TESTIMONY OF REBECCA FRICKE

Senate Bill 2160 – Non-Grandfathered Plan Coverage for State Employees and Non-Medicare Retirees

Good afternoon, Mr. Chairman and members of the Committee. My name is Rebecca Fricke and I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appreciate the Committee taking the time to analyze Senate Bill 2160, which requires that effective January 1, 2027, the NDPERS health insurance plan provided to state employees and non-Medicare retirees to include Affordable Care Act (ACA) large employer group mandated coverage, thus requiring the plan to be a non-grandfathered plan under the ACA. I am here today on behalf of the NDPERS Board to provide information in a neutral capacity so the policy makers are able to make an informed decision regarding the bill.

Senate Bill 2160 does the following effective January 1, 2027:

- Requires ACA non-grandfathered large employer group coverage, in addition to existing grandfathered plan coverage, for eligible state employees and pre-Medicare retirees. This coverage would include (list is not all inclusive):
    - Copayments apply towards Out-of-Pocket Maximums
    - Preventive colonoscopies covered at 100%
    - Contraception covered at 100%
    - Additional well child-care coverage
    - Preventative screening for adults covered at 100%
    - Tobacco cessation services
    - Breast pumps
    - Routine prenatal and postnatal care
    - Lactation counseling

- Excludes political subdivisions currently participating in NDPERS grandfathered plan
    - NDPERS would maintain Grandfathered PPO/Basic Plan for this population
        - Majority of participating political subdivisions are small and therefore, if they lose grandfathered status, they lose eligibility to participate in NDPERS health insurance
        - The consultant also notes that it could result in higher, or lower, premiums in the future for the state and/or political subdivisions that participate in the NDPERS health plan. Currently these groups are

pooled together for pricing but with this change, the state and political subdivisions would be pooled separately. Therefore, each group would experience premium differentials based upon their overall claims experience, rather than as a larger pooled group.

- Removes language regarding district health units and Garrison Diversion participating in same manner as state agencies:
    - Requires same premium structure, thus could charge similar flat rate as currently done, rather than single/family rate

NDPERS already administers a large employer non-grandfathered PPO/Basic Plan with these mandated benefits for the large group political subdivisions population. Currently there is 1 political subdivision participating. This volume has varied since the Affordable Care Act was passed. This non-grandfathered plan also provides existing grandfathered PPO/Basic Plan coverage, such as infertility benefits, prosthetic repair & replacement with prior authorization.

Our consultant estimates that the bill would have a financial impact on the NDPERS health insurance plan and estimates an increase in premium of $6,589,000, for the 2025-2027 biennium due to the delayed effective date of January 1, 2027 since this would only include 6 months of the biennium.

NDPERS also asked for guidance from our federal tax compliance consultant. They note that certain restrictions would be removed due to a loss of or move from grandfathered status. These include:

- Coverage or plan design can be modified to shift out-of-pocket costs to the employee (including Legislators on the plan) without regard to limits placed on a grandfathered plan
    - There are cost-sharing limitations applicable for non-grandfathered plans, but they are higher than our current grandfathered plan limitations
    - Coverage provided must also provide minimum value under the ACA to avoid tax penalties.
- Share of premium paid by employees (including Legislators on the plan) could be increased without regard to limits placed on a grandfathered plan
    - Non-grandfathered plans only need to ensure that the amount of premium charged to an employee towards single coverage (not family) be affordable under ACA regulations to avoid employer penalties

Therefore, by becoming non-grandfathered, there is more flexibility to shift plan expenses to the employee either through requiring employees (including Legislators on the plan) to pay towards premium or by changing plan design to shift out-of-pocket

expenses to be more employee (including Legislators on the plan) paid rather than plan paid.

There is additional reporting required by the federal government if the plan becomes non-grandfathered that NDPERS would be responsible for ensuring occurs.

The new coverages are enhancements to what is currently covered in our grandfathered plan. However, the coverage comes at a price, which is why the legislative body has historically wanted NDPERS to remain grandfathered since the passing of the ACA in March 2010.

Ultimately, the decision to move to a non-grandfathered plan is a one-time, irreversible decision. Once you move away from the grandfathered plan, you cannot go back. You will always be required to pay the additional cost of the enhanced benefits required by the ACA, which were priced as an additional 3.9% of premium for a biennium, or $26,353,000 based upon our current plan experience, medical inflation and utilization. This amount will likely increase in the future due to claims experience and medical inflation. Of course, a plan may experience long-term savings to help offset this additional cost in the means of preventing more significant costs due to the additional preventative screenings which could catch certain diseases or conditions earlier. However, the amount of the long-term savings and comparison to additional costs cannot be determined.

In addition, the use of the health insurance reserve fund as a one-time funding source for the upcoming biennium means that in addition to the need to increase premium the following biennium due to plan experience and medical inflation, the amount used in reserves will also need to be made up, making the premium increase the following biennium greater.

Senate Bill 2160 was a bill introduced during the interim, with the analysis provided to the Employee Benefits Programs Committee, which gave the bill a favorable recommendation. The consultant and federal compliance analysis provided to the Committee is included as an attachment to the end of my testimony (please note this was bill draft 142 during the interim session).

