

NDPERS BOARD MEETING

Agenda

Bismarck Location:
ND Association of Counties
1661 Capitol Way
Fargo Location:
Sanford Health Plan
1749 38th Street South

October 19, 2017

Time: 8:30 AM

I. MINUTES

- A. September 21
- B. September 29 Special Meeting

II. PRESENTATIONS

- A. Actuarial Valuations - GRS
- B. Annual Investment Report – Darren Schulz, RIO (Information)

III. RETIREMENT

- A. Job Service COLA – Kathy (Board Action)
- B. GASB 74-75 update – Derrick (Information)
- C. TIAA Contract – Kathy (Board Action)

IV. GROUP INSURANCE

- A. Applied Behavioral Analysis -- Sparb (Board Action)
- B. Dental RFP – Bryan (Information)
- C. Claims Processing Review – Bryan (Information)
- D. Health Statutes – Sparb (Information)
- E. About the Patient – Sparb (Board Action)

V. DEFERRED COMP

- A. Investment Options Summary – Bryan (Information)

VI. FLEX COMP

- A. Flex Comp Plan Document – Kathy (Board Action)

VII. MISCELLANEOUS

- A. Transition Update – Sparb (Board Action)
- B. 2018 Board Meeting Dates – Sharon (Information)
- C. Electronic Payment Policy – Derrick (Board Action)
- D. November Meeting – Sparb (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.



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Public Employees Retirement System
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Executive Director
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Memorandum

TO: PERS Board

FROM: Sparb/Sharon

DATE: October 19, 2017

SUBJECT: 2017 Actuarial Valuation Reports

Gabriel Roeder Smith will be at the Board meeting to review the results of the 2017 actuarial valuations. They will be reviewing the attached PowerPoint presentation.

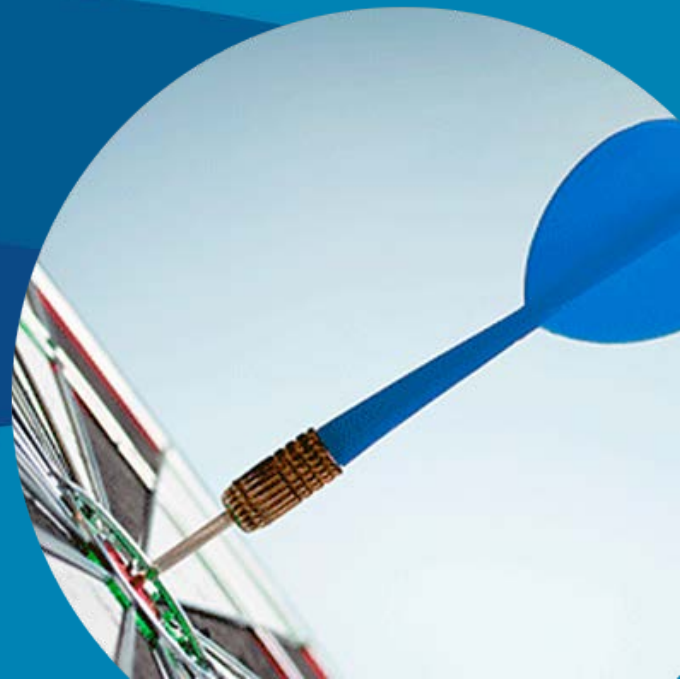
This information will also be presented to the Legislative Employee Benefits Programs Committee on October 26.

North Dakota Public Employees' Retirement System

Presentation of July 1, 2017
Actuarial Valuation Results

October 19, 2017

Amy Williams, ASA, MAAA, FCA
Lance Weiss, EA, MAAA, FCA



Agenda

- GRS Actuarial Valuation Methodology and Approach
- Demographic Data
- Contribution Rate Results
- Funded Ratio Results
- Reconciliation of Unfunded Liability, Actuarial Contribution Rate and Funded Ratio
- Summary Comments on Actuarial Valuation
- Actuarial Valuation Results Recommendations
- Summary of Board Action on Actuarial-Related Issues
- Questions
 - Appendix

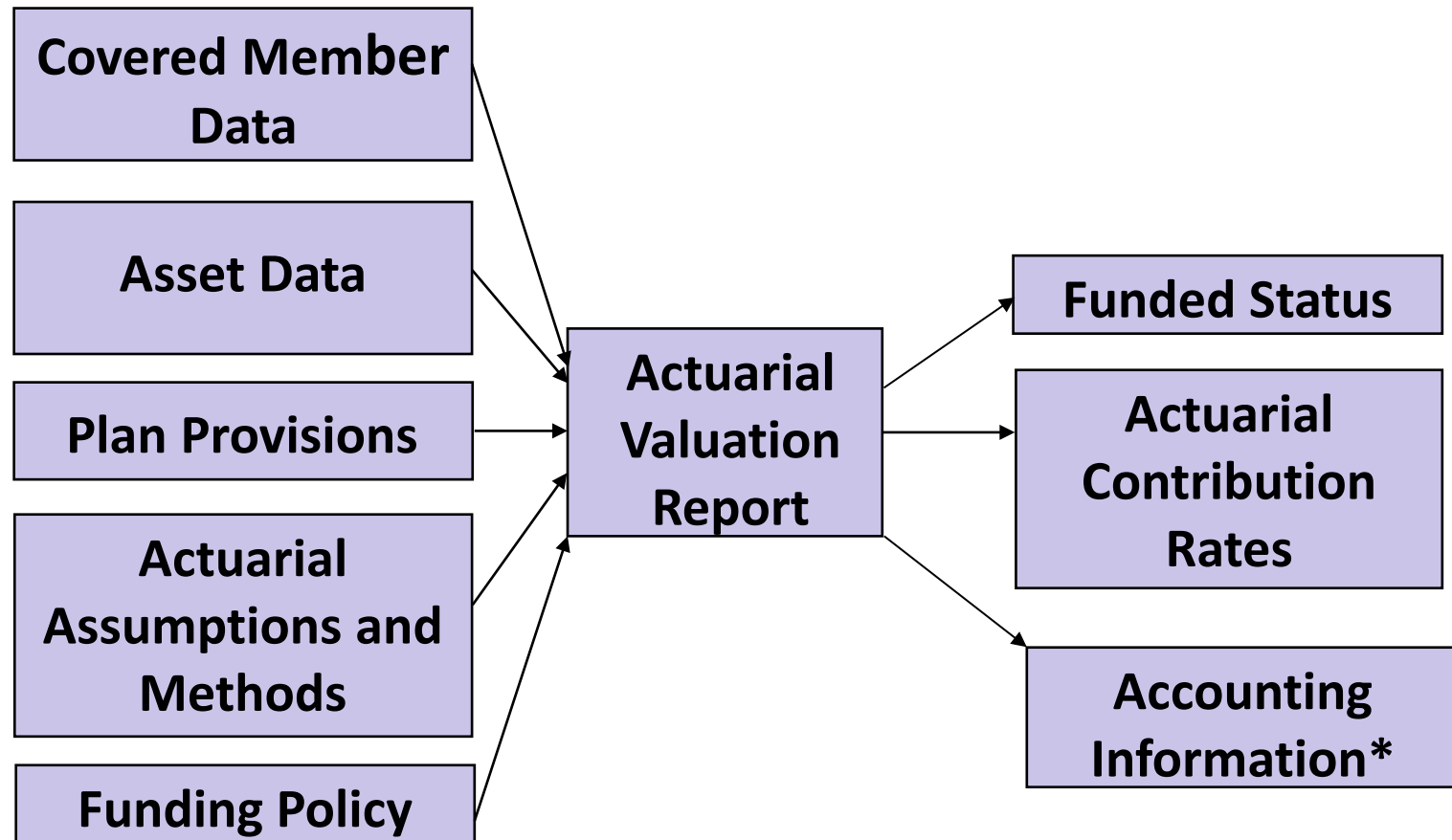
GRS Actuarial Valuation Methodology and Approach



Purpose of Actuarial Valuation

- Determine Funding Status
- Develop Actuarial Contribution Rates and Compare to Statutory Rates
- Provide Accounting and Other Data
 - Under the current accounting standards, a separate accounting valuation is performed

Actuarial Valuation Process



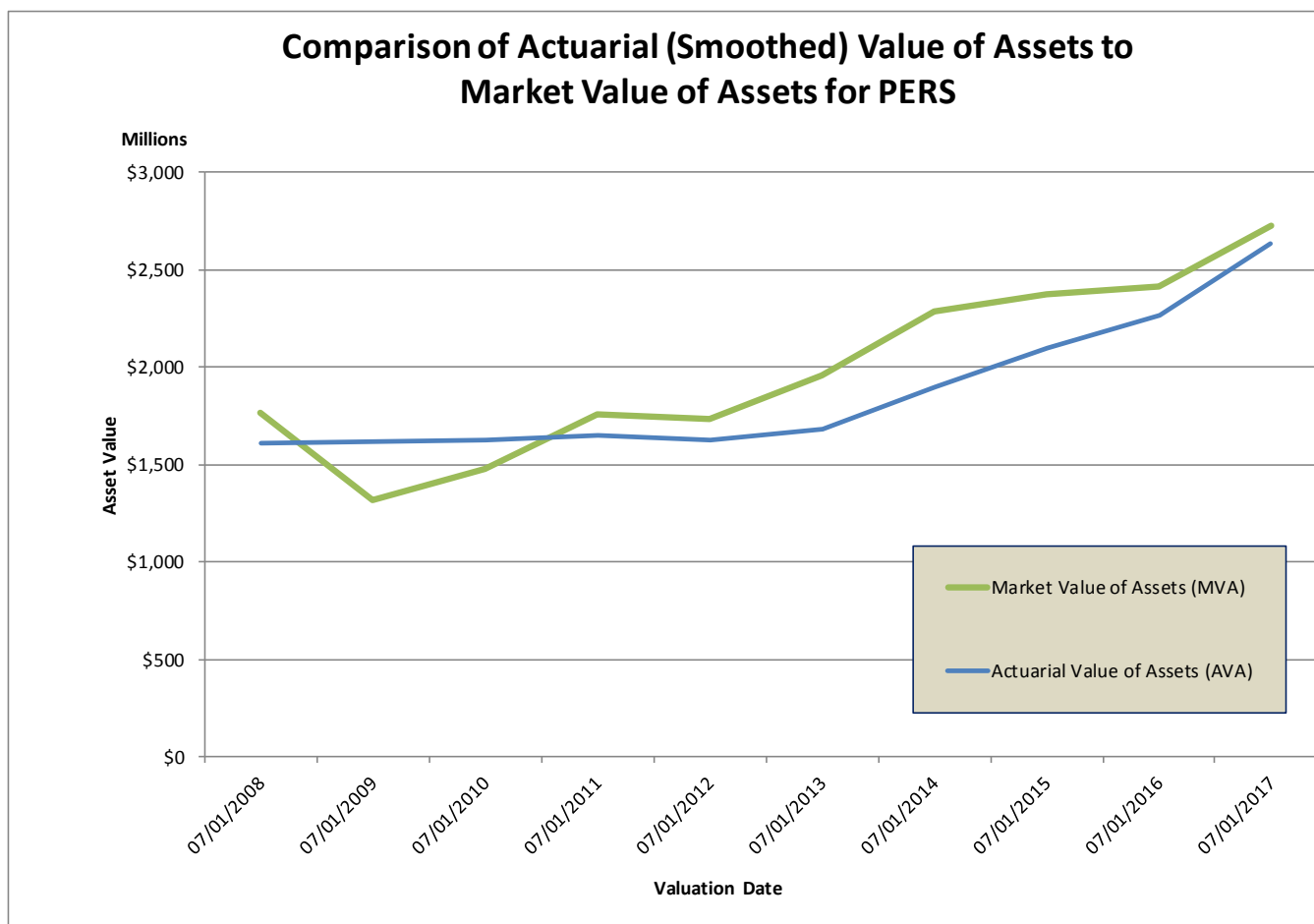
** Under the current accounting requirements, GASB 67 and 68, a separate accounting valuation report is issued.*

Actuarial Value of Assets

Asset Smoothing

- Actuarial Value of Assets (AVA or Smoothed Value of Assets)
 - Method was changed for actuarial valuation as of July 1, 2017
 - Net deferred asset gains and losses attributable to fiscal years 2016 and prior were fully recognized as of July, 2017
 - Beginning with fiscal year 2017, total investment gains and losses compared to the investment return assumption are recognized over a five-year period
 - Prior asset method
 - Immediately recognized interest and dividends
 - Recognized the total appreciation or depreciation from the current year (net change in fair value of investments) over a five-year period
 - Had a systematic basis toward the actuarial value of assets being lower than the market value of assets

Actuarial Value of Assets



Selection of Actuarial Assumptions

What

Economic

- Investment Return
- Payroll Growth Rate
- Population Growth Rate
(Usually, a constant population size is assumed)

Demographic

- Retirement Rates
- Promotional/Step Pay Increases
- Disability
- Turnover
- Mortality

Who Selects

- Board, Actuary, Other Advisors
- Board, Actuary, Staff

Actuarial Assumptions

- Actuarial assumptions should be reviewed periodically (at least every three to five years) to ensure they continue to reasonably represent past and expected future experience
 - Last experience study (performed by prior actuary) covered the period July 1, 2009, through July 1, 2014, and updated actuarial assumptions were adopted in the July 1, 2015, actuarial valuation
 - GRS performed a review of the economic assumptions in 2017 and updated economic assumptions were adopted and first effective with the July 1, 2017, actuarial valuation
- We recommend that an analysis of the assumption for eligible members who use RHIC benefits be performed prior to the July 1, 2018, actuarial valuation and any changes be implemented in the 2018 actuarial valuation

Actuarial Assumptions

- The following changes in actuarial assumptions were included in the 2017 actuarial valuation and affected all plans
 - Decrease in the investment return assumption from 8.00% to 7.75% for PERS and Highway Patrol, 8.00% to 7.50% for RHIC, and 7.00% to 5.70% for Job Service
 - Decrease in the payroll growth assumption from 4.50% to 3.75% (4.00% to 3.25% for Judges)
 - Decrease in the price inflation assumption from 3.50% to 2.50%
 - Update to the asset smoothing method

Actuarial Assumptions

- The following changes in actuarial assumptions were included in the 2017 actuarial valuation and affected certain plans
 - Update in the actuarial cost method from Projected Unit Credit to Entry Age Normal Cost for RHIC
 - Decrease in the benefit indexing assumption for inactive members in Highway Patrol from 4.00% to 3.00%
 - Decrease in the assumed rate of increase in the IRC Section 415 benefit limit from 3.50% to 2.50% (affects Highway Patrol)

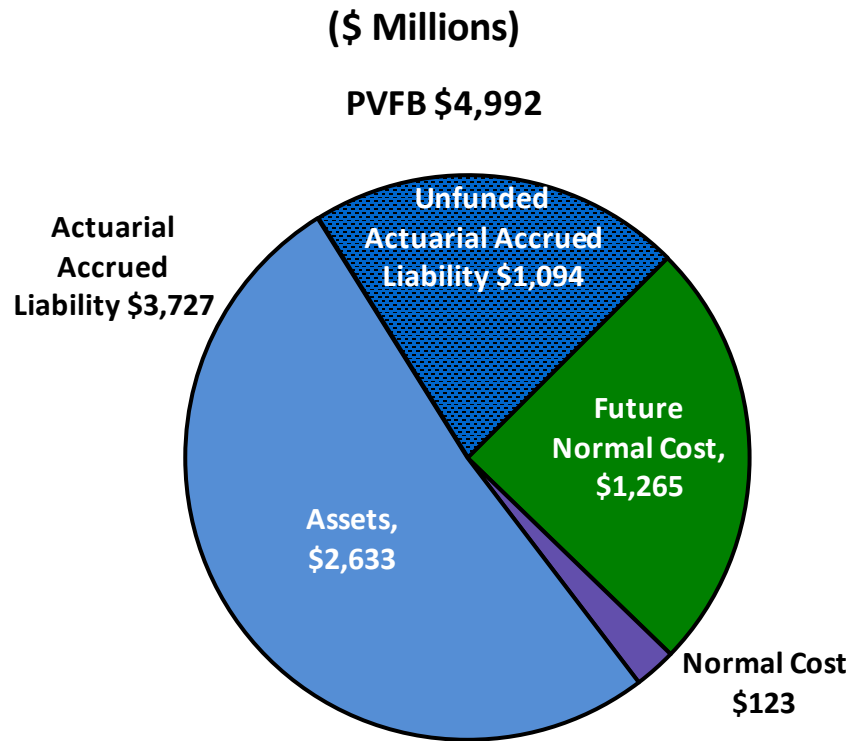
Actuarial Cost Method

Plan	Actuarial Cost Method
Main System	Entry Age Normal
Judges	Entry Age Normal
Law Enforcement	Entry Age Normal
Highway Patrol	Entry Age Normal
Job Service	Aggregate
RHIC	Entry Age Normal

Cost Method changed from Projected Unit Credit to Entry Age Normal first effective with the actuarial valuation as of July 1, 2017, for RHIC. Entry Age Normal is required to be used for accounting purposes under the Governmental Accounting Standards Board for all Systems.

Actuarial Cost Method

- **Present value of future benefits** –
present value of all future benefits (PVFB) payable to current participants (active, retired, terminated vested)
- **Actuarial accrued liability** – portion of PVFB allocated to prior years (equal to unfunded actuarial accrued liability plus assets)
- **Normal cost** – portion of PVFB allocated to current year
- **Future normal costs** – portion of PVFB allocated to future years



Causes of Unfunded Liability

- Granting initial benefits or granting benefit increases for service already rendered.
- Actual experience which is less favorable than assumed. Examples:
 - Lower rates of investment earnings;
 - Higher salary increases;
 - Earlier retirement date(s); and
 - Lower rates of non-death terminations.
- Not contributing at least Normal Cost + Interest on the Unfunded Liability.

Current Funding Policy

- Employer contribution rates are based on fixed rates set by Statute or the Board
 - 7.12% - Main System
 - 17.52% - Judges
 - 9.81% - Law Enforcement with Prior Main System Service
 - 7.93% - Law Enforcement without Prior Main System Service
 - 19.70% - Highway Patrolmen's Retirement System
 - 1.14% - Retiree Health Insurance Credit Fund (RHIC)
 - 0% - Job Service

Current Funding Policy

- Actuarial employer contribution rate equals
 - Employer Normal Cost, plus
 - Amortization of Unfunded Liability
 - Level percent of pay amortization
 - Payment increases as a dollar amount and remains level as a percentage of pay
 - Payroll is assumed to increase by 3.75% each year (3.25% for Judges)
 - Amortization Period
 - 20-year open period (Main System, Judges, Law Enforcement, Highway Patrol)
 - 40-year closed period beginning July 1, 1990, 13 years remaining as of July 1, 2017 (RHIC)
 - Not currently applicable for Job Service due to large surplus and Aggregate cost method

Changes in Provisions

- There have been no new changes in plan provisions since the last actuarial valuations as of July 1, 2016
 - Later retirement eligibility conditions for members enrolled in the Main System after December 31, 2015, are reflected in this actuarial valuation

Demographic Data



Demographic Data

PERS Plans

PERS							
Statistics as of July 1							
2017					2016	Total	
Main System	Judges	Law Enforcement		Total PERS	Total PERS	% Change	
		With Prior Main	Without Prior Main				
Membership Counts							
Active Members	22,574	54	498	117	23,243	23,416	-0.7%
Retired Members ¹	10,957	50	90	6	11,103	10,518	5.6%
Vested Former Members	11,336	4	229	85	11,654	10,733	8.6%
Total	44,867	108	817	208	46,000	44,667	3.0%
Average Age (Active)							
	46.4	56.8	37.4	38.9	46.2	46.3	0.0%
Average Ben Service (Active)							
	9.7	9.3	7.0	4.4	9.6	9.6	0.7%
Total Base Payroll	\$1,020,843,253	\$7,866,090	\$28,765,678	\$5,896,777	\$1,063,371,798	\$1,048,548,467	1.4%
Average Pay	45,222	145,668	57,762	50,400	45,750	44,779	2.2%
Total Retiree Benefits ¹							
	\$152,770,344	\$2,639,954	\$1,836,456	\$70,665	\$157,317,419	\$143,226,474	9.8%
Avg. Annual Benefit	13,943	52,799	20,405	11,778	14,169	13,617	4.1%

¹ Main System includes 3 pensioners in 2016 and 0 pensioners in 2017 receiving benefits under the Special Prior Service Plan.

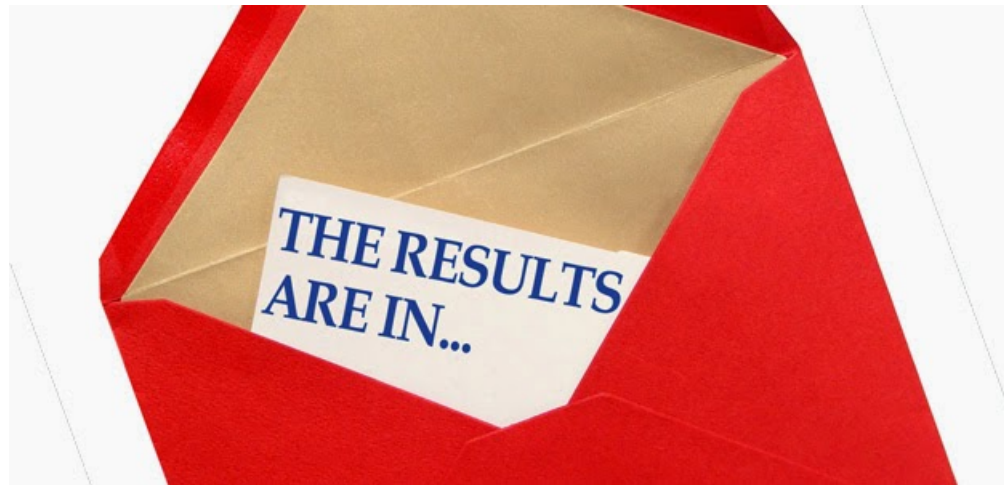
Demographic Data

Highway Patrol, Job Service, RHIC

	Highway Patrol			Job Service			RHIC		
	Statistics as of July 1		%	Statistics as of July 1		%	Statistics as of July 1		%
	2017	2016	Change	2017	2016	Change	2017	2016	Change
Membership Counts									
Active Members	151	156	-3.2%	8	9	-11.1%	23,497	23,664	-0.7%
Retired Members	127	123	3.3%	199	206	-3.4%	11,232	10,320	8.8%
Vested Former Members	39	39	0.0%	1	1	0.0%	-	-	
Total	317	318	-0.3%	208	216	-3.7%	34,729	33,984	2.2%
Average Age (Active)	37.1	36.4	0.8	62.1	61.6	0.5	46.2	46.2	(0.0)
Average Ben Service (Active)	10.5	9.6	0.8	41.1	40.1	1.0	9.6	9.5	0.1
Total Base Payroll	\$10,629,403	\$10,526,791	1.0%	\$498,564	\$564,684	-11.7%	\$1,081,841,008	\$1,066,653,605	1.4%
Average Pay	70,393	67,479	4.3%	62,321	62,743	-0.7%	46,042	45,075	2.1%
Total Retiree Benefits	\$4,733,027	\$4,586,664	3.2%	\$4,527,455	\$4,607,049	-1.7%	\$13,061,774	\$12,369,833	5.6%
Avg. Annual Benefit	37,268	37,290	-0.1%	22,751	22,364	1.7%	1,163	1,199	-3.0%

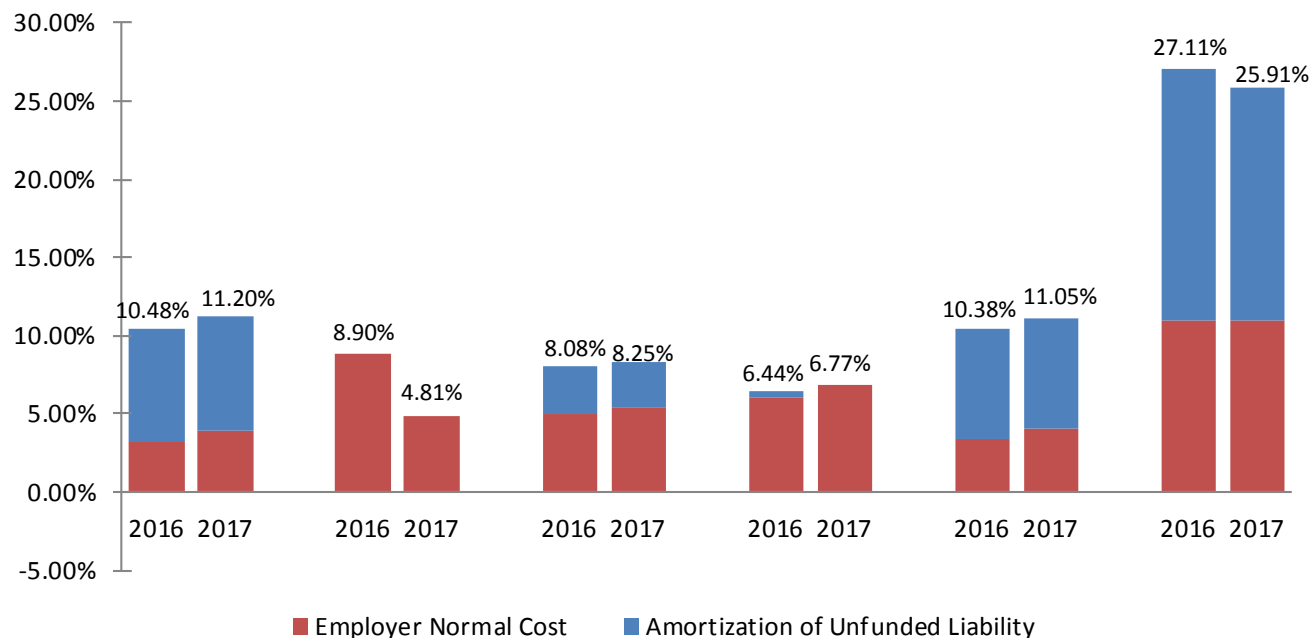
Retiree benefit amounts for Job Service exclude the portion of the total benefit amount paid by Travelers.

Contribution Rate Results



Contribution Rate Results

Actuarial Contribution Rate

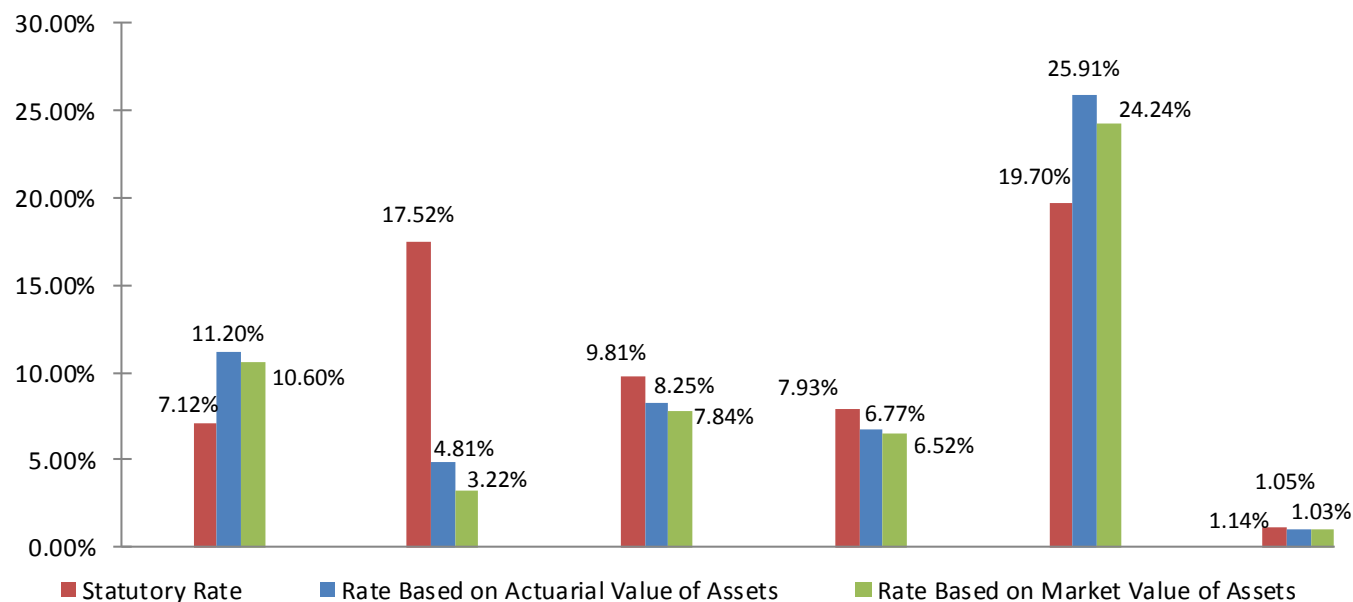


	Main System	Judges	Law Enforcement		Total PERS	Highway Patrol
			With Prior Main	Without Prior Main		
Employer Normal Cost Rates						
FY 2018 (2017 Valuation)	3.96%	11.36%	5.42%	6.81%	4.07%	11.03%
FY 2017 (2016 Valuation)	3.24%	10.40%	4.92%	6.07%	3.35%	10.92%
Amortization of Unfunded Liability Rates						
FY 2018 (2017 Valuation)	7.24%	-6.55%	2.83%	-0.04%	6.98%	14.88%
FY 2017 (2016 Valuation)	7.24%	-1.50%	3.16%	0.37%	7.03%	16.19%

Amount shown in graph for Judges is the employer normal cost rate net of the unfunded liability contribution.

Contribution Rate Results

Comparison of Statutory and Actuarial Contribution Rates



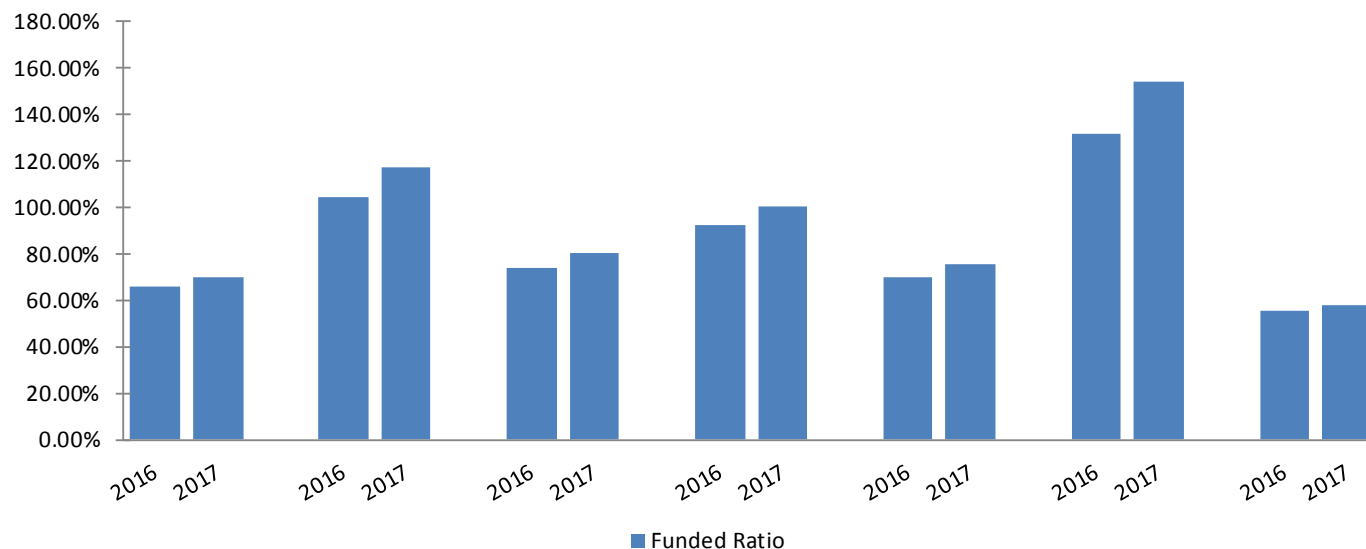
Valuation Results	Main System	Judges	Law Enforcement		Highway Patrol	RHIC
			With Prior Main	Without Prior Main		
Statutory Contribution Rate	7.12%	17.52%	9.81%	7.93%	19.70%	1.14%
Actuarial Contribution Rate (AVA)	11.20%	4.81%	8.25%	6.77%	25.91%	1.05%
Statutory Rate Excess/(Deficiency)	-4.08%	12.71%	1.56%	1.16%	-6.21%	0.09%
Actuarial Contribution Rate (MVA)	10.60%	3.22%	7.84%	6.52%	24.24%	1.03%
Statutory Rate Excess/(Deficiency)	-3.48%	14.30%	1.97%	1.41%	-4.54%	0.11%

Funded Ratio Results



Funded Ratio Results

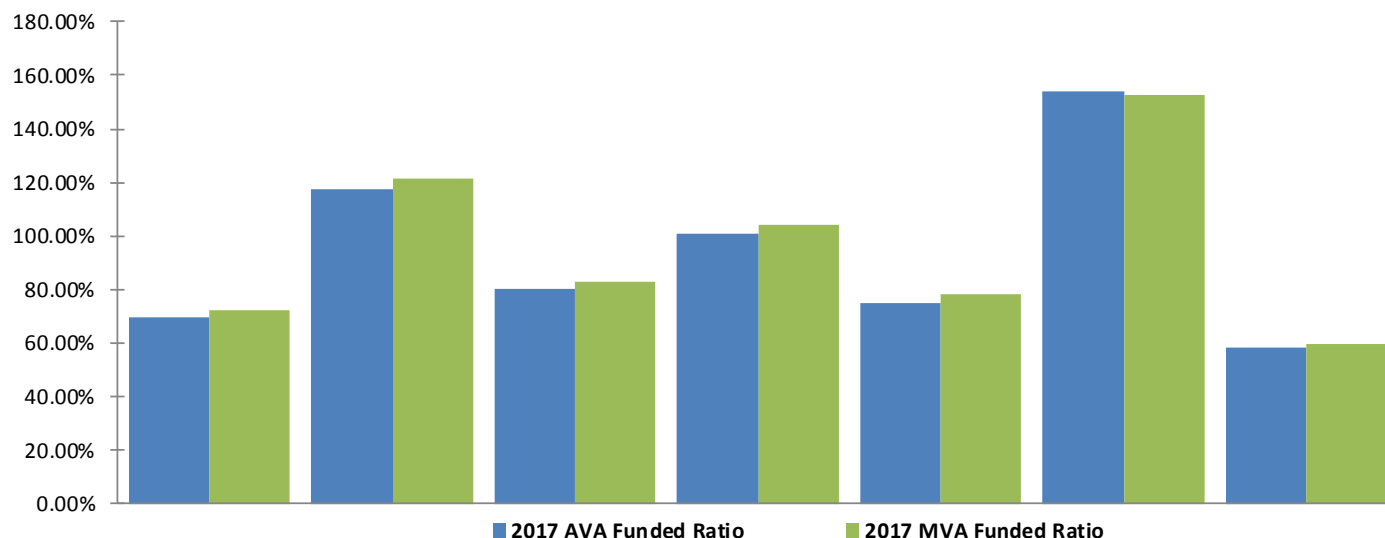
All Plans – Actuarial Value of Assets



Valuation Results	Main System	Judges	Law Enforcement		Highway Patrol	Job Service	RHIC
			With Prior Main	Without Prior Main			
Actuarial Accrued Liability	\$ 3,618,083,973	\$ 40,763,862	\$ 61,543,047	\$ 6,424,205	\$ 94,047,078	\$ 63,822,722	\$ 196,694,770
Actuarial Value of Assets	2,529,631,008	47,856,615	49,254,041	6,456,968	70,722,302	98,356,137	114,602,927
2017 Unfunded Actuarial Liability	1,088,452,965	(7,092,753)	12,289,006	(32,763)	23,324,776	(34,533,415)	82,091,843
UAL as Percent of Payroll	107%	-90%	43%	-1%	219%	-6927%	8%
2016 Unfunded Actuarial Liability	\$ 1,118,632,484	\$ (1,707,391)	\$ 14,085,816	\$ 276,917	\$ 26,188,050	\$ (19,609,202)	\$ 78,810,783
2017 Funded Ratio	69.9%	117.4%	80.0%	100.5%	75.2%	154.1%	58.3%
2016 Funded Ratio	66.1%	104.3%	73.8%	92.1%	70.2%	132.0%	55.4%

Funded Ratio Results

All Plans – Actuarial/Market Value



Valuation Results	Main System		Judges		Law Enforcement		Highway Patrol	Job Service	RHIC
					With Prior Main	Without Prior Main			
2017 Unfunded Actuarial Liability (AVA)	\$ 1,088,452,965	\$	(7,092,753)	\$	12,289,006	\$ (32,763)	\$ 23,324,776	\$ (34,533,415)	\$ 82,091,843
2016 Unfunded Actuarial Liability (AVA)	1,118,632,484		(1,707,391)		14,085,816	276,917	26,188,050	(19,609,202)	78,810,783
2017 Unfunded Actuarial Liability (MVA)	997,538,220		(8,812,716)		10,518,819	(264,826)	20,710,762	(33,442,689)	79,101,080
2016 Unfunded Actuarial Liability (MVA)	974,597,477		(4,450,173)		11,458,454	64,052	22,110,623	(35,162,658)	73,671,832
2017 Funded Ratio (AVA)	69.9%		117.4%		80.0%	100.5%	75.2%	154.1%	58.3%
2016 Funded Ratio (AVA)	66.1%		104.3%		73.8%	92.1%	70.2%	132.0%	55.4%
2017 Funded Ratio (MVA)	72.4%		121.6%		82.9%	104.1%	78.0%	152.4%	59.8%
2016 Funded Ratio (MVA)	70.5%		111.2%		78.7%	98.2%	74.9%	157.3%	58.3%

Reconciliation of Unfunded Liability, Actuarial Contribution Rate and Funded Ratio



Unfunded Liability Reconciliation

PERS Plans

	Main System	Judges	Law Enforcement With Prior Main	Law Enforcement Without Prior Main
Unfunded liability at previous valuation	\$ 1,118,632,484	\$ (1,707,391)	\$ 14,085,816	\$ 276,917
Expected unfunded liability at current valuation				
Normal cost for plan year	110,394,156	1,518,782	3,263,502	598,561
Interest on unfunded liability and normal cost	93,821,415	(77,009)	1,254,894	45,635
Contributions using actuarial rate with interest to current valuation date	<u>195,857,346</u>	<u>1,449,480</u>	<u>4,413,149</u>	<u>642,127</u>
Total expected change in unfunded liability at current valuation	8,358,225	(7,707)	105,247	2,069
Total expected unfunded liability at current valuation	1,126,990,709	(1,715,098)	14,191,063	278,986
Change due to:				
Amount and timing of contributions and expenses (based on statutory rate)	41,410,178	(616,339)	538,537	(10,421)
Recognition of asset (gains)/losses	(22,653,955)	(392,774)	(573,618)	(90,933)
Salary experience	(6,933,984)	(106,637)	(993,976)	(95,943)
Demographic and other experience	6,121,254	(2,303,760)	636,851	64,175
Change in actuarial assumptions	(56,481,237)	(1,958,145)	(1,509,851)	(178,627)
Changes in plan provisions	-	-	-	-
Total change	<u>(38,537,744)</u>	<u>(5,377,655)</u>	<u>(1,902,057)</u>	<u>(311,749)</u>
Unfunded liability at current valuation	\$ 1,088,452,965	\$ (7,092,753)	\$ 12,289,006	\$ (32,763)

Unfunded Liability Reconciliation

Highway Patrol, RHIC, Job Service

	Highway Patrol	RHIC	Job Service
Unfunded liability at previous valuation	\$ 26,188,050	\$ 78,810,783	\$ (19,609,202)
Expected unfunded liability at current valuation			
Normal cost for plan year	2,733,877	\$ 4,512,801	33,382
Interest on unfunded liability and normal cost	2,202,295	\$ 6,481,902	(1,371,496)
Contributions using actuarial rate with interest to current valuation date	<u>4,740,500</u>	\$ 12,155,308	<u>45,698</u>
Total expected change in unfunded liability at current valuation	195,672	(1,160,605)	(1,383,812)
Total expected unfunded liability at current valuation	26,383,722	77,650,178	(20,993,014)
Change due to:			
Amount and timing of contributions and expenses (based on statutory rate)	984,888	(933,765)	(16,485)
Recognition of asset (gains)/losses	(654,788)	(747,691)	272,682
Salary experience	(827,849)	-	(68,715)
Demographic and other experience	590,191	(2,897,484)	(1,568,042)
Change in actuarial assumptions	(3,151,388)	9,020,605	(12,159,841)
Changes in plan provisions	<u>-</u>	<u>-</u>	<u>-</u>
Total change	(3,058,946)	4,441,665	(13,540,401)
Unfunded liability at current valuation	\$ 23,324,776	\$ 82,091,843	\$ (34,533,415)

Assumption changes: Includes difference in liability due to changes in the investment return assumption, inflation assumption, COLA assumption (Job Service) and the actuarial cost method (RHIC). Includes difference in asset value due to full recognition of net deferred asset gains attributable to fiscal years 2016 and prior under the updated asset smoothing method.

Other experience: Includes COLA gain for Job Service (0% actual increase, 3% expected).

Funded Ratio Reconciliation

Based on Actuarial Value of Asses – All Plans

	Main System	Judges	Law Enforcement		Highway Patrol	RHIC	Job Service
			With Prior*	Without Prior*			
July 1, 2016 Funded Ratio (AVA)	66.1%	104.3%	73.9%	92.1%	70.2%	55.4%	132.0%
Expected July 1, 2017 Funded Ratio (AVA)	67.9%	104.1%	76.3%	93.6%	71.6%	57.9%	134.4%
Change due to:							
Amount and timing of contributions and expenses**	-1.2%	1.5%	-0.9%	0.2%	-1.1%	0.5%	0.0%
Recognition of asset (gains)/losses	0.7%	0.9%	1.0%	2.1%	0.7%	0.4%	-0.5%
Salary experience	0.1%	0.3%	1.3%	2.2%	0.6%	0.0%	0.2%
Demographic and other experience	0.0%	6.2%	-0.8%	-0.4%	-0.4%	1.1%	4.0%
Change in actuarial assumptions	2.5%	4.5%	3.2%	2.9%	3.7%	-1.6%	16.4%
Changes in plan provisions	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total change	2.0%	13.3%	3.7%	7.0%	3.7%	0.4%	20.1%
July 1, 2017 Funded Ratio (AVA)	69.9%	117.4%	80.0%	100.5%	75.2%	58.3%	154.6%

* Law Enforcement with prior Main System service and Law Enforcement without prior Main System service.

** Expected funded ratio is based on contributions using the actuarial rate. The change due to amount and timing of contributions is based on the statutory contributions that were made compared to the actuarial contributions.

Assumption changes:

Includes difference in asset value due to full recognition of net deferred asset gains attributable to fiscal years 2016 and prior under the updated asset smoothing method.

Includes difference in liability due to changes in the investment return assumption and inflation assumption.

For RHIC, includes difference in liability due to the change in the actuarial cost method.

For Highway Patrol, includes difference in liability due to the change in the benefit indexing assumption for inactive members and assumed rate of increase in the IRC 415 limit.

Actuarial Contribution Rate Reconciliation

All Plans

	Main System	Judges	Law Enforcement		Highway Patrol	RHIC
			With Prior*	Without Prior*		
FY 2017 Actuarial Employer Contribution	10.48%	8.90%	8.08%	6.44%	27.11%	1.02%
Expected FY 2018 Actuarial Employer Contribution	10.22%	8.95%	7.96%	6.42%	26.53%	1.02%
Change due to:						
Amount and timing of contributions and expenses**	0.25%	-0.53%	0.11%	-0.02%	0.56%	0.00%
Recognition of asset (gains)/losses	-0.14%	-0.33%	-0.12%	-0.11%	-0.39%	-0.01%
Salary experience	0.12%	-0.11%	-0.10%	-0.12%	-0.11%	0.02%
Demographic and other experience	0.84%	-1.18%	0.63%	0.79%	0.68%	-0.01%
Change in actuarial assumptions	-0.09%	-1.99%	-0.23%	-0.19%	-1.36%	0.03%
Changes in plan provisions	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total change	0.98%	-4.14%	0.29%	0.35%	-0.62%	0.03%
FY 2018 Actuarial Employer Contribution	11.20%	4.81%	8.25%	6.77%	25.91%	1.05%

Excludes Job Service due to Job Service being in a surplus position with no required contributions.

* *Law Enforcement with prior Main System service and Law Enforcement without prior Main System service.*

** *Expected funded ratio is based on contributions using the actuarial rate. The change due to amount and timing of contributions is based on the statutory contributions that were made compared to the actuarial contributions.*

Assumption changes:

Includes difference in asset value due to full recognition of net deferred asset gains attributable to fiscal years 2016 and prior under the updated asset smoothing method.

Includes difference in liability due to changes in the investment return assumption and inflation assumption.

For RHIC, includes difference in liability due to the change in the actuarial cost method.

For Highway Patrol, includes difference in liability due to the change in the benefit indexing assumption for inactive members and assumed rate of increase in the IRC 415 limit.

Summary of Change in Results

All Plans

			Law Enforcement					
	Main System	Judges	With Prior*	Without Prior*	Highway Patrol	RHIC	Job Service	
Unfunded Liability								
Based on Actuarial Value of Assets								
Unfunded liability at previous valuation	\$ 1,118,632,484	\$ (1,707,391)	\$ 14,085,816	\$ 276,917	\$ 26,188,050	\$ 78,810,783	\$ (19,609,202)	
Unfunded liability at current valuation	1,088,452,965	(7,092,753)	12,289,006	(32,763)	23,324,776	82,091,843	(34,533,415)	
Change	(30,179,519)	(5,385,362)	(1,796,810)	(309,680)	(2,863,274)	3,281,060	(14,924,213)	
Based on Market Value of Assets								
Unfunded liability at previous valuation	\$ 974,597,477	\$ (4,450,173)	\$ 11,458,454	\$ 64,052	\$ 22,110,623	\$ 73,671,832	\$ (35,162,658)	
Unfunded liability at current valuation	997,538,220	(8,812,716)	10,518,819	(264,826)	20,710,762	79,101,080	(33,442,689)	
Change	22,940,743	(4,362,543)	(939,635)	(328,878)	(1,399,861)	5,429,248	1,719,969	
Actuarial Employer Contribution Rate								
Based on Actuarial Value of Assets								
FY 2017 Actuarial Employer Contribution	10.48%	8.90%	8.08%	6.44%	27.11%	1.02%	NA	
FY 2018 Actuarial Employer Contribution	11.20%	4.81%	8.25%	6.77%	25.91%	1.05%	NA	
Change	0.72%	-4.09%	0.17%	0.33%	-1.20%	0.03%	NA	
Based on Market Value of Assets								
FY 2017 Actuarial Employer Contribution	9.55%	6.48%	7.49%	6.15%	24.59%	0.98%	NA	
FY 2018 Actuarial Employer Contribution	10.60%	3.22%	7.84%	6.52%	24.24%	1.03%	NA	
Change	1.05%	-3.26%	0.35%	0.37%	-0.35%	0.05%	NA	

Job Service is in a surplus position with no required contributions.

**Law Enforcement with prior Main System service and Law Enforcement without prior Main System service.*

Summary Comments on Actuarial Valuation

- Public Employees' Retirement System Plans
 - Actuarial employer contribution rates have increased for FY 2018 compared to FY 2017 for all PERS plans except Judges
 - Actual plan experience resulted in a net decrease in the actuarial contribution rates compared to the expected rates
 - Asset Experience
 - » The investment rate of return was approximately 12.9% on a market value of assets basis
 - » The investment rate of return was approximately 9.0% on an actuarial value of assets basis
 - Liability Experience
 - » There were lower salary increases than assumed
 - Statutory contribution rate is lower than the actuarial contribution rates (AVA and MVA) for the Main System
 - Funded ratio changes between July 1, 2016 and July 1, 2017
 - Increases (AVA basis) of between 2% (Main) and 13% (Judges)
 - Increases attributable to updated asset smoothing method (which offset liability increases) and FY 2017 asset gains

Summary Comments on Actuarial Valuation

- Highway Patrolmen's Retirement System

- Actuarial employer contribution rate has decreased for FY 2018 compared to FY 2017
- However, the Statutory contribution rate is lower than the actuarial contribution rates (AVA and MVA)
 - Updated assumptions resulted in a net decrease in the unfunded liability, mainly due to the full recognition of net deferred asset gains attributable to fiscal years 2016 and prior under the updated asset smoothing method
 - Actual plan experience (excluding the assumption changes) resulted in a net increase in the actuarial contribution rate compared to the expected rate
 - Asset Experience
 - » The investment rate of return was approximately 13.0% on a market value of assets basis
 - » The investment rate of return was approximately 9.0% on an actuarial value of assets basis
 - » Because the asset return was more than the assumed rate for fiscal year 2017 of 8.0%, there was a gain due to assets
 - Contribution Experience
 - » The statutory contribution rate is lower than the actuarial contribution rate, which caused the actuarial contribution rate for FY 2018 to increase
 - Liability Experience
 - » Salary increases were lower than assumed
 - » There was a net loss from all other demographic experience
- Funded ratio increased on both an AVA and MVA basis between July 1, 2016 and July 1, 2017

Summary Comments on Actuarial Valuation

- Retiree Health Insurance Credit Fund
 - Actuarial employer contribution rate has increased slightly for FY 2018 compared to FY 2017
 - There was a net increase in the unfunded liability due to assumption changes (reduction in the investment return assumption and change to the Entry Age Normal actuarial cost method)
 - Plan experience, including statutory contributions that were higher than the actuarial rate and favorable demographic and asset experience, partially offset the increase in the contribution rate due to assumption changes
 - Statutory contribution rate is still higher than the actuarial contribution rates (AVA and MVA)
 - The statutory contribution rate is approximately 0.10% of pay higher than the actuarial rates
 - Funded ratio increased on both an AVA basis (to 58.3%) and an MVA basis (to 59.8%) between July 1, 2016 and July 1, 2017

Summary Comments on Actuarial Valuation

- Retirement Plan for Employees of Job Service
 - The plan surplus has increased by about \$15 million on an AVA basis and has decreased by about \$1.7 million on an MVA basis from July 1, 2016, to July 1, 2017
 - Asset Experience
 - The investment rate of return was approximately 5.6% on a market value of assets basis
 - The investment rate of return was approximately 6.7% on an actuarial value of assets basis
 - The investment rate of return was lower than both the previous assumption of 7.00% and the current assumption of 5.70%
 - Liability Experience
 - There was a COLA gain due to no COLA increases being granted on retiree benefits compared to the FY 2017 actuarial assumption of 3.0%
 - Funded ratio increased on an AVA basis from 132.0% to 154.1% and decreased on an MVA basis from 157.3% to 152.4% between July 1, 2016 and July 1, 2017

Actuarial Valuation Results

Recommendations

- The statutory employer contribution rates are lower than the actuarial employer contribution rates for the Main System and Highway Patrol
 - We recommend that the statutory employer contribution rates be increased such that the unfunded liability is amortized over a period of no longer than a closed 30-year period (to reach 100% funded within 30 years)
- The Job Service investment return assumption was decreased from 7.00% to 5.70%. We recommend considering an additional decrease in the assumption
 - There would also be a surplus based on an assumption lower than 5.00%
- There has been favorable demographic experience for RHIC. We recommend that an analysis of the assumption for eligible members who use RHIC benefits be conducted prior to the July 1, 2018, actuarial valuation and changes be implemented in the 2018 actuarial valuation.

Summary of Board Actions on Actuarial-Related Issues



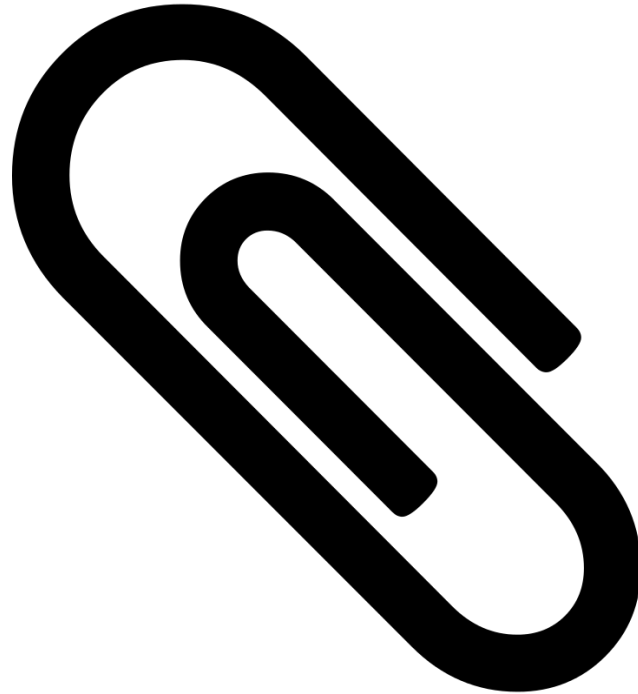
Summary of Board Actions on Actuarial-Related Issues

- Updated economic assumptions first used in actuarial valuations as of July 1, 2017
- Adopted updated actuarial equivalence factors that will be first used effective January 1, 2018
- Adopted updated service purchase methodology which will also incorporate updated assumptions
- Adopted Return to Work methodology

Questions?

