NDPERS BOARD SPECIAL MEETING

Agenda

Location:
ND Attorney General's Office
Conference Room
17th Floor, State Capitol
Bismarck, ND

January 4, 2017 **Time: 12:00 p.m.**

I. IRS Cycle C Filing – Sparb (Information)

II. Legislation – Sparb (Board Action)

III. Health Plan Update - (Information)

Any individual requiring an auxiliary aid or service must contact the NDPERS ADA Coordinator at 328-3900, at least 5 business days before the scheduled meeting.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● www.nd.gov/ndpers

Memorandum

TO: NDPERS Board

FROM: Sparb

DATE: January 3, 2017

SUBJECT: Special Board Meeting

At this special meeting we have three agenda items:

I. IRS Cycle C Filing – Sparb (Information)
II. Legislation – Sparb (Board Action)
III. Health Plan Update - (Information)

IRS Cycle C Filing

Attached please find from the IRS favorable determination letters on the Main PERS Hybrid plan and the Highway Patrol Retirement Plan (attachments 1 & 1a). Pursuant to this review it was noted that we need to add some clarification to our statute for both plans. That clarification is attachment #2 and is a proposed amendment to our administrative bill. Jan will be at the meeting to review this with you. **Staff is seeking your approval to submit the proposed amendment at our legislative hearing on January 5.**

Recovery Bill

As was noted at the last meeting funding for the recovery bill was not included in the Executive Budget. The Executive Budget also did not provide a salary increase for employees for 2017 and a 1% increase in 2018.

Attachment #3 is the draft testimony for our recovery bill. The need for the 4th year of the recovery plan is outlined in this testimony. However the reality is that it will not pass with the 2018 effective date given the fiscal situation facing our participating employers and now our state employees.

Given this further clarification that has been provided to us since we submitted the bill we have two options going forward:

I. Move forward with the bill as submitted. This bill will have its first hearing on the House side before the Government And Veterans Affairs Committee.
II. We could propose an amendment to the bill moving the effective date of the contribution increase from January 2018 to later in this biennium such as Jan 2019. However this would still would still require funds to be added to this budget making it very unlikely to pass. Other possible alternative dates would be in the next biennium including January of 2020 or 2021. This would require no funding to be added to this biennium and hopefully salary adjustments at that time could make this more affordable for employees at that time.

The effect of making this change would still accomplish our third goal of putting the plan on track to getting back to 100% funded status. It would only delay it by approximately the number of year the implementation is moved. Without passage of the bill in some form we have not meet our third goal.

GRS will be on the phone for discussion of this item and available to answer any questions.

Staff is seeking the boards direction on how to move forward with the Recovery Bill.

Health Plan Update

Bryan has been working with Sanford on the rates for the 2017-19 biennium. He will have an update at the meeting. We will provide other updates at that time on any new legislation or proposals.

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: DEC 22 2016

Employer Identification Number:
45-0309764
DLN:
17007030721026
Person to Contact:
CHRISTINE L CHAILLE ID# 31324
Contact Telephone Number:
(513) 263-4558
Plan Name:
NORTH DAKOTA PUBLIC EMPLOYEES
RETIREMENT SYSTEM HYBRID PLAN
Plan Number: 002

STATE OF NORTH DAKOTA
400 EAST BROADWAY SUITE 505
BISMARCK, ND 58502

Dear Applicant:

Based on the information you provided, we are issuing this favorable determination letter for your plan listed above. However, our favorable determination only applies to the status of your plan under the Internal Revenue Code and is not a determination on the effect of other federal or local statutes. To use this letter as proof of the plan's status, you must keep this letter, the application forms, and all correspondence with us about your application.

Your determination letter does not apply to any qualification changes that become effective, any guidance issued, or any statutes enacted after the dates specified in the Cumulative List of Changes in Plan Requirements (the Cumulative List) for the cycle you submitted your application under, unless the new item was identified in the Cumulative List.

Your plan's continued qualification in its present form will depend on its effect in operation (Section 1.401-1(b)(3) of the Income Tax Regulations). We may review the status of the plan in operation periodically.

You can find more information on favorable determination letters in Publication 794, Favorable Determination Letter, including:

The significance and scope of reliance on this letter,
The effect of any elective determination request in your application materials,
The reporting requirements for qualified plans, and
Examples of the effect of a plan's operation on its qualified status.

You can get a copy of Publication 794 by visiting our website at www.irs.gov/formspubs or by calling 1-800-TAX-FORM (1-800-829-3676) to request a copy.

This letter considered the 2014 Cumulative List of Changes in Plan Qualification Requirements.

We made this determination on the condition that you adopt the proposed

STATE OF NORTH DAKOTA

amendments you submitted in your letter dated 12/19/16, on or before the date the Income Tax Regulations provide under Section 401(b) of the Internal Revenue Code.

Based on the information you provided, you are a participating employer in a multiple employer plan under Section 413(c) of the Internal Revenue Code.

We based this determination letter solely on your claim that the plan meets the requirements of a governmental plan under Section 414(d) of the Internal Revenue Code.

This determination letter applies to the plan and related documents you submitted with the application you filed during the remedial amendment cycle ending 1/31/16.

This determination letter expresses no opinion as to the federal tax consequences of the replacement, or proposed replacement, of any joint and survivor, single life or other annuity being paid with a lump sum payment or other accelerated form of distribution.

If you submitted a Form 2848, Power of Attorney and Declaration of Representative, or Form 8821, Tax Information Authorization, with your application and asked us to send your authorized representative or appointee copies of written communications, we will send a copy of this letter to him or her.

If you have any questions, you can contact the person listed at the top of this letter.

Sincerely,

Karen D. Truss
Director, EP Rulings & Agreements

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: DEC 02 2016

STATE OF NORTH DAKOTA
400 EAST BROADWAY STE 505
BISMARCK, ND 58502

Employer Identification Number:
45-0309764
DLN:
17007030723026
Person to Contact:
CHRISTINE L CHAILLE ID# 31324
Contact Telephone Number:
(513) 263-4558
Plan Name:
HIGHWAY PATROLMENS RETIREMENT SYSTEM
Plan Number: 001

Dear Applicant:

Based on the information you provided, we are issuing this favorable determination letter for your plan listed above. However, our favorable determination only applies to the status of your plan under the Internal Revenue Code and is not a determination on the effect of other federal or local statutes. To use this letter as proof of the plan's status, you must keep this letter, the application forms, and all correspondence with us about your application.

Your determination letter does not apply to any qualification changes that become effective, any guidance issued, or any statutes enacted after the dates specified in the Cumulative List of Changes in Plan Requirements (the Cumulative List) for the cycle you submitted your application under, unless the new item was identified in the Cumulative List.

Your plan's continued qualification in its present form will depend on its effect in operation (Section 1.401-1(b)(3) of the Income Tax Regulations). We may review the status of the plan in operation periodically.

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The significance and scope of reliance on this letter,
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You can get a copy of Publication 794 by visiting our website at www.irs.gov/formspubs or by calling 1-800-TAX-FORM (1-800-829-3676) to request a copy.

This letter considered the 2014 Cumulative List of Changes in Plan Qualification Requirements.

We made this determination on the condition that you adopt the proposed

amendments you submitted in your letter dated 11/22/16, on or before the date the Income Tax Regulations provide under Section 401(b) of the Internal Revenue Code.

We based this determination letter solely on your claim that the plan meets the requirements of a governmental plan under Section 414(d) of the Internal Revenue Code.

This determination letter applies to the plan and related documents you submitted with the application you filed during the remedial amendment cycle ending January 31, 2016.

