HEALTH CARE REFORM REVIEW COMMITTEE

The Health Care Reform Review Committee was assigned three charges.

The Legislative Management directed the committee to monitor and review proposed federal changes to the federal Affordable Care Act (ACA).

The Legislative Management directed the committee to study the public employee health insurance plan, including the feasibility and desirability of transitioning to a self-insurance plan. The study must include a review of the current plan and consideration of the costs and benefits of the current plan compared to the costs and benefits of a self-insurance plan.

Section 32 of House Bill No 1012 (2017) directed a study of options to operate the state medical assistance program and other related programs, as managed care. The study must identify and review populations to consider for managed care, including individuals eligible under traditional medical assistance, Medicaid Expansion, the children's health insurance program (CHIP), and individuals receiving services through the long-term care and developmental disabilities programs; consider the needs of individuals receiving services from managed care programs in similar-sized states, and the alignment of benefit packages; review populations covered by the program of all-inclusive care for the elderly in other states; consider options for including services under a managed care arrangement; consider developing a proposed plan, cost estimates, and potential timeline for implementing the managed care options identified; and consider preparing and distributing a request for information from managed care organizations regarding the managed care options identified.

Committee members were Representatives George J. Keiser (Chairman), Rick C. Becker, Bill Devlin, Gretchen Dobervich, Kathy Hogan, Jim Kasper, Mike Lefor, Karen M. Rohr, and Robin Weisz and Senators Dick Dever, Jerry Klein, Karen K. Krebsbach, Oley Larsen, Judy Lee, Carolyn C. Nelson, and Nicole Poolman.

The committee submitted this report to the Legislative Management at the biennial meeting of the Legislative Management in November 2018. The Legislative Management accepted the report for submission to the 66th Legislative Assembly.

AFFORDABLE CARE ACT STUDY

Background

In March 2010 President Barack Obama signed into law two pieces of legislation that laid the foundation for a multiyear effort to implement health care reform in the United States--the Patient Protection and Affordable Care Act (House Resolution No. 3590) and the Health Care and Education Reconciliation Act of 2010 (House Resolution No. 4872)--which together are referred to as ACA. The Affordable Care Act affects states in multiple areas, including insurance regulation, taxes, human services, labor laws, and employee benefits.

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

Health Benefit Exchanges

During the November 2011 special legislative session, the Legislative Assembly did not enact legislation providing for a state-administered health benefit exchange or to allow for state participation in a federally administered health benefit exchange; therefore, the state is allowing the federal government to administer its health benefit exchange. A state may alter its exchange structure and administration model by submitting an exchange blueprint and having it approved by the United States Department of Health and Human Services (HHS).

Essential Health Benefits

Starting January 1, 2014, ACA required individual and small group plans to include all essential health benefits, limit consumers' out-of-pocket costs, and meet the bronze, silver, gold, and platinum coverage level standards; however, grandfathered and self-insured plans are exempt. Large group plans are required to meet the cost-sharing limits and the benefit levels, but are not required to provide the full scope of benefits in the essential health benefits package.

For the initial plan year, HHS issued a bulletin providing that each state may choose a benchmark plan from one of the following four benchmark plan types:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;

2. Any of the largest three state employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employees Health Benefits Program options by enrollment; or
4. The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

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

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

If a state failed to choose a benchmark plan by September 30, 2012, the default plan was the nongrandfathered small group plan with the largest enrollment in the state, which in North Dakota was the Medica Choice Passport plan. On September 28, 2012, the Insurance Commissioner submitted a selection of an essential health benefit benchmark plan to HHS, designating the Sanford Health Plan, the largest insured commercial non-Medicaid HMO operating in the state. This benchmark plan applied in 2014, 2015, and 2016 plan years.

For plan years 2017 and beyond, the federal government again directed the states to select their essential health benefits. The basic process for selecting the state's employee health benefits package was the same as before; however, the federal government selected a June 1, 2015, deadline for states to make this selection. Again, if a state failed to choose a benchmark plan by the federal deadline, the default plan was the nongrandfathered small group plan with the largest enrollment in the state. The 2015-16 interim Health Care Reform Review Committee recommended to the Legislative Management the state choose the default plan. For plan years 2017, 2018, and 2019, the state's essential health benefits are based on the new default benchmark plan.

Medicaid Expansion

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

Section 1 of House Bill No. 1362 (2013) enacted Section 50-24.1-37, directing the Department of Human Services (DHS) to expand the state's Medicaid program coverage as authorized under ACA. The department was directed to implement the expansion by bidding through private carriers or utilizing the health benefit exchange. The 2013 legislative measure became effective January 1, 2014, and had an August 1, 2017, expiration date. In 2017 the Legislative Assembly extended the expiration date to August 1, 2019, with a contingent repeal of the Medicaid Expansion program if the federal government ends the Medicaid Expansion program.

Previous Legislative Studies

Beginning with the passage of ACA in March of 2010, the Legislative Management has been studying the implementation of ACA. During the 2009-10 interim, the Industry, Business, and Labor Committee incorporated a study of ACA as part of the committee's charge to study factors impacting the cost of health insurance and health insurance company reserves. During the 2011-12, 2013-14, and 2015-16 interims, the Health Care Reform Review Committee pursued the specific charge to study the implementation of ACA and the state's health care delivery system.

Testimony

At each of the eight committee meetings held during the 2017-18 interim, the committee agenda included an ACA status report from the Insurance Department which typically included an ACA implementation update and an update on

ACA federal initiatives. The status reports were regularly accompanied by a health insurance carrier panel discussion regarding related ACA topics.

In addition to receiving ACA status reports, the committee received updates on activities of other states regarding pursuit of ACA Section 1332 State Innovation Waivers, which allow states to pursue innovative strategies for providing residents with access to high-quality affordable health insurance while retaining the basic protections of the ACA. At the end of the interim, the committee received a report from the Insurance Department on the results its efforts to study possible opportunities for the state to purse a Section 1332 State Innovation Waiver.

Federal Initiatives

The committee received updates on federal initiatives impacting the ACA. Some of these initiatives were accomplished through legislation and some through executive order.

The federal Tax Cuts and Jobs Act of 2017 reduced the ACA individual mandate to $0. This reduction will be effective for insurance coverage during 2019, for taxes filed 2020.

The continuing resolution to fund the federal government passed by Congress on January 22, 2018, impacted the ACA in a number of ways:

- Extension of the federal children's health insurance program funding for 6 years.
- Moratorium on the ACA Health Insurance Tax (HIT) for 2019;
- Extension of the moratorium on the ACA "Cadillac tax" and the medical device tax for 2 years, through 2022; and
- Suspension of the Medical Device Tax for 2 years, 2018 and 2019.

Executive Order 13813, signed by President Donald J. Trump on October 12, 2017, directs federal agencies to modify how the ACA is implemented. In a separate announcement made the same day this order was signed, the President announced he would end cost-sharing reductions (CSRs) to health insurance companies that sell to low-income consumers through the state health insurance marketplaces.

The committee was informed the three primary directives of the executive order:

1. Direct the Secretary of Labor to consider proposing regulation and revising guidance to expand Association Health Plans (AHPs);
2. Direct the Secretaries of HHS, Treasury, and Labor to consider proposing regulations or revising guidance to expand short-term limited duration insurance (STLDI); and
3. Direct the Secretaries of HHS, Treasury, and Labor to consider proposing regulations or revising guidance to expand Health Reimbursement Arrangements (HRAs).

The committee received testimony regarding the implementation timeline for the executive order which indicated:

- The executive order was signed October 12, 2017;
- Agencies have until April 10, 2018--180 days--to report on findings of rules and regulations that should or could be changed; and
- Any significant changes would not take effect until the 2019 plan year at the earliest.