Mr. Chairman, I appreciate the Committee taking the time to learn more about the impact this bill will have to our state. This concludes my testimony, and I'd be happy to answer any questions the Committee may have.

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Memo

Date: February 24, 2025

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0142.02007**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data were reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contain errors or anomalies that were unknown at the time the data were provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The current Bill amends and reenacts sections 54-52.1-01, 54-52.1-02, and 54-52.1-03.1 of the North Dakota Century Code relating to health insurance benefits coverage provided by the Uniform Group Insurance Program. The Bill also provides an appropriation and a statement of legislative intent to fund the changes outlined in the Bill. The amendment changes the following:

- Consolidates the definition of "carrier" to an entity that is authorized to provide health insurance in the state:
    - The prior definition splits out coverage for medical benefits coverage and hospital coverage.
- Revises the definition for "health insurance benefits coverage" to be a non-grandfathered PPO health plan sponsored by a large employer that offers hospital coverage, medical coverage, or both coverages.
- Defines a non-grandfathered health plan to mean a plan that does not qualify as a grandfathered plan under the Patient Protection and Affordable Care Act (PPACA).
- Requires that State active employees and non-Medicare retirees will solely be offered the NDPERS non-grandfathered health plan. Political subgroups will still be offered the

grandfathered health plan alongside the non-grandfathered plan. Additionally, any political subdivisions that are currently offered the grandfathered plan can continue to participate in this plan.

- Specifies that Garrison Diversion Conservancy District and district health units that are required to participate in the retirement system may participate in the Uniform Group Insurance Program. The premium structure for these members will mirror what is offered to state employees.
- Requires that the Uniform Group Insurance program must provide health insurance benefits.
- Appropriates $1,900,000 from the state treasury's general fund and $2,400,000 from federal and other special funds to pay for the cost increases associated with the plan changes listed in this Bill

It is important to note that the specified changes outlined in this Bill would become effective on January 1, 2027. The NDPERS biennium runs from July 1, 2025 to June 30, 2027, so the impact of the Bill would only affect a portion of the biennium time period.

IMPLICATIONS OF BILL

One of the impacts of Senate Bill 2160 will result in a shift of the State active employee and non-Medicare retiree populations to a non-grandfathered health plan as determined by the PPACA. By moving to a non-grandfathered plan, the following plan design enhancements will be mandated for covered individuals:

1) Large group employer non-grandfathered plans must offer a minimum value standard of coverage as determined by the PPACA. To meet the minimum value threshold, plans must adhere to the following:

    a. Plans must cover at least 60% of total allowed costs of benefits that are expected to be incurred under the plan. The employee is responsible for the remaining costs through deductibles, copayments, and coinsurance. Plans must receive an actuarial certification that deems that the minimum actuarial value is at least 60% in order to meet this requirement.

    b. Large group employers must offer significant coverage for core services in order to be compliant under non-grandfathered PPACA requirements. These services include:

        i. Coverage for room and board, nursing care, and other hospital services when admitted as an inpatient.

        ii. Coverage for both physician and specialist visits during an inpatient stay, including follow-up care.

        iii. Coverage for surgical services, including pre- and post-operative care. This includes the cost of procedure and the cost of consultation with surgeons, anesthesiologists, and other physicians involved in inpatient surgical procedures.

        iv. Coverage for intensive care units (ICUs), neonatal intensive care (NICU), and other specialized inpatient services.

        v. Coverage for prescription drugs administered during a hospital stay.

vi. Coverage for diagnostic tests, imaging, and lab work performed during an inpatient visit.

vii. Coverage for inpatient rehabilitation services such as physical therapy, occupational therapy, and speech therapy.

viii. Coverage for primary care physician (PCP) visits, routine check-ups, and outpatient treatment of illness.

ix. Coverage for specialist visits.

x. Coverage for diagnostic tests, imaging, and lab work performed in an outpatient setting.

xi. Coverage for outpatient mental health and substance abuse disorder services.

2) Plans are prohibited from imposing annual or lifetime limits on the dollar value of the services mentioned above.

3) Plans must cover preventative services without any cost-sharing requirements. Preventative services include (but are not limited to):

   a. Vaccinations for adults and children;

   b. Routine annual wellness visits;

   c. Routine Diagnostic screenings;

   d. Screenings for cervical, colorectal, and prostate cancer;

   e. Tobacco Cessation programs and eligible supplies;

   f. Preventative medications and supplements;

   g. Childcare visits up to the age of 6;

   h. Coverage for contraception; and

   i. Women's wellness visits and breastfeeding support (including breast pump coverage).

4) Non-grandfathered health plans must comply with out-of-pocket maximum limits set by the PPACA. All member costs such as deductible or copay costs must accumulate towards their out-of-pocket maximum.

5) Out-of-Network emergency room services will be covered at the same level as in-network services.

6) A non-grandfathered plan, unlike a grandfathered plan, must comply with all PPACA reporting provisions. This includes Transparency in Coverage reporting, RxDC reporting, and the No Surprises Act attestations.