This determination letter expresses no opinion as to the federal tax consequences of the replacement, or proposed replacement, of any joint and survivor, single life or other annuity being paid with a lump sum payment or other accelerated form of distribution.

If you submitted a Form 2848, Power of Attorney and Declaration of Representative, or Form 8821, Tax Information Authorization, with your application and asked us to send your authorized representative or appointee copies of written communications, we will send a copy of this letter to him or her.

If you have any questions, you can contact the person listed at the top of this letter.

Sincerely,

Karen D. Truss

Karen D. Truss
Director, EP Rulings & Agreements

PROPOSED AMENDMENTS TO SENATE BILL NO. 2053

Page 1, line 1, after "reenact" insert "subsection 4 of section 39-03.1-11.2,"

Page 1, line 2, after the first comma, insert "subsection 4 of section 54-52-28,"

Page 1, line 4, after "to" insert "eligible rollover distributions to nonspouse beneficiaries under the Highway Patrolmen's Retirement System and the Public Employees Retirement System,"

Page 1, after line 12, insert:

"SECTION 1. AMENDMENT. Subsection 4 of section 39-03.1-11.2 of the North Dakota Century Code is amended and reenacted as follows:

4. The rollover rules under section 401(a)(31) of the Internal Revenue Code. Accordingly, a distributee may elect to have an eligible rollover distribution, as defined in section 402(c)(4) of the Internal Revenue Code, paid in a direct rollover to an eligible retirement plan, as defined in section 402(c)(8)(B) of the Internal Revenue Code, specified by the distributee. For purposes of this section, "distributee" includes a nonspouse beneficiary of a deceased member; provided, however, that in the case of a nonspouse beneficiary, the direct rollover may only be made to an individual retirement account or individual retirement annuity described in section 408 or 408A of the Internal Revenue Code that is established on behalf of the nonspouse beneficiary and will be treated as an inherited individual retirement account or individual retirement annuity pursuant to section 402(c)(11) of the Internal Revenue Code."

Page 12, after line 3, insert:

"**SECTION 5. AMENDMENT**. Subsection 4 of section 54-52-28 of the North Dakota Century Code is amended and reenacted as follows:

4. The rollover rules under section 401(a)(31) of the Internal Revenue Code. Accordingly, a distributee may elect to have an eligible rollover distribution, as defined in section 402(c)(4) of the Internal Revenue Code, paid in a direct rollover to an eligible retirement plan, as defined in section 402(c)(8)(B) of the Internal Revenue Code, specified by the distributee. For purposes of this section, "distributee" includes a nonspouse beneficiary of a deceased member; provided, however, that in the case of a nonspouse beneficiary, the direct rollover may only be made to an individual retirement account or individual retirement annuity described in section 408 or 408A of the Internal Revenue Code that is established on behalf of the nonspouse beneficiary and will be treated as an inherited

TESTIMONY OF SPARB COLLINS

2017 Recovery Bill

Good morning, my name is Sparb Collins. I am the Executive Director of the North Dakota Public Employees Retirement System (NDPERS). I appear before you today concerning the retirement plans we administer and in support of House Bill 1080.

The following table shows the provisions of the bill.

Provisions
Increase employer/employee contributions by 1% each (Temporary employees 2%)

The bill before you today is for the last year of the four year recovery plan for the PERS Main Retirement Plan. The first two years were approved during the 2011 session. The third year was approved during the 2013 session. This last year of the recovery plan as proposed would increase both the employer contribution rates and the member contribution rates for the PERS Main/Hybrid Plan (Main/hybrid and Judges only) and the PERS Defined Contribution Plan by 1% for the employer and member beginning January 2018. The bill also would change the member contribution rates for the following groups:

- Temporary employees in the Hybrid Plan and Defined Contribution Plan, for which the member contribution rate would increase by 2% annually, instead of 1%, over the same period.

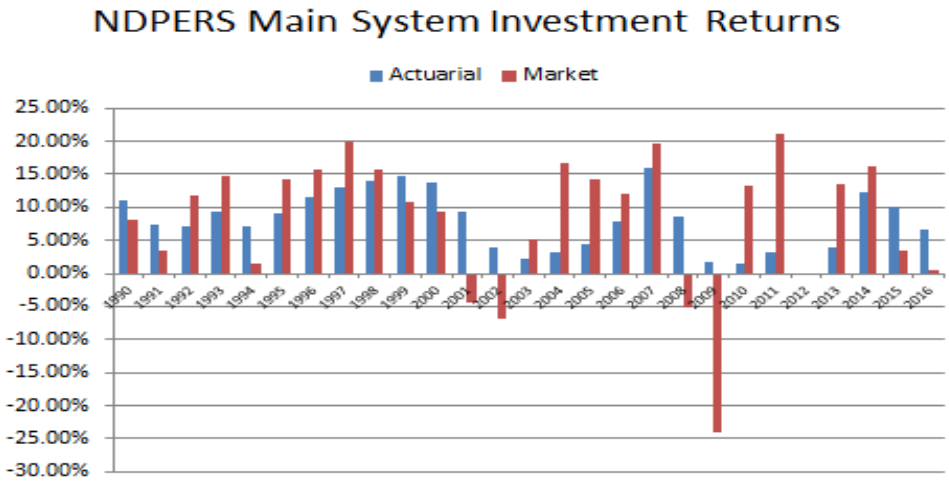
Retirement Fund	HB 1080 *Increase employee and employee contributions equally**
Main	• 1% employee increase and a 1% employer increase o ***Section 1*** increases the temporary employee contribution* o ***Section 2*** increases the employee contribution o ***Section 3*** increases the employer contribution
Law Enf	• .5% employee decrease o ***Section 4*** decreases the employee contribution
DC Plan	• 1% employee increase and a 1% employer increase (Jan of 2018) o ***Section -7*** increases temporary employees contribution o ***Section 8*** increases employer and employee contributions

**Temporary employee contributions increase by 2%.*

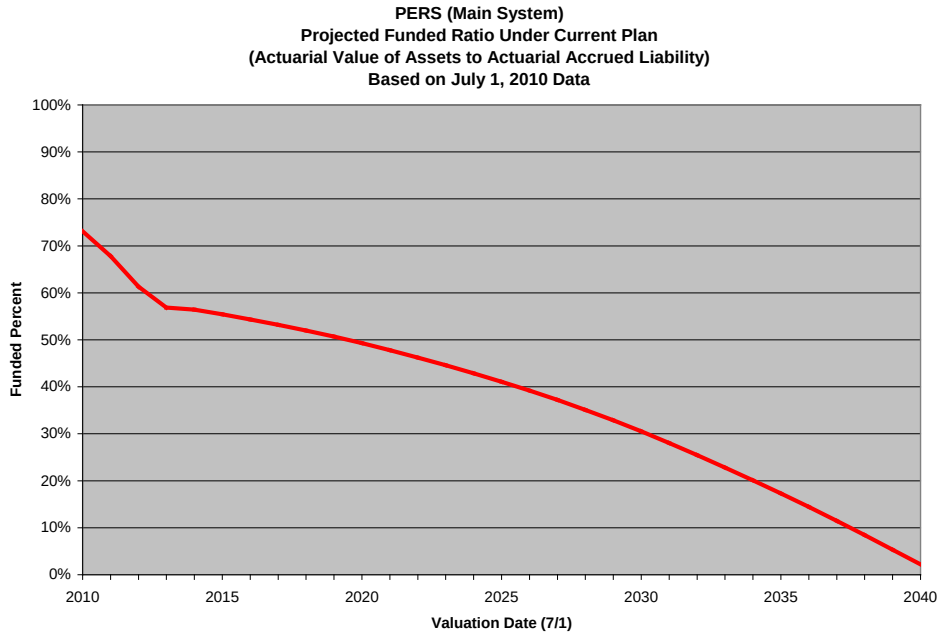
This bill addresses the funding shortfall that has occurred in both the PERS defined contribution plan and the PERS defined benefit/hybrid plans as a result of the downturn in the financial markets. Let me start by providing you some background and a summary of the actions taken to date.

