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September 13, 2010
Representative Bette Grande, Chair
Legislative Employee Benefits Committee
State Capital
600 East Boulevard
Bismarck, North Dakota 58505-0360

Dear Representative Grande:

RE: REVIEW OF PROPOSED BILL 10103.0100 IMPLEMENTING AND ADMINISTERING A CONSUMER-DIRECTED HEALTH SAVINGS ACCOUNT OPTION

The following summarizes the proposed legislation as well as our assessment of the financial and technical impacts of the bill.

OVERVIEW OF PROPOSED BILL

As proposed, this bill would allow for the implementation and administration of a consumer-directed health savings account option as well as allow the Board to adopt incentives to encourage participation in this option.

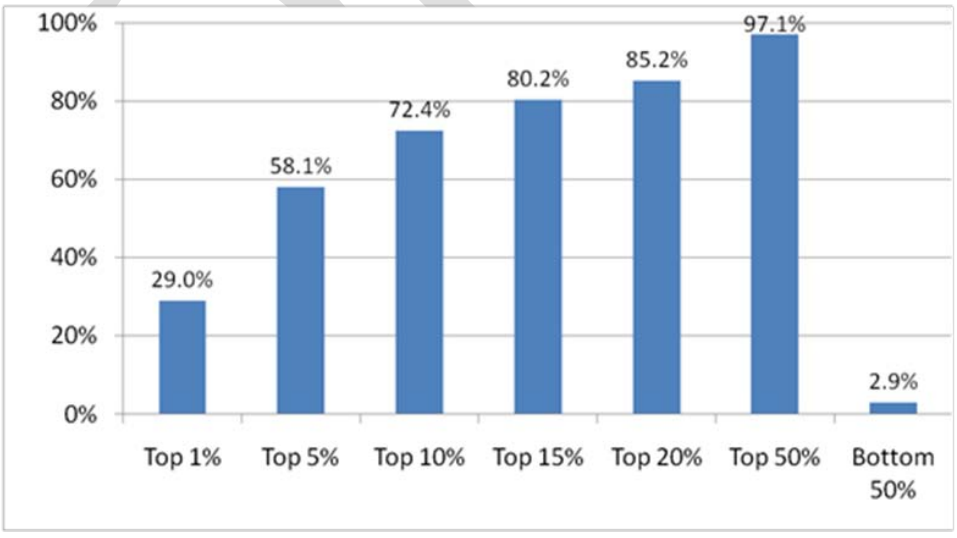
Federal law authorizes the establishment of High Deductible Health Plans (HDHP), under which individuals may establish Health Savings Accounts (HSA) into which they and their employers can make federal tax-exempt contributions that can be used for the payment of certain qualified medical expenses. Annual contribution limits are established under federal law and are based on the individual's status, eligibility, and health plan coverage. As a condition of establishing a Health Savings Account, an individual must be covered under a High Deductible Health Plan. The specific requirements of high-deductible health plans are provided in federal law, but generally require the payment of a certain minimum deductible and the expenditure of certain out-of-pocket expenses before an individual's medical services are covered under the plan. For 2010 the federal law states that in order to be eligible to establish a health savings account the qualified high deductible health plan must have deductible limits of at least $1,200 single and $2,400 family and the maximum out-of-pocket expenses must be no more than $5,950 single and $11,900 family. HDHP plans may also cover preventive services before application of the deductible.

The uniform group insurance program is currently fully insured with Blue Cross Blue Shield of North Dakota. Benefits are generally a $400 single deductible and $1,200 family deductible with the State required to pay the full cost of premium (NDCC 54-52.1-06). This change would require a significant reduction in the value of benefits. However, the difference could be added to the member's health savings account.

Plan Design	NDPERS PPO/Basic	High Deductible Health Plan
Single Deductible	$400	At least $1,200
Family Deductible	$1,200 (embedded deductible of $400 per family member)	At least $2,400 (no embedded deductible)
Single Out-of-pocket maximum	$1,150	No more than $5,950
Family Out-of-pocket maximum	$2,700	No more than $11,900
Copayments (office visits, therapy)	$20/25/30	Subject to Deductible and Out-of-pocket maximum
Prescription Drugs (generic, brand, non-formulary)	$5/20/25	Subject to Deductible and Out-of-pocket maximum

The fundamental premise of a high deductible health plan and health savings account is that the employer-funded health savings account will provide incentives for members to consume their health savings account balance wisely. More specifically the goal of HDHP's is to reduce discretionary utilization by plan participants. These plans are then linked to Health Care Savings accounts (HSA) funded by the premium savings which are used to help pay the higher deductibles when incurred. In addition a participant in an HSA can keep the funds in the savings plan if they don't use it for expenses in the year contributed. Those funds that are saved in a year can be carried over each year and may be used for health care expenses incurred at a later time or even into retirement. In theory, this ability to save the funds in an account creates the incentive for people to reduce discretionary services.

