constant. For example the same plan design will cost more next year than it does this year. This is why we generally see health premiums go up year over year. This bill proposes to move the 24 month period forward 6 months. This will result in the first 6 months dropping off (which are generally at the lower end of the trend costs) and adding on 6 months at the end (which are generally at the higher end of the plan costs. The following chart shows the effect:



pg 4

The annual blended medical and pharmacy trend assumption utilized in the most recent NDPERS claims projections conducted by Deloitte was 6.2%. Using this assumption, the expected trend impact of moving the biennium coverage period forward by six months without any other plan changes is 3.1%. Since the bill as proposed does not provide a mechanism for increasing contributions to recognize the increase in premiums, the only option for the board at the time would be to change the plan design. If the impact on premiums was 3.1%, it would require changes to the plan design to offset this increase.

IV. IMPACT OF LOSS OF GRANDFATHERED STATUS

As previously discussed, Sanford has recommended all possible plan design changes that would allow the plan to reduce premium while maintaining grandfathered status effective July 1, 2017. These changes would reduce the actuarial value ("AV") of the plan by 4.4%. Therefore, any additional plan changes made to offset the cost increase caused by moving to a January 1, 2018 biennium would trigger a loss of grandfathered status and introduce various other mandated PPACA coverage provisions. Sanford estimates the expected cost increase of these mandated plan design changes would be 3%. Additional plan design reductions would need to be made to offset the cost increase caused by the mandated plan provisions or premiums would need to be increased.

V. IMPACT ON PLAN DESIGN OR PREMIUMS

The aforementioned plan design changes estimated by Sanford equating to a reduction in AV of 4.4% (maintain grandfathered status 7/1/17) are summarized as follows:

PPO Plan Design Provision	Current	Proposed
Pharmacy Copays: (Generic/Formulary/Non-Formulary)	$5/$20/$25	$10/$25/$30
Pharmacy Coinsurance (after copay)	85%/75%/50%	
Pharmacy Coinsurance Maximum (Per Person)	$1,000	$1,200
Office Visits	$25	$30
Emergency Room	$50	$60
Deductible (Single/Family)	$400/$1,200	$500/$1,500
Medical Coinsurance Maximum (Single/Family)	$750/$1,500	$1,000/$2,000

The reduction in plan design required to offset the trend impact (3.1%) and the loss of grandfathered status (3%) effective January 1, 2018 equals a reduction in AV of approximately 6%.

Sanford modeled several different plan design changes. The design that most closely results in the required reduction would include the changes above plus a further increase in deductible to $1,250 for single contracts.

PPO Plan Design Provision	Proposed 7/1/17	Proposed 1/1/18
Deductible (Single/Family)	$500/$1,000	$1,250/$3,750

If the cost of trend impact and loss of grandfathered status is offset by changing premiums instead of the plan design above, the following additional premium increase and associated costs would be required:

Bill and fiscal impact summary:

A 6% increase in premiums from the State premium reduced for plan design changes ($1268.14) would be an increase of $76.09 per contract per month ($1,344.23).

State fiscal effect:

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$12,103,631	$9,918,065	$4,034,544	$3,306,022
Appropriations	$0	$0	$12,103,631	$9,918,065	$4,034,544	$3,306,022

County, city, school district and township fiscal effect:

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	$0	$3,171,750	$1,057,250
Cities	$0	$2,650,500	$883,500
School Districts	$0	$1,611,000	$537,000
Townships	$0	$0	$0

The uniform group insurance program is also planning to use a portion of its reserves to fund the difference between the total premium level and the appropriated funding level for the coverage period beginning July 1, 2017. This reserve buy-down would be equal to approximately 1.65% of premiums. Under the plan design changes listed above, this reserve buy-down is assumed to be still in effect.

VI. INTERIM PERIOD FROM JULY 1, 2017 TO JANUARY 1, 2018

Moving the start date of the coverage period to January 1, 2018 raises an issue around the interim six month period from July 1, 2017 to December 31, 2017. The current renewal offer from Sanford assumes a 2-year coverage period beginning July 1, 2017. Sanford may require a different premium rate to insure a six month period than was agreed upon for a 2-year period or they may be opposed to insuring the plan for that period at all. Because the budget has already been appropriated and NDPERS was planning to fund a portion of premiums with their contingency reserves, any increase in premiums will impact the associated reserve spend or require a reduction in plan design. The PERS attorney has reviewed this and indicated that if PERS was unable to negotiate

an extension with the existing carrier, it would not be able to consider self-insurance for the interim time period under existing statute unless a full bid process was undertaken. The board would have to start a new bid process upon notification that they could not extend the contract, which likely could not be completed by July 1. The result would be no coverage until a new arrangement could be reached, pursuant to existing statutory requirements.

VII. IMPLICATIONS FOR SELF-INSURANCE IN THE BIDDING PROCESS

One outcome of the proposed bill would be the requirement to conduct an RFP for plan administration or insurance for coverage beginning January 1, 2018. If the RFP results in the decision to self-fund the plan, the statutory requirements under 54-52.1-04.3 state that the board must have a plan to establish contingency reserves equaling 1.5 to 3 months of paid claims within 5 years. Preliminary analysis suggests that self-funded premium rates may need to be increased by 0.5% to 1.5% in order to build reserves to the required level. The high end accounts for the use of contingency reserves to buy down premium. Consequently, it should be noted that this would be an additional consideration in the bidding process.

In the past bid process and renewal, within the budget PERS included authority for two additional staff so that the plan could consider self-insurance. Since PERS did not elect this option, it was taken out during the budget consideration process. Pursuant to this bill, the timeframe change would necessitate that these two additional staff be added back into the budget so PERS can fully consider self-insurance in the bid process.

VIII. OTHER TECHNICAL CONSIDERATIONS

(The following was developed in collaboration with PERS staff)

a. BID TIMEFRAME AND IMPLEMENTATION TIMEFRAME

Implementation timeframe is not required if the existing vendor is selected after this process. However, in planning the timeline we need to assume time to implement if a new vendor is selected. This timeline is about 90 days. Implementation took almost 120 days the last time a new vendor was selected.

Assuming 90 days of implementation, the bidding process needs to be completed by Sept 30th. The review period, including interviews, take 60 to 90 days. This means the due date of the bids would need to be between July 1 and August 1.

From the time the bill is signed, July 1 to August 1 would be the period for bid solicitation. Consequently, the timeline under this bill would create challenges related to the usual timeline for bidding being abbreviated. Specifically, vendors would not be allowed as much time to respond to the RFP and the review period would be shorter. The result is that we may have less vendors interested in responding.

b. IMPLICATION OF APPROPRIATION LIMITATION (Section 1 of the bill #2)

Section 1 of the bill item #2 states:

> *2. The board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly*

This section indicated that any new contract must be equal to the appropriated amount. Consequently:

1. As noted above if the new bids are higher than the amount appropriated, the only alternative will be to adjust plan design. As noted above, this could be significant, resulting in large increases in member out of pocket costs. Other alternatives would be to change the plan design to have more restrictive networks that limit member choices as to who they could see, but could result in better contracting arrangements for the plan, thereby reducing the required changes to plan design.