Background

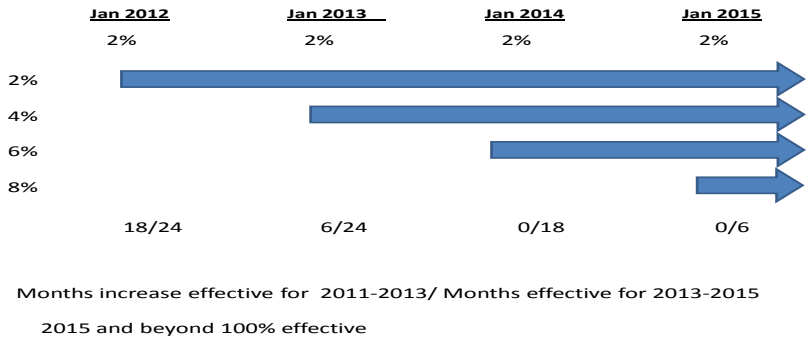
In the 2008/2009 fiscal year the financial market had a major correction that was preceded by the tech market collapse in 2001-2002. However, the most significant effect occurred in 2008/2009 when the PERS plan lost about 24.5%. The following table shows the history of returns and the returns in that year.



The financial consultant to the State Investment Board, which manages the PERS assets, reported that out of 224 years of US stock performance only 4 years were worse than the returns in 2008. What the plan experienced was truly a unique and significant event. As a result of this dramatic downturn in the financial markets, the long term funded status of PERS was affected as shown on this graph.



The above projections of the future funded status of the Main plan showed the plan could become insolvent in approximately 2040. After a significant amount of study, a proposal was brought forward to increase the contributions by 8% over the period from January 2012 to January 2015 which was projected to close this funding deficit. It became known as the PERS 4-year recovery plan and was based upon the concept that the recovery should be shared between the employer and employee. The thought was that neither party should be responsible for the full cost of the recovery. It was proposed to be spread over 4 years to reduce the effect of the increase in any given year on either party.

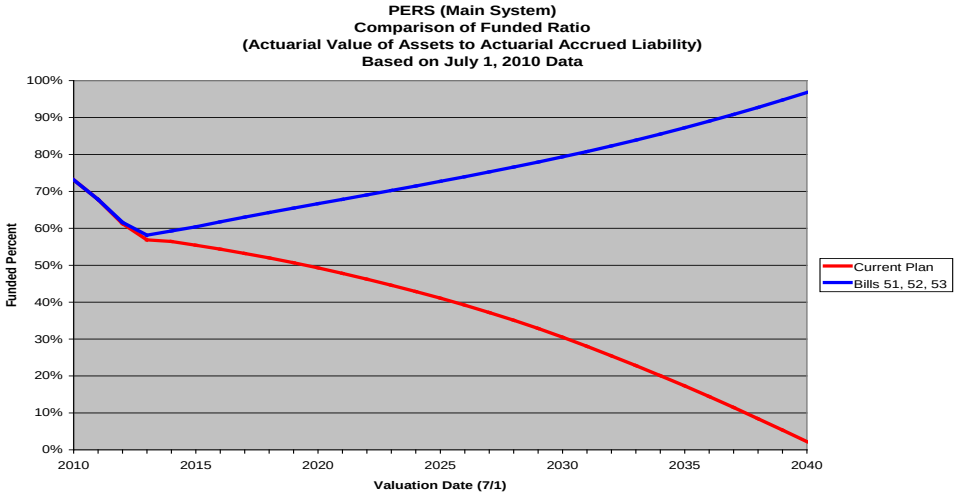


This proposal came together in SB 2108 that was considered during the 2011 session. This proposal was intended to accomplish three objectives:

1. To stop the downward trend in the funded status of the plans
2. To stabilize the plans
3. To put the plans on a course back to 100% funded status

The following graphs were reviewed during that session showing the projected status of the funds without the increase and the projected status with the increases proposed in the recovery plan.

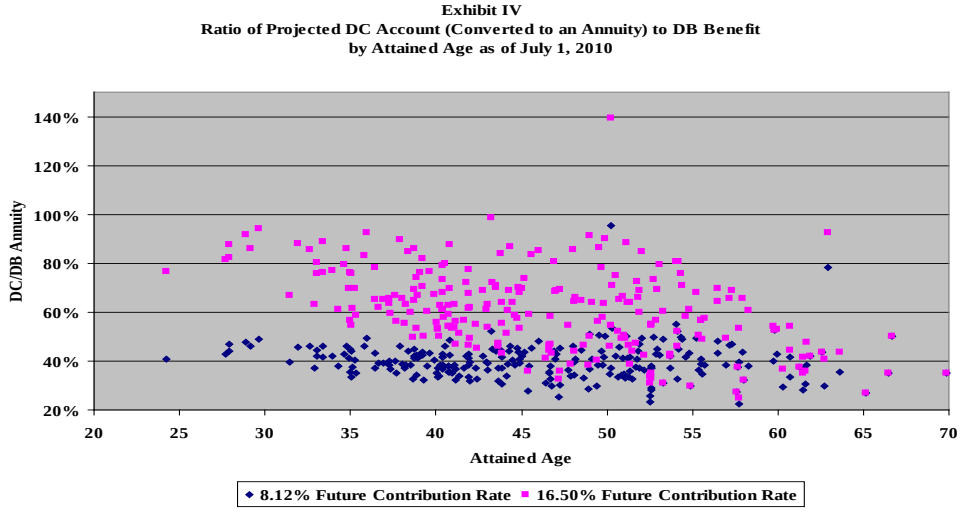
Graph 2



It was also noted that the downturn had a significant impact for members of the PERS defined contribution plan. The following table shows the challenge faced by that plan in 2010:

Graph 2

Comment [LU1]: Possibly pull chart and just include comments that this also applied to DC plan



The diamonds show the challenge the defined contribution plan members faced and the squares show the benefit of the increase in contributions to 16.5% over a four-year

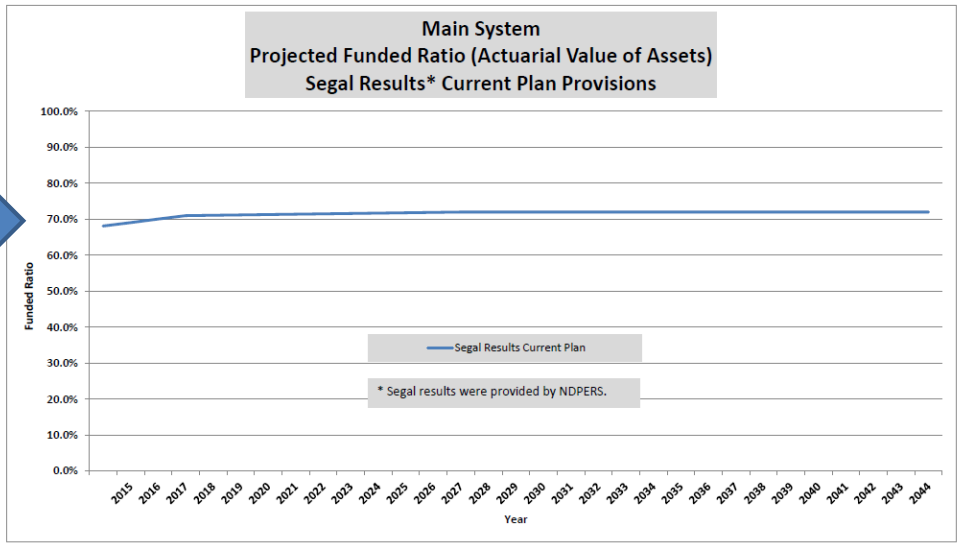
period. The graph makes it clear that a total contribution level of 8.12% would not meet the objective for long term retirement savings for the members of this plan.