Political subgroups that are offered health insurance by NDPERS will still be eligible for a grandfathered plan. When developing the premium of both health plans, the non-grandfathered plan will utilize experience from the State employee and non-Medicare population, whereas the political subgroups will be underwritten separately. This is a deviation from how premium rates were developed in prior biennia.

State active employee premiums are currently established using a single rate per contract. The premium for a State employee with dependents is set at the same level as a State employee that only covers themselves. Political subgroups have two rates: one for employee only coverage and one for covering families. A political subgroup employee that covers their family will have a premium set at a higher level than an employee that only covers themselves. Senate Bill 2160 requires that the Garrison Diversion Conservancy District and district health units' premium structures to be treated in the same manner as State employees. The premium rates for these employees will be calculated based on grandfathered plan experience however, instead of charging two rates like other political subgroups, these employees will be offered a single flat rate like the premium structure for State employees.

ESTIMATED FINANCIAL IMPACT

Based on the review of current offerings and the stipulations within the current legislation, it is anticipated that moving State active employees and non-Medicare retirees from grandfathered to non-grandfathered status will have a financial impact on the Uniform Group Insurance Program. As stated earlier, the plan design changes would only apply to the period of 1/1/2027 to 6/30/2027 of the biennium. It is estimated the financial impact of this move is approximately $6,589,000 in the 2025 – 2027 biennium ending 6/30/2027.

Currently, the NDPERS plan does meet many of the non-grandfathered plan design requirements that were listed earlier. However, the following changes must be made to fully comply with the non-grandfathered plan design requirements:

- All copays will accumulate towards a member's plan out-of-pocket maximum.
- Preventative services will be covered with no cost-sharing responsibilities for members:
    - Currently, the NDPERS plan has an annual wellness allowance of $200. Once this allowance is exhausted, preventative services are covered with a member cost share. This cost-sharing responsibility has been removed when analyzing the financial impact.
    - Additionally, preventative care will now include 100% coverage for breast pumps, an increase in coverage for childcare wellness visits, contraceptive medications regardless of formulary status, tobacco cessation, colonoscopies, and cancer screenings without any service limits. Previously, there services were not covered at 100% and included some service limits.

The development of the estimated claims impact utilized an internal Medical Rate Model, which includes medical and pharmacy benefit designs and is based on over 40 million active/non-Medicare retiree claims. The Medical Rate Model functions as a claims repayment model, applying detailed input plan provisions against the claims record database, effectively repricing the claims, and producing the expected plan claim payments versus allowed charges.

It is estimated the plan design changes required as a result of the proposed Bill would produce a 3.0% increase to the expected total claims paid *for State employees and non-Medicare retirees* covered under the Uniform Group Insurance Program (no change for other covered groups). This is the impact of increasing the richness of coverage under the plan. Additionally, an increase in the

richness of benefits may lead to an increase in service utilization. Members, once hearing about a richer benefit offering, may withhold utilization until the new plan provisions are active, which may lead to pent-up demand once the new benefits are in place. The estimated increase in cost due to this uptick in utilization is 1.0%. The combination of these two factors impacting claims would result in approximately a **3.9% increase to premiums for the State Active and non-Medicare Retiree plans**. However, this increase in premium would only affect the periods of 1/1/2027 to 6/30/2027 which would lower the overall impact of the design change to approximately **1.0% for the 2025 – 2027 biennium.**

The Political Subgroup plans and the Medicare population are not anticipated to see an impact to their plan offerings as a result of the Bill. Political Subgroups will still have access to the grandfathered plans and the Medicare population will have access to the same plans as they currently do. Therefore, these two groups are **not expected to experience any increase in premiums**.

When combining the estimated impact of the premium increase to State Active and Non-Medicare Retiree plans to the current costs of the Political Subgroup and Medicare plans, the result is approximately a **0.8% increase in total plan 2025-2027 biennium costs** for the Uniform Group Insurance Program. The anticipated change to expected claims cost was applied to the estimated biennium claims for the active and pre-Medicare groups enrolled in the PPO/Basic Grandfathered plan, which were derived from the 2025 – 2027 renewal rates. The design changes were only applied to the plan after the effective date of Senate Bill 2160.

The table below outlines the estimated impact of Senate Bill 2160 for each subgroup under NDPERS:

Group	State Actives	Political Subgroups	Non-Medicare Retirees	Medicare	Total Cost
Status Quo 2025 -2027 Cost	$667,166,000	$132,048,000	$14,204,000	$50,426,000	**$863,844,000**
Plan Design Change Actuarial Value Adjustment for the period of 1/1/2027 – 6/30/2027	3.0%	No Impact	3.0%	No Impact	
Initial Utilization Change for the period of 1/1/2027 – 6/30/2027	1.0%		1.0%		
Adjusted Estimated Total Cost for 2025 – 2027 Biennium	$673,617,000	$132,048,000	$14,342,000	$50,426,000	**$870,433,000**
Estimated Total Cost % Impact	**1.0%**	**0.0%**	**1.0%**	**0.0%**	**0.8%**

It is estimated that the financial impact of the proposed legislation on the Uniform Group Insurance Program is approximately $6,589,000 in the 2025-2027 biennium ending 6/30/2027.