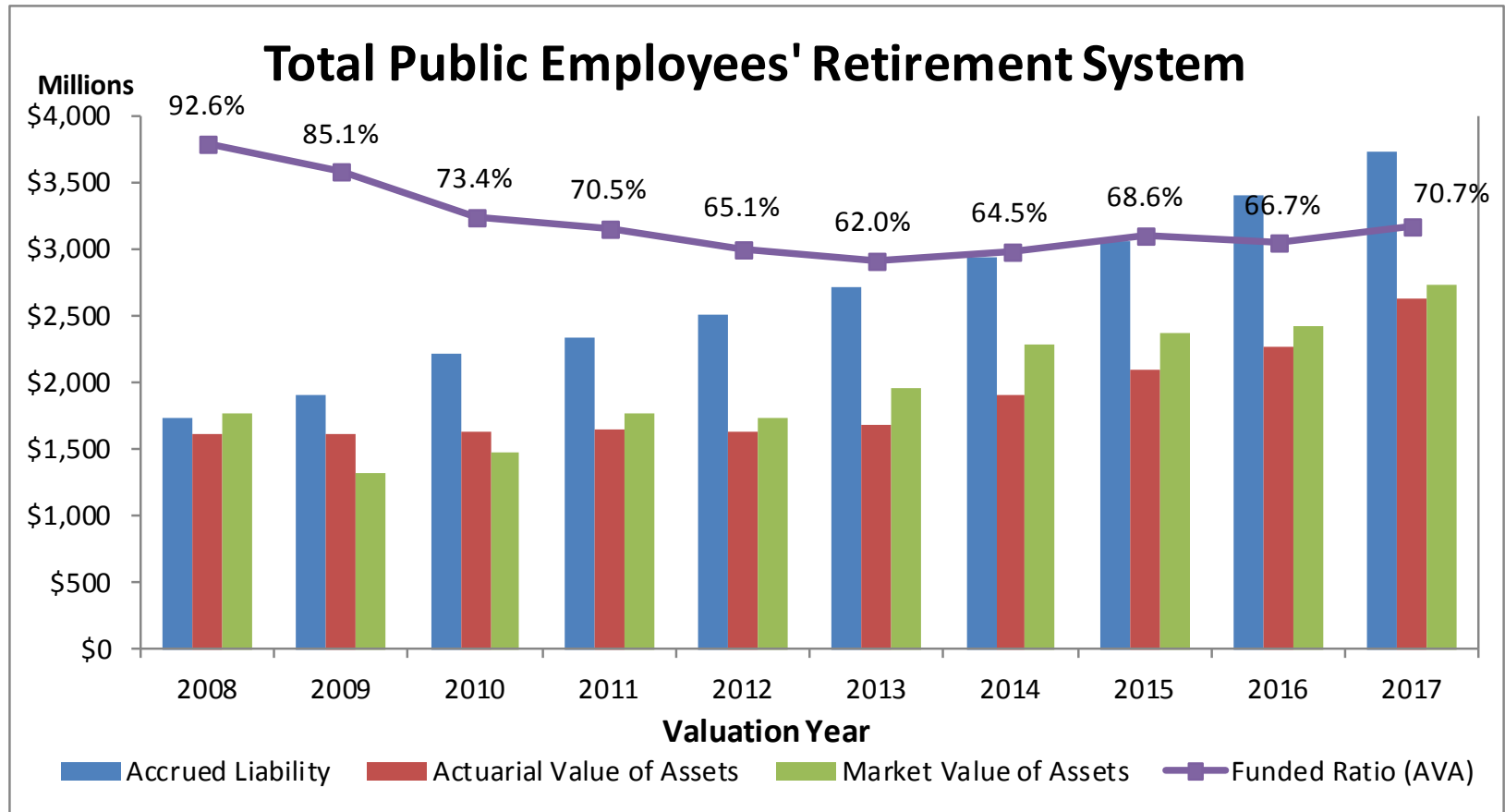


Appendix



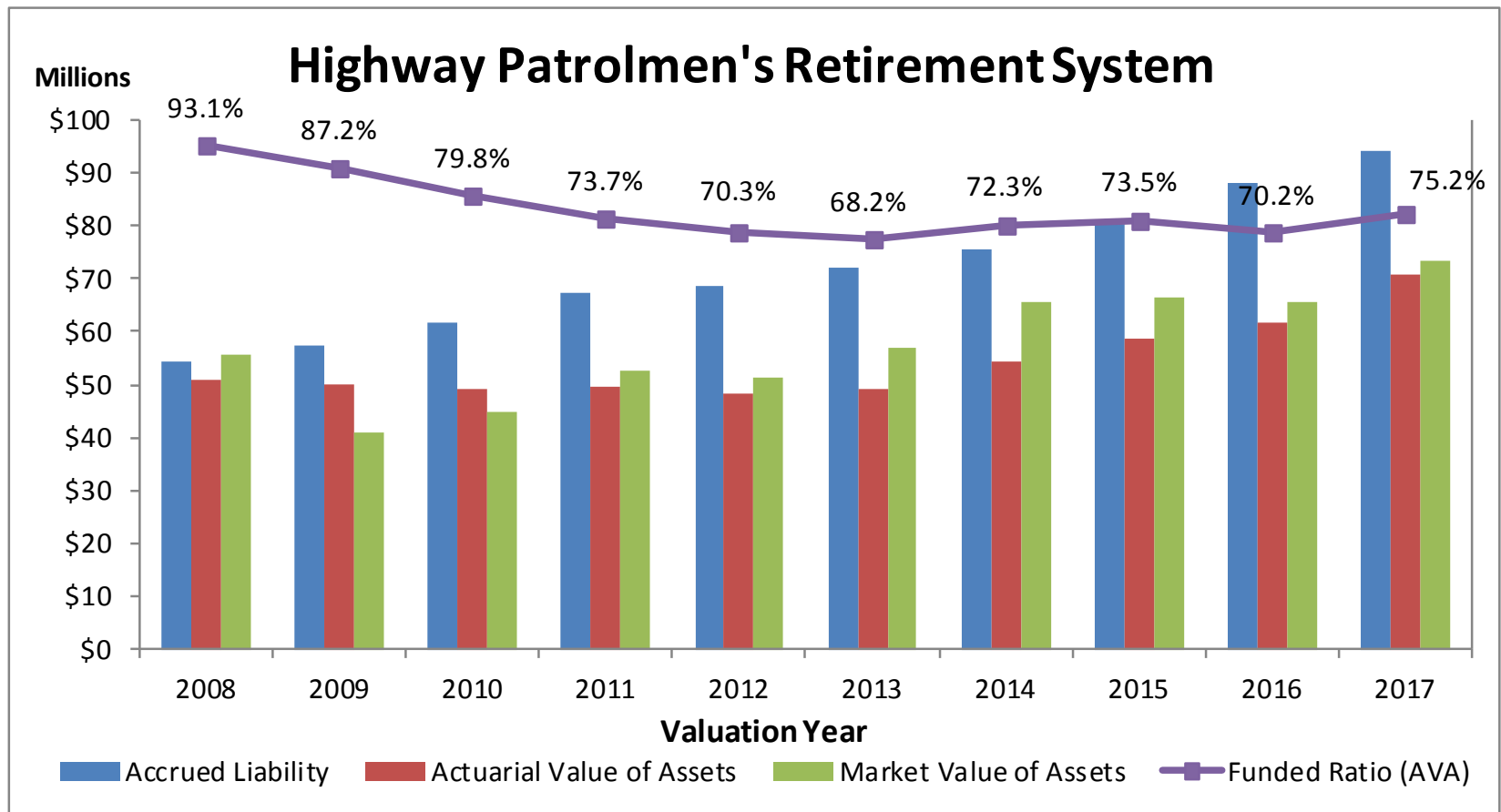
Historical Trends

Change in Funded Status



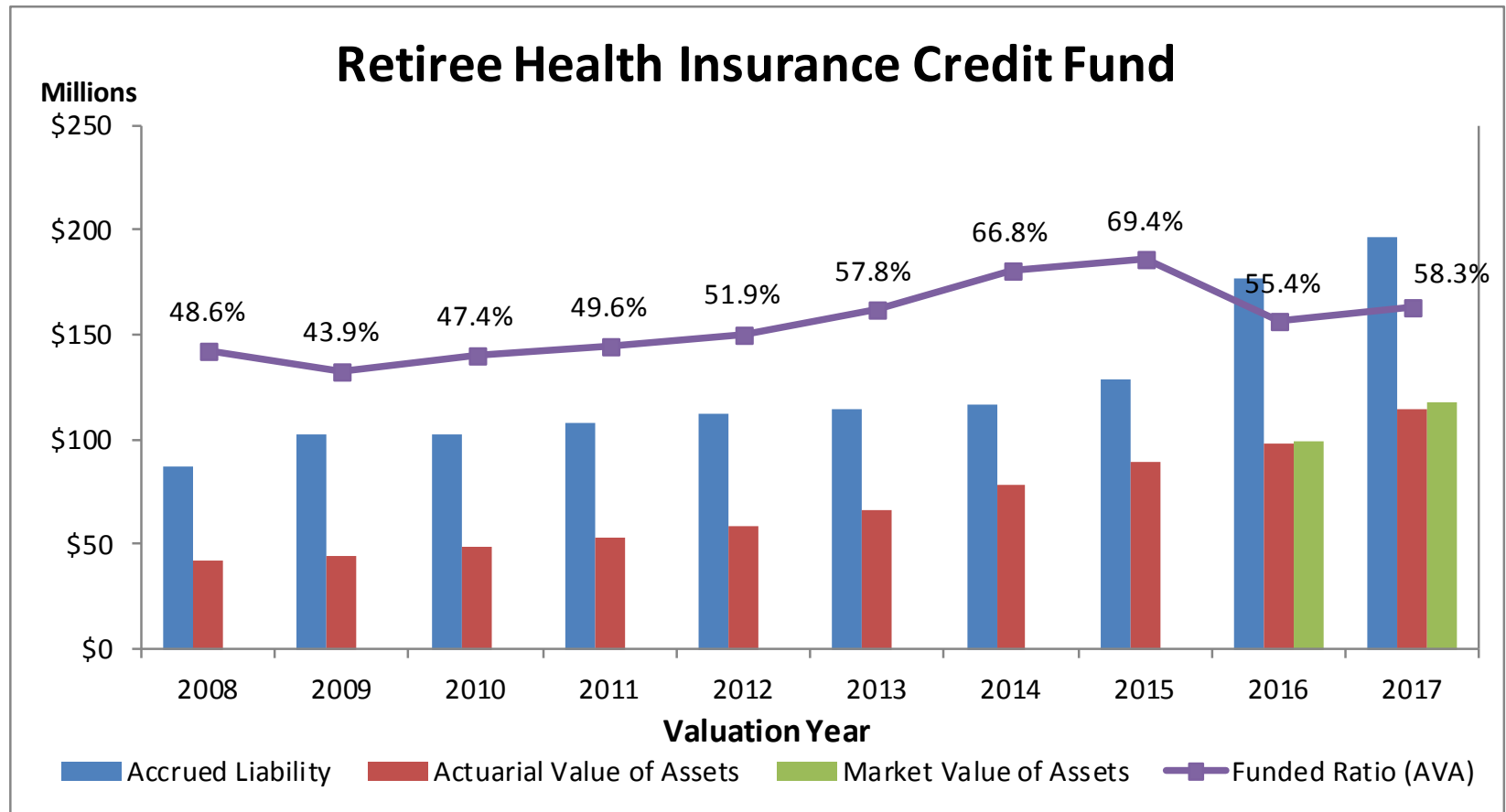
Historical Trends

Change in Funded Status



Historical Trends

Change in Funded Status



Disclosures

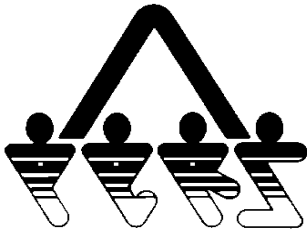


Disclosures

- This presentation shall not be construed to provide tax advice, legal advice or investment advice.
- The actuaries submitting this presentation (Lance J. Weiss and Amy Williams) are Members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.
- The purposes of the actuarial valuation are to measure the financial position of the North Dakota Public Employees' Retirement System, calculate the actuarial employer contribution rates and provide actuarial reporting and disclosure information for financial reporting.
- The assumptions used in the calculation of the July 1, 2017 actuarial valuation results are the same as those used in the July 1, 2016 actuarial valuation (except for the changes described herein) and were provided by, and are the responsibility of, the NDPERS Board.

Disclosures

- Future actuarial measurements may differ significantly from the current and projected measurements presented in this presentation due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the plan's funded status); and changes in plan provisions or applicable law.
- This is one of multiple documents comprising the actuarial reports for the NDPERS Plans. Additional information regarding actuarial assumptions and methods and important additional disclosures are provided in the Actuarial Valuation Reports as of July 1, 2017.
- If you need additional information to make an informed decision about the contents of this presentation, or if anything appears to be missing or incomplete, please contact us before relying on this presentation.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: October 19, 2017
SUBJECT: Investment Update

The *Statement of Investment Objectives and Policies*, adopted by the Board, states the following:

An annual performance report must be provided to the Board by the State Investment Officer at a regularly scheduled NDPERS Board meeting. The annual performance report must include asset returns and allocation data as well as information regarding all significant or material matters and changes pertaining to the investment of the Fund, including:

- *Changes in asset class portfolio structures, tactical approaches and market values;*
- *All pertinent legal or legislative proceedings affecting the SIB.*
- *Compliance with these investment goals, objectives and policies.*
- *A general market overview and market expectations.*
- *A Review of fund progress and its asset allocation strategy.*
- *A report on investment fees and the SIB's effort relating to Section 6. To measure investment cost PERS requires as part of the annual review information from an investment consultant showing the value added versus the cost.*

Darren Schultz from the Investment Office will be at the meeting to provide the annual report to the PERS Board. Attached is his presentation

PERS Investment Update

For the Periods Ended June 30, 2017

October 19, 2017

Note: This document contains unaudited data which is deemed to be materially accurate, but is unaudited and subject to change.

Darren Schulz, Deputy Chief Investment Officer
ND Retirement & Investment Office (RIO)
State Investment Board (SIB)

Executive Summary for periods ended June 30, 2017

Investment Performance Update –

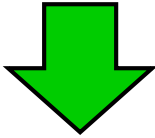
- **For the fiscal year ended June 30, 2017, PERS earned a net return of 13.0% versus a policy benchmark of less than 12%.** The financial markets were surprisingly robust and resilient in fiscal 2017. Global equities rose 18.8% last year with PERS's International Equity portfolio (up 21%) outperforming our U.S. Equity managers (up 17%). PERS fixed income returns far exceeded expectations with our U.S. debt portfolio posting a 6% gain versus 3% for the benchmark. PERS international debt portfolio earned less than 1% in fiscal 2017 but beat the global fixed income index which was negative due to low “real” rates outside the U.S. Real Assets were mixed with Real Estate and Infrastructure each earning over 9% in fiscal 2017, while **Timber fell over 9%** this past year.
- **Asset allocation is the primary driver of returns noting that PERS target allocation is currently at 58% Equity, 23% Fixed Income and 19% Real Assets. PERS earned a net return of 9.1% for the 5-years ended June 30, 2017, which exceeded the policy benchmark of 8.3% by over 0.65%.** During the last 5-years, PERS earned **\$980 million** of net investment income including **\$910 million** (or 93%) from asset allocation and **\$70 million₁** (7%) from active management.
- PERS investment returns were ranked in the **26th** percentile for the 5-years ended June 30, 2017, based on Callan's Public Fund Sponsor Database (on an unadjusted risk basis).

Investment Policy Statement Update –

- The SIB recently approved structural changes to eliminate \$575 million of agency MBS and international debt strategies. These changes are expected to materially improve risk adjusted returns within the Pension Trust largely due to the elimination of international fixed income with low expected returns and high expected volatility. **In order to implement these changes, PERS asset allocation within Fixed Income should be revised to reduce Investment Grade to 16% (from 19%) while increasing Non-Investment Grade to 7% (from 4%). The total allocation to Fixed Income will remain constant at 23%.**

PERS Investment Ends – June 30, 2017

SIB clients should receive net investment returns consistent with their written investment policies and market variables. This “End” is evaluated based on comparison of each client’s (a) actual net investment return, (b) standard deviation and (c) risk adjusted excess return, to the client’s policy benchmark over 5 years.

PERS earned \$320 million of net income in fiscal 2017.							
		1 Yr. Ended 6/30/2017	3 Yrs Ended 6/30/2017	5 Yrs Ended 6/30/2017	Risk 5 Yrs Ended 6/30/2017	Risk Adj Excess Return 5 Yrs Ended 6/30/2017	
Total Fund Return - Net	a	13.05%	5.49%	9.16%	4.8%		
Policy Benchmark Return	b	11.87%	4.75%	8.25%	4.6%		
Excess Return	a - b	1.18%	0.74%	0.90%	105%	0.50%	

Key: PERS investments averaged over \$2.2 billion the last 5-years and Excess Return has exceeded **0.65%** per annum. **PERS use of active management has enhanced Net Investment Returns by \$70 million for the 5-years ended June 30, 2017** (or \$2.2 billion x **0.65%** = \$14 million x 5 years = **\$70 million**). These returns were achieved while adhering to prescribed Risk limits (e.g. 105% versus a policy limit of 115%).

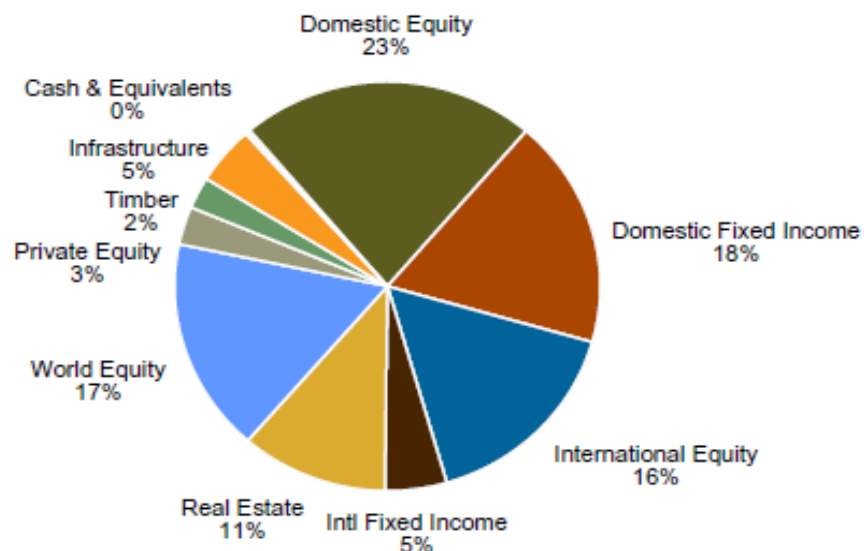
5-Yr. Returns June 30, 2017	Asset Allocation	Benchmark Return	Allocation x Return
<i>Asset Class</i>	<i>a</i>	<i>b</i>	<i>a x b</i>
Equity	58%	11%	6.4%
Fixed Income	23%	2.6%	0.6%
Real Assets	19%	7.3%	1.4%
Policy Benchmark Return (5-years)			8.3%

Current Policy Benchmark: 58% Equity (31% U.S., 21% Non-U.S., 6% Private); 23% Fixed Income (13% U.S., 6% Non-U.S. 4% High Yield); 19% Real Assets (11% Real Estate; 5% Infrastructure; 3% Timber).

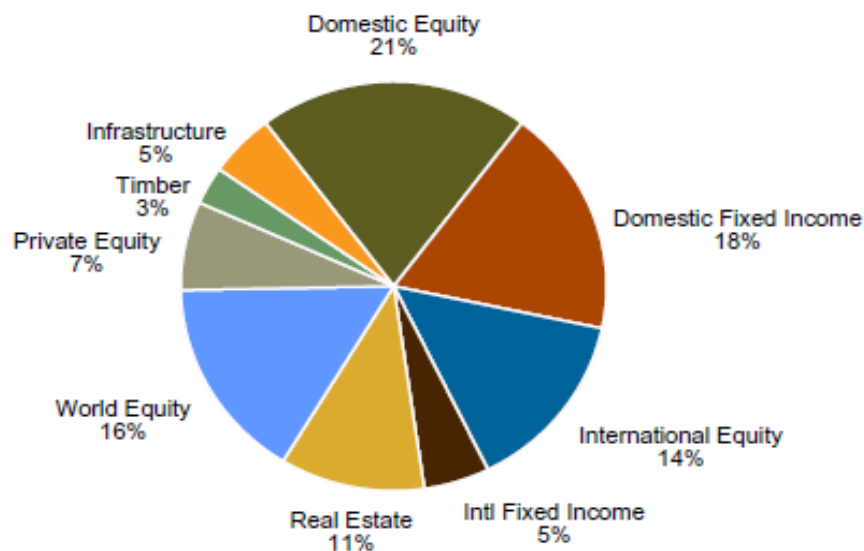
Actual Asset Allocations are within 4% of Target

The **Private Equity Underweight of 4.0%** is offset by **Overweight allocations to Domestic Equity of 2.1%, Int'l. Equity of 1.7% and World Equity of 0.9%.**

Actual Asset Allocation



Target Asset Allocation



Asset Class	\$000s Actual	Weight Actual	Target	Percent Difference	\$000s Difference
Domestic Equity	631,278	22.7%	20.6%	2.1% ←	58,320
Domestic Fixed Income	502,620	18.1%	18.0%	0.1%	1,978
International Equity	447,370	16.1%	14.4%	1.7% ←	46,856
Intl Fixed Income	130,196	4.7%	5.0%	(0.3%)	(8,871)
Real Estate	311,147	11.2%	11.0%	0.2%	5,199
World Equity	468,680	16.9%	16.0%	0.9% ←	23,665
Private Equity	83,863	3.0%	7.0%	(4.0%) →	(110,832)
Timber	68,943	2.5%	3.0%	(0.5%)	(14,498)
Infrastructure	126,764	4.6%	5.0%	(0.4%)	(12,304)
Cash & Equivalents	10,486	0.4%	0.0%	0.4%	10,486
Total	2,781,347	100.0%	100.0%		

Asset Class Performance

Periodic Table of Investment Returns
for Periods Ended June 30, 2017

Best



Worst

Last Quarter	Last Year	Last 3 Years	Last 5 Years	Last 10 Years	Last 20 Years
MSCI:EM Gross 6.4%	Russell:2000 Index 24.6%	S&P:500 9.6%	S&P:500 14.6%	S&P:500 7.2%	Russell:2000 Index 8.0%
MSCI:EAFE 6.1%	MSCI:EM Gross 24.2%	Russell:2000 Index 7.4%	Russell:2000 Index 13.7%	Russell:2000 Index 6.9%	S&P:500 7.2%
S&P:500 3.1%	MSCI:EAFE 20.3%	Blmbg:Aggregate 2.5%	MSCI:EAFE 8.7%	Blmbg:Aggregate 4.5%	MSCI:EM Gross 5.8%
Russell:2000 Index 2.5%	S&P:500 17.9%	MSCI:EM Gross 1.4%	MSCI:EM Gross 4.3%	MSCI:EM Gross 2.2%	Blmbg:Aggregate 5.2%
Blmbg:Aggregate 1.4%	3 Month T-Bill 0.5%	MSCI:EAFE 1.1%	Blmbg:Aggregate 2.2%	MSCI:EAFE 1.0%	MSCI:EAFE 4.3%
3 Month T-Bill 0.2%	Blmbg:Aggregate (0.3%)	3 Month T-Bill 0.2%	3 Month T-Bill 0.2%	3 Month T-Bill 0.6%	3 Month T-Bill 2.2%
Blmbg:Commodity Price Idx (3.2%)	Blmbg:Commodity Price Idx (7.0%)	Blmbg:Commodity Price Idx (15.0%)	Blmbg:Commodity Price Idx (9.4%)	Blmbg:Commodity Price Idx (6.9%)	Blmbg:Commodity Price Idx (1.8%)

U.S. Small Caps (**Russell 2000**) and Emerging Markets (**MSCI EM**) returned over 24% for the 1-year ended June 30, 2017, while International Equity (**MSCI EAFE**) was up 20% and U.S. Large Cap (**S&P 500**) was up 18%. U.S. Fixed Income (**Blmbg. Aggregate**) **declined 0.3%** in Fiscal 2017.

Global Equity, Fixed Income and Real Asset Valuations

PERS investment income was \$107 million last quarter while net outflows were < \$697,000.

Asset Class Allocation

	June 30, 2017				March 31, 2017	
	Market Value	Weight	Net New Inv.	Inv. Return	Market Value	Weight
GLOBAL EQUITY	\$1,631,190,921	58.65%	\$(12,153,247)	\$74,222,991	\$1,569,121,178	58.66%
Domestic Equity	\$631,277,502	22.70%	\$(6,609,511)	\$18,782,920	\$619,104,093	23.14%
Large Cap	479,066,241	17.22%	(6,365,156)	14,240,466	471,190,931	17.61%
Small Cap	152,211,261	5.47%	(244,355)	4,542,455	147,913,162	5.53%
International Equity	\$447,370,457	16.08%	\$(5,449,971)	\$27,777,639	\$425,042,789	15.89%
Developed Intl Equity	329,244,317	11.84%	(3,649,971)	20,993,261	311,901,027	11.66%
Emerging Markets	118,126,139	4.25%	(1,800,000)	6,784,378	113,141,762	4.23%
World Equity	\$468,680,340	16.85%	\$(37,663)	\$21,613,291	\$447,104,711	16.71%
Private Equity	\$83,862,623	3.02%	\$(56,102)	\$6,049,140	\$77,869,585	2.91%
GLOBAL FIXED INCOME	\$632,816,497	22.75%	\$(1,417,328)	\$16,919,646	\$617,314,180	23.08%
Domestic Fixed Income	\$502,620,244	18.07%	\$(1,288,857)	\$11,830,531	\$492,078,570	18.40%
Inv. Grade Fixed Income	359,796,107	12.94%	(514,777)	8,019,552	352,291,332	13.17%
Below Inv. Grade Fixed Income	142,824,137	5.14%	(774,081)	3,810,979	139,787,238	5.23%
International Fixed Income	\$130,196,253	4.68%	\$(128,471)	\$5,089,114	\$125,235,610	4.68%
GLOBAL REAL ASSETS	\$506,853,480	18.22%	\$10,284,400	\$15,815,993	\$480,753,087	17.97%
Real Estate	311,147,233	11.19%	1,592,603	9,851,031	299,703,599	11.20%
Timber	68,942,678	2.48%	(652,614)	(949,432)	70,544,724	2.64%
Infrastructure	126,763,569	4.56%	9,344,411	6,914,395	110,504,763	4.13%
Cash & Equivalents	\$10,486,155	0.38%	\$2,662,685	\$26,761	\$7,796,709	0.29%
Securities Lending Income	\$0	0.00%	\$(73,054)	\$73,054	-	-
Total Fund	\$2,781,347,053	100.0%	\$(696,544)	\$107,058,444	\$2,674,985,154	100.0%

Cash Outflows



Cash Inflows







Comparison of Major Asset Class Returns vs. Benchmark

Global Equities earned 18.85% for the 1-year ended June 30, 2017, which was 0.06% above the benchmark, while the 5-year return of 11.28% surpassed the benchmark of 10.75% by 0.53%.

Global Fixed Income earned 5.02% last year and 4.65% the last 5-years due to strong returns in U.S. Fixed Income including high yield & private credit offset by weaker returns in International Debt and Long Term Treasuries due to rising rates.

Global Real Assets were mixed with Real Estate and Infrastructure earning over 9.1% last year, while **Timber returns were -9.4%** in fiscal 2017.

Every major asset class outperformed their respective benchmarks for the 5-years ended June 30, 2017, with the largest excess return (of 1.95%) created within Global Fixed Income.

NDPERS Allocation	Target Allocation	1-year	5-years
Global Equity	58%		
- Actual		18.85%	11.28%
- Benchmark		<u>18.79%</u>	<u>10.75%</u>
		0.06%	0.53% 
Global Fixed Income	23%		
- Actual		5.02%	4.65%
- Benchmark		<u>1.73%</u>	<u>2.70%</u>
		3.29%	1.95% 
Global Real Assets	19%		
- Actual		6.15%	8.40%
- Benchmark		<u>4.70%</u>	<u>7.26%</u>
		1.45%	1.14% 
Cash Equivalents	< 1%		
- Actual		0.74%	0.24%
- Benchmark		<u>0.49%</u>	<u>0.17%</u>
		0.25%	0.07%
TFFR - Total Fund	100%		
- Actual		13.05%	9.16%
- Benchmark		<u>11.87%</u>	<u>8.25%</u>
		1.18%	0.90% 

PERS Returns for 1- and 5- years ended June 30, 2017

**PERS earned
13.0% and 9.1%
for the 1- and 5-
years ended June
30, 2017, beating
the Policy Target
Benchmarks.**

**Equity markets
were strong with
Global Equities up
18.8% the last
year and 11.3%
the last 5-years
beating our
Benchmarks for
the 1- and 5-years
ended June 30,
2017.**

	June-17			Fiscal 2017	5 Years Ended 6/30/2017
	Market Value	Actual	Policy	Net	Net
TOTAL FUND	2,781,347,058	100%	100%	13.05%	9.16%
<i>POLICY TARGET BENCHMARK</i>				11.87%	8.25%
EXCESS RETURN (over Benchmark)				1.18%	0.90%
GLOBAL EQUITIES	1,631,190,926	58.6%	58.0%	18.85%	11.28%
<i>Benchmark</i>				18.79%	10.75%
Epoch Global Choice (1)	208,607,374	7.5%	7.0%	16.96%	10.71%
LSV Global Value Equity	260,072,966	9.4%	9.0%	23.29%	N/A
Total Global Equities	468,680,340	16.9%	16.0%	20.57%	10.62%
<i>MSCI World</i>				18.20%	11.38%
<i>Domestic - broad</i>	631,277,505	22.7%	20.6%	17.10%	14.85%
<i>Benchmark</i>				19.58%	14.51%
LA Capital Large Cap Growth	182,563,127	6.6%	6.3%	15.66%	15.27%
LA Capital Large Cap Index/Active	106,120,946	3.8%	3.2%	15.44%	14.81%
<i>Russell 1000</i>				18.03%	14.67%
NTAM - Quant Enhanced S&P 500	88,590,653	3.2%	3.2%	16.51%	14.28%
Clifton Group Enhanced S&P 500	101,791,517	3.7%	3.2%	17.72%	14.70%
<i>S&P 500</i>				17.90%	14.63%
Total Large Cap Domestic	479,066,244	17.2%	15.8%	16.20%	15.31%
<i>Russell 1000 (2)</i>				18.03%	14.67%
Atlanta Capital Small Cap Equity Fund	68,626,878	2.5%	2.4%	14.98%	N/A
Clifton Group Enhanced Russell 2000	83,584,383	3.0%	2.4%	24.44%	14.25%
Total Small Cap Domestic	152,211,261	5.5%	4.8%	20.08%	13.09%
<i>Russell 2000</i>				24.60%	13.70%
<i>International - broad</i>	447,370,459	16.1%	14.4%	21.18%	9.13%
<i>Benchmark</i>				20.53%	7.53%
NTAM - MSCI World ex-US Index	156,739,205	0.0%	5.5%	19.92%	N/A
<i>MSCI World Ex US</i>				19.49%	
William Blair International Leaders	76,100,978	2.7%	3.3%	19.77%	N/A
<i>MSCI ACWI ex-US IMI (Net)</i>				20.43%	
DFA Intl. Small Cap Value Portfolio (4)	45,622,857	1.6%	1.1%	28.80%	13.77%
Wellington International Small Cap Op	50,781,278	1.8%	1.1%	19.62%	14.12%
<i>S&P/Citigroup BMI EPAC < \$2BN</i>				20.89%	12.00%
Total Developed International	329,244,318	11.8%	11.0%	21.05%	10.27%
<i>MSCI World Ex US (3)</i>				19.49%	8.55%
Axiom Emerging Markets Equity Fund	89,447,891	3.2%	2.6%	22.29%	N/A
DFA Emerging Markets Small Cap Po	28,678,250	1.0%	0.9%	19.53%	6.86%
Total Emerging Markets	118,126,140	4.2%	3.4%	21.55%	4.94%
<i>MSCI Emerging Markets</i>				23.74%	3.96%
Total Private Equity (4)	83,862,622	3.0%	7.0%	11.12%	1.60%

NOTE: Monthly returns and market values are preliminary and subject to change.

PERS Returns for the 1- and 5-years ended June 30, 2017

Global Fixed Income
earned over 4.6% for the
1- and 5-years ended
June 30, 2017, exceeding
Benchmarks. Strong
returns in U.S. Fixed
Income including Private
Credit and High Yield
where offset by weak
results in International
Fixed Income.

Global Real Assets
earned 6.1% last year and
8.4% per annum over the
last 5-years. Real Estate
and Infrastructure earned
12.5% and 6.6%,
respectively, the last 5-
years, while **Timber**
returns disappointed at
only 0.3% per annum for
the 5-years ended June
30, 2017.

	June-17			Fiscal 2017	5 Years Ended 6/30/2017
	Market Value	Actual	Policy	Net	Net
GLOBAL FIXED INCOME	632,816,498	22.8%	23.0%	5.02%	4.65%
Benchmark				1.73%	2.70%
Domestic Fixed Income	502,620,245	18.1%	18.0%	6.30%	5.61%
Benchmark				3.23%	3.57%
PIMCO Distressed Senior Credit Oppo	55,316,665	2.0%	2.0%	17.08%	13.70%
Bloomberg Aggregate				-0.31%	
State Street Long U.S. Treasury Index	60,882,047	2.2%	1.3%	-7.27%	N/A
Bloomberg Long Treasuries				-7.22%	
PIMCO Unconstrained Bond Fund	34,704,050	1.2%	1.7%	9.22%	N/A
Declaration Total Return Bond Fund (4	46,751,080	1.7%	1.6%	4.99%	5.14%
3m LIBOR				0.98%	
JP Morgan Mortgage Backed Securitie	67,592,541	2.4%	2.6%	0.61%	N/A
PIMCO Agency MBS	94,549,724	3.4%	3.9%	0.19%	9.48%
Bloomberg Mortgage Backed Securities Index				-0.06%	
Total Investment Grade Fixed Inco	359,796,107	12.9%	13.0%	3.65%	4.55%
Bloomberg Aggregate				-0.31%	2.21%
Loomis Sayles High Yield	110,353,972	4.0%	3.8%	12.91%	7.41%
PIMCO BRAVO II (4)	31,491,553	1.1%	1.1%	13.38%	N/A
Total Below Investment Grade Fixe	142,824,137	5.1%	5.0%	12.86%	8.21%
Bloomberg High Yield 2% Issuer Constrained Index				12.69%	6.90%
International Fixed Income	130,196,253	4.7%	5.0%	0.79%	1.24%
Benchmark				-3.80%	-0.36%
UBS Global (ex-US) Bond Strategy	53,104,130	1.9%	2.5%	-4.00%	-0.86%
Brandywine Global Opportunistic Fixe	77,092,123	2.8%	2.5%	4.38%	3.15%
GLOBAL REAL ASSETS	506,853,480	18.2%	19.0%	6.15%	8.40%
Benchmark				4.70%	7.26%
Invesco Core Real Estate - U.S.A., L.F	140,782,671			8.16%	11.58%
Invesco Real Estate Fund III, LP (4)	11,925,960			11.58%	15.89%
Invesco U.S. Value-Add Fund IV, L.P.	24,216,147			8.07%	N/A
Invesco Asia Real Estate Fund III, L.P	11,856,673			21.25%	N/A
JP Morgan Strategic & Special Situati	107,883,754			7.08%	11.84%
JP Morgan European Opportunistic Pr	5,441,695			-0.51%	9.48%
JP Morgan Greater China Property Fu	8,624,839			37.81%	24.95%
Total Global Real Estate	311,147,233	11.2%	11.0%	9.13%	12.47%
NCREIF TOTAL INDEX				6.97%	10.49%
TIR Teredo Timber, LLC	15,883,699	0.6%		-7.02%	5.75%
TIR Springbank, LLC	53,058,979	1.9%		-10.13%	-2.37%
Total Timber (4)	68,942,678	2.5%	3.0%	-9.44%	0.27%
NCREIF Timberland Index				3.35%	7.16%
JP Morgan Asian Infrastructure & Rela	12,071,004	0.4%		35.48%	8.92%
JP Morgan Infrastructure Investments	91,657,971	3.3%		6.33%	5.72%
Grosvenor Customized Infrastructure S	19,207,968	0.7%		8.70%	8.94%
Grosvenor Customized Infrastructure S	3,826,627	0.1%		3.28%	N/A
Total Infrastructure	126,763,569	4.6%	5.0%	9.21%	6.57%
CPI				1.50%	1.11%
Northern Trust Collective STIF	7,777,863			0.75%	0.25%
Bank of ND	2,708,292		N/A	N/A	N/A
Total Cash Equivalents	10,486,155	0.4%	0.0%	0.74%	0.24%
90 Day T-Bill				0.49%	0.17%

NOTE: Monthly returns and market values are preliminary and subject to change.

PERS Long Term Results are Near Long-Term Assumptions

ND RETIREMENT AND INVESTMENT OFFICE
ND STATE INVESTMENT BOARD
INVESTMENT PERFORMANCE SUMMARY
AS OF JUNE 30, 2017

Investment Performance (net of fees)

Fund Name	Quarter Ended				FYTD 2017	Fiscal Years ended June 30					Periods ended 6/30/17 (annualized)				
	9/30/16	12/31/16	3/31/17	6/30/17		2016	2015	2014	2013	2012	3 Years	5 Years	15 Years	25 Years	30 Years
NDPERS	3.68%	0.49%	4.40%	3.93%	13.05%	0.28%	3.53%	16.38%	13.44%	-0.12%	5.48%	9.16%	7.21%	7.84%	7.85%

The TFFR Pension Plan is a Long Term Investor

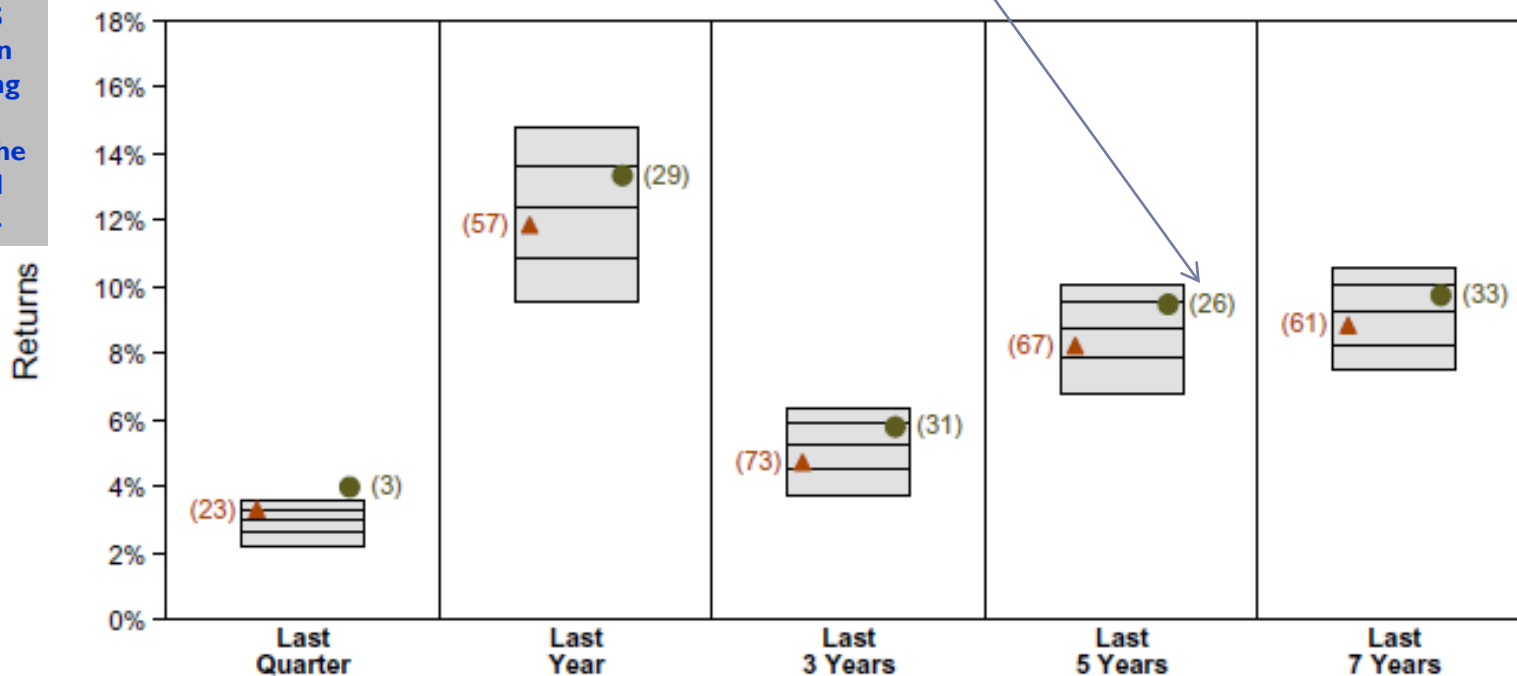
Net investment returns for the PERS Pension Plan have approximated 7.85% for the last 30-years which is materially consistent with the plan's long term actuarial assumption of 7.75%.

PERS “gross” returns were ranked in the 26th percentile for the 5-years ended June 30, 2017, based on Callan’s “Public Fund Sponsor Database”.

CAI Public Fund Sponsor Database

Unadjusted Ranking

NOTE: PERS asset allocation adjusted ranking is in the 14th percentile for the 5-years ended June 30, 2017.

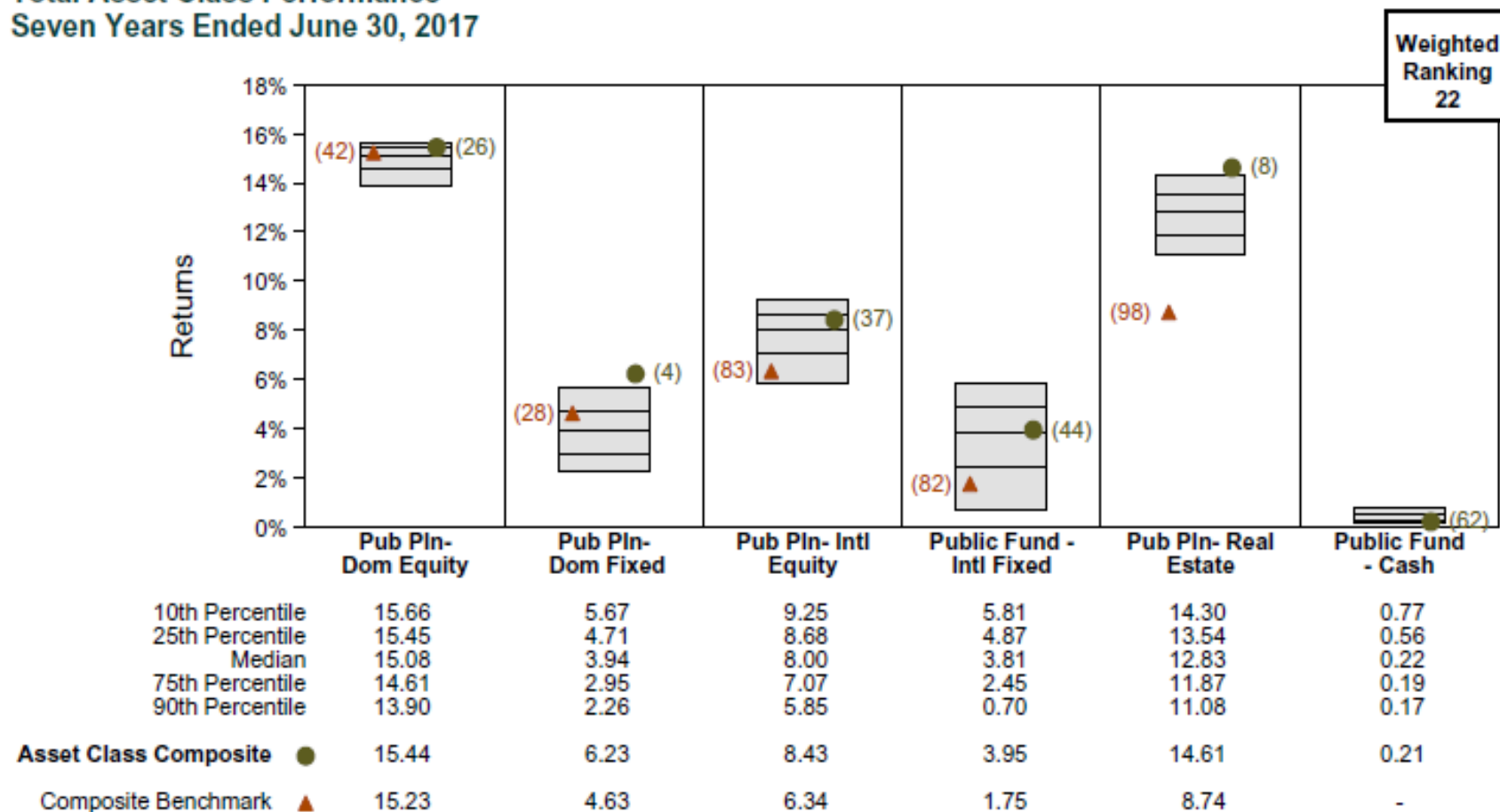


	Last Quarter	Last Year	Last 3 Years	Last 5 Years	Last 7 Years
10th Percentile	3.57	14.82	6.37	10.09	10.59
25th Percentile	3.31	13.62	5.95	9.53	10.04
Median	3.04	12.42	5.30	8.78	9.24
75th Percentile	2.62	10.86	4.56	7.86	8.22
90th Percentile	2.23	9.59	3.73	6.82	7.53
Total Fund ●	4.00	13.35	5.81	9.49	9.75
Policy Target ▲	3.33	11.87	4.74	8.25	8.86

* Current Quarter Target = 16.6% Russell 1000 Index, 16.0% MSCI World, 13.0% Blmbg Aggregate, 11.8% MSCI World ex US, 10.0% NCREIF Total Index, 6.0% Blmbg Glob Agg ex USD, 6.0% NDSIB TFFR - Private Equity, 5.0% CPI-W, 4.8% Russell 2000 Index, 4.0% Blmbg HY 2% Iss Cap, 3.0% NCREIF Timberland Index, 2.8% MSCI EM and 1.0% 3-month Treasury Bill.

PERS managers performed well in the public markets over the last 7 years, but have been challenged in private equity and timber.

Total Asset Class Performance
Seven Years Ended June 30, 2017



NOTE: SIB utilizes the private markets to invest in real estate, infrastructure and timber (in addition to private equity and private debt).

NDSIB Watch List

Data as of 06/30/2017

Note: Return data is gross of fee due to data availability.

JP Morgan MBS (Pen.)		\$131,206,979	
	Returns	Index ¹	Excess
1 Year	0.82	(0.06)	0.87
Inception*	2.76	2.30	0.46
*Funded 09/30/2014			

1 – Bloomberg Mortgage Backed Market Index

UBS International Fixed (Pen.)		\$105,946,147	
	Returns	Index ²	Excess
1 Year	(3.69)	(3.80)	0.10
3 Year	(2.44)	(2.42)	(0.01)
Inception*	5.93	5.64	0.29
*Funded 07/01/1989			

2 – Bloomberg Global Aggregate ex-U.S. Fixed Income Index

UPDATE:

The SIB confirmed RIO's recommendation to keep JPMorgan's Agency MBS strategy (\$131 million) and the UBS International Fixed Income mandate (\$106 million) on Watch at the August 25, 2017 board meeting.

The SIB removed Adams Street Partners from Watch on April 28, 2017, following transparency enhancement initiatives implemented during the fourth quarter of 2016 and first quarter of 2017. PIMCO was removed from Watch on August 25, 2017, after RIO conducted extensive onsite due diligence during the past six months. PIMCO was originally placed on Watch in September of 2014 following the resignation of former CIO and co-founder Bill Gross. Recent staff meetings with PIMCO's current CEO Emmanuel Roman and Group CIO Dan Ivascyn confirm RIO's belief that PIMCO has successfully emerged from the post-Bill Gross era noting that firm level assets have stabilized at \$1.6 trillion. Callan concurs with these watch list recommendations and was instrumental in providing valuable market insight and investment research.

PERS Activity from June 30, 2016 to June 30, 2017

Net Investment Position - June 30. 2016	\$2,457	a
---	---------	---

Net Contributions	\$2	b
-------------------	-----	---

Investment Earnings	\$334	
Investment Expenses	<u>(\$14)</u>	
Net Investment Earnings	<u>\$320</u>	c

Net Investment Position - June 30. 2017	<u>\$2,779</u>	d
---	----------------	---

Change in Net Investment Position	(d - a)	<u>\$322</u>	e
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Net Investment Position improved by \$322 million (e) as Pension Contributions exceeded Benefit Payments by \$2 million (b), while Net Investment Earnings were \$320 million (c) after investment expenses.

The SIB and RIO have been working to restructure the fixed income allocation within the Pension Trust during the past year. The following three pages provide an overview of the fixed income restructuring plan as shared with the SIB in recent board meetings.

Fixed Income Restructuring Overview

August 25, 2017

Dave Hunter, Darren Schulz and Eric Chin

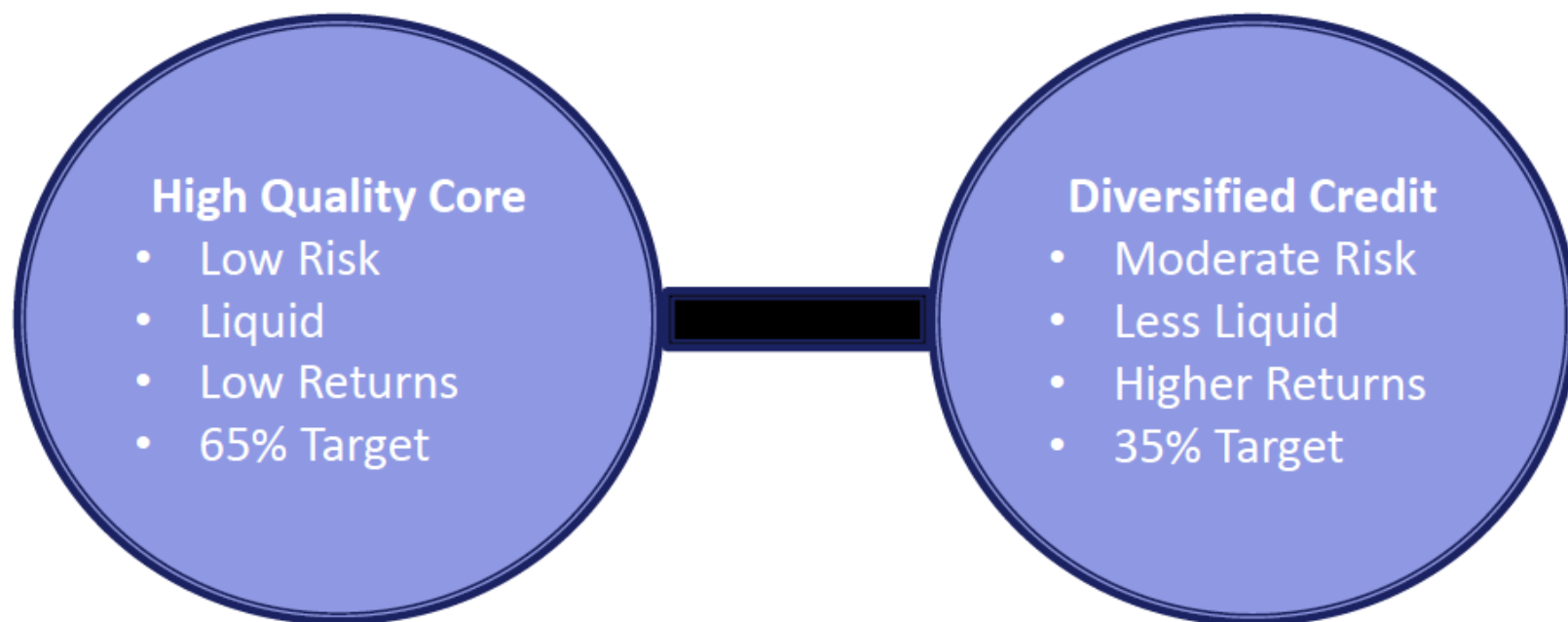
Pension Trust Fixed Income Structure

- ▶ Evolving fixed income landscape and stage of credit cycle merited a review of the Pension Trust's current fixed income manager structure
- ▶ In January, Staff presented a conceptual framework encompassing the following changes:
 - ➡ Increasing anchor of high quality, low risk, highly liquid U.S. investment grade core fixed income aka "High Quality Core"
 - ➡ Diversifying traditional non-investment grade with high yield/loan alternatives and private credit aka "Diversified Credit"
 - ➡ Transitioning non-U.S./global developed fixed income into U.S. centric fixed income

Fixed Income Structure Proposal

Initially discussed at the Jan. 2017 Board Meeting

- Barbelled approach



- Increase allocation to investment grade instruments
- Reallocate current investment grade assets into two Core Bond mandates—allow managers to tactically shift allocations across investment grade assets

Higher Expected Risk-Adjusted Returns

PENSION TRUST - Fixed Income Only				
Fixed Income Restructuring to Improve Returns and Reduce Risk				
CURRENT	Target	Projected	Projected	
Pension Trust	<u>Allocation</u>	<u>Return</u>	<u>Risk</u>	
U.S. Investment Grade (IG)	13.3%	3.0%	3.8%	
U.S. High Yield Debt (HY)	4.6%	4.8%	10.4%	
International Debt	5.4%	1.4%	9.2%	
Fixed Income	23.3%	(1) 3.0%	6.3% (3)	\$5,299 Pension \$
PROPOSED	Target	Projected	Projected	\$5.3 billion
Pension Trust	<u>Allocation</u>	<u>Return</u>	<u>Risk</u>	
U.S. Investment Grade (IG)	16.3%	3.0%	3.8%	\$864
Diversified Credit (DC)	7.0%	4.8%	10.4%	\$371
International Debt (a)	0.0%	1.4%	9.2%	\$0
Fixed Income	23.3%	(2) 3.5%	5.7% (4)	\$1,235
RIO's Fixed Income Recommendation:				
If International Debt (a) is eliminated while U.S. Investment Grade and Diversified Credit are increased by 3% and 2.4%, respectively, Projected Return would increase from 3.0% (1) to 3.5% (2), while Projected Risk would decline from 6.3% (3) to 5.7% (4).				
Key Point: RIO's Recommendation Increases Projected Returns 0.5% and Decreases Projected Risk 0.6% of "Fixed Income" in the Pension Trust.				