The committee received testimony that on June 19, 2018, the Department of Labor issued its final rule on AHPs. The goal of this final rule is to make it easier for sole proprietors and small businesses to band together to buy health insurance without some of the regulatory requirements individual states and the ACA impose on smaller employers. This broader interpretation of the federal Employee Retirement Income Security Act of 1974 (ERISA) will allow employers that can pass a "commonality of interest" test to join together to offer health care coverage to their employees. Sole proprietors and small businesses will be able to access the small group health insurance market if they join an association that has at least 51 people, which is the number needed for an association to access the small group market. A sole proprietor also would be able to obtain coverage for their spouse and children through the qualified AHP. An Association Health Plan is a group health plan that employer groups and associations offer to provide health coverage for their members' employees, allowing small employers, through associations, to gain regulatory and economic advantages available to larger employers.

The committee received testimony that the possible benefits of AHPs may include more coverage options, affordable pricing, less regulatory burden and complexity, and reduced administrative costs. The benefits have been available to small employers previously but the final rule provides a new pathway for working owners without employees, including sole proprietors, to join together and access the small group market as well as for small businesses that meet the commonality of interest test to join together. The final rule does not affect previously existing AHPs, which were allowed under prior guidance, but which were subject to stricter geographic and commonality restrictions.

According to the testimony, the Insurance Department, through its regulation of multiple employer welfare arrangements (MEWAs), is one of a handful of state regulators that have adopted rules designed to regulate AHPs more effectively. The department's MEWA rules are designed to ensure the plans will be appropriately capitalized and grant the department continuing authority to examine the financial health of each plan. The department's rules also contain important protections for consumers who enroll in an AHP.

Important dates for AHP expansion under the final rule include:

- September 1, 2018, all associations, new or existing, may establish a fully insured AHP;
- January 1, 2019, existing associations that sponsored an AHP on or before the date the final rule was published may establish a self-funded AHP; and
- April 1, 2019, all other associations, new or existing, may establish a self-funded AHP.

The committee received testimony that on August 1, 2018, final rules were issued on STLDI, which became effective October 1, 2018. A short-term limited duration insurance is a type of coverage primarily designed to fill gaps in coverage which may occur when an individual is transitioning from one plan or coverage to another plan or coverage. This coverage is not subject to the provisions of the ACA. The final rules change the definition of STLDI to policies that are less than 12 months, provide policies may be renewed for up to 36 months, and contain certain disclosure provisions. This final rule does not trump state law. Although North Dakota law defines "insurer", "policy", and "short-term" and provides short-term policies are limited to no more than 185 days, state law is silent on renewal options.

According to the testimony, STLDI plans serve a narrow purpose. Generally, these plans, which are not comprehensive coverage and are simply to provide a stop-gap, are intended for people who are between jobs or have a short-term coverage gap. Until the final rules become effective, STLDI plans are limited to 90 days in duration.

The committee reviewed Bulletin 2018-2, issued by the Insurance Commissioner on September 19, 2018. This bulletin clarifies the final federal rules and the state law, rules, and policies relating to STLDIs.

The committee received testimony that in response to the October 12, 2017, presidential announcement, the administration no longer will be making CSR payments to insurance companies and several carriers and 19 states have filed lawsuits seeking to reinstate the payments.

The Insurance Commissioner's response to the termination of the CSR payments is addressed under "Federal Marketplace."

State Innovation Waivers

Section 1332 of the ACA permits a state to apply for a State Innovation Waiver to pursue strategies for providing its residents with access to high-quality affordable health insurance while retaining the basic protections of the ACA. State Innovation Waivers allow states to implement new ways to provide access to quality health care which are at least as comprehensive and affordable as would be provided absent the waiver, provide coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and do not increase the federal deficit.

The committee considered a letter dated September 8, 2017, from the Insurance Commissioner to Senator Lamar Alexander, Chairman, Senate Committee on Health, Education, Labor and Pensions, expressing the commissioner's concerns with the State Innovation Waiver. The letter identified the following three possible barriers to North Dakota pursuing a waiver:

1. North Dakota has a federally run exchange and because of this, our options under the current regulations are limited. Any changes made with a 1332 waiver would leave the state to cover the cost of implementation. In essence, we would have to take over the federally run exchange, at great expense to the North Dakota taxpayer. We simply do not have the state funds to undertake a change of that magnitude. Also, given the uncertainty of what a new health care law would look like, we believe given the status of our market, we should not be placing a further burden on our state funds to support a system that will ultimately change in the coming months or years.

2. The areas in which other states have chosen to write waivers would also require a massive amount of state dollars to accomplish if North Dakota were to follow. Further, subsidizing premiums or putting more money into reinsurance all require an influx of state dollars that North Dakota simply does not have. The cost of a waiver in similar states ranges between $100 million to $300 million and those dollars do not even include the cost of developing and implementing the waiver. North Dakota does not have the state funds to continue to support a failing system with partial waivers.
3. Any changes as a result of a 1332 waiver are not only cost prohibitive for North Dakota on the front end but would also carry grave concerns about the longer-term sustainability of any additional funds being placed into the ACA model. It is one thing to cover a one-time expense of $100 million but for that waiver to continue, it is our belief that it would become an annual expense that would only continue to grow, further depleting our state budget.

In this letter, the Insurance Commissioner additionally stated the State Innovation Waiver is focusing on the wrong targets as although the ACA was intended to have significant impacts, the main impact experienced in North Dakota is an unsustainable health insurance cost trajectory. The commissioner stated to address the cost of the ACA, states should be afforded the option of a true waiver and allowed to waive out of the provisions that have dramatically increased the cost of health insurance. The commissioner identified the following provisions as creating this unsustainable trajectory:

- Essential health benefits benchmarks;
- Three-to-one rate bands based on age;
- Guaranteed availability and issue requirements;
- Prohibitions on pre-existing condition exclusions; and
- Prohibitions on annual and lifetime limitations.

The Insurance Commissioner reported the Insurance Department contracted with an actuarial firm to conduct a multiphased approach to modeling and analyzing health insurance reform options for a Section 1332 State Innovation Waiver. The goal for the analysis is for the Insurance Department to understand how each option would affect the state's individual health insurance marketplace to allow the department to make a determination about which, if any, options to propose to the Legislative Assembly for the 2019 legislative session. The Insurance Commissioner testified he would not pursue a State Innovation Waiver without legislative directive.

In addition to analyzing Idaho's state-based plan initiative and how a similar state-based plan allowance could operate in North Dakota, the analysis conducted for the Insurance Department was based on the following three identified strategies:

1. Modification of the Comprehensive Health Association of North Dakota (CHAND) to allow a greater number of high-risk North Dakotans to obtain health insurance from CHAND, along with an analysis of the corresponding insurance company assessments necessary for CHAND to successfully operate with an increased high-risk membership.
2. Modification of CHAND into an invisible high-risk pool through which an insurance company would cede the high-risk members' claims to the pool in exchange for the premium. This approach would have no effect on the insureds because insureds' premiums would be unaffected and the insured still could select any plan they choose.
3. Creation of a reinsurance program independent of CHAND. A reinsurance program would limit the amount of risk insurance companies would assume for the high-risk North Dakotans they insure.

The Insurance Commissioner and the department's consultant presented a final report outlining the best two State Innovation Waiver options for North Dakota:

1. Creation of an invisible reinsurance pool; and
2. Creation of a state-based plan to be sold by insurance companies.

The analysis shows an invisible reinsurance pool has the ability to reduce individual health insurance premiums between an estimated 10 to 20 percent in 2020, compared to the baseline premium depending on the attachment point chosen. Due to the reduced premium, membership in the 2020 individual market is estimated to increase 1 percent compared to the baseline without the waiver.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. The approach of invisible reinsurance allows enrollees to remain in the individual market with their current plan and carrier, but a portion of enrollees' claims are reimbursed by the reinsurance pool. The enrollee is not aware the enrollee's claim is being paid via

the reinsurance pool, meaning there is no effect on the enrollee since the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

For 2020, the proposed reinsurance program would cover 75 percent of paid claims between the attachment point and $1 million. The attachment points being considered are $100,000 and $200,000. This level of reinsurance was assumed in projections, but North Dakota could have the flexibility to change the parameters.