Senate Bill 2160 will also provide a pool of funds totaling $4,300,000 to pay for the plan design changes specified within the Bill. After accounting for these funds, the remaining 2025-2027 biennium cost associated with the financial impact of this Bill would be approximately $2,289,000.

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MEMORANDUM

TO: **Rebecca Fricke, North Dakota PERS**

FROM: **Christopher S. Sears, ICE MILLER LLP**

DATE: **October 16, 2024**

RE: **Bill Draft # 142 - Mandating ACA Coverage for State of North Dakota**

This memorandum is given to you in confidence and with the attorney-client privilege. We have not delivered or mailed any copies of this memorandum to anyone else, other than those individuals noted in this memorandum. You should disclose the contents of this memorandum only to those officers or trustees who need to know the contents in order to make informed decisions on the matters discussed herein.

We have reviewed the proposed changes (Bill Draft #142, attached as provided to us on September 23, 2024) to the current uniform group insurance program ("Program") codified at NDCC Section 54.52.1-02. In short, the Bill Draft requires the Program to provide a new non-grandfathered health plan that would provide enhanced coverage that includes all of the benefits required under the Affordable Care Act ("ACA") for non-grandfathered plans. We also understand that the Bill Draft is intended to require the new plan to include the benefits that are also covered under the currently existing grandfathered plan such as infertility benefits and prosthetics repair/replacement. We will refer to this new coverage as "Enhanced Coverage." This memorandum addresses a number of issues under the ACA for your consideration related to the Bill Draft.

Relevant Facts

It is our understanding the Program is fully insured and has maintained its "grandfathered" status under the ACA since 2010. We also understand that it is the Bill Draft's sponsor's intent to require Enhanced Coverage for State employees/former employees and all non-Medicare age retirees who are currently eligible for the Program. The Enhanced Coverage would require the State to provide these individuals with ACA mandated coverage for non-grandfathered plans. The Enhanced Coverage would not apply to current employees who work for a political subdivision that participates in NDPERS, or retirees who are of Medicare age. Further, the intent is to have individuals who are not eligible for the Enhanced Coverage (*e.g.* political subdivisions) remain in the current grandfathered plan. The effective date for the Enhanced Coverage is January 1, 2026.

Coverage Required to be Added to a Non-Grandfathered Plan

The creation of the Enhanced Coverage will result in a non-grandfathered plan under the ACA. Such plans must offer benefits that are not required to be offered under grandfathered plans. The benefits that must be added to the Enhanced Coverage include:

- Coverage of preventive care without employee cost-sharing (Public Health Service Act ["PHSA"] Section 2713);
- Limitations on out-of-pocket maximums (PHSA Section 2707);
- Expanded claims and appeal requirements (PHSA Section 2719);
- Additional patient protections (right to choose a primary care provider designation, OB/GYN access without a referral, and coverage for out-of-network emergency department services) (PHSA Section 2719A); and
- Coverage of routine costs associated with clinical trials (PHSA Section 2709).

If NDPERS uses an insured product to provide the Enhanced Coverage (as it does for the current Program), the policy will almost certainly contain those benefits. If NDPERS decides to self-insure the Enhanced Coverage, it will need to ensure that these additional benefits are included in the Coverage.

Restrictions Removed As a Result of Losing Grandfathered Status

As you know, maintaining grandfathered status came with a loss of flexibility with respect to member premiums and costs associated with the Program. For example, to maintain grandfathered status, the Program was limited in raising cost-sharing requirements such as deductibles, copayments, and coinsurance, eliminating benefits, and increasing employees' share of premiums. As a non-grandfathered plan, the Enhanced Coverage could be modified without regard to the limits placed on grandfathered plans. As a result, out-of-pocket cost sharing could be increased year-to-year (subject to the ACA's statutory limits on out-of-pocket costs as described below), benefits could be added or eliminated (presumably provided the benefits that are also provided under the current grandfathered plan are not eliminated), and the share of the premium paid by employees may be increased without regard to the limits imposed by the grandfather rule. This obviously would provide NDPERS with additional tools to deal with the rising cost of health care.

Remaining Restrictions

NDPERS' ability to increase cost-sharing and premiums in a manner not allowed by the grandfather rule is subject to certain restrictions.

Restrictions on Cost-Sharing

First, Section 2707(b) of the PHSA generally applies to non-grandfathered governmental plans. PHSA Section 2707(b) provides, "[a] group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under [42 USC §18022(c)]." Further, guidance issued by CMS provides, "[PHSA S]ection 2707(b), as added by the Affordable Care Act, provides that a non-grandfathered group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under sections 1302(c)(1) and (c)(2) of the Affordable Care Act. Section 1302(c)(1) limits out-of-pocket costs . . . ." (CMS.gov, Affordable Care Act Implementation FAQs – Set 18, last modified September 6, 2023; see also, CMS.gov, Affordable Care Act Implementation FAQs — Set 12 ("As stated in the preamble to the HHS final regulation on standards related to essential health benefits, the Departments read PHS Act section 2707(b) as requiring all non-grandfathered group health plans to comply with the annual limitation on out-of-pocket maximums described in section 1302(c)(1) of the Affordable Care Act")).