PERS Investment Policy Statement Review – Oct. 19, 2017

I. PLAN CHARACTERISTICS AND FUND CONSTRAINTS

The North Dakota Public Employees Retirement System (NDPERS) and the Highway Patrol Retirement System (HPRS) are pension benefit plans established to provide retirement income to state employees and employees of participating political subdivisions. The plans are administered by a seven member Board of Trustees (the Board). The Chair is appointed by the governor, three members are elected by the active members of the plans, one member is elected by the retired members, one is appointed by the Attorney General and the seventh member is the State Health Officer or their designee.

The NDPERS plan is a multi-employer hybrid benefit public pension plan that provides retirement benefits, disability retirement benefits, and survivor benefits, in accordance with Chapter 54-52 of the North Dakota Century Code (NDCC). Monthly retirement benefits for the Main, National Guard and Law Enforcement Plans are based on the formula: number of Years of Service times 2.0% times the final average salary. For the NDPERS Judges Plan the retirement formula is: for the first ten years of service of the formula is final average salary times 3.5%, for the second ten years of service the formula is final average salary times 2.80% and for all remaining years of service the formula is final average salary times 1.25%.

The Highway Patrol plan is a single employer plan that provides retirement benefits, disability benefits, and survivor benefits in accordance with Chapter 39-03.1 of the North Dakota Century Code. Monthly retirement benefits are based upon on the formula: first 25 years of credit service times 3.25% and all remaining years of service times 1.75%.

Funding for the NDPERS plan is provided by monthly employee contributions and employer contributions with the amount varying based upon which NDPERS plan the member participates in. For the Main NDPERS plan the employee contribution is 7% and the employer contribution is 7.12%, for the Judges Plan the employee contribution is 8% and employer contribution is 17.52%, for the National Guard Plan the employee contribution is 5.5% and employer contribution is 6.5%, for the Law Enforcement Plan with prior service the employee contribution is 4% and the employer contribution is 9.81% and for the Law Enforcement Plan without prior service the employee contribution rate is 5.5% and the employer rate is 7.93%.

Funding for the Highway Patrol plan is provided by a monthly employee contribution of 13.3% and an employer contribution of 19.7%

Each year the Board has an actuarial valuation performed. The current actuarial assumed rate of return on assets for all plans is **7.75%**.

2. RESPONSIBILITIES AND DISCRETION OF THE STATE INVESTMENT BOARD (SIB)

Aggregate plan contributions plus earnings, minus allowable expenses constitute the Fund. The Board is charged by NDCC chapters 54-52, 21-10-01, and 39-03.1 to establish policies for the investment goals and asset allocation of the Fund. The State Investment Board (SIB) is charged with implementing the asset allocation as promptly and prudently as possible in accordance with the Board's policies by investing the assets of the Fund in the manner provided in the prudent investor rule, which provides:

Fund fiduciaries shall exercise the judgment and care, under the circumstances then prevailing, that an institutional investor of ordinary prudence, discretion, and intelligence exercises in the management of large investments entrusted to it, not in regard to speculation but in regard to the permanent disposition of funds, considering probable safety of capital as well as probable income. The retirement funds belonging to the teachers' and for retirement and the public employees retirement system must be invested exclusively for the benefit of their members and in accordance with the respective funds' investment goals and objectives. (NDCC 21-10-07)

The SIB may delegate investment responsibility of the Fund or any portion of the Fund to professional money managers. Where a money manager has been retained, the SIB's role in determining investment strategy is supervisory not advisory.

The SIB may at its discretion, pool the assets of the Fund with another fund or funds having similar investment objectives and time horizons in order to maximize returns and minimize costs. In pooling fund assets the SIB will establish asset class pools it deems necessary to achieve the specific quality, diversification, restrictions, and performance objectives subject to the prudent investor rule and the objectives of the funds participating in the pools.

The SIB is responsible for establishing the selection criteria, determining the performance measures, and retaining all fund money managers. SIB is also responsible for the selection and retention of any investment consultants that may be employed in the investment of the Fund assets.

PERS Investment Policy Statement Review - Oct. 19, 2017

3. DELEGATION OF AUTHORITY

Management responsibility for NDPERS funds not assigned to the North Dakota State Investment Board (SIB) in Chapter 21-10 of the North Dakota Century Code (NDCC) is hereby delegated to the SIB, which must establish written policies and procedures for the operation of the NDPERS funds, consistent with this investment policy.

Such procedures must provide for:

1. The definition and assignment of duties and responsibilities to advisory services and persons employed by the SIB pursuant to NDCC 21-10-02.1(1) (a).
2. Investment diversification, investment quality, qualification of money managers, and amounts to be invested by money managers pursuant to NDCC 21-10-02.1(1)(e).
In developing these policies it is understood:
 - a. Futures and options may be used to hedge or replicate underlying index exposure, but not for speculation.
 - b. The use of derivatives will be monitored to ensure that undue risks are not taken by the money managers.
 - c. All assets must be held in custody by the SIB's master custodian or such other custodians as are selected by the SIB.
3. Guidelines for selection and redemption of investments will be in accordance with NDCC 21-10-02.1(1) (d).
4. The criteria for making decisions with respect to hiring, retention, and termination of money managers will be clearly defined. This also includes selecting performance measurement standards, consultants, report formats, and frequency of meetings with money managers.

All participants in the investment process must seek to act responsibly as custodians of the public trust.

4. INVESTMENT GOALS

The investment goals of the Fund have been established by the NDPERS Board based upon consideration of the Board's strategic objectives and a comprehensive review of the current and projected financial requirements. These goals are to be viewed over the long term.

Goal # 1 Accumulate sufficient wealth through a diversified portfolio of investments which will enable the State of North Dakota to pay all current and future retirement benefits and expense obligations of the Fund.

Goal # 2 To obtain an investment return in excess of that needed to allow for increases in a retiree's annuity to maintain the purchasing power of their retirement benefit.

The Board acknowledges the material impact that funding the pension plan has on the State's financial performance. To enable the State to continue offering secure pension benefits to plan participants, the Board believes that the Fund should pursue the following **secondary goals**:

1. Stabilize the employee and employer contributions needed to fund the Plan over the long term.
2. Avoid both substantial volatility in contributions and sizable fluctuations in the funding status of the Plan.

These two secondary goals affect the Fund's investment strategies and often represent conflicting goals. That is, minimizing the long-term funding costs implies a less conservative investment program, whereas dampening the volatility of contributions and avoiding large swings in the funding status implies a more conservative investment program. The Board places greater emphasis on the strategy of stabilizing the employee and employer contribution needed to fund the plan over the long term as it assists our participating employers by having a predictable contribution for budgeting.

Board Action Requested

PERS Investment Policy Statement Review - Oct. 19, 2017

6. INVESTMENT PERFORMANCE OBJECTIVE

The Board's investment objectives are expressed in terms of reward and risk expectations relative to investable, passive benchmarks. The Fund's policy benchmark is comprised of policy mix weights of appropriate asset class benchmarks as set by the SIB.

1. The fund's rate of return, net of fees and expenses, should at least match that of the policy benchmark over a minimum evaluation period of five years.
2. The fund's risk, measured by the standard deviation of net returns, should not exceed **115%** of the policy benchmark over a minimum evaluation period of five years.
3. The risk-adjusted performance of the fund, net of fees and expenses, should at least match that of the policy benchmark over a minimum evaluation period of five years.

7. ASSET ALLOCATION

In recognition of the plan's performance objectives, benefit projections, and capital market expectations, the NDPERS Board has established the following asset allocation:

Asset Class	Policy Target (%)	Rebalancing Range (%)
Global Equity	57	46-66
Public Equity	51	42-57
Private Equity	7	4-9
Global Fixed Income	23	16-30
Investment Grade	18 16	13-23 11-21
Non-Investment Grade	5 7	3-7 5-9
Global Real Assets	19	10-25
Global Real Estate	11	5-15
Other (Infrastructure/Timber)	8	0-10
Global Alternatives		0-10
Cash	0	0-2

The Total Fixed Income allocation of 23% remains constant, but Investment Grade is reduced to 16% (from 18%) while Non-Investment Grade is raised to 7% (from 5%). The Rebalancing Range will remain at +/- 5% for IG and +/- 2% for NIG.

The Board does not endorse tactical asset allocation, therefore, it is anticipated the portfolio be managed as close to the policy target as is prudent and practicable while minimizing re-balancing costs. Any allocation to Global Alternatives shall not increase the expected volatility of the portfolio as measured in Section #5, and all other targets will be adjusted pro-rata. PERS requires that in implementing this asset allocation that the State Investment Board seek to maximize return within the scope of these policies while limiting investment costs.

RIO recommends PERS approve the Fixed Income allocation for Investment Grade (IG) be reduced to 16% (from 18%) and Non-Investment Grade (NIG) be increased to 7% (from 5%). This recommendation will reduce expected risk and increase expected return by eliminating International Fixed Income which has high expected volatility and a low expected return for the next 5-to-10 years (based on Callan's Capital Market Assumptions as well as many other consultants). A supporting example is provided on page 18.

PERS Investment Policy Statement Review – Oct. 19, 2017

7. RESTRICTIONS

- A. Futures and options may be used to hedge or replicate underlying index exposure, but not for speculation.
- B. Use of derivatives will be monitored to ensure that undue risks are not taken by the money managers
- C. No transaction may be made which threatens the tax exempt status of the Fund.
- D. No unhedged short sales or speculative margin purchases may be made.

Social Investing is defined as *"The investment or commitment of public pension fund money for the purpose of obtaining an effect other than a maximized return to the intended beneficiaries."*

- E. Social investing is prohibited unless it meets the Exclusive Benefit Rule and it can be substantiated that the investment must provide an equivalent or superior rate of return for a similar investment with a similar time horizon and similar risk.

Economically targeted investing is defined as an investment designed to produce a competitive rate of return commensurate with risk involved, as well as to create collateral economic benefits for a targeted geographic area, group of people, or sector of the economy.

- F. Economically targeted investing is prohibited unless the investment meets the Exclusive Benefit Rule.

The Exclusive Benefit Rule is met if the following four conditions are satisfied:

- (1) The cost does not exceed the fair market value at the time of investment.
- (2) The investment provides the Fund with an equivalent or superior rate of return for a similar investment with a similar time horizon and similar risk.
- (3) Sufficient liquidity is maintained in the Fund to permit distributions in accordance with the terms of the plan.
- (4) The safeguards and diversity that a prudent investor would adhere to are present.

Where investment characteristics, including yield, risk, and liquidity are equivalent, the Board's policy favors investments which will have a positive impact on the economy of North Dakota.

- G. Publicly Traded REITs may not be used in the Real Estate asset allocation.

Where investment characteristics, including yield, risk, and liquidity are equivalent, the Board's policy favors investments which will have a positive impact on the economy of North Dakota.

8. INTERNAL CONTROLS

The SIB must have a system of internal controls to prevent losses of public funds arising from fraud or employee error. The controls deemed most important are the separation of responsibilities for investment purchases from the recording of investment activity, custodial safekeeping, written confirmation of investment transactions, and established criteria for broker relationships. The annual financial audit must include a comprehensive review of the portfolio, accounting procedures for security transactions and compliance with the investment policy.

PERS Investment Policy Statement Review – Oct. 19, 2017

9. EVALUATION

Investment management of the Fund will be evaluated against the Fund's investment objectives and investment performance standards.

An annual performance report must be provided to the Board by the State Investment Officer at a regularly scheduled NDPERS Board meeting. The annual performance report must include asset returns and allocation data as well as information regarding all significant or material matters and changes pertaining to the investment of the Fund, including:

- Changes in asset class portfolio structures, tactical approaches and market values;
- All pertinent legal or legislative proceedings affecting the SIB.
- Compliance with these investment goals, objectives and policies.
- A general market overview and market expectations.
- A review of fund progress and its asset allocation strategy.
- A report on investment fees and the SIB's effort relating to Section 6. To measure investment cost PERS requires as part of the annual review information from Callan, CEM or other acceptable source showing the value added versus the cost.
- Changes/additions to benchmarks utilized to monitor the funds.

In addition, the State Investment Officer shall review with the Board the procedures and policies established by the SIB relating to this statement of investment goals, objectives, and policies.

J. Sparb Collins
Executive Director
North Dakota Public Employees Retirement System

David Hunter
Executive Director / Chief Investment Officer
North Dakota Retirement and Investment Office

Date: _____

Date: _____

Job Service, Retiree Health and Group Insurance - June 30, 2017

	1 Yr. Ended 6/30/2017	3 Yrs Ended 6/30/2017	5 Yrs Ended 6/30/2017	Risk 5 Yrs Ended 6/30/2017	Risk Adj Excess Return 5 Yrs Ended 6/30/2017
Job Service - \$97 million					
Total Fund Return - Net	5.63%	4.79%	7.86%	3.9%	0.79%
Policy Benchmark Return	7.85%	3.85%	6.42%	3.6%	
Excess Return	-2.22%	0.95%	1.44%	109%	

Asset Allocation:

Job Service (30% Equity / 70% Bonds) underperformed in fiscal 2017 due its de-risking strategy being out of favor including low-volatility equities & core fixed income.

	1-Year 6/30/2017	3 Yrs Ended 6/30/2017	5 Yrs Ended 6/30/2017	Risk 5 Yrs Ended 6/30/2017	Risk Adj Excess Return 5 Yrs Ended 6/30/2017
PERS Retiree Health - \$116 million					
Total Fund Return - Net	11.81%	5.09%	8.80%	5.3%	-0.64%
Policy Benchmark Return	11.32%	5.42%	8.83%	4.9%	
Excess Return	0.49%	-0.32%	-0.03%	OK	

Retiree Health

(60% Equity / 40% Bonds) performed well in fiscal 2017, but slightly below benchmark (-0.03%) for the 5-years ended June 30, 2017.

PERS Group Insurance - \$37 million					
Total Fund Return - Net	0.08%	0.52%	0.38%	0.6%	-0.06%
Policy Benchmark Return	0.37%	0.65%	0.42%	0.5%	
Excess Return	-0.29%	-0.12%	-0.04%	OK	

Group Insurance

(90% short-term bonds and 10% cash) underperformed by 0.04% for the 5-years ended June 30, 2017.

Appendix of Supporting Materials

PERS Update as of June 30, 2017

Callan's Quarterly Reports of investment performance are available on the following web address:

<http://www.nd.gov/rio/SIB/Board/SIB%20Meeting%20Materials/2017-08-25.pdf>

Board members can review monthly manager level performance using the following web address:

http://www.nd.gov/rio/RIO_ref/performance/PERS/201706.pdf

ND PUBLIC EMPLOYEES RETIREMENT SYSTEM
INVESTMENT PERFORMANCE REPORT AS OF JUNE 30, 2017

	June-17					March-17					December-16					September-16					Current Fiscal YTD		Prior Year FY16		3 Years Ended 6/30/2017		5 Years Ended 6/30/2017	
	Allocation		Quarter			Allocation		Quarter			Allocation		Quarter			Allocation		Quarter			Gross ⁽¹⁾	Net	Gross ⁽¹⁾	Net	Gross ⁽¹⁾	Net	Gross ⁽¹⁾	Net
	Market Value	Actual	Policy	Gross ⁽¹⁾	Net	Market Value	Actual	Policy	Gross ⁽¹⁾	Net	Market Value	Actual	Policy	Gross ⁽¹⁾	Net	Market Value	Actual	Policy	Gross ⁽¹⁾	Net								
TOTAL FUND	2,781,347,068	100.0%	100.0%	4.00%	3.89%	2,674,865,165	100.0%	100.0%	4.48%	4.40%	2,683,018,848	100.0%	100.0%	0.68%	0.49%	2,648,430,038	100.0%	100.0%	3.76%	3.88%	13.36%	13.06%	0.81%	0.28%	6.81%	6.48%	9.48%	9.18%
POLICY TARGET BENCHMARK				3.33%	3.33%				3.73%	3.73%				0.74%	0.74%				3.61%	3.61%	11.87%	11.87%	0.66%	0.66%	4.74%	4.74%	8.26%	8.26%
ATTRIBUTION ANALYSIS																												
Asset Allocation				-0.12%	-0.12%				0.00%	0.00%				-0.03%	-0.03%				0.08%	0.08%	0.23%	0.23%	-0.03%	-0.03%	0.04%	0.04%	0.06%	0.06%
Manager Selection				0.78%	0.71%				0.41%	0.36%				-0.18%	-0.22%				0.08%	0.01%	1.26%	0.84%	0.89%	-0.24%	1.03%	0.70%	1.18%	0.84%
TOTAL RELATIVE RETURN				0.65%	0.51%				0.73%	0.56%				-0.19%	-0.25%				0.15%	0.07%	1.48%	1.18%	0.95%	-0.28%	1.07%	0.74%	1.24%	0.90%
GLOBAL EQUITIES	1,631,190,926	58.6%	58.0%	4.73%	4.68%	1,669,121,184	58.7%	58.0%	6.19%	6.14%	1,494,703,178	56.3%	58.0%	1.61%	1.56%	1,473,368,642	57.8%	58.0%	6.42%	6.32%	19.13%	18.88%	-3.69%	-3.90%	5.96%	5.64%	11.63%	11.28%
Benchmark				61.0%	4.68%				61.0%	6.44%				61.0%	2.36%				61.0%	6.27%	18.774%	18.79%	-3.86%	-3.86%	5.06%	5.06%	10.75%	10.75%
Epoch Global Choice (1)	208,607,374	7.5%	7.0%	6.32%	6.15%	196,369,747	7.3%	7.0%	8.70%	8.53%	180,646,123	7.0%	7.0%	-1.26%	-1.42%	183,039,665	7.2%	7.0%	3.15%	2.98%	17.71%	16.96%	-5.93%	-6.53%	6.33%	5.65%	11.43%	10.71%
LSV Global Value Equity	260,072,965	9.4%	9.0%	3.67%	3.55%	250,734,965	9.4%	9.0%	5.73%	5.71%	253,511,907	9.9%	9.0%	5.45%	5.42%	240,199,121	9.4%	9.0%	6.84%	6.74%	23.50%	23.29%	-7.05%	-7.85%	5.38%	4.70%	N/A	N/A
Total Global Equities	468,680,340	16.9%	16.0%	4.83%	4.70%	447,104,711	16.7%	16.0%	8.99%	8.91%	434,158,030	16.9%	16.0%	2.66%	2.48%	423,238,786	16.6%	16.0%	6.21%	6.08%	21.01%	20.67%	-8.63%	-7.27%	6.78%	6.10%	11.30%	10.82%
MSCI World				4.03%	4.03%				6.38%	6.38%				1.86%	1.86%				4.87%	4.87%	18.20%	18.20%	-2.78%	-2.78%	5.24%	5.24%	11.38%	11.38%
Domestic - broad	631,277,605	22.7%	20.6%	3.03%	3.00%	619,104,101	23.1%	20.6%	4.82%	4.78%	593,665,640	23.2%	20.6%	4.17%	4.13%	568,369,962	22.3%	20.6%	4.32%	4.19%	17.38%	17.10%	2.03%	1.90%	9.17%	8.98%	15.10%	14.85%
Benchmark				2.94%	2.94%				6.19%	6.19%				6.03%	6.03%				6.16%	6.16%	19.58%	19.58%	0.72%	0.72%	8.91%	8.91%	14.51%	14.51%
Large Cap Domestic																												
LA Capital Large Cap Growth	182,563,127	6.6%	6.3%	3.68%	3.63%	181,250,818	6.8%	6.3%	6.62%	6.57%	169,591,422	6.6%	6.3%	1.04%	0.99%	165,620,573	6.5%	6.3%	3.76%	3.71%	15.90%	15.66%	5.17%	4.95%	11.18%	10.95%	15.50%	15.27%
Russell 1000 Growth				4.67%	4.67%				8.91%	8.91%				1.01%	1.01%				4.58%	4.58%	20.42%	20.42%	3.02%	3.02%	11.11%	11.11%	15.30%	15.30%
LA Capital 60% Large Cap/40% Large Cap Active Extension	106,120,946	3.8%	3.2%	2.45%	2.42%	103,030,434	3.9%	3.2%	4.52%	4.50%	102,825,654	4.0%	3.2%	4.54%	4.52%	102,235,473	4.0%	3.2%	3.23%	3.20%	15.56%	15.44%	6.04%	5.92%	9.88%	9.75%	14.96%	14.81%
Russell 1000				3.06%	3.06%				6.03%	6.03%				3.83%	3.83%				4.03%	4.03%	18.03%	18.03%	2.94%	2.94%	9.26%	9.26%	14.67%	14.67%
NTAM - Quant Enhanced S&P 500	88,590,653	3.2%	3.2%	2.11%	2.11%	86,266,199	3.2%	3.2%	4.94%	4.94%	81,967,952	3.2%	3.2%	4.22%	4.22%	77,564,879	3.0%	3.2%	4.32%	4.32%	16.51%	16.51%	1.76%	1.76%	8.00%	7.88%	14.59%	14.28%
Clifton Group Enhanced S&P 500	101,751,517	3.7%	3.2%	3.19%	3.19%	100,643,489	3.8%	3.2%	5.96%	5.96%	94,709,033	3.7%	3.2%	3.88%	3.88%	89,911,356	3.5%	3.2%	3.86%	3.65%	17.97%	17.72%	4.50%	4.50%	9.85%	9.77%	14.76%	14.70%
S&P 500				3.09%	3.09%				6.07%	6.07%				3.82%	3.82%				3.88%	3.88%	17.90%	17.90%	3.99%	3.99%	9.61%	9.61%	14.63%	14.63%
Total Large Cap Domestic	478,088,244	17.2%	16.8%	3.02%	3.00%	471,180,898	17.6%	16.8%	6.70%	6.67%	448,084,082	17.6%	16.8%	2.98%	2.97%	436,332,281	17.1%	16.8%	3.76%	3.69%	16.37%	16.20%	4.83%	4.62%	10.06%	9.80%	15.48%	15.31%
Russell 1000 (2)				3.06%	3.06%				6.03%	6.03%				3.83%	3.83%				4.03%	4.03%	18.03%	18.03%	2.94%	2.94%	9.26%	9.26%	14.67%	14.67%
Small Cap Domestic																												
Atlanta Capital Small Cap Equity Fund	68,626,878	2.5%	2.4%	3.65%	3.46%	66,386,034	2.5%	2.4%	1.71%	1.52%	65,164,822	2.5%	2.4%	7.24%	7.03%	60,525,276	2.4%	2.4%	2.46%	2.28%	15.83%	14.98%	N/A	N/A	N/A	N/A	N/A	N/A
Clifton Group Enhanced Russell 2000	83,584,383	3.0%	2.4%	2.61%	2.61%	81,527,128	3.0%	2.4%	2.44%	2.44%	79,306,656	3.1%	2.4%	8.73%	8.73%	72,512,406	2.8%	2.4%	9.35%	8.88%	24.97%	24.44%	-5.49%	-5.85%	8.31%	7.89%	14.75%	14.25%
Total Small Cap Domestic	162,211,261	6.6%	4.8%	3.07%	2.99%	147,913,162	6.6%	4.8%	2.11%	2.03%	144,471,478	6.6%	4.8%	8.04%	7.86%	133,037,882	6.2%	4.8%	8.18%	6.86%	20.74%	20.08%	-8.88%	-7.04%	6.86%	6.82%	13.68%	13.08%
Russell 2000				2.46%	2.46%				2.47%	2.47%				8.83%	8.83%				9.05%	9.05%	24.60%	24.60%	-6.73%	-6.73%	7.36%	7.36%	13.70%	13.70%
International - broad	447,370,469	16.1%	14.4%	6.53%	6.50%	425,042,787	15.9%	14.4%	8.87%	8.83%	390,567,334	16.2%	14.4%	-3.18%	-3.23%	403,486,478	16.8%	14.4%	8.08%	8.05%	21.37%	21.18%	-7.76%	-7.96%	2.96%	2.76%	9.46%	9.13%
Benchmark				6.78%	6.78%				7.89%	7.89%				-1.26%	-1.26%				6.94%	6.94%	20.53%	20.53%	-10.46%	-10.46%	1.06%	1.06%	7.53%	7.53%
Developed International																												
NTAM - MSCI World ex-US Index	156,739,205	0.0%	5.5%	5.80%	5.80%	149,814,569	0.0%	5.5%	6.94%	6.93%	140,099,666	0.0%	5.5%	-0.32%	-0.33%	140,513,278	0.0%	5.5%	6.35%	6.34%	19.94%	19.92%	-9.50%	-9.54%	1.04%	1.01%	N/A	N/A
MSCI World Ex US				6.63%	6.63%				6.81%	6.81%				-0.36%	-0.36%				6.29%	6.29%	19.49%	19.49%	-8.84%	-8.84%	0.67%	0.67%		
William Blair International Leaders	76,100,978	2.7%	3.3%	7.92%	7.83%	70,213,982	2.6%	3.3%	7.65%	7.55%	65,287,227	2.5%	3.3%	-5.89%	-5.88%	69,421,696	2.7%	3.3%	9.89%	9.86%	20.15%	19.77%	N/A	N/A	N/A	N/A	N/A	N/A
MSCI ACWI ex-US (Net)				6.86%	6.86%				7.99%	7.99%				-1.67%	-1.67%				7.05%	7.05%	20.43%	20.43%						
DFA Intl. Small Cap Value Portfolio (4)	45,622,857	1.6%	1.1%	6.33%	6.33%	45,126,344	1.7%	1.1%	7.73%	7.73%	41,888,875	1.6%	1.1%	1.71%	1.71%	41,168,138	1.6%	1.1%	10.54%	10.54%	28.80%	28.80%	-9.28%	-9.28%	4.16%	4.16%	14.04%	13.77%
Wellington International Small Cap Opportunities	50,781,278	1.8%	1.1%	8.28%	8.07%	46,746,131	1.7%	1.1%	9.82%	9.80%	42,653,038	1.7%	1.1%	-4.94%	-5.15%	44,951,355	1.8%	1.1%	6.71%	6.47%	20.62%	19.62%	1.90%	1.06%	7.31%	6.42%	15.04%	14.12%
S&P500/BM EPAC + \$2BN				7.33%	7.33%				7.79%	7.79%				-3.16%	-3.16%				7.90%	7.90%	20.89%	20.89%	-3.37%	-3.37%	6.71%	6.71%	12.00%	12.00%
Total Developed International	328,244,318	11.8%	11.0%	6.73%	6.68%	311,801,026	11.7%	11.0%	7.84%	7.68%	288,828,807	11.3%	11.0%	-2.06%	-2.10%	298,064,487	11.8%	11.0%	7.76%	7.74%	21.30%	21.06%	-7.88%	-7.82%	2.77%	2.62%	10.84%	10.27%
MSCI World Ex US (3)				6.63%	6.63%				6.81%	6.81%				-0.36%	-0.36%				6.29%	6.29%	19.49%	19.49%	-10.16%	-10.16%	0.93%	0.93%	8.55%	8.55%
Emerging Markets																												
Axiom Emerging Markets Equity Fund (4)	89,447,891	3.2%	2.6%	7.39%	7.39%	82,559,762	3.1%	2.6%	11.56%	11.56%	74,004,908	2.9%	2.6%	-6.47%	-6.47%	79,852,096	3.1%	2.6%	9.13%	9.13%	22.29%	22.29%	-10.32%	-10.32%	N/A	N/A	N/A	N/A
DFA Emerging Markets Small Cap Portfolio (4)	28,578,250	1.0%	0.9%	2.28%	2.28%	30,581,999	1.1%	0.9%	14.82%	14.82%	26,633,619	1.0%	0.9%	-5.92%	-5.92%	27,579,915	1.1%	0.9%	8.18%	8.18%	19.53%	19.53%	-5.54%	-5.54%	3.49%	3.49%	7.14%	6.86%
Total Emerging Markets	118,126,140	4.2%	3.4%	8.00%	8.00%	113,141,762	4.2%	3.4%	12.42%	12.42%	100,638,527	3.9%	3.4%	-8.32%	-8.32%	107,432,011	4.2%	3.4%	8.88%	8.88%	21.66%	21.66%	-8.28%	-8.28%	3.99%	3.92%	6.20%	4.94%
MSCI Emerging Markets				6.27%	6.27%				11.44%	11.44%				-4.16%	-4.16%				9.03%	9.03%	23.74%	23.74%	-12.06%	-12.06%	1.07%	1.07%	3.96%	3.96%

ND PUBLIC EMPLOYEES RETIREMENT SYSTEM
INVESTMENT PERFORMANCE REPORT AS OF JUNE 30, 2017

	June-17					March-17					December-16					September-16					Current Fiscal YTD		Prior Year FY16		3 Years Ended 6/30/2017		5 Years Ended 6/30/2017		
	Allocation			Quarter		Allocation			Quarter		Allocation			Quarter		Allocation			Quarter		Gross ⁽¹⁾	Net	Gross ⁽¹⁾	Net	Gross ⁽¹⁾	Net	Gross ⁽¹⁾	Net	
	Market Value	Actual	Policy	Gross ⁽¹⁾	Net	Market Value	Actual	Policy	Gross ⁽¹⁾	Net	Market Value	Actual	Policy	Gross ⁽¹⁾	Net	Market Value	Actual	Policy	Gross ⁽¹⁾	Net									
Private Equity																													
Adams Street-Brinson 1998 Partnership Fund	63,015	0.0%		0.78%	0.78%	62,526	0.0%		-0.44%	-0.44%	62,803	0.0%		-0.16%	-0.16%	62,903	0.0%		-0.33%	-0.33%	-0.16%	-0.16%	4.14%	4.14%	1.08%	1.08%	4.12%	4.12%	
Adams Street-Brinson 1999 Partnership Fund	169,140	0.0%		3.55%	3.55%	163,346	0.0%		-2.15%	-2.15%	166,928	0.0%		2.13%	2.13%	163,454	0.0%		-3.60%	-3.60%	-0.25%	-0.25%	12.03%	12.03%	-2.85%	-2.85%	3.36%	3.36%	
Adams Street-Brinson 2000 Partnership Fund	277,862	0.0%		2.86%	2.86%	471,240	0.0%		-0.50%	-0.50%	473,609	0.0%		0.94%	0.94%	469,182	0.0%		-0.30%	-0.30%	3.00%	3.00%	-1.75%	-1.75%	-0.33%	-0.33%	0.71%	0.71%	
Adams Street-Brinson 2001 Partnership Fund	667,064	0.0%		4.37%	4.37%	639,121	0.0%		-3.53%	-3.53%	662,501	0.0%		8.47%	8.47%	749,479	0.0%		-1.49%	-1.49%	7.59%	7.59%	-10.11%	-10.11%	-1.19%	-1.19%	5.31%	5.31%	
Adams Street-Brinson 2002 Partnership Fund	170,182	0.0%		2.55%	2.55%	165,945	0.0%		0.04%	0.04%	165,887	0.0%		15.92%	15.92%	372,459	0.0%		0.54%	0.54%	19.56%	19.56%	9.43%	9.43%	1.75%	1.75%	5.99%	5.99%	
Adams Street-Brinson 2003 Partnership Fund	144,554	0.0%		5.79%	5.79%	159,805	0.0%		-1.10%	-1.10%	161,577	0.0%		6.39%	6.39%	151,872	0.0%		0.12%	0.12%	11.44%	11.44%	-2.55%	-2.55%	7.19%	7.19%	11.45%	11.45%	
Total Adams Street-Brinson Partnership Funds	1,491,816	0.1%		3.76%	3.76%	1,661,982	0.1%		-1.85%	-1.85%	1,693,304	0.1%		6.45%	6.45%	1,969,349	0.1%		-0.85%	-0.85%	7.49%	7.49%	-1.98%	-1.98%	-0.71%	-0.71%	4.31%	4.31%	
Adams Street-Brinson 1999 Non-US Partnership Fund	34,933	0.0%		3.72%	3.72%	33,681	0.0%		-2.30%	-2.30%	34,475	0.0%		9.08%	9.08%	31,604	0.0%		-8.08%	-8.08%	1.60%	1.60%	13.44%	13.44%	0.03%	0.03%	6.19%	6.19%	
Adams Street-Brinson 2000 Non-US Partnership Fund	266,388	0.0%		4.75%	4.75%	254,314	0.0%		4.25%	4.25%	368,692	0.0%		0.17%	0.17%	368,051	0.0%		3.37%	3.37%	13.07%	13.07%	-7.68%	-7.68%	-0.25%	-0.25%	0.63%	0.63%	
Adams Street-Brinson 2001 Non-US Partnership Fund	81,520	0.0%		10.18%	10.18%	73,988	0.0%		-0.88%	-0.88%	74,648	0.0%		-11.28%	-11.28%	84,142	0.0%		-1.30%	-1.30%	-4.37%	-4.37%	23.36%	23.36%	11.33%	11.33%	14.86%	14.86%	
Adams Street-Brinson 2002 Non-US Partnership Fund	251,500	0.0%		3.27%	3.27%	343,574	0.0%		-4.49%	-4.49%	359,710	0.0%		-3.54%	-3.54%	515,033	0.0%		-0.16%	-0.16%	-5.01%	-5.01%	29.09%	29.09%	4.42%	4.42%	5.43%	5.43%	
Adams Street-Brinson 2003 Non-US Partnership Fund	162,284	0.0%		4.87%	4.87%	154,747	0.0%		11.46%	11.46%	138,835	0.0%		5.28%	5.28%	291,491	0.0%		2.82%	2.82%	26.53%	26.53%	18.08%	18.08%	13.54%	13.54%	18.17%	18.17%	
Adams Street-Brinson 2004 Non-US Partnership Fund	160,537	0.0%		6.83%	6.83%	150,279	0.0%		-4.88%	-4.88%	157,995	0.0%		3.48%	3.48%	210,355	0.0%		4.08%	4.08%	9.42%	9.42%	-8.26%	-8.26%	-2.02%	-2.02%	7.06%	7.06%	
Total Adams Street-Brinson Non-US Partnership Funds	967,563	0.0%		5.12%	5.12%	1,010,583	0.0%		0.10%	0.10%	1,134,354	0.0%		-0.51%	-0.51%	1,500,676	0.0%		0.61%	0.61%	5.22%	5.22%	10.65%	10.65%	3.61%	3.61%	7.82%	7.82%	
Adams Street 2008 Non-US Partnership Fund	3,898,181	0.1%		8.34%	8.34%	3,786,248	0.1%		0.01%	0.01%	3,765,745	0.1%		6.75%	6.75%	3,621,229	0.1%		0.00%	0.00%	16.67%	16.67%	11.84%	11.84%	11.65%	11.65%	12.86%	12.86%	
Adams Street-Brinson BVCF IV	1,736,009	0.1%		4.54%	4.54%	1,660,609	0.1%		-0.01%	-0.01%	1,849,680	0.1%		3.23%	3.23%	1,888,686	0.1%		0.00%	0.00%	7.51%	7.51%	-1.65%	-1.65%	14.68%	14.68%	18.81%	18.81%	
Adams Street Direct Co-Investment Fund	1,640,826	0.1%		-0.99%	-0.99%	1,657,199	0.1%		-9.94%	-9.94%	2,082,325	0.1%		7.53%	7.53%	2,338,164	0.1%		0.00%	0.00%	-4.11%	-4.11%	8.30%	8.30%	8.35%	8.35%	11.03%	10.79%	
Adams Street 2010 - Direct Fund	517,489	0.0%		7.99%	7.99%	470,707	0.0%		-2.88%	-2.88%	582,591	0.0%		6.82%	6.82%	614,523	0.0%		0.00%	0.00%	12.03%	12.03%	7.48%	7.48%	8.00%	8.00%	11.92%	11.92%	
Adams Street 2010 - Non-US Emerging Mkts	721,475	0.0%		4.09%	4.09%	693,102	0.0%		0.60%	0.60%	688,956	0.0%		5.16%	5.16%	647,480	0.0%		0.00%	0.00%	10.13%	10.13%	10.50%	10.50%	14.02%	14.02%	7.90%	7.90%	
Adams Street 2010 - Non-US Developed Mkts	1,579,541	0.1%		9.68%	9.68%	1,440,085	0.1%		1.53%	1.53%	1,471,376	0.1%		9.22%	9.22%	1,299,398	0.1%		0.00%	0.00%	21.63%	21.63%	9.63%	9.63%	9.17%	9.17%	10.50%	10.50%	
Adams Street 2010 - Partnership Fund	3,118,676	0.1%		3.66%	3.66%	3,069,784	0.1%		1.70%	1.70%	2,980,910	0.1%		9.20%	9.20%	2,765,892	0.1%		0.00%	0.00%	15.12%	15.12%	6.18%	6.18%	13.11%	13.11%	13.30%	13.30%	
Total Adams Street 2010 Funds	5,937,181	0.2%		5.63%	5.63%	5,673,678	0.2%		1.10%	1.10%	5,723,833	0.2%		8.43%	8.43%	5,327,292	0.2%		0.00%	0.00%	15.79%	15.79%	7.80%	7.80%	11.36%	11.36%	12.12%	12.12%	
Adams Street 2015 Global Fund	4,049,380	0.1%		5.17%	5.17%	3,173,037	0.1%		12.14%	12.14%	1,672,789	0.1%		28.68%	28.68%	1,299,947	0.1%		0.00%	0.00%	51.76%	51.76%	N/A	N/A	N/A	N/A	N/A	N/A	
Adams Street 2016 Global Fund	1,067,792	0.0%		3.34%	3.34%	531,532	0.0%		41.27%	41.27%	376,264	0.0%		N/A	N/A	-	0.0%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Blackrock PEP	4,320,397	0.2%		-3.26%	-3.26%	2,372,305	0.1%		N/A	N/A	-	0.0%		N/A	N/A	-	0.0%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Martin Patterson - Global Opportunities II	580,474	0.0%		-10.52%	-10.52%	648,735	0.0%		-20.08%	-20.08%	811,692	0.0%		-0.49%	-0.49%	815,701	0.0%		0.00%	0.00%	-28.84%	-28.84%	7.27%	7.27%	-2.99%	-2.99%	-7.23%	-7.23%	
Martin Patterson - Global Opportunities III	12,437,005	0.4%		6.35%	6.35%	13,341,492	0.5%		-0.93%	-0.93%	13,722,567	0.5%		1.41%	1.41%	13,531,512	0.5%		0.00%	0.00%	6.84%	6.84%	-5.66%	-5.66%	-0.58%	-0.58%	5.14%	5.14%	
InvestAmerica - Lewis and Clark Fund	814,147	0.0%		22.02%	22.02%	667,195	0.0%		0.00%	0.00%	667,195	0.0%		0.00%	0.00%	667,195	0.0%		0.00%	0.00%	22.02%	22.02%	-51.19%	-51.19%	-26.04%	-26.04%	-17.39%	-17.39%	
InvestAmerica - L&C II	4,574,756	0.2%		7.99%	7.98%	4,377,972	0.2%		2.64%	2.64%	4,483,024	0.2%		0.00%	0.00%	4,822,765	0.2%		0.00%	0.00%	10.83%	10.83%	1.88%	1.88%	-1.11%	N/A	N/A	-2.96%	N/A
Corair III	7,203,906	0.3%		3.05%	3.05%	6,990,849	0.3%		-2.62%	-2.62%	7,139,730	0.3%		6.91%	6.91%	6,719,925	0.3%		-0.42%	-0.42%	6.83%	6.83%	34.22%	34.22%	9.34%	9.34%	3.15%	3.15%	
Corair III - ND Investors LLC	-	0.0%		N/A	N/A	-	0.0%		N/A	N/A	-	0.0%		N/A	N/A	-	0.0%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Capital International - Fund V	12,068,230	0.4%		12.67%	12.67%	10,709,741	0.4%		2.94%	2.94%	10,505,955	0.4%		7.17%	7.17%	11,615,235	0.5%		-1.06%	-1.06%	22.98%	22.98%	-2.38%	-2.38%	15.91%	15.91%	14.40%	14.40%	
Capital International - Fund V	1,010,059	0.0%		-34.83%	-34.83%	2,595,538	0.1%		-8.92%	-8.92%	2,835,260	0.1%		-14.38%	-14.38%	3,811,740	0.1%		-0.60%	-0.60%	-49.48%	-49.48%	-25.52%	-25.52%	-31.17%	-31.17%	-20.15%	-20.15%	
Capital International - Fund VI	11,841,140	0.4%		10.27%	10.27%	10,738,143	0.4%		-0.82%	-0.82%	9,731,269	0.4%		1.05%	1.05%	9,763,022	0.4%		-0.87%	-0.87%	9.55%	9.55%	1.06%	1.06%	-4.66%	-4.66%	-8.71%	-8.71%	
ELG (formerly TCW)	3,060,041	0.1%		19.09%	19.09%	2,568,606	0.1%		12.39%	12.39%	2,286,299	0.1%		-15.90%	-15.90%	2,588,338	0.1%		-0.41%	-0.41%	12.11%	12.11%	-67.59%	-67.59%	-34.78%	-34.78%	-23.36%	-23.36%	
Quantum - Resources	-	0.0%		N/A	N/A	19,878	0.0%		N/A	N/A	19,878	0.0%		N/A	N/A	25,905	0.0%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Quantum - Energy Partners	4,023,514	0.1%		56.03%	56.03%	2,578,582	0.1%		0.00%	0.00%	3,551,268	0.1%		0.62%	0.62%	3,852,146	0.2%		7.24%	7.24%	68.38%	68.38%	-22.63%	-22.63%	1.68%	1.68%	10.37%	10.37%	
Total Private Equity (4)	88,882,822	3.0%	7.0%	7.70%	7.70%	77,889,686	2.9%	7.0%	-1.18%	-1.18%	78,412,274	3.0%	7.0%	2.86%	2.86%	78,273,418	3.1%	7.0%	1.71%	1.71%	11.12%	11.12%	-7.19%	-7.20%	-0.81%	-0.82%	1.81%	1.80%	
GLOBAL FIXED INCOME																													
Benchmark	632,816,498	22.8%	23.0%	2.74%	2.68%	617,374,180	23.1%	23.0%	2.68%	2.52%	605,634,712	22.1%	23.0%	-2.29%	-2.35%	578,897,676	22.7%	23.0%	2.23%	2.16%	6.27%	6.02%	4.76%	4.50%	3.54%	3.29%	4.90%	4.68%	
				2.09%	2.09%				1.62%	1.62%				-3.61%	-3.61%				1.72%	1.72%	1.73%	1.73%	6.21%	6.21%	1.85%	1.85%	2.70%	2.70%	
Domestic Fixed Income																													
Benchmark	502,820,245	18.1%	18.0%	2.41%	2.35%	492,078,570	18.4%	18.0%	2.24%	2.19%	445,402,470	17.4%	18.0%	-0.69%	-0.75%	448,431,043	17.6%	18.0%	2.46%	2.40%	6.53%	6.30%	3.86%	3.63%	4.58%	4.38%	5.82%	5.61%	

ND PUBLIC EMPLOYEES RETIREMENT SYSTEM
INVESTMENT PERFORMANCE REPORT AS OF JUNE 30, 2017

	June-17					March-17					December-16					September-16					Current		Prior Year		3 Years Ended		5 Years Ended	
	Allocation				Quarter	Allocation				Quarter	Allocation				Quarter	Allocation				Fiscal YTD	FY16		6/30/2017		6/30/2017			
	Market Value	Actual	Policy	Gross ⁽¹⁾ Net		Market Value	Actual	Policy	Gross ⁽¹⁾ Net		Market Value	Actual	Policy	Gross ⁽¹⁾ Net		Market Value	Actual	Policy	Gross ⁽¹⁾ Net		Gross ⁽¹⁾ Net	Gross ⁽¹⁾ Net	Gross ⁽¹⁾ Net	Gross ⁽¹⁾ Net	Gross ⁽¹⁾ Net			
International Fixed Income Benchmark	130,188,263	4.7%	6.0%	4.08% 3.87% 3.55% 3.55%		126,236,810	4.7%	6.0%	3.87% 3.77% 2.48% 2.48%		120,232,242	4.7%	6.0%	-7.77% -7.88% -10.26% -10.26%		130,488,833	6.1%	6.0%	1.47% 1.38% 1.03% 1.03%	1.15% 0.79% -3.80% -3.80%	7.88% 7.50% 11.24% 11.24%	-0.37% -0.74% -2.43% -2.43%	1.80% 1.24% -0.36% -0.36%					
Developed Investment Grade Int'l FI																												
UBS Global (ex-US) Bond Strategy	53,104,130	1.9%	2.5%	3.89% 3.81% 3.55% 3.55%		51,160,795	1.9%	2.5%	2.37% 2.28% 2.48% 2.48%		49,831,273	1.9%	2.5%	-10.50% -10.58% -10.26% -10.26%		55,718,700	2.2%	2.5%	1.18% 1.10% 1.03% 1.03%	-3.69% -4.00% -3.80% -3.80%	11.43% 11.07% 11.24% 11.24%	-2.44% -2.78% -2.43% -2.43%	-0.55% -0.56% -0.36% -0.36%					
Bloomberg Global Aggregate ex-US																												
Brandywine Global Opportunistic Fixed Income	77,092,123	2.8%	2.5%	4.18% 4.09% 2.60% 2.60%		74,074,815	2.8%	2.5%	4.92% 4.82% 1.76% 1.76%		70,400,969	2.7%	2.5%	-5.74% -5.83% -7.07% -7.07%		74,747,933	2.9%	2.5%	1.69% 1.59% 0.82% 0.82%	4.78% 4.38% -2.18% -2.18%	5.12% 4.73% 8.87% 8.87%	1.39% 1.00% -0.36% -0.36%	3.55% 3.15% 0.77% 0.77%					
Total Developed Investment Grade Int'l FI	130,188,263	4.7%	6.0%	4.08% 3.87% 3.55% 3.55%		126,236,810	4.7%	6.0%	3.87% 3.77% 2.48% 2.48%		120,232,242	4.7%	6.0%	-7.77% -7.88% -10.26% -10.26%		130,488,833	6.1%	6.0%	1.47% 1.38% 1.03% 1.03%	1.15% 0.79% -3.80% -3.80%	7.88% 7.50% 11.24% 11.24%	-0.37% -0.74% -2.43% -2.43%	1.80% 1.24% -0.36% -0.36%					
Bloomberg Global Aggregate ex-US																												
GLOBAL REAL ASSETS Benchmark	506,853,480	18.2%	19.0%	3.32% 3.18% 1.17% 1.17%		480,753,081	18.0%	19.0%	1.48% 1.38% 1.20% 1.20%		483,306,474	18.9%	19.0%	0.77% 0.67% 1.18% 1.18%		474,876,466	18.6%	19.0%	0.89% 0.81% 1.07% 1.07%	6.59% 6.18% 4.70% 4.70%	8.53% 7.99% 6.25% 6.25%	8.19% 7.73% 6.56% 6.56%	8.84% 8.40% 7.26% 7.26%					
Global Real Estate																												
Invesco Core Real Estate - U.S.A., L.P.	140,782,671			1.88% 1.79%		139,295,120			2.54% 2.45%		136,965,624			2.17% 2.08%		135,176,323			1.68% 1.59%	8.53% 8.16%	10.96% 10.59%	11.91% 11.52%	12.00% 11.58%					
INVESCO Real Estate Fund II (4)	102,899			3.30% 3.30%		99,592			22.17% 22.17%		81,518			-2.76% -2.76%		2,893,926			0.00% 0.00%	22.72% 22.72%	6.65% 6.65%	11.61% 11.61%	14.46% 14.46%					
Invesco Real Estate Fund III, LP (4)	11,925,960			-2.76% -2.76%		17,599,727			7.77% 7.77%		16,330,153			6.47% 6.47%		15,337,301			0.00% 0.00%	11.58% 11.58%	14.25% 14.25%	14.81% 14.81%	15.89% 15.89%					
Invesco U.S. Value-Add Fund IV, LP (4)	24,216,147			4.24% 4.24%		14,222,938			1.05% 1.05%		16,219,914			2.59% 2.59%		12,317,313			0.00% 0.00%	8.07% 8.07%	4.66% 4.66%	N/A N/A	N/A N/A					
Invesco Asia Real Estate Fund I, L.P. (4)	152,612			83.64% 83.64%		397,859			786.62% 786.62%		44,874			-31.45% -31.45%		569,912			-3.02% -3.02%	982.41% 982.41%	121.40% 121.40%	203.10% 203.10%	97.81% 97.81%					
Invesco Asia Real Estate Fund III, L.P. (4)	11,856,673			21.68% 21.68%		9,426,563			-3.05% -3.05%		10,621,592			3.46% 3.46%		7,389,980			-0.64% -0.64%	21.25% 21.25%	N/A N/A	N/A N/A	N/A N/A					
JP Morgan Strategic & Special Situation Property Blend	107,883,754			1.70% 1.48%		107,116,362			1.97% 1.74%		106,175,986			2.18% 1.95%		103,912,878			1.97% 1.73%	8.05% 7.08%	12.25% 10.95%	11.64% 10.52%	12.91% 11.84%					
JP Morgan Alternative Property Fund	159,984			2.17% 2.17%		156,557			3.35% 3.35%		151,484			1.07% 1.07%		170,645			0.00% 0.00%	6.73% 6.73%	2.80% 2.80%	-9.88% -9.88%	-2.55% -2.57%					
JP Morgan European Opportunistic Property Fund III (4)	5,441,695			8.96% 8.96%		4,995,157			1.47% 1.47%		4,925,391			-11.05% -11.05%		5,541,308			1.16% 1.16%	-0.51% -0.51%	24.44% 24.44%	13.11% 13.11%	4.37% 9.48%					
JP Morgan Greater China Property Fund (4)	8,624,839			34.91% 34.91%		6,393,718			-1.11% -1.11%		6,467,642			3.30% 3.30%		6,263,312			0.00% 0.00%	37.81% 37.81%	16.24% 16.24%	23.20% 23.20%	24.95% 24.95%					
Total Global Real Estate	311,147,233	11.2%	11.0%	9.32% 8.19% 1.75% 1.75%		288,703,684	11.2%	11.0%	2.38% 2.28% 1.55% 1.55%		287,884,177	11.8%	11.0%	2.16% 2.03% 1.73% 1.73%		288,672,887	11.4%	11.0%	1.48% 1.38% 1.77% 1.77%	8.86% 8.19% 6.97% 6.97%	11.88% 11.34% 10.64% 10.64%	12.44% 11.88% 10.17% 10.17%	13.01% 12.47% 10.49% 10.49%					
NCREIF TOTAL INDEX																												
Timber																												
TIR Tereco Timber, LLC	15,883,699			-1.75% -1.75%		16,165,887			-5.82% -5.82%		17,164,570			0.47% 0.47%		17,083,529			0.00% 0.00%	-7.02% -7.02%	9.29% 9.29%	5.49% 5.49%	5.75% 5.75%					
TIR Springbank, LLC	53,058,979			-1.24% -1.24%		54,378,838			-1.15% -1.15%		55,012,679			-7.94% -7.94%		59,992,203			0.00% 0.00%	-10.13% -10.13%	2.97% 2.97%	-3.20% -3.20%	-2.37% -2.37%					
Total Timber (4)	68,942,678	2.6%	3.0%	-1.36% -1.36% 0.70% 0.70%		70,544,724	2.8%	3.0%	-2.28% -2.28% 0.76% 0.76%		72,177,248	2.8%	3.0%	-8.07% -8.07% 1.18% 1.18%		77,076,733	3.0%	3.0%	0.00% 0.00% 0.67% 0.67%	-8.44% -8.44% 3.35% 3.35%	4.94% 4.94% 3.39% 3.39%	-0.80% -0.80% 5.64% 5.64%	0.27% 0.27% 7.16% 7.16%					
NCREIF Timberland Index																												
Infrastructure																												
JP Morgan Asian Infrastructure & Related Resources (4)	12,071,004			0.4%		11,965,425			29.84% 29.84%		14,988,852			3.69% 3.69%		14,184,663			-0.47% -0.47%	35.48% 35.48%	-9.66% -9.66%	6.04% 6.04%	8.92% 8.92%					
JP Morgan Infrastructure Investments Fund (IIF)	91,657,971			6.87% 6.48%		76,587,670			-1.41% -1.57%		77,837,245			1.62% 1.45%		71,935,417			0.00% 0.00%	7.06% 6.33%	5.11% 3.93%	4.38% 3.46%	6.68% 5.72%					
Grosvenor Customized Infrastructure Strategies, LP (4)	19,207,968			7.52% 7.52%		17,794,045			-0.16% -0.16%		17,419,293			1.64% 1.64%		20,227,344			-0.37% -0.37%	8.70% 8.70%	8.42% 8.42%	7.49% 7.49%	8.94% 8.94%					
Grosvenor Customized Infrastructure Strategies II (4)	3,626,627			5.35% 5.35%		4,157,623			-1.35% -1.35%		2,899,659			0.27% 0.27%		1,880,414			-0.89% -0.89%	3.28% 3.28%	6.10% 6.10%	N/A N/A	N/A N/A					
Total Infrastructure	128,783,688	4.8%	6.0%	8.28% 8.02% 0.49% 0.49%		110,604,783	4.1%	6.0%	1.62% 1.40% 0.96% 0.96%		113,146,048	4.4%	6.0%	1.86% 1.73% -0.04% -0.04%		108,227,837	4.2%	6.0%	-0.16% -0.16% 0.09% 0.09%	8.73% 8.21% 1.50% 1.50%	3.88% 2.88% 0.64% 0.64%	4.81% 4.21% 0.58% 0.58%	7.21% 6.67% 1.11% 1.11%					
CP																												
Cash Equivalents																												
Northern Trust Collective STIF	7,777,863			0.25% 0.25%		4,934,393			0.21% 0.21%		14,847,123			0.17% 0.17%		14,629,052			0.13% 0.13%	0.75% 0.75%	0.29% 0.29%	0.37% 0.37%	0.25% 0.25%					
Bank of ND	2,708,292			0.23% 0.23%		2,862,316			0.17% 0.17%		4,527,480			0.12% 0.12%		6,558,200			N/A N/A	N/A N/A	N/A N/A	N/A N/A	N/A N/A					
Total Cash Equivalents	10,486,155	0.4%	0.0%	0.26% 0.26% 0.20% 0.20%		7,796,709	0.3%	0.0%	0.20% 0.20% 0.10% 0.10%		19,374,683	0.8%	0.0%	0.18% 0.18% 0.09% 0.09%		21,287,262	0.8%	0.0%	0.12% 0.12% 0.10% 0.10%	0.74% 0.74% 0.49% 0.49%	0.29% 0.29% 0.19% 0.19%	0.38% 0.38% 0.23% 0.23%	0.24% 0.24% 0.17% 0.17%					
90 Day T-Bill																												

NOTE: Monthly returns and market values are preliminary and subject to change.