2. If state members are required to pay a part of the premium, these funds are not appropriated. However, this section requires that the plan design needs to match the appropriated funds. Consequently, the plan design would need to be reduced by at the amount of member premium payment (5% as suggested). The result would be to eliminate the need for the member payments or depending on how that is drafted, a logic loop that could not be met.

3. If this section's intent is that the total state appropriation passed this session limits the total amount the plan can pay for all participants, this could result in removing the following groups since they are not a part of the appropriated budget passed during the session:

    a. political subdivisions

    b. retirees

    c. non-state employees (retired legislators, pre-Medicare retirees, etc.)

4. Federal law requires provisions for COBRA and certain types of leave. These are not a part of the appropriated amounts and, therefore, could create a conflict with those laws since state law may not allow inclusion of those members.

5. This would eliminate the use of PERS reserves since it is not appropriated in the biennial appropriation. This would require cuts in the plan design or an increase in the appropriation of about 1.65%.

c. COORDINATION WITH THE BUDGET PROCESS

Presently (and in the past) the health funding process has been, and is, coordinated with the budget process. For the executive budgeting process, PERS is able to estimate for a bid process, and know for a renewal, the plan design that is being purchased. For the Legislature, PERS was able to specifically identify the plan design being purchased for the quoted premiums. Under this bill the legislature would be giving up the certainty of the plan design, since PERS would not know what could be purchased until the legislature has adjourned. Any variance from estimates would result in changes to plan design for the remaining part of the biennium until the legislature re-adjourned to address the situation at the next scheduled session (or if the nature of plan design change is so unacceptable it required a special session). This is not required in the present contracting process since the legislature is provided all information during the regular session and any necessary action can be taken immediately.

d. SELF FUNDED STAFFING

If the plan was to become self-insured, contingent appropriation authority and FTE (2) should be added to the budget as proposed in the past. Self-insurance would clearly add additional administrative efforts (medical and Rx) and would also substantially increase PERS accountability for the plan. Today, most of our administrative and financial/operational risk is transferred to Sanford Health Plan. However, on a self-insured basis that becomes the Board's responsibility. Therefore, funding would need to be included for additional staffing.

IX. OVERALL CONCLUSIONS AND OBSERVATIONS

- This bill could have a material impact on the Health Plan resulting in significant reductions in the plan design or requiring additional appropriations if the existing plan design is to be maintained (as funded in the executive budget; also see III. – V above).
- This bill could affect the willingness of new carriers to bid on the plan and could have the unintentional effect of reducing future competition for the NDPERS plan.
- Requiring a bid process every two years versus a six year process could result in carriers being less aggressive in the bids knowing that they would face another bid in two years. A six year process may encourage carriers to invest in the relationship by being more aggressive in pricing and other guarantees.
- There may be concerns with Section 18 of Article I of the North Dakota Constitution relating to impairment of contract.
- If the emergency provision is passed it will require an abbreviated bid process (see bid and implementation timelines above VIII.a above).
- The modified fully insured method has allowed NDPERS reserves to be used to buy down premiums in past biennia. If the plan were self-insured, these funds may be required to be maintained as plan contingency reserves in compliance with the

NDCC-54-52.1-04.3 or be reflected as a cost in the analysis process(see VII above).

- Since bids benefit from additional months of claims data in determining the premium, the existing renewal process was modified several years ago to have a February re-projection to take advantage of any improvements due to additional months of actual claims data. If the data shows a need for additional funding the September agreed amount is the maximum. The modified process captures the benefit of a later projection, but eliminates the risk of higher premiums (see III above. (see III above)
- This proposal would add six months of higher claims to the end of the projection period, which are generally more expensive, and drop 6 months of claims at the beginning of the projection period, which are generally lower cost. Deloitte has projected that this will increase costs about 3.1% based upon current factors, which would result in plan design reduction or the need for higher premiums.
- If additional funding is not added to offset the increase noted above, the plan will lose its grandfathered status resulting in about 3% more in premium costs or benefit reductions. (see IV above)
- If the two items noted above occur, this will result in the need for about 6% in benefit cuts which would increase the deductible to about $1,250 (see V above).
- This bill will result in a compressed timeline for the bid and implementation (See VII.a above).
- Section 1, Item 2 limits the plan to the appropriation passed during the most recent session. If employees pay a portion of the premium, which is not counted in the appropriation and, therefore, pursuant to this legislation, the plan may need to be cut by 5% to balance as prescribed. Also, if the limitation is interpreted to be a total for the plan, then others such as retirees, political subdivisions and others may be required to leave the plan. In addition, since use of reserves are not appropriated on a biennium to biennium basis, they may not be available to be used resulting in a 1.65% cost increase to premiums or reduction in plan design. (see VII.b above)
- Moving the plan to a January start date instead of a July start date will cause it to no longer be coordinated with the budgeting process. Since it is currently coordinated, PERS is able to let the legislature know the exact plan design it is purchasing. Under this bill they would no longer be coordinated and the legislature would have to use estimates. If the estimates vary significantly from the resulting bid, the PERS Board would need to make plan design cuts to balance the plan or the Legislature would need to have a special session to address any shortfall. (see VII.c above)

- Additional contingent authority should be added in case the plan was to consider going self-insured (see VII.d).
- The effect on membership should be minimal as a result of bidding the plan more often. However, if the result is changes in the carrier every two years, this could have an effect on members. Networks, formularies and other items may change even without any changes in the plan design. This was seen during the last transfer to Sanford even though the plan design did not change.