The proposed recovery plan outlined above for the retirement plans, including the DC plan, accomplished all three goals. That is, the downward trend in funding has been reversed. The plans are stabilized and are on a course to 100% funded status. However, for the DC plan we note that while the proposal does much to help the members, they are not returned to a 100% level.

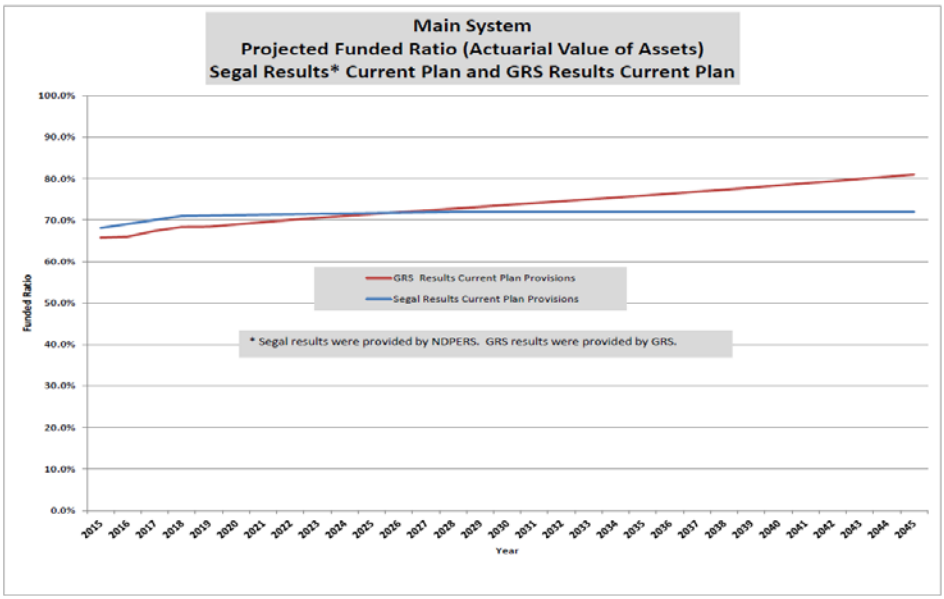
That session, the legislature approved the first two years of the recovery plan which included the 2012 and 2013 increases, and last session the third year was approved for 2014.

Accomplishments and Final Year of Recovery Plan

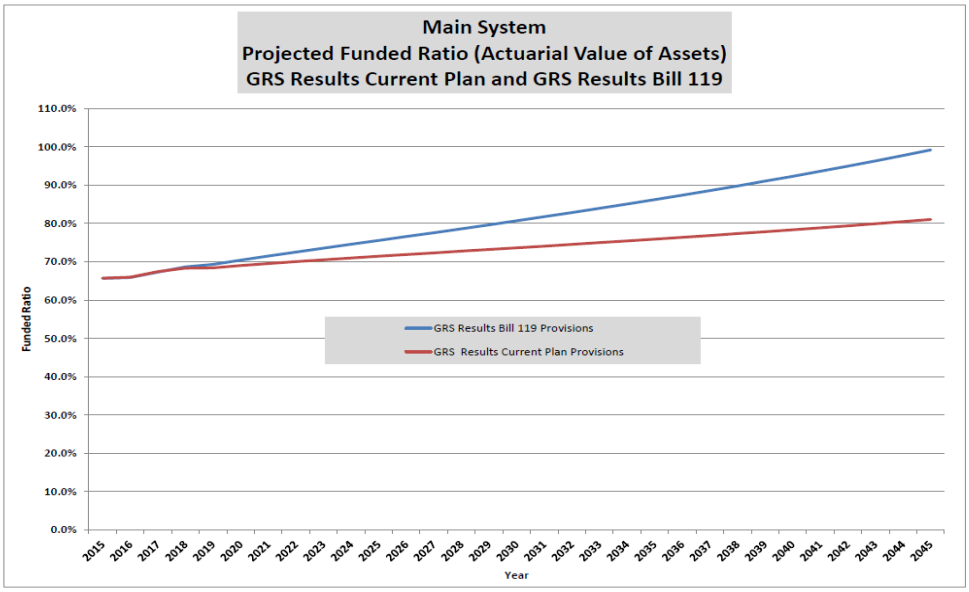
New projections have been completed for the plan this year as part of the ongoing study and consideration process for the last year of the recovery plan. The following graphs show what was accomplished by the action of adopting the first three years of the recovery plan and the effect of adopting the last year of the recovery plan proposed in this bill.



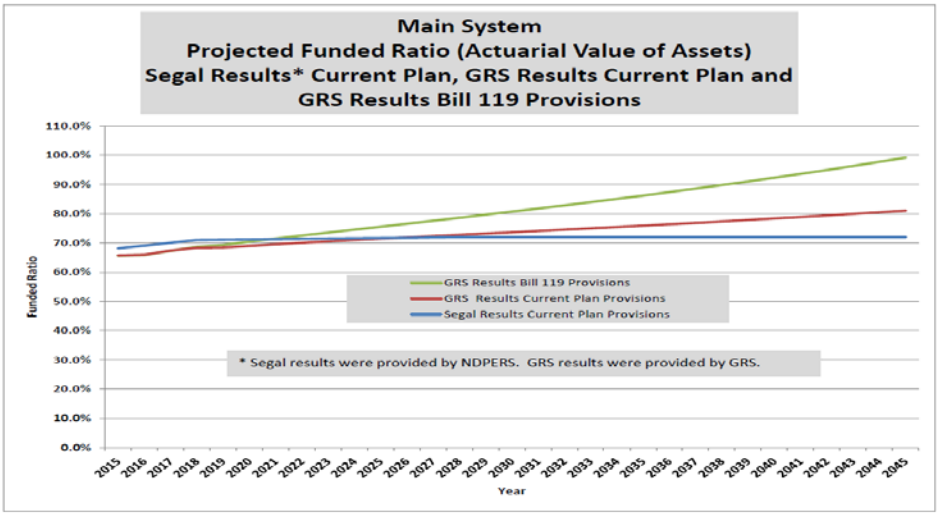
As the above shows, the PERS plan is on a course to remain at about 70% funded status. NDPERS switched retirement actuaries this past year. A new projection from GRS shows a slight improvement in the funded status.



If the provisions of HB 1080 are passed, the following graph shows that the plan will be on a course to 100% funded status by about 2045.

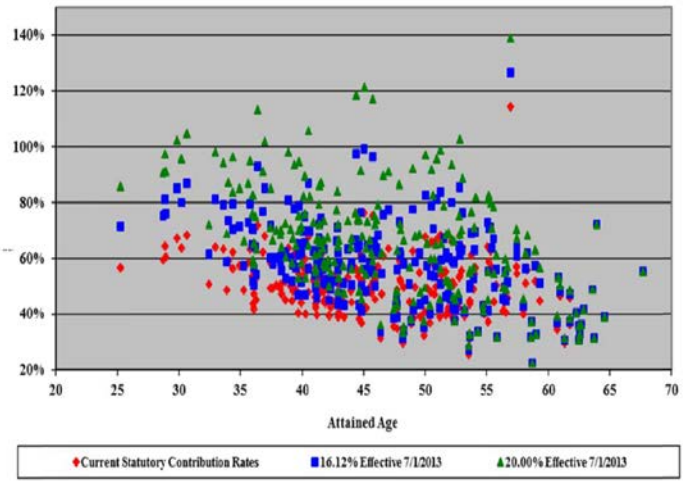


The following is a summary of all three graphs:



The following table is for the defined contribution plan.