New asset class structure began October 1, 2011. Composite returns for new composites not available prior to that date.

Portfolios moved between asset classes will show historical returns in new position.

(1) Epoch was included in the Large Cap Domestic Equity composite through 12/31/11.

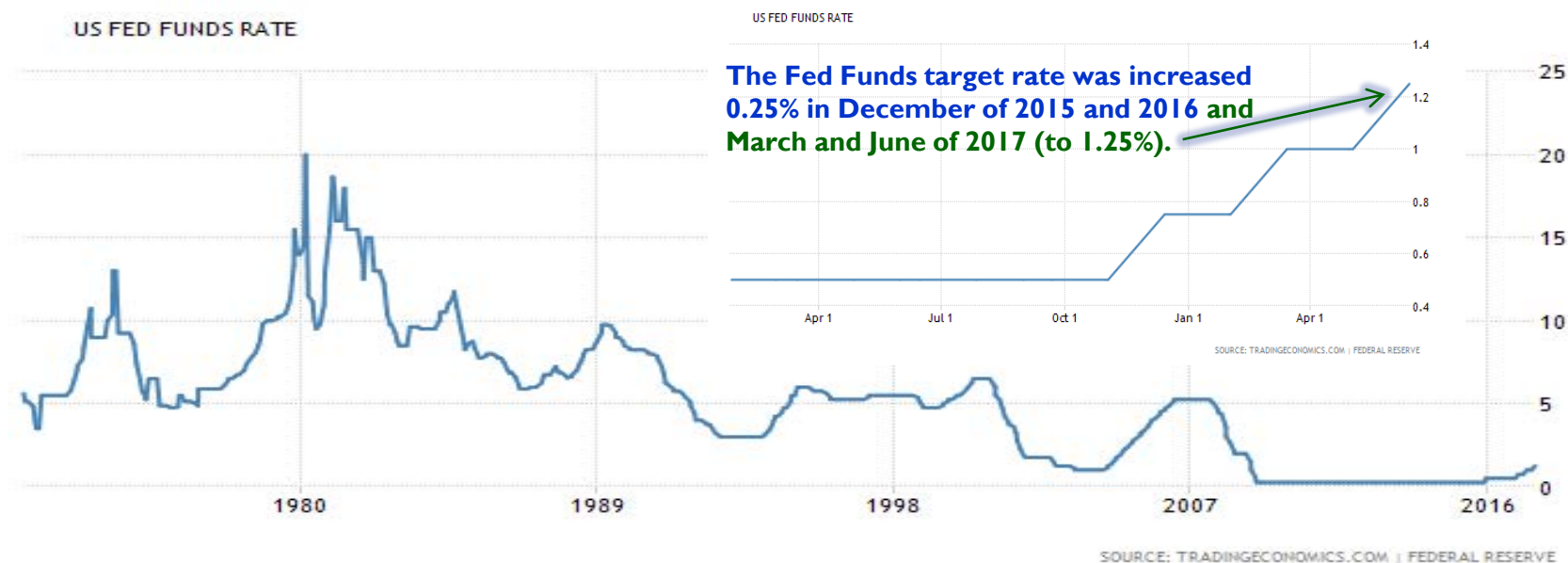
(2) Prior to January 1, 2012, the benchmark was S&P 500.

(3) This benchmark was changed to the MSCI World ex-US as of July 1, 2016 and the MSCI EAFE (unhedged) as of April 1, 2011.

(4) All limited partnership-type (and mutual funds as of 7/1/14) investment returns will only be reported net of fees, which is standard practice by the investment consultant.

U.S. Fed Funds Rate (1971 to 2017)

Background: The **federal funds rate** is the interest rate at which banks lend reserve balances to other banks overnight (on an uncollateralized basis). Banks with surplus balances lend to those in need of larger balances. Reserve balances are held at the Federal Reserve to maintain the banks' reserve requirements. **Changes in the federal funds rate trigger a chain of events that affect other short-term interest rates**, foreign exchange rates, long-term interest rates, the amount of money and credit, and, ultimately, a range of economic variables, including employment, output, and prices of goods and services. The Federal Reserve uses "monetary policy" to influence the availability and cost of money and credit to help promote national economic goals.



The Federal Reserve raised the target range for its federal funds rate by 25bps to 1% to 1.25% during its June 2017 meeting, in line with market expectations. Policymakers kept forecasts for one more rate hike this year while increasing growth projections and lowering inflation expectations. In addition, details on how the central bank will start reducing its USD 4.5 trillion portfolio were also provided. Interest Rate in the United States averaged 5.79 percent from 1971 until 2017, reaching an all time high of 20 percent in March of 1980 and a record low of 0.25 percent in December of 2008.

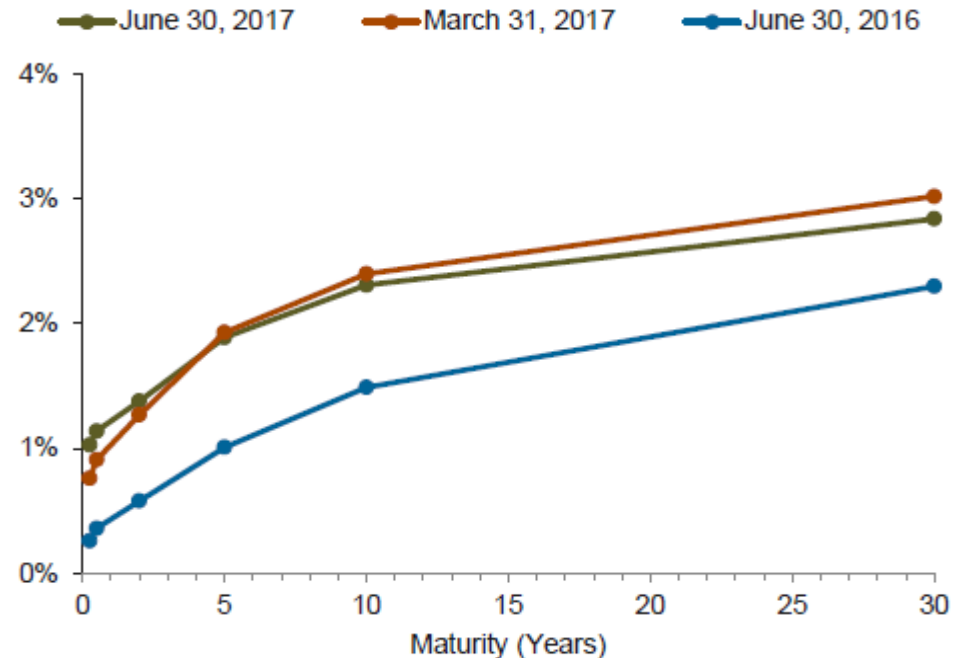
Yield Curve Changes

Periods Ending June 30, 2017

The Treasury yield curve flattened with short term rates rising along with Fed action and long term rates falling on expectations of a slower growth trajectory.

The yield on 10-year and 30-year treasuries dropped 0.09% and 0.18%, respectively, while 3-month rates rose 0.27%.

U.S. Treasury Yield Curves

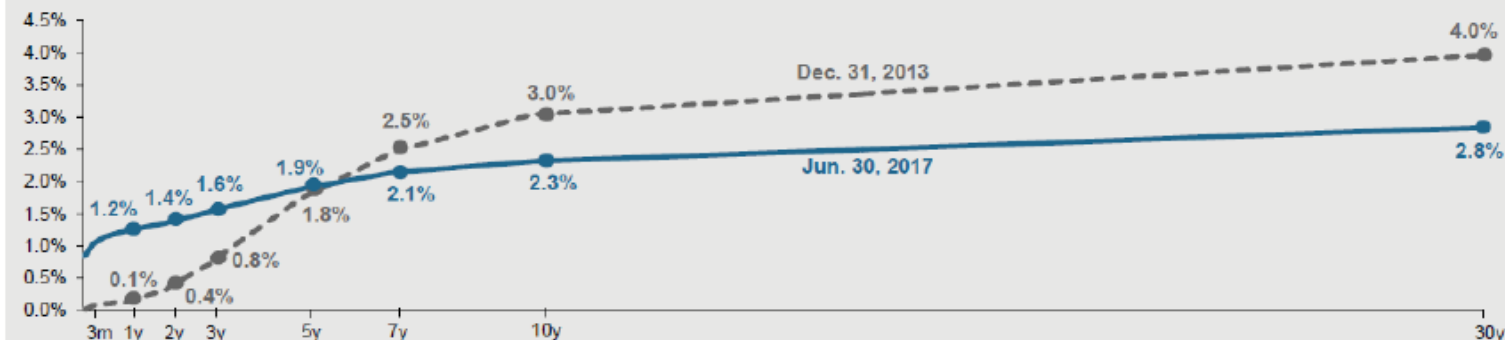


Source: U.S. Department of the Treasury

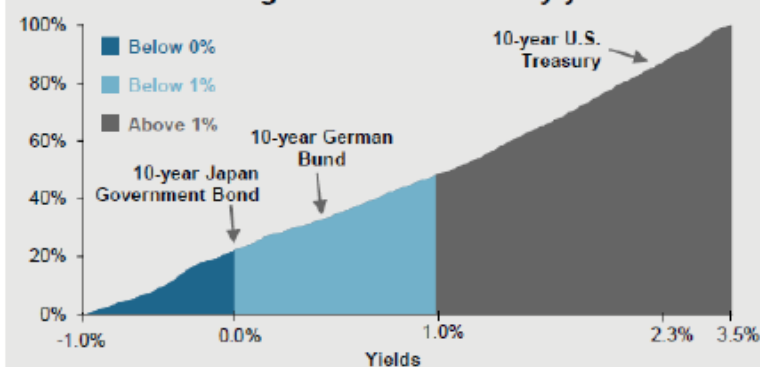
Bond Market Dynamics

Yield curve

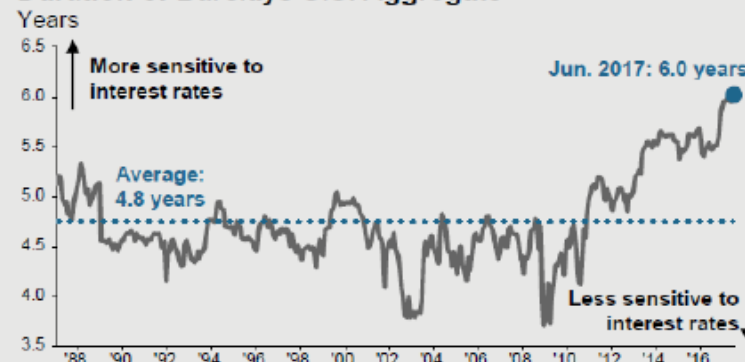
U.S. Treasury yield curve



Breakdown of DM government bonds by yield



Duration of Barclays U.S. Aggregate



- Historically high duration means the U.S. Aggregate is more sensitive to interest rate changes; however, higher yields in the U.S. relative to other developed markets increases global demand which could slow the pace at which long rates rise.

Source: FactSet, J.P. Morgan Asset Management; (Bottom left) Bloomberg, BofA/Merrill Lynch. (Bottom right) Barclays, Bloomberg. The Developed Market Government Bond Index is the Bank of America/Merrill Lynch Global Government Index. Duration measures the sensitivity of the price of a bond to a change in interest rates. The higher the duration the greater the sensitivity bond is to movements in the interest rate. Guide to the Markets – U.S. Data are as of June 30, 2017.

ND Public Employees Retirement System Schedule of Investment Expenses

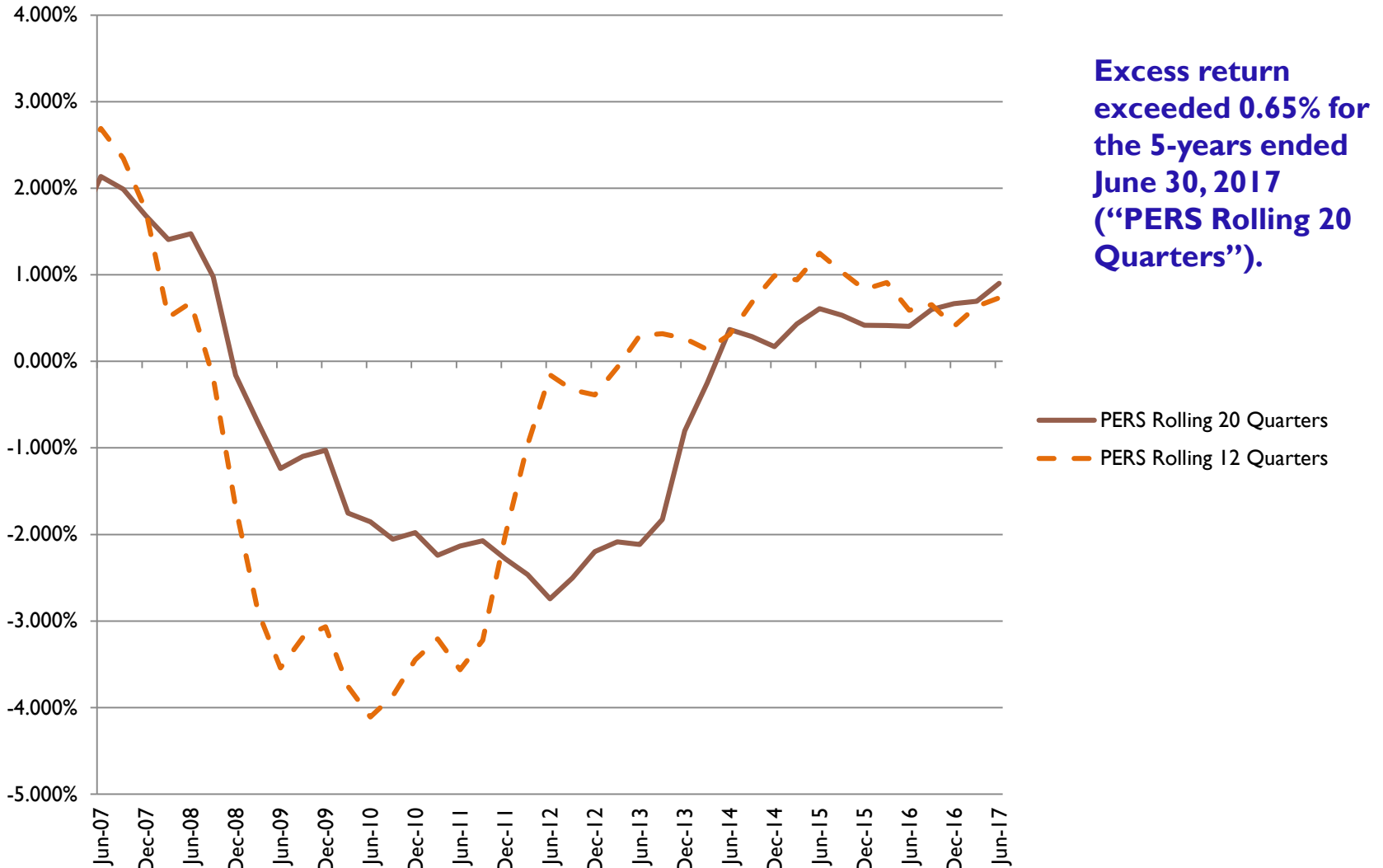
	FY 2017				FY 2016			
	Average Market Value	Fees in \$	Fees in %	Contribution to Total Fees	Average Market Value	Fees in \$	Fees in %	Contribution to Total Fees
Investment managers' fees:								
Global equity managers	443,295,467	1,716,931	0.39%	0.06%	381,723,510	1,463,105	0.38%	0.06%
Domestic large cap equity managers	458,670,881	654,319	0.14%	0.02%	415,066,060	1,042,600	0.25%	0.04%
Domestic small cap equity managers	144,408,396	561,231	0.39%	0.02%	117,678,274	661,525	0.56%	0.03%
Developed international equity managers	306,782,154	969,488	0.32%	0.04%	268,317,607	1,087,387	0.41%	0.05%
Emerging markets equity managers	109,834,610	898,494	0.82%	0.03%	88,000,359	717,641	0.82%	0.03%
Investment grade domestic fixed income managers	335,502,197	2,399,466	0.72%	0.09%	301,575,217	1,164,370	0.39%	0.05%
Below investment grade fixed income managers	136,630,885	1,854,744	1.36%	0.07%	128,662,524	1,349,888	1.05%	0.06%
Developed international fixed income managers	126,532,685	452,558	0.36%	0.02%	121,049,255	428,095	0.35%	0.02%
Real estate managers	299,601,975	3,348,730	1.12%	0.13%	256,587,200	2,470,029	0.96%	0.10%
Timber managers	72,185,096	485,605	0.67%	0.02%	80,540,706	(1,054,317)	-1.31%	-0.04%
Infrastructure managers	114,660,304	917,728	0.80%	0.03%	108,898,046	1,148,047	1.05%	0.05%
Private equity managers	79,104,475	1,335,628	1.69%	0.05%	84,636,554	1,524,925	1.80%	0.06%
Cash & equivalents managers	14,736,175	17,861	0.12%	0.00%	34,951,692	34,800	0.10%	0.00%
Total investment managers' fees	2,641,945,299	15,612,783	0.59%		2,387,687,004	12,038,095	0.50%	
Custodian fees		250,055	0.01%	0.01%		227,822	0.01%	0.01%
Investment consultant fees		111,406	0.00%	0.00%		150,745	0.01%	0.01%
Total investment expenses		15,974,244	0.60%			12,416,661	0.52%	
Actual Investment Performance (Net of Fees)			13.05%				0.28%	
Policy Benchmark			11.87%				0.56%	
Outperformance			1.18%				-0.28%	

PERS fees increased to 0.60% in FY 2017 from 0.52% in FY 2016 mostly due to the Timber fee reversal of -1.31%. Performance fees (including U.S. fixed income) were higher in 2017 than 2016.

Note: All amounts are deemed to be materially accurate, but are unaudited and subject to change.

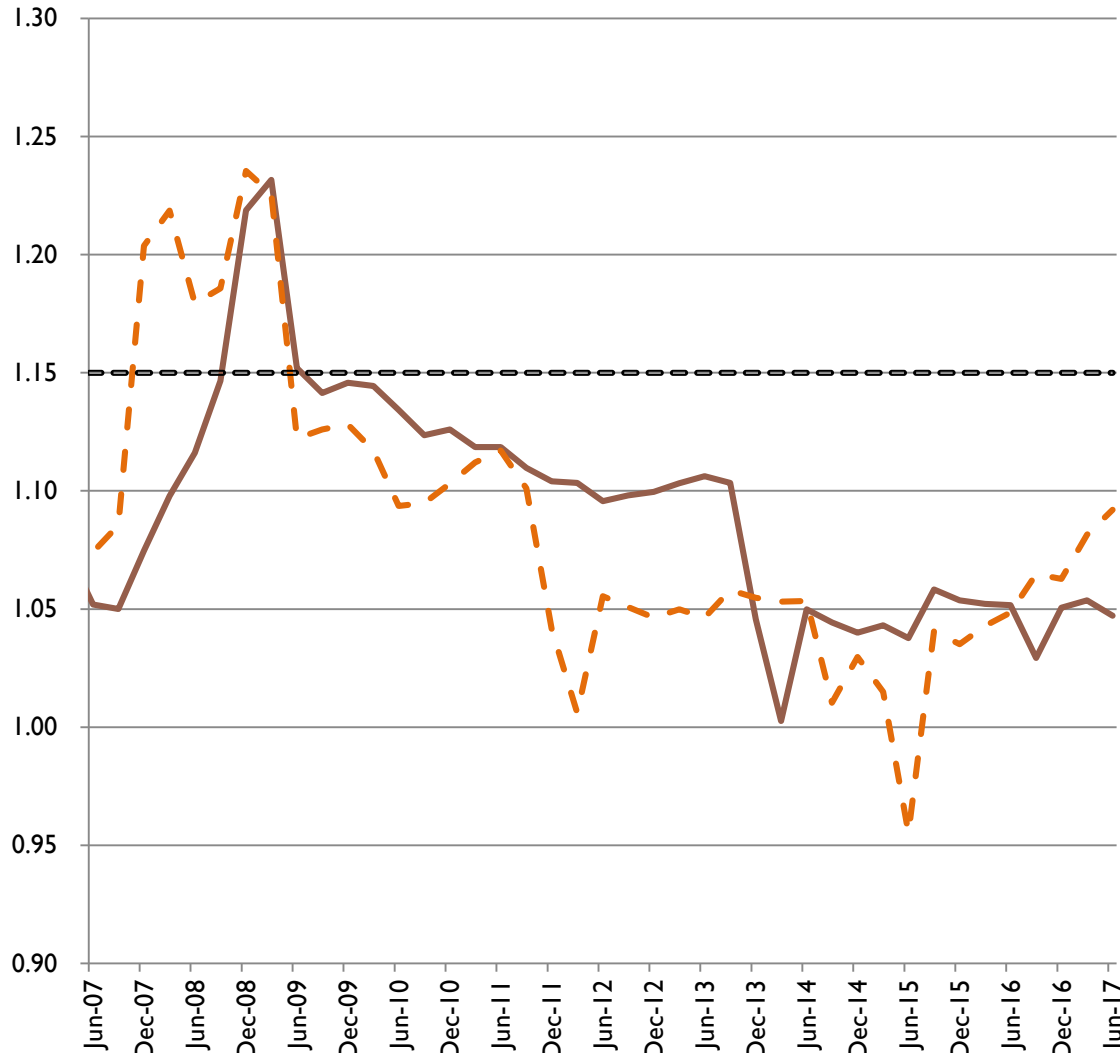
Excess Return Relative to Policy Benchmark

10 Years Ended 6/30/2017



Relative Standard Deviation Relative to Policy Benchmark

10 Years Ended 6/30/2017

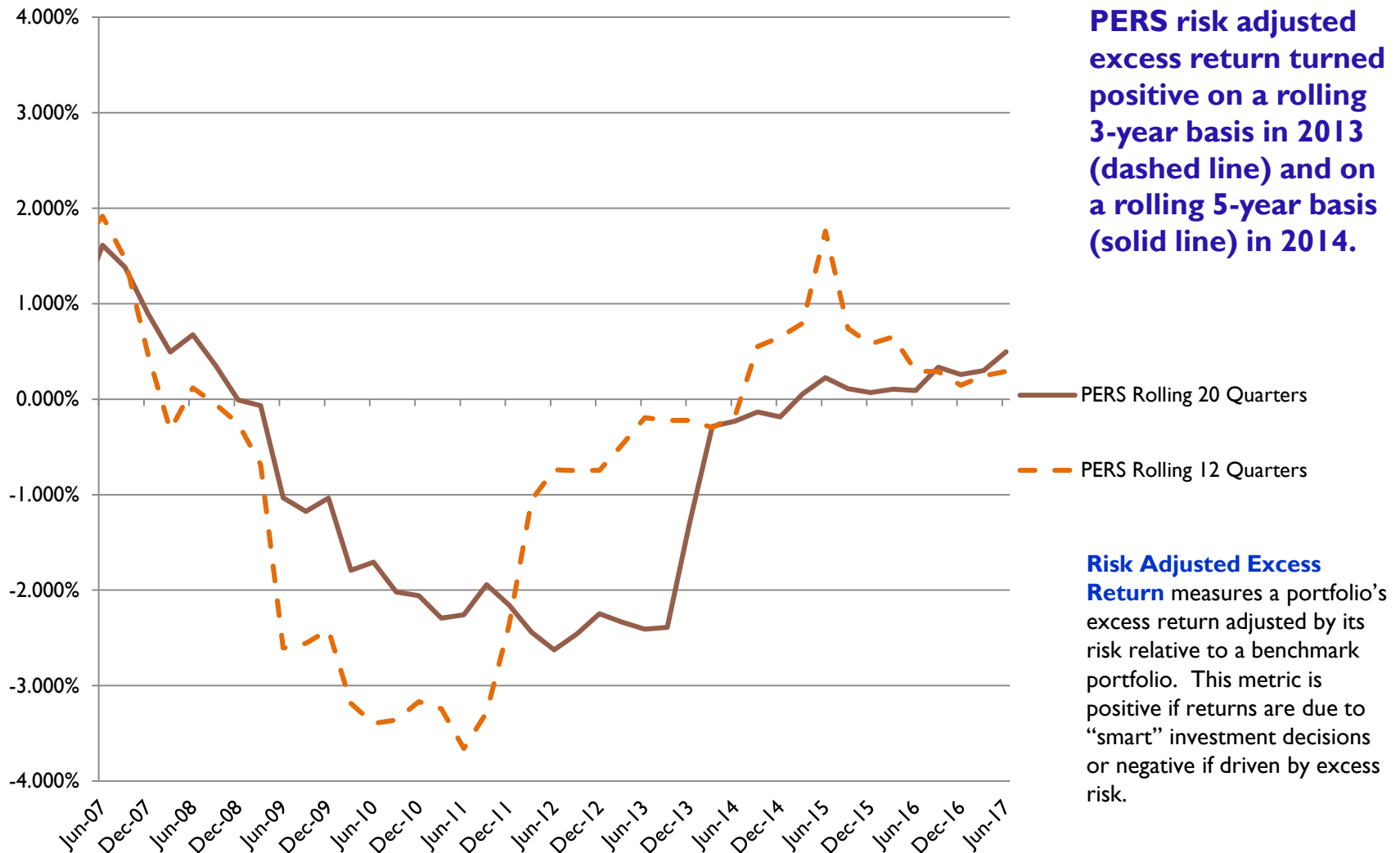


Investment risk, as measured by standard deviation, remains within investment guidelines of 1.15 (or 115% of the policy benchmark) over the last 5 years.

PERS standard deviation for the 5-years ended June 30, 2017 was 105% (or 1.05 times) the policy benchmark.

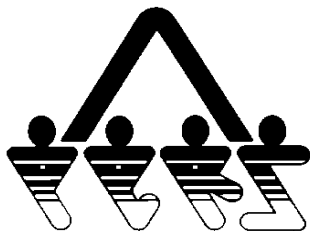
Risk Adjusted Excess Return

10 Years Ended 6/30/2017



U.S. Defined Contribution Plan Trends to Improve Participant Outcomes & Mitigate Fiduciary Risk

- PERS has “continually worked to lower investment fees by going to bid on a regular basis and checking the marketplace to make sure a sound plan is offered to participants”. PERS has frequently “restructured contracts” to achieve this goal while conducting “quarterly investment sub-committee meetings to review fund offerings and overall performance”. PERS also “publishes investment fees for all products on a public website which is updated regularly”. Once “enrolled in a product, the offering materials or prospectus for each investment is provided for each investment.” TIAA also provides “quarterly performance updates attended by the investment sub-committee and RIO personnel”. In summary, RIO commends PERS strong focus on the importance of participant education and long-term asset allocation decisions.
- Continue to pursue offering the lowest cost eligible share class to participants.
- Consider simplifying core investment menu and eliminating revenue sharing in order to improve fee transparency (e.g. charge a separate quarterly record keeping fee of \$12.50 per participant or 0.03% of investments, not to exceed \$50/year).
- Consider requesting service provider to confirm their fiduciary responsibility particularly as it relates to overall plan design and fee transparency.



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Memorandum

DATE: October 16, 2017
TO: NDPERS Board
FROM: Kathy
SUBJECT: Job Service COLA

This year the COLA index for the Federal Civil Service Plan is 2%. Therefore, a 2% COLA increase is indicated for the Job Service retirees paid by NDPERS as well as for the Job Service retirees paid by MetLife. The increase would be effective December 1, 2017. The last increase for annuitants in this system was 0.3 effective December 1, 2016.

The actuarial assumption used in the annual valuation for the COLA is 5.0% per year; therefore, the 2% increase represents a gain to the system.

Board Action Requested

Determine whether to approve the 2% COLA increase for Job Service annuitants.



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Memorandum

TO: PERS Board

FROM: Derrick Hohbein, CPA

DATE: October 19, 2017

SUBJECT: GASB 74 & 75

In June 2015, the Governmental Accounting Standards Board (GASB) issued two new standards that will change the accounting and financial reporting of systems that offer other post employment benefits (OPEB) and the state and local governments that participate in such plans. The Retiree Health Insurance Credit (RHIC) plan that NDPERS administers is covered under these standards. GASB Statement No 74, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, replaces plan reporting requirements and is for financial statements for periods beginning after June 15, 2016. GASB Statement No 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, establishes new accounting and financial reporting requirements for governments that provide financial support for OPEB provided to the employees of other entities and is effective for fiscal years beginning after June 15, 2017. These new GASB statements will apply the same theory experienced by the defined benefit retirement plan as a result of GASB 67 & 68, to the RHIC plan.

Implementation of these standards will require additional audit work by our external audit firm CliftonLarsonAllen (CLA) and required an amendment to our current audit contract. The state auditor's office requested an amendment to our contract, and agreed to a cost of \$17,500 and includes an audit of the census data for the 6/30/17 audit of the RHIC plan.

These standards also require additional work by our actuary Gabriel Roeder Smith & Company (GRS) who will need to allocate the unfunded liability to each of the participating employers by providing a Schedule of OPEB amounts by Employer. The additional fee for GRS to provide these services for the fiscal year ending 6/30/17 is \$7,500.

Communication efforts to make participating employers aware of the change are beginning.

This is for your information and I would be happy to answer any questions you may have.



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Memorandum

TO: NDPERS Board

FROM: Sparb & Kathy

DATE: October 19, 2017

SUBJECT: TIAA Contract

At the June meeting you approved the TIAA contract subject to review by our attorney Jan. As part of that review one item came up that we want to have your concurrence with prior to signing the agreement.

In the event that the Reconciliation Process determines that the plan(s) did not generate sufficient revenue to meet TIAA's Revenue Requirement and therefore results in a shortfall, the Employer understands and agrees that TIAA shall invoice the Employer for such shortfall and the Employer agrees to (i) pay such invoice within thirty days of receipt; or (ii) shall by amendment to this Agreement authorize TIAA to deduct a Plan servicing fee from Plan participants Plan accounts to pay for such shortfall. In the event the Employer authorizes TIAA to deduct a Plan servicing fee, the amount of such fee will be determined and assessed pro rata against the participant's plan accounts to the extent permitted under the terms of the annuity contracts and mutual funds in such participant's account. In the event a Plan servicing fee is charged, the Employer shall amend this Agreement to document the amount of such fee and the time period that such fee shall be in effect. Notwithstanding the foregoing, no invoice to the Employer shall be sent if the Plan's shortfall amount determined by the Reconciliation Process is less than \$2,500 for any given reconciliation year.

The proposed agreement only provided that PERS would be invoiced for the shortfall. Since we could not be confident that we would be in a position to pay such an invoice we suggested adding the additional underlined wording.

Board Action Requested

Approve the above addition to the TIAA contract.



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Memorandum

TO: NDPERS Board

FROM: Sparb

DATE: October 19, 2017

SUBJECT: Applied Behavioral Analysis

Item for Board Consideration

Recently I received the following from Steve Webster at Sanford:

SHP is moving in the direction to provide coverage in ND to large group, non-grandfathered plans, effective 1.1.18. This email is seeking your input on whether PERS would consider adding such a benefit on 1.1.18, understanding the legislature has just approved the 17-19 budget.

Tentative Benefits:

< age 6 – Coverage up to \$36,000
7-13 - Coverage up to \$25,000
14-18 - Coverage up to \$12,500
**Prior Authorization required.*

The cost for adding this coverage to the PERS plan for this biennium would need to be funded through reserves since rates have already been set. The estimated cost per month would be about \$28,000 per month. Adding this starting in January of 2018 would mean it would in the plan for about 18 months so the total cost would be about \$504,000 for the remainder of this biennium.

Background

At the August meeting, we discussed that during this last session HB 1434 was submitted. The proposed bill would have:

Created a new section to chapter 26.1-36 and a new section to chapter 54-52.1 of the North Dakota Century Code, containing health insurance coverage mandates for autism-related services

Sponsors of the bill were:

Introduced by

Representatives Beadle, Kasper, B. Koppelman, Maragos, Steiner

Senators Burckhard, Dever, Heckaman

The bill was heard during the interim by the Legislative Employee Benefits Committee and got an Unfavorable Recommendation.

The following is the legislative history of the bill as it was heard during the session:

Date	Chamber	Meeting Description
01/16	House	Introduced, first reading, referred Human Services Committee
01/30	House	Committee Hearing 02:45
02/08	House	Reported back amended, do pass, amendment placed on calendar 9 2 3
02/09	House	Amendment adopted
		Rereferred to Appropriations
02/14	House	Reported back, do not pass, placed on calendar 16 4 1
		Second reading, failed, lacks constitutional majority yeas 47 nays 43
02/15	House	Reconsidered
		Second reading, passed, yeas 61 nays 29
02/17	Senate	Received from House
		Introduced, first reading, referred Human Services Committee
03/06	Senate	Committee Hearing 09:00
03/20	Senate	Reported back amended, do not pass, placed on calendar 4 3 0
03/21	Senate	Amendment adopted, placed on calendar
		Amendment proposed on floor
		Amendment failed
		Second reading, failed to pass, yeas 16 nays 31

Very compelling and extensive testimony was given concerning the need for the above coverage. Ultimately the bill did not pass. A couple of observations:

1. My perception was that most legislators agreed with the need for this coverage and that it appeared the reason it didn't pass was a consensus that the best way for this coverage to be provided would be through the insurance companies designing and offering the coverage as part of their health plans rather than because of a legislative mandate. Both BCBS and Sanford indicated that is what they intended to do if the bill did not pass. Consequently, to me it seemed the issue was not if the coverage should be provided but if it should be a mandate and that is why the bill failed.
2. It was also noted that if the bill passed as a mandate NDCC pursuant to NDCC 54-03-28(2)(b):

The application of the mandate is limited to the public employee's health insurance program and the public employee retiree health insurance program.

The application of such mandate begins with every contract for health insurance which becomes effective after June thirtieth of the year in which the measure becomes effective.

Consequently, if this was to pass as a mandate it would go into PERS in 2017 but would not go into the general marketplace until 2019. Given the commitment by the insurance companies to include this coverage in there plans this meant the coverage would become more generally available faster if the mandate bill (HB 1403) did not pass.

Question from August Meeting

At the August meeting, we discussed the above and several questions were asked for staff to follow-up on. The following are those questions:

Does the board have the authority to add this coverage?

See attachment 1 from Jan Murtha

What coverage is BCBS going to offer in their plans?

Coverage is currently available for the full range of diagnostic assessments, including physical evaluations, specialty evaluations, psychiatric and psychological evaluations, sensory testing, imaging and laboratory testing that may be necessary for a comprehensive medical evaluation to fully assess an individual's Autism Spectrum Disorder (ASD) needs.

BCBSND is adding a benefit for Behavioral Modification Interventions (BMI) that includes evidence-based techniques used in the assessment, treatment and prevention of challenging behaviors associated with ASDs.

Does PERS provide an expanded coverage in this area already?

Please find the Speech therapy side by side comparison. Please note the **30 visits/CY** is available for each type of Rehab Therapy. Examples are Speech and Physical therapy.

ND Commercial Plans

- *Outpatient Rehabilitative Therapy (including Speech Therapy) which is expected to provide significant improvement within two (2) months, as certified on a prospective and timely basis by the Plan. Coverage is limited to thirty (30) visits per Calendar Year.*

NDPERS Benefits - All Plans:

- *Speech Therapy: Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.*

NDPERS members have 90 visits per year (without taking account the consecutive), while ND Commercial has only 30 that are covered.

With this being said, Sanford mentioned that Speech Therapy is only a portion of what may be required for Autism treatment and is something completely different from Behavioral Therapy. Further ABA therapy and Speech therapy are two distinct disciplines in themselves, however, Speech therapy serves as a radiator of ABA treatment since social and language skills are integral components of ABA treatment.

Dr. Donelan from Sanford will be available via conference call to discuss questions the board may have.

Additional Information

As mentioned above extensive consideration was given to this benefit during the last session. At <https://ndpers.nd.gov/image/cache/october-19-2017--board-book.pdf> on our website you will find the legislative history of the bill and all the information presented. The following is a short table of contents of the information for you to use in looking at the information:

PERS Fiscal note	Page 1
House Committee Minutes	Page 17
<u>House Testimony:</u>	
Rep Beadle Testimony	Page 88
Judith Ursittii Autism Speaks	Page 90
Jennifer Skjod – Parent	Page 108
Dr. Daisha	Page 109
Chelsea Evenstad ND Autism Center	Page 114
Ethan Suda	Page 123
Charlie Kern	Page 125
Kenny Kern	Page 126
Tommy Kern	Page 127
Jack Kern	Page 128
Janice Kern	Page 129
Jens Sharbono	Page 130
Kristin Sharbono	Page 131
Doug Sharbono	Page 133
Ted Fogarty	Page 135
Sandy Smith	Page 138
Eric Mauch	Page 140
Jen Werder	Page 141
Samantha Stewart	Page 143
Dr. Newman	Page 145
Autism Speaks	Page 146
Dr. Stephanie Hanson	Page 147

Pam Gallagher	Page 148
Elizabeth Faust	Page 149
Brent Bogar	Page 151
Dr. Tiongson	Page 152
Dr. Carrie Brower-Breitwieser	Page 153
Dr. Patrick Welle	Page 154
Actuarial Analysis of bill by Acumen Actuarial	Page 156
<u>Senate Testimony</u>	
Rep Beadle	Page 187
Pew Charitable Trust Study	Page 194
Chelsea Evenstad	Page 208
Sandy Smith ND Autism Center	Page 217
Catherine Yeager	Page 230
Charlie Kern	Page 236
Sharon Alexander	Page 237
Doug Sharbono	Page 240
Holly Johnson	Page 242
Kristen Sharbono	Page 243
Elizabeth Faust	Page 246
Dr. Barbara Stanton	Page 250
Summary Evidence Base Practices	Page 255
Dan Hannaher, Sanford	Page 258
Supplemental Report Acumen Actuarial	Page 264
Brent Bogar	Page 291
Judith Ursitti Autism Speaks	Page 293
ND Autism Spectrum Disorder Coalition	Page 303

Staff Recommendation

Add the coverage to the PERS plan effective January 2018.

Applied Behavioral Analysis
Attachment #1 From Jan Murtha

In follow up to the Board's prior discussion on autism related services, you had asked me to confirm that the PERS Board has the legal authority to provide and pay for increased insurance coverage. As we have discussed NDCC 54-52-04(13) (copied below) permits the Board to provide increased insurance coverage to members, and to pay for such amounts from excess reserve funds. It should be noted that subsection 13 also permits the Board to use these excess funds to offset premium costs. Therefore, the Board has the legal authority to provide and pay for increased insurance coverage and the discretion to determine whether and when such coverage is provided.

"13. The board may use any amount credited to the separate uniform group insurance program fund created by section 54-52.1-06 in excess of the costs of administration of the uniform group insurance program to reduce the amount of premium amounts paid monthly by enrolled members of the uniform group insurance program, to reduce any increase in premium amounts paid monthly by enrolled members, or to provide increased insurance coverage to the members, as the board may determine."

Please let me know if you would like to discuss this further.



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Memorandum

TO: NDPERS Board

FROM: Bryan

DATE: October 19, 2017

SUBJECT: Dental RFP

NDPERS staff and Conduent have begun work on the RFP for the dental plan. We have a working draft and should be on track for the following timeline.

October, 2017	Begin work on dental RFP.
January, 2018	Submit dental RFP to PERS Board for approval. Consultant should be available either by teleconference or video conference to review and answer questions for the Board.
February, 2018	Issue dental RFP.
April, 2018	Receive and begin evaluation of dental RFP's.
May, 2018	Submit dental evaluation to NDPERS Board. The consultant should plan to attend this NDPERS meeting via conference call.
June, 2018	Interview and select dental vendor. The consultant should plan to attend this NDPERS meeting.

If you have any questions or suggestions as we begin this work, we will be available at the NDPERS Board meeting.



Memo

To: NDPERS Board
From: Bryan T. Reinhardt
Date: 10/19/2017
Re: 2017 Sanford Claims Review

Each year we conduct an audit to check the accuracy of the health plan claims processing. Because of all the plan design changes effective July 1st 2017 and the complexity of a mid-year adjustment, we did an extra claims review. On September 1st, I was at the Sanford corporate office in Fargo to review a sample of 50 NDPERS claims. A list of the claim specifications with a focus on the plan design changes is below. Note that this is not a random sample of all claims, but a select sample from specific areas that we wanted to review. Sanford did a good job of having everything ready for me and having staff available to answer my questions and explain the claims payment process.

50 active claims incurred July-August 2017:

Deductible

5 – Hospital claims where member \$400 deductible met before July 1st

Copayments

5 – Non-PPO Basic office visits

5 – PPO office visits

5 – PPO ER

Coinsurance Maximum

5 – Two hospital & three clinic where member \$1,250 Non-PPO Basic met before July 1st

5 – Two hospital & three clinic where member \$750 PPO max met before July 1st

Prescription Drugs

5 – Formulary Generic

5 – Formulary Brand

5 – Nonformulary

5 – Where member \$1,000 RX coinsurance max met before July 1st

The member cost sharing for the institutional and professional audit claims were applied correctly. The Sanford “Epic” system accommodates these types of plan modifications. We did discover an error in the processing of a Formulary Brand copayment for a pharmacy claim. Express Scripts had a double copayment for the drug Stelera. Sanford investigated this with ESI and it appears that this was only happening for this drug. ESI indicated they are fixing the error and Sanford requested a summary of the issue including corrective actions being taken.

We did discuss some ways to ‘standardize’ the NDPERS benefits, such as the out-of-pocket for chiropractic and physical therapy.

If you have any questions, I will be available at the Board meeting.



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Memorandum

TO: NDPERS Board

FROM: Sparb

DATE: October 19, 2018

SUBJECT: Health Care Reform Committee

Attached for your information and reference is a copy of a portion of a presentation I gave to the Health Care Reform Committee and the Legislative Employee Benefits Committee concerning the statutory requirements that PERS must meet in bidding out the health plan. Please note slide 30 and those items with a star after them. I mentioned to the committee that these are statutory requirements that have been the foundation for many of the discussions during the last several sessions and could be areas that they may want to change if they want to provide the board with different direction. These are also areas the board may want to review at another meeting, prior to submitting its legislative bills in March.

Health Care Reform Committee

NDPERS Presentation

Sept 14, 2017

STATUTORY REQUIREMENTS

Program Goal 54-52.1-02

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

Program Goal 54-52.1-02

This is the only goal provided to the board. Other items have been discussed such as plan performance, cost increases, utilization, plan design, etc. May be helpful to add other ideas to the goal to provide guidance to the board

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Program Goal 54-52.1-02

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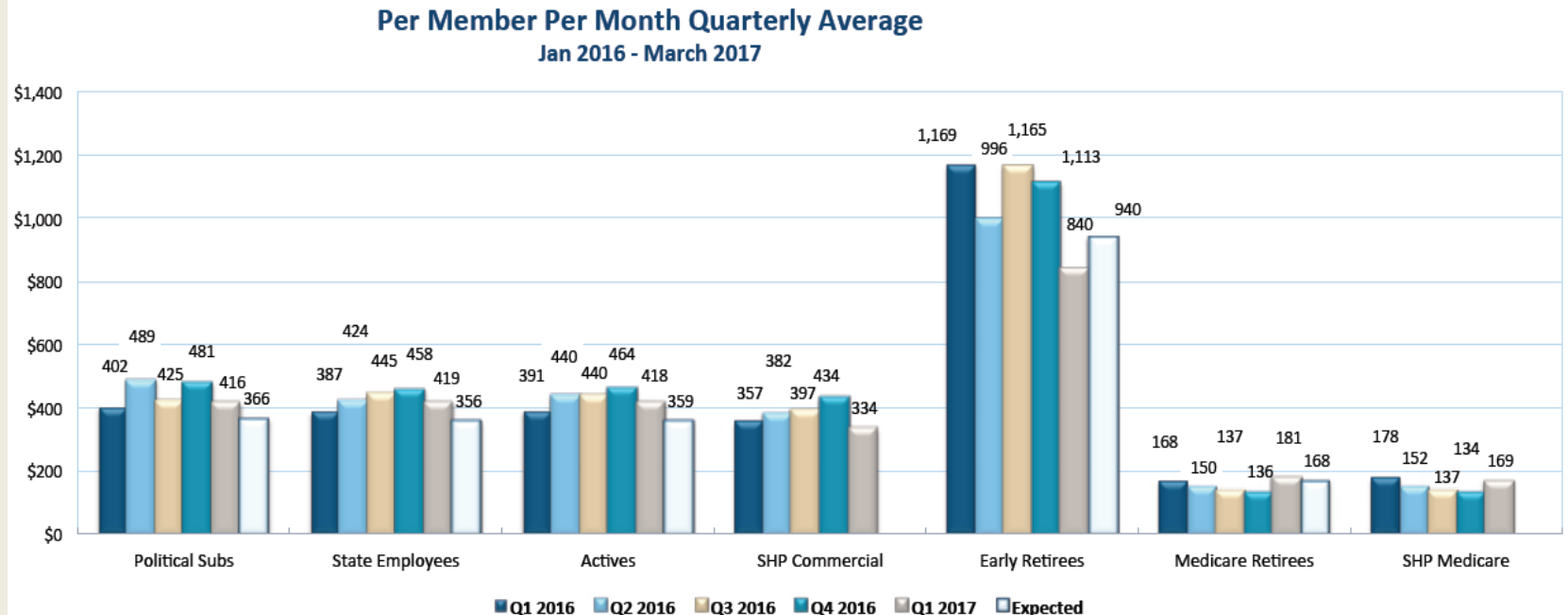
- The average YOS of the current active state employees is 12.12 years (median 9.17 years).
- A nationwide statistic is a median of 4.2 years in 2016 from the bureau of labor statistics

Statutory Requirements - Adm

1. Health Plan Groups & Participation (54-52.1-02) & (54-52.1-03.1)
2. Plans (54-52.1-04.1)&(54-52.1-18)
3. Mandated Benefits (54-52.1-04.4; 04.5; 04.6; 04.10; 04.11 & 04.13;04.14)
4. Bid Process Gen Requirements (54-52.1-04)
5. Board contracting (54-52.1-05)
6. Bid Process Renewals (54-52.1-05)
7. Bid Timeline (54-52.1-04 & 04.2)
8. Decision Criteria (54.52.1-04)
9. Self Insurance Stop Loss Req. (54.52.1-04.2)
10. Self Insurance Decision Criteria (54-52.1-04.2)
11. Contingency Res. for Self Ins (54-52.1-04.3)
12. State Contribution (54-52.1-06)
13. Reserve Direction (54-52-04)
14. Rx Preference (54-52.1-04.15)

1. Participation

- Groups 54-52.1-02 Active, (1) Pre-Medicare (1), Retiree (3)
- Temp Employees (54-52.1-03.4)
- Political Sub Participation (54-52.1-03.1)



2. Plans

- HMO (54-52.1-04.1)
- High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) (54-52.1-18)

3. Statutory Requirements – Mandated Benefits

- Mammograms 54-52.1-04.4;
- Complications of pregnancy 54-52.1-04.5;
- Treatment of certain disorders 54-52.1- 04.6;
- Dental anesthesia and hosp. 54-52.1-04.10;
- Food/Metabolic Diseases 54-52.12-04.11;
- Services related to intoxication 54-52.1-04.13;
- Telemedicine 54-52.1-04.14
- Coverage of cancer treatment medications 54-52.1-04.14

4. Bid Process – General Requirements

Unbundle.
Conflict in
sections.
Consideration
should be
given to
harmonizing
these
provisions

- The board shall receive bids for the providing of hospital benefits coverage, medical benefits coverage**(54-52.1-04 NDCC)**;
- The board may receive bids separately for prescription drug coverage **(54-52.1-04 NDCC)**;
 - Self insurance (can only self Ins)
 - Stop Loss (required to have stop loss 54-52.1-04.2)
- The board shall accept one or more bids of and contract with the carriers that in the judgment of the board best serves the interests of the state and its eligible employees **(54-52.1-04 NDCC)**
- In preparing bid proposals and evaluating bids, the board may utilize the services of consultants on a contract basis in order that the bids received may be uniformly compared and properly evaluated **(54-52.1-04 NDCC)**.
- The board may reject any or all bids and, in the event it does so, shall again solicit bids as provided in this section **(54-52.1-04 NDCC)**.

