EMPLOYEE BENEFITS PROGRAMS COMMITTEE BILL NO. 33

SUMMARY OUTLINE

I. Uniform Group Insurance Program

A. Purpose
1. Promote economy and efficiency of state employment
2. Reduce personnel turnover
3. Offer incentive to high-grade individuals to enter and remain in state employment

B. Composition
1. Composed of eligible and retired employees
2. Formed to provide hospital, medical and life insurance coverage

C. Subgroups (possible)
1. Medical and hospital coverage group
   a. Includes active and retireds not eligible for Medicare
   b. Premiums for retireds not eligible for Medicare
      (1) Single = 150% of active member single rate
      (2) Family of two = 2 X Single not eligible for Medicare
      (3) Family of 3+ = 2.5 X Single not eligible for Medicare
2. Retired Medicare-eligible – medical and hospital coverage
3. Active eligible – life insurance
4. Retired employee – life insurance
5. Terminated employee continuation – medical and hospital
6. Terminated employee conversion – medical and hospital
7. Dental coverage
8. Vision coverage
9. Long-term care coverage
10. Employee assistance coverage
11. Retired Medicare-eligible – prescription drug coverage
12. Healthy ND health insurance coverage

II. Definitions

III. Create "Healthy North Dakota Authority"

A. Composition
1. Non-voting Members (5)
   a. Executive Director of PERS – initial chair until Board elects chair from voting members
   b. 4 - from Advisory Committee who are health care personnel and administrators (selected by Advisory Committee)

2. Voting Members (16) – appointed by Governor for staggered 6-year terms
    a. 4 – from list submitted by statewide labor union coalitions (1 must be public employee)
    b. 4 – from list submitted by statewide business and employer organizations (1 must be public employer)
    c. 1 – from list submitted by ND association of nonprofit organizations
    d. 1 – from list submitted by statewide small business organizations
    e. 2 – farmers, from list submitted by statewide general farm organizations
    f. 1 – self employed individual
    g. 3 – from list submitted by statewide health care consumer organizations.

B. Duties of the Board
    1. Establish and administer health care system
    2. Ensure all eligible persons have access to high-quality, timely and affordable health care
        a. Goals include:
            (1) Every resident must have access to affordable, comprehensive health care services
            (2) Health care reform must maintain and improve choice of providers and high-quality services
            (3) Health care reform must implement cost-containment strategies that retain and assure affordable coverage for all residents
    3. Establish, manage and fund the Plan
    4. Appoint executive director
    5. Provide mechanism to enroll every resident
        a. Any contract with providers must include provisions to enroll all eligible individuals at the point of service
        b. Any contract with providers must include outreach programs to assure every eligible individual becomes enrolled in the Plan
    6. Create program for consumer protection and dispute resolution
    7. Establish independent and binding appeals process
    8. Submit annual report to Governor
    9. Contract for annual, independent program evaluations and audits
    10. Accept bids from health care networks. Consult with PERS in determining most efficient and effective way
    11. Audit health care networks and providers
    12. Establish (with ND Health Department) policies to ensure residents are healthiest in US by 2020

C. Board Pay: $62.50 per day plus mileage and travel expenses

IV. Eligibility

A. Individual eligible if all the following are satisfied:
   1. Maintained "place of permanent abode" in ND for at least 12 months
   2. Maintain "substantial presence" in ND
   3. Is under 65 years of age
   4. Is not
      a. Eligible for health care coverage from federal or foreign government
      b. Inmate of a penal facility
      c. In an institution for mentally ill or developmentally disabled

B. If individual does not satisfy A1 or A2, but is gainfully employed in ND, then eligible for Plan.

C. If individual does not satisfy A1 but has child under age 18 living with them, child is eligible for Plan

D. If pregnant woman does not satisfy A1, but resides in ND, then eligible for Plan

E. DHS can develop requests for federal funds to be used for health care coverage

F. Board to define
   1. "place of permanent abode"
   2. "substantial presence in ND"
   3. "immediate family"
   4. "gainfully employed"