5

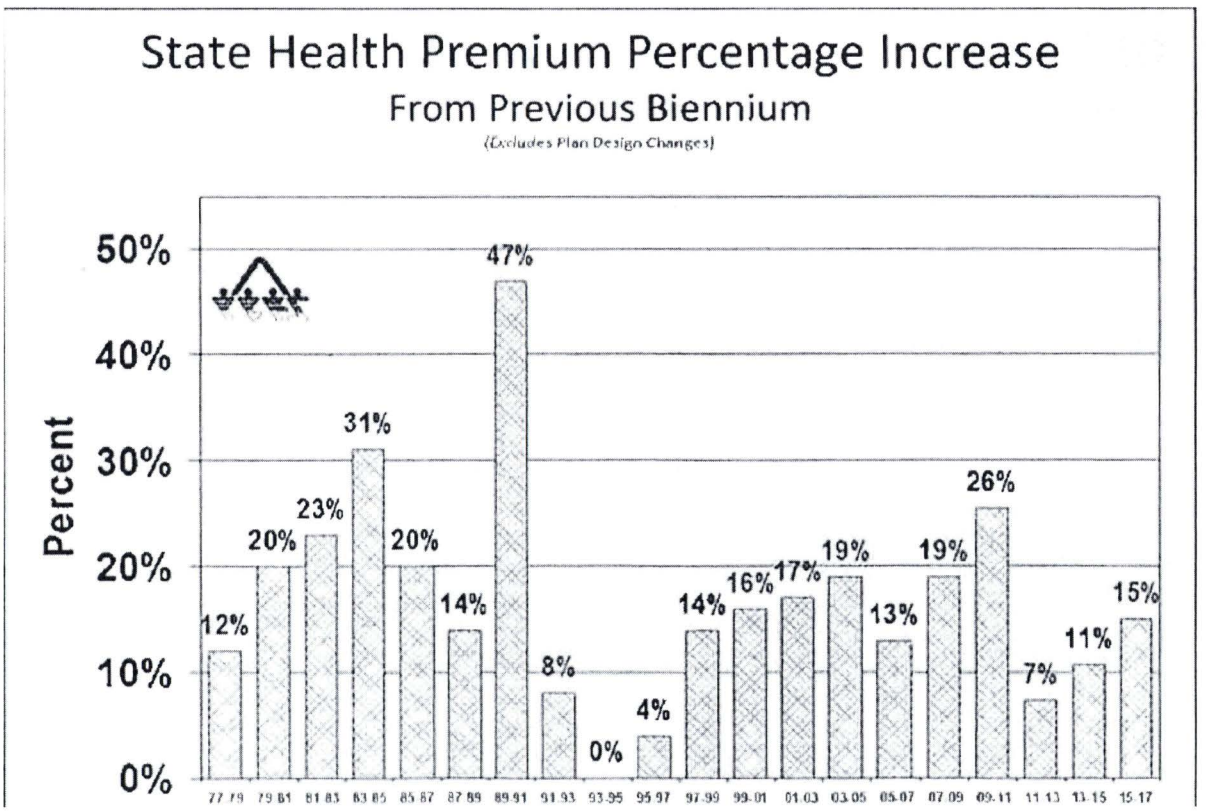
Plan on the best fit.

SANFORD HEALTH PLAN

Industry, Business, and Labor Committee Hearing
Rep. George J. Keiser, Chairman
January 25, 2017

Chairman Keiser, members of the IB&L Committee, I am Lisa Carlson, Senior Director of Market Strategy at Sanford Health Plan. I appear before you to oppose HB 1406 and HB 1407 to shorten the fully-insured contract period from 6 years to 2 years.

The PERS health plan will get a rate increase of 8.7% beginning July 1, 2017 (that's a 17.4% increase over the biennium). As a comparison, over the past 12 years, the PERS' rate increases have averaged 7.3% per year, on average. There has been some discussion that Sanford Health Plan underbid the initial PERS contract, however, our bid was within a mere 5% of the incumbent health carrier's bid. The below grid illustrates prior premium increases.



In the past 20 years, PERS has dipped into reserves 6 times with the incumbent carrier, and for the first time with Sanford Health Plan in the 2017-2019 biennium. The below numbers show the amount per contract (policyholder) that the state used from its reserves. The state was under a fully-insured arrangement during this time period.

Biennium	Amount used from Reserves (per contract)	PERS Carrier
1997-1999	$20.71	Blue Cross Blue Shield
1999-2001	$9.35	Blue Cross Blue Shield
2003-2005	$10.00	Blue Cross Blue Shield
2005-2007	$24.52	Blue Cross Blue Shield
2009-2011	$0.14	Blue Cross Blue Shield
2013-2015	$20.04	Blue Cross Blue Shield
2017-2019	$18.67	Sanford Health Plan

I share this information to frame up a very important conversation about the impact being fully-insured versus self-funded has on the length of the PERS contract. A short 2 year contract period is inconsequential if the contract is self-funded. However, if the contract is fully-insured, the length of the contract period is critical, and a short contract period will adversely affect the State.

Fully-Insured Contract: Today, North Dakota PERS pays Sanford Health Plan on a capitated basis, which means that PERS pays Sanford Health Plan a fixed monthly premium. Because Sanford Health Plan is paid on fixed fee, we are at risk if the health care services cost more than the amount of premiums collected. When PERS uses a fully-insured contract, the state is protected from financial risk (i.e. fluctuations in utilizations, catastrophic claims, etc). For example, Sanford Health Plan's bid may assume we will need $20M per month to pay claims for 68,000 members. If the members use $23M worth of claims that month, Sanford Health Plan is at a loss of $3M dollars.

Self-Funded Contract: Conversely, if the state pursues a self-funded arrangement, the state assumes financial risk. PERS may budget (estimate) that they'll need $300M per year to pay for claims. If claims come in at $310M, the state will need to find $10M to pay those claims. Also, if the legislators' projections/ assumptions to set the budget at $300M per year to pay for claims are off by only 2% on a $300M cost - that equates to $6 million of losses to the state. Because the state assumes financial risk, the longevity of the contract is irrelevant, because the state will have to fund the claims every month, through all the highs and lows.

But because North Dakota bids its contracts as fully-insured, the bidder is compelled to ensure it does not lose money in the short 2 year period it has to manage the risk.

- A contract this large takes a significant investment to onboard and transition 68K employees from one carrier to another. Cases being managed by nurses such as members in the middle of chemotherapy, high risk pregnancies, transplants, etc. all need to be carefully transitioned to the new carrier. It takes time to communicate to members to ensure a smooth transition and not disrupt care. Because PERS is a July 1 contract year, members' deductibles and out-of-pocket amounts also need to be carried over from on carrier to another. These tasks cannot reasonably be done in a couple of months without being disruptive to members.

- A 2 year contract will discourage potential bidders on a fully-insured contract. In order to control costs and not lose money on a fully-insured contract, carriers must do care management. Nationally renowned actuarial firm, Milliman Inc., estimates the value of managed care can be worth up to 10% of costs. Managed care savings manifests itself in the forms of: prior authorizations, discharge management, drug compliance, disease management programs, formulary usage, etc.

- A carrier needs time to influence individuals' health. Nurses may not reduce the Hemoglobin A1c in a diabetic in four months, but may get a patient compliant in 18 months, thus getting the patient off expensive medications and leading a healthier life, using less healthcare services.

- With a short, 2 year, fully-insured contract, competing carriers may not bid, or if they do, they would be less likely to be aggressive in the premium rates when they know the program will go out to bid every 2 years.

- Carriers are more likely to be aggressive in their bid when there is enough time to implement their managed care programs to improve health outcomes.