The intent of a state-specific plan similar to the plan proposed in Idaho is to have an affordable option for healthier individuals who have foregone purchasing health insurance and to inject healthier risk into the single risk pool. Healthier individuals would pay a reduced premium. This state plan would cover all essential health benefits, but would allow a higher cost-sharing compared to the ACA metallic level plans. The plans would be guaranteed issue, but in the event of a coverage lapse, carriers would be allowed to implement a waiting period consistent with the provisions of the ACA before pre-existing conditions would be covered.

The analysis shows the invisible reinsurance pool would reduce premiums and the state plan would provide a low-cost alternative to healthier individuals, resulting in more individuals with health insurance and a more stable individual market, thus protecting carriers from unpredictable high-cost claims. This also would result in carriers being more willing to participate in the North Dakota individual insurance market.

The reinsurance pool would be funded by a combination of federal funds and assessments. The federal funding would be in the form of advance premium tax credits, and assessments would be placed on insurance companies selling in the state's health insurance market.

In addition to the waiver, the lower premium charged to healthy individuals under the state plan would provide an alternative when rate increases result in individuals and families dropping coverage which could lead to a larger insured population and a more stable market.

The committee received testimony from health insurance carriers regarding the Insurance Department's report on Section 1332 State Innovation Waiver options. Carriers expressed interest in the funding mechanism that would be used to fund the state plan, including whether assessments would be charges for administration of self-insurance plans.

Comprehensive Health Association of North Dakota

The committee received an overview of the history of CHAND, the state's health insurance high-risk pool, which was enacted in 1981 and codified under Chapter 26.1-08. When created, pre-ACA, the purpose of CHAND was to provide comprehensive health insurance benefits to residents of the state who had been denied health insurance or had been given restricted coverage or excessive health premiums because of high-risk health problems and to cover major medical and prescription drug expenses, subject to benefit plan limitations and exclusions.

Under CHAND the individual member premiums fund approximately one-half to two-thirds of the cost of the program, not to exceed 135 percent of premiums charged in North Dakota for similar coverage. The balance of the cost of the program is covered by assessments to companies that write $100,000 or more of annual major medical and Medicare supplement premiums on behalf of residents of North Dakota. Comprehensive Health Association of North Dakota assessments may be taken as a credit against premium taxes due.

When compared to a traditional platinum ACA plan, CHAND plans offer similar cost-sharing benefits for in-network and out-of-network services. Generally, CHAND plans provide cost-sharing benefits at least equal to or better than cost-sharing provisions in bronze, silver, and gold ACA plans. In North Dakota, CHAND and traditional ACA plans have a similar provider network. Outside North Dakota, a traditional ACA plan network is quite broad but may be different from the network available through a CHAND plan. A Comprehensive Health Association of North Dakota plan includes a $1 million lifetime benefit limit and a 180-day waiting period for pre-existing conditions - traditional ACA plans do not include these provisions.

A representative of the Insurance Department reported it is a public policy decision whether to change or eliminate CHAND plan provisions. According to the Insurance Department, as the federal debate over the future of health care continues, CHAND remains a viable option for North Dakotans in need of health insurance. By having CHAND in place, North Dakota is well positioned to adapt to health insurance changes made at the federal level.

Federal Marketplace

The committee received status reports on annual enrollment through the federal marketplace for plan years 2018 and 2019. Due to federal changes, the length of the open enrollment period has been shortened from 90 days to 45 days and federal funding for enrollment assistance has been cut.

The committee received testimony from health insurance carriers participating in the ACA federal marketplace, including testimony on the impact of the October 12, 2017, executive statement eliminating CSR payments to carriers. For the 2018 plan year, the carriers absorbed the costs associated with lack of funding from the CSR program, but premium prices for the 2019 plan year will reflect this loss of CSR payments.

The testimony from the Insurance Commissioner indicated during rate filings for the 2018 plan year, the Insurance Department requested all companies be ready to go with a CSR rate and a non-CSR rate. On October 13, 2017, the department was in contact with the Centers for Medicare and Medicaid Services and requested non-CSR rates from the carriers in North Dakota. Upon review of those rates, the Insurance Commissioner decided not to allow any adjustments to the rates previously approved by the department and released on October 1, 2017.

The Insurance Commissioner testified uncertainty should be in the hands of the insurance carriers, not the consumers. The testimony noted for the short term, carriers are better suited to handle the federal uncertainty.

The committee received testimony regarding health benefit coverage of North Dakotans:

- Employer-sponsored - 55 percent of the state's residents participated in a group health insurance plan offered by an employer. This includes employees of large and small private companies; federal, state and local government employees; and active military.
- Public programs - 29 percent of the state's residents received health care benefits through Medicare and Medicaid.
- Individually purchased - 8 percent of the state's residents purchased health insurance on their own through the federal marketplace or an agent.
- Uninsured - 8 percent of the state's residents remained uninsured.

Litigation

The committee received testimony regarding North Dakota's participation in *Texas v. Azar*, a case filed in the United States District Court in the Northern District of Texas. In this case, a coalition of 20 states, including North Dakota, is suing the federal government claiming the ACA is no longer constitutional following the repeal of the requirement people have health insurance or pay a fine for lack of coverage.

The committee received testimony that although the United States Department of Justice will not defend much of the lawsuit, 17 states have filed as interveners to defend the lawsuit. This case likely is bound for the United States Supreme Court, but it likely will be years before a final decision is issued.

Considerations and Conclusions

The committee received testimony it is likely the Insurance Department will introduce legislation to pursue a Section 1332 State Innovation Waiver to move forward with creation of an invisible reinsurance pool and the creation of a state-based plan to be sold by insurance companies. The committee makes no recommendation regarding this study.

STATE EMPLOYEE HEALTH INSURANCE BENEFITS STUDY

Background

The committee studied the public employee health insurance plan, including the feasibility and desirability of transitioning to a self-insurance health plan. The study included a review of the current plan and consideration of the costs and benefits of the current plan compared to the costs and benefits of a self-insurance health plan.

Previous Legislative Studies

Although the topic of the Public Employees Retirement System (PERS) transitioning from a fully insured to a self-insurance health plan to provide health benefits coverage has not been studied by the Legislative Management in recent history, Legislative Management interim committees and the Employee Benefits Programs Committee have conducted studies relating to public employee health benefits coverage.

During the 2013-14 interim, the Government Finance Committee studied the state contribution to the cost of state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution for state employee health insurance premiums. The committee received information the state health insurance plan is exempt from certain provisions of the ACA as long as the plan's grandfathered status is continued. The plan's grandfathered status may be lost if certain existing plan benefits are not maintained or if an employee is required to pay more than 5 percent of a single or family premium rate.

The 2013-14 Government Finance Committee recommended and the Legislative Assembly approved House Concurrent Resolution No. 3003, which provided for a study of the state contribution to the cost of state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution for state employee health insurance premiums and the effect of losing the state's grandfathered status under the ACA.

Although the 2015-16 Health Care Reform Review Committee considered a bill draft to remove the statutory requirement the state fund 100 percent of the cost of state employee health insurance premiums, the committee did not make any recommendations relating to the study.

The Employee Benefits Programs Committee is a statutory committee that receives status reports from PERS, including the activities of the PERS Board relating to the public employee health benefits coverage, and reviews bill drafts and bills that may affect public employee health benefits coverage.