V. Office of Outreach, Enrollment, and Advocacy

A. Board must establish Office of Outreach, Enrollment and Advocacy
   1. Contract with nonprofit organizations to do it
   2. Review health care payment and service records of individuals

B. Duties
   1. Aggressive outreach to enroll eligible individuals
   2. Assist eligible individuals in choosing health care coverage
   3. Inform participants about role they can play to hold down costs by:
      a. preventive care;

b. enrolling in chronic disease management programs if appropriate;
c. responsibly utilizing medical services; and
d. engaging in healthy lifestyles

4. Establish process for resolving disputes (at direction of Board)
5. Act as advocate for Plan participants
6. Inform participant of legal recourse if complaint not resolved
7. Provide information (and recommendation) regarding problems and concerns of Plan participants
8. Ensure participants have timely access to this Office

C. Conflict of interest cannot be present for Office, its employees and contractors

VI. Benefits

A. Same as current state plan

B. Board can provide additional cost-efficient treatment options (evidence-based)

C. Plan must cover mental health/alcohol and drug abuse treatment; and preventive dental benefits up to age 18

VII. Cost-Sharing

A. No-cost preventive services
1. Prenatal care for women
2. Well-baby care
3. Medically appropriate exams and immunizations for children up to 18 years of age
4. Medically appropriate gynecological exams, papanicolau tests and mammograms
5. Medically appropriate regular medical exams for adults, as determined by best practices
6. Medically appropriate colonoscopies
7. Preventive dental care up to 18 years of age
8. Other preventive services, as determined by the Board, for which there is scientific evidence that not having cost-sharing is likely to reduce health care costs or avoid health risks
9. Chronic care services, provided it is within a chronic disease management program as defined by the Board

B. Deductibles
1. Individual 18 or older on Jan. 1 - $300 annual deductible

2. Family (2 or more participants 18 or older on Jan. 1) - $600 annual deductible
3. Individual under age 18 on Jan. 1 – No deductible for that year
4. Cannot refuse services because deductible has not been paid
5. Provider cannot charge interest, penalty, or late fee on deductible owed unless:
    a. Deductible amount is at least 6 months past due
    b. Provider notified participant at least 90 days before interest, penalty, late fee is due
    c. Interest cannot exceed 1% per month
    d. Any penalty/late fee cannot exceed reasonable cost to administer the bill
6. Board can adjust deductibles, but only to reduce them

C. Copayments and Coinsurance
1. Individual 18 or older on Jan. 1 - $20 copay
2. Any participant going to specialist provider without referral from primary provider – 25% of cost
3. Individual 18 or older on Jan. 1 - $60 copay for inappropriate ER use (determined by Board)
4. Prescriptions – all participants
    a. Generic drug on formulary - $5 copay
    b. Brand name drug on formulary - $15 copay
    c. Brand name drug not on formulary - $40 copay
    d. Participant cannot pay more than actual cost of drug plus negotiated dispensing fee
5. Board can adjust copay and coinsurance amounts

D. Maximums (Total cost-sharing = deductibles, copays, coinsurance)
1. Individual 18 or older on Jan. 1 - $2,000 total cost-sharing in that year
2. Family (2+ participants) - $3,000 total cost-sharing in that year

VIII. Service Areas

A. Board establishes areas of the state for purposes of receiving bids from health care networks to:
1. Maximize competition
2. Increase provider choices available

B. In each area, Board must offer the following options:
1. Fee for service
2. Health care networks
3. Board must annually solicit premium bids from "qualifying" health care networks
4. Criteria for "qualifying" health care networks (13)