- If there are no competing bidders, the end result will be a single carrier market for PERS, removing competition and possibly dissuading the single carrier from offering competitive, affordable renewals.

Lastly, if this bill is passed, Sanford Health Plan believes it will unconstitutionally impair Sanford Health Plan's existing contract with PERS.

In summary, Sanford Health Plan supports a market that fosters competition and choice for businesses and consumers. Taking a fully-insured contract that currently has a 6 year term and shortening it to 2 years, will only inhibit competition for the PERS program, ultimately driving up costs in the long run.

Thank you for your time and consideration.

Wednesday, January 25, 2017

HOUSE INDUSTRY, BUSINESS & LABOR COMMITTEE
HB 1406 & 1407

CHAIRMAN KEISER AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP. AHIP is the national trade association representing the health insurance industry.

AHIP members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual and small group insurance markets, and public programs such as Medicare and Medicaid.

AHIP respectfully opposes both HB 1406 and HB 1407.

AHIP members are private insurance businesses competing in the world of private industry. As such, AHIP supports a market that fosters competition and choice for businesses and consumers

The North Dakota Public Employee Retirement System (PERS) insures 68K state employees. A client of this size should attract competitive bids from a healthy insurance market. AHIP believes competitive bidding results in the best product for public entities.

However, a contract that size also takes a significant investment on behalf of carriers to onboard and transition 68K employees from one carrier to another. If the legislature were to take action to force the PERS contract to go out for a public bid every 2 years (instead of every 6), this may discourage potential bidders.

A short, 2 year contract will discourage carriers from bidding, or if they do bid, carriers will be less likely to be aggressive with their bid when they know the contract is limited to 2 years. Carriers are more likely to be aggressive in their bid when there is enough time to invest in the relationship.

If there are no competing bidders, the result will be a single carrier market for PERS, removing competition and possibly dissuading even the single carrier from offering competitive, affordable renewals.

We respectfully request a Do Not Pass on HB 1406 & HB 1407.

Thank you for your time and consideration. I'd be happy to answer any questions.

HOUSE BILL NO. 1406 (2017) - SUMMARY

This memorandum provides a summary of 2017 House Bill No. 1406 (attached). The bill creates a new section to North Dakota Century Code Chapter 54-52.1, the law providing for the Public Employees Retirement System (PERS) uniform group insurance program. The PERS health benefits plans are among several types of group insurance plans addressed in this chapter, which includes life insurance plans, dental insurance plans, vision insurance plans, long-term care plans, and employee assistance plans.

The PERS health benefits plans may be provided through a private carrier (Section 54-52.1-04), through a health maintenance organization (Section 54-52.1-04.1), or through a self-insurance plan (Section 54-52.1-04.2). The term of a health benefits plan contract may not exceed 2 years, and there are statutory requirements that need to be followed if the contract is renewed (Section 54-52.1-05). The current PERS health benefits plans are provided through a private carrier, and the 2-year contract corresponds with the state's biennium--July 1 of an odd-numbered year through June 30 of the next odd-numbered year. The following table reflects the contract renewal and bidding schedule PERS follows for health benefits contracts and the schedule that would likely result under the bill:

Current Schedule	Typical PERS Health Benefits Plan Contract Timeline		House Bill No. 1406 Schedule
	PERS Activities		
	Renewal Activities	Bid Activities	
May		Prepare request for proposal (RFP)	November
June		Prepare RFP	December
July	Conduct renewal estimate	Prepare RFP	**January***
August	Consider proposed renewal	Prepare RFP	**February***
September	Make renewal decision - If not renewed, go to bid		**March***
October		If goes to bid, issue RFP	**April***
November*		Receive bids	May
December		Review bids	June
January*		Review bids	July
February*		Review bids	August
March*	Sign contract	Make award and sign contract	September
April*			October
May			November
June			December
July	Contract begins	Contract begins	January
***Legislative session**			

House Bill No. 1406 applies to PERS health benefits plans, regardless of type. The changes in law would provide a 2-year health benefits plan contract must begin on January 1 of an even-numbered year, resulting in the plan year beginning the January immediately following the completion of a regular legislative session. Additionally, the bill provides the terms of the health benefits plan must be consistent with the appropriation for the uniform group health insurance program benefits coverage enacted by the most recent Legislative Assembly.

The application clause in the bill would allow for the transition from the current fiscal biennium contract term to the new calendar year contract term. Additionally, the bill includes an emergency clause.

HB 1406 3-3-17 #1

HB 1406 3-2-17 #2 pg 1

Senate Government and
Veterans Affairs Committee
HB 1406 Testimony
March 2, 2017
NDPERS

Sheyenne River Room

HB 1406 3-2-17 #2 pg 2

TESTIMONY OF NDPERS
HOUSE BILL 1406

Madame Chair, members of the committee my name is Sparb Collins. I am the Executive Director of the North Dakota Public Employees Retirement System (NDPERS). I appear before you today on behalf of the PERS Board and in opposition to this bill. House Bill 1406 would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that the term of a uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage (insured or self-insured) may not exceed two years and must begin on January 1st of an even-numbered year. Further, the board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly. I've had the opportunity to review this information with the PERS Board and would like to share with you today some observations. I have also attached a review of this bill conducted by our consultant which was shared with the legislative Employee Benefits Programs Committee.

OVERALL CONCLUSIONS AND OBSERVATIONS

- This bill could have a material impact on the Health Plan resulting in significant reductions in the plan design or requiring additional appropriations if the existing plan design is to be maintained (as funded in the executive budget).
- This bill could affect the willingness of new carriers to bid on the plan and could have the unintentional effect of reducing future competition for the NDPERS plan.
- Having a required two year bid process versus a six year process could result in carriers being less aggressive in the bids knowing that they would face another bid in two years. A six year process may encourage carriers to invest in the relationship by being more aggressive in pricing and other guarantees.
- There may be concerns with Section 18 of Article I of the North Dakota Constitution relating to impairment of contract.
- If the emergency provision is passed, it will require an abbreviated bid process.
- This proposal would add in six months of higher claims after the end of the projection period which are generally more expensive and drop 6 months of claims at the beginning of the projection period which are generally lower cost. Deloitte has projected that this will increase costs about 3.1% based upon current factors which would result in plan design reductions or the need for higher premiums.

- If additional funding is not added to offset the increase noted above, the plan will lose its grandfathered status resulting in about 3% more in premium costs or benefit reductions.

- If the two items noted above occur, this will result in the need for about 6% in benefit cuts which would increase the single deductible to about $1,250 or require an increase in premiums.

- This bill will result in a compressed timeline for the bid and implementation.