During the 2013-14 interim, PERS reported to the Employee Benefits Programs Committee on the status of the PERS request for proposals for health benefits coverage for the 2015-17 biennium. This 2014 solicitation is the most recent request for proposal for public employee health benefits coverage. This solicitation included a request for a fully insured plan as well as for a self-insurance plan. The Public Employees Retirement System Board awarded Sanford Health Plan (SHP) a contract for a fully insured plan. This 2-year contract with SHP has the option of up to two 2-year renewals. The contract was renewed to provide coverage for the 2017-19 biennium. During the summer of 2018 the Employee Benefits Programs Committee received status reports from PERS on the PERS Board's review of SHP's performance under the contract, an analysis of proposed rate increases for the 2019-21 biennium, and possible contract renewal or solicitation of bids.

Plan History

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

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

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

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

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

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

1. Implementation of a program of concurrent review of inpatient hospitalizations designed to eliminate unnecessary treatment or prolonged hospital stays and to allow consideration of less expensive appropriate treatment for long-term medical care.
2. Implementation of a program of mandatory second surgical opinions for certain elective surgeries. This program did not generate anticipated results, and after a 1-year trial period, was discontinued.
3. Expansion of contract deductibles to include all inpatient, outpatient, and physician services.
4. Increase of the coinsurance base from the first $2,000 in charges to the first $4,000 in charges.

5. Implementation of a preferred pharmacy program.
6. Establishment of a separate premium rate for retirees, based on retiree claims experience.
7. Introduction of a $25 copayment for each hospital emergency room visit.
8. Adjustment of the Medicare coordination of benefits formula applied to retiree members of the plan.

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

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

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

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

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

Biennium	Single Plan	Percentage Change	Family Plan	Percentage Change	Combination Rate	Percentage Change
1963-65	$5.00		$21.00			
1965-67	$8.55	71.0%	$21.50	2.4%		
1967-69	$10.75	25.7%	$25.00	16.3%		
1969-71	$14.45	34.4%	$34.90	39.6%		
1971-73	$15.95	10.4%	$41.90	20.1%		
1973-75	$14.46	(9.3%)	$41.90	0.0%		
1975-77	$19.50	34.9%	$59.95	43.1%		
1977-79	$25.50	30.8%	$67.42	12.5%		
1979-81	$34.84	36.6%	$87.40	29.6%		
1981-83	$42.68	22.5%	$107.07	22.5%		
1983-85	$50.28	17.8%	$140.28	31.0%		
1985-87	$60.00	19.3%	$168.00	19.8%		
1987-89	$68.28	13.8%	$191.28	13.9%		
1989-91	$99.82	46.2%	$280.39	46.6%		
1991-93	$108.00	8.2%	$304.00	8.4%		
1993-95					$254.00	
1995-97					$265.00	4.3%
1997-99					$301.00	13.6%
1999-2001					$349.72	16.2%
2001-03					$409.09	17.0%
2003-05					$488.70	19.5%
2005-07					$553.95	13.4%
2007-09					$658.08	18.8%
2009-11					$825.66	25.5%
2011-13					$886.62	7.4%
2013-15					$981.69	10.7%
2015-17					$1,130.22	15.1%
2017-19					$1,265.34	9.8%

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

and employees choosing a family plan paid any additional cost. Since 1979 the state has paid the full cost of a single or family plan for eligible state employees.

Fully Insured Health Plan Option

The Public Employees Retirement System Board has contracted to provide health benefits coverage through a fully insured plan from July 1989 to the present. Before July 1989, the coverage was provided through a self-insurance health plan; however, the plan exhausted its funding during the 1987-89 biennium resulting in the change to the fully insured plan. The board contracted with BCBSND from July 1989 through June 2015 and with SHP from July 2015 to the present.

Although the PERS health benefits coverage technically is provided through a fully insured plan, it is actually provided though a modified fully insured plan. Because of the large size of the group, PERS historically has been able to negotiate a gain-sharing and loss corridor provision - 50/50 in the first $6 million of loss and the remainder of the loss to the carrier and 50/50 in the first $3 million of gain and the remainder to PERS. With the most recent contract renewal for coverage during the 2017-19 biennium, PERS shares in any gain, but does not share in any loss.

Self-Insurance Health Plan Option

Section 54-52.1-04.2 provides if the PERS Board determines a self-insurance plan is less costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits, the board may establish a self-insurance health plan for providing health benefits coverage. This analysis likely would take place at the time the board reviews bids received as part of the rebidding of the contract. If the board finds self-insurance is less than the lowest bid, the board is not required to establish a self-insurance health plan, because the law is permissive.

If the PERS Board establishes a self-insurance health plan, the plan must be offered through an administrative services only plan or a third-party administrator plan, and the plan may be for all of the health benefits coverages, with or without prescription drug coverage, or may be limited to prescription drug coverage.

If the PERS Board establishes a self-insurance health plan:

- The bid period must close by January 1 of an odd-numbered year, and the award must be made by March 1 of that year.
- The board is required to solicit a bid once every other biennium; however, the board may renegotiate an existing plan during the interim.
- Individual stop-loss coverage must be made a part of the plan.

Under Section 54-52.1-04.3, if the PERS Board establishes a self-insurance health plan, the board also is required to establish a contingency reserve fund to provide for adverse fluctuations in future charges, claims, costs, or expenses of the plan. The board is required to establish a balance amount necessary for claims paid, between 1.5 and 3 months of claims paid. In addition, the board is required to establish an additional balance amount necessary for claims incurred, but not yet reported, between 1 and 1.5 months. Upon the initial changeover from a contract for insurance to a self-insurance health plan, the board is required to have in place a plan reasonably calculated to meet the funding requirements within 60 months.

If the PERS Board establishes a self-insurance health plan, political subdivisions participating in the state's uniform group health benefits coverage under Section 54-52.1-03.1 also would transition to participate in the self-insurance health plan. In practice, the move from a traditional insurance carrier to self-insurance would have very little impact on the political subdivision participants, as the participants would continue to pay a monthly premium regardless of whether self-insured. A political subdivision may withdraw from participation in the PERS health benefits coverage at any time; however, if at the time of withdrawal, the political subdivision has not completed 60 months of participation in the PERS plan, the political subdivision may be subject to additional costs for early withdrawal.

High-Deductible Plan

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

Calculation of Health Insurance Premiums

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

Affordable Care Act

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

Testimony and Committee Considerations

Over the course of the interim, the committee received testimony from stakeholders, including representatives of PERS, health insurance carriers, and the Insurance Department. The committee received multiple status reports on the activities of the PERS Board, including the board's consideration of whether to renew for the 2019-21 biennium its contract with the current health insurance carrier.

The committee reviewed the history of PERS health benefits, including a plan overview reviewing membership, premium history, reserve history and use of reserve funds for premium buydown since 1997, current and past plan designs and the impact of agency budgets on plan design, plan participation, the contract renewal and bid process, and recent legislation relating to PERS health benefits.

Health Benefits Contract Renewal

The committee received updates on the PERS Board's consideration of whether to renew the health benefits contract for an additional 2 years. In accordance with section 54-52.1-05, in August and September 2018, the committee completed the following review:

- August 23, 2018 - The carrier initially proposed a 14.5 percent increase for the PERS health benefits contract renewal.
- September 11, 2018 - The PERS Board considered the carrier's proposal, and at the board's direction, PERS engaged the carrier in negotiations regarding the proposed increase.
- September 20, 2018 - The carrier reduced its proposed increase for the PERS plan to 13.5 percent and the board requested further negotiations.
- September 25, 2018 - The carrier's final proposal was a 13.1 percent increase. The carrier also agreed to implement several additional programs, if the board requests, designed to bring down the trend. The board's consultant projected a 13.3 percent increase for the health benefits contract renewal. The board unanimously voted to approve renewal of the contract indicating:

  The carrier's performance generally was ahead of where it was 2 years ago and meeting the board's expectations;

  The carrier's proposed premium renewal amounts were consistent with the board's expectations; and

  Additional relevant considerations weighed in favor of renewing.