To gain a perspective on the distribution of PERS health plans expenses please note the following table:



This table shows that 85.2% of PERS expenses relate to 20% of PERS members, 80.2% of PERS expenses relates to 15% of PERS members and 58.1% expenses relate to 5% of PERS members. What this shows is that most of PERS plan expenses are concentrated in a few members who have significant life events (cancer, heart disease, etc). Much of the health care delivered to these individuals is not discretionary. Consequently for PERS to reduce health plan costs relating to these types of expenses, the plan must prevent these health issues from arising. In recognition of this challenge PERS has put into place workplace wellness program incentives and individual wellness incentives to encourage members to engage in a more healthy lifestyle. Prevention of chronic health issues can significantly reduce costs.

Looking at the above table from a different perspective you can gain an understanding of the costs associated with more routine types of health plan services that are more discretionary. The table shows that 50% of membership account for 2.9% of our expenses or 80% of our members account for 14.8% of our expenses (top 20% reversed). These discretionary services would be the most sensitive to a HDHP.

In the 2009 renewal PERS did request a bid for a HDHP design and shared it along with other options for consideration by the Governor and Legislature. This bid provides a perspective of the estimated savings a HDHP plan design has on premium. The following is from the renewal document:

> Product Description: High Deductible Health Plan with $1,250 CYD single and $2,500 family (comprehensive) deductible; 80%/20% coinsurance with $1,250 maximum per single and $2,500 maximum per family; deductibles and coinsurance apply to all services including prescription drugs.
>
> "No Individual Choice Scenario"
>
> Election to participate in HDHP made at the employer level for all employees. No individual election by employees allowed. Election may not be changed for two years. Renewal rate for current PERS benefit design (net of $2.80 PERS fee): $843.84 composite pcpm (EPO & PPO). Rate for HDHP product as described above: $749.10 composite pcpm. "Cost neutral" annual employer contribution to HSA (equal to premium differential): $546.21 per single, $1,327.25 per family.
>
> "Individual Choice Scenario"
>
> Election to participate in HDHP made by the individual. Election may not be changed for two years. Risk charge of 2.0% added to all premium rates (both PPO/EPO and HDHP). Renewal rate for current PERS benefit design (net of $2.80 PERS fee): $860.72 composite pcpm (EPO & PPO). Rate for HDHP product as described above: $764.08 composite pcpm. "Cost neutral" annual employer contribution to HSA (equal to premium differential): $557.13 per single, $1,353.80 per family.

If this plan had been adopted for this biennium for everyone (No individual choice) the composite state rate would have been $749.10 instead of $843.84 (as a result of other changes the final rate was

$825.66). The HDHP premiums would have been about 12% lower. The difference, if funded could have been used for individual accounts and overall cost neutral. If choice would have been offered at an individual level (offered on an optional basis) the premium would have increased to $764.08 or 2% due to additional risk from adverse selection.

A major issue facing optional HDHP/HSA plans is the potential for "adverse selection". In simple terms this means those participants that perceive themselves to be healthier and likely to come out ahead on a cost/benefit basis will be more likely to take the HDHP with much lower premiums than the PPO plan. That will leave the sicker people in the PPO plan, causing the entire programs average costs to increase.

There are three main cost drivers that impact the cost of this legislative bill to the state program:

1. Offered as an option or full replacement: When offered as a separate option, the healthier individuals often move to the high deductible health plan to receive the employer contribution causing an increase in overall costs. Based on 2009 experience, over 40% of members had claims of less than $1,200 (minimum single deductible). If offered on an optional basis, many of these lower cost members would choose the HDHP and actually cost the program more. History has shown that HDHP plans, with an HSA contribution, that are offered on an optional basis actually cost more due to this HSA contribution now going to members that incur no or minimal claims expenses.

2. Level of HSA contributions/Opt-outs Returning: A small percentage of state employees currently opt-out of coverage. We would estimate that a portion of those will opt back into the program in order to receive the state's health savings account contribution. Further analysis would be required to determine the financial impact this would have on the program.

3. Unused Health Savings Account Funds: In any given year, many employees will not use all the health savings account funds in their account. As these funds are considered employees money, the state will not receive back any unused funds.

EXPECTED FINANCIAL IMPACT

Offering a high deductible plan as described in this legislative bill will have potential impact on the overall programs cost. Blue Cross Blue Shield of North Dakota evaluated a High Deductible Health Plan offering for the 2009-2011 plan years. They found that you could have a cost neutral plan if offered as full replacement. However, if offered as an optional plan, overall premiums increased 2%.