- Section 1 item 2 limits the plan to the appropriation passed during the most recent session. If employees pay a part of the premium that is not counted in the appropriation and, therefore, pursuant to this legislation, the plan may need to be cut by 5% to balance as prescribed. Also, if the limitation is interpreted to be a total for the plan, then others such as retirees, political subdivisions and others may be required to leave the plan. Additionally, since use of reserves are not appropriated on a biennium to biennium basis, they may not be available to be used resulting in a 1.65% cost increase to premiums or reductions in plan design.

- Moving the plan to a January start date instead of a July date will mean that it will no longer be coordinated with the budgeting process. Today since it is coordinated, PERS is able to let the Legislature know the exact plan design it is purchasing. Under this bill it would no longer be coordinated so the Legislature would have to make decisions based on estimates. If the estimates do not match the resulting bid, the PERS Board would need to make plan design cuts to balance the plan or the Legislature would need to have a special session to address any shortfall.

- Additional contingent authority should be added in case the plan was to consider going self-insured.

- The effect on membership should be minimal as a result of bidding the plan more often. However, if the result is changes in the carrier every two years, this could have an effect on members since networks, formularies and other items may change even though there may not be any changes in the plan design. During the transfer to Sanford, even though the plan design did not change, some members experienced the above adjustments.

I stand before you today to request that you do not support House Bill 1406.

Madame Chair, members of the committee, thank you, and this concludes my testimony. If I can assist you with your considerations, please let me know.

HB 1406 3-2-17 #2 pg 1

Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000
Fax: 612 397 4450
www.deloitte.com

Memo (revised 1/25)

Date: January 24, 2017

To: Senator Krebsbach, Chair
Legislative Employee Benefits Programs Committee

From: Josh Johnson and Jon Herschbach, Deloitte Consulting LLP

Subject: ACTUARIAL REVIEW OF PROPOSED BILL 17.0790.01000 (HB1406) REGARDING THE CONTRACT TERM AND PLAN DESIGN FOR HEALTH BENEFITS COVERAGE

The following summarizes our review of the proposed legislation.

I. OVERVIEW OF PROPOSED BILL

The proposed bill would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that the term of a uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage (insured or self-insured) may not exceed two years and must begin on January 1st of an even-numbered year. Further, the board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly.

II. CURRENT STATE - JULY 1, 2017 PREMIUM AND FUNDING

The PERS board voted to renew with Sanford on a fully insured basis for the biennium beginning July 1, 2017. The rate increase from the biennium ending June 30, 2017 for the uniform group health insurance program was 17.4% assuming no changes to plan design. In order to reduce premiums, Sanford has identified all available plan design changes that would not trigger a loss of grandfathered status under PPACA. These changes reduced the premium increase to 12.2% and are as follows:

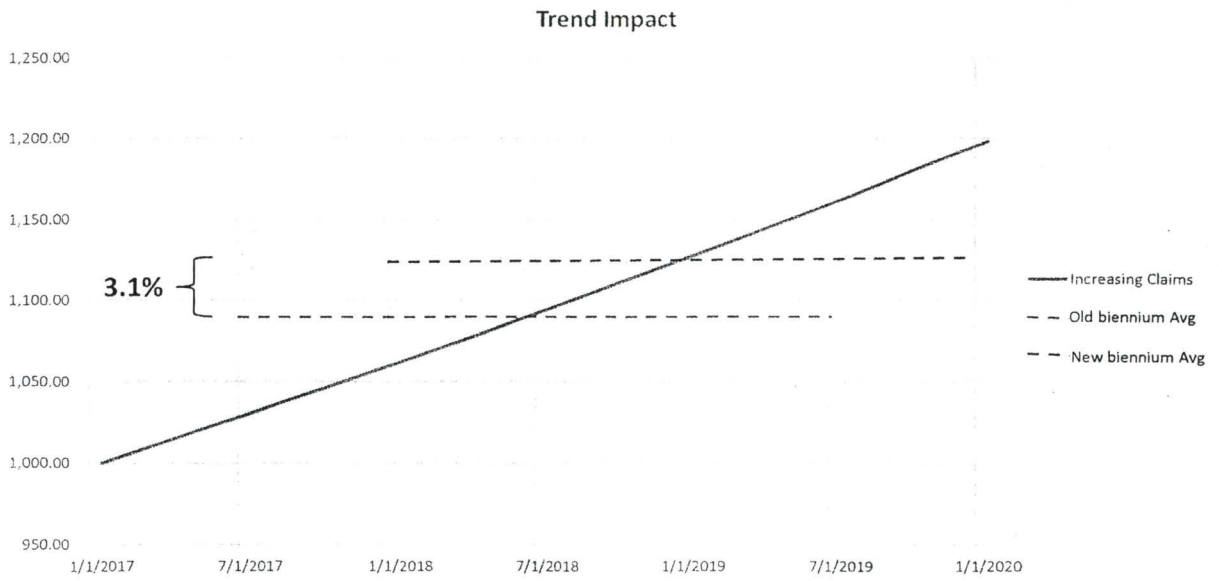
Plan design changes
1. Change Deductible from $400 to $500
2. Increase the single co-insurance maximum for the PPO plan from $750 to $1,000 and for the basic plan from $1,250 to $1,500. Increase the family co-insurance max from $1,500 for the PPO plan to $2,000 and for the Basic plan from $2,500 to $3,000.

3. Increase office call co-payment for the single PPO plan from $25 to $30 and for the basic plan from $30 to $35. Increase the Emergency room co-payment from $50 to $60.
4. Increase the co-payment for generic Rx from $5 to $10 Increase the co-payment for Brand Rx from $20 to $25 Increase the co-payment for Non-formulary Rx from $25 to $30

The governor appropriated funding equal to an increase of 10.55%. The difference between the appropriated funding and the rates quoted by Sanford (including the plan changes above) is 1.65% which is proposed to be paid from the uniform group insurance program's contingency reserves.

III. IMPACT OF MOVING BIENNIUM

Changing the start date of the 2-year coverage period from July 1, 2017 to January 1, 2018 will have a trend impact equal to six months of medical and pharmacy trend. Trend is the rate of increase in health care costs from one period of time to another (month to month; year over year, etc). The trend impact causes an increase in cost when changing from one period of time to another assuming all other variables remain constant. For example the same plan design will cost more next year than it does this year. This is why we generally see health premiums go up year over year. This bill proposes to move the 24 month period forward 6 months. This will result in the first 6 months dropping off (which are generally at the lower end of the trend costs) and adding on 6 months at the end (which are generally at the higher end of the plan costs. The following chart shows the effect:



The annual blended medical and pharmacy trend assumption utilized in the most recent NDPERS claims projections conducted by Deloitte was 6.2%. Using this assumption, the expected trend impact of moving the biennium coverage period forward by six months without any other plan changes is 3.1%. Since the bill as proposed does not provide a mechanism for increasing contributions to recognize the increase in premiums, the only option for the board at the time would be to change the plan design. If the impact on premiums was 3.1%, it would require changes to the plan design to offset this increase.