The committee received the following fiscal information regarding the renewal rates:

		2017-19 Premiums	2019-21 Premiums	% Increase
What we **pay** Sanford each month (**premium** increase)	State with Wellness	$1,265.34	$1,431.10	13.1%
		Difference is buydown of ($27.32) and PERS Retention of $2.80	No buydown and PERS Retention of $2.80	
What we **bill** employers each month (**budget** increase)		**2017-19 Billed Rate (with buydown)**	**2019-21 Billed Rate (without buydown)**	**% Increase**
	State with Wellness	$1,240.82	$1,433.90	15.56%

Active State Renewal Rate - Employer Cost (Preliminary Numbers Only)	
	13.1 Percent Increase
2017-19 state rate (with buydown)*	$1,240.82
Projected 2019-21 rate (no buydown)	$1,433.90
2019-21 dollar increase	$193.08
2019-21 percentage increase	15.56 percent
Total state additional funds**	$73.4 million
Total additional general funds***	$40.4 million
Total current premium (2017-19)	$471.9 million
Total projected premium (2019-21)	$545.4 million

*Projected buydown for 2017-19 biennium (state, nonstate, and retirees) is $13.3 million
**For biennium assuming 15,847 state budgeted FTEs
***Assumed to be 55 percent of total funds

Medicare Part D Renewal

The committee received updates on the PERS Board's consideration of whether to renew the Medicare Part D contract. Although the PERS Board considered unbundling the Medicare Part D benefits from the medical supplement policy and, therefore, not renewing the contract, the board decided to renew the contract and additionally consider whether to unbundle the benefits in the future.

The committee received testimony the Medicare Part D renewal rates for 2019 were reduced 9.6 percent, from a monthly rate of $95.38 to $86.26. This rate includes addition of an opioid management program for an additional cost of 26 cents per policy per month.

Medicare Part D Options

Although the PERS Board renewed the Medicare Part D plan for 2019, the board continues to review options for providing this benefit. The committee received an overview of the history and current status of the PERS Medicare Part D benefit.

Historically, before Medicare Part D was created by the federal government, PERS offered a Medicare supplement that included drug coverage. When Part D was enacted, the carrier developed a product for PERS which captured the Part D subsidy, retained the existing plan of benefits for drug coverage, and did not have a doughnut hole.

Currently, PERS provides Medicare Part D coverage as part of a bundled product, which means it includes medical and drug coverage. In electing this coverage through PERS, a member is required to take both the drug and the medical coverage. However, the federal government provides Medicare retirees with an annual open enrollment giving retirees the opportunity to select drug coverage from numerous products in the marketplace with varying plan designs, formularies, and pricing. This open enrollment has resulted in confusion because PERS members receive information on the federal open enrollment, believe this is something available to members, and enroll for other Part D coverage. Because PERS members may not be enrolled in two Part D products, the federal government cancels the PERS member's Part D coverage with PERS. The unintended outcome is the member's eligibility for continued medical coverage is jeopardized because PERS cannot cancel drug coverage without also cancelling the medical coverage because the product is bundled.

In determining whether to retain the bundled benefit structure, the PERS Board Retiree Subcommittee reviewed the following two options and related considerations:

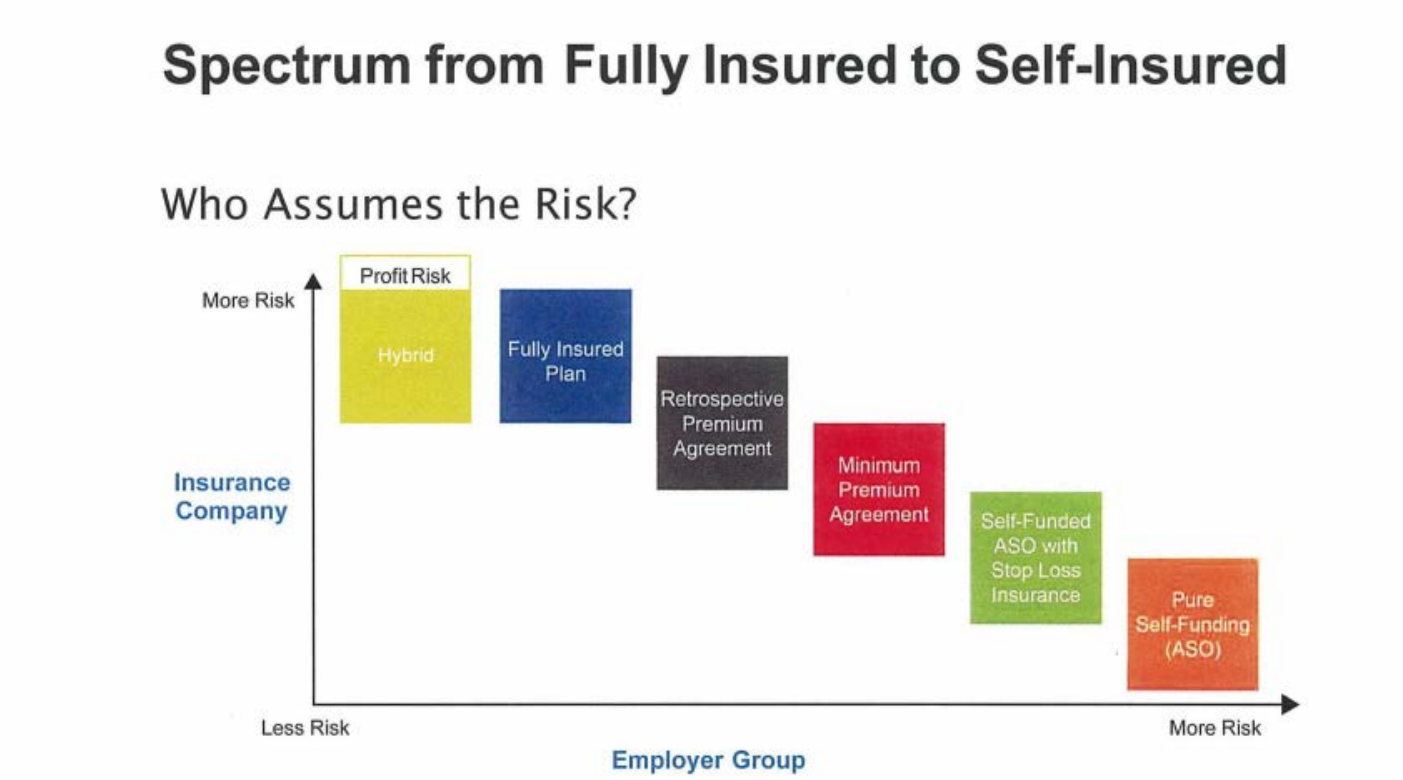
1. Option 1 - Remain bundled.
    - Maintaining status quo would not increase or decrease adverse selection to the plan;
    - May be less confusing for the member;
    - Stability of the group historically has resulted in stable premiums;
    - For some members, the PERS premium may be higher than unbundled options; and
    - May need to make plan design changes in the future to offset premium increase.
2. Option 2 - Unbundle.
    - Members would have the ability to stay in the PERS supplement plan but select a different drug plan;
    - Members would have more choice on type of plan;

- The different drug plan may have advantages over the PERS Part D plan;
- Similar plans or alternative plans with different cost-sharing amounts may be less expensive than the PERS Part D plan;
- The PERS Part D rates may increase in the long term, possibly resulting in adverse selection further causing the premium to increase;
- The current carrier appears to be willing to offer the plans unbundled;
- No adverse effect on premiums in the near term;
- The PERS Part D plan would no longer be unique in the marketplace;
- Does not require statutory change if eligibility is not changed; and
- Unbundling could be accomplished by continuing to offer both the supplement and the Part D plans, phasing out of offering a PERS Part D plan but offer other Part D plans from other carriers, phasing out offering a PERS Part D plan, or offsetting premium by making the Part D plan design more competitive.