5. Contracting

- Requirement:
 - State law
 - Coverage must be detailed
 - Options

- Provisions
 - Initial must be 2 yrs
 - Board may renew
 - Only 1 renewal for Self insured (54-52.1-04.2)

These provisions provide specific legislative direction to the board on contracting. If further clarification is needed these sections should be changed

- Each uniform group insurance contract entered by the board must be consistent with the provisions of this chapter, must be signed for the state of North Dakota by the chairman of the board, and must include the following:
 - a. As many optional coverages as deemed feasible and advantageous by the board.
 - b. A detailed statement of benefits offered, including maximum limitations and exclusions, and such other provisions as the board may deem necessary or desirable. **54-52.1-05**
- The initial term or the renewal term of a fully insured uniform group insurance contract for hospital benefits coverage, medical benefits coverage, or prescription drug coverage may not exceed two years.
 - a. The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations and the proposed premium renewal amount does not exceed the board's expectations. **54-52.1-05**
- Upon establishing a self-insurance plan, the board shall solicit bids for an administrative services only or third-party administrator contract only every other biennium, and the board is authorized to renegotiate an existing administrative services only or third-party administrator contract during the interim (54-52.1-04.2 NDCC)

6. Bid Process –Renewals – 54-52.1-05

1. Use the services of a consultant to concurrently and independently prepare a renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.
2. Solicit a renewal from the existing vendor
3. Review the carrier's performance measures, including payment accuracy, claim processing time, member service center metrics, wellness or other special program participation levels, and any other measures the board determines relevant to making the determination and shall consider these measures in determining the board's satisfaction with the carrier's performance.
4. *If the board determines the carrier's performance under the existing contract does not meet the board's expectations or the proposed premium renewal amount exceeds the board's expectations and the board determines to solicit a bid under section 54-52.1-04, the board shall specify its reasons for the determination to solicit a bid.*

Preference Criteria(?): Board discussed that this may be a preference criteria for existing contract. Clarification on this point may be helpful

7. Bid Timeline

Not sure why timelines are different.
Consideration could be given to standardizing these provisions

- Solicitations must be made not later than ninety days before the expiration of an existing uniform group insurance contract (54-52.1-04 NDCC)
- All bids under this section are due no later than January first, and must be awarded no later than March first, preceding the end of each biennium. All bids under this section must be opened at a public meeting of the board. **(For self insurance)** (54-52.1-04.2 NDCC)
- Bids must be solicited by advertisement in a manner selected by the board that will provide reasonable notice to prospective bidders (54-52.1-04 NDCC)

8. Decision Criteria (54-52.1-04 NDCC)

This is the decision criteria guidance provided to the board. If other items should be considered they should be added here

- In determining which bid, if any, will best serve the interests of eligible employees and the state, the board shall give adequate consideration to the following factors:
 - The economy to be effected.
 - The ease of administration.
 - The adequacy of the coverages.
 - The financial position of the carrier, with special emphasis as to its solvency.
 - The reputation of the carrier and any other information that is available tending to show past experience with the carrier in matters of claim settlement, underwriting, and services.

9. Self Ins Stop Loss Req 54-52.1-04.2

Some large plans do not have stop loss, they fund reserves so they do not have to make this payment. If not required this would make self insurance even more competitive but it would require even more “funding discipline”. Consideration could be given to changing this requirement.

- The board may establish a self-insurance plan for providing:
 - Health insurance benefits coverage;
 - Health insurance benefits coverage excluding all or part of prescription drug coverage; or
 - All or part of prescription drug coverage
- In addition, individual stop-loss coverage insured by a carrier authorized to do business in this state must be made part of any self-insured plan.
- Any self-insurance plan under this section must be provided under an administrative services only (ASO) contract or a third-party administrator (TPA) contract under the uniform group insurance program,

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Individual Stop Loss	
Deductible	Estimated Cost (PCPM)
\$500,000	\$28 - \$35
\$750,000	\$15 - \$20
\$1,000,000	\$7 - \$10

Aggregate Stop Loss	
Attachment Point	Estimated Cost (PCPM)
120%	\$0.50 - \$1.00
125%	\$0.40 - \$0.75

10. Self insurance Decision Criteria (54-52.1-04.2 NDC)

Preference Criteria:

Significant direction item to PERS Board. It tells the board **they can only select self insurance if it is lower than fully insured.** If this is no longer the appropriate direction, this could be changed. High threshold

- Any self insurance plan under this sectionmay be established only if it is determined by the board that an administrative services only or third-party administrator plan is less costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits.

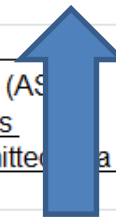
BCBS Insured vs Sanford Insured for 2015-17 Biennium (Summary of Major Bid Components)

	BCBS			Sanford
	Self-Insured			Fully-Insured
	\$1,000,000 Stop Loss	\$750,000 Stop Loss	\$500,000 Stop Loss	Re-Bid
				Bid
<i>Risk/Contingency</i>	\$0	\$0	\$0	\$11,874,600
<i>Reinsurance (Individual Stop Loss Coverage)</i>	\$3,798,258	\$7,698,504	\$14,859,877	\$0
<i>Conversion Charges</i>	\$0	\$0	\$0	\$0
<i>Administration & Wellness</i>	\$23,369,213	\$23,369,213	\$23,369,213	\$23,369,213
<i>PPACA Fees</i>	\$3,061,008	\$3,061,008	\$3,061,008	\$17,489,966
<i>Total Retention/Admin/ACA</i>	\$30,228,479	\$34,128,725	\$41,290,098	\$52,733,779
<i>Claims Projection</i>	\$541,808,232	\$541,808,232	\$541,808,232	
<i>Projected Total Cost</i>	\$572,036,711	\$575,936,957	\$583,098,330	\$601,777,188
<i>Increase From 2013-15 Biennium</i>	14.4%	15.2%	16.7%	20.4%

NDCC decision requirement: "Any self-insurance plan under this section must be provided under an administrative services only (ASO) contract or a third-party administrator (TPA) contract under the uniform group insurance program, and may be established only if it is determined by the board that an administrative services only or third-party administrator plan is less costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits."

2013-15 Total Cost \$499,830,000

Other: PERS did receive a self insured proposal from Sanford but that was eliminated from final consideration due to price



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	BCBS			Sanford	
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	\$1,000,000 Stop Loss	\$750,000 Stop Loss	\$500,000 Stop Loss	Re-Bid	Bid
<i>Risk/Contingency</i>	\$0	\$0	\$0	\$11,874,600	\$6,538,460
<i>Reinsurance (Individual Stop Loss Coverage)</i>	\$3,798,258	\$7,698,504	\$14,859,877	\$0	\$0
<i>Conversion Charges</i>	\$0	\$0	\$0	\$0	\$0
<i>Administration & Wellness</i>	\$23,369,213	\$23,369,213	\$23,369,213	\$23,369,213	\$20,631,583
<i>PPACA Fees</i>	\$3,061,008	\$3,061,008	\$3,061,008	\$17,489,966	\$12,535,392
<i>Total Retention/Admin/ACA</i>	\$30,228,479	\$34,128,725	\$41,290,098	\$52,733,779	\$39,705,435
<i>Claims Projection</i>	\$541,808,232	\$541,808,232	\$541,808,232		
<i>Projected Total Cost</i>	\$572,036,711	\$575,936,957	\$583,098,330	\$601,777,188	\$574,824,615
<i>Increase From 2013-15 Biennium</i>	14.4%	15.2%	16.7%	20.4%	15.0%

NDCC decision requirement: "Any self-insurance plan under this section may be provided under an administrative services only (ASO) contract or a third-party administrator (TPA) contract under the uniform group-term life insurance program and may be established only if it is determined by the board that an administrative services only or third-party administrator plan is not more costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits."

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Other: PERS did receive a self insured proposal from Sanford but that was eliminated from final consideration due to price

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	BCBS			Sanford
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	\$1,000,000 Stop Loss	\$750,000 Stop Loss	\$500,000 Stop Loss	Re-Bid
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Risk/Contingency	\$0	\$0	\$0	\$11,874,600
Reinsurance (Individual Stop Loss Coverage)	\$3,798,258	\$7,698,504	\$14,859,877	\$0
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11. Self insurance Reserve Requirement (54-52.1-04.3 NDCC)

\$26.9M claims per month

- The board shall establish under a self-insurance plan a contingency reserve fund to provide for adverse fluctuations in future charges, claims, costs, or expenses of the uniform group insurance program.
- **The board shall determine the amount necessary to provide a balance in the contingency reserve fund between one and one-half months and three months of claims paid based *on the average monthly claims paid during the twelve-month period immediately preceding March first of each year.***
- The board also shall determine the amount necessary to provide an additional balance in the contingency reserve fund between one month and one and one-half months for claims incurred but not yet reported.
- The board may arrange for the services of an actuarial consultant to assist the board in making these determinations
- Upon the initial changeover from a contract for insurance pursuant to section 54-52.1-04 to a self-insurance plan pursuant to section 54-52.1-04.2, the board must have a plan in place which is reasonably calculated to meet the funding requirements of this chapter within sixty months.

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**This amount would develop in the initial changeover to self insured

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Total Reserves Needed
\$67.3M - \$121.2M**

\$8.6 - \$32.6 PCPM

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** This amount would be reduced by existing reserves and the above amount

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12. State Premium Requirement

This requirement is the deciding factor on what the Plan Design will be for the next biennium since it must match up with the funds approved by the legislature and approved by the Governor.

- **54-52.1-06. State contribution.**

Each department, board, or agency shall pay to the board each month from its funds appropriated for payroll and salary amounts a state contribution in the amount as determined by the primary carrier of the group contract for the full single rate monthly premium for each of its eligible employees enrolled in the uniform group insurance program and the full rate monthly premium, in an amount equal to that contributed under the alternate family contract, including major medical coverage, for hospital and medical benefits coverage for spouses and dependent children of its eligible employees enrolled in the uniform group insurance program pursuant to

13. Reserve Direction 54-52-04 (13)

The board may use any amount credited to the separate uniform group insurance program fund created by section 54-52.1-06 in excess of the costs of administration of the uniform group insurance program to reduce the amount of premium amounts paid monthly by enrolled members of the uniform group insurance program, to reduce any increase in premium amounts paid monthly by enrolled members, or to provide increased insurance coverage to the members, as the board may determine.

14. Rx Preference 54-52.1-04.15

- Preference Criteria

***Prescription drug coverage - Transparency
- Audits - Confidentiality***

Statutory Requirements - Adm

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4. **Bid Process Gen Reg (54-52.1-04)** ★ Rx Unbundle
5. Board contracting (54-52.1-05)
6. **Bid Process Renewals (54-52.1-05)** ★ Preference Criteria
7. Bid Timeline (54-52.1-04 & 04.2)
8. Decision Criteria (54.52.1-04)
9. **Self Insurance stop loss (54.52.1-04.2)** ★
10. **Self Insurance Decision Criteria (54-52.1-04.2)** ★ Preference Criteria
11. Contingency Res. for Self Ins (54-52.1-04.3)
12. **State Contribution (54-52.1-06)** ★ Limits plan design
13. Reserve Direction
14. Rx Preference (52-52.1-04.15)

Other Statutory Requirements - Adm

- Wellness program (54-52.1-14)
- Collaborative Drug Therapy Program (54-52.1-16 & 17)
- Provision of contract (54-52.1-05)
- Appropriation authority (54-52.1-06.1)
- Promulgation of rules (54-52.1-08)
- Data Ownership, confidentiality & disclosure (54-52.1-05.1; 11& 12)
- Acceptance of third party payments (54-52.1-15)
- State Premium tax (54-52.1-10)



**North Dakota
Public Employees Retirement System**
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Bismarck, North Dakota 58502-1657

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Executive Director
(701) 328-3900
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Memorandum

TO: NDPERS Board

FROM: Sparb

DATE: October 19, 2017

SUBJECT: About the Patient Program

Recently we renewed the About the Patient Program for the 2017-19 biennium. As part of the discussion of that renewal several questions were asked. The following is information relating to the two questions.

1. Does state statute require PERS to offer this program?

NDCC states:

54-52.1-17. Uniform group insurance program - Collaborative drug therapy program - Funding.

1. The board shall establish a collaborative drug therapy program that is to be available to individuals in the medical and hospital benefits coverage group. The purpose of the collaborative drug therapy program is to improve the health of individuals with diabetes and to manage health care expenditures.
2. The board shall involve physicians, pharmacists, and certified diabetes educators to coordinate health care for covered individuals with diabetes in order to improve health outcomes and reduce spending on diabetes care. Under the program, pharmacists and certified diabetes educators may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals with diabetes. To encourage enrollment in the plan, the board shall provide incentives to covered individuals who have diabetes which may include waived or reduced copayment for diabetes treatment drugs and supplies.
3. The North Dakota pharmacists association or a specified delegate shall implement a formalized diabetes management program with the approval of the prescriptive

practices committee established in section 43-15-31.4, which must serve to standardize diabetes care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of diabetes care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.

4. The board shall fund the program from any available funds in the uniform group insurance program and if necessary the fund may add up to a two dollar per month charge on the policy premium for medical and hospital benefits coverage. A state agency shall pay any additional premium from the agency's existing appropriation.

This question has been referred to Jan Murtha for an answer. Attachment #1 is her response.

2. Has the effectiveness of this program been reviewed? Is there an estimate of ROI?

Initially, after the program was started, the board had a study completed. Attachment #2 is the study conducted by the Center for Health Promotion and Prevention Research at UND. Attachment #3 is the response from the ND Pharmacy program. On page 16 they address the ROI of the program:

Return on investment calculations. *The DMP clinical coordinator estimated that the total DMP administrative and participant incentive costs for 346 persons as of June 30, 2010 were \$373,405. However, our study analyzed 302 DMP participants with data ending no later than April 30, 2010. It may be that some of the DMP participants represented in this study did not receive incentives in the final quarter in which administrative costs were calculated, therefore we adjusted the incentive costs down from the January-June 2010 six month costs of \$66,668 to a four month total of \$44,445. This resulted in a total DMP cost of \$351,182 for the July 2008-April 2010 22-month period or \$52.86 per month per each of the 302 participants.*

Adding the monthly per participant program costs to any estimated DMP cost savings found in the study to calculate a return-on-investment (ROI) is problematic because our analyses indicated costs changes were not significantly different from baseline costs in either group, nor were differences between the groups significant. This means that these estimated mean costs could not be replicated with any confidence for future DMPs. However, in the spirit of exploration, if we assume that the estimated mean differences were reliable and could be replicated, the analysis would be as follows:

*Total health costs changes from baseline for control group = +\$30 (increase) PPPM
Total health costs changes from baseline for DMP group = -\$94 (decrease) PPPM
Total health costs savings for DMP participants = \$124 PPPM. \$124 PPPM health costs minus \$52.86 monthly program costs = \$71.14 PPPM health costs savings (\$2.34 saved for every \$1 spent for the DMP).*

Thus, for the July 2009-April 2010 22 months period, 302 DMP participants reduced their health costs by an estimated \$21,484 from the previous 12 month period, after subtracting program costs.

Results of the study indicate these savings could not necessarily be replicated at another time or for another sample of participants; therefore extrapolating from these figures to estimate savings in the total NDPERS population of persons with diabetes is not appropriate.

However, to get a full perspective of the study results the report needs to be reviewed in its entirety since other parts of the report temper or qualify this finding.

Other Considerations

At the board planning meeting this summer we discussed this program and if we should again do a study of its effectiveness. In 2009 when we went to bid on the program we received 4 responses. The following are the results of that process as reviewed by the board at that time:

Diabetes Pilot F POINTS	NDSU	Segal	U of M	UND
10 #2	8.5	7.4	8.1	7.5
15 #3	12.4	10.6	11.5	10.6
15 #4	10.1	12.4	10.8	11.0
5 #5	4.3	4.9	4.6	4.3
15 #6	12.1	12.0	12.8	10.6
40 #7	16.8	19.0	27.1	40.0
100	64.2	66.3	74.8	84.0
Price	\$75,428	\$66,640	\$46,890	\$31,728
Hours	2220	97	633	451
Hourly	\$33.98	\$687.01	\$74.08	\$70.35

As you the above shows the cost of the assessment ranged from \$75,000 to \$32,000.

Given the above information staff is seeking your direction on how to proceed. The following are some options:

1. Set time aside at a future meeting to review the attached reports in more detail and then determine how to proceed
2. Move forward with a new RFP to update the attached study with the additional data from the last several years.
3. Take no further action on program evaluation at this point in time.

Board Action Requested

Provide staff direction on how to proceed at this time.

ABOUT THE PATIENT
ATTACHMENT # 1
MEMO FROM JAN MURTHA

Please accept this email in response to the following two questions: must NDPERS utilize the diabetes management program currently offered by the North Dakota Pharmacists Association to fulfill its obligations under NDCC 54-52.1-17; and can NDPERS offer more than one program under NDCC 54-52.1-17.

Subsection 3 of 54-52.1-17 contains the specific reference to collaboration with the NDPA, and states that "The North Dakota pharmacists association or a specified delegate shall implement a formalized diabetes management program with the approval of the prescriptive practices committee established in section 43-15-41.4, which must serve to standardize diabetes care and improve patient outcomes." For your reference NDCC 43-15-41.4 refers to the limited prescriptive practices of pharmacists which is overseen collectively by the Boards of Medicine, Nursing and Pharmacy.

Use of the phrase "or a specified delegate" was somewhat ambiguous because it was unclear upon first reading if the delegate was that of NDPERS or NDPA. NDCC 1-02-39 permits review of the legislative history to aid in the interpretation of an ambiguous statute. 54-52.1-17 and 54-52.1-16 were both passed during the 2007 legislative session, and were so closely discussed that the same legislative history appears for both. While there was substantial discussion regarding these sections, most of the discussion focused on funding as opposed to the specifics of program responsibility. Included in the legislative history however was an email dated 1/22/07 received by a Clara Sue Price containing suggested revisions to the proposed sections which the history reveals were substantially incorporated. One of the suggested revisions added the term "or specified delegate" after the reference to NDPA, and was included because it appears the sponsors were first considering a program offered through the American Pharmacy Association which was proprietary and required a fee and the suggested language was intended to allow for other programs. In addition, though it was not discussed, the initial version of the bill required that NDPERS seek a bid for the program, which was obviously removed. Though minor references, I think a good faith inference can be drawn from this history that the language relating to "or a specified delegate" was added with the intent to give NDPERS the discretion to consider any program. The program must, however, contain collaboration with pharmacists as a component as indicated by the reference to NDCC 43-15-41.4.

In addition, while reference to the program throughout the statute appears in the singular, NDCC 1-01-35 permits words used in the singular to be considered in the plural, unless a contrary intention is obvious. Therefore, it is within the discretion of NDPERS to implement multiple diabetes management programs provided the total cost of such programs do not exceed the specific spending authority/restrictions granted to the Board under subsection 4 of NDCC 54-52.1-17.

Please let me know if you have any questions or would like to discuss this matter further.

Thanks,
Janilyn

Costs Analysis of the North Dakota Diabetes Management Program

Report to the North Dakota Public Employees Retirement System

**Center for Health Promotion & Prevention Research
University of North Dakota School of Medicine & Health Sciences
Grand Forks, ND**

**Dr. Nancy Vogeltanz-Holm, Director
Dr. Jeffrey Holm, Senior Scientist**

November 2010

Table of Contents

Introduction.....	2
Research Design and Methods	3
Results	11
Primary Analyses	11
Secondary Analyses	16
Discussion and Conclusions.....	24

INTRODUCTION

This report summarizes a non-randomized controlled cost evaluation of the North Dakota Diabetes Management Program (DMP). Sponsored by the North Dakota Public Employees Retirement System (NDPERS), the DMP was implemented in July 2008 to provide community pharmacy-based diabetes management services for NDPERS members and their dependents diagnosed with diabetes. In brief, the DMP utilizes a network of certified diabetes educator pharmacists and “other providers” to “complete an assessment, develop a care plan, and provide follow-up services and referrals” for individuals who self-select into the DMP (J. Steig, DMP Clinical Coordinator, 2010).

NDPERS members and dependents who select to participate in the DMP may receive up to 6 free educational care visits with their DMP provider over a 12-month period and an additional two visits during the 13-24 month period. DMP participants also receive waived co-payments for their diabetes and certain other medications and co-insurance on diabetic testing supplies. As of June 30, 2010, DMP clinical coordinator J. Steig reported that 346 DMP participants have completed at least one care visit in over 70 North Dakota provider sites involving over 125 individual providers. For more information about the DMP, please refer to the implementing agency, the North Dakota Pharmacy Service Corporation (in collaboration with the North Dakota Pharmacists Association, the North Dakota Society of Health-System Pharmacists, and the North Dakota State University College of Pharmacy, Nursing, and Allied Sciences).

NDPERS contracted with researchers at the Center for Health Promotion and Prevention Research (CHPPR) at the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) to provide an independent costs evaluation of the DMP. The primary task for CHPPR researchers was to analyze changes in total health claims costs from a baseline period (June 2007-2008) to 22 months after the DMP start date (July 2008-April 2010) for the DMP participants compared to a control group of NDPERS members and dependents who did not participate in the program. Costs of the DMP were added to health costs to determine the average return on investment for the DMP. All claims cost data used in the study originated from North Dakota Blue Cross and Blue Shield (BCBS), made available to the authors by NDPERS. DMP participant data was provided by J. Steig, Frontier Pharmacy Services, Inc., and made available to the authors by NDPERS.

Secondary analyses examined the effects of participant characteristics on changes in costs and glycemic control (hemoglobin A1c levels) for the DMP-only participants. Results of both primary and secondary analyses are interpreted in the context of the current literature on the cost-effectiveness of educational/self-management programs for persons with diabetes.



RESEARCH DESIGN AND METHODS

DMP Eligibility for NDPERS Members and Their Dependents

NDPERS non-retired members and their dependents were eligible for the DMP if they were diagnosed with Type 1 diabetes (T1D) or Type 2 diabetes (T2D), as determined by claims specialists at North Dakota BCBS. Further details of criteria used for diabetes diagnoses may be obtained from BCBS or the DMP Clinical Coordinator.

The number of NDPERS members and their dependents who were identified as eligible for the DMP varied across the study period. Steig (2010) reported 2,871 eligible persons in August 2008; NDPERS provided CHPPR researchers with claims costs data for an eligible sample of 2,707 persons in January 2010. An additional 27 persons were identified in June 2010, resulting in 2,734 persons who were eligible for the DMP and therefore considered for inclusion in the study sample.

DMP Participants and Non-Participant Controls

Prior to the start date, and continuing thereafter, NDPERS notified members and their dependents about the DMP through mailings and mass media promotions. All participants self-selected into the DMP. According to Steig (2010), 346 persons had enrolled into the DMP (had at least one care visit) as of June 30, 2010 (12.7% enrollment rate).

Phase I, non-matched study sample. Eligible persons who enrolled in the DMP (had at least one DMP care visit) before November 15, 2009 and had continuous health claims data for at least six months prior to, and six months after, their enrollment formed the DMP group in the first phase of the study analyses. The control group consisted of all eligible participants who did not enroll in the DMP and who had continuous health claims data for at least six months prior to, and six months after, the July 2008 DMP start date. Based on these criteria, the Phase I total study population included 302 DMP participants and 2,140 non-participant controls ($N=2,442$).

As expected, given the non-randomization of the study groups and the low (12.7%) enrollment rate into the DMP, the Phase I DMP and control groups were significantly unbalanced at baseline (see Table 1). The DMP group, compared to controls, had higher proportions of participants who were women ($p=.07$), older ($p=.10$), and who had T1D ($p<.001$). Mean per person per month (PPPM) baseline costs for total, provider/clinic, and pharmacy sources were significantly higher in the DMP group compared to controls ($p<.01$), but not for hospital costs ($p=.28$).

Phase II, matched study sample. When baseline differences between treatment and control groups on variables known to influence the treatment outcome are substantial, as in this study, adjustment through regression techniques, e.g., use of difference scores or analysis of covariance, generally lead to biased estimates with the true effects

of treatment either under- or over-estimated (Basu, Polsky, & Manning, 2008; Jones, 2008). Under these circumstances, researchers generally consider the use of propensity score matching (PSM) as the most effective method for reducing conditional bias (e.g., Austin, 2009). Essentially, PSM estimates how the observed variables (e.g., baseline costs, diabetes type, etc.) affect the probability of treatment receipt (e.g., enrolling in the DMP), then derives a score based on this estimation and compares observed baseline characteristics between participants and non-participants conditional on this score (Rubin, 2006).

Therefore, to reduce potential bias from the imbalance between the DMP and control groups at baseline, we used baseline costs (provider/clinic, pharmacy, and hospital), diabetes type, gender, and age to conduct PSM to derive a 1:1 matched sample. Our procedure used logistic regression to derive scores and the nearest neighbor technique without replacement (with replacement trial was not as balanced). Balance from this initial PSM trial was improved by further segregating baseline costs predictors into diabetes-related costs and non-diabetes costs. The six cost predictors along with age, gender, and diabetes type resulted in a 1:1 matched sample that was significantly more balanced than the Phase I sample on all covariates (see Table 2 and Figures 1-7). All subsequent analyses testing the effects of DMP participation (hereafter called “treatment”) on changes in costs from baseline were conducted comparing the 302 DMP participants and their 302 matched controls ($N=604$).

Description of Claims Costs Data

All analyses are based on BCBS-designated *paid* health claims costs from provider/clinic (hereafter called “clinic” costs), pharmacy, and hospital sources. All costs were adjusted to 2007 dollars to control for inflationary increases from the beginning of the 2007 baseline period (adjustment factors provided by NDPERS/BCBS). Baseline costs were totaled over the median 12-month period preceding the July 2008 DMP start date (July 2007-June 2008) and were averaged to derive the mean per person per month (PPPM) cost. Post-DMP start costs were totaled over the median 21-month period from the DMP start in July 2008 to the study closing date of April 2010 and were averaged to derive the mean PPPM cost. Although study participants were included with a minimum of six months of baseline and post-start date claims costs data, 91.2% of the sample had at least one year of continuous baseline and one year of continuous post-DMP cost data.

Table 1

Phase I Study Sample: Baseline Comparisons of Diabetes Management Program (DMP) Participants (n=302) and Non-Participant Controls (n=2,140)

	DMP	Controls	P value
Gender			
Women	51.7%	46.1%	p=.07
Men	48.3%	53.9%	
Age			
Mean	54.8	53.7	p<.07
SD	9.7	11.1	p<.001
Median	57	56	p=.39
Diabetes Type			
Type 1	27.8%	15%	p<.001
Type 2	72.2%	85%	
Total PPPM Costs			
Mean	\$745	\$511	p=.002
SD	\$1248	\$1201	p=.03
Median	\$347	\$205	p<.001
Clinic PPPM Costs			
Mean	\$239	\$165	p=.01
SD	\$499	\$331	p<.001
Median	\$94	\$65	p<.001
Pharmacy PPPM Costs			
Mean	\$221	\$119	p<.001
SD	\$280	\$169	p<.001
Median	\$163	\$69	p<.001
Hospital PPPM Costs			
Mean	\$286	\$227	p=.28
SD	\$835	\$895	p=.14
Median	\$8	\$4	p=.01

Notes. SD=standard deviation. PPPM=per person per month, adjusted to 2007 dollars. Differences in DMP and control group means were tested using *Independent Sample t-tests*, differences in medians were tested using the *Medians Test*, and differences in variances (SD) were tested using *Levine's Test for Equality of Variances*. The *Kolmogorov-Smirnov Test of Equality of Distributions* showed significant differences ($p<.05$) between DMP and control group distributions for total, clinic, pharmacy, and hospital costs.

Table 2.

Phase II Propensity Score Matched Sample: Baseline Comparisons of Diabetes Management Program (DMP) Participants (n=302) and Non-Participant Matched Controls (n=302)

	DMP	Controls	P value
Gender			
Women	51.7%	52.6%	p=.81
Men	48.3%	47.4%	
Age			
Mean	54.8	55.6	p=.33
SD	9.7	10.3	p=.08
Median	57	57	p=.17
Diabetes Type			
Type 1	27.8%	28.5%	p=.86
Type 2	72.2%	71.5%	
Total PPPM Costs			
Mean	\$745	\$681	p=.48
SD	\$1248	\$964	p=.40
Median	\$347	\$343	p=.87
Clinic PPPM Costs			
Mean	\$239	\$229	p=.77
SD	\$499	\$313	p=.36
Median	\$94	\$123	p=.03
Pharmacy PPPM Costs			
Mean	\$221	\$213	p=.75
SD	\$280	\$289	p=.51
Median	\$163	\$148	p=.42
Hospital PPPM Costs			
Mean	\$286	\$239	p=.44
SD	\$835	\$604	p=.11
Median	\$8	\$10	p=.87

Notes. SD=standard deviation. PPPM=per person per month, adjusted to 2007 dollars. Differences in DMP and control group means were tested using *Independent Sample t-tests*, differences in medians were tested using the *Medians Test*, and differences in variances (SD) were tested using *Levine's Test for Equality of Variances*. The *Kolmogorov-Smirnov Test of Equality of Distributions* showed no significant differences ($p>.05$) between DMP and control group distributions for total, clinic, pharmacy, and hospital costs.

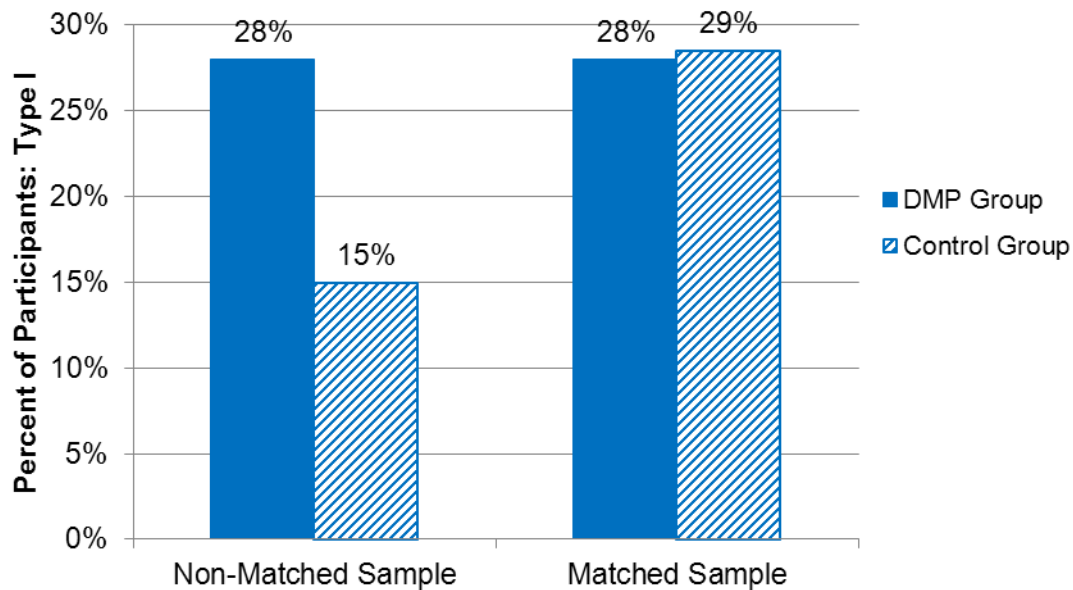


Figure 1. *Percent of Persons with Type 1 Diabetes in Groups for the Phase I Non-Matched (N=2, 442) and Phase II Matched Samples (N=604)*

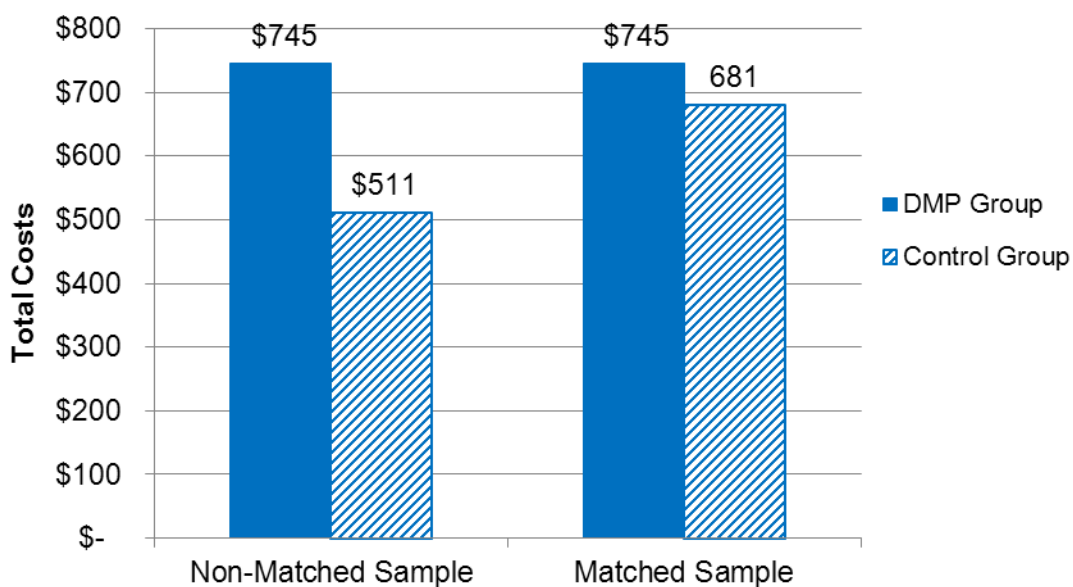


Figure 2. *Total Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)*

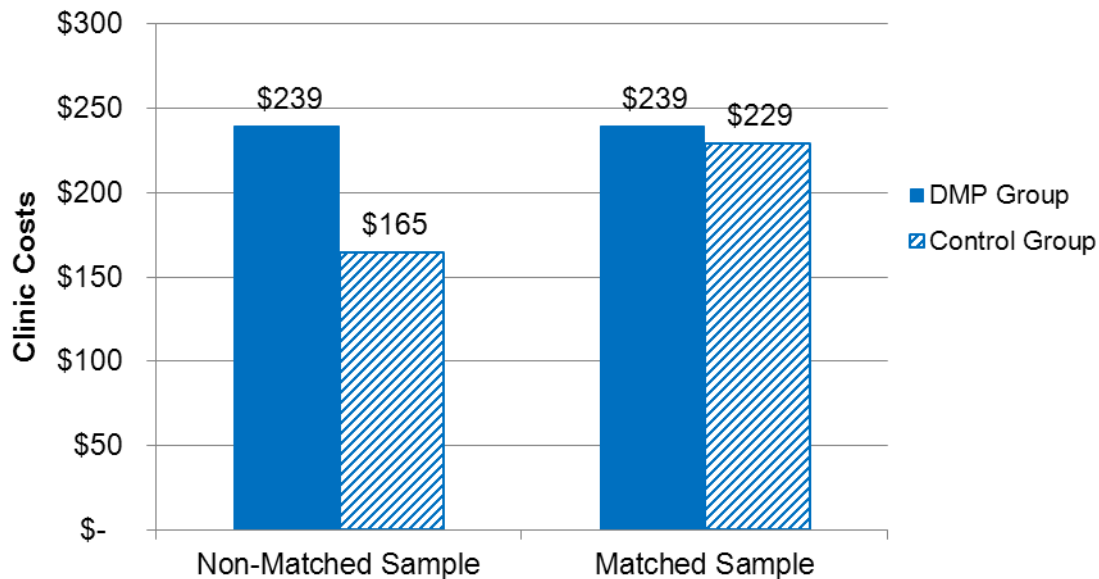


Figure 3. Clinic Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)

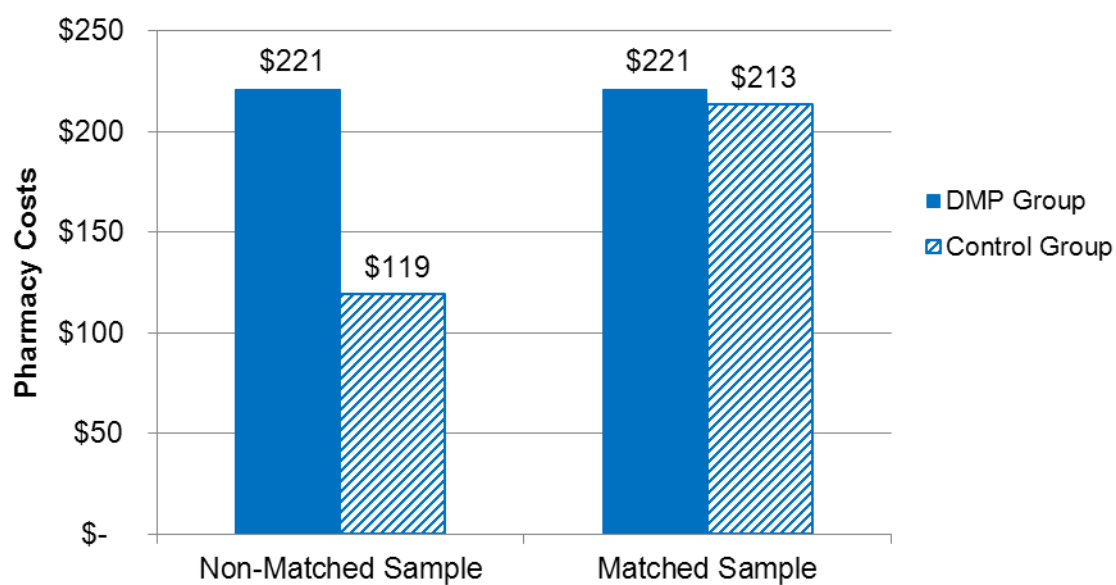


Figure 4. Pharmacy Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)

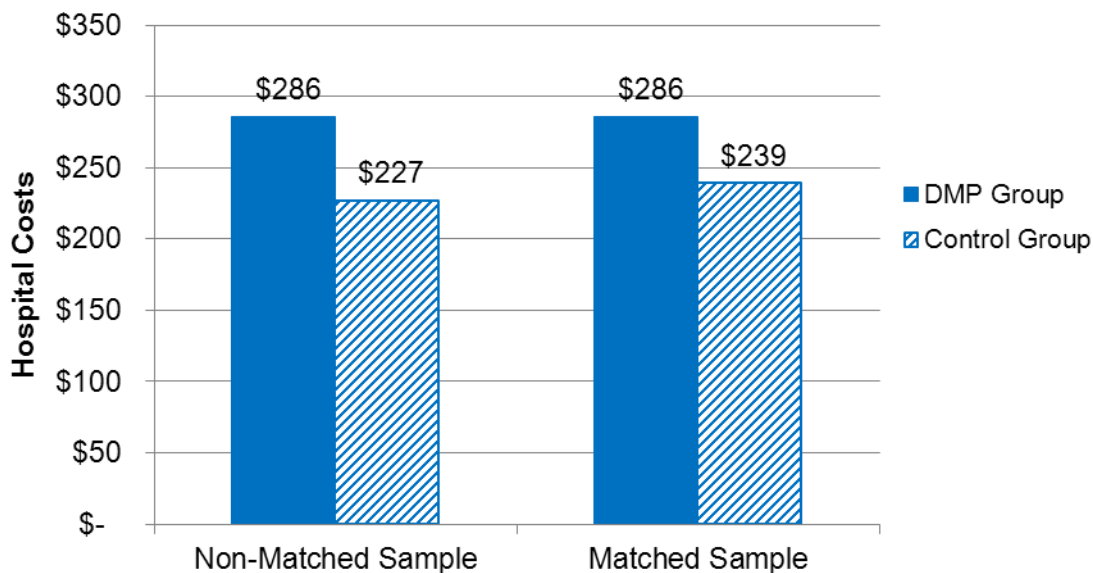


Figure 5. *Hospital Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)*

Statistical Design

Primary analyses: Effects of treatment from pre- to post-DMP on costs. Even though we effectively controlled for unequal baselines on several key predictors by matching, inferential statistical analyses were further complicated by the distribution of the cost data which was, as expected, non-normal (non-linear) and characterized as extremely right-skewed and with numerous zero values in the hospital costs data (39% of the sample). Because linear regression techniques assume normal distributions and are generally not appropriate for use in estimating health costs, we used a sensitivity analysis approach to determine which of two estimation procedures most often used with non-linear cost data would best model the data: log-transforming raw costs to achieve a normal distribution and then using Ordinary Least-Squares (OLS) Regression (with retransformation to actual dollars); or using a non-linear distribution with a log-link within the generalized linear model (GLM) approach. Although modeling cost data with a non-linear distribution appears to more consistently result in less biased estimates and has the advantage of not requiring retransformation, econometricians point out that log-transformed OLS models may be more precise with certain distributions even though bias may still be a concern (Buntin & Zaslavsky, 2004; Manning & Mullahy, 2001).

To account for (i.e., control) the correlation in repeated (pre-post) cost data, we used Generalized Estimating Equations (GEE). GEE has the further advantage of accommodating linear and non-linear data distributions. The non-linear gamma

distribution with a log-link best fit total, clinic, and pharmacy costs data; and we specified the unstructured covariance matrix to account for the within-subjects (pre-post) correlations. The hospital costs data with its numerous zeros was modeled with the non-linear Tweedie distribution with a log-link and an unstructured covariance matrix. The GEE analyses modeling linear distributions with identity-links used log-transformed total, clinic, pharmacy, and hospital costs and specified independent covariance matrices. All models tested the effects of DMP treatment, relative to the control group, on changes across time (baseline to post-DMP) in health claims costs or the *treatment by time interaction effect*. The effects of gender, age, and diabetes type were controlled in all models. Results were that both the linear log-transformed models and the non-linear models were very similar, with no differences between the two approaches on tests of significance for treatment effects. We therefore present the potentially less biased non-linear distribution models which also allow for direct reporting of the mean differences in costs without the need for retransforming logged values into actual dollars. All analyses used SPSS, version 18.0.

Secondary analyses: Effects of DMP variables on DMP participants' costs and clinical outcomes. Secondary GEE analyses within the DMP group ($n=302$), tested the effects of participant characteristics on changes from baseline to post-DMP in (a) health costs (total, clinic, pharmacy, hospital); and (b) A1c levels. The model testing changes in costs used the gamma distribution with a log-link and an unstructured covariance matrix. The model testing changes in A1c levels used the linear distribution with an identity-link and an unstructured covariance matrix. For participants with more than one post-DMP A1c value, we used the last reported level. Predictors used in the costs and A1c models were gender, age, diabetes type, number of DMP participants served by the provider site, number of months with diabetes, number of other medical conditions, and number of completed DMP sessions. Baseline A1c level was also used in the model predicting changes in costs.

We note here that our original analytic plan proposed using linear mixed models (LMM) for analyzing the secondary (DMP only) data. With LMM, we can not only control for the correlations inherent in repeated cost data as in the GEE procedure, but LMM also controls for the correlations that arise from clustered or nested data such as when DMP participants receive treatment from the same pharmacist/provider within the same provider site. The clinical data for the 302 DMP study participants indicated that 64 different provider sites were used with 56% of sites serving fewer than five participants and only six sites serving more than 10 participants (mean number served=4.72 per site, $SD=3.53$). Thus, we could not analyze the effects of sites/providers (clusters) on treatment, and so used the more flexible GEE approach for analyzing the secondary data. As described above, we include a provider site predictor in these models (i.e., number of participants served by the provider site), as one way to examine the influence of providers on participants' changes in costs and A1c levels.

RESULTS

Primary Analyses

Effects of DMP treatment. As shown in Table 3 (tests of significance) and Table 4 (adjusted mean estimates of costs changes), and as illustrated in Figures 6-9, the primary result of the study was that the DMP and control groups did not significantly differ in their total, clinic, pharmacy, or hospital costs changes from baseline to 22 months post-DMP start. Of most importance, the treatment X time interaction was not significant, indicating that the DMP did not significantly improve costs for participants relative to a group of matched non-participants. The non-significant mean differences, however, were in the hypothesized direction: total costs for the DMP group decreased from baseline by \$30 PPM (CI, -\$158 to \$99) and increased in the control group by \$94 (CI, -\$48 to \$246). Most of the non-significant change in total PPM costs was related to a trend towards significance for changes in hospital PPM costs: the DMP group hospital costs decreased \$56 (CI, -\$149 to \$37) while control group hospital costs increased \$57 (CI, -\$40 to \$154). Pharmacy costs significantly increased from baseline for both the DMP and control groups, but at the same rate resulting in no group differences.

There were significant main effects for the control variables (gender, age, and diabetes type) on some of the costs components (see Table 3), indicating that, averaging across both baseline and post-DMP costs, women had significantly higher pharmacy costs than men; older compared to younger persons had higher total, clinic, and hospital costs; and T1D compared to T2D persons had higher costs in all costs categories.

Exploratory subgroup analyses (data not shown) examined the effects of the DMP separately for T1D person and for T2D persons. Although T1D persons who participated in the DMP did have significant total and hospital costs decreases from baseline relative to non-participants, this difference was due to DMP T1D persons having substantially higher baseline costs relative to controls. Once these differences were controlled, there were no group differences.

Various other exploratory analyses examined the effects of DMP on costs changes for (a) the 10% of the sample with the highest baseline costs; (b) the 20% of the sample with highest baseline costs; (c) only those participants who completed six or more DMP sessions; and (d) modeling the data with different distributional assumptions that might have improved the estimation procedures (repeated measures ANOVA, ANCOVA, OLS regression with and without log transformations). All results were similar with no significant DMP treatment effects for any of the costs components. Although power was limited in analyses with smaller sample sizes (10% of highest costs), inspection of means suggested similar levels of changes as a result of treatment.

Table 3.

Wald Chi-Square Tests of Significance from Generalized Estimating Equations (GEE): Effects of DMP Treatment (n=302) Compared to Controls (n=302) on Changes in Mean PPPM Costs from Baseline to Post-DMP

	Total Costs	Clinic Costs	Pharmacy Costs	Hospital Costs
Gender	$X^2(1)=.36$	$X^2(1)=2.52$	$X^2(1)=3.99^{\dagger}$	$X^2(1)=1.29$
Age	$X^2(1)=12.03^*$	$X^2(1)=5.92^{\dagger}$	$X^2(1)=.01$	$X^2(1)=14.38^{**}$
Diabetes Type	$X^2(1)=7.29^*$	$X^2(1)=5.41^{\dagger}$	$X^2(1)=5.66^{\dagger}$	$X^2(1)=3.95^{\dagger}$
Treatment	$X^2(1)=.01$	$X^2(1)=.08$	$X^2(1)=.57$	$X^2(1)=.11$
Time	$X^2(1)=.44$	$X^2(1)=.78$	$X^2(1)=10.95^*$	$X^2(1)=.01$
Treatment X Time	$X^2(1)=1.63$	$X^2(1)=.26$	$X^2(1)=.02$	$X^2(1)=2.89^{\dagger\dagger}$

Notes. PPPM=per person per month. Significant main effects indicate higher average baseline and post-DMP costs in the following directions: women higher than men; T1D higher than T2D; older higher than younger; time 2/post-DMP higher than time 1/baseline.

Treatment X time interaction ($p<.10$) indicates a trend toward lower hospital costs in the DMP treatment group compared to controls.

$^{**}p < .001$. $^*p < .01$. $^{\dagger}p < .05$. $^{\dagger\dagger}p < .10$

Table 4.

GEE Results: DMP and Control Group Mean PPPM Changes in Costs from Baseline to Post-DMP

	Baseline	Post-DMP	Difference [‡]	P Value [Ⓟ]
Total PPPM Costs				
DMP Group	\$776 (\$630, \$922)	\$746 (\$629, \$864)	-\$30 (-\$158, \$99)	<i>p</i> =.193
Control Group	\$725 (\$609, \$840)	\$819 (\$674, \$963)	\$94 (-\$48, \$246)	<i>p</i> =.652
Clinic PPPM Costs				
DMP Group	\$242 (\$189, \$295)	\$249 (\$199, \$299)	\$7 (-\$43, \$57)	<i>p</i> =.772
Control Group	\$241 (\$202, \$280)	\$270 (\$204, \$335)	\$29 (-\$35, \$93)	<i>p</i> =.795
Pharmacy PPPM Costs				
DMP Group	\$231 (\$198, \$264)	\$248 (\$211, \$285)	\$17 (\$5, \$29)	<i>p</i> =.005
Control Group	\$224 (\$191, \$257)	\$242 (\$204, \$280)	\$18 (\$0, \$36)	<i>p</i> =.048
Hospital PPPM Costs				
DMP Group	\$295 (\$194, \$395)	\$239 (\$176, \$301)	-\$56 (-\$149, \$37)	<i>p</i> =.237
Control Group	\$252 (\$183, \$321)	\$309 (\$229, \$389)	\$57 (-\$40, \$154)	<i>p</i> =.251

Notes. PPPM=per person per month. Means are without parentheses, 95% confidence intervals are within parentheses. There were no significant differences between DMP and controls on all baseline costs or on all post-DMP costs.

[‡] Negative dollar amounts indicate decreases in costs from baseline to post-DMP.

[Ⓟ] Pairwise comparisons of estimated marginal means from the Generalized Estimating Equations models that controlled for gender, age, and diabetes type.

