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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 10038.0100 PURCHASING PERS HEALTH INSURANCE FOR EACH MEDICAID-ELIGIBLE INDIVIDUAL IN LIEU OF MEDICAID COVERAGE

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 modify the North Dakota Century Code relating to the powers and duties of the Department of Human Services as follows:

- To purchase PERS Health Insurance coverage for each Medicaid-eligible individual in lieu of Medicaid coverage

EXPECTED FINANCIAL IMPACT

The bill authorizes the Department of Human Services to consider purchasing PERS coverage for Medicaid. The bill does not provide any similar authorization to PERS to extend such coverage to Medicaid participates or set the parameters for such an offering. This has the following implications:

1. The PERS statute would need to be modified to allow offering this coverage. PERS statute 54-52.1 would need to be altered:
    a. PERS is designed around active employees, temporary employees and retirees. This group would need to be identified as eligible in statute.
    b. PERS has specific subgroups for the above membership groups. Medicaid participants would need to be identified within the existing subgroups or identified separately.
    c. Eligibility processes would need to be set up in statute.
    d. Appropriation and billing processes will need to be established in statute.

    e. Extensive changes will need to be made to the PERS business system. A separate analysis will need to be done and a separate appropriation will need to set.

2. Currently PERS only has one plan design and it would not meet the federal cost sharing requirements. Medicaid-eligible participants adopting the PERS benefit design be subject to result in higher deductibles/copays/coinsurances for the Medicaid-eligible members as compared with their current Medicaid plan design copays. It would require submission of a state plan amendment, but more likely a waiver as PERS plan design costs will clearly exceed 5% of income for many Medicaid enrollees (statutory cap set by CMS). It is highly unlikely that a state amendment or waiver would be approved for this level of cost sharing.

3. PERS currently purchases health insurance on a fully insured basis from Blue Cross Blue Shield of North Dakota (BCBSND). PERS is set up to charge premiums to the members through employers. This group would require a substantially different billing arrangements. Statutory procedures would need to be established within PERS and the Department of Human Services for payment and administrative services.

Medicaid plans are regulated by the Center for Medicare and Medicaid Services (CMS) and are extremely complex. Most states have a substantial staff dedicated to the administration of the program. Without a study to determine needed staffing by PERS and BCBSND, it is difficult to estimate with any confidence the additional administrative costs to take on such a group of individuals.

For the biennium beginning July 1, 2011, PERS group health insurance plan intends to maintain its status as 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 the principle purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

If PERS 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.

APPENDIX CC

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.

ADDITIONAL FINANCIAL IMPACTS

If the Medicaid-eligible individuals are included in the same experience pool as the existing PERS population and are considered in the PERS premium rate calculations, there will be a financial impact to the existing PERS group health plan. The size and impact of this change on PERS group health plan premium rates would require further detailed analysis but likely to significantly increase premium costs. Also an assessment will need to be done if the PERS statute is modified that would be based upon these changes to determine the effect it would have on the GASB 45/OPEB liability for the State of North Dakota

This will also have a general cost effect on the state since Medicaid provides reimbursement rates lower than commercial health insurance reimbursement. As PERS currently purchases insurance from BCBSND the change from the Medicaid fee schedule to a commercial fee schedule will increase costs to the state for the same services.

States that wish to adopt alternate cost sharing allowed under Soc. Sec. Act §1916A must provide for public comment on the proposed state plan amendment (SPA) before submitting it to CMS. If the amended state plan would allow a family's aggregate cost sharing obligations to exceed 5 percent of income, the proposed SPA must describe: (1) the methodology the state will use to identify for providers the patients and/or services not subject to cost sharing; (2) the methodology the state will use to track the cost sharing paid by families so that they do not exceed the 5 percent aggregate limit for the state's designated period of eligibility; and (3) how beneficiaries may request a redetermination of their cost sharing responsibility when their income is reduced or their assistance has been terminated for failure to pay premiums. The SPA also must specify how providers will be able to determine whether a beneficiary may be required to pay cost sharing before receiving services.

Because Medicaid is a joint Federal-State program, the State of North Dakota receives matching funds from the Federal Government to subsidize the program. If the State purchases PERS health insurance coverage for these participants, it is possible the State will lose its Federal Medicaid subsidy if viewed as no longer being enrolled in Medicaid.

TECHNICAL COMMENTS

The Board would be required to apply to the federal government to receive exempt status under the Employee Retirement Income Security Act (ERISA) for the uniform group insurance plan. Such a waiver would be required to allow a governmental plan to cover non-governmental entities and private citizens without losing its status as a governmental plan. ERISA section 3(32) and Internal Revenue Code section 414(d) define a governmental plan as one established by a governmental unit for its employees. It is not clear how the Board should proceed if an ERISA "waiver" is not granted.

While this bill would allow the Department of Human Services to negotiate for coverage through PERS additional extensive changes in the PERS statute are needed to offer such coverage.

The Board would also need Statute changes to section 54-52 allowing these individuals to be added to PERS.

Sincerely,

Patrick L. Pechacek, CEBS
Director

Peter Roverud .
Senior Manager

CC: Sparb Collins, NDPERS