IV. IMPACT OF LOSS OF GRANDFATHERED STATUS

As previously discussed, Sanford has recommended all possible plan design changes that would allow the plan to reduce premium while maintaining grandfathered status effective July 1, 2017. These changes would reduce the actuarial value ("AV") of the plan by 4.4%. Therefore, any additional plan changes made to offset the cost increase caused by moving to a January 1, 2018 biennium would trigger a loss of grandfathered status and introduce various other mandated PPACA coverage provisions. Sanford estimates the expected cost increase of these mandated plan design changes would be 3%. Additional plan design reductions would need to be made to offset the cost increase caused by the mandated plan provisions or premiums would need to be increased.

V. IMPACT ON PLAN DESIGN OR PREMIUMS

The aforementioned plan design changes estimated by Sanford equating to a reduction in AV of 4.4% (maintain grandfathered status 7/1/17) are summarized as follows:

PPO Plan Design Provision	Current	Proposed
Pharmacy Copays: (Generic/Formulary/Non-Formulary)	$5/$20/$25	$10/$25/$30
Pharmacy Coinsurance (after copay)	85%/75%/50%	
Pharmacy Coinsurance Maximum (Per Person)	$1,000	$1,200
Office Visits	$25	$30
Emergency Room	$50	$60
Deductible (Single/Family)	$400/$1,200	$500/$1,500
Medical Coinsurance Maximum (Single/Family)	$750/$1,500	$1,000/$2,000

The reduction in plan design required to offset the trend impact (3.1%) and the loss of grandfathered status (3%) effective January 1, 2018 equals a reduction in AV of approximately 6%.

Sanford modeled several different plan design changes. The design that most closely results in the required reduction would include the changes above plus a further increase in deductible to $1,250 for single contracts.

PPO Plan Design Provision	Proposed 7/1/17	Proposed 1/1/18
Deductible (Single/Family)	$500/$1,000	$1,250/$3,750

If the cost of trend impact and loss of grandfathered status is offset by changing premiums instead of the plan design above, the following additional premium increase and associated costs would be required:

Bill and fiscal impact summary:

A 6% increase in premiums from the State premium reduced for plan design changes ($1268.14) would be an increase of $76.09 per contract per month ($1,344.23).

State fiscal effect:

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$12,103,631	$9,918,065	$4,034,544	$3,306,022
Appropriations	$0	$0	$12,103,631	$9,918,065	$4,034,544	$3,306,022

County, city, school district and township fiscal effect:

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	$0	$3,171,750	$1,057,250
Cities	$0	$2,650,500	$883,500
School Districts	$0	$1,611,000	$537,000
Townships	$0	$0	$0

The uniform group insurance program is also planning to use a portion of its reserves to fund the difference between the total premium level and the appropriated funding level for the coverage period beginning July 1, 2017. This reserve buy-down would be equal to approximately 1.65% of premiums. Under the plan design changes listed above, this reserve buy-down is assumed to be still in effect.

VI. INTERIM PERIOD FROM JULY 1, 2017 TO JANUARY 1, 2018

Moving the start date of the coverage period to January 1, 2018 raises an issue around the interim six month period from July 1, 2017 to December 31, 2017. The current renewal offer from Sanford assumes a 2-year coverage period beginning July 1, 2017. Sanford may require a different premium rate to insure a six month period than was agreed upon for a 2-year period or they may be opposed to insuring the plan for that period at all. Because the budget has already been appropriated and NDPERS was planning to fund a portion of premiums with their contingency reserves, any increase in premiums will impact the associated reserve spend or require a reduction in plan design. The PERS attorney has reviewed this and indicated that if PERS was unable to negotiate

an extension with the existing carrier, it would not be able to consider self-insurance for the interim time period under existing statute unless a full bid process was undertaken. The board would have to start a new bid process upon notification that they could not extend the contract, which likely could not be completed by July 1. The result would be no coverage until a new arrangement could be reached, pursuant to existing statutory requirements.

VII. IMPLICATIONS FOR SELF-INSURANCE IN THE BIDDING PROCESS

One outcome of the proposed bill would be the requirement to conduct an RFP for plan administration or insurance for coverage beginning January 1, 2018. If the RFP results in the decision to self-fund the plan, the statutory requirements under 54-52.1-04.3 state that the board must have a plan to establish contingency reserves equaling 1.5 to 3 months of paid claims within 5 years. Preliminary analysis suggests that self-funded premium rates may need to be increased by 0.5% to 1.5% in order to build reserves to the required level. The high end accounts for the use of contingency reserves to buy down premium. Consequently, it should be noted that this would be an additional consideration in the bidding process.

In the past bid process and renewal, within the budget PERS included authority for two additional staff so that the plan could consider self-insurance. Since PERS did not elect this option, it was taken out during the budget consideration process. Pursuant to this bill, the timeframe change would necessitate that these two additional staff be added back into the budget so PERS can fully consider self-insurance in the bid process.

VIII. OTHER TECHNICAL CONSIDERATIONS

(The following was developed in collaboration with PERS staff)

a. BID TIMEFRAME AND IMPLEMENTATION TIMEFRAME

Implementation timeframe is not required if the existing vendor is selected after this process. However, in planning the timeline we need to assume time to implement if a new vendor is selected. This timeline is about 90 days. Implementation took almost 120 days the last time a new vendor was selected.

Assuming 90 days of implementation, the bidding process needs to be completed by Sept 30th. The review period, including interviews, take 60 to 90 days. This means the due date of the bids would need to be between July 1 and August 1.

From the time the bill is signed, July 1 to August 1 would be the period for bid solicitation. Consequently, the timeline under this bill would create challenges related to the usual timeline for bidding being abbreviated. Specifically, vendors would not be allowed as much time to respond to the RFP and the review period would be shorter. The result is that we may have less vendors interested in responding.

b. IMPLICATION OF APPROPRIATION LIMITATION (Section 1 of the bill #2)

Section 1 of the bill item #2 states:

> *2. The board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly*

This section indicated that any new contract must be equal to the appropriated amount. Consequently:

1. As noted above if the new bids are higher than the amount appropriated, the only alternative will be to adjust plan design. As noted above, this could be significant, resulting in large increases in member out of pocket costs. Other alternatives would be to change the plan design to have more restrictive networks that limit member choices as to who they could see, but could result in better contracting arrangements for the plan, thereby reducing the required changes to plan design.

2. If state members are required to pay a part of the premium, these funds are not appropriated. However, this section requires that the plan design needs to match the appropriated funds. Consequently, the plan design would need to be reduced by the amount of member premium payment (5% as suggested). The result would be to eliminate the need for the member payments or depending on how that is drafted, a logic loop that could not be met.