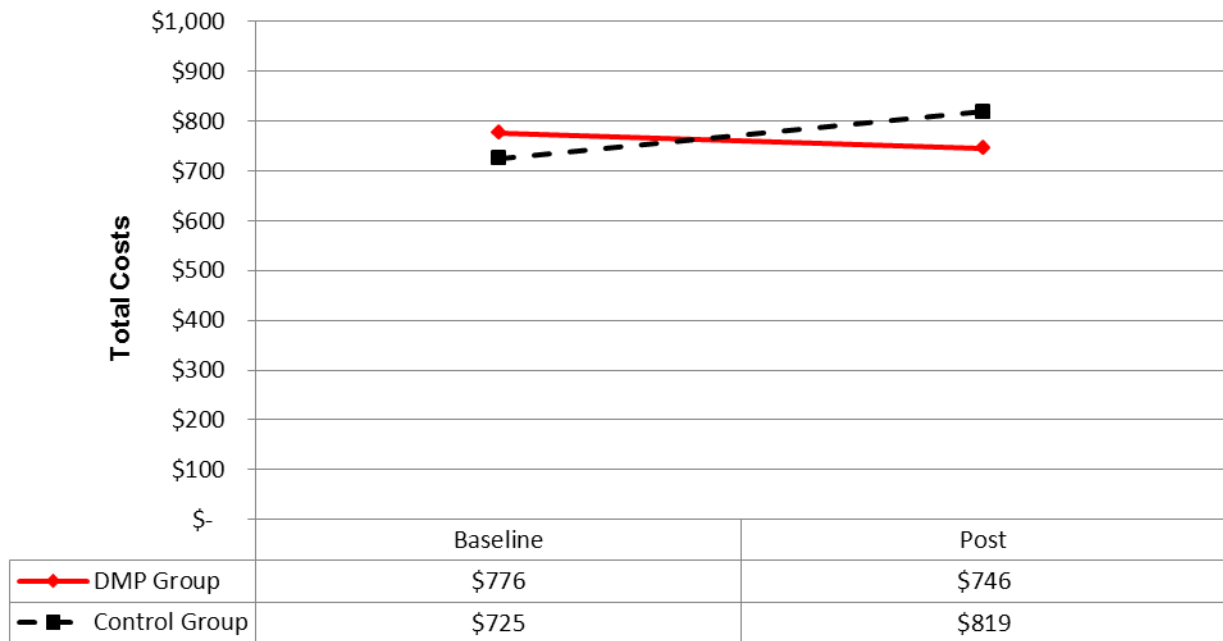


Figure 6. DMP and Control Groups Total PPPM Changes in Costs from Baseline to Post-DMP

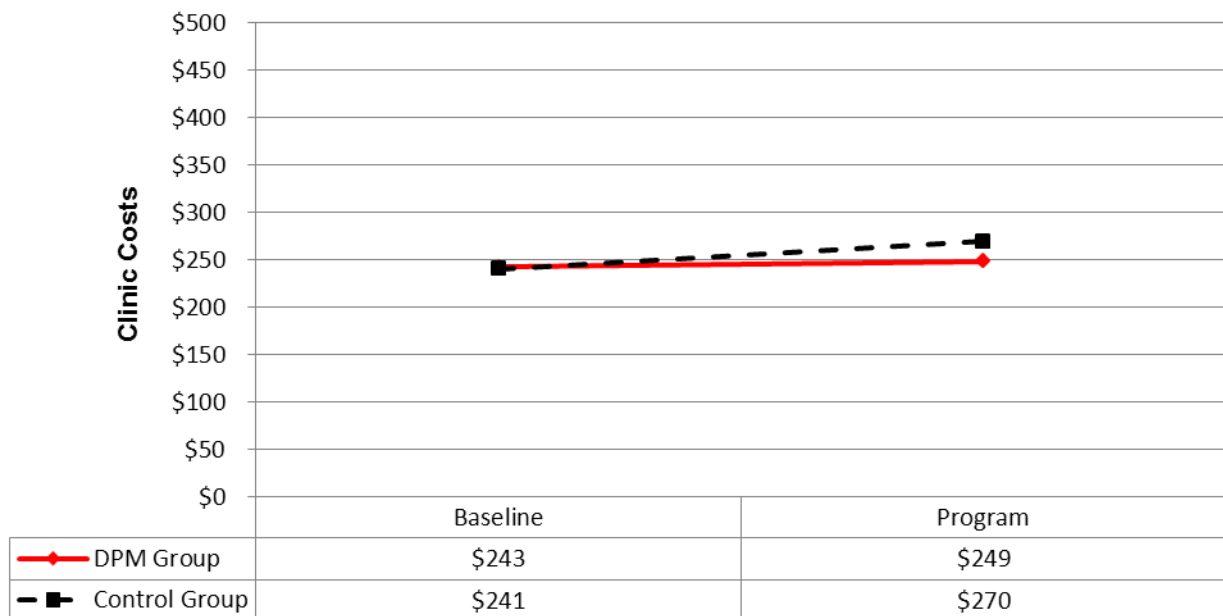


Figure 7. DMP and Control Groups Clinic PPPM Changes in Costs from Baseline to Post-DMP

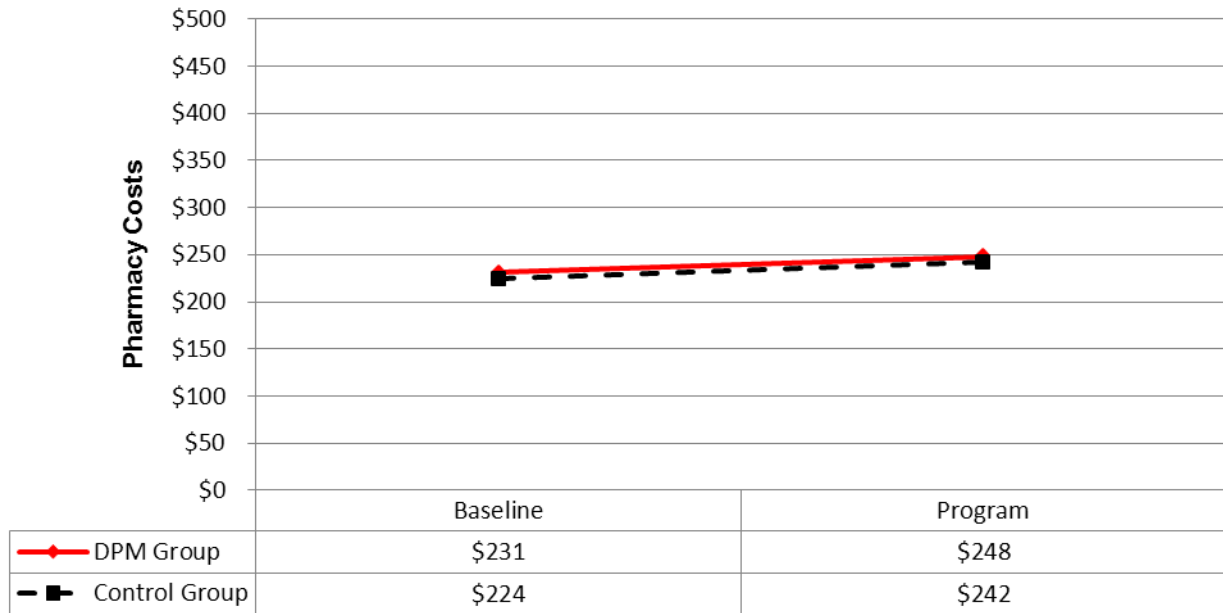


Figure 8. DMP and Control Groups Pharmacy PPPM Changes in Costs from Baseline to Post-DMP

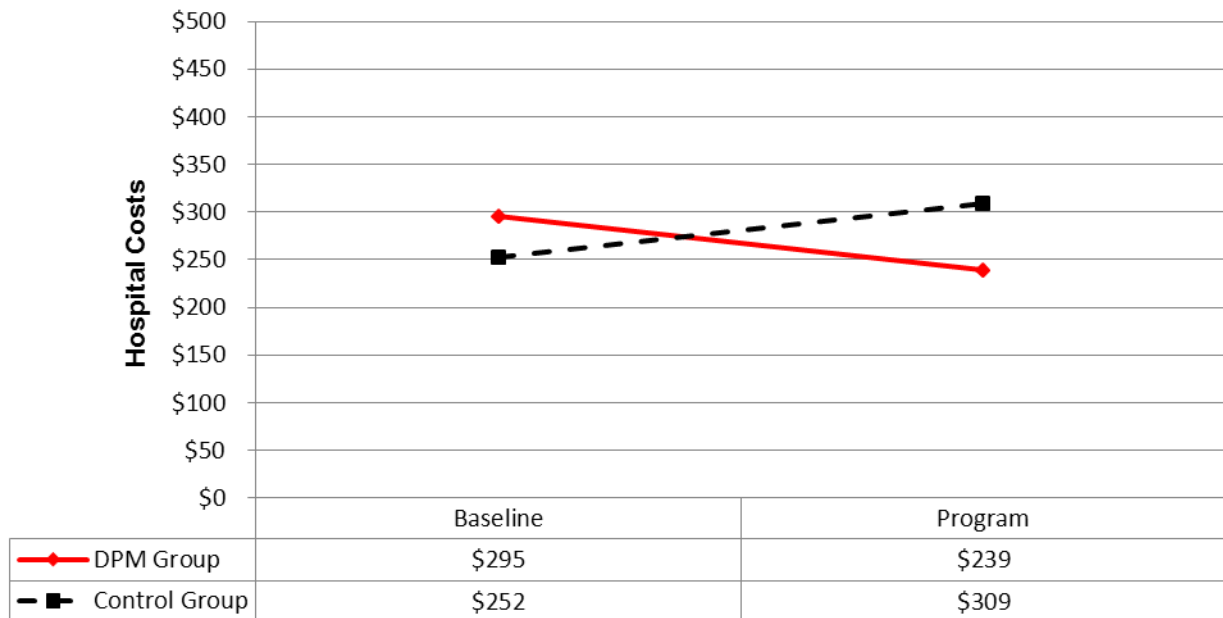


Figure 9. DMP and Control Groups Hospital PPPM Changes in Costs from Baseline to Post-DMP

Return on investment calculations. The DMP clinical coordinator estimated that the total DMP administrative and participant incentive costs for 346 persons as of June 30, 2010 were \$373,405. However, our study analyzed 302 DMP participants with data ending no later than April 30, 2010. It may be that some of the DMP participants represented in this study did not receive incentives in the final quarter in which administrative costs were calculated, therefore we adjusted the incentive costs down from the January-June 2010 six month costs of \$66,668 to a four month total of \$44,445. This resulted in a total DMP cost of \$351,182 for the July 2008-April 2010 22-month period or \$52.86 per month per each of the 302 participants.

Adding the monthly per participant program costs to any estimated DMP cost savings found in the study to calculate a return-on-investment (ROI) is problematic because our analyses indicated costs changes were not significantly different from baseline costs in either group, nor were differences between the groups significant. This means that these estimated mean costs could not be replicated with any confidence for future DMPs. However, in the spirit of exploration, if we assume that the estimated mean differences were reliable and could be replicated, the analysis would be as follows:

Total health costs changes from baseline for control group = +\$30 (increase) PPPM
Total health costs changes from baseline for DMP group = -\$94 (decrease) PPPM
Total health costs *savings* for DMP participants = \$124 PPPM

\$124 PPPM health costs minus \$52.86 monthly program costs = \$71.14 PPPM health costs savings (\$2.34 saved for every \$1 spent for the DMP).

Thus, for the July 2009-April 2010 22 months period, 302 DMP participants reduced their health costs by an estimated \$21,484 from the previous 12 month period, after subtracting program costs.

Results of the study indicate these savings could not necessarily be replicated at another time or for another sample of participants; therefore extrapolating from these figures to estimate savings in the total NDPERS population of persons with diabetes is not appropriate.

Secondary Analyses

As shown in Table 5, 90% of DMP participants reported having 3 or more other medical conditions with 49% reporting 6 or more other medical conditions. The majority of participants (77%) had diabetes for 2 or more years at baseline with 54% reporting having diabetes for five or more years. Almost one-half (48%) had baseline A1c levels of 7.0 or higher (mean baseline A1c of 7.2). The median number of sessions completed was six, with 76% of the participants completing five or more sessions. Sixty-seven percent of participants used provider/pharmacist sites that served five or more DMP participants during the 22 month study period. Table 6 shows dichotomized values for participant characteristics used in GEE analyses.

Table 5.

Baseline DMP and Clinical Characteristics of DMP Participants

	Number of DMP Participants	Percent	Mean (SD)
Provider Site, No. of Participants Served			
Provider site for 1-2 participants	30	10%	
Provider site for 3-4 participants	51	17%	
Provider site for 5-6 participants	56	19%	
Provider site for 7-8 participants	72	24%	
Provider site for 9-10 participants	18	6%	
Provider site for 11-12 participants	44	15%	
Provider site for 13-14 participants	13	4%	
Provider site for 15-16 participants	0	0%	
Provider site for 17-18 participants	18	6%	
Number of Completed DMP Sessions			5.47 (1.63)
1 session	6	2%	
2 sessions	20	7%	
3 sessions	16	5%	
4 sessions	31	10%	
5 sessions	37	12%	
6 sessions	101	33%	
7 sessions	86	29%	
8 sessions	5	2%	
Baseline A1c Levels			7.22 (1.30)
4.4% to 6.5%	59	25%	
6.5% to 6.9%	62	27%	
7.0% to 12.9%	112	48%	
Months with Diabetes			
< 12 months	22	9%	
12 to 23 months	34	14%	
24 to 59 months	55	23%	
60 to 119 months	56	23%	
120 or more months	75	31%	
Number of Other Medical Conditions			5.93 (3.09)
0 to 2 other conditions	36	12%	
3 to 5 other conditions	123	41%	
6 to 8 other conditions	80	27%	
9 to 10 other conditions	33	11%	
11 to 15 other conditions	30	11%	

All clinical data provided by J. Steig, DMP Clinical Coordinator.

Table 6.

Baseline DMP and Clinical Characteristics of DMP Participants, Dichotomized for GEE Analyses

	Number of DMP Participants	Percent
Provider Site, No. of Participants Served		
Provider site for 1-6 participants	137	45%
Provider site for 7-18 participants	165	55%
Number of Completed DMP Sessions		
1 to 5 sessions	110	36%
6 to 8 sessions	192	64%
Baseline A1c Levels		
4.4% to 6.9%	121	52%
7.0% to 12.9%	112	48%
Months with Diabetes		
< 60 months	111	46%
≥ 60 months	131	54%
Number of Other Medical Conditions		
0 to 5 other conditions	159	53%
6 to 15 other conditions	143	47%

Notes. Number of completed sessions was dichotomized at less than full treatment vs. full treatment plus boosters. Baseline A1c was dichotomized at a clinically relevant value for acceptable glycemic control (ADA, 2002). Provider site, number served, and number of other medical conditions were dichotomized at median values.

Effects of participants' characteristics on changes in costs. GEE analyses were used to test the effects of DMP participants' characteristics on changes in costs from baseline to post-DMP (see Table 7). Results were that participants with baseline $\geq 7.0\%$ A1c levels had significantly increased pharmacy costs from baseline to post-DMP compared to participants with baseline $< 7.0\%$ A1c levels, controlling for all other variables in the model. Additionally, participants that used DMP provider sites that served < 7 participants had significantly higher total and clinic costs from baseline to post-DMP than participants using DMP provider sites that served ≥ 7 participants. However, supplemental analyses controlling for baseline differences, found that changes from baseline to post-DMP for both total and clinic costs were not significantly different between those participants using provider sites serving < 7 and those serving ≥ 7 participants (see Table 8).

Effects of participants' characteristics on changes in A1c levels. Table 9 shows results from GEE analyses testing the effects of DMP participants' characteristics on changes in A1c levels from baseline to post-DMP. Analyses included only participants with at least two A1c measures, using the last measure as the post-DMP value ($n=233$). There were significant main effects of age, months with diabetes, and time, indicating that overall A1c levels were higher in older persons, those with diabetes ≥ 60 months, and at baseline. As shown in Figure 10, the significant adjusted mean decrease in A1c levels from the baseline of 7.28% to post-DMP of 6.97% was 0.31%. There was also a significant time by number of months with diabetes interaction, indicating that participants with diabetes for < 60 months had significantly greater decreases in A1c levels from baseline compared to participants with diabetes for ≥ 60 months (see Table 10).

We calculated that 7.3% of DMP participants reduced their baseline A1c levels by 1% or more; however, 15.9% had increases of 1% or more from baseline. At baseline, 51.9% of DMP participants had A1c levels below the clinically relevant level of 7.0%, and at post-DMP, 57.1% had A1c levels below 7.0%. The difference between these two proportions (-5.2%) was not significant ($Z=-1.589$, $p=.1122$).

Table 7.

Wald Chi-Square Tests of Significance from Generalized Estimating Equations (GEE): Effects of Baseline DMP Participant Characteristics on DMP Participants' Changes in Mean PPPM Costs from Baseline to Post-DMP (n=302)

	Total Costs	Clinic Costs	Pharmacy Costs	Hospital Costs
Gender	$\chi^2(1)=.04$	$\chi^2(1)=4.85^{\dagger}$	$\chi^2(1)=5.94^{\dagger}$	$\chi^2(1)=.38$
Age	$\chi^2(1)=.01$	$\chi^2(1)=.36$	$\chi^2(1)=10.20^*$	$\chi^2(1)=2.44$
Diabetes Type	$\chi^2(1)=10.38^*$	$\chi^2(1)=7.89^*$	$\chi^2(1)=2.25$	$\chi^2(1)=8.87^*$
No. of Other Conditions	$\chi^2(1)=21.76^{**}$	$\chi^2(1)=19.23^{**}$	$\chi^2(1)=14.91^{**}$	$\chi^2(1)=6.96^*$
Months with Diabetes	$\chi^2(1)=.08$	$\chi^2(1)=.11$	$\chi^2(1)=1.44$	$\chi^2(1)=.38$
Baseline A1c Levels	$\chi^2(1)=5.24^{\dagger}$	$\chi^2(1)=2.28$	$\chi^2(1)=.16$	$\chi^2(1)=5.80^{\dagger}$
No. of DMP Sessions	$\chi^2(1)=.86$	$\chi^2(1)=1.33$	$\chi^2(1)=.98$	$\chi^2(1)=.92$
Provider Site, No. Served	$\chi^2(1)=2.59$	$\chi^2(1)=1.21$	$\chi^2(1)=.25$	$\chi^2(1)=6.68^{\dagger}$
Time	$\chi^2(1)=.64$	$\chi^2(1)=3.33^{\dagger\dagger}$	$\chi^2(1)=1.37$	$\chi^2(1)=.04$
Diabetes Type X Time	$\chi^2(1)=.21$	$\chi^2(1)=.45$	$\chi^2(1)=.17$	$\chi^2(1)=.21$
Other Conditions X Time	$\chi^2(1)=.40$	$\chi^2(1)=1.27$	$\chi^2(1)=.03$	$\chi^2(1)=.07$
Months of Diabetes X Time	$\chi^2(1)=.02$	$\chi^2(1)=.16$	$\chi^2(1)=2.21$	$\chi^2(1)=.01$
A1c Levels X Time	$\chi^2(1)=.01$	$\chi^2(1)=.09$	$\chi^2(1)=5.45^{\dagger}$	$\chi^2(1)=.40$
No. DMP Sessions X Time	$\chi^2(1)=.10$	$\chi^2(1)=.01$	$\chi^2(1)=.53$	$\chi^2(1)=.13$
Site, No. Served X Time	$\chi^2(1)=4.59^{\dagger}$	$\chi^2(1)=4.32^{\dagger}$	$\chi^2(1)=1.46$	$\chi^2(1)=2.42$

Notes. Significant main effects indicate higher average baseline and post-DMP costs in the following directions: women higher than men; older persons higher than younger; time 2/post-DMP costs higher than time 1/baseline; T1D higher than T2D; ≥ 6 other medical conditions higher than < 6 ; ≥ 7.0 A1c level higher than < 7.0 ; ≥ 7 participants served at site higher than < 7 .

Significant A1c X time interaction indicates that participants with A1c levels ≥ 7.0 had significant increases in pharmacy costs from baseline compared to participants with A1c < 7.0 .

Significant provider site, number served X time interaction indicates that participants from sites that served < 7 participants had significant increases in total and clinic costs from baseline compared to participants from sites serving ≥ 7 participants.

** $p < .001$. * $p < .01$. $^{\dagger} p < .05$. $^{\dagger\dagger} p < .10$

Table 8.

GEE Results: Significant Effects of Number of Participants Served at Site and Baseline A1c on Changes in PPM Total and Pharmacy Costs from Baseline to Post-DMP

	Baseline	Post-DMP	Difference [‡]	P Value [Ⓟ]
Site, No. Participants Served				
Total Costs				
1 to 6	\$568 (\$439, \$696)	\$731 (\$562, \$900)	\$163 (-\$13, \$314)	<i>p</i> =.034
7 to 18	\$836* (\$575, \$1096)	\$766 (\$511, \$1021)	-\$69 (-\$295, \$156)	<i>p</i> =.547
Site, No. Participants Served				
Clinic Costs				
1 to 6	\$172 (128, \$216)	\$246 (\$174, \$319)	\$74 (-\$13, \$135)	<i>p</i> =.017
7 to 18	\$244* (\$165, \$322)	\$250 (\$144, \$355)	\$6 (-\$57, \$69)	<i>p</i> =.852
Baseline A1c Levels				
Pharmacy Costs				
4.4% to 6.9%	\$214 (\$163, \$264)	\$211 (\$159, \$264)	-\$3 (-\$24, \$19)	<i>p</i> =.822
7.0% to 12.9%	\$211 (\$165, \$256)	\$237 (\$192, \$283)	\$26 (-\$2, \$52)	<i>p</i> =.031

Notes. PPM=per person per month. Means are without parentheses, 95% confidence intervals are within parentheses.

* Participants from sites serving ≥ 7 participants had significantly higher baseline total and clinic costs compared to those from sites serving < 7 . After controlling for this baseline difference, the finding of increased total and clinic costs for participants using sites serving fewer participants compared to larger numbers of participants was no longer significant.

[‡] Negative dollar amounts indicate decreases in costs from baseline to post-DMP.

[Ⓟ] Pairwise comparisons of estimated marginal means from the Generalized Estimating Equations models that controlled for several predictors (main effects and time X predictor interaction effects), see table 7.

Table 9.

Wald Chi-Square Tests of Significance from Generalized Estimating Equations (GEE): Effects of Baseline DMP Participant Characteristics on DMP Participants' Changes in Mean A1c Levels from Baseline to Post-DMP (n=233)

	A1c Levels
Gender	$X^2(1)=1.75$
Age	$X^2(1)=4.86^{\dagger}$
Diabetes Type	$X^2(1)=.54$
No. Other Conditions	$X^2(1)=1.33$
Months with Diabetes	$X^2(1)=8.27^*$
No. of DMP Sessions	$X^2(1)=.02$
Provider Site, No. Served	$X^2(1)=.78$
Time	$X^2(1)=12.33^{**}$
Diabetes Type X Time	$X^2(1)=.37$
Other Conditions X Time	$X^2(1)=.59$
Months of Diabetes X Time	$X^2(1)=4.29^{\dagger}$
No. DMP Sessions X Time	$X^2(1)=.58$
Site, No. Served X Time	$X^2(1)=.17$

Notes. Significant main effects indicate higher average baseline and post-DMP A1c levels in the following directions: older participants' levels higher than younger participants; time 1/baseline levels higher than time 2/post-DMP; ≥ 60 months with diabetes levels higher than < 60 months.

Significant months of diabetes X time interaction indicates that DMP participants with diabetes for < 60 months had significant decreases in A1c levels from baseline compared to those with diabetes ≥ 60 months.

** $p < .001$. * $p < .01$. $\dagger p < .05$.

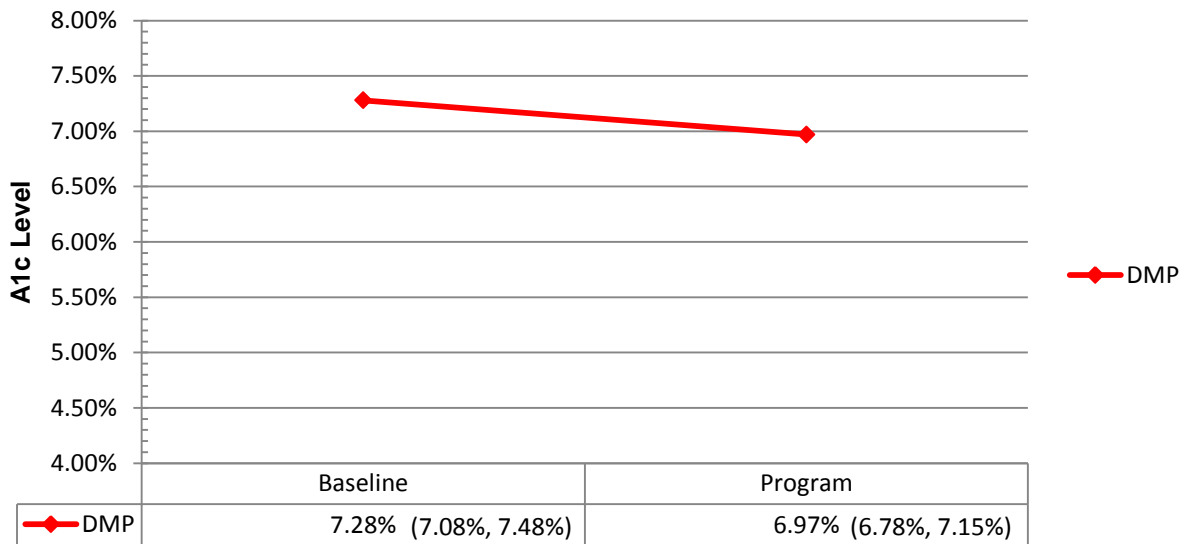


Figure 10. Mean Change in A1c Levels from Baseline to Post-DMP for DMP Participants
 Notes. 95% confidence intervals are in parentheses. The model controlled for the effects of gender, age, diabetes type, and five DMP participation predictors.

Table 10.

GEE Results: Significant Effect of Number of Months with Diabetes on Changes in A1c Levels from Baseline to Post-DMP

	Baseline	Post-DMP	Difference [‡]	P Value ^Φ
Months with Diabetes				
A1c Levels				
< 60 months	7.15%	6.67%	-.48%	<i>p</i> =.001
	(6.85%, 7.45%)	(6.43%, 6.90%)	(-.75%, .21%)	
≥ 60 months	7.41%	7.27%*	-.14%	<i>p</i> =.149
	(7.17%, 7.66%)	(7.03%, 7.51%)	(-.34%, .05%)	

Notes. Means are without parentheses, 95% confidence intervals are within parentheses.

*Post-DMP A1c levels were significantly higher in those with diabetes ≥ 60 months compared to those with diabetes < 60 months.

[‡] Negative values indicate a decrease in A1C level.

^Φ Pairwise comparisons of estimated marginal means from the Generalized Estimating Equations models that controlled for several predictors (main effects and time X predictor interaction effects, see table 9).

DISCUSSION AND CONCLUSIONS

The results of this study provide a controlled evaluation of the effects of a 22-month, pharmacy-based, diabetes management program (DMP) on changes in health claims costs. To our knowledge, this is the first study using a matched control group to evaluate a DMP based on the Asheville (North Carolina) project model. As in the Asheville model, the North Dakota DMP employed community pharmacists trained as diabetes educators to deliver free diabetes care sessions and provided incentives (waived copayments for medications and supplies) for participation. Unlike the Asheville model, the North Dakota DMP was not implemented through employer sites, but was promoted statewide through mailings and mass media to all NDPERS members and their dependents with diabetes. For further information about the North Dakota DMP and how it differed from the Asheville project, see Steig (2010).

The results of the analyses show that changes in costs from baseline to post-DMP did not differ for DMP participants and their matched controls. As discussed below, several factors influenced these results including selection bias, variability of individuals' health costs, and DMP treatment effectiveness relative to treatment as usual. We conclude our discussion by using results from the DMP participants-only analyses to explore the DMP's potential clinical and cost effectiveness value for future participants.

Selection Bias

The selection or enrollment rate into the DMP by eligible NDPERS members and dependents was very low—approximately 12.5% using estimates from Steig (2010) or about 350 persons enrolled from an eligible population of about 2800 persons. Selection *bias* occurs when individuals that share some characteristic are more likely to select treatment and therefore comparison with non-participants is unbalanced and leads to biased estimates of treatment effectiveness. Selection bias is increased when only a small percent of the population choose treatment, as was the case in the DMP. DMP participants and non-participants significantly varied at baseline on the primary analysis variable—health care costs. Compounding this problem was that DMP participants were more likely to have Type 1 diabetes—which also was related to having higher baseline costs and potentially leads to a differential response to treatment compared to persons with Type 2 diabetes.

Fortunately, through propensity score matching, we were able to derive a matched sample that was comparable to the DMP participants on all measured variables (baseline costs, diabetes type, gender, and age), thus reducing bias and confounding in the analytic models. It is possible that participants and non-participants might have shown significant differences on various unmeasured factors such as education, income, social support, and measures of health and functioning, and the match might have been improved if we could have included some of these factors as well as some of the clinical data that were obtained for DMP participants (e.g., A1c level and months with diabetes) but were not available for control participants. However, given that the

matched sample was comparable to the DMP participants on all measured variables and that we did not find any significant treatment effects/group differences, concerns about the effects of unmeasured variables are reduced.

The Effects of High Variability in Non-Linear Health Costs Data

Our analytic strategy for detecting group differences in changes in costs used state of the art prediction modeling methods appropriate for health data which are typically skewed (non-normal) in their distributions. As expected, the median health costs were much lower than mean costs, reflecting the very high costs for a few individuals which distort mean estimates and necessitates using non-linear statistical techniques. Our analyses also used an analytic technique that controlled for the correlations inherent in outcome measures (costs) that are repeated over multiple time periods. Finally, we conducted sensitivity analyses (alternative models) to determine if our results held under different assumptions, e.g., within a linear distribution and for the Type 1 vs. Type 2 diabetes groups modeled separately. All alternative and exploratory examinations resulted in similar results; thus, we can be highly confident about our conclusions.

Although the findings do point in the hypothesized direction of the DMP participants decreasing costs relative to non-participants, the observed group differences are not at a level that could be replicated with another sample with confidence. However tempting it may be to say that the non-significant estimated savings of \$124 per person per month (PPPM) in total costs for the DMP group compared to the control group is indeed meaningful, this is not a scientifically justified conclusion. To easily illustrate this, inspection of the confidence intervals around the estimates of costs show that the “true” difference between DMP participants and matched controls lies between the best case estimate of DMP participants saving \$404 PPPM more than non-participants to the worst case in which DMP participants could actually cost \$147 PPPM more than non-participants. Put another way, when large differences in group means are due to only a few individuals, as inherent in health cost data, this high variation makes it difficult to assert that the differences are not due to chance alone.

Factors Influencing Treatment Effectiveness on Costs and Clinical Outcomes

Treatment intensity. The next important question for discussion then is “why was treatment not effective in reducing costs?” Of course we cannot answer this question with certainty, but we offer a few possible explanations. DMP participants, relative to all eligible persons with diabetes, were older, had higher baseline costs, and had a higher percentage of persons with Type 1 diabetes. It seems likely that the incentives established to encourage participation in the DMP (co-payment waivers) were more attractive to those with higher costs and other complicating medical factors, and may have inadvertently led to this self-selection bias. To examine treatment effects it was necessary to equalize the groups by matching the DMP participants with controls who were similar in gender, age, type of diabetes, and baseline costs. Therefore, the resulting sample for analyses contained persons who clearly have had significant contact with health providers as demonstrated by their high provider/clinic, pharmacy,

and hospital costs. Although we don't know if DMP participants and controls were equal in their baseline clinical characteristics (e.g., number of other conditions, length of diabetes diagnosis, A1c levels), we can assume a relatively equal clinical profile given the equal costs profile. It may be that a brief (six to eight sessions) diabetes education intervention delivered at the participants' community pharmacy may not have been of sufficient intensity to (a) affect costs changes when costs are high and potentially related to many different health conditions; and/or (b) affect costs changes significantly more than a comparison group which are potentially receiving equally high levels of contact with and services from their usual medical providers. Perhaps if both participants and controls had been composed of more persons who were younger, healthier, and with lower baseline costs, i.e., were more like the general population of adults with diabetes, treatment may have had a more significant effect on participants' present and even future health costs relative to controls who may not be receiving regular medical care for their not yet complicated diabetes. This hypothesis is supported by the finding that DMP participants who had diabetes for less than five years showed greater decreases in A1c levels than those having diabetes for a longer time.

Treatment fidelity and adherence. Another influence on treatment is the degree to which providers reliably and effectively deliver the DMP treatment (fidelity). We did not have information for this analysis about the fidelity in which the treatment was delivered by pharmacists, how pharmacists altered their management for persons with Type 1 vs. Type 2 diabetes, or about participants' adherence to recommendations. However, our confidence in fidelity is increased because all pharmacists/providers received similar training and were certified as diabetes educators. If possible, DMP coordinators should further analyze the effects of DMP providers on participants' costs.

Long-term complications and costs. Despite the importance of all the above considerations, the lack of treatment effects in diabetes management programs is often attributed to the fact that disease complications occur over time and the economic benefits of preventing such complications cannot adequately be assessed without study periods of at least five years. Although it is outside the scope of this report to fully review the literature on this issue related to the cost effectiveness of diabetes educational/self-management interventions, we briefly consider how our study results fit within the current knowledge base.

Previous studies of cost-effectiveness of diabetes interventions. There have been very few well-designed studies examining economic outcomes of educational/self-management interventions for diabetes. Recent reviews (Boren et al., 2009; Urbanski et al., 2008) suggest that self-management for Type 2 diabetes may be cost-effective, but most studies were short-term and did not include enough data to allow for critical review of outcomes. For example, the primary study of the Asheville project, on which the current DMP is based (Cranor et al., 2003), indicated that pharmacy-based diabetes education interventions decreased total costs from baseline in every year of the five-year study. However, methodological problems including lack of a control group, lack of adjustment for drop-outs, small sample size, biased estimation procedures, and lack of effects in the multivariate logistic regressions limit confidence in the reported outcomes.

Although there are no well-designed, long-term studies examining the cost-effectiveness of diabetes self-management programs, one recent short-term study by Brownson et al. (2009) estimated lifetime benefits of their self-management program. The study involved results from the Robert Wood Johnson (RWJ) Diabetes Initiative in which adults with Type 2 diabetes received self-management interventions in primary care settings. Results were mean 0.5% decreases in A1c levels, 10% decreases in cholesterol, and \$866 annual per person program costs. The simulation model used (CDC, 2002) assumed the improvements in health and costs would be maintained in the long-term and also estimated changes in quality-adjusted life years (QALYs). The diabetes self-management program was estimated to save approximately \$3400 per person in lifetime treatment and complication costs, but the estimated per person lifetime costs of \$15,000 for the program far exceeded savings. The authors concluded, however, that the estimated increase in QALYs justified the program's costs which were below standard benchmarks for many commonly adopted medical interventions.

This study showed that self-management interventions resulting in A1c reductions as small as 0.5%, maintained long-term, provide added QALYs. Unfortunately, results to date from high-quality studies using randomized controlled trials designs estimate that, at best, educational and behavioral interventions for adults with Type 2 diabetes have modest effects on lowering A1c: about 0.4% reductions (Gary et al., 2003).

DMP Participants' Clinical Data: Promising Outcomes and Future Considerations

DMP participants had a significant mean reduction in their A1c levels of 0.31%. This level of improvement, if maintained over several years, would likely result in lifetime improvements in health with potentially added QALYs. Although the annual cost of the DMP at \$634 is lower than costs estimated by Brownson et al. (2008), it is still unlikely that the program would result in costs savings and we cannot confidently assume that the decreases would be maintained over several years. Moreover, without a control group for comparison, we cannot determine if the significant decrease in A1c was due to the DMP treatment. There is some evidence that glycemic control (A1c < 7.0%) improved in the general U. S. population from 1999-2000 to 2003-2004, suggesting improvements in public health messaging and/or medical care for persons with diabetes and pre-diabetes (Ford et al., 2008). It will be important to assess for the long-term maintenance of DMP participants' A1c decreases. Finally, we did not assess changes in DMP participants' blood pressure, which will be an important additional indicator of the DMP's potential for health and costs improvement. Unlike lifetime glycemic control estimates which improve health but do not save costs, there is good evidence that maintaining a lifetime healthy blood pressure results in both health improvements and costs savings in persons with Type 2 diabetes (CDC, 2002).

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NDPERS Diabetes Management Program

Next Steps

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Program Overview

- Diabetes care services are provided by a network of pharmacists and other providers who have completed an accredited diabetes certification program
- Providers “coach” eligible participants on how to self-manage their diabetes
- Modeled after “Asheville Project”
 - Some variations

Program Overview Continued...

- Providers complete an assessment, develop a care plan and provide follow-up services and referrals
- Clinical, humanistic, and economic measures are recorded for analysis
 - Refer to Sept 2010 presentation for more information
- Initially 6 visits over 12 month period
 - 7th and 8th visits added for 24 month program
- Over 70 provider sites in North Dakota
 - Over 125 individual providers

Program Promotion

- Program launch
 - Mailings to all eligible members with follow up postcards 1 month later
- PERS website – link to program website
- Wellness newsletters
- Annual Wellness Forum presentation
 - Did not occur in 2010
- Monthly mailing to newly identified eligible members

Patient Participation

- 3,078 eligible members in Jan 2011 according to eligibility file
 - Approximately 30-40 letters mailed by NDPERS each month to newly identified eligible members
- 352 members have completed at least 1 visit
 - 11.5% enrollment
 - Asheville – 67% enrollment

Patient Incentives

- Patients receive financial incentives for participating
 - Copay on formulary diabetic medications, ACE inhibitors, and ARBs (\$5 generic, \$20 brand)
 - Coinsurance on diabetic testing supplies
 - Issued quarterly
 - 2010 costs/quarter
 - \$20,799 total (\$83.85/member)
 - \$4,444 supplies (\$17.92/member)
 - \$16,355 medications (\$65.93/member)
 - Range - \$5 to \$330 quarterly

Program Costs

- Next biennium estimates (July 2011-June 2013)
 - Visits - \$38,400
 - Incentives - \$29,000
 - Admin Fee - \$10,000
 - Total - \$77,400
- Based off of current program structure (enrollment rates and incentives)

UND Analysis

- Independent analysis provided results similar to that of similar studies
- Statistically significant clinical outcomes
 - Participants health improved
- Economic analysis showed positive trends, but were not statistically significant
 - Due to large standard deviation in costs and small sample size
 - Occurs this way in many studies of this type
 - Including Asheville Project

UND Analysis – Points of Interest

- Selection Bias – to be expected
 - Those with higher costs enrolled
 - Incentive structure played a role
 - More Type I vs Type II
 - UND Discussion – select those closer to “average”
 - Those with diabetes less than 5 years had greater reductions in A1C than those with diabetes longer

UND Analysis – Points of Interest

- Health care costs
 - PPSM cost savings of \$124 comparing participants vs control (\$1488 annually)
 - \$71.14 when program costs included
 - Not significant due to large variation
 - Savings occurred mainly in hospital costs
 - Pharmacy costs increased at a similar rate in participants vs control
 - Pharmacy costs increase significantly in other studies, including Asheville

UND Analysis – Points of Interest

- Health care costs

- Note – diabetes related costs were not broken out from non-diabetes related costs
 - Done in many studies
 - Could have helped answer some questions related to costs, etc
 - Could have reduced some of the variability
 - ie, did an asthma attack or some accident result in added hospital costs in one group vs the other, etc

UND Analysis – Points of Interest

○ Discussion

- Authors mention use of blood pressure as a valuable indicator for health and cost improvement
- This data, along with other secondary outcomes, was available, but not analyzed
- Data is included in following slides

Systolic

- 282 have multiple values
 - 1st visit avg = 132
 - Most recent avg = 130
 - Std dev 16.5, 15.4
- 47.5% did not initially meet goal
 - 32% of those now meet goal
 - 1st value avg = 146
 - Most recent avg = 138
 - Std dev 11.35, 15.03

Diastolic

- 279 have multiple values
 - 1st visit avg = 78
 - Most recent avg = 77
 - Std dev 9.93, 9.09
- 41% did not initially meet goal
 - 47% of those now meet goal
 - 1st value avg = 84.88
 - Most recent avg = 80.3
 - Std dev 10.13, 9.22

UND Analysis

- Summary

- Focused on economic analysis
- Shows positive trends, but due to lack of statistical significance, cannot extrapolate to entire NDPERS diabetic population
- Identifies potential areas for improvement
 - Selection bias
 - Increased participation

How do we compare?

Outcome	About the Patient	Asheville	10 City Challenge
Hemoglobin A1C (base/~ 1 yr)	7.25/6.98 N=249	7.7/6.7 N=81	7.5/7.1 N=554
LDL	95/93 N=172	115/108.5 N=70	97.5/94.1 N=528
HDL	45/44 N=181	46/47.5 N=72	Not reported
SBP	132/130 N=282	Not reported	132.5/130.1 N=551
DBP	78/77 N=279	Not reported	80.8/77.6 N=550
Annual healthcare spending reduction	\$853.68/patient*	\$1079/patient**	\$1200-1872/patient***
Patient Satisfaction	90+ %	90+ %	90+ %

* - \$1488 if program costs & incentives are excluded

** - did not include program costs & incentives

*** - savings from "projected" costs



How do we compare?

- Notes on comparison chart
 - NDPERS participants, on average, were healthier than Asheville and 10 City Challenge patients upon enrollment
 - Easier to go from A1C of 8 to 7 than 7 to 6
 - Yet, clinical outcome endpoints were still similar
 - Each study used different methods to calculate economic outcomes
 - Asheville did not include program costs
 - Each study showed positive, but not statistically significant, trends in controlling health care costs

Keep in mind....

- Wellness programs have difficulty showing immediate returns
 - Long term benefits – reducing complications
 - No definitive long term studies

Moving forward – next steps

- Use UND Study and clinical data to improve program
- Goals
 - Increase enrollment
 - Decrease selection bias
 - Maintain positive clinical outcomes
 - Further demonstrate cost savings

Moving forward – Increase Enrollment

- Allow About the Patient program do promote the program and send out enrollment information
 - Similar to other pharmacy based programs
 - Asheville, Medicare Part D MTM
 - Provide pharmacy claim information with eligibility file – allows for local contact
 - Removes administrative burden from NDPERS staff

Moving forward – Decrease Selection Bias

- Perform a mailed, paper survey on a “focus group” of past participants
 - Select variety of patients based on age, time with diabetes, baseline levels
 - Look for motivators for participation
 - Use results to make modifications to program visit design and structure

Moving forward – Decrease Selection Bias

- Review incentive structure
 - Large reason for selection bias
 - Those with largest costs had greatest motivation to participate
 - Use focus group results
 - Possible solution – change incentive to a per visit payment
 - Give everyone the same incentive for participating
 - May increase participation of those newly diagnosed that do not yet have large costs
 - UND Study identified this group as the most benefited
 - Example - \$80 per visit
 - Currently \$83.85/member/quarter
 - Similar to other wellness incentives
 - Health risk assessments, health clubs
 - Decreases administrative burden

Moving forward

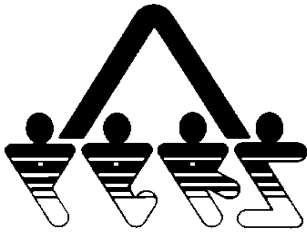
- Maintain positive outcomes
 - About the Patient responsibility
 - Maintain competent provider network
 - Keep up to date on diabetes treatment developments
- Further Demonstrate Cost Savings
 - NDPERS decision
 - Assess long term cost effects of program
 - Do participants stay healthy after participation?
 - Assess effects of program changes on cost

Summary

- Program has had successes and challenges
- Challenges
 - Low enrollment rate
 - Selection bias
- Successes
 - Clinical outcomes
 - Broad network
 - Patient satisfaction
- Unknown
 - Economic outcomes
- Successes outweigh challenges
 - Use lessons learned to improve program

Thank you

- Questions/Discussion



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Memorandum

TO: PERS Board
FROM: Bryan
DATE: October 19, 2017
SUBJECT: Updated Investment Options Summary

The updated Investment Options Summary for the NDPERS 457 Deferred Compensation Plan is now available. The booklet contains information on all the providers and investment options available in the plan. Inside you will find a description of the investments options available and the contact information for all the active providers. For each provider, all the investments are listed along with their investment objective, associated expenses and historical performance. The investment options summary is located on the NDPERS web site at: <https://ndpers.nd.gov/image/cache/investment-options.pdf>





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TO: NDPERS Board
FROM: Kathy
DATE: October 17, 2017
SUBJECT: FlexComp Plan Document

At the April meeting, the Board was provided information regarding updates to our FlexComp Plan Document. The following items were presented and approved:

- Incorporate language to recognize lag policy for implementing IRS medical spending inflation adjustments in Section 5.02.
- Allow for pretaxing of HSA contributions in Section 5.04.
- Change our enrollment policy from 60 days to 31 days to be consistent with our group insurance plans in Sections 3.01, 3.03, 3.04(f), 3.06(c), 3.07(c).
- Updated definition of spouse to allow coverage regardless of the jurisdiction in which the marriage occurred in Section 2.24.

In addition to the above, we requested Groom Law to audit the plan document and identify any other areas that may require updating in order to ensure compliance with the Section 125 regulations. They made various revisions with regard to citing specific IRS 125 code sections as they apply to provisions already included in our document as well as some corrections to language contained in the document. With the exception of the items outlined above, none of the Groom recommendations represented any material change to the provisions or administration of the plan. The document was also reviewed and approved by our legal counsel. The plan document will be provided under separate cover prior to the meeting.

Staff recommends approval of the restated FlexComp Plan Document effective January 1, 2018.

Board Action Requested

Approve the restated FlexComp Plan Document effective January 1, 2018.

STATE OF NORTH DAKOTA
FLEXCOMP PLAN DOCUMENT
Effective January 1, 2018

ADOPTION RESOLUTION

Resolved, that effective January 1, 2018, the State of North Dakota has adopted the attached amended and restated Section 125 FlexComp Plan. The Plan is intended to satisfy the requirements of Section 125 of the Internal Revenue Code, as amended, and its associated regulations.

By: _____

Title: _____

Dated: _____

TABLE OF CONTENTS

	<u>Page</u>
ARTICLE I. PURPOSE OF PLAN	1
ARTICLE II. DEFINITIONS	2
ARTICLE III. ELIGIBILITY AND PARTICIPATION	7
ARTICLE IV. BENEFITS	18
ARTICLE V. SALARY REDUCTIONS	19
ARTICLE VI. SALARY REDUCTION ELECTIONS	21
ARTICLE VII. PAYMENT OF CLAIMS	25
ARTICLE VIII. ADMINISTRATION.....	30
ARTICLE IX. APPEALS PROCEDURE	33
ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN.....	34
ARTICLE XI. GENERAL PROVISIONS	35

ARTICLE I. PURPOSE OF PLAN

The purpose of the State of North Dakota FlexComp Plan (“Plan”) is to allow Employees to pay medical, dental, vision, group term life, disability and cancer insurance premiums and other medical and dependent care expenses using pre-tax dollars.

The Board (pursuant to North Dakota Century Code Section 54-52-04) has, therefore, adopted the Plan as set forth herein and as amended from time to time, effective January 1, 2018 for the exclusive benefit of those Employees.

The Plan is intended to qualify as a cafeteria plan within the meaning of Code section 125 and shall be construed in a manner consistent with that section such that salary reduction elections will be eligible for exclusion from a Participant’s taxable income. The Dependent Care FSA Plan is intended to qualify as a dependent care assistance program within the meaning of Code section 129, and the Health FSA Plan is intended to qualify as a self-insured medical reimbursement plan under Code section 105. The tax implications of this Plan, however, are subject to rulings, regulations and the application of the tax laws of the state and federal government. Although it may anticipate certain tax consequences as being likely, neither the Board nor an Employer represents or warrants to any Participant that any particular tax consequence will result from participation in this Plan. By participating in the Plan, each Participant understands and agrees that in the event the Internal Revenue Service or any state or political subdivision thereof should ever assess or impose any taxes, charges and/or penalties upon any benefits received under the Plan, the recipient of the benefit will be responsible for those amounts, without contribution from the Board or an Employer.

This Plan is intended not to discriminate as to eligibility or benefits in favor of the prohibited group under Code sections 105, 125, and 129. The Plan provisions shall apply uniformly to all Employees.

ARTICLE II. DEFINITIONS

The following words and phrases have the following meaning, unless a different meaning is plainly required by the text:

- 2.01 Board.** “Board” means the North Dakota Public Employees Retirement System (PERS) board.
- 2.02 Benefit Package Option.** “Benefit Package Option” means a qualified benefit under Code section 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan
- 2.03 Benefit Plan.** “Benefit Plan” means the life insurance, medical, dental, vision, cancer insurance and in some cases disability plans and any alternate medical coverage under a health maintenance organization approved by the Board.
- 2.04 Code.** “Code” means the Internal Revenue Code of 1986, as amended.
- 2.05 Dependent Care Center.** “Dependent Care Center” means any facility which:
- a. complies with all applicable laws and regulations of the State of North Dakota and unit of local government in which it is located;
 - b. provides care for more than six (6) individuals (other than individuals who reside at the center); and
 - c. receives a fee, payment or grant for providing services for any such individuals (regardless of whether such facility is operated for profit).
- 2.06 Dependent Care FSA Plan.** “Dependent Care FSA Plan” means the dependent care assistance plan under this Plan that permits Employees to receive reimbursements from Qualified Dependent Care Expense accounts.
- 2.07 Dependent Child.** For purposes of payment of the Pre-Tax Premiums to a Benefit Plan, “Dependent Child” means a child who is the Participant’s “qualifying child” or “qualifying relative” as those terms are defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) and subject to the special rule in Code section 152(e) for divorced or separated parents or a child (within the meaning of Code section 152(f)(1)) who has not attained age 27 as of the end of the year. For purposes of the Qualified Health Care Expense accounts, “Dependent Child” means a child (within the meaning of Code section 152(f)(1)) who is either (1) a “qualifying child” as that term is defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) and subject to the special rules in Code section 152(e) for divorced or separate parents or (2) a child (within the meaning of Code section 152(f)(1)) who has not attained age 27 as of the end of the year.

Notwithstanding the foregoing, a child named in a qualified medical child support order (QMCSO) as defined in section 609 of the Employee Retirement Security Income Act (ERISA) shall be a Dependent Child to the extent specified in the QMCSO. The

preceding sentence applies only to the Pre-Tax Premiums for a Benefit Plan and the Qualified Health Care Expense accounts under this Plan.

2.08 Earned Income. “Earned Income” means earned income as set forth in Code section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

2.09 Employee. “Employee” means employees of the State of North Dakota and district health units that are eligible to participate in the Plan. In addition, members of the Legislative Assembly are considered employees and eligible to participate in the Plan. Employees of higher education and political subdivisions are excluded from participation in the Plan.

Eligible employees who are eighteen (18) years of age, whose services are not limited in duration, who are filling an approved and regularly funded position, and who are employed at least seventeen and one-half (17 ½) per week and at least five (5) months each year, or those first employed after August 1, 2003 who are employed at least twenty (20) hours per week and at least twenty (20) weeks each year, are eligible to participate in the Plan.

2.10 Employer. “Employer” means the State of North Dakota, excluding higher education, and any participating district health units as defined in Section 54-52.3-01 of the North Dakota Century Code.

2.11 Grace Period. “Grace Period” shall mean the period that begins immediately following the close of a Plan Year and ends on the day that is two (2) months plus fifteen (15) days following the close of that Plan Year.

2.12 Health Care Expense. “Health Care Expense” means expenses incurred by a Participant for “medical care” within the meaning of Code section 213(d), incurred by a Participant, Spouse, or Dependent Child, but do not include premium payments for other medical plan coverage, including premiums paid for medical coverage under a plan maintained by the employer of a Spouse or Dependent Child or “qualified long-term care services,” as described in Code section 213(d)(1)(C). For over-the-counter (OTC) drugs and medicines (other than insulin) which are for medical care as defined in Code section 213(d) will not be reimbursable as a Health Care Expense unless the Participant, Spouse or Dependent Child has a prescription for such drug or medicine. However, OTC products that are not considered drugs or medicines continue to be reimbursable if the product is for medical care as defined in Code section 213(d) and is not merely for good health or for cosmetic purposes.

2.13 Health FSA Plan. “Health FSA Plan” means the health flexible spending arrangement plan under this Plan that permits Employees to receive reimbursements from Qualified Health Care Expense accounts.

2.14 Health Savings Account (HSA). “Health Savings Account” or “HSA” means a health savings account established under Code section 223 as an individual trust or custodial account, each separately established and maintained by an Employee with a qualified trustee or custodian.

- 2.15 Participant.** “Participant” means an Employee who is participating in the Plan.
- 2.16 Plan.** “Plan” means the State of North Dakota FlexComp Plan, as set forth herein.
- 2.17 Plan Administrator.** “Plan Administrator” means the North Dakota Public Employees Retirement System (PERS) with the authority and responsibility to manage and direct the operation and administration of the Plan. Plan Administrator includes any designated agent to which specified administrative functions under the Plan have been delegated, to the extent of such delegation.
- 2.18 Plan Year.** “Plan Year” means a twelve (12) consecutive month period beginning January 1 and ending December 31.
- 2.19 Pre-Tax Premium(s).** “Pre-Tax Premium(s)” means the cost of life, disability, medical, dental, vision and cancer insurance under the Benefit Plan which a Participant is required, as a condition for coverage, to defray. The amount of the Pre-Tax Premium(s) under the Benefit Plan shall be approved by the Board in accordance with the Board’s policies that are applied to all Employees in a consistent manner.
- 2.20 Qualified Beneficiary.** “Qualified Beneficiary” means an individual who, on the day before a Qualifying Event, is a Spouse or Dependent Child of a Participant in the Health FSA Plan. A person who becomes a new Spouse of an existing Qualified Beneficiary during a period of continuation coverage is not a Qualified Beneficiary.

In the case of a Qualifying Event that is termination of employment or reduction in hours, Qualified Beneficiary also includes an individual, who on the day before such Qualifying Event, is a Participant in the Health FSA Plan.

A newborn child or adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not a covered Employee will be entitled to the same continuation coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary. A newborn child or adopted child of a Qualified Beneficiary or child placed for adoption with a Qualified Beneficiary who was a covered Employee shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.

A Qualified Beneficiary must notify the Board within thirty (30) days of the child’s birth, adoption or placement for adoption in order to add the child to the continuation coverage.

- 2.21 Qualified Dependent Care Expense.** “Qualified Dependent Care Expense” means any employment-related dependent care expense eligible for reimbursement under the Plan as determined under Code sections 129(e)(1) and 21(b)(2). Such expense includes amounts paid for household services and for the care of Qualifying Individuals enabling the Employee and his/her Spouse to be gainfully employed or the Spouse to be a Student.
- 2.22 Qualified Health Care Expense.** “Qualified Health Care Expense” means any Health Care Expense which is not otherwise reimbursable under a Benefit Plan or other plan or entity.

2.23 Qualifying Event. “Qualifying Event” means any of the following with respect to continued participation in the Health FSA Plan under Section 3.07, if it results in termination of coverage:

- a. The death of a Participant.
- b. The voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of a Participant.
- c. The divorce or legal separation of a Participant from his/her Spouse.
- d. A Dependent Child ceasing to be a Dependent Child.

2.24 Qualifying Individual. “Qualifying Individual” means, for purposes of a Qualified Dependent Care Expense account, any individual who is:

- a. The Participant’s dependent child (as defined in Code section 152(a)(1) and who has not attained age thirteen (13); or
- b. The Participant’s dependent (as defined in Code section 152 (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof)), who (i) is physically or mentally incapable of caring for himself or herself; and (ii) has the same principal place of abode as the Participant for more than one-half of the Plan Year; or
- c. The Participant’s Spouse if the Spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of the Plan Year.

Notwithstanding the foregoing, in the case of divorced or separated parents (within the meaning of Code section 152(e), a Qualifying Individual who is a child shall, as provided in Code section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code section 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

Expenses incurred outside the Participant’s household for a Qualifying Individual under (b) or (c) above shall constitute Qualified Dependent Care Expenses only if the Qualifying Individual regularly spends at least eight (8) hours each day in the Participant's household.

2.25 Salary Reduction Agreement. “Salary Reduction Agreement” means an agreement by a Participant to reduce his/her salary or wage to pay for applicable Pre-Tax Premiums, to allocate to a Qualified Health Care Expense account or Qualified Dependent Care Expense account, or to contribute to an HSA.

2.26 Spouse. “Spouse” means the spouse of a Participant but shall not include an individual legally separated from a Participant under a decree of divorce or of separate maintenance. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign

jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.

- 2.27** **Student.** “Student” means an individual who, during each of five (5) calendar months during a taxable year is a full-time student at an educational institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.01 Eligibility. All Employees eligible to participate in a Benefit Plan are eligible to participate in the Plan for purposes of payment of Pre-Tax Premiums under section 4.01. All Employees are eligible to participate in the Plan for purposes of payment of eligible Qualified Health Care Expenses under Section 4.02, except that an Employee with any contributions to a Health Savings Account in a Plan Year cannot participate in the Qualified Health Care Expense Account portion of the Plan for such Plan Year. All Employees are eligible to participate in the Plan for purposes of payment of Qualified Dependent Care Expenses under Section 4.03.