Comment [LU2]: Pull this chart?



The diamonds show how the adoption of the first three years of the recovery plan has helped this plan's members. The adoption of the last year is shown by the squares. The last set is the triangles and shows the benefit of a 20% contribution level to this plan.

Summary

This recovery plan as originally proposed and offered in the attached amendments has had considerable study over the years including:

1. The PERS Board worked with our members in developing this proposal. The significant part of this effort is the development of a shared recovery plan with both the member and employer sharing the contribution increase.
2. The Legislative Employee Benefits Committee studied the 4 year recovery proposal in the 2010 interim. They had several hearings on the proposal and reviewed detailed actuarial information over a 5 month period. That committee gave the 4 year recovery plan a favorable recommendation. During the 2012 interim, the Legislative Employee Benefits Committee reviewed the proposal for the last 2 years of the recovery plan. They held hearings and reviewed updated

actuarial information and again gave it a favorable recommendation. This interim, after study by the committee the bill was given a "no recommendation".

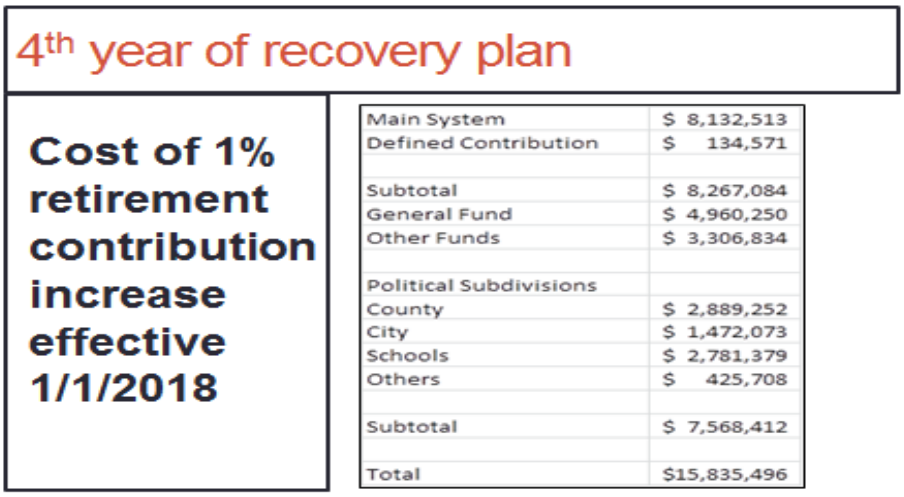
Comment [LU3]: update

3. The Executive budget for 2011-13 recommended the 2012 and 2013 increases and the Executive budget for 2013 to 2015 recommended the 2014 and 2015 increases to complete the recovery plan.
4.

Comment [LU4]: Add narrative on exec recommendation

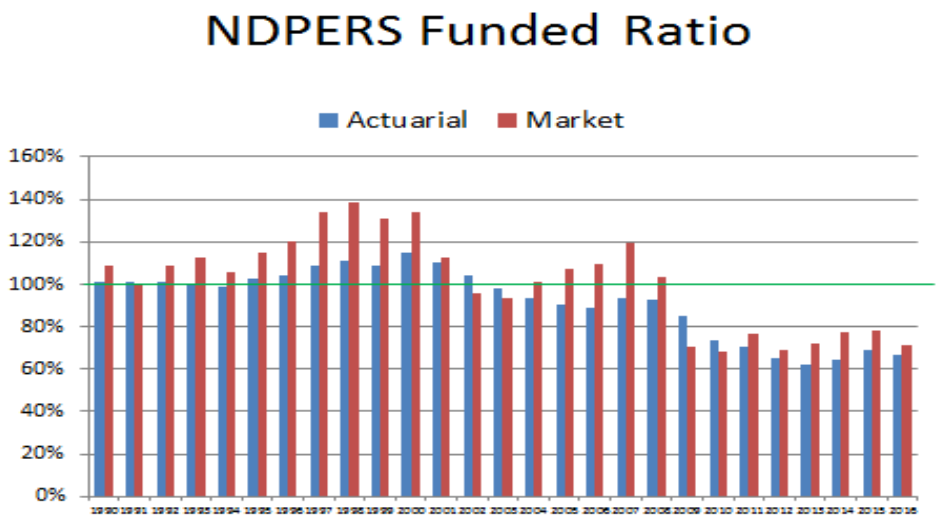
Attached is the fiscal note for this bill. We appreciate that the cost of the recovery is significant, but we are confident that based upon the studies to date, this will put all plans back on track to 100% funded status in what we believe is a lower cost approach in the long term.

Comment [LU5]: Update chart from exec rec



As noted at the beginning, the investment consultant to the State Investment Board stated that the year we had the large loss that created this situation was truly unique. And to have this event preceded by the tech market collapse is truly a significant combination of events which hopefully we will not experience again in our lifetimes. Thankfully, as result of your leadership and that of others, the plans went into this situation in a strong

funded position. The following shows the funded status of the PERS plan on both an actuarial and a market basis.



If we are going to meet our future challenges as effectively as our past leaders have prepared us for this one, we need to regain the same funded basis that they gave us. Consequently, I stand before you today to request your positive consideration of this bill, the last year of the original recovery plan, which will put us on a course back to 100% funded status and make sure we have a strong future.

Thank you and this concludes my testimony. If we can assist you with your considerations, please let me know.

Mr. Chairman, members of the committee, I would also like to take this opportunity on behalf of PERS to thank you for your past support. Together we have provided our members valuable benefits that have truly made a significant difference in people's lives and helped to support the economic health of North Dakota. We look forward to continuing to work with you in the future. Again, thank you, and this concludes our testimony.

individual retirement account or individual retirement annuity pursuant to section 402(c)(11) of the Internal Revenue Code."

Renumber accordingly

NDPERS BOARD SPECIAL MEETING

Agenda

Location:
Office of the Attorney General
Conference Room
17th Floor, State Capitol
Bismarck, ND

January 24, 2017 **Time: 12:00 p.m.**

I. Legislation – Sparb (Board Action)

Any individual requiring an auxiliary aid or service must contact the NDPERS ADA Coordinator at 328-3900, at least 5 business days before the scheduled meeting.

North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 ● Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 ● EMAIL: NDPERS-info@nd.gov ● www.nd.gov/ndpers

Memorandum

TO: PERS Board

FROM: Sparb

DATE: January 24, 2017

SUBJECT: HB 1403; HB 1406 & HB 1407

Attached are the actuarial/technical reviews for HB 1403 & HB 1406. The review for HB 1407 was in the Board book forwarded to you on Friday. I need your guidance tomorrow on how to testify on the boards behalf (in favor of bill, opposed or neutral)

HB 1403

Staff recommendation would be to take a neutral position on the bill and share the comments from Deloitte. I would further suggest that we indicate we would be favorable to the bill if the language is for self insurance.

HB 1406

There are three major provisions to this bill.

1. First is to move the contracting period from July to June, to January to December every two years. I would recommend being opposed to this unless additional funding is provided so the board would not have to make reductions this year without the benefit of the Legislature being able to address them if they are opposed.
2. Second is to require a bid every 2 years. Here again this is a policy decision and I would recommend taking a neutral position but indicate our recommendation would be to leave it as is or every 4 years which is the same as our statutory requirement for self insurance
3. Third is the emergency clause. I would suggest being neutral on this since I believe we could get this done.