PHSA §2707 provides that cost-sharing for self-only coverage may not exceed $9,450 in 2024 (subject to annual changes). For other coverage (*e.g.*, family), cost-sharing may not exceed twice the amount in the preceding sentence (*i.e.*, $18,900 in 2024). Cost-sharing is generally defined as: (i) amounts spent on deductibles, coinsurance, copayments, or similar charges; and (ii) other expenses paid by the insured individual which are considered qualified medical expenses with respect to essential health benefits covered under the plan. "Cost-sharing" for these purposes does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

Accordingly, the NDPERS will want to carefully review the terms of the Enhanced Coverage to ensure cost-sharing is limited to what is allowed by PHSA §2707.

Restrictions on Premium Increases

Even though the grandfather rule would not limit premium increases in the non-grandfathered Enhanced Coverage like it does in the current Program, another provision of the ACA has the practical effect of limiting the premium NDPERS may charge members for the Enhanced Coverage.

Under Code Section 4980H, an applicable large employer may be subject to tax penalties if it does not offer "affordable" coverage to at least 95% of its full-time employees and their dependents. The coverage must also offer "minimum value." The State is an applicable large employer. The penalty can be triggered when one or more full-time employees receive a premium tax-credit or cost sharing reduction to purchase health coverage on a health insurance exchange because the coverage offered is deemed to be "unaffordable" or fails to provide "minimum value." Subject to certain adjustments, the Code Section 4980H(b) penalty is $4,460 per affected employee (or $371.67 per month) in 2024.

The "affordability" standard is keyed to the employee's required monthly contribution for single coverage under the employer's lowest cost health plan. The coverage is considered "unaffordable" if it exceeds 8.39% (as of 2024, subject to adjustments for inflation) of the employee's household income for the tax year. Because most employers will not know an employee's annual household income, the Internal Revenue Service ("IRS") has prescribed 3 optional affordability safe harbors to avoid the Code §4890H(b) penalty:

1. Form W-2 Safe Harbor. In general, this safe harbor is met if a full-time employee's required contribution for the calendar year for the employer's lowest cost self-only coverage that provides minimum value during the entire calendar year does not exceed 8.39% in 2024 (subject to annual adjustments) of the employee's Form W-2 wages (*i.e.*, Box 1 wages). (Treas. Reg. §54.4980H-5(e)(2)(ii)(A); Proposed Reliance Treas. Reg. §54.4980H-5(e)(2)(ii)(A); Rev. Proc. 2023-29)). In situations where an employee is not offered coverage for the entire calendar year, the employee's Form W-2 wages (*i.e.*, Box 1 wages) are adjusted to reflect the period when coverage was offered based on the months coverage as offered. (Treas. Reg. §54.4980H-5(e)(2)(ii)(B); Proposed Reliance Treas. Reg. §54.4980H-5(e)(2)(ii)(A); Rev. Proc. 2023-29)).

2. Rate of Pay Safe Harbor. In general, an applicable large employer satisfies this safe harbor for an hourly employee in any month where the employee's required contribution for the employer's lowest cost self-only coverage that provides minimum value does not exceed 8.39% in 2024 (subject to adjustments) of an amount equal to 130 hours multiplied by the lower of: (i) the employees hourly rate as of the first day of the coverage period (*e.g.*, first day of the plan year); or (ii) the employee's lowest hourly rate of pay during the calendar month. With respect to a non-hourly employee, this safe harbor is generally satisfied in any month where the employee's required contribution for the employer's lowest cost self-only coverage that provides minimum value does not exceed 8.39% in 2024 (subject to adjustments) of the employee's monthly salary as of the 1st day of the coverage period. (Treas. Reg. §54.4980H-5(e)(2)(ii)(B); Proposed Reliance Treas. Reg. §54.4980H-5(e)(2)(iii); Rev. Proc. 2023-29)).

3. Federal Poverty Line Safe Harbor. This safe harbor is generally satisfied during a month when the employee's required contribution for the applicable large employer's lowest cost self-only coverage that provides minimum value does not exceed $101.93 per month in 2024 (subject to annual adjustments). (Treas. Reg. §24.4980H-5(e)(2)(iv); Proposed Reliance Treas. Reg. §24.4980H-5(e)(2)(ii)(A); Rev. Proc. 2023-29)).

Thus, NDPERS will need to be mindful of this limitation when setting employee premiums for the Enhanced Coverage. We note that this limitation only applies to active full-time employees. It does not apply to terminated employees who may participate in the Enhanced Coverage such as retirees not yet eligible for Medicare.