3. If this section's intent is that the total state appropriation passed this session limits the total amount the plan can pay for all participants, this could result in removing the following groups since they are not a part of the appropriated budget passed during the session:

    a. political subdivisions

    b. retirees

    c. non-state employees (retired legislators, pre-Medicare retirees, etc.)

4. Federal law requires provisions for COBRA and certain types of leave. These are not a part of the appropriated amounts and, therefore, could create a conflict with those laws since state law may not allow inclusion of those members.

5. This would eliminate the use of PERS reserves since it is not appropriated in the biennial appropriation. This would require cuts in the plan design or an increase in the appropriation of about 1.65%.

c. COORDINATION WITH THE BUDGET PROCESS

Presently (and in the past) the health funding process has been, and is, coordinated with the budget process. For the executive budgeting process, PERS is able to estimate for a bid process, and know for a renewal, the plan design that is being purchased. For the Legislature, PERS was able to specifically identify the plan design being purchased for the quoted premiums. Under this bill the legislature would be giving up the certainty of the plan design, since PERS would not know what could be purchased until the legislature has adjourned. Any variance from estimates would result in changes to plan design for the remaining part of the biennium until the legislature re-adjourned to address the situation at the next scheduled session (or if the nature of plan design change is so unacceptable it required a special session). This is not required in the present contracting process since the legislature is provided all information during the regular session and any necessary action can be taken immediately.

d. SELF FUNDED STAFFING

If the plan was to become self-insured, contingent appropriation authority and FTE (2) should be added to the budget as proposed in the past. Self-insurance would clearly add additional administrative efforts (medical and Rx) and would also substantially increase PERS accountability for the plan. Today, most of our administrative and financial/operational risk is transferred to Sanford Health Plan. However, on a self-insured basis that becomes the Board's responsibility. Therefore, funding would need to be included for additional staffing.

IX. OVERALL CONCLUSIONS AND OBSERVATIONS

- This bill could have a material impact on the Health Plan resulting in significant reductions in the plan design or requiring additional appropriations if the existing plan design is to be maintained (as funded in the executive budget; also see III. – V above).
- This bill could affect the willingness of new carriers to bid on the plan and could have the unintentional effect of reducing future competition for the NDPERS plan.
- There may be concerns with Section 18 of Article I of the North Dakota Constitution relating to impairment of contract.
- If the emergency provision is passed it will require an abbreviated bid process (see bid and implementation timelines VIII.a above).
- The modified fully insured method has allowed NDPERS reserves to be used to buy down premiums in past biennia. If the plan were self-insured, these funds may be required to be maintained as plan contingency reserves in compliance with the NDCC-54-52.1-04.3 or be reflected as a cost in the analysis process (see VII above).
- Since bids benefit from additional months of claims data in determining the premium, the existing renewal process was modified several years ago to have a February re-projection to take advantage of any improvements due to additional months of actual claims data. If the data shows a need for additional funding the September agreed amount is the maximum. The modified process captures the benefit of a later projection, but eliminates the risk of higher premiums.

HB 1406 3-2-17 #2 Pg 11

- This proposal would add six months of higher claims to the end of the projection period, which are generally more expensive, and drop 6 months of claims at the beginning of the projection period, which are generally lower cost. Deloitte has projected that this will increase costs about 3.1% based upon current factors, which would result in plan design reduction or the need for higher premiums (see III above).
- If additional funding is not added to offset the increase noted above, the plan will lose its grandfathered status resulting in about 3% more in premium costs or benefit reductions (see IV above).
- If the two items noted above occur, this will result in the need for about 6% in benefit cuts which would increase the deductible to about $1,250 (see V above).
- This bill will result in a compressed timeline for the bid and implementation (see VIII.a above).
- Section 1, Item 2 limits the plan to the appropriation passed during the most recent session. If employees pay a portion of the premium, this is not counted in the appropriation. Therefore, pursuant to this legislation, the plan may need to be cut by 5% to balance as prescribed. Also, if the limitation is interpreted to be a total for the plan, then others such as retirees and political subdivisions may be required to leave the plan. In addition, since use of reserves are not appropriated on a biennium to biennium basis, they may not be available to be used resulting in a 1.65% cost increase to premiums or reduction in plan design (see VIII.b above).
- Moving the plan to a January start date instead of a July start date will cause it to no longer be coordinated with the budgeting process. Since currently it is coordinated, PERS is able to let the legislature know the exact plan design it is purchasing. Under this bill they would no longer be coordinated and the legislature would have to use estimates. If the estimates vary significantly from the resulting bid, the PERS Board would need to make plan design cuts to balance the plan or the Legislature would need to have a special session to address any shortfall (see VIII.c above).
- Additional contingent authority should be added in case the plan was to consider going self-insured (see VIII.d).
- The effect on membership should be minimal as a result of bidding the plan more often. However, if the result is changes in the carrier every two years, this could have an effect on members. Networks, formularies and other items may change even without any changes in the plan design. This was seen during the last transfer to Sanford even though the plan design did not change.

HB 1406 3-2-17 #3 pg1

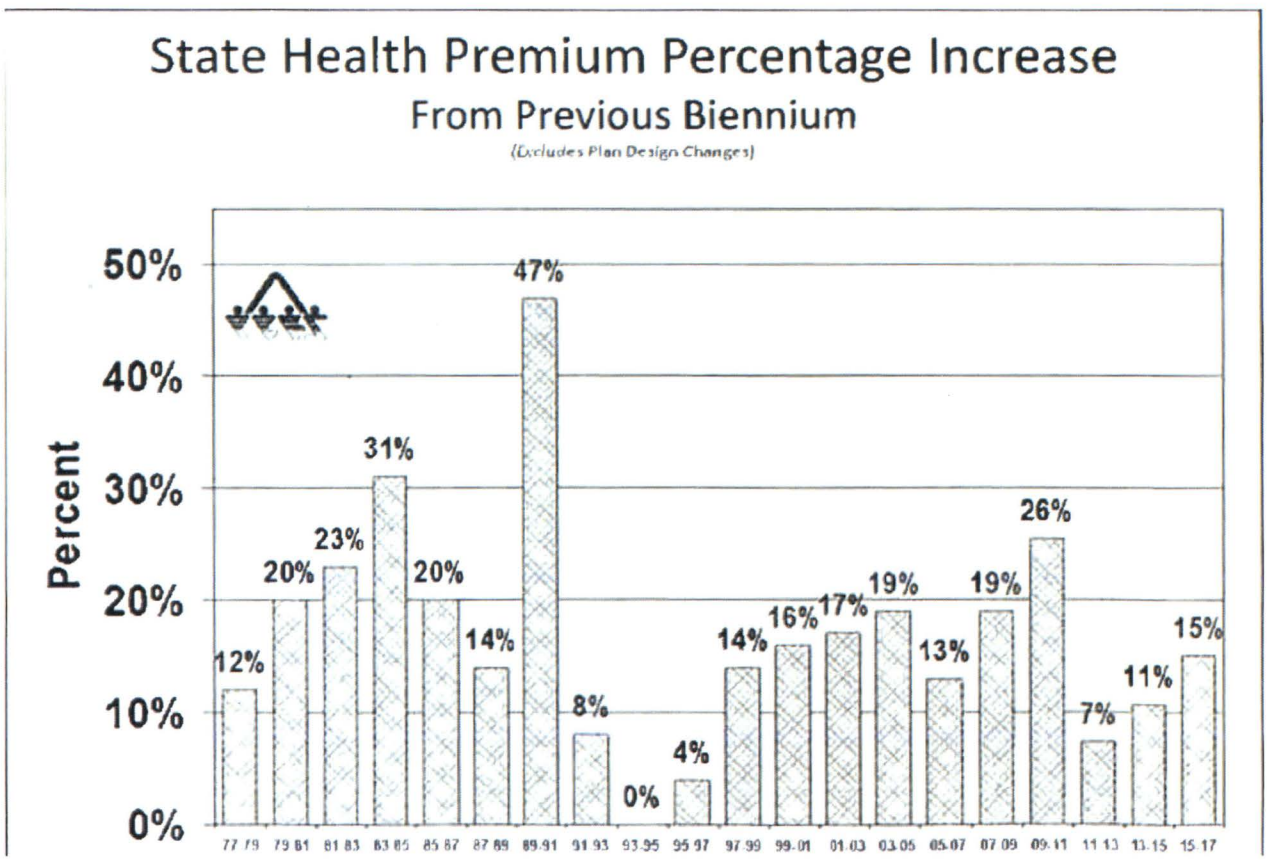
Plan on the best fit.