An employee who becomes an eligible Employee during the Plan Year shall be allowed to participate the first day of the month following the date he or she becomes an Employee. An Employee shall also be allowed to participate if he or she experiences a change in participation status, as described in section 3.03.

3.02 Participation. Participation is established on a Plan Year to Plan Year basis. Each Employee shall be a Participant in the Plan for a Plan Year as follows:

- a. For purposes of receiving Pre-Tax Premium benefits under Section 4.01 and HSA benefits under Section 4.04, participation will become effective when the appropriate Salary Reduction Agreement has been submitted as outlined in Article VI.

For the purpose of receiving employee supplemental life insurance Pre-Tax Premium benefits for the first \$50,000 in coverage, participation will be automatic unless an employee elects not to participate under this Plan for the Plan Year for the purpose of Pre-Tax Premium. An Employee who is eligible to participate may elect not to participate by completing and submitting the Premium Conversion declination submitting an appropriate declination form with the Employer within the election period established by the Board. An Employee who elects not to participate with regard to payment of Pre-tax Premiums for life insurance shall pay for such Pre-tax Premiums for life insurance under the Benefit Plan on an after-tax basis.

- b. For purposes of receiving reimbursement for Qualified Health Care Expenses and/or Qualified Dependent Care Expenses, participation will begin when the appropriate Salary Reduction Agreement(s) have been submitted and become effective under Article VI.

A Participant's Salary Reduction Agreement shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year.

3.03 Changes in Participation Status. With respect to the Pre-Tax Premiums, Qualified Health Care Expense accounts, and Qualified Dependent Care Expense accounts, a Participant may revoke or amend participation in the Plan during a Plan Year only on account of and consistent with a change in status or other circumstances allowed under applicable law or regulation.

Unless otherwise specified, a revocation or amendment of participation must be made within thirty-one (31) days after the change in status occurs and will be effective for the balance of the Plan Year in which the election is made, beginning with the first appropriate pay period after the election is received.

A Participant reducing his/her election, based on a change in status, cannot reduce his/her Salary Reduction Agreement election to the point where his/her contributions to a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for the Plan Year are less than the amount already reimbursed for that Plan Year.

With respect to the HSA, a Participant who makes an election to contribute an amount on a pre-tax salary reduction basis to his or her HSA may change such election on a prospective basis at any time during the Plan Year.

- a. Change in Status Events. *(Applies to Pre-Tax Premiums, Qualified Health Care Expense accounts and Qualified Dependent Care Expense accounts.)*
1. Change in the Participant's legal marital status, including marriage, divorce, death of Spouse, legal separation, or annulment.
 2. Change in number of the Participant's Dependent Children, including birth, adoption, placement for adoption, or death.
 3. Change in the employment status of the Participant, Spouse, or Dependent Child, including the following:
 - (a) Termination or commencement of employment.
 - (b) A reduction or increase in hours of employment by the Employee, the Employee's Spouse or the Employee's Dependent Child, including a switch between part-time and full-time status or commencement of or return from an unpaid leave of absence.
 - (c) A change in employment status that results in the Participant, Spouse, or Dependent Child becoming or ceasing to be eligible for benefits under the individual's plan (such as switching from part-time to full-time or from full-time to part-time employment status).
 - (d) Any situation where the Employee, the Employee's Spouse or the Employee's Dependent Child has special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described in Section 3.04.
 4. Dependent Child satisfies (or ceases to satisfy) dependent eligibility requirements, such as attainment of age, Student status or any similar circumstances.
- b. Change in Residence. *(Applies to Pre-Tax Premiums only.)* A change in residence of the Employee, Spouse, or Dependent Child is considered a status change event. An election change is permissible if the change in residence affects the Participant's eligibility for coverage.

- c. Change in Cost. (*Applies to Pre-Tax Premiums and the Dependent Care Expense accounts.*) A Participant may make election changes as a result of changes in cost under the following circumstances:

1. If the cost of a qualified benefits plan increases (or decreases), the Plan may automatically make a prospective increase (or decrease) in Employee contributions for the Plan.
2. If the cost of a Benefit Package Option significantly increases or significantly decreases, a Participant may make a prospective increase or decrease in payments or revoke his/her election and, in lieu thereof, choose another Benefit Package Option providing similar coverage, prospectively. This paragraph only applies in the case of the dependent care expense accounts if the cost change is imposed by a dependent care provider who is not a relative of the Employee.

For purposes of the dependent care expense accounts, a change in provider is a significant change in coverage similar to a Benefit Package Option becoming available, and may permit an election change under this Section 3.03.

- d. Change in Coverage. (*Applies to Pre-Tax Premiums*) A Participant may make election changes as a result of changes in coverage under the following circumstances:

1. If the coverage under the Benefit Plan is significantly curtailed without a loss of coverage, a Participant may revoke his/her election for that coverage. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to Participants under the Benefit Plan so as to constitute reduced coverage to Participants generally.

If the coverage under the Benefit Plan is significantly curtailed and a loss of coverage occurs, a Participant may revoke his/her election. The Participant may make a new prospective election of coverage under another Benefit Package Option providing similar coverage or to drop coverage if no similar Benefit Package Option is available. A loss of coverage means a complete loss of coverage under the Benefit Package Option, or other coverage option, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation.

2. If the Benefit Plan adds a new Benefit Package Option or improves a Benefit Package Option, or other coverage option (or eliminates an existing option) a Participant may elect the newly added option (or elect another option if an option has been eliminated) prospectively and may make corresponding election changes with respect to other Benefit Package Options providing similar coverage. The Plan may permit eligible Employees who have not

previously made an election to make an election on a prospective basis for coverage under a new or improved Benefit Package Option.

- e. With the exception of Qualified Health Care Expense accounts, a Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan, including a plan of the same employer or of another employer, if:
 - 1. The other plan permits the Participant to make an election change that would be permitted under federal regulations; or
 - 2. The plan permits Participants to make an election for a period of coverage that is different from the period of coverage under this Plan.
- f. A Participant may make an election change on a prospective basis to add coverage under a Benefit Plan for the Employee, Spouse or Dependent Child if the Employee, Spouse or Dependent Child loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following:
 - 1. A state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act;
 - 2. A medical care program of an Indian Tribal government (as defined in Code section 7701(a)(40)), the Indian Health Service, or a tribal organization;
 - 3. A state health benefits risk pool; or
 - 4. A foreign government group health plan.
- g. Judgement, Decrees and Orders. (*Applies to Pre-Tax Premiums and Qualified Health Care Expense accounts.*) In the case of a Benefit Plan that provides health or accident coverage, and for Qualified Health Care Expense accounts, a Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:
 - 1. If a judgment, decree, or order (collectively, "Order") results from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (QMCSO) defined in ERISA section 609) that requires accident or health coverage for an Employee's Dependent Child or for a foster child who is a dependent of the Employee; and
 - 2. The Employee changes his/her election to provide coverage for the Dependent Child or foster child if the Order requires coverage under the Employee's plan; or
 - 3. The Employee changes his/her election to revoke coverage for the Dependent Child or foster child if the Order requires the former spouse to provide coverage.
- h. Entitlement to Medicare and Medicaid. (*Applies to Pre-Tax Premiums and Qualified Health Care Expense accounts.*) In the case of a Benefit Plan that provides health or accident coverage, a Participant's revocation or amendment of

participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

1. If the Employee, Spouse, or Dependent Child becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines); and
 2. If the Employee changes his/her election to revoke coverage for that Employee, Spouse or Dependent Child under the Benefit Plan or Qualified Health Care Expense account.
- i. Consistency Rules Applicable to Change in Status Events. A Participant's mid-year election change under this Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects the Participant's, Spouse's or Dependent Child's eligibility or loss of eligibility for coverage under an employer's plan.

If the change in status event is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent Child, or a Dependent Child ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent Child, or the Dependent Child that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances fails to correspond with the change in status event.

If a Participant, Spouse or Dependent Child gains eligibility for coverage under a cafeteria plan or qualified benefits plan of the employer of the Spouse or Dependent Child as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other plan. The Plan may rely on the Participant's certification that such individual has obtained or will obtain coverage under the other plan unless the Plan has reason to believe that the Participant's certification is incorrect.

Notwithstanding the foregoing, for purposes of the Qualified Dependent Care Expense account, a Participant's mid-year election change under Section 3.03 satisfies the requirements of the consistency rule if the election change is on account of and corresponds with a change in status event that affects expenses described in Code section 129 (including employment-related expenses as defined in Code section 21(b)(1) with respect to dependent care assistance).

The Plan Administrator, in its sole discretion, shall determine, based on the surrounding facts and circumstances and prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a change in status event.

3.04 HIPAA Special Enrollment Rights. *(Applies to Pre-Tax Premiums only.)* A Participant may make a change to an annual election during the Plan Year if the change corresponds to a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Code section 9801(f), whether or not the change is permitted under any other section of this Plan, as follows:

- a. Acquisition of a new Spouse or Dependent Child as a result of marriage, birth, adoption or placement for adoption.
- b. Loss of eligibility under another group health plan or other health insurance by anyone who would otherwise be eligible under this Plan, including for (but not limited to) the following reasons:
 - 1. Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation, cessation of dependent status, or
 - 2. Loss of coverage through an HMO that does not provide benefits to individuals who do not reside, live or work in the service area, or
 - 3. Termination of employer contributions toward that other coverage, or
 - 4. If the other coverage was COBRA continuation coverage and the coverage was exhausted.
- c. Loss of eligibility for coverage under Title XIX of the Social Security Act (Medicaid) or under Title XXI of the Social Security Act that is coverage under a state children's health insurance program (SCHIP) or becoming eligible for a premium assistance subsidy from Medicaid or SCHIP. A Participant has sixty (60) days after the date of the event to change his or her election.
- d. For individuals losing other coverage, an Employee may revoke participation in a Benefit Plan and make a new election if the Employee is eligible, but not enrolled, for coverage under the terms of the Benefit Plan (or a Spouse or Dependent Child of such an Employee if the Spouse or Dependent Child is eligible, but not enrolled, for coverage); and
 - 1. The Employee, Spouse or Dependent Child was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Employee.
 - 2. The Employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment.
 - 3. The Employee's, Spouse's or Dependent Child's coverage under a group health plan or health insurance was under a COBRA continuation provision and the coverage under such provision was exhausted, or not under a COBRA continuation provision and either the coverage was

terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or the Employer contributions towards such coverage were terminated.

Under this subsection d., a revocation or amendment of participation must be made within thirty (30) days after the date of exhaustion of coverage described in paragraph 1. or the termination of coverage or Employer contribution described in paragraph 3. and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the election is made.

- e. For acquisition of a Spouse or Dependent Child, an Employee may revoke participation in a Benefit Plan and make a new election if:
 - 1. A person becomes a Spouse or a Dependent Child of the Participant through marriage, birth, or adoption or placement for adoption, and
 - 2. The Participant elects to enroll himself/herself, the Spouse, and/or the Participant's Dependent Child or Children in the Plan, to the extent that the Spouse or Dependent Children are otherwise eligible for coverage.

Under this subsection e., a revocation or amendment of participation must be made within thirty-one (31) days after the date dependent coverage is made available or the date of the marriage, birth, or adoption or placement for adoption and will be effective for the balance of the Plan Year in which the election is made, and in the case of marriage, beginning with the first appropriate pay period after the election is received; or in the case of a Dependent Child's birth, as of the date of such birth; or in the case of a Dependent Child's adoption or placement for adoption, the date of such adoption or placement for adoption.

- f. An election change on account of birth, adoption or placement for adoption will be effective retroactive to the date of birth, adoption or placement for adoption, provided the request to change the annual election is made within thirty-one (31) days of the birth, adoption or placement for adoption. Except as otherwise provided for herein, election changes for other special enrollment events (e.g., marriage or loss of other health coverage) will be effective as soon as practicable once a request for such election changes has been received, provided the request to change the annual election is made within thirty-one (31) (or sixty (60) days, as applicable) of the event.
- g. Retroactive coverage of a newly acquired Dependent Child on account of birth, adoption or placement for adoption applies to the Pre-Tax Premiums under section 4.01 and Qualified Health Care Expense accounts, but not to the Qualified Dependent Care Expense accounts. The effective date of coverage of a new Spouse or Dependent Child under the Qualified Dependent Care Expense account in accordance with Section 3.03 will be prospective for the balance of the Plan Year

beginning as soon as practicable after the date the new Salary Reduction Agreement is received by the Plan Administrator.

- h. Payroll changes made in accordance with special enrollment under this Section 3.04 will be effective with the first pay period following approval of a request to change a salary reduction election amount even if the effective date of a Dependent Child's coverage is retroactive.

3.05 Additional Election Change Pursuant to IRS Notice 2014-55. (*Applies to Pre-Tax Premiums for accident and health coverage only.*) An Employee who is eligible to enroll in a government sponsored exchange (marketplace coverage) during a marketplace special enrollment or open enrollment period may drop Benefit Plan accident and health coverage midyear, but only if the change corresponds to the Employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in marketplace coverage that is effective no later than the day after the last day of the original coverage.

3.06 Termination of Participation.

- a. Pre-Tax Premium(s). Participation with regard to Pre-Tax Premium(s) provided under this Plan during a Plan Year terminates on the first to occur of the following:
 - 1. The end of the month following the month of termination of employment;
 - 2. The date the applicable Salary Reduction Agreement is revoked;
 - 3. The date the Plan or applicable Benefit Plan is terminated; or
 - 4. The date of a change in employment status from permanent to temporary or reduction in hours to less than twenty (20) hours per week.
- b. Qualified Health Care Expenses. Participation with regard to Qualified Health Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:
 - 1. The last day of month in which a Participant ceases to be an Employee;
 - 2. The date the applicable Salary Reduction Agreement is revoked;
 - 3. The date the Plan or the Health FSA Plan is terminated; or
 - 4. The date of a change in employment status from permanent to temporary or reduction in hours to less than twenty (20) hours per week.
- c. Qualified Dependent Care Expenses. Participation with regard to Qualified Dependent Care Expenses provided under this Plan during a Plan Year terminates on the first to occur of the following:

1. Upon exhaustion of the account balance during the Plan Year in which the Employee ceases employment;
2. The date the applicable Salary Reduction Agreement is revoked;
3. The date the Plan or the Dependent Care FSA Plan is terminated; or
4. The date of a change in employment status from permanent to temporary or reduction in hours to less than twenty (20) hours per week.

Notwithstanding any provision of the Plan to the contrary, a former Participant shall be entitled to submit a request for reimbursement of Qualified Health Care Expenses, in accordance with Article VII, as if he/she were a Participant, provided such Qualified Health Care Expenses were incurred while the former Participant participated in the Plan.

If participation terminates because the Participant ceases to be an Employee and the individual returns to eligible employment with the Employer in the same Plan Year within thirty (30) days, and without any other intervening event that would permit a Participant to revoke or amend participation, then the Employee will be required to take the same benefit election for the remaining portion of the Plan Year as he/she had before he/she terminated. Participation shall be effective the first of the month following such election.

If the individual returns to employment, with the Employer, after more than thirty (30) days he/she will not be eligible to participate in the Pre-tax Premium benefit, the Qualified Health Care Expense account or the Qualified Dependent Care Expense account for the remainder of the Plan Year. Notwithstanding the foregoing, an individual who returns to employment with the Employer after more than thirty (30) days and within thirteen (13) weeks is eligible to participate in the Pre-tax Premium benefit with respect to group health plan coverage only.

Notwithstanding any provisions of the Plan to the contrary, a Qualified Beneficiary may elect to continue coverage for Qualified Health Care Expenses by electing continuation coverage as set forth in Section 3.07.

3.07 Continuation Coverage.

- a. Eligibility. A Qualified Beneficiary may continue coverage under the Health FSA Plan under this Section 3.07 by making election to do so with the Employer and submitting the applicable continuation coverage contribution, subject to all conditions and limitations under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The amount of the monthly contribution will be established by the Plan Administrator and will be paid on an after-tax basis on a uniform and consistent basis. However, Qualified Beneficiaries who elect COBRA are permitted to pay the COBRA premiums on a pre-tax basis through the end of the current Plan Year from their final paychecks.
- b. Maximum Self-Payment Period. A Qualified Beneficiary may elect continuation coverage because of a Qualifying Event described in Section 2.21 only for the remainder of the Plan Year in which the Qualifying Event occurs (plus the Grace Period).

c. Procedures to Elect Continuation Coverage.

1. In the case of a Qualifying Event described in Section 2.21, a. or b (death, termination of employment or reduction in hours) a Qualified Beneficiary will receive information concerning continuation coverage, including the rates, within forty-four (44) days of loss of coverage.
2. In the case of a Qualifying Event as described in Section 2.21, c. or e., (legal separation or divorce, or a child no longer qualifies as a Dependent Child) a Qualified Beneficiary must notify the Plan Administrator within sixty(60) days of the Qualifying Event. If notice is not received within sixty (60) days of the Qualifying Event, the Qualified Beneficiary will not be eligible for continuation coverage.

Following receipt of timely notice of a Qualifying Event and within fourteen (14) days of receipt of such notice, the Plan Administrator will provide the Qualified Beneficiary with information concerning continuation coverage and rates.

3. After notification of continuation coverage, the Qualified Beneficiary will have sixty (60) days to elect continuation coverage, after the **later** of:
 - (a) the date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event; or
 - (b) the date that the Qualified Beneficiary is sent such the COBRA election notice.

If a Qualified Beneficiary chooses to waive coverage, a waiver of continuation coverage will be effective on the date that the waiver is received by the Plan Administrator.

A Qualified Beneficiary who, during the election period, waives continuation coverage can revoke the waiver at any time before the end of the election period. However, if a Qualified Beneficiary who waives continuation coverage later revokes the waiver, coverage will be effective on the date that the revocation of the waiver and election to continue is received by the Plan Administrator.

4. The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Plan Administrator within forty-five (45) days of the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is elected, and shall be considered timely if received within thirty (30) days of the date due.
5. If premiums are not received in a timely manner, coverage will terminate. No claims will be paid until premium payment is received by the Plan Administrator in accordance with paragraph 4. above.
6. The election must specify which Qualified Beneficiaries are electing COBRA continuation coverage. If it does not specify the Qualified Beneficiaries, the election shall be deemed to be an election on behalf of all Qualified Beneficiaries.

- d. Termination of Continuation Coverage. Continuation coverage as provided under this section will terminate on the **earliest** of the following dates, as applicable:
1. The date after election of continuation coverage that the Qualified Beneficiary first becomes covered under any other group medical coverage as an employee or dependent.
 2. The end of the period for which the last payment was made for coverage in a timely manner.
 3. The end of the Plan Year in which the Qualifying Event occurs (plus the Grace Period).
 4. The date the Qualified Beneficiary becomes entitled to Medicare.
 5. Under any circumstance where a non-COBRA beneficiary would have benefits terminated for cause (e.g., fraud).
 6. The date the Board or the applicable Employer ceases to provide any group health plan.

3.08 Death of a Participant. With respect to Qualified Dependent Care Expenses, if a Participant dies, his/her participation in the Plan shall cease. However, such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year or, if earlier, until the account balance is exhausted.

With respect to Qualified Health Care Expenses, if a Participant dies, his/her participation in the Plan shall cease on the last day of such month. However, there are two ways for a deceased Participant's family members to access the money in the Participant's Qualified Health Care Expense account. Such Participant's estate (or the Participant's heirs, if there is no estate) may submit claims for expenses incurred prior to the Participant's death for the remainder of the Plan Year. In addition, a Qualified Beneficiary may be eligible to elect COBRA continuation coverage in accordance with Section 3.07 and obtain reimbursement for their own health care expenses incurred after the Participant's death through the end of the Plan Year and Grace Period.

ARTICLE IV. BENEFITS

- 4.01 Pre-Tax Premium(s).** An Employee may elect to pay Pre-Tax Premium(s) for a Benefit Plan subject to the provisions of Section 5.01.
- 4.02 Qualified Health Care Expenses.** The Plan Administrator or designated agent shall reimburse a Participant for Qualified Health Care Expenses incurred by the Participant or the Participant's Spouse or Dependent Child in accordance with the provisions of Section 5.02. Reimbursement for Qualified Health Care Expenses during a Plan Year is limited to the annualized amount elected by the Participant to the Qualified Health Care Expense account under a valid Salary Reduction Agreement. The annual amount elected by the Participant for a Qualified Health Care Expense account under a valid Salary Reduction Agreement (minus any reimbursed expenses for the Plan Year) shall be available at all times during the applicable period of coverage regardless of the actual amount deducted from the Participant's salary for the Plan Year. An Employee who is enrolled in a High Deductible Health Plan with contributions to a Health Savings Account cannot participate in the Qualified Health Care Expense account portion of this Plan.
- 4.03 Qualified Dependent Care Expenses.** The Plan Administrator or designated agent shall reimburse a Participant for Qualified Dependent Care Expenses in accordance with the provisions of Section 5.03. Reimbursement for Qualified Dependent Care Expenses during a Plan Year is limited to the amount of expenses incurred, not to exceed the amount in the Participant's account at the time a claim is made.
- 4.04 HSA.** An Employee may elect to contribute on a pre-tax basis to an HSA.
- 4.05 Determination of Noncompliance.** It is the intent of this Plan to provide a benefits plan that is nondiscriminatory and provide benefits to a classification of Employees while not discriminating in favor of any group, as set forth in Code sections 125, 105, and 129. In the event that a determination is made that all or any part of the contributions to the Plan do not qualify as non-taxable contributions under Code sections 125, 105, and/or 129, the affected contributions made by any Participant shall be treated as taxable salary and, to the extent not yet expended, returned to such Participant. The Participant shall pay:
- a. Any state or federal income taxes due with respect to such amount, together with any interest or penalties imposed thereon;
 - b. The Participant's share (as determined in good faith) of any applicable FICA contributions which would have been withheld from such amounts, had such amounts been treated as taxable salary and not as Qualifying Dependent Care Expenses or Qualified Health Care Expenses.

ARTICLE V. SALARY REDUCTIONS

5.01 Pre-Tax Premium(s). A Participant agrees to reduce the Participant's salary or wage each month by the amount of the Pre-Tax Premium(s) under the Benefit Plan under a Salary Reduction Agreement.

5.02 Qualified Health Care Expense Account.

- a. Qualified Health Care Expenses shall be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement.
- b. A Participant's salary or wage may be reduced under this Section 5.02 in an amount not to exceed \$2,500, as adjusted in accordance with Code section 125(i) to the extent such adjustment is approved by the Board.
 - 1. The salary reduction amount so elected shall be paid pro rata over the number of consecutive pay periods in the Plan Year. The salary reduction amount for any single pay period may not exceed the amount of the Participant's salary or wage for that period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.
 - 2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period; however, the total amount of salary reduction must equal the annual election amount.
- c. The Plan Administrator or designated agent shall establish individual Qualified Health Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.02. The Plan Administrator or designated agent shall reimburse Participants for Qualified Health Care Expenses in accordance with Article VII.

5.03 Qualified Dependent Care Expense Account.

- a. Qualified Dependent Care Expenses may be reimbursed to a Participant to the extent the Participant has elected to reduce the Participant's salary or wage for the Plan Year under a valid Salary Reduction Agreement, not to exceed the amount in the Participant's account at the time reimbursement is required.
- b. A Participant's salary or wage may be reduced under this Section 5.03 each Plan Year in an amount not to exceed the lesser of (1) the earned income limitation described in Code section 129(b) or (2) \$5,000 or \$2,500 if the Participant is married, but filing separately. In the case of a married Participant who elected an amount in excess of \$2,500, the Plan Administrator shall be entitled to rely on the Participant's election as constituting a certification by the Participant that he or she will file a joint tax return.
 - 1. The salary reduction amount so elected shall be paid pro rata over the number of consecutive pay periods in the Plan Year. The salary reduction

amount for any single pay period may not exceed the amount of the Participant's salary or wage for the pay period. Salary reduction amounts for a pay period shall be reduced by the amount it exceeds the Participant's salary or wage for that period.

2. For members of the Legislative Assembly, the salary reduction amount may vary per pay period; however, the total amount of salary reduction must equal the annual election amount.
- c. The Plan Administrator or designated agent shall establish individual Qualified Dependent Care Expense accounts for each Participant and shall credit to each Participant's account salary reduction amounts elected under this Section 5.03. The Plan Administrator or designated agent shall reimburse Participants for Qualified Dependent Care Expenses in accordance with Article VII.

5.04 Funding of Health Savings Accounts.

Effective January 1, 2019. An Employee can elect to participate in the Health Savings Account portion of the Plan by electing to make pre-tax contributions to an HSA via a valid Salary Reduction Agreement. Such amounts will be contributed to a Health Savings Account established and maintained outside this Plan by a trustee or custodian. The benefits under the HSA portion of the Plan consist solely of an Employee's ability to make pre-tax contributions to a Health Savings Account. The terms and conditions of each applicable Participant's HSA is governed by the Health Savings Account trust and/or custodial agreement. An Employee's election under a Salary Reduction Agreement to contribute to a Health Savings Account can be increased, decreased or revoked prospectively at any time during the Plan Year. Contributions to an HSA cannot be elected with benefits under a Qualified Health Care Expense account.

A participant who has an election for Qualified Health Care Expenses that is in effect on the last day of a Plan Year cannot elect HSA contributions for any of the first three months following the close of that Plan Year, unless the Participant's Qualified Health Care Expense account balance is \$0 as of the last day of that Plan Year.

In no event shall the amount contributed to a Participant's Health Savings Account, including pre-tax contributions under this Plan, any after-tax employee contributions, and any employer contributions, exceed the maximum amount under Code section 223(b), as prorated for the number of months the Participant is eligible to contribute to an HSA, in accordance with Code section 223(b). **5.05 Accounting.** The Plan Administrator or designated agent shall maintain complete records of all amounts to be credited as a contribution or debited as a reimbursement of Qualified Health Care Expenses or Qualified Dependent Care Expenses on behalf of any Participant for six (6) years.

ARTICLE VI. SALARY REDUCTION ELECTIONS

6.01 Election Period for Salary Reduction.

- a. In order to contribute to a Qualified Health Care Expense account or a Qualified Dependent Care Expense account for a Plan Year, a Participant must submit to the Plan Administrator an appropriate Salary Reduction Agreement election form within the applicable election period.
- b. An Employee who elects salary reduction for Pre-Tax Premium(s) must submit to the Plan Administrator an appropriate Salary Reduction Agreement within the applicable election period.
- c. For the purpose of employee supplemental life insurance Pre-tax Premium benefits for the first \$50,000 of coverage, an employee may elect not to participate by completing an appropriate Salary Reduction Agreement declination form within the applicable election period.

6.02 Termination, Revocation, or Amendment of Salary Reduction Elections.

- a. A Participant's Salary Reduction Agreement for a Plan Year shall terminate at the end of the Plan Year. A Participant must make an affirmative election for salary reduction for each Plan Year. Failure to make such an election will result in waiving participation in the Plan for the Plan Year.
- b. The employee supplemental life insurance Pre-tax benefits for the first \$50,000 of coverage will be automatic unless an Employee declines this action.
- c. Termination, revocation or amendment of salary reduction elections may only be made by a Participant in accordance with Article III.

6.03 Limitations on Exclusion from Gross Income for Dependent Care Expense Account.

- a. Reimbursements under the Plan for Qualified Dependent Care Expenses shall be excluded from the gross income of a Participant during a Plan Year in accordance with Code section 129. An Employee's exclusion from gross income under the Plan in a calendar year shall not exceed the lesser of:
 - 1. \$5,000 if the Employee is married and filing a joint return or if the Employee is a single parent or \$2,500 if the employee is married, but filing separately; or
 - 2. In the case of an Employee who is not married at the close of such Plan Year, the Earned Income of such Employee for such Plan Year; or
 - 3. In the case of an Employee who is married at the close of such Plan Year, the lesser of the Earned Income of such Employee or the Earned Income of the Spouse of such Employee for such Plan Year.

To the extent reimbursements exceed the maximum amount excludable from a Participant's gross income, the reimbursements shall be treated as taxable income to the Participant.

- b. The amount excluded from the income of an Employee under the Plan for any Plan Year shall not include:
 - 1. Payments made or incurred to an individual who can be claimed as a Dependent Child of the Employee or the Spouse of such Employee; or
 - 2. Payments made or incurred to an individual who is a child, under the age of nineteen (19), of such Employee or the Spouse of such Employee.

6.04 Forfeiture of Salary Reduction Amounts.

- a. If a Participant fails to claim any amounts in the Qualified Health Care Expense account or Qualified Dependent Care Expense account by the time allowed in Section 7.04, d., and Section 7.05, d., such amounts shall not be carried over to reimburse the Participant for expenses incurred during a subsequent Plan Year and rights to such amounts shall be forfeited by the Participant.
- b. All forfeitures under this Plan shall be used first to offset any losses experienced by the Board during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the amounts paid by such Participant via salary reductions. Second, forfeitures shall be used to reduce the Board's cost of administering this Plan during the Plan Year.

6.05 Amendment of Salary Reduction Elections Due To Leave of Absence, Family and Medical Leave Act (FMLA) or Military Leave.

- a. Pre-Tax Premiums and Qualified Health Care Expense Account.
 - 1. *Leave with taxable compensation.* Pre-tax contributions during a leave will continue to be made if taxable compensation is due to the Participant while on leave of absence, FMLA leave, or military leave.
 - 2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.
 - 3. *FMLA.* A Participant commencing a qualifying leave under FMLA may, to the extent required by the FMLA, continue to maintain coverage under the Benefit Plan and Qualified Health Care Expense Account under the terms and conditions set forth hereafter.
 - 4. With respect to a Benefit Plan, for unpaid leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election has not been amended, as provided in 6.05, a., 2., then the same election the

Participant had before the leave must be maintained for the remainder of the Plan Year upon return from the leave.

(a) *“Pre-pay option”*: A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.

(b) *“Catch-up option”*: Employer will continue coverage during the leave. A Participant must make pre-tax contributions after he or she returns from leave to make up missed contributions.

5. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis or by after tax contributions described in paragraph 4 above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed for Qualified Health Care Expenses as described in section 4.02 herein.

6. *USERRA*. If a Participant returns from a qualified military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and commences employment again, he/she may choose to become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2 above, or to elect not to participate for the remainder of the Plan Year.

7. For the Qualified Health Care Expense account, if a Participant revokes coverage upon commencement of the leave and elects to be reinstated upon return from the leave, the Participant has a choice between two options:

(a) *Full Coverage*: The Participant may maintain the same election the Participant had before the leave and reinstate the level of coverage in effect when the leave began, provided that the Participant makes contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account for the contributions that were missed during the leave.

(b) *Prorated Coverage*: The Participant may reinstate a level of coverage that is reduced by the amount of contributions to reduce his/her salary or wage to fund the Qualified Health Care Expense account that were missed during the leave.

b. Qualified Dependent Care Expense Account.

1. *Leave with taxable compensation*. Pre-tax contributions during a leave may be made if taxable compensation is due to the Participant while on leave of

absence, FMLA leave, or military leave and the employee has Qualified Dependent Care Expenses.

2. *Leave without taxable compensation.* An unpaid leave of absence will be considered a change in status, and the Participant may amend salary reduction elections to be consistent with the change in status.
3. *FMLA.* A Participant commencing a qualifying leave under FMLA may continue to maintain coverage under the Qualified Dependent Care Expense Account under the terms and conditions set forth hereafter. For unpaid leaves of absence and leaves under FMLA, if no coverage during leave is elected and the Participant returns to active work during the same Plan Year, and the salary reduction election has not been amended, as provided in paragraph 2 above, then the same election the Participant had before the leave must be maintained for the remainder of the calendar year upon return from the leave.
 - (a) *“Pre-pay option”:* A Participant may make pre-tax contributions by increasing his/her salary reduction contributions before taking the leave, but only for the portion of the leave that occurs during the Plan Year.
 - (b) *“Catch-up option”:* Employer will continue coverage during the leave. A Participant must make pre-tax contributions after he or she returns from the leave to make up missed contributions.
4. A Participant may elect not to continue coverage during the leave. If the Participant does not make the salary reduction on a pre-tax basis described in paragraph 3 above, his/her participation will cease the last day of the month in which a contribution is received. The Participant may submit claims for eligible expenses incurred before participation ended, and will be reimbursed as described in section 4.03 herein. Eligible expenses are only those expenses that enable the Employee or the Employee and the Employee’s Spouse to be gainfully employed or the Spouse to be a Student. Any other expenses would not be reimbursable during the leave of absence period.
5. *USERRA.* If a Participant returns from a qualified military leave under USERRA and commences employment again, he/she may choose to become a Participant and salary reduction contributions will be increased to reflect any contributions for the Plan Year not yet paid or to amend the salary reduction election, as provided in paragraph 2 above, or to elect not to participate for the remainder of the Plan Year.

ARTICLE VII. PAYMENT OF CLAIMS

- 7.01 Determination of Status of Eligible Expenses.** After receiving an appropriately submitted claim and the information required under Section 7.04 or Section 7.05, the Plan Administrator shall determine whether such expenses are Qualified Health Care Expenses or Qualified Dependent Care Expenses. The Plan Administrator may delegate the authority to administer claims under the Plan to a designated agent.
- 7.02 Payment of Claims.** The Plan Administrator will authorize payment of properly submitted claims for reimbursement at such intervals, as it may consider appropriate.
- 7.03 Expenses.** All administrative expenses incurred prior to the termination of the Plan that arise in connection with the administration of the Plan shall be paid as authorized by the Plan Administrator.
- 7.04 Claims Reimbursement for Qualified Health Care Expenses.**
- a. The Participant must submit a properly completed claim form to the Plan Administrator or the designated agent along with written evidence from an independent third party describing the Health Care Expense that has been incurred, the person on whose behalf such Health Care Expense has been incurred, the date such expense was incurred, the amount of such expense, and such other information as the Plan Administrator may find necessary.
 - b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Health Care Expenses.
 - c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Health Care Expenses.
 - d. All claims for reimbursement must be submitted no later than April 30 following the end of the Plan Year in which the expense was incurred.
 - e. Claims reimbursement for Qualified Health Care Expenses using a debit card shall be made in accordance with the terms of the debit card agreement and Proposed Treasury Regulations section 1.125-6 and other applicable IRS rulings.
- 7.05 Claims Reimbursement for Qualified Dependent Care Expenses.**
- a. To make a claim for reimbursement of Qualified Dependent Care Expenses, the Participant shall submit a statement to the Plan Administrator or the designated agent on an appropriate form adopted by the Plan Administrator which may contain the following information:
 - 1. The Qualifying Individual(s) for whom the Qualified Dependent Care Expenses were incurred;

2. A statement to substantiate that the dependent or dependents are Qualifying Individuals, such as the age of the dependent or a statement as to the physical or mental capacity of the dependent;
3. The nature of the services which will generate the Qualified Dependent Care Expenses;
4. Written evidence from an independent third party stating the expenses have been incurred, the amount of such expense, the date of such expense, and such other information as the Plan Administrator in its sole discretion may request;
5. The name of the person, organization or entity to who the expense was paid, including the taxpayer identification number, and the relationship, if any, of the person performing the services to the Participant;
6. A statement as to where the services were performed;
7. If the services are to be performed in a Dependent Care Center, a statement verifying that each of the requirements for a Dependent Care Center specified in Section 2.05 of the Plan are met;
8. A statement indicating whether the services are necessary to enable the Participant to be gainfully employed;
9. If the Participant is married, a statement:
 - (a) that the Spouse is employed; or
 - (b) if the Spouse is not employed, a statement that he/she is incapacitated or that he/she is a Student within the meaning of Section 2.25 of the Plan.

If an Employee's Spouse is not employed, not incapacitated, nor a Student as defined in Section 2.25 at the time the expense was incurred, the expense is not a Qualified Dependent Care Expense; and

10. A statement that the Qualified Dependent Care Expenses have not been reimbursed and are not reimbursable under any other plan or by any other entity.
- b. The Participant must submit with other required documents a signed statement in such form as determined by the Plan Administrator or designated agent certifying that the expenses for which reimbursement is sought are expenses that the Participant believes in good faith are Qualified Dependent Care Expenses.
 - c. The Plan Administrator reserves the right to verify to its satisfaction all claimed expenses prior to reimbursement and to refuse to reimburse any amounts which are not Qualified Dependent Care Expenses.

- d. All claims for reimbursement must be submitted not later than April 30 following the end of the Plan Year in which the expense was incurred.

7.06 Grace Period for Qualified Health Care Expenses. Amounts remaining in a Participant's Qualified Health Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Health Care Expenses that are incurred during Grace Period under the following conditions:

- a. Applicability. In order for an individual to be reimbursed for Qualified Health Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Health Care Expense account at the end of the Plan Year to which that Grace Period relates, he or she must be either (1) a Participant with Health Care Expense account coverage that is in effect on the last day of that Plan Year; or (2) a Qualified Beneficiary (as defined under COBRA) who has COBRA coverage under the Health Care Expense account component on the last day of that Plan Year.
- b. No Cash-Out or Conversion. Prior Plan Year Qualified Health Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a prior Plan Year Health Care Expense account may not be used to reimburse Qualified Dependent Care Expenses.
- c. Reimbursement of Grace Period Expenses. Qualified Health Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Health Care Expense account component will be reimbursed and charged first from any available prior Plan Year Qualified Health Care Expense account balance. If a current Plan Year Qualified Health Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Health Care Expense account component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.
- d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Health Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from prior Plan Year Qualified Health Care Expense account amounts. Any prior Plan Year Qualified Health Care Expense account amounts that remain after all reimbursement have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends.

The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in section 6.04 of the Plan.

- e. Qualified Health Care Expense Account Balance, Grace Period and Health Savings Accounts. This Plan's Qualified Health Care Expense account operates with a Grace Period. Under IRS rules regarding a Qualified Health Care Expense Account's Grace Period, if a Participant's Qualified Health Care Expense Account is in effect with any balance in that account on the last day of a Plan Year, the

Participant (and their Spouse, if married), nor an Employer on behalf of the Participant, can contribute to a Health Savings Account during the first three (3) months following the close of the Plan Year.

- f. Employee Participation in a Qualified Health Care Expenses Account Prevents Spouse or Dependent Child from Contributing to an HSA. Since this Plan's Qualified Health Care Expenses account is a general purpose account that permits reimbursement of qualifying medical expenses of Employees, Spouses and Dependent Children, under IRS rules, if the Spouse (or Dependent Child) of the Employee is enrolled in a High Deductible Health Plan with Health Savings Account, the Spouse (and Dependent Child) cannot contribute to an HSA while the Employee is enrolled in a general purpose Qualified Health Care Expenses account.

7.07 Grace Period for Qualified Dependent Care Expenses. Amounts remaining in a Participant's Qualified Dependent Care Expense account at the end of a Plan Year can be used to reimburse the Participant for Qualified Dependent Care Expenses that are incurred during the Grace Period under the following conditions:

- a. Applicability. In order for an individual to be reimbursed for Qualified Dependent Care Expenses incurred during a Grace Period from amounts remaining in his or her Qualified Dependent Care Expense Account at the end of the Plan Year to which that Grace Period relates, he or she must be a Participant with Qualified Dependent Care Expense account coverage that is in effect on the last day of that Plan Year.
- b. No Cash-Out or Conversion. Prior Plan Year Qualified Dependent Care Expense accounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, a Prior Plan Year Qualified Dependent Care Expense account may not be used to reimburse Qualified Health Care Expenses.
- c. Reimbursement of Grace Period Expenses. Qualified Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with the Plan's claims procedure for the Qualified Dependent Care Expense account will be reimbursed and charged first from any available prior Plan Year Qualified Dependent Care Expense account. If a current Plan Year Qualified Dependent Care Expense should subsequently be submitted, the claims for reimbursement under the Qualified Dependent Care Expense account will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed so as to pay it (or treat it as paid) from amounts attributable to a different Plan Year or period of coverage.
- d. Run-Out Period and Forfeitures. Claims for reimbursement of Qualified Dependent Care Expenses incurred during a Plan Year or its related Grace Period must be submitted no later than the April 30 following the close of the Plan Year in order to be reimbursed from a prior Plan Year Qualified Dependent Care Expense account balance. Any prior Plan Year Qualified Dependent Care Expense account balance that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred after the Grace Period ends.

The Participant will forfeit all rights with respect to such balance, which will be subject to the Plan's provisions regarding forfeitures in Section 6.04 of the Plan.

- e. Grace Period Effect on Dependent Care Expense Account Exclusions. Grace Periods may have an adverse effect on the exclusions or credits that individuals report on their personal income tax return. There may be taxable income to an individual if the Qualified Dependent Care Expense account reimbursements exceed IRS permitted Qualified Dependent Care Expense Account exclusion amounts as a result of the Grace Period. For example, if as a result of the Grace Period, a participant receives Qualified Dependent Care Expense account reimbursements for services incurred in a year that exceed his or her maximum Qualified Dependent Care Expense account exclusion, the excess may be included in the Participant's taxable income. Individuals should be guided by the advice of their tax professional(s).

ARTICLE VIII. ADMINISTRATION

- 8.01 Board Powers and Duties.** The Board shall interpret the Plan and decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Board with respect to any matter under the Plan shall be conclusive and binding on all persons. The Board shall:
- a. Make and enforce administrative rules or policies.
 - b. Decide questions concerning the Plan.
 - c. Provide a review to any Participant whose claim for benefits has been denied in whole or in part.
- 8.02 Plan Administrator Duties.** The Plan Administrator or designated agent shall manage and administer the Plan. The Plan Administrator shall:
- a. Require any person to furnish such information as it may request for the purpose of the proper administration of the Plan and as a condition to receiving any benefits under the Plan.
 - b. Prescribe the use of administrative policies and procedures as it considers necessary for the efficient administration of the Plan.
 - c. Determine the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan.
 - d. Determine the amount of benefits which are payable to any person in accordance with the provisions of the Plan.
- 8.03 Additional Operating Rules.** A Participant's salary reduction amount will generally not be subject to federal income tax withholding or to applicable Social Security (FICA) tax withholding. Salary reduction amounts will generally not be subject to any state income tax withholding unless otherwise prohibited by applicable state law.
- 8.04 Use and Disclosure of Protected Health Information.** The Health FSA Plan will use protected health information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). Specifically, the Health FSA Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Health FSA Plan rarely, if ever, uses or discloses PHI for treatment purposes. In addition, the Health FSA Plan does not use or disclose PHI that is genetic information (as defined in 45 CFR 160.103) for underwriting purposes, as set forth in 45 CFR 164.502(a)(5)(1)).

The Health FSA Plan may disclose PHI to a Benefit Plan for purposes related to administration of these plans, as permitted by law.

The Health FSA Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that the Employer, as Plan sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Health FSA Plan document or as required by law;
- b. Ensure that any agents to whom the Health FSA Plan sponsor provides PHI received from the Health FSA Plan agree to the same restrictions and conditions that apply to the Health FSA Plan sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- d. Not use or discloses PHI in connection with any other benefit or employee benefit plan of the Health FSA Plan sponsor unless authorized by an individual;
- e. Report to the Health FSA Plan any PHI use or disclosure that is inconsistent with the uses or disclosure provided for of which it becomes aware;
- f. Make PHI available to an individual in accordance with HIPAA's access requirements;
- g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- h. Make available the information required to provide an accounting of disclosures;
- i. Make internal practices, books and records relating to the use and disclosure of PHI received from the Health FSA Plan available to the HHS Secretary for the purposes of determining the Health FSA Plan's compliance with HIPAA;
- j. If feasible, return or destroy all PHI received from the Health FSA Plan that the Plan sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- k. If a breach of unsecured protected health information (PHI) occurs, the Health FSA Plan will notify affected individuals in accordance with applicable federal law and regulations.

In accordance with HIPAA, only the Executive Director of the Public Employees Retirement System and staff designated by the Executive Director may be given access to PHI. Such persons may only have access to and use and disclose PHI for Health FSA Plan administration functions that the Plan sponsor performs for the Health FSA Plan. If such persons do not comply with this Section 8.04, the Health FSA Plan sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

In addition, the Health FSA Plan sponsor will comply with the following HIPAA security standards:

- a. **Safeguards.** The plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality,

integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Health FSA Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the “HIPAA Security Standards”).

- b. **Agents**. The plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information
- c. **Security Incidents**. The plans sponsor shall report to the Health FSA Plan any security incident under the HIPAA Security Standards of which it becomes aware.
- d. **Adequate Separation**. The plan sponsor shall establish reasonable and appropriate security measures to ensure adequate separation between the Health FSA Plan and plan sponsor.

ARTICLE IX. APPEALS PROCEDURE

- 9.01 Notice to Employee**. Any person who claims he/she has been denied a benefit under the Plan shall be entitled, upon written request to the Plan Administrator to receive, within

sixty (60) days of receipt of such request, a written notice of such action, together with a full and clear statement of the specific reasons therefore, citing pertinent provisions of the Plan and a statement of the procedure to be followed in requesting a review of his/her claim.

9.02 Late Claim Appeal. Claims for the reimbursement of Qualified Health Care Expenses incurred in a Plan Year shall be paid as soon after a claim has been filed as is administratively practicable. If a Participant fails to submit a claim within the four (4) month period immediately following end of the Plan Year, those Health Care Expense claims shall not be considered for reimbursement by the Plan Administrator or designated agent; provided however, after four (4) months from the close of the Plan Year and before the end of three hundred sixty (360) days following the close of the Plan Year, a Participant may request the Board to authorize reimbursement of a Qualifying Health Care Expense incurred during the Plan Year by the Participant. The Participant must submit a written request to the Board specifying the request and the reason(s) why the Qualifying Health Care Expense was not submitted on or before the end of the 4th month following the close of the Plan Year. The Board may authorize payment for any reason constituting good cause not involving fault on the part of the Participant if such payment would be permitted under the Plan. Upon authorization of the Board, the Plan Administrator or designated agent shall reimburse the Participant for the amount not to exceed the Qualified Health Care Expense account balance for that Plan Year. The decision of the Board shall be final.

9.03 Appeal of Denial of Benefit. If the claimant wishes further consideration of his/her claim, he/she may request a review. The Plan Administrator shall schedule a review by the Board on the issue within sixty (60) days following receipt of the claimant's request for such review. The decision following such review shall be communicated in writing to the claimant and, if the claim is denied, shall set forth the specific reasons for such denial, citing the pertinent provisions of the Plan. The decision of the Board as to all claims shall be final.

ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN

The Board reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Code) to modify or amend, in whole or in part, any or all of the provisions of the Plan provided, however, that no such modifications or amendment shall divest a Participant of a right to a benefit to which he becomes entitled in accordance with the Plan. The Board reserves the power to discontinue or terminate the Plan at any time. Any such amendment, discontinuance or termination shall be effective as of such date as the Board shall determine.

ARTICLE XI. GENERAL PROVISIONS

- 11.01 No Right to be Retained in Employment.** Nothing contained in the Plan shall give any Employee the right to be retained in the employment of any Employer or affect the right of the Employer to dismiss any Employee.
- 11.02 Alienation of Benefits.** No benefit under the Plan is subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so is void.
- 11.03 Use of Form Required.** All communications in connection with the Plan made by a Participant are effective only when submitted to the Plan Administrator or designated agent.
- 11.04 Applicable Law.** The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of North Dakota.
- 11.05 Statement of Benefits.** On or before January 31 of each year, the Board or a designated agent will furnish each Participant who received Qualified Dependent Care Expense account benefits under the Plan a written statement on appropriate forms required by the Internal Revenue Service, showing the amounts paid or incurred by the Plan in providing reimbursement under the Plan for Qualified Dependent Care Expenses with respect to the Participant for the prior Plan Year.
- 11.06 Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of a Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan shall, to the extent it deems administratively possible and otherwise permissible under Code section 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he/she is properly entitled under the Plan. Such actions by the Plan may include withholding any amounts due to the Plan or the Employer from compensation paid by the Employer.



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Memorandum

TO: NDPERS Board

FROM: Sparb

DATE: October 19, 2017

SUBJECT: Executive Director Recruitment

In talking with EFL they are looking for your thoughts on a couple items relating to the recruitment.

1. Salary Range

What is the salary range? My present salary is \$16,558 or \$198,696 per year. This is also the salary that is in the PERS Budget for 2017-19. Should they consider this the top of the salary range, the bottom or middle? HRMS has information from a survey done by their professional organization which shows the following information for similar positions

Average -	\$198,599
Median -	\$181,674
Lowest -	\$ 91,437
Highest -	\$651,157

2. Benefits

What is the benefits for the position? Is this going to the standard state benefits? Will the attached policy adopted by the board in 2008 still apply?

3. Moving Expenses

Will PERS be willing to pay moving expenses? If so:

- a. All expenses.
- b. Up to a fixed amount, and if so what amount.

Policy for sick and annual leave for PERS appointed/nonclassified officials

The policies governing earning and use of sick and annual leave including the disposition of leave balances upon termination for the PERS appointed/nonclassified officials shall be the same as the PERS classified employees.

The PERS Board may, however, approve a higher annual leave earnings amount within the schedule established for classified employees when initially hiring the Executive Director. The Board may allow the carry over of sick leave and annual leave. Once the starting amount of the annual leave to be earned by the Executive Director is established by the PERS Board, the rate of annual earnings shall be advanced to the next increment of earnings as required for classified employees.

Annual and sick leave records for the Executive Director shall be maintained as for the classified employees and be available for the Board's inspection.

The Executive Director shall submit leave slips to the Internal Auditor. The Internal Auditor Manager shall review and sign off on the slips and if the auditor has any concerns, it shall be brought to the Internal Audit Committee for review and action.



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Memorandum

TO: PERS Board

FROM: Sharon Schiermeister

DATE: October 19, 2017

SUBJECT: Proposed Board Meeting Schedule for 2018 (2nd Tuesday)

Following are the proposed meeting dates for 2018. All meetings are scheduled to be held at the North Dakota Association of Counties conference room located at 1661 Capitol Way, Bismarck.

- January 9
- February 6
- March 13
- April 10
- May 8
- June 12
- July 10
- August 23
- September 11
- October 9
- November 13
- December 11

Please review and let us know if one of the dates should be changed. Once the dates are finalized, Jan will post the dates with the Secretary of State's office and set these meetings up on your Outlook calendars.



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Memorandum

TO: PERS Board

FROM: Derrick Hohbein, CPA

DATE: October 19, 2017

SUBJECT: Electronic Payment Policy

At the September 2017 board meeting, the Board reviewed the legislative direction received in NDCC 54-52-04 that states "The Board shall establish policies and implement procedures to make and collect payments in the most cost-effective manner, including the use of electronic transfer of funds."

Staff took a look at the different incoming and outgoing payment streams, the demographics for those receiving and making payments by check, and the OMB policy and is recommending the following approach:

New Retirees:

Staff recommends holding the first retirement & RHIC benefit until direct deposit information is received. Member must demonstrate a hardship to receive payment by check. Staff also looked into the use of a prepaid card option to offer those that do not want to provide direct deposit information. The card we researched required no credit checks, could be integrated into our system without enhancements, and was a no cost option to the plan or our members. The state does have a contract with Conduent for Electronic Payment Card Services for programs such as child support, unemployment, and workers compensation where an RFP wouldn't need to be conducted, but if we find the Electronic Payment Card through Conduent wouldn't be sufficient to fill our needs an RFP would be necessary.

Existing Retirees:

Given the demographics of the population receiving payments by check (82% of this population is 70+), staff is recommending they be allowed to continue receiving a check. However, we have the ability to directly communicate to these members by including a flyer and ACH form with their checks going out so we would recommend that we continue to make the effort to try and convert this population to ACH.

Refunds/Rollovers:

Staff recommends holding the refund payment until direct deposit information is received for those applying for a refund of their account. Member must demonstrate a hardship to receive payment by check. For the rollover organization payments and the automatic refunds of unvested account balances under \$1,000, staff recommends continuing to issue those one time payments by check. It isn't feasible/cost effective for these one time payments to be required to go by ACH when members aren't applying to get the refund and most rollover institutions require rollover payments to be in the form of a check.

FlexComp Reimbursements:

Staff recommends keeping the current policy of encouraging but not requiring direct deposit of FlexComp benefits. NDPERS does not collect the ACH information of active employees and WageWorks cannot accommodate a mandate of requiring payments to be made by ACH. Staff currently follows up on 4-5 outstanding checks a year from WageWorks, so the maintenance is very minimal to our agency.

Individual Insurance Billings (IBS) – New Retirees:

Staff recommends requiring insurance deductions to be taken from the pension check when possible. If a member isn't receiving a pension check (or if the pension check isn't large enough to cover the insurance premiums), require premiums to be electronically pulled from the member's bank account. Members must demonstrate a hardship to pay by check with the understanding after 4/1/18 billing statements will no longer be mailed and it will be the member's responsibility to have payment to the PERS office by the 1st of each month or risk having their coverage canceled.