In addition, the Enhanced Coverage should provide "minimum value" to avoid potential ACA tax penalties for the employer. In general, a plan provides "minimum value" for an

employee or related individual where it provides: (i) a minimum value percentage of at least 60% based on the plan's share of total allowed costs of benefits provided to the employee or related individual; and (ii) the plan provides substantial coverage of inpatient hospital services and physician services. (Treas. Reg. §1.36B-6(a)(1)-(2)(i)). The State's insurance carrier should be able to easily let you know whether the Enhanced Coverage provides minimum value.

Employer Shared Responsibility Payment Reporting Requirements

We assume that under the current Program, the insurer furnishes each member with a Form 1095-B and files Forms 1094-B and 1095-B with the IRS. We further assume that NDPERS (or some other State agency) provides active full-time employees participating in the Program with Parts I and II of the Form 1095-C and files Forms 1094-C and 1095-C to the IRS. If this is not the case, please let us know. These filing obligations would not change under the Enhanced Coverage. These filing obligations apply regardless of whether an employer sponsors a grandfathered or non-grandfathered plan.

Transparency in Coverage

Section 1311 of the ACA, along with its implementing regulations (The Transparency in Coverage Final Rules or "TiC" Final Rules) requires non-grandfathered employer plans and health insurance issuers offering non-grandfathered coverage to disclose, on a public website, information regarding in-network rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in separate machine-readable files. The machine-readable file requirements of the TiC Final Rules were applicable for plan years beginning on or after January 1, 2022, although enforcement of various parts of the TiC Final Rules were delayed in certain respects. Additionally, the TiC Final Rules require plans and issuers to make price comparison information available to participants through an internet-based self-service tool and in paper form, upon request. This information must be available for plan years beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments in Table 1 in the preamble to the TiC Final Rules, and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.

These obligations apply to both the group health plan and any insurer of a group health plan. Thus, the requirements would apply to NDPERS (as sponsor of the Enhanced Coverage) and any insurer of the Enhanced Coverage. However, the TiC Final Rules contain a nonduplication provision. It provides that, "to the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements . . . if the plan requires the health insurance issuer offering the coverage to provide the information required by [the TiC Final Rules] in compliance with [the TiC Final Rules] pursuant to a written agreement. Accordingly, if a health insurance issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under [the TiC Final Rules] . . . and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of [the TiC Final Rules]. (45 CFR 147.211(b)(3)). Thus, if NDPERS is required

to implement the Enhanced Coverage and it is insured, NDPERS should enter into a contract with the insurer that imposes the TiC Final Rules' responsibilities on the insurer.

Prescription Drug Reporting (RxDC)

We assume that you are already aware of the No Surprises Act's requirements for plans and issuers to report information about prescription drug spending because it is applicable to group health plans like the Program and the Enhanced Coverage regardless of grandfathered status. However, we at least wanted to note it here to ensure you are aware of the obligation. NDPERS and/or the Rx benefit provider for the Program should already be complying with this obligation. It will apply equally to any Enhanced Coverage that is implemented.

Bill Draft Text

We understand the Bill Draft to have three primary goals:

1. To require the creation of a new health plan that contains the benefits required under the ACA for non-grandfathered plans;

2. To require the new plan to also cover the benefits that are currently covered by the current grandfathered plan, such as infertility benefits and prosthetic repair/replacement; and

3. To maintain the grandfathered plan for entities that are not eligible to participate in the new non-grandfathered plan such as political subdivisions.

We are attaching a mark-up of the Bill Draft with our specific comments and proposed edits related to whether the Bill Draft's language achieves these goals.

We believe the Bill Draft's language achieves the first goal.

With respect to the second goal, it is not clear to us what the scope of the new language at NDCC Section 54-52.1-01.5.1 is trying to achieve. It states that the new plan must include "benefits provided under the uniform group insurance program's grandfathered preferred provider organization plan." This language is vague. Are the benefits to be preserved as of the date of the amendment's enactment? What if the grandfathered plan is amended in the future to add a new benefit? Will the new non-grandfathered plan have to be amended to adopt the new benefit, too? This language could also limit flexibility in the new plan. For example, it could not be converted into a high-deductible health plan, particularly if the equivalency requirement also applies to deductibles, copayments, coinsurance, and out-of-pocket limits. We believe that this section could benefit from additional clarity.

With respect to the third goal, it is not clear to us that the new Section 54-52.1-03.1.2 transparently states that the current grandfathered plan must remain available to political

subdivisions. The new language states, "For purposes of this Section, the uniform group insurance program must provide health insurance benefit coverage as defined in Section 54-52.1-01." "Health insurance coverage" (as amended by the Bill Draft) means the non-grandfathered plan, hospital benefits coverage, and medical benefits coverage. That definition does not include the grandfathered health plan, yet it is our understanding that the intent is for political subdivisions covered by Section 54-52.1-03.01 to remain eligible to participate in the grandfathered plan. Assuming that is true, it should be more clearly stated. Perhaps a new definition for the grandfathered plan could be added to Section 54-52.1-01 (e.g., "the plan sponsored by the State that is a grandfathered plan as that term is defined by 42 U.S.C. 18011(e)"). Then, the new language at 54-52.1-03.1.2 could state, "For purposes of this Section, the uniform group insurance program offered under the section must include, to the extent still offered by the State, the grandfathered plan."