The committee received testimony that additional options regarding Medicare Part D benefits include discontinuing the benefit to reduce the agency's budget in accordance with the Governor's budget guidelines, which call for a reduction of the agency's budget by 10 percent and a reduction of the agency's full-time equivalent positions by 5 percent.

Health Benefit Products

The committee received testimony from carriers regarding the types of health benefits products available for groups and the risk associated with these different types of products. The testimony included the pros and cons of the different health benefits products.



Survey of Neighboring States

At the request of the committee, PERS surveyed surrounding states - Idaho, Iowa, Minnesota, Montana, South Dakota, Wisconsin, and Wyoming - to determine how those states provide health benefits for public employees. The survey found:

1. Grandfathered status:

   One state grandfathered; and

   Six states nongrandfathered.

2. Employer types:

   Four states limit coverage to state employers;

   Two states cover state and political subdivision employers; and

   One state has separate plans for state and political subdivision employers.

3. Regulation of plans varies from Department of Insurance, executive branch, legislature, and plan administrator.

   Member complaints:

      Fully insured file with carrier; and

      Self-insured handled internally.

   Plan documents:

      Fully insured approved by Department of Insurance; and

      Self-insured not approved by Department of Insurance.

4. Funding arrangements:

   Four states are self-insured;

   One state has a fully insured hybrid;

   One state has both fully insured and self-insured plans; and

   One state has a retrospective premium agreement.

5. Plan design varies by administrative agency, executive branch, and legislative branch.

6. Number of plans offered:

   Two states offer a single plan; and

   Five states offer multiple plans (2-5).

7. Number of carriers:

   Five states use a single carrier; and

   Two states have multiple carriers.

8. Premiums generally are developed 6 to 9 months in advance for upcoming year.

9. Rates are set annually.

10. Length of contract:

    Four states have 5-year contracts with 1-year renewals;

    Two states have 3-year contracts with 1-year renewals; and

    The contracts generally go out to bid at the end of the contract.

11. Stop loss for self-insured plans. Only one state carries stop loss, which is aggregate only, per statute.

12. Reserve for self-insured plans.

    Reserve levels vary based on a percentage of claims, percentage of risk-based capital, and number of months.

    Types of reserves vary from general reserves, incurred but not reported, and incurred but not paid.

County Health Benefits

The committee received testimony from counties regarding county provision of health benefits for county employees. A representative of the North Dakota Association of Counties provided the results of its 2017 survey of counties relating to county health plans. The survey indicated 38 counties are enrolled in the PERS health plan, 5 counties self-insure with BCBSND as administrator, and 10 counties purchase a health plan directly from BCBSND.

The survey results indicated little change provided over the past 10 years, with two counties switching from PERS to BCBSND. On average, counties contribute 82 percent of the cost of a family policy premium, with 15 counties paying 100 percent. All but 5 counties pay 100 percent of a single policy premium.

The following tables provide data regarding survey results of counties that do not participate in the PERS health plan:

	Self-Insured Counties - Blue Cross Blue Shield of North Dakota Administered										
			Current Monthly Premium Amounts				Annual Percentage Increase in Premiums				
	Eligible Employees	Enrolled Employees	Single Adult Coverage	Single Adult + Dependents	Family Coverage	Employer Share of Family	Most Recent	1 Year Prior	2 Years Prior	3 Years Prior	4 Years Prior
Cass	425	403	$624	$1,098	$1,621	79%	1%	2%	7%	10%	0%
McKenzie	205	200	$672	$1,183	$1,748	85%	0%	0%	6%	4%	6%
Mercer	78	67	$448	$789	$1,166	90%	20%	5%	0%	0%	0%
Ramsey	65	65	$248	$436	$644	100%	14%	12%	19%	7%	3%
Williams	254	239				100%	0%	2%	5%	4%	7%
Total	1,027	974			Average	91%	7%	4%	7%	5%	3%

	Blue Cross Blue Shield of North Dakota Contract Counties										
			Current Monthly Premium Amounts				Annual Percentage Increase in Premiums				
	Eligible Employees	Enrolled Employees	Single Adult Coverage	Single Adult + Dependents	Family Coverage	Employer Share of Family	Most Recent	1 Year Prior	2 Years Prior	3 Years Prior	4 Years Prior
Adams	33	31	$654	$1,149	$1,699	50%	16%	(4%)	15%	0%	11%
Divide	48	45	$657	$1,157	$1,709	100%	23%				
Golden Valley	23	18	$626	$1,102	$1,628	75%	2%	1%	0%	17%	9%
Grand Forks	298	256	$557	$981	$1,449	82%	(19%)	14%	8%	2%	0%
Hettinger			$641	$1,130	$1,669	90%	4%	5%	4%	8%	
Renville	30	30	$618	$1,086	$1,604	38%	2%	1%	2%	23%	1%
Sioux						52%					
Slope	16	15	$727	$1,277	$1,888	100%	6%	4%	7%	12%	1%
Walsh	80	73	$566	$995	$1,470	75%	25%	17%	0%	11%	2%
Wells	47	46	$632	$1,136	$1,642	92%	17%	6%	16%		
Total	575	514			Average	75%	7%	7%	5%	12%	3%

Self-Insurance - Overview

The committee reviewed Chapter 54-52.1, the law relating to PERS uniform group insurance, including the option for PERS to provide health benefits through a self-insurance health plan. As part of this review a representative of PERS identified portions of Chapter 54-52.1 which could be updated.

The testimony from representatives of BCBSND and SHP provided detailed overviews of the carriers' experiences with self-insurance. According to the testimony, when an employer changes from a fully insured to a self-insured health plan, the employees notice very little change, because the change primarily is a financial arrangement regarding payment of claims. The carriers did not identify any significant concerns with the PERS self-insurance health plan statutes.

The committee received testimony regarding the statutory requirement for PERS and the common practices relating to the purchase of stop-loss coverage for a self-insurance health plan. It is not uncommon for a group to purchase specific stop loss for very large claims and aggregate coverage for all claims below the specific stop-loss deductible.

The testimony indicated when determining if the self-insurance health plan is less costly than a fully insured plan, PERS would look at both the expected cost of the self-insurance health plan and the maximum costs. It was noted a group can pay a premium for specific stop-loss coverage for the deductible selected, but aggregate coverage only applies if the total claims below the specific target are greater than some multiplier of the expected costs. For a group the size of PERS, the factor would be in the 10 to 15 percent range. Thus, there are two "costs" that could be compared:

1. Expected cost = specific stop-loss premium + aggregate stop-loss premium + administration fees + 100 percent of aggregate claims; and
2. Maximum cost = specific stop loss premium + aggregate stop-loss premium + administration fees + 110 to 115 percent of aggregate claims.

The committee received testimony from representatives of the Insurance Department regarding regulation of a PERS self-insurance health plan. As a government plan, a PERS self-insurance health plan would be exempt from ERISA, and if the PERS plan continues to have state and political subdivision participants it may be subject to the Insurance Department's MEWA rules. If the PERS plan is limited to state participants, it is unclear how the plan would be regulated.

The committee worked with PERS and the Insurance Department to prepare a bill draft that provides a PERS self-insurance health plan would be subject to the regulation of the Insurance Department and establishes the parameters of that regulation; revises the law establishing the requirements of a PERS self-insurance health plan to provide individual stop loss is optional, to increase the minimum amount of the required contingency reserve funds for a PERS self-insurance health plan, and to remove the 5-year timeline within which PERS would be required to meet the funding requirements if PERS transitions to a self-insurance health plan; and grants the Insurance Commissioner emergency rulemaking authority to adopt rules to regulate PERS self-insurance health plans.