5. Board reviews bids to determine "quality" health care networks
    a. Board classifies them according to price and quality measures
    b. Classified as lowest-cost; low-cost; higher-cost networks
6. Board must provide annual open enrollment period when each participant chooses a certified health care network; or a Fee for Service option
    a. Coverage effective Jan.1
    b. If participant does not choose, they are randomly assigned to a network that is lowest-cost or low-cost that performs well on quality measures
    c. If participant chooses higher-cost net work, and does not pay the additional cost, they are randomly assigned to a network that is lowest-cost or low-cost that performs well on quality measures
7. Payment to providers
    a. Board pays health care network the PMPM amount bid by the network for those selecting well performing lowest-cost or low-cost network
        (1) Dollar amount is actuarially adjusted for participant's age, sex and other appropriate risk factors determined by the Board
        (2) Participant who selects lowest-cost or low-cost network may not be required to pay any additional amount
    b. If participant chooses higher-cost network, Board pays to the network an amount equal to bid submitted by well-performing lowest-cost network; participant pays the balance (monthly)
    c. Board can retain a % to pay certified health care networks that have incurred disproportionate risk not fully compensated by actuarial adjustment
    d. Board establishes payment rates for participants choosing a Fee-for-Service option (details available)
8. Board to establish financial incentives for Fee-for-Service providers and facilities to collaborate with each other
    a. Pool infrastructure and resources
    b. Implement use of best practices and quality measures
    c. Establish organized processes resulting in high-quality low-cost medical care
9. Board pays for prescription drugs (after deductible)
    a. Board to replicate prescription drug buying system developed by retirement board for drug coverage under state benefit plan (unless Board determines another approach is more cost effective)

b. Board can join with other states to form multi-state purchasing group
c. Board can contract with 3rd party (PBM) to negotiate for reduced prices

IX. Subrogation

X. Employer not prohibited from, for their employees

A. Paying all or a part of any cost-sharing

B. Providing any health care benefits not provided under the Plan

XI. Assessments

A. Board must calculate the following assessments:
1. For employee under age 65
a. If SS wages less than 100% poverty line, no assessment
b. If no dependents and SS wages 100%-200% poverty line, sliding scale 0-4% of employee's SS wages
c. If employee has one or more dependents, or is single and pregnant, and SS wages 150%-300% poverty line, sliding scale 0-4% of employee's SS wages
2. For self-employed individual under age 65, 9%-10% SS wages
3. For individual with no SS wages, 10% Federal Adjusted Gross Income, up to max income subject to SS tax

B. Board calculates assessment based on anticipated revenue needs equal to 9%-12% aggregate SS wages

C. Collection and Calculation of Assessments
1. Beginning with taxable years after 12/31/09, Tax Commissioner collects assessments as part of income tax due (or other method devised by Tax Commissioner)
2. Assessments are deposited into Healthy ND Trust Fund; appropriated to Board on continuing basis
3. Board may annually increase or decrease assessments; % increase cannot exceed % increase in medical inflation (defined)

D. Maximum wage base subject to assessment is maximum SS wage base

XII. Advisory Committee

A. Provide advice to Board (14)
1. Promoting healthier lifestyles
2. Promoting health care quality

3. Increasing transparency of health care cost and quality information
4. Preventive care
5. Early identification of health disorders
6. Disease management
7. Appropriate use of primary care, medical specialists, prescription drugs, and hospital emergency rooms
8. Confidentiality of medical information
9. Appropriate use of technology
10. Benefit design
11. Availability of physicians, hospitals, and other providers
12. Reduction of health care costs
13. Any subject assigned to it by the Board
14. Any subject deemed appropriate by the committee

B. Members to include:
1. At least one designated by NDMA
2. At least one designated by ND Academy of Family Physicians
3. At least one designated by ND Healthcare Association
4. One member designated by President of State Board of Higher Education who is knowledgeable in the field of medicine and public health
5. One member designated by the Dean of the UND School of Medicine and Health Sciences
6. Two members designated by ND Nurses Association
7. One member designated by statewide organizations interested in mental health organizations
8. One member representing health care administrators
9. Other members representing health care professionals

XIII. Effective Date: Taxable years after 12/31/08