Final Thoughts

As you know, there are a myriad of disclosure and other obligations applicable to group health plans. In keeping with our understanding of your original e-mail, we have focused on those that will be new or otherwise change if the Enhanced Coverage is implemented. We are very happy to provide more detail on the obligations discussed in this e-mail.

25.0142.02000

Sixty-ninth
Legislative Assembly
of North Dakota

BILL NO.

Introduced by

Senator Davison

A BILL for an Act to amend and reenact sections 54-52.1-01, 54-52.1-02, and 54-52.1-03.1 of the North Dakota Century Code, relating to health insurance benefits coverage provided by the uniform group insurance program; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-52.1-01 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-01. Definitions.

As used in this chapter~~, unless the context otherwise requires~~:

1. "Board" means the public employees retirement board.
2. "Carrier" means:
   a. For ~~the hospital~~health insurance benefits coverage, an insurance company authorized to do business in the state, or a nonprofit hospital service association, or a prepaid group practice hospital or medical care plan authorized to do business in the state, or the state if a self-insurance health plan is used for providing hospital or medical benefits coverage.
   b. ~~For the medical benefits coverage, an insurance company authorized to do business in the state, or a nonprofit medical service association, or a prepaid group practice medical care plan authorized to do business in the state, or the state if a self-insurance health plan is used for providing medical benefits coverage.~~
   ~~c.~~ For ~~the~~ life insurance benefits coverage, an insurance company authorized to do business in the state.
3. "Department, board, or agency" means ~~the departments~~a department, ~~boards~~board, ~~agencies~~agency, or ~~associations~~association of this state. The term includes the state's

charitable, penal, and higher educational institutions; the Bank of North Dakota; the state mill and elevator association; and counties, cities, district health units, and school districts.

4. "Eligible employee" means every permanent employee who is employed by a governmental unit, as that term is defined in section 54-52-01. "Eligible employee" includes members of the legislative assembly, judges of the supreme court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by section 54-06-01, and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund. As used in this subsection, "permanent employee" means one whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. For purposes of sections 54-52.1-04.1, 54-52.1-04.7, 54-52.1-04.8, and 54-52.1-11, "eligible employee" includes retired and terminated employees who remain eligible to participate in the uniform group insurance program pursuant to applicable state or federal law.

5. "Health insurance benefits coverage" means ~~hospital~~:

   a. A nongrandfathered group health plan sponsored by a large employer which meets the applicable requirements of 42 U.S.C. chapter 6A, subchapter XXV, without regard to 42 U.S.C. 18011, including benefits provided under the uniform group insurance program's grandfathered preferred provider organization plan;

   b. Hospital benefits coverage ~~or medical~~;

   c. Medical benefits coverage~~,~~; or ~~both~~

   d. Both hospital and medical benefits coverage.

6. "Health maintenance organization" means an organization certified to establish and operate a health maintenance organization in compliance with chapter 26.1-18.1.

Commented [CSS1]: This still feels very vague. Is this as those benefits existed under the grandfathered plan as of the date of this amendment's enactment? What if the GF plan is amended? Does that require an automatic amendment of the NGF plan? What if the NGF plans gets turned into a high deductible health plan. If that's the case, then the benefits will necessarily be different. What if there are other policy or legal reasons for them to differ? Does this also mean that their deductible/copayment/coinsurance/out-of-pocket max structures have to be the same? This section should have more clarity.

7. "Hospital benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for hospital services incurred in accordance with the uniform contract.

8. "Life insurance benefits coverage" means a plan that provides both term life insurance and accidental death and dismemberment insurance in amounts determined by the board, with a minimum of one thousand dollars provided for the term life insurance portion of the coverage.

9. "Medical benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for medical services in accordance with the uniform contract.

10. "Member contribution" means the payment by the member into the retiree health benefits fund pursuant to sections 54-52-02.9 and 54-52-17.4.

11. "Member's account balance" means the member's contributions plus interest at the rate set by the board.

~~12.~~ 12. "Nongrandfathered health plan" means a plan that is not a "grandfathered health plan" as that term is defined by 42 U.S.C. 18011(e)~~does not qualify as a grandfathered plan under the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].~~

~~13.~~ 13. "Self-insurance health plan" means a plan of self-insurance providing health insurance benefits coverage under section 54-52.1-04.2.

~~13.~~14. "Temporary employee" means a governmental unit employee who is not filling an approved and regularly funded position in an eligible governmental unit and whose services may or may not be limited in duration.

SECTION 2. AMENDMENT. Section 54-52.1-02 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-02. Uniform group insurance program created - Formation into subgroups. In order to promote the economy and efficiency of employment in the state's service, reduce personnel turnover, and offer an incentive to high-grade individuals to enter and remain in the service of state employment, there is created a uniform group insurance program.