SANFORD HEALTH PLAN

Government and Veterans Affairs
Senator Nicole Poolman, Chairwoman
March 2, 2017

Chairwoman Poolman, members of the Government & Veterans Affairs Committee, I am Lisa Carlson, Senior Director of Market Strategy at Sanford Health Plan. I appear before you to oppose HB 1406 and HB 1407 to shorten the fully-insured contract period from 6 years to 2 years.

The PERS health plan will get a rate increase of 8.7% beginning July 1, 2017 (that's a 17.4% increase over the biennium). As a comparison, over the past 12 years, the PERS' rate increases have averaged 7.3% per year, on average. The Sanford Health Plan bid in 2014 was within a mere 5% of the incumbent health carrier's bid. The below grid illustrates prior premium increases.



In the past 20 years, PERS has dipped into reserves 6 times with the incumbent carrier, and for the first time with Sanford Health Plan in the 2017-2019 biennium. The below numbers show the amount per contract (policyholder) that the state used from its reserves. The state was under a fully-insured arrangement during this time period.

Biennium	Amount used from Reserves (per contract)	PERS Carrier
1997-1999	$20.71	Blue Cross Blue Shield
1999-2001	$9.35	Blue Cross Blue Shield
2003-2005	$10.00	Blue Cross Blue Shield
2005-2007	$24.52	Blue Cross Blue Shield
2009-2011	$0.14	Blue Cross Blue Shield
2013-2015	$20.04	Blue Cross Blue Shield
2017-2019	$18.67	Sanford Health Plan

I share this information to frame up a very important conversation about the impact being fully-insured versus self-funded has on the length of the PERS contract. A short 2 year contract period is inconsequential if the contract is self-funded. However, if the contract is fully-insured, the length of the contract period is critical, and a short contract period will adversely affect the State.

Fully-Insured Contract: Today, North Dakota PERS pays Sanford Health Plan on a capitated basis, which means that PERS pays Sanford Health Plan a fixed monthly premium. Because Sanford Health Plan is paid on fixed fee, we are at risk if the health care services cost more than the amount of premiums collected. When PERS uses a fully-insured contract, the state is protected from financial risk (i.e. fluctuations in utilizations, catastrophic claims, etc). For example, Sanford Health Plan's bid may assume we will need $20M per month to pay claims for 68,000 members. If the members use $23M worth of claims that month, Sanford Health Plan is at a loss of $3M dollars.

Self-Funded Contract: Conversely, if the state pursues a self-funded arrangement, the state assumes financial risk. PERS may budget (estimate) that they'll need $300M per year to pay for claims. If claims come in at $310M, the state will need to find $10M to pay those claims. Also, if the legislators' projections/ assumptions to set the budget at $300M per year to pay for claims are off by only 2% on a $300M cost - that equates to $6 million of losses to the state. Because the state assumes financial risk, the longevity of the contract is irrelevant, because the state will have to fund the claims every month, through all the highs and lows.

But because North Dakota bids its contracts as fully-insured, the bidder is compelled to protect itself from financial loss in the short 2 year period it has to manage the risk.

- A contract this large takes a significant investment to onboard and transition 68K employees from one carrier to another. Cases being managed by nurses such as members in the middle of chemotherapy, high risk pregnancies, transplants, etc. all need to be carefully transitioned to the new carrier. It takes time to communicate to members to ensure a smooth transition and not disrupt care. Because PERS is a July 1 contract year, members' deductibles and out-of-pocket amounts also need to be carried over from on carrier to another. These tasks cannot reasonably be done in a couple of months without being disruptive to members.

- A 2 year contract will discourage potential bidders on a fully-insured contract. In order to control costs and not lose money on a fully-insured contract, carriers must do care management. Nationally renowned actuarial firm, Milliman Inc., estimates the value of managed care can be worth up to 10% of costs. Managed care savings manifests itself in the forms of: prior authorizations, discharge management, drug compliance, disease management programs, formulary usage, etc.

- A carrier needs time to influence individuals' health. Nurses may not reduce the Hemoglobin A1c in a diabetic in four months, but may get a patient compliant in 18

months, thus getting the patient off expensive medications and leading a healthier life, using less healthcare services and fewer prescription drugs.

- Carriers are more likely to be aggressive in their bid when there is enough time to implement their managed care programs to improve health outcomes.

- With a short, 2 year, fully-insured contract, competing carriers may not bid, or if they do, they would be less likely to be aggressive in the premium rates when they know the program will go out to bid every 2 years.

- If there are no competing bidders, the end result will be a single carrier market for PERS, removing competition and possibly dissuading the single carrier from offering competitive, affordable renewals.

Lastly, if this bill is passed, Sanford Health Plan believes it will unconstitutionally impair Sanford Health Plan's existing contract with PERS.

In summary, Sanford Health Plan supports a market that fosters competition and choice for businesses and consumers. Taking a fully-insured contract that currently has a 6 year term and shortening it to 2 years, will only inhibit competition for the PERS program, ultimately driving up costs in the long run.

Thank you for your time and consideration.