TECHNINCAL COMMENTS

The current Bill requires the board to implement and administer a consumer directed health savings option for eligible employees. Additional guidance is needed or clarification of how this would relate to other statutory provisions. The following are some areas for guidance or clarification:

- While the bill provides authorization to set up an HSA it does not provide authorization to develop a high deductible health plan,
- The bill should clarify if PERS will contract with a HSA administrator to hold, invest and distribute health savings account assets also guidance should be provided on how such a vendor would be selected,

- The bill should clarify if the HDHP is an additional offering or total replacement,
- In 54-52.1-06 it indicates the state will pay the full cost of the health premium. If an HDHP is added will that cost be for the HDHP or for the existing plan. Statutory clarification is needed. If the HDHP is an option it should state that the premium difference between the HDHP and the regular plan is available to the HSA.
- Will the state be responsible for HSA administrative and account charges, if so an additional appropriation may be required?
- Define if the HDHP is intended to cover political subdivisions and the state? Will it be optional, mandatory and can both be offered?
- If the HSA contribution is not the difference between the high option plan and the HDHP then how is the HSA contribution to be developed and paid?
- How will this apply to pre-medicare retirees and the rate process set in statute?
- An appropriation will need to be provided to PERS for changes to its business system based upon the guidance and clarifications provided.
- Clarify the effective date for implementation.

Some additional technical commentary to consider is below:

- Health savings accounts are designed to belong to the individual and move freely with the individual. These funds move from employer to employer or can be held directly by the individual if the employer does not offer a health savings account.
- Health savings accounts must be held in trust and contributions to a health savings account must be vested immediately.
- Health savings account dollars can be used for additional benefits not currently covered. Long Term Care insurance, some over the counter drugs, retiree insurance, etc.
- You may not have a Flexible Spending Account and a Health Savings Account unless the Flexible Savings Account is for limited use (services not covered by the health plan). The state presently has a flexible spending account for employees.
- To have a successful high deductible health plan model, the administrator needs new consumer support tools that are may not be yet fully developed in the local market. Examples of tools are: drug cost calculators, provider quality and cost data, account balance management capabilities, and treatment options with associated costs.
- An additional administrative expense is needed to set up a trust to hold, invest and distribute health savings account assets. In addition, the program will incur more expenses to bid and implement the program.
- To be most successful a high deductible health plan and corresponding health savings account needs employee readiness. This is not something that can be successfully implemented without thorough planning, communication, and implementation. This could represent a significant increase in administrative expenses for PERS.

Lastly, for the biennium beginning July 1, 2011, PERS group health insurance plan intends to be a "Grandfathered Plan". Section 1251 of the Patient Protection and Affordable Care Act ("PPACA") exempts from certain of the PPACA's group health plan reforms any group health plan in existence on March 23, 2010 ("grandfathered plans"). Losing grandfather status means losing the benefit of the

exemption and subjecting the plan to additional requirements, such as mandatory coverage for certain preventive services, nondiscrimination rules for fully-insured plans, and special claims procedure requirements.

Interim final regulations (dated June 17, 2010) state that if a plan has increase in fixed-amount cost-sharing requirement that is greater than the maximum percentage increase (such as moving to a HDHP) the coverage will cease to be a grandfathered health plan.

If NDPERS were to lose its grandfathered status the following additional mandates may apply (subject to final rules and regulations):

1. Meet the rules on deductible maximums and out of pocket maximums

   We believe that this will have little or no impact since the maximums would most likely align with the levels associated with HSA qualified plans.

2. Required coverage of preventive services with no cost sharing (BCBS has indicated that complying with this could cost between $10 – $14 per contract per month)

   As we understand it, the plan would need to cover additional amounts beyond the $200 limit currently in place for this benefit. We believe that this will have a cost impact. We don't have the level of claim detail that BCBS has to develop such an estimate at this time. We would be happy to review the information and cost development by BCBS.

3. Internal and external appeal process

   We believe that this should be of minimal cost impact, but would increase administrative costs for PERS.

4. No prior authorization for ob-gyn visits

   Based on our experience with clients that allow ob-gyn visits without prior authorization, we suspect that this would have minimal cost impact.

5. Emergency care must have same payment in and out of network, authorization

   Again, we suspect that the cost impact will be minimal given that it is for emergency care only.

6. Nondiscrimination in both insured and self-insured plans

   Should not be an issue for the PERS plan.

7. Coverage of treatment for those in clinical tests

   We would expect that this would have some cost impact, but depends upon the future guidance on clinical trial qualification and coverage levels.

Sincerely,

Patrick L. Pechacek, CEBS
Director

Peter Roverud
Senior Manager

CC: Sparb Collins, NDPERS