1. The uniform group insurance program must ~~be~~:

   a. Be composed of eligible and retired employees ~~and be formed to provide hospital benefits coverage, medical benefits coverage,~~;

Commented [CSS2]: What is hospital benefits coverage and medical benefits coverage? Are these concepts really relevant? How are these different from the GF and NGF plans?

Commented [CSS3]: See prior comment.

b. Except as provided in subsection 2 of section 54-52.1-03.1, provide coverage as defined in subdivision a of subsection 5 of section 54-52.1-01; and

c. Provide life insurance benefits coverage ~~in the manner set forth in this chapter~~.

2. The board may divide the uniform group ~~may be divided~~ into the following subgroups ~~at the discretion of the board~~:

~~1. Medical and hospital~~

a. Health insurance benefits coverage group consisting of active eligible employees and retired employees not eligible for Medicare, except for employees who first retire after July 1, 2015, and are not eligible for Medicare on their retirement. In determining premiums for coverage under this ~~subsection~~subdivision for retired employees not eligible for Medicare, the rate for a non-Medicare retiree single plan is one hundred fifty percent of the active member single plan rate, the rate for a non-Medicare retiree family plan of two people is twice the non-Medicare retiree single plan rate, and the rate for a non-Medicare retiree family plan of three or more persons is two and one-half times the non-Medicare retiree single plan rate.

~~2.~~ b. In addition to the coverage provided in ~~subsection 1~~subdivision a, another coverage option may be provided for retired employees not eligible for Medicare, except for employees who first retire after July 1, 2015, and are not eligible for Medicare on their retirement, provided the option does not increase the implicit subsidy as determined by the governmental accounting standards board's other postemployment benefit reporting procedure. In offering this additional option, the board may have an open enrollment but thereafter enrollment for this option must be as specified in section 54-52.1-03.

~~3.~~ c. Retired Medicare-eligible employee group ~~medical and hospital~~health insurance benefits coverage.

~~4.~~ d. Active eligible employee life insurance benefits coverage.

~~5.~~ e. Retired employee life insurance benefits coverage.

~~6.~~ f. Terminated employee continuation group ~~medical and hospital~~health insurance benefits coverage.

~~7.~~ g. Terminated employee conversion group ~~medical and hospital~~health insurance benefits coverage.

~~8.~~ h. Dental benefits coverage.

~~9.~~ i. Vision benefits coverage.

~~10.~~ j. Long-term care benefits coverage.

~~11.~~ k. Employee assistance benefits coverage.

~~12.~~ l. Prescription drug coverage.

SECTION 3. AMENDMENT. Section 54-52.1-03.1 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-03.1. Certain political subdivisions authorized to join uniform group insurance program - Employer contribution.

1. If eligible under federal law, a political subdivision may extend the benefits of the uniform group insurance program under this chapter to its permanent employees, subject to ~~minimum~~ requirements established by the board and aas follows:

   a. A minimum period of participation of sixty months. If the political subdivision withdraws from participation in the uniform group insurance program, before completing sixty months of participation, unless federal or state laws or rules are modified or interpreted in a way that makes participation by the political subdivision in the uniform group insurance program no longer allowable or appropriate, the political subdivision shall make payment to the board in an amount equal to any expenses incurred in the uniform group insurance program that exceed income received on behalf of the political subdivision's employees as determined under rules adopted by the board.

   b. The Garrison Diversion Conservancy District, and district health units required to participate in the public employees retirement system under section 54-52-02, shall participate in the uniform group insurance program under the same ~~terms and conditions~~premium structures as state agencies.

   c. A retiree who has accepted a retirement allowance from a participating political subdivision's retirement plan may elect to participate in the uniform group under this chapter without meeting minimum requirements at age sixty-five, when the employee's spouse reaches age sixty-five, upon the receipt of a benefit, when the

political subdivision joins the uniform group insurance plan if the retiree was a member of the former plan, or when the spouse terminates employment. If a retiree or surviving spouse does not elect to participate at the times specified in this ~~section~~subdivision, the retiree or surviving spouse must meet the minimum requirements established by the board.

d. Each retiree or surviving spouse shall pay directly to the board the premiums in effect for the coverage then being provided. The board may require documentation that the retiree has accepted a retirement allowance from an eligible retirement plan other than the public employees retirement system.

2. For purposes of this section, the uniform group insurance program must provide health insurance benefits coverage as defined in section 54-52.1-01.

SECTION 4. EFFECTIVE DATE. This Act becomes effective on January 1, 2026.

Commented [CSS4]: We believe it is still not clear what has to be offered to the polisubs. "Health insurance benefits coverage" (as amended by this bill) means the NGF plan, hospital benefits coverage, and medical benefits coverage. The definition does not include the GF plan, but our understanding that the polisubs are supposed to still have the GF plan available to them. Assuming that's true, then that should just be clearly stated. Perhaps add a definition of GF plan at 54-52.1-01 (e.g., the plan sponsored by the State that is a GF plan as defined by 42 U.S.C. 18011(e)), and then say here that, "For purposes of this section, the uniform group insurance program offered under this section must include the NGF plan and, to the extent still offered by the State, the GF plan." It is just better to state clearly what must be offered.