HB 1407

There are two major provisions to this bill.

1. First is to require a bid every 2 years. This is a policy decision and I would recommend taking a neutral position but indicate our recommendation would be to leave it as is or every 4 years which is the same as our statutory requirement for self insurance.
2. Second is the emergency clause. I would recommend opposing this provision since I am not sure we could get the work done by July.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000
Fax: 612 397 4450
www.deloitte.com

Memo

DRAFT

Date: January 23, 2017

To: Sparb Collins

From: Josh Johnson and Drew Rasmussen, Deloitte Consulting LLP

Subject: REVIEW OF PROPOSED BILL 17.0720.01000 (HB1403) REGARDING HEALTH INSURANCE BENEFITS COVERAGE – PRESCRIPTIO DRUG COVERAGE – TRANSPARENCY – AUDITS - CONFIDENTIALITY

The following summarizes our review of the proposed legislation.

OVERVIEW OF PROPOSED BILL

The proposed bill would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that for health insurance benefits contracts that use a pharmacy benefits manager ("PBM") the insurance contract between the health insurer and the PBM must be disclosed to the board. Further, all invoices must contain the corresponding pharmacy claims, clinical and utilization management programs must be disclosed prior to implementation, audit rights must include the ability to select an auditor and conduct annual audits of the PBM.

COMMENTARY ON PROPOSED BILL

Section 1.1 (page 1, lines 8-10)

Proposed language:

"If the prescription drug coverage of the health insurance benefits coverage utilizes the services of a pharmacy benefits manager, the insurer's contract with the board must include the following terms:"

Comments: We recommend specifying the language if the intent is to address instances where a health insurer contracts with a PBM for pharmacy services (i.e. Sanford and Express Scripts) or if the board contracts directly with a PBM for services (i.e. a "carve-out" contract).

Revised language recommendation: "If the prescription drug coverage of the health insurance benefits coverage utilizes the services of a pharmacy benefits manager, either

contracted directly with a pharmacy benefits manager or indirectly through the health insurer, the contract provisions that include pharmacy benefits administration with the board must include the following terms:"

Section 1.1.a (page 1, lines 11-14)

Proposed language:

"The insurer shall provide the board with a copy of the insurer's current contract with the pharmacy benefit management company and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract"

Comments: We recommend clarifying the intent of this provision. If the intent is to review the contract agreement between the health insurer and the PBM, it is unlikely that either entity will agree to share their contract with the board. The insurer and the PBM will deem the contract proprietary.

If the intent of the provision is to review the pharmacy benefits contract agreement between the health insurer and/or PBM and the plan sponsor (the board) then the language could be modified to address this requirement directly.

Revised language recommendation: "The entity contracted for pharmacy benefits insurance coverage shall provide the board with a copy of the contract between the insurer and the plan sponsor, and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract"

Section 1.1.b (page 1, lines 15-18)

Proposed language:

"The health insurer or pharmacy benefit manager shall provide with each invoice statement and for each annual audit a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board"

Comments: We recommend receiving claims from the prescription drug provider on a monthly basis, consistent with current practice. This allows for all claims to be finalized before they are submitted for Data Warehousing. It also allows for appropriate comparison and reconciliation of the invoices to the paid pharmacy claims.

Revised language recommendation: "The health insurer or pharmacy benefit manager shall provide monthly and for each annual audit a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board"

Section 1.1.c (page 1, lines 19-22)

Proposed language:

"The health insurer shall provide the board a list of all programs that will be implemented, including prior authorization programs, step therapy programs, quality limit programs, and mandatory generic programs. The list must include the drugs in each program and the specifics about each drug."

Comments: We recommend changing "quality limits" to "quantity limits" (likely an auto-correct).

We recommended clarifying what information is being requested for "the specifics about each drug". It would be helpful to clarify if the intent is to request the rationale for including each drug in the program, the anticipated disruption to members, expected cost avoidance, and/or details about each drug such as NDC Number, Drug Strength, Drug Indication, ect.

Revised language recommendation: "The health insurer shall provide the board a list of all programs that will be implemented, including but not limited to: prior authorization programs, step therapy programs, quantity limit programs, and mandatory generic programs. The list must include the drugs in each program, the cost of the program, the anticipated member disruption, process for override (if applicable), anticipated cost savings (or cost avoidance), performance guarantees (if applicable), and anticipated clinical outcomes."

Section 1.1.d (1) (page 2, lines 1-4)

Proposed language:

"The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefits manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor"

Comments: No comments, we agree with the provision as written.

Section 1.1.d (2) (page 2, lines 5-12)

Proposed language:

"The board may conduct annual audits to verify the pharmacy benefit manager is satisfying the terms of its contract with the health insurer; assess the costs resulting from the health insurer's contract with the pharmacy benefit manager and make recommendations as to amendments in that contract which would decrease costs; and assess the programs being implemented and make recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment."

Comments: We recommend clarifying if the intent is to audit the terms between the health insurer and the PBM or to audit the terms between the pharmacy benefits insurer and the plan sponsor.

Assessments of the clinical and/or utilization management programs should happen annually as part of the review process with the PBM. An audit of the terms of the contract may only result in the affirmation that a program is in place but might not lead to recommendations as to the outcomes of the program related to clinical outcomes or avoided cost.

Revised language recommendation: "The board may conduct annual audits to verify the pharmacy benefit provider is satisfying the terms of its contract with the plan sponsor; assess the costs resulting from the pharmacy benefit contract with the plan sponsor and make recommendations as to amendments in that contract which would decrease costs. The board requires, at minimum, annual review of the operational, clinical, and financial outcomes of the programs implemented and recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment."

Section 2 (page 2, lines 13-16)

Proposed language:

"Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts."

Comments: No comments, we agree with the provision as written.

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Memo

DRAFT

Date: January 23, 2017

To: Sparb Collins

From: Josh Johnson and Jon Herschbach, Deloitte Consulting LLP

Subject: ACTUARIAL REVIEW OF PROPOSED BILL 17.0790.01000 (HB1406) REGARDING THE CONTRACT TERM AND PLAN DESIGN FOR HEALTH BENEFITS COVERAGE

The following summarizes our review of the proposed legislation.

I. OVERVIEW OF PROPOSED BILL

The proposed bill would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that the term of a uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage (insured or self-insured) may not exceed two years and must begin on January 1st of an even-numbered year. Further, the board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly.