The committee worked with PERS to prepare a bill draft that updates the law relating to PERS uniform group insurance for health benefits coverage, clarifying PERS may receive bids for all or part of prescription drug coverage, providing PERS may establish a self-insurance health plan if doing so best serves the interests of the state and the state's eligible employees, and providing the interests of the state and the state's employees is a factor for PERS to take into consideration when determining whether to renew a health benefits contract.

Recommendation

The committee recommends House Bill No. 1028 which combines the two bill drafts the committee considered. The bill:

- Provides PERS self-insurance health plans are subject to the regulation of the Insurance Department;
- Establishes the parameters of the regulation of PERS self-insurance health plans;
- Allows PERS to establish a self-insurance health plan if doing so best serves the interests of the state and the state's eligible employees;
- Revises the requirements of a PERS self-insurance health plan to provide stop-loss coverage is allowed but not required, the minimum amount of the reserve fund is no longer codified, and the plan must provide coverage for all the same health benefit mandates as required under a fully insured plan;
- Authorizes the Bank of North Dakota to extend PERS a line of credit to help administer a self-insurance health plan;
- Provides PERS may not renew a health benefits contract unless doing so best serves the interests of the state and the state's employees;
- Clarifies PERS may receive bids for all or part of prescription drug coverage; and
- Declares the act is an emergency measure.

PUBLIC BENEFITS MANAGED CARE STUDY

Background

Previous Legislative Studies

Although the topic of managed care for public benefit programs has not been the subject of an interim study in recent history, for the previous three interims the Legislative Management's interim Health Care Reform Review Committee has conducted ongoing studies of the state's health care delivery system with an eye to providing North Dakotans affordable health care. In the course of the Health Care Reform Review Committee's studies, the committee received information regarding the state's medical assistance program, Medicaid Expansion program, and CHIP, as well as regarding the provision of medical services through a medical home model.

During the 2015-16 interim, the Health Care Reform Review Committee considered several alternative recommendations with the goal of decreasing the state's financial liability for the Medicaid Expansion program to alleviate the financial impact of removing the July 31, 2017, sunset. House Bill No. 1032 (2017) was one such alternative recommendation made by the committee which would have removed the sunset, provided Medicaid Expansion provider reimbursement rates are the same as under the traditional Medicaid program, and removed the requirement the Medicaid Expansion program be provided through a private carrier or by utilizing the health insurance exchange. In effect, this bill would have moved the Medicaid Expansion from a managed care program to a fee-for-service program. This bill failed in the House and instead, under Section 38 of House Bill No. 1012 (2017), the Legislative Assembly extended the sunset to July 31, 2019, without amending the law regarding private carriers and without statutorily setting provider reimbursement rates.

North Dakota

Under Chapter 50-24.1, DHS administers the state's Medicaid program, known as medical assistance; under Section 50-24.1-37, DHS administers the Medicaid Expansion program, which is scheduled to sunset July 31, 2019; and under Chapter 50-29, DHS administers CHIP, known as Healthy Steps. These programs are federal-state partnerships and subject to changes in federal law. While the state is able to design program services, eligibility, and operational protocols,

the federal government contributes funding, dictates the minimum standards, and sets requirements for various program operations. Each of these programs provides health care coverage to qualified applicants and each program has its own set of qualification requirements.

Within these public benefit programs, eligible recipients fall into multiple classifications, and based on these classifications, the type of managed care that may be appropriate or allowed by the federal government may vary. For example, within Medicaid, the following applicants may be eligible:

- Low-income individuals from birth;
- Children in foster care or subsidized adoption;
- Former foster care children;
- Children with disabilities;
- Pregnant women;
- Women with breast or cervical cancer;
- Workers with disabilities;
- Other blind or disabled individuals; and
- Low-income Medicare beneficiaries.

In addition to the various eligibility classifications for these programs, within the programs, DHS is operating under multiple federal waivers. A state change in any of these programs may require federal approval.

There appears to be federal and state support for implementing managed care within the programs. The Center for Medicaid and CHIP Services is one of six centers within the Centers for Medicare and Medicaid Services, which is an agency of the HHS. The Center for Medicaid and CHIP Services reports:

- Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.
- By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.
- Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high-quality care.

The Center for Medicaid and CHIP Services publishes managed care profiles for each state. North Dakota's profile and DHS's website indicate DHS utilizes the following four managed care programs for its public benefit programs:

1. Primary Care Case Management program;
2. Health Management program;
3. Program of All-Inclusive Care for the Elderly (PACE); and
4. Medicaid Expansion through an MCO.

Medicaid and Children's Health Insurance Program Managed Care Final Rule

Recent federal developments may affect the state's ability to implement managed care or require the state to implement additional managed care provisions. On April 25, 2016, Centers for Medicare and Medicaid Services put on display the Medicaid and CHIP Managed Care Final Rule. The reported key goals of the final rule are to:

- Support state efforts to advance delivery system reform and improve the quality of care;
- Strengthen the beneficiary experience of care and key beneficiary protections;
- Strengthen program integrity by improving accountability and transparency; and
- Align key Medicaid and CHIP managed care requirements with other health coverage programs.

The effective date of the final rule was July 5, 2016, with phased implementation of new provisions primarily taking place over 3 years, starting with contracts entered after June 30, 2017. State CHIP and Medicaid programs will be required to comply with this final rule.

Testimony and Committee Considerations

Managed Care Overview

The committee received testimony from representatives of Leavitt Partners providing an overview of managed care options for public benefit programs, including the evolution of managed care, managed care efforts being taken in other states, and how managed care philosophy may impact the choices a state makes.

The committee considered whether federal block grants may be a factor in considering managed care. Block grants mean different things to different entities. For states, block grants mean increased flexibility; whereas, for the federal government, block grants are a way to limit financial liability. The competing forces are that the federal government wants to provide the minimum amount of funding and the states want to receive the maximum amount of funding.

According to the testimony, there is not one ideal model of managed care which is the right model for a state. The model chosen should be related to the goals and objectives of implementing managed care. Considerations in evaluating whether to implement a new managed care model and to consider during implementation may include:

- The public benefit programs' populations, including:
  - The needs of the populations;
  - The utilization patterns of the populations; and
  - Provider readiness for change.
- The managed care model chosen needs to reflect the goals, not the inverse.
- Participation by stakeholders, including providers and recipients, and some resistance from stakeholders should be expected.
- There are benefits to reviewing models other states have implemented and the processes used to evaluate model selection and implementation.
- It may be desirable to phase-in new managed care models, based on factors such as population groups or geography.
- The appropriate role of the state agency.
- During implementation, have a strong contracting process, including a clear contract with clear expectations.
- During and following implementation, continue to monitor and refine because continuously refining will be necessary to meet the state's objectives.

The committee received testimony providing a national overview of managed care in the Medicaid market. The trend is for MCOs to provide managed care through a risk-based, per member, per month capitated payment. The managed care organization relationships are selected through a procurement process. Thirty-eight states, the District of Columbia, and Puerto Rico have Medicaid MCOs. Seventy percent of all Medicaid beneficiaries--52 million enrollees--are enrolled in MCOs. There are 336 Medicaid health plans in the United States. Populations frequently served by Medicaid MCOs include traditional Medicaid, CHIP children, pregnant women, the aged, blind, and disabled population, foster children, long-term care residents, and the dual eligible population.

The committee received testimony providing an overview of how Indiana implemented managed care for its Medicaid population. Indiana phased in population groups beginning in 1994 and in 2015 included foster children and the aged, blind, and disabled populations. Indiana's Medicaid managed care program saved that state between $406 million to $811 million from 1994-2015.

Department of Human Services

The committee received testimony from representatives of DHS regarding the following DHS managed care initiatives: Primary Care Case Management (PCCM); PACE; and MCOs for CHIP and Medicaid Expansion.