II. CURRENT STATE - JULY 1, 2017 PREMIUM AND FUNDING

The PERS board voted to renew with Sanford on a fully insured basis for the biennium beginning July 1, 2017. The rate increase from the biennium ending June 30, 2017 for the uniform group health insurance program was 17.4% assuming no changes to plan design. In order to reduce premiums, Sanford has identified all available plan design changes that would not trigger a loss of Grandfathered status under PPACA. These changes reduced the premium increase to 12.2% and are as follows:

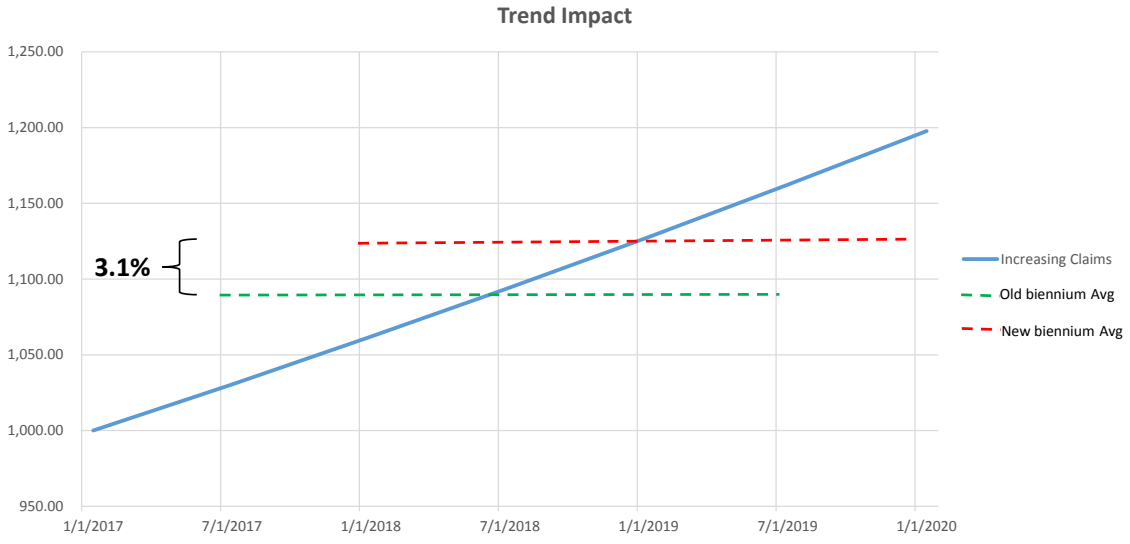
Plan design changes
1. Change Deductible from $400 to $500
2. Increase the single co-insurance maximum for the PPO plan from $750 to $1,000 and for the basic plan from $1,250 to $1,500. Increase the family co-insurance max from $1,500 for the PPO plan to $2,000 and for the Basic plan from $2,500 to $3,00

3. Increase office call co-payment for the single PPO plan from $25 to $30 and for the basic plan from $30 to $35. Increase the Emergency room co-payment from $50 to $60.
4. Increase the co-payment for generic Rx from $5 to $10 Increase the co-payment for Brand Rx from $20 to $25 Increase the co-payment for Non-formulary Rx from $25 to $30

The governor appropriated funding equal to an increase of 10.55%. The difference between the appropriated funding and the rates quoted by Sanford (including the plan changes above) is 1.65% which is proposed to be paid from the uniform group insurance program's contingency reserves.

III. IMPACT OF MOVING BIENNIUM

Changing the start date of the 2-year coverage period from July 1, 2017 to January 1, 2018 will have a trend impact equal to six months of medical and pharmacy trend. Trend is the rate of increase in health care costs from one period of time to another (month to month; year over year, etc). The trend impact causes an increase in cost when changing from one period of time to another assuming all other variables remain constant. For example the same plan design will cost more next year than it does this year. This is why we generally see health premiums go up year over year. This bill proposes to move the 24 month period forward 6 months. This will result in the first 6 months dropping off (which are generally at the lower end of the trend costs) and adding on 6 months at the end (which are generally at the higher end of the plan costs. The following chart shows the effect:



. The annual blended medical and pharmacy trend assumption utilized in the most recent NDPERS claims projections conducted by Deloitte was 6.2%. Using this assumption, the expected trend impact of moving the biennium coverage period forward by six months without any other plan changes is 3.1%. Since the bill as proposed does not provide a mechanism for increasing contributions to recognize the increase in premiums, the only option for the board at the time would be to change the plan design. If the impact on premiums was 3.1% it would require the changes to the plan design to offset this increase.

IV. IMPACT OF LOSS OF GRANDFATHERED STATUS

As previously discussed, Sanford has recommended all possible plan design changes that would allow the plan to reduce premium while maintaining grandfathered status effective July 1, 2017. These changes would reduce the actuarial value ("AV") of the plan by 4.4%. Therefore, any additional plan changes made to offset the cost increase caused by moving to a January 1, 2018 biennium would trigger a loss of grandfathered status and introduce various other mandated PPACA coverage provisions. Sanford estimates the expected cost increase of these mandated plan design changes would be 3%. Additional plan design reductions would need to be made to offset the cost increase caused by the mandated plan provisions or premiums would need to be increased.

V. IMPACT ON PLAN DESIGN OR PREMIUMS

The aforementioned plan design changes estimated by Sanford equating to a reduction in AV of 4.4% (maintain grandfathered status 7/1/17) are summarized as follows:

PPO Plan Design Provision	Current	Proposed
Pharmacy Copays: (Generic/Formulary/Non-Formulary)	$5/$20/$25	$10/$25/$30
Pharmacy Coinsurance (after copay)	85%/75%/50%	
Pharmacy Coinsurance Maximum (Per Person)	$1,000	$1,200
Office Visits	$25	$30
Emergency Room	$50	$60
Deductible (Single/Family)	$400/$1,200	$500/$1,500
Medical Coinsurance Maximum (Single/Family)	$750/$1,500	$1,000/$2,000

The reduction in plan design required to offset the trend impact (3.1%) and the loss of grandfathered status (3%) effective January 1, 2018 equals a reduction in AV of approximately 6%.

Sanford modeled several different plan design changes. The design that most closely results in the required reduction would include the changes above plus a further increase in deductible to $1,250 for single contracts.

PPO Plan Design Provision	Proposed 7/1/17	Proposed 1/1/18

Deductible (Single/Family)	$500/$1,000	$1,250/$3,750

If the cost of trend impact and loss of grandfathered status is offset by changing premiums instead of the plan design above, the following additional premium increase and associated costs would be required:

Bill and fiscal impact summary:

A 6% increase in premiums from the State premium reduced for plan design changes ($1268.14) would be an increase of $76.09 per contract per month ($1,344.23).

State fiscal effect:

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$12,103,631	$9,918,065	$4,034,544	$3,306,022
Appropriations	$0	$0	$12,103,631	$9,918,065	$4,034,544	$3,306,022

County, city, school district and township fiscal effect:

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	$0	$3,171,750	$1,057,250
Cities	$0	$2,650,500	$883,500
School Districts	$0	$1,611,000	$537,000
Townships	$0	$0	$0

The uniform group insurance program is also planning to use a portion of its reserves to fund the difference between the total premium level and the appropriated funding level for the coverage period beginning July 1, 2017. This reserve buy-down would be equal to approximately 1.5% of premiums. Under the plan design changes listed above, this reserve buy-down is assumed to be still in effect.

VI. INTERIM PERIOD FROM JULY 1, 2017 TO JANUARY 1, 2018

Moving the start date of the coverage period to January 1, 2018 raises an issue around the interim six month period from July 1, 2017 to December 31, 2017. The current renewal offer from Sanford assumes a 2-year coverage period beginning July 1, 2017. Sanford may require a different premium rate to insure a six month period than was agreed upon for a 2-year period or they may be opposed to insuring the plan for that period at all. Because the budget has already been appropriated and NDPERS was planning to fund a portion of premiums with their contingency reserves, any increase in premiums will impact the associated reserve spend or require a reduction in plan design. The PERS attorney has reviewed this and indicated that if PERS was unable to negotiate an extension with the existing carrier it would not be able to consider self-insurance for the interim time period under existing statute unless a full bid process was undertaken. The board would have to start a new bid process upon notification that they could not extend the contract, which likely could not be completed by July 1. The result would be no coverage until a new arrangement could be reached, pursuant to existing statutory requirements.

VII. IMPLICATIONS FOR SELF-INSURANCE IN THE BIDDING PROCESS

One potential outcome of this proposed bill would be the requirement to conduct an RFP for plan administration or insurance for coverage beginning January 1, 2018. If the RFP results in the decision to self-fund the plan, the statutory requirements under 54-52.1-04.3 state that the board must have a plan to establish contingency reserves equaling 1.5 to 3 months of paid claims within 5 years. Preliminary analysis suggests that self-funded premium rates may need to be increased by 0.5% to 1.5% in order to build reserves to the required level. The high end accounts for the use of contingency reserves to buy down premium. Consequently, it should be noted that this would be an additional consideration in the bidding process.

In the past bid process and renewal, PERS included in the budget authority for two additional staff so that the plan could consider self-insurance. Since PERS did not elect this option, it was taken out during the budget consideration process. Pursuant to this bill, the timeframe changed would necessitate that these two additional staff be added back into the budget so PERS can fully consider self-insurance in the bid process.

VIII. OTHER TECHNICAL CONSIDERATIONS

(The following was developed in collaboration with PERS staff)

a. BID TIMEFRAME AND IMPLEMENTATION TIMEFRAME

Implementation timeframe is not required if the existing vendor is selected after this process. However, in planning the timeline we need assume time to implement if a new vendor is selected. This timeline is about 90 days. Implementation took almost 120 days the last time a new vendor was selected.

Assuming 90 days of implementation, the bidding process needs to be completed by Sept 30th. The review period, including interviews, take 60 to 90 days. This means the due date of the bids would need to be between July 1 and August 1.

From the time the bill is signed until July 1 to August 1 would be the period for bid solicitation. Consequently, the timeline under this bill would create challenges related to the usual timeline for bidding being abbreviated. Specifically, vendors would not be allowed as much time to respond to the RFP and the review period would be shorter. The result is that we may have less vendors interested in responding.

b. IMPLICATION OF APPROPRIATION LIMITATION (Section 1 of the bill #2)

Section 1 of the bill item #2 states:

> *2. The board may not sign a contract unless the terms of the plan design are consistent with the appropriation for uniform group health insurance program benefits coverage enacted by the most recent legislative assembly*

This section indicated that any new contract must be equal to the appropriated amount. Consequently:

1. As noted above if the new bids are higher than the amount appropriated the only alternative will be adjust plan design. As noted above, this could be significant, resulting in large increases in member out of pocket costs. Other alternatives would be to change the plan design to have more restrictive networks that limit member choices as to who they could see, but could result in better contracting arrangements for the plan thereby reducing the required changes to plan design

2. If state members are required to pay a part of the premium these funds are not appropriated. However this section requires that the plan design needs to match the appropriated funds. Consequently the plan design would need to be reduced by at the amount of member premium payment (5% as suggested). The result would be to eliminate the need the member payments or depending on how that is drafted a logic loop that could not be meet.

3. If this section's intent is that the total state appropriation passed this session limits the total amount the plan can pay for all participants this could result in removing the following groups since they are not a part of appropriated budget passed during the session:

    a. political subdivisions

    b. retirees

    c. non-state employees (retired legislators, pre-Medicare retirees, etc.)

4. Federal law requires provisions for COBRA and certain types of leave. These are not a part of the appropriated amounts and, therefore, could create a conflict with those laws since state law may not allow inclusion of those members.

5. This would eliminate the use of PERS reserves since it is not appropriated in the biennial appropriation. This would require cuts in the plan design or an increase in the appropriation of about 1.65%.

c. COORDINATION WITH THE BUDGET PROCESS

Presently (and in the past) the health funding process has been, and is, coordinated with the budget process. For the executive budgeting process, PERS is able to estimate for a bid process, and know for a renewal, the plan design that is being purchased. For the Legislature PERS was able to specifically identify the plan design being purchased for the quoted premiums. Under this bill the legislature would be giving up that certainty around plan design, since PERS would not know what could be purchased until the legislature has adjourned. Any variance from estimates would result in changes to plan design for

remaining part of the biennium until the legislature re-adjourned to address the situation at the next scheduled session (or if the nature of plan design change is so unacceptable it required a special session). This is not required in the present contracting process since the legislature is provided all information during the regular session and any necessary action can be taken immediately.

d. SELF FUNDED STAFFING

If the plan was to become self-insured, contingent appropriation authority and FTE (2) should be added to the budget as proposed in the past. Self-insurance would clearly add additional administrative efforts (medical and Rx) and would also substantially increase PERS accountability for the plan. Today, most of our administrative and financial/operational risk is transferred to Sanford Health Plan. However, on a self-insured basis that becomes the Board's responsibility. Therefore, funding would need to be included for additional staffing.

IX. OVERALL CONCLUSIONS AND OBSERVATIONS

- This bill could have a material impact on the Health Plan resulting in significant reductions in the plan design or requiring additional appropriations if the existing plan design is to be maintained (as funded in the executive budget; also see III. – V above)
- This bill could affect the willingness of new carriers to bid on the plan and could have the unintentional effect of reducing future competition for the NDPERS plan
- Requiring a bid process every two years versus a six year process could result in carriers being less aggressive in the bids knowing that they would face another bid in two years. A six year process may encourage carriers to invest in the relationship by being more aggressive in pricing and other guarantees.
- There may be concerns with Section 18 of Article I of the North Dakota Constitution relating to impairment of contract
- If the emergency provision is passed it will require an abbreviated bid process (see bid and implementation timelines above VIII.a above)
- The modified fully insured method has allowed NDPERS reserves to be used to buy down premiums in past biennia. If the plan were self-insured these funds may be required to be maintained as plan contingency reserves in compliance with the NDCC-54-52.1-04.3 or be reflected as a cost in the analysis process(see VII above)
- Since bids benefit from additional months of claims data in determining the premium, the existing renewal process was modified several years ago to have a

February re-projection to take advantage of any improvements due to additional months of actual claims data. If the data shows a need for additional funding the September agreed amount is the maximum. The modified process captures the benefit of a later projection but eliminates the risk of higher premiums (see III above. (see III above).

- This proposal would add six months of higher claims to the end of the projection period, which are generally more expensive, and drop 6 months of claims at the beginning of the projection period, which are generally lower cost. Deloitte has projected that this will increase costs about 3.1% based upon current factors, which would result in plan design reduction or the need for higher premiums
- If addition funding is not added to offset the increase noted above the plan will lose its grandfathered status resulting in about 3% more in premium costs or benefit reductions. (see IV above)
- If the two items noted above occur this will result in the need for about 6% in benefit cuts which would increase the deductible to about $1,250 (see V above)
- This bill will result in a compressed timeline for the bid and implementation (See VII.a above)
- Section 1 Item 2 limits the plan to the appropriation passed during the most recent session. If employees pay a portion of the premium which is not counted in the appropriation and therefor pursuant to this legislation the plan may need to be cut by 5% to balance as prescribed. Also, if the limitation is interpreted to be a total for the plan then others such as retiree, political subdivisions and others may be required to leave the plan. In addition, since use of reserves are not appropriated on a biennium to biennium basis they may not be able to be used resulting in a 1.65% cost increase to premiums or reduction in plan design.(see VII.b above)
- Moving the plan to a January start date instead of a July start date will cause it to no longer be coordinated with the budgeting process. Since it is currently coordinated, PERS is able to let the legislature know the exact plan design it is purchasing. Under this bill they would no longer be coordinated and the legislature would have to use estimates. If the estimates very significantly from the resulting bid, the PERS Board would need to make plan design cuts to balance the plan or the Legislature would need to have a special session to address any shortfall. (see VII.c above)
- Additional contingent authority should be added in case the plan was to consider going self-insured (see VII.d).
- The effect on membership should be minimal as a result of bidding the plan more often. However, if the result is changes in the carrier every two years this could have an effect on members. Networks, formularies and other items may change even without any changes in the plan design. This was seen during the last transfer to Sanford even though the plan design did not change.