Considerations and possible steps to take if Medicaid managed care is expanded include preparation of a request for proposal, consideration of statutory changes, pursuit of federal waivers for state plan changes to CHIP and Medicaid, review of Medicaid management information system (MMIS) functionality, and allowing time for procurement protests.

According to the testimony, the MMIS may be impacted if additional managed care programs are implemented. The Medicaid managed care and Health Enterprise MMIS renewal and extension options expire in October 2020. The Department of Human Services indicated it will need to procure services appropriately based on the status of the addition

of managed care programs as well as submit the appropriate changes request for the current contract. It was noted a change request requires time and money. Any timeline for implementation of additional managed care programs should factor in these requirements.

The committee received testimony from representatives of DHS regarding the relationship of managed care to Medicaid and department operations. Over the last 5 bienniums, developmental disability, medical, and long-term care have driven growth in spending. While the percentage of the state's population on Medicaid is low at 13 percent, our spending of $10,000 per enrollee is the highest in the country.

The Department of Human Services has several ongoing and strategic initiatives to address costs and additional priorities. The department's strategies and actions include:

- In the delivery of human services, multiple components must be delivered to optimize return on investment.

  If one component is optimized, it may not be as impactful if other components are not optimized in parallel or correspondingly.

  The state has been successful in keeping Medicaid enrollment low through multiple community resources and policy; however, the cost per beneficiary is significantly higher than national averages.
- For system stability, incrementally move from cost, to service, to outcome-based reimbursement across all payment systems.
- Move toward administrative simplification, reduction of complexity, stability for state Medicaid. Medicaid stability relies heavily on information technology tools and resources.
- Increase focus on client and needs through functional support and enhance supports for behavioral health and service in the least restrictive environment.

  There is inconsistency across waivers that do not align services to needs.

  Behavioral health coverage is inadequate, particularly around targeted case management.

  Some elderly are having difficulty staying home.

  Optimize coverage to better align services to needs for children, disabled, and elderly.

Providers

The committee received testimony from representatives of rural hospitals and federally qualified health centers regarding collaboration taking place in bringing health care to rural North Dakota. Barriers these stakeholders are facing include regulatory and reimbursement silos and economic factors such as workforce shortages.

The committee received testimony from a representative of the North Dakota Long Term Care Association in opposition to implementing managed care for the Medicaid long-term care population. The testimony noted the best approach is to learn from other states with managed care experience and to continue on our path of incremental improvements.

The committee received testimony providing an overview of PACE, which provides a full range of preventive, primary, acute, and long-term care services that enable seniors to live in their own homes as long as possible.

The committee received testimony from a representative of the North Dakota Association of Community Providers which provided a summary of the recently completed 9-year process to develop a new developmental disabilities payment system. The testimony supported the gathering of data on how this new system works and how to move forward after this data has been analyzed to gauge the success or failure of this new payment system.

Throughout the interim, the committee received status reports on the activities of the North Dakotans for the Advancement of Care Medicaid Working Group regarding the status of its activities. This group of tertiary hospitals in the state worked with critical access hospitals to move forward on a managed care initiative proposal.

The working group's initial recommendations are:

Initial Program Recommendations	
Model vision	• Population-based alternative payment model in which one or more affordable care organizations (ACOs) contract with the state to take responsibility for delivering cost-effective care to a defined panel of Medicaid enrollees
Covered population	• All traditional and expansion Medicaid enrollees, excluding the developmentally disabled population (Approximately 80,000 mandatory enrollees)

Initial Program Recommendations	
Services included	• Required: physical health, behavioral health, long-term services and support, Rx services; Optional: oral health (to be phased in over time), non-emergency transportation
	• Long-term services and support and Rx services included in total cost of care calculations beginning PY3; non-emergency transportation not included in total cost of care calculations
Provider configuration	• Program to include multiple ACOs, comprising all of the state's eligible providers who will work collaboratively toward shared goals
	• Participation will be mandatory for all eligible Medicaid providers, though approaches to participation may vary
Governance model	• State → Convener → ACOs
Geographic coverage	• Initially piloted in select region(s), then expanded statewide after initial phase-in period
Financial risk	• ACOs will eventually share downside risk for actual expenditures exceeding a predetermined target, with increasing levels of risk/reward over time.

Pharmacy

The committee received testimony regarding Medicaid and Medicaid Expansion pharmacy benefits and steps the state could take to help control costs. As part of this presentation the committee also considered whether some of these steps also may be applicable to PERS prescription drug benefits for the PERS health plan and the Medicare Part D benefits. Recommendations relating to this testimony included:

- For PERS drug benefits and Medicaid Expansion, either revise the contract to establish drug pricing terms and guarantees or carve out coverage so drugs are not moved between the medical and the pharmacy sides.
- Conduct a quick, independent analysis of Medicaid drug-by-drug costs and rebates with Medicaid Expansion. If Medicaid Expansion drug costs are far more expensive than traditional Medicaid, North Dakota should consider bringing its Medicaid Expansion program in house to decrease its Medicaid Expansion drug costs.
- Authorize Medicaid to exclude more drugs and pursue more steerage programs to provide less-costly and wiser drug coverage.
- Authorize Medicaid to pursue and expand its site-of-care steerage programs.
- Implement a loophole-free and exclusivity-free pharmacy benefits management (PBM) contract for PERS prescription drug benefits.

The committee received testimony from representatives of the North Dakota Pharmacists Association in opposition to including prescription drug benefits in any Medicaid managed care programs. The testimony noted DHS has had success in controlling its drug spending.

The committee received testimony from representatives of PBMs regarding the role of PBMs in the health care system, including state and federal regulation of PBMs and an overview of clinical PBM tools and the value of PBMs.

The committee received testimony and data regarding the pharmacy services for traditional Medicaid and Medicaid Expansion, including the most expensive classes of drugs, the net spend for traditional Medicaid, traditional Medicaid rebates, narcotic trends, and fraud cases.

Managed Care Organizations

The committee received extensive testimony from MCOs regarding opportunities for managed care in the state. The Department of Human Services assisted the committee in drafting an informal request for information regarding how Medicaid managed care could be implemented in the state. The request for information addressed--whether a North Dakota managed care program should be tailored, enrollment, benefits, provider contracting, access, and social determinants of health.

Six MCOs participated in panel discussions and were given the opportunity to submit written responses and verbal responses to detailed questions. Representatives of DHS were invited to join the committee members to participate in the panel discussions and ask questions.

Indian Country

The committee received testimony providing an overview of the federal policy change that allows for 100 percent federal reimbursement for Medicaid services provided through Indian Health Services or Public Law 93-638, known as tribal 638 health facilities, if there are care coordination agreements in place between the tribal providers and nontribal providers. Participation in this program is voluntary.

House Bill No. 1012 (2017) provided legislative intent for DHS to help facilitate care coordination agreements and provided any increased federal Medicaid reimbursements resulting from these agreements be deposited in a separate account of the health care trust fund. Participating tribes do not receive any of these funds.

The committee received testimony from representatives of the Three Affiliated Tribes of the Fort Berthold Reservation, the Spirit Lake Tribe, the Standing Rock Sioux Tribe, and the Turtle Mountain Band of Chippewa Indians regarding each tribe's experiences of providing health services in Indian country through a managed care model and regarding the status of care coordination agreements for the provision of Medicaid in Indian country.

The delivery of health services in Indian country varies from reservation to reservation based in part on whether health services are delivered by Indian Health Services or are delivered by tribal 638 health facilities. Testimony focused on tribal willingness to participate in Medicaid care coordination agreements to increase federal reimbursement for services. However, the tribal representatives testified the care coordination agreements require additional resources. The tribal representatives requested the state share increased federal Medicaid reimbursement with the tribes to help fund unmet health needs in Indian country.

Recommendations

The committee makes no recommendation regarding the public benefits managed care study.