IBS – Existing Retirees:

Staff recommends requiring insurance deductions to be taken from pension checks when possible. If no pension check, or pension check isn't large enough to cover the insurance premiums staff recommends encouraging ACH payment, but would continue accepting checks as a form of payment with the understanding after 4/1/18 billing statements will no longer be mailed and it will be the member's responsibility to have payment to the PERS office by the 1st of each month or risk having their coverage canceled.

IBS - COBRA Coverage:

Encourage ACH, but continue the ability to pay by check with the understanding after 4/1/18 billing statements will no longer be mailed and it will be the member's responsibility to have payment to the PERS office by the 1st of each month or risk having their coverage canceled.

IBS - TFFR/Higher Ed Retirees:

Staff recommends keeping the current practice of encouraging pension deductions for TFFR and requiring ACH on other payments.

Employer Payments:

Staff recommends requiring employers to electronically submit their payments through the ACH debit functionality that exists within PERSLink. Employers must demonstrate a hardship to continue making payments by check. Staff would further recommend that employers be given until 7/1/19 to move to this payment method, to allow for any system enhancements, if necessary.

A matrix depicting the type of payment made/received, staff's recommendation, and additional information (if necessary) is also attached for consideration.

Board Action Requested

Provide direction on the recommended policy for each category of payment streams, and provide direction on whether staff should pursue implementing a reloadable card as a payment option for retirees.

Attachment

Benefit Payment Type	Recommendation	Additional Information
<p>1) New Retiree Pension Benefits</p>	<p>Hold first payment until direct deposit authorization is received. Those who don't want to provide direct deposit authorization can be paid with a reloadable card or a check if a hardship is demonstrated and signed off on by the executive director.</p> <p>Mimic the OMB hardship policy which states:</p> <p>If a member is not able to lawfully maintain a checking or savings account in the United States OR upon written approval from the executive director, based on a determination that the direct deposit requirement would cause hardship to the member.</p>	<p>Include a disclaimer on the direct deposit form that the bank information will be shared with ASI Flex so RHIC benefits can be made electronically and that benefits will be suspended until we receive new ACH information on closed bank accounts.</p> <p>We would want this to have an effective date possibly 1/1/18 to implement the new forms for both retirement and RHIC benefit payments.</p>
<p>2) Existing Retiree Pension Benefits</p> <p>Ages of those currently receiving checks:</p> <p>< 60 = 12</p> <p>60 -69 =55</p> <p>70-79 = 96</p> <p>80 – 89 = 153</p> <p>90 – 99 = 56</p> <p>Total - 373 Checks</p>	<p>Encourage direct deposit, but do not require it and continue giving retirees the option of how they want to be paid</p>	<p>Our checks are sorted by retirement benefit option, so including a flyer when mailing out a check to a targeted audience is easy to accommodate with minimal additional costs. We propose including a flyer stating the legislature's intent to move towards ACH payments and include the direct deposit form, but given the ages of those that receive checks currently we felt grandfathering those currently receiving checks may be warranted</p>
<p>3) Refund/Rollover Payment</p>	<p>Hold payment until direct deposit authorization is received. Those who don't want to provide direct deposit authorization can be paid with a reloadable card or a check if a hardship is demonstrated and signed off on by the executive director.</p> <p>Payments to rollover organizations will continue to be made by check</p>	
<p>4) Auto Refund of Unvested Account Balances Under \$1,000</p>	<p>Follow current practice and have the system automatically generate a check as the members aren't applying for the refund.</p> <p>Explore the feasibility of offering the reloadable card on these members, but because they aren't going out of their way to apply for the refund it'd require additional in house administration to set them up for the card that currently doesn't exist</p>	<p>Current practice - no modifications needed</p>

Benefit Payment Type	Recommendation	Additional Information
5) RHIC Reimbursements for new retirees (processed through ASIFlex)	<p>Hold first payment until direct deposit authorization is received. Those who don't want to provide direct deposit authorization can be paid with a reloadable card or a check if a hardship is demonstrated and signed off on by the executive director.</p> <p>If receiving a check is approved, benefits would accumulate until they exceed a \$25 threshold before being paid out. All benefits - even those under \$25 will be paid out at the end of the plan year.</p>	ASI Flex has the ability to accumulate claims until they exceed a \$25 threshold.
<p>6) RHIC Reimbursements (processed through ASIFlex) for existing retirees.</p> <p>Ages of those currently receiving RHIC checks: <60 = 303 60 – 69 = 1,406 70-79 = 963 80-89 = 460 90-99 = 91 100+ = 2</p> <p>Total - 3,225 members</p>	<p>Encourage direct deposit, but do not require it and continue giving retirees the option of how they want to be paid. If members are receiving a monthly check, benefits would accumulate until they exceed the \$25 threshold before being paid out. All benefits - even those under \$25 will be paid out at the end of the plan year.</p> <p>Our proposed administrative rule changes state if there are 2 or more outstanding ASI checks, the RHIC benefit will be suspended until the member contacts the PERS office for payment arrangements. That won't be effective until 4/1/18, however.</p>	<p>Members would need to sign off on the new ACH form in order to give us authority to pass the ACH information to ASI Flex</p> <p>ASI Flex has the ability to accumulate claims until they exceed a \$25 threshold, and we'd propose making this change to both existing and new retirees.</p>
7) FlexComp Reimbursements (processed through WageWorks)	<p>Staff will continue to encourage direct deposit but WageWorks cannot mandate direct deposit.</p> <p>The follow up on FlexComp reimbursements is extremely minimal - there are 4-5 payments a year that NDPERS staff needs to follow up on.</p>	<p>Current practice - no modifications needed. We don't collect ACH information on the active members so we wouldn't have the information to pass to WageWorks.</p>

Receipt of Payments:	Recommendation	Additional Information
1) IBS Insurance Premium Payments - New retirees	Require insurance deductions to be taken from the pension check when possible, including existing retirees. If no pension check, or pension check isn't large enough to cover insurance premiums, require premiums to be electronically pulled through customer's bank account. Member must demonstrate a hardship to pay by check. If paying by check, no IBS billing statement will be sent after 4/1/18 with the proposed administrative rule changes.	
2) IBS Insurance Premium Payments - existing retirees	Require insurance deductions to be taken from the pension check when possible, including existing retirees. If no pension check, or pension check isn't large enough to cover insurance premiums, encourage ACH payment, but continue accepting checks as a form of payment.	Proposed rule changes include discontinuing the generation of IBS billing statements, so as of 4/1/18 members will no longer receive invoices from PERS for their monthly insurance premiums. Include ACH forms with the IBS statements we send out between now and 4/1/18 stating the legislative intent to move towards electronic payments and include the ACH forms as well as notice that as of 4/1/18 they will no longer receive a monthly invoice and it's their responsibility to make sure payments are made by the 1st of the month or risk having their coverage be canceled.
3) COBRA Coverage	Encourage ACH, but do not mandate if the member wants to pay by check.	Ensure member understands that a billing statement won't be sent each month, and if they choose to pay by check it is their responsibility to make sure payment is received by the 1st of each month or risk having coverage be canceled
4) TFFR/Higher Ed	Encourage pension deductions for TFFR, and require ACH on other payments	Current practice - no modifications needed
5) Contribution / Premium Payments Received from Employers	Require employers to submit their payments to NDPERS electronically through ACH debit - which is functionality that exists within PERSLink today.	<p>Allow employers to "opt in" between now and 7/2019 and begin the communication effort and encourage participation at the start of 2018.</p> <p>There may be some employer programming needed in order to accommodate this so we'd recommend forcing employers to comply by 7/2019.</p>



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: October 19, 2017

SUBJECT: November Meeting

Items for discussion:

- Ground transportation –
Fleet vehicles for staff and board members?
Board members to use personal vehicles and carpool?
Travel schedule?
- Lodging –
Hotel arrangements for staff and board members?
- Locations –
BCBS – 4510 13th Avenue South
(new) Sanford Medical Center – 5225 23rd Avenue South
Sanford Health Plan office – 1749 38th Street South

NDPERS BOARD MEETING

Agenda

November Meeting
attachment

1749 38th Street South

November 15 - 16, 2017

PROPOSED AGENDA

Wednesday, November 15, 2017

1:00-3:00 pm Meeting with BCBS

3:30-5:30 pm Tour of Sanford Hospital

Thursday, November 16, 2017

1749 38th Street South, Fargo

8:30 am

I. MINUTES

A. October 19

II. MISCELLANEOUS

A. Transition update – Sharon (Information)

B. Confirmation of 2018 Board Meeting dates – Sharon (Information)

III. SANFORD HEALTH PLAN

A. Quarterly Report

B. Review of Member Services

C. Administrative Review

D. Wellness Program Review

E. Discuss Medical Home

F. EOB

G. Discuss Transfer from Accordant to Sanford

H. Financial operations

I. Pharmacy

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

November meeting
attachment

1-800-803-7377

FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • <https://ndpers.nd.gov>

Memorandum

TO: NDPERS Board
FROM: Sparb
DATE: September 21, 2017
SUBJECT: November Board Meeting

Looking ahead to the November PERS Board meeting one idea would be to have it in Fargo at the Sanford Office. For those who have not been there it would be an opportunity to see the facility and meet some of the staff. Sanford has also indicated that they could arrange a tour of the new hospital for the Board as well. A tentative agenda for the meeting would be:

1. Presentation of the Sanford Quarterly Report
2. Sanford operational review
 - a. Organizational Review
 - b. Review of Operational Savings Efforts
3. Review of Sanford Disease Management Programs
4. Discussion of Wellness Program
5. Discussion of the Pharmacies items
6. Tour of Sanford Hospital

I would anticipate that you should be done with the above items by 2:00 p.m. (assuming you start at 8:30).

In addition, while the Board is in Fargo we could also ask BCBS if they would be available for a brief visit by the Board to get an update from them on their current efforts. If you are interested in exploring this it could be from 3:00 to 5:00 p.m.

Board Action Requested

1. Determine if the board would like to have an on-site meeting at Sanford in Fargo.
2. Determine if staff should ask BCBS if they would be available for a visit from the Board to get an update on their activities.

FISCAL NOTE
Requested by Legislative Council
03/20/2017

Amendment to: Engrossed HB 1434

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	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	\$265,117	\$217,244	\$265,117	\$217,244
Appropriations	\$0	\$0	\$265,117	\$217,244	\$265,117	\$217,244

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	\$0	\$0	\$69,480
Cities	\$0	\$0	\$58,050
School Districts	\$0	\$0	\$35,280
Townships	\$0	\$0	\$0

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The bill provides health plan coverage for autism disorders.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Sanford Health Plan estimates a \$1.25 per contract per month premium impact from this bill. Their estimate is based on analysis done on other similar mandates in other states.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

N/A

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$482,361 for the biennium (\$265,117 general funds and \$217,244 other funds).

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The appropriation for this bill is not in the executive budget. As amended this bill would be effective for the July 1, 2017 contract period.

Name: Bryan Reinhardt

Agency: NDPERS

Telephone: 701-328-3919

Date Prepared: 01/18/2017

2017-2019 NDPERS Health Plan HB 1434				\$1.25		
		Executive Budget				
		2017-2019	Monthly	17-19 Funding Adjustments		
	Department	FTE	Change	General	Other	Total
101	Office of the Governor	18.00	\$1.250	\$540.00	\$0.00	\$540.00
108	Office of the Secretary of State	33.00	\$1.250	\$960.04	\$29.96	\$990.00
110	Office of Management and Budget	119.00	\$1.250	\$2,934.92	\$635.08	\$3,570.00
112	Information Technology Department	349.30	\$1.250	\$1,872.83	\$8,606.17	\$10,479.00
117	Office of the State Auditor	53.80	\$1.250	\$1,224.72	\$389.28	\$1,614.00
120	Office of the State Treasurer	8.00	\$1.250	\$240.00	\$0.00	\$240.00
125	Office of the Attorney General	234.00	\$1.250	\$6,430.95	\$589.05	\$7,020.00
127	Office of the Sate Tax Commissioner	133.00	\$1.250	\$3,990.00	\$0.00	\$3,990.00
140	Office of Administrative Hearings	5.00	\$1.250	\$0.00	\$150.00	\$150.00
150	Legislative Assembly	141.00	\$1.250	\$4,230.00	\$0.00	\$4,230.00
160	Legislative Council	36.00	\$1.250	\$1,080.00	\$0.00	\$1,080.00
180	Judicial Branch	354.50	\$1.250	\$10,635.00	\$0.00	\$10,635.00
188	Legal Counsel of Indigents	40.00	\$1.250	\$1,170.95	\$29.05	\$1,200.00
190	Retirement and Investment Office	19.00	\$1.250	\$0.00	\$570.00	\$570.00
192	Public Employees Retirement System	34.50	\$1.250	\$0.00	\$1,035.00	\$1,035.00
201	Department of Public Instruction	97.75	\$1.250	\$905.15	\$2,027.35	\$2,932.50
226	Department of Trust Lands	32.00	\$1.250	\$672.08	\$287.92	\$960.00
250	State Library	29.75	\$1.250	\$0.00	\$892.50	\$892.50
252	School for the Deaf	45.61	\$1.250	\$527.84	\$840.46	\$1,368.30
253	N.D. Vision Services	29.50	\$1.250	\$386.20	\$498.80	\$885.00
270	Dept of Career and Technical Ed	25.50	\$1.250	\$324.07	\$440.93	\$765.00
215	ND University System	148.40	\$1.250	\$1,164.86	\$3,287.14	\$4,452.00
227	Bismarck State College	358.35	\$1.250	\$2,636.02	\$8,114.48	\$10,750.50
228	Lake Region State College	129.61	\$1.250	\$953.25	\$2,935.05	\$3,888.30
229	Williston State College	100.75	\$1.250	\$1,493.96	\$1,528.54	\$3,022.50
230	University of North Dakota	2218.07	\$1.250	\$37,118.25	\$29,423.85	\$66,542.10
232	UND Medical Center	435.75	\$1.250	\$4,302.93	\$8,769.57	\$13,072.50
235	North Dakota State University	1895.66	\$1.250	\$24,821.37	\$32,048.43	\$56,869.80
238	ND State College of Science	345.04	\$1.250	\$5,030.05	\$5,321.15	\$10,351.20
239	Dickinson State University	168.90	\$1.250	\$2,369.28	\$2,697.72	\$5,067.00
240	Mayville State University	210.53	\$1.250	\$6,315.90	\$0.00	\$6,315.90
241	Minot State University	441.65	\$1.250	\$11,569.17	\$1,680.33	\$13,249.50
242	Valley City State University	202.75	\$1.250	\$5,905.77	\$176.73	\$6,082.50
243	Dakota College Bottineau	84.30	\$1.250	\$2,526.90	\$2.10	\$2,529.00
244	ND Forest Service	27.00	\$1.250	\$810.00	\$0.00	\$810.00
301	North Dakota Department of Health	381.00	\$1.250	\$5,910.49	\$5,519.51	\$11,430.00
305	Tobacco Prevention	0.00	\$1.250	\$0.00	\$0.00	\$0.00
313	Veterans Home	120.72	\$1.250	\$1,235.17	\$2,386.43	\$3,621.60
316	Indian Affairs Commission	4.00	\$1.250	\$120.00	\$0.00	\$120.00
321	Department of Veterans Affairs	9.00	\$1.250	\$234.41	\$35.59	\$270.00
325	Department of Human Services	2204.23	\$1.250	\$55,482.19	\$10,644.71	\$66,126.90
360	Protection and Advocacy Project	27.50	\$1.250	\$825.00	\$0.00	\$825.00
380	Job Service North Dakota	181.61	\$1.250	\$36.50	\$5,411.80	\$5,448.30
401	Office of the Insurance Commissioner	47.00	\$1.250	\$0.00	\$1,410.00	\$1,410.00
405	Industrial Commission	105.25	\$1.250	\$2,968.25	\$189.25	\$3,157.50
406	Office of the Labor Commissioner	14.00	\$1.250	\$420.00	\$0.00	\$420.00
408	Public Service Commission	45.00	\$1.250	\$819.94	\$530.06	\$1,350.00
412	Aeronautics Commission	7.00	\$1.250	\$0.00	\$210.00	\$210.00
413	Department of Financial Institutions	30.00	\$1.250	\$0.00	\$900.00	\$900.00
414	Office of the Securities Commissioner	9.00	\$1.250	\$0.00	\$270.00	\$270.00
471	Bank of North Dakota	181.50	\$1.250	\$0.00	\$5,445.00	\$5,445.00
473	North Dakota Housing Finance Agency	46.00	\$1.250	\$0.00	\$1,380.00	\$1,380.00
475	North Dakota Mill & Elevator Association	153.00	\$1.250	\$0.00	\$4,590.00	\$4,590.00
485	Workforce Safety & Insurance	260.14	\$1.250	\$0.00	\$7,804.20	\$7,804.20
504	Highway Patrol	206.00	\$1.250	\$4,938.86	\$1,241.14	\$6,180.00
530	Department of Corrections and Rehabilitation	846.29	\$1.250	\$23,750.07	\$1,638.63	\$25,388.70
540	Adjutant General	234.00	\$1.250	\$2,815.72	\$4,204.28	\$7,020.00
601	Department of Commerce	66.40	\$1.250	\$1,559.65	\$432.35	\$1,992.00
602	Department of Agriculture	75.00	\$1.250	\$1,236.36	\$1,013.64	\$2,250.00
627	Upper Great Plains Transportation Institute	43.88	\$1.250	\$331.36	\$985.04	\$1,316.40
628	Branch Research Centers	110.29	\$1.250	\$2,415.82	\$892.88	\$3,308.70
630	NDSU Extension Service	252.98	\$1.250	\$3,867.44	\$3,721.96	\$7,589.40
638	Northern Crops Institute	11.80	\$1.250	\$299.17	\$54.83	\$354.00
640	NDSU Main Research Center	336.12	\$1.250	\$6,508.40	\$3,575.20	\$10,083.60
649	Agronomy Seed Farm	3.00	\$1.250	\$0.00	\$90.00	\$90.00
670	Racing Commission	2.00	\$1.250	\$60.00	\$0.00	\$60.00
701	State Historical Society	77.00	\$1.250	\$2,112.41	\$197.59	\$2,310.00
709	Council on the Arts	5.00	\$1.250	\$150.00	\$0.00	\$150.00
720	Game & Fish Department	163.00	\$1.250	\$0.00	\$4,890.00	\$4,890.00
750	Department of Parks & Recreation	65.00	\$1.250	\$1,876.86	\$73.14	\$1,950.00
770	State Water Commission	96.00	\$1.250	\$0.00	\$2,880.00	\$2,880.00
801	Department Of Transportation	1054.01	\$1.250	\$0.00	\$31,620.30	\$31,620.30
	State Total	16078.69	\$1.250	\$265,117	\$217,244	\$482,361

FISCAL NOTE
Requested by Legislative Council
02/08/2017

Amendment to: HB 1434

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	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	\$265,117	\$217,244	\$265,117	\$217,244
Appropriations	\$0	\$0	\$265,117	\$217,244	\$265,117	\$217,244

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	\$0	\$0	\$69,480
Cities	\$0	\$0	\$58,050
School Districts	\$0	\$0	\$35,280
Townships	\$0	\$0	\$0

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The bill provides health plan coverage for autism disorders.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Sanford Health Plan estimates a \$1.25 per contract per month premium impact from this bill. Their estimate is based on analysis done on other similar mandates in other states.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

N/A

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$482,361 for the biennium (\$265,117 general funds and \$217,244 other funds).

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The appropriation for this bill is not in the executive budget. As amended this bill would be effective for the July 1, 2017 contract period.

Name: Bryan Reinhardt

Agency: NDPERS

Telephone: 701-328-3919

Date Prepared: 01/18/2017

2017-2019 NDPERS Health Plan HB 1434				\$1.25		
		Executive Budget				
		2017-2019	Monthly	17-19 Funding Adjustments		
Department	FTE	Change	General	Other	Total	
101 Office of the Governor	18.00	\$1.250	\$540.00	\$0.00	\$540.00	
108 Office of the Secretary of State	33.00	\$1.250	\$960.04	\$29.96	\$990.00	
110 Office of Management and Budget	119.00	\$1.250	\$2,934.92	\$635.08	\$3,570.00	
112 Information Technology Department	349.30	\$1.250	\$1,872.83	\$8,606.17	\$10,479.00	
117 Office of the State Auditor	53.80	\$1.250	\$1,224.72	\$389.28	\$1,614.00	
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125 Office of the Attorney General	234.00	\$1.250	\$6,430.95	\$589.05	\$7,020.00	
127 Office of the Sate Tax Commissioner	133.00	\$1.250	\$3,990.00	\$0.00	\$3,990.00	
140 Office of Administrative Hearings	5.00	\$1.250	\$0.00	\$150.00	\$150.00	
150 Legislative Assembly	141.00	\$1.250	\$4,230.00	\$0.00	\$4,230.00	
160 Legislative Council	36.00	\$1.250	\$1,080.00	\$0.00	\$1,080.00	
180 Judicial Branch	354.50	\$1.250	\$10,635.00	\$0.00	\$10,635.00	
188 Legal Counsel of Indigents	40.00	\$1.250	\$1,170.95	\$29.05	\$1,200.00	
190 Retirement and Investment Office	19.00	\$1.250	\$0.00	\$570.00	\$570.00	
192 Public Employees Retirement System	34.50	\$1.250	\$0.00	\$1,035.00	\$1,035.00	
201 Department of Public Instruction	97.75	\$1.250	\$905.15	\$2,027.35	\$2,932.50	
226 Department of Trust Lands	32.00	\$1.250	\$672.08	\$287.92	\$960.00	
250 State Library	29.75	\$1.250	\$0.00	\$892.50	\$892.50	
252 School for the Deaf	45.61	\$1.250	\$527.84	\$840.46	\$1,368.30	
253 N.D. Vision Services	29.50	\$1.250	\$386.20	\$498.80	\$885.00	
270 Dept of Career and Technical Ed	25.50	\$1.250	\$324.07	\$440.93	\$765.00	
215 ND University System	148.40	\$1.250	\$1,164.86	\$3,287.14	\$4,452.00	
227 Bismarck State College	358.35	\$1.250	\$2,636.02	\$8,114.48	\$10,750.50	
228 Lake Region State College	129.61	\$1.250	\$953.25	\$2,935.05	\$3,888.30	
229 Williston State College	100.75	\$1.250	\$1,493.96	\$1,528.54	\$3,022.50	
230 University of North Dakota	2218.07	\$1.250	\$37,118.25	\$29,423.85	\$66,542.10	
232 UND Medical Center	435.75	\$1.250	\$4,302.93	\$8,769.57	\$13,072.50	
235 North Dakota State University	1895.66	\$1.250	\$24,821.37	\$32,048.43	\$56,869.80	
238 ND State College of Science	345.04	\$1.250	\$5,030.05	\$5,321.15	\$10,351.20	
239 Dickinson State University	168.90	\$1.250	\$2,369.28	\$2,697.72	\$5,067.00	
240 Mayville State University	210.53	\$1.250	\$6,315.90	\$0.00	\$6,315.90	
241 Minot State University	441.65	\$1.250	\$11,569.17	\$1,680.33	\$13,249.50	
242 Valley City State University	202.75	\$1.250	\$5,905.77	\$176.73	\$6,082.50	
243 Dakota College Bottineau	84.30	\$1.250	\$2,526.90	\$2.10	\$2,529.00	
244 ND Forest Service	27.00	\$1.250	\$810.00	\$0.00	\$810.00	
301 North Dakota Department of Health	381.00	\$1.250	\$5,910.49	\$5,519.51	\$11,430.00	
305 Tobacco Prevention	0.00	\$1.250	\$0.00	\$0.00	\$0.00	
313 Veterans Home	120.72	\$1.250	\$1,235.17	\$2,386.43	\$3,621.60	
316 Indian Affairs Commission	4.00	\$1.250	\$120.00	\$0.00	\$120.00	
321 Department of Veterans Affairs	9.00	\$1.250	\$234.41	\$35.59	\$270.00	
325 Department of Human Services	2204.23	\$1.250	\$55,482.19	\$10,644.71	\$66,126.90	
360 Protection and Advocacy Project	27.50	\$1.250	\$825.00	\$0.00	\$825.00	
380 Job Service North Dakota	181.61	\$1.250	\$36.50	\$5,411.80	\$5,448.30	
401 Office of the Insurance Commissioner	47.00	\$1.250	\$0.00	\$1,410.00	\$1,410.00	
405 Industrial Commission	105.25	\$1.250	\$2,968.25	\$189.25	\$3,157.50	
406 Office of the Labor Commissioner	14.00	\$1.250	\$420.00	\$0.00	\$420.00	
408 Public Service Commission	45.00	\$1.250	\$819.94	\$530.06	\$1,350.00	
412 Aeronautics Commission	7.00	\$1.250	\$0.00	\$210.00	\$210.00	
413 Department of Financial Institutions	30.00	\$1.250	\$0.00	\$900.00	\$900.00	
414 Office of the Securities Commissioner	9.00	\$1.250	\$0.00	\$270.00	\$270.00	
471 Bank of North Dakota	181.50	\$1.250	\$0.00	\$5,445.00	\$5,445.00	
473 North Dakota Housing Finance Agency	46.00	\$1.250	\$0.00	\$1,380.00	\$1,380.00	
475 North Dakota Mill & Elevator Association	153.00	\$1.250	\$0.00	\$4,590.00	\$4,590.00	
485 Workforce Safety & Insurance	260.14	\$1.250	\$0.00	\$7,804.20	\$7,804.20	
504 Highway Patrol	206.00	\$1.250	\$4,938.86	\$1,241.14	\$6,180.00	
530 Department of Corrections and Rehabilitation	846.29	\$1.250	\$23,750.07	\$1,638.63	\$25,388.70	
540 Adjutant General	234.00	\$1.250	\$2,815.72	\$4,204.28	\$7,020.00	
601 Department of Commerce	66.40	\$1.250	\$1,559.65	\$432.35	\$1,992.00	
602 Department of Agriculture	75.00	\$1.250	\$1,236.36	\$1,013.64	\$2,250.00	
627 Upper Great Plains Transportation Institute	43.88	\$1.250	\$331.36	\$985.04	\$1,316.40	
628 Branch Research Centers	110.29	\$1.250	\$2,415.82	\$892.88	\$3,308.70	
630 NDSU Extension Service	252.98	\$1.250	\$3,867.44	\$3,721.96	\$7,589.40	
638 Northern Crops Institute	11.80	\$1.250	\$299.17	\$54.83	\$354.00	
640 NDSU Main Research Center	336.12	\$1.250	\$6,508.40	\$3,575.20	\$10,083.60	
649 Agronomy Seed Farm	3.00	\$1.250	\$0.00	\$90.00	\$90.00	
670 Racing Commission	2.00	\$1.250	\$60.00	\$0.00	\$60.00	
701 State Historical Society	77.00	\$1.250	\$2,112.41	\$197.59	\$2,310.00	
709 Council on the Arts	5.00	\$1.250	\$150.00	\$0.00	\$150.00	
720 Game & Fish Department	163.00	\$1.250	\$0.00	\$4,890.00	\$4,890.00	
750 Department of Parks & Recreation	65.00	\$1.250	\$1,876.86	\$73.14	\$1,950.00	
770 State Water Commission	96.00	\$1.250	\$0.00	\$2,880.00	\$2,880.00	
801 Department Of Transportation	1054.01	\$1.250	\$0.00	\$31,620.30	\$31,620.30	
State Total	16078.69	\$1.250	\$265,117	\$217,244	\$482,361	

FISCAL NOTE
Requested by Legislative Council
01/16/2017

Revised
 Bill/Resolution No.: HB 1434

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	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	\$397,675	\$325,866	\$397,675	\$325,866
Appropriations	\$0	\$0	\$397,675	\$325,866	\$397,675	\$325,866

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	\$0	\$104,220	\$104,220
Cities	\$0	\$87,075	\$87,075
School Districts	\$0	\$52,920	\$52,920
Townships	\$0	\$0	\$0

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The bill mandates health plan coverage for autism disorders.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Sanford Health Plan estimates a \$1.875 per contract per month premium impact from this bill. Their estimate is based on analysis done on other similar mandates in other states.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

N/A

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$723,541 for the biennium (\$397,675 general funds and \$325,866 other funds).

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The appropriation is not in the executive budget. Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$723,541 for the biennium (\$397,675 general funds and \$325,866 other funds).

Name: Bryan Reinhardt

Agency: NDPERS

Telephone: 701-328-3919

Date Prepared: 01/18/2017

2017-2019 NDPERS Health Plan HB 1434				\$1.875		
		Executive Budget				
		2017-2019	Monthly	15-17 Funding Adjustments		
	Department	FTE	Change	General	Other	Total
101	Office of the Governor	18.00	\$1.875	\$810.00	\$0.00	\$810.00
108	Office of the Secretary of State	33.00	\$1.875	\$1,440.06	\$44.94	\$1,485.00
110	Office of Management and Budget	119.00	\$1.875	\$4,402.38	\$952.62	\$5,355.00
112	Information Technology Department	349.30	\$1.875	\$2,809.24	\$12,909.26	\$15,718.50
117	Office of the State Auditor	53.80	\$1.875	\$1,837.08	\$583.92	\$2,421.00
120	Office of the State Treasurer	8.00	\$1.875	\$360.00	\$0.00	\$360.00
125	Office of the Attorney General	234.00	\$1.875	\$9,646.42	\$883.58	\$10,530.00
127	Office of the Sate Tax Commissioner	133.00	\$1.875	\$5,985.00	\$0.00	\$5,985.00
140	Office of Administrative Hearings	5.00	\$1.875	\$0.00	\$225.00	\$225.00
150	Legislative Assembly	141.00	\$1.875	\$6,345.00	\$0.00	\$6,345.00
160	Legislative Council	36.00	\$1.875	\$1,620.00	\$0.00	\$1,620.00
180	Judicial Branch	354.50	\$1.875	\$15,952.50	\$0.00	\$15,952.50
188	Legal Counsel of Indigents	40.00	\$1.875	\$1,756.42	\$43.58	\$1,800.00
190	Retirement and Investment Office	19.00	\$1.875	\$0.00	\$855.00	\$855.00
192	Public Employees Retirement System	34.50	\$1.875	\$0.00	\$1,552.50	\$1,552.50
201	Department of Public Instruction	97.75	\$1.875	\$1,357.73	\$3,041.02	\$4,398.75
226	Department of Trust Lands	32.00	\$1.875	\$1,008.12	\$431.88	\$1,440.00
250	State Library	29.75	\$1.875	\$0.00	\$1,338.75	\$1,338.75
252	School for the Deaf	45.61	\$1.875	\$791.76	\$1,260.69	\$2,052.45
253	N.D. Vision Services	29.50	\$1.875	\$579.31	\$748.19	\$1,327.50
270	Dept of Career and Technical Ed	25.50	\$1.875	\$486.11	\$661.39	\$1,147.50
215	ND University System	148.40	\$1.875	\$1,747.29	\$4,930.71	\$6,678.00
227	Bismarck State College	358.35	\$1.875	\$3,954.03	\$12,171.72	\$16,125.75
228	Lake Region State College	129.61	\$1.875	\$1,429.87	\$4,402.58	\$5,832.45
229	Williston State College	100.75	\$1.875	\$2,240.94	\$2,292.81	\$4,533.75
230	University of North Dakota	2218.07	\$1.875	\$55,677.38	\$44,135.77	\$99,813.15
232	UND Medical Center	435.75	\$1.875	\$6,454.40	\$13,154.35	\$19,608.75
235	North Dakota State University	1895.66	\$1.875	\$37,232.06	\$48,072.64	\$85,304.70
238	ND State College of Science	345.04	\$1.875	\$7,545.08	\$7,981.72	\$15,526.80
239	Dickinson State University	168.90	\$1.875	\$3,553.92	\$4,046.58	\$7,600.50
240	Mayville State University	210.53	\$1.875	\$9,473.85	\$0.00	\$9,473.85
241	Minot State University	441.65	\$1.875	\$17,353.76	\$2,520.49	\$19,874.25
242	Valley City State University	202.75	\$1.875	\$8,858.65	\$265.10	\$9,123.75
243	Dakota College Bottineau	84.30	\$1.875	\$3,790.35	\$3.15	\$3,793.50
244	ND Forest Service	27.00	\$1.875	\$1,215.00	\$0.00	\$1,215.00
301	North Dakota Department of Health	381.00	\$1.875	\$8,865.74	\$8,279.26	\$17,145.00
305	Tobacco Prevention	0.00	\$1.875	\$0.00	\$0.00	\$0.00
313	Veterans Home	120.72	\$1.875	\$1,852.75	\$3,579.65	\$5,432.40
316	Indian Affairs Commission	4.00	\$1.875	\$180.00	\$0.00	\$180.00
321	Department of Veterans Affairs	9.00	\$1.875	\$351.62	\$53.38	\$405.00
325	Department of Human Services	2204.23	\$1.875	\$83,223.29	\$15,967.06	\$99,190.35
360	Protection and Advocacy Project	27.50	\$1.875	\$1,237.50	\$0.00	\$1,237.50
380	Job Service North Dakota	181.61	\$1.875	\$54.75	\$8,117.70	\$8,172.45
401	Office of the Insurance Commissioner	47.00	\$1.875	\$0.00	\$2,115.00	\$2,115.00
405	Industrial Commission	105.25	\$1.875	\$4,452.37	\$283.88	\$4,736.25
406	Office of the Labor Commissioner	14.00	\$1.875	\$630.00	\$0.00	\$630.00
408	Public Service Commission	45.00	\$1.875	\$1,229.90	\$795.10	\$2,025.00
412	Aeronautics Commission	7.00	\$1.875	\$0.00	\$315.00	\$315.00
413	Department of Financial Institutions	30.00	\$1.875	\$0.00	\$1,350.00	\$1,350.00
414	Office of the Securities Commissioner	9.00	\$1.875	\$0.00	\$405.00	\$405.00
471	Bank of North Dakota	181.50	\$1.875	\$0.00	\$8,167.50	\$8,167.50
473	North Dakota Housing Finance Agency	46.00	\$1.875	\$0.00	\$2,070.00	\$2,070.00
475	North Dakota Mill & Elevator Association	153.00	\$1.875	\$0.00	\$6,885.00	\$6,885.00
485	Workforce Safety & Insurance	260.14	\$1.875	\$0.00	\$11,706.30	\$11,706.30
504	Highway Patrol	206.00	\$1.875	\$7,408.29	\$1,861.71	\$9,270.00
530	Department of Corrections and Rehabilitation	846.29	\$1.875	\$35,625.10	\$2,457.95	\$38,083.05
540	Adjutant General	234.00	\$1.875	\$4,223.59	\$6,306.41	\$10,530.00
601	Department of Commerce	66.40	\$1.875	\$2,339.48	\$648.52	\$2,988.00
602	Department of Agriculture	75.00	\$1.875	\$1,854.55	\$1,520.45	\$3,375.00
627	Upper Great Plains Transportation Institute	43.88	\$1.875	\$497.04	\$1,477.56	\$1,974.60
628	Branch Research Centers	110.29	\$1.875	\$3,623.73	\$1,339.32	\$4,963.05
630	NDSU Extension Service	252.98	\$1.875	\$5,801.17	\$5,582.93	\$11,384.10
638	Northern Crops Institute	11.80	\$1.875	\$448.75	\$82.25	\$531.00
640	NDSU Main Research Center	336.12	\$1.875	\$9,762.59	\$5,362.81	\$15,125.40
649	Agronomy Seed Farm	3.00	\$1.875	\$0.00	\$135.00	\$135.00
670	Racing Commission	2.00	\$1.875	\$90.00	\$0.00	\$90.00
701	State Historical Society	77.00	\$1.875	\$3,168.62	\$296.38	\$3,465.00
709	Council on the Arts	5.00	\$1.875	\$225.00	\$0.00	\$225.00
720	Game & Fish Department	163.00	\$1.875	\$0.00	\$7,335.00	\$7,335.00
750	Department of Parks & Recreation	65.00	\$1.875	\$2,815.29	\$109.71	\$2,925.00
770	State Water Commission	96.00	\$1.875	\$0.00	\$4,320.00	\$4,320.00
801	Department Of Transportation	1054.01	\$1.875	\$0.00	\$47,430.45	\$47,430.45
State Total		16078.69	\$1.875	\$397,675	\$325,866	\$723,541

FISCAL NOTE
Requested by Legislative Council
01/16/2017

Revised
 Bill/Resolution No.: HB 1434

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	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	\$397,675	\$325,866	\$397,675	\$325,866
Appropriations	\$0	\$0	\$397,675	\$325,866	\$397,675	\$325,866

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	\$0	\$104,220	\$104,220
Cities	\$0	\$87,075	\$87,075
School Districts	\$0	\$52,920	\$52,920
Townships	\$0	\$0	\$0

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The bill mandates health plan coverage for autism disorders.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Sanford Health Plan estimates a \$1.875 per contract per month premium impact from this bill. Their estimate is based on analysis done on other similar mandates in other states.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

N/A

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$723,541 for the biennium (\$397,675 general funds and \$325,866 other funds).

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The appropriation is not in the executive budget. Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$723,541 for the biennium (\$397,675 general funds and \$325,866 other funds).

Name: Bryan Reinhardt

Agency: NDPERS

Telephone: 701-328-3919

Date Prepared: 01/18/2017

2017-2019 NDPERS Health Plan HB 1434				\$1.875		
		Executive Budget				
		2017-2019	Monthly	15-17 Funding Adjustments		
	Department	FTE	Change	General	Other	Total
101	Office of the Governor	18.00	\$1.875	\$810.00	\$0.00	\$810.00
108	Office of the Secretary of State	33.00	\$1.875	\$1,440.06	\$44.94	\$1,485.00
110	Office of Management and Budget	119.00	\$1.875	\$4,402.38	\$952.62	\$5,355.00
112	Information Technology Department	349.30	\$1.875	\$2,809.24	\$12,909.26	\$15,718.50
117	Office of the State Auditor	53.80	\$1.875	\$1,837.08	\$583.92	\$2,421.00
120	Office of the State Treasurer	8.00	\$1.875	\$360.00	\$0.00	\$360.00
125	Office of the Attorney General	234.00	\$1.875	\$9,646.42	\$883.58	\$10,530.00
127	Office of the Sate Tax Commissioner	133.00	\$1.875	\$5,985.00	\$0.00	\$5,985.00
140	Office of Administrative Hearings	5.00	\$1.875	\$0.00	\$225.00	\$225.00
150	Legislative Assembly	141.00	\$1.875	\$6,345.00	\$0.00	\$6,345.00
160	Legislative Council	36.00	\$1.875	\$1,620.00	\$0.00	\$1,620.00
180	Judicial Branch	354.50	\$1.875	\$15,952.50	\$0.00	\$15,952.50
188	Legal Counsel of Indigents	40.00	\$1.875	\$1,756.42	\$43.58	\$1,800.00
190	Retirement and Investment Office	19.00	\$1.875	\$0.00	\$855.00	\$855.00
192	Public Employees Retirement System	34.50	\$1.875	\$0.00	\$1,552.50	\$1,552.50
201	Department of Public Instruction	97.75	\$1.875	\$1,357.73	\$3,041.02	\$4,398.75
226	Department of Trust Lands	32.00	\$1.875	\$1,008.12	\$431.88	\$1,440.00
250	State Library	29.75	\$1.875	\$0.00	\$1,338.75	\$1,338.75
252	School for the Deaf	45.61	\$1.875	\$791.76	\$1,260.69	\$2,052.45
253	N.D. Vision Services	29.50	\$1.875	\$579.31	\$748.19	\$1,327.50
270	Dept of Career and Technical Ed	25.50	\$1.875	\$486.11	\$661.39	\$1,147.50
215	ND University System	148.40	\$1.875	\$1,747.29	\$4,930.71	\$6,678.00
227	Bismarck State College	358.35	\$1.875	\$3,954.03	\$12,171.72	\$16,125.75
228	Lake Region State College	129.61	\$1.875	\$1,429.87	\$4,402.58	\$5,832.45
229	Williston State College	100.75	\$1.875	\$2,240.94	\$2,292.81	\$4,533.75
230	University of North Dakota	2218.07	\$1.875	\$55,677.38	\$44,135.77	\$99,813.15
232	UND Medical Center	435.75	\$1.875	\$6,454.40	\$13,154.35	\$19,608.75
235	North Dakota State University	1895.66	\$1.875	\$37,232.06	\$48,072.64	\$85,304.70
238	ND State College of Science	345.04	\$1.875	\$7,545.08	\$7,981.72	\$15,526.80
239	Dickinson State University	168.90	\$1.875	\$3,553.92	\$4,046.58	\$7,600.50
240	Mayville State University	210.53	\$1.875	\$9,473.85	\$0.00	\$9,473.85
241	Minot State University	441.65	\$1.875	\$17,353.76	\$2,520.49	\$19,874.25
242	Valley City State University	202.75	\$1.875	\$8,858.65	\$265.10	\$9,123.75
243	Dakota College Bottineau	84.30	\$1.875	\$3,790.35	\$3.15	\$3,793.50
244	ND Forest Service	27.00	\$1.875	\$1,215.00	\$0.00	\$1,215.00
301	North Dakota Department of Health	381.00	\$1.875	\$8,865.74	\$8,279.26	\$17,145.00
305	Tobacco Prevention	0.00	\$1.875	\$0.00	\$0.00	\$0.00
313	Veterans Home	120.72	\$1.875	\$1,852.75	\$3,579.65	\$5,432.40
316	Indian Affairs Commission	4.00	\$1.875	\$180.00	\$0.00	\$180.00
321	Department of Veterans Affairs	9.00	\$1.875	\$351.62	\$53.38	\$405.00
325	Department of Human Services	2204.23	\$1.875	\$83,223.29	\$15,967.06	\$99,190.35
360	Protection and Advocacy Project	27.50	\$1.875	\$1,237.50	\$0.00	\$1,237.50
380	Job Service North Dakota	181.61	\$1.875	\$54.75	\$8,117.70	\$8,172.45
401	Office of the Insurance Commissioner	47.00	\$1.875	\$0.00	\$2,115.00	\$2,115.00
405	Industrial Commission	105.25	\$1.875	\$4,452.37	\$283.88	\$4,736.25
406	Office of the Labor Commissioner	14.00	\$1.875	\$630.00	\$0.00	\$630.00
408	Public Service Commission	45.00	\$1.875	\$1,229.90	\$795.10	\$2,025.00
412	Aeronautics Commission	7.00	\$1.875	\$0.00	\$315.00	\$315.00
413	Department of Financial Institutions	30.00	\$1.875	\$0.00	\$1,350.00	\$1,350.00
414	Office of the Securities Commissioner	9.00	\$1.875	\$0.00	\$405.00	\$405.00
471	Bank of North Dakota	181.50	\$1.875	\$0.00	\$8,167.50	\$8,167.50
473	North Dakota Housing Finance Agency	46.00	\$1.875	\$0.00	\$2,070.00	\$2,070.00
475	North Dakota Mill & Elevator Association	153.00	\$1.875	\$0.00	\$6,885.00	\$6,885.00
485	Workforce Safety & Insurance	260.14	\$1.875	\$0.00	\$11,706.30	\$11,706.30
504	Highway Patrol	206.00	\$1.875	\$7,408.29	\$1,861.71	\$9,270.00
530	Department of Corrections and Rehabilitation	846.29	\$1.875	\$35,625.10	\$2,457.95	\$38,083.05
540	Adjutant General	234.00	\$1.875	\$4,223.59	\$6,306.41	\$10,530.00
601	Department of Commerce	66.40	\$1.875	\$2,339.48	\$648.52	\$2,988.00
602	Department of Agriculture	75.00	\$1.875	\$1,854.55	\$1,520.45	\$3,375.00
627	Upper Great Plains Transportation Institute	43.88	\$1.875	\$497.04	\$1,477.56	\$1,974.60
628	Branch Research Centers	110.29	\$1.875	\$3,623.73	\$1,339.32	\$4,963.05
630	NDSU Extension Service	252.98	\$1.875	\$5,801.17	\$5,582.93	\$11,384.10
638	Northern Crops Institute	11.80	\$1.875	\$448.75	\$82.25	\$531.00
640	NDSU Main Research Center	336.12	\$1.875	\$9,762.59	\$5,362.81	\$15,125.40
649	Agronomy Seed Farm	3.00	\$1.875	\$0.00	\$135.00	\$135.00
670	Racing Commission	2.00	\$1.875	\$90.00	\$0.00	\$90.00
701	State Historical Society	77.00	\$1.875	\$3,168.62	\$296.38	\$3,465.00
709	Council on the Arts	5.00	\$1.875	\$225.00	\$0.00	\$225.00
720	Game & Fish Department	163.00	\$1.875	\$0.00	\$7,335.00	\$7,335.00
750	Department of Parks & Recreation	65.00	\$1.875	\$2,815.29	\$109.71	\$2,925.00
770	State Water Commission	96.00	\$1.875	\$0.00	\$4,320.00	\$4,320.00
801	Department Of Transportation	1054.01	\$1.875	\$0.00	\$47,430.45	\$47,430.45
	State Total	16078.69	\$1.875	\$397,675	\$325,866	\$723,541

FISCAL NOTE
Requested by Legislative Council
01/16/2017

Bill/Resolution No.: HB 1434

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	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	\$1,336,187	\$1,094,910	\$1,336,187	\$1,094,910
Appropriations	\$0	\$0	\$1,336,187	\$1,094,910	\$1,336,187	\$1,094,910

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	\$0	\$350,179	\$350,179
Cities	\$0	\$292,572	\$292,572
School Districts	\$0	\$177,811	\$177,811
Townships	\$0	\$0	\$0

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The bill mandates health plan coverage for autism disorders.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Sanford Health Plan estimates a \$6.30 per contract per month premium impact from this bill. Their estimate is based on analysis done on other similar mandates in other states.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

N/A

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$2,431,098 for the biennium (\$1,336,187 general funds and \$1,094,910 other funds).

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The appropriation is not in the executive budget. Based on the executive budget FTE count, the additional premium required for the autism coverage would be \$2,431,098 for the biennium (\$1,336,187 general funds and \$1,094,910 other funds).

Name: Bryan Reinhardt

Agency: NDPERS

Telephone: 701-328-3919

Date Prepared: 01/18/2017

2017-2019 NDPERS Health Plan HB 1434				\$6.30		
		Executive Budget				
		2017-2019	Monthly	15-17 Funding Adjustments		
	Department	FTE	Change	General	Other	Total
101	Office of the Governor	18.00	\$6.30	\$2,721.60	\$0.00	\$2,721.60
108	Office of the Secretary of State	33.00	\$6.30	\$4,838.61	\$150.99	\$4,989.60
110	Office of Management and Budget	119.00	\$6.30	\$14,792.01	\$3,200.79	\$17,992.80
112	Information Technology Department	349.30	\$6.30	\$9,439.04	\$43,375.12	\$52,814.16
117	Office of the State Auditor	53.80	\$6.30	\$6,172.60	\$1,961.96	\$8,134.56
120	Office of the State Treasurer	8.00	\$6.30	\$1,209.60	\$0.00	\$1,209.60
125	Office of the Attorney General	234.00	\$6.30	\$32,411.97	\$2,968.83	\$35,380.80
127	Office of the Sate Tax Commissioner	133.00	\$6.30	\$20,109.60	\$0.00	\$20,109.60
140	Office of Administrative Hearings	5.00	\$6.30	\$0.00	\$756.00	\$756.00
150	Legislative Assembly	141.00	\$6.30	\$21,319.20	\$0.00	\$21,319.20
160	Legislative Council	36.00	\$6.30	\$5,443.20	\$0.00	\$5,443.20
180	Judicial Branch	354.50	\$6.30	\$53,600.40	\$0.00	\$53,600.40
188	Legal Counsel of Indigents	40.00	\$6.30	\$5,901.57	\$146.43	\$6,048.00
190	Retirement and Investment Office	19.00	\$6.30	\$0.00	\$2,872.80	\$2,872.80
192	Public Employees Retirement System	34.50	\$6.30	\$0.00	\$5,216.40	\$5,216.40
201	Department of Public Instruction	97.75	\$6.30	\$4,561.98	\$10,217.82	\$14,779.80
226	Department of Trust Lands	32.00	\$6.30	\$3,387.29	\$1,451.11	\$4,838.40
250	State Library	29.75	\$6.30	\$0.00	\$4,498.20	\$4,498.20
252	School for the Deaf	45.61	\$6.30	\$2,660.31	\$4,235.92	\$6,896.23
253	N.D. Vision Services	29.50	\$6.30	\$1,946.47	\$2,513.93	\$4,460.40
270	Dept of Career and Technical Ed	25.50	\$6.30	\$1,633.34	\$2,222.26	\$3,855.60
215	ND University System	148.40	\$6.30	\$5,870.91	\$16,567.17	\$22,438.08
227	Bismarck State College	358.35	\$6.30	\$13,285.55	\$40,896.97	\$54,182.52
228	Lake Region State College	129.61	\$6.30	\$4,804.37	\$14,792.67	\$19,597.03
229	Williston State College	100.75	\$6.30	\$7,529.57	\$7,703.83	\$15,233.40
230	University of North Dakota	2218.07	\$6.30	\$187,075.98	\$148,296.20	\$335,372.18
232	UND Medical Center	435.75	\$6.30	\$21,686.78	\$44,198.62	\$65,885.40
235	North Dakota State University	1895.66	\$6.30	\$125,099.71	\$161,524.08	\$286,623.79
238	ND State College of Science	345.04	\$6.30	\$25,351.46	\$26,818.59	\$52,170.05
239	Dickinson State University	168.90	\$6.30	\$11,941.18	\$13,596.50	\$25,537.68
240	Mayville State University	210.53	\$6.30	\$31,832.14	\$0.00	\$31,832.14
241	Minot State University	441.65	\$6.30	\$58,308.63	\$8,468.85	\$66,777.48
242	Valley City State University	202.75	\$6.30	\$29,765.06	\$890.74	\$30,655.80
243	Dakota College Bottineau	84.30	\$6.30	\$12,735.59	\$10.57	\$12,746.16
244	ND Forest Service	27.00	\$6.30	\$4,082.40	\$0.00	\$4,082.40
301	North Dakota Department of Health	381.00	\$6.30	\$29,788.88	\$27,818.32	\$57,607.20
305	Tobacco Prevention	0.00	\$6.30	\$0.00	\$0.00	\$0.00
313	Veterans Home	120.72	\$6.30	\$6,225.24	\$12,027.62	\$18,252.86
316	Indian Affairs Commission	4.00	\$6.30	\$604.80	\$0.00	\$604.80
321	Department of Veterans Affairs	9.00	\$6.30	\$1,181.44	\$179.36	\$1,360.80
325	Department of Human Services	2204.23	\$6.30	\$279,630.26	\$53,649.32	\$333,279.58
360	Protection and Advocacy Project	27.50	\$6.30	\$4,158.00	\$0.00	\$4,158.00
380	Job Service North Dakota	181.61	\$6.30	\$183.97	\$27,275.46	\$27,459.43
401	Office of the Insurance Commissioner	47.00	\$6.30	\$0.00	\$7,106.40	\$7,106.40
405	Industrial Commission	105.25	\$6.30	\$14,959.97	\$953.83	\$15,913.80
406	Office of the Labor Commissioner	14.00	\$6.30	\$2,116.80	\$0.00	\$2,116.80
408	Public Service Commission	45.00	\$6.30	\$4,132.48	\$2,671.52	\$6,804.00
412	Aeronautics Commission	7.00	\$6.30	\$0.00	\$1,058.40	\$1,058.40
413	Department of Financial Institutions	30.00	\$6.30	\$0.00	\$4,536.00	\$4,536.00
414	Office of the Securities Commissioner	9.00	\$6.30	\$0.00	\$1,360.80	\$1,360.80
471	Bank of North Dakota	181.50	\$6.30	\$0.00	\$27,442.80	\$27,442.80
473	North Dakota Housing Finance Agency	46.00	\$6.30	\$0.00	\$6,955.20	\$6,955.20
475	North Dakota Mill & Elevator Association	153.00	\$6.30	\$0.00	\$23,133.60	\$23,133.60
485	Workforce Safety & Insurance	260.14	\$6.30	\$0.00	\$39,333.17	\$39,333.17
504	Highway Patrol	206.00	\$6.30	\$24,891.84	\$6,255.36	\$31,147.20
530	Department of Corrections and Rehabilitation	846.29	\$6.30	\$119,700.33	\$8,258.72	\$127,959.05
540	Adjutant General	234.00	\$6.30	\$14,191.25	\$21,189.55	\$35,380.80
601	Department of Commerce	66.40	\$6.30	\$7,860.64	\$2,179.04	\$10,039.68
602	Department of Agriculture	75.00	\$6.30	\$6,231.28	\$5,108.72	\$11,340.00
627	Upper Great Plains Transportation Institute	43.88	\$6.30	\$1,670.05	\$4,964.60	\$6,634.66
628	Branch Research Centers	110.29	\$6.30	\$12,175.72	\$4,500.13	\$16,675.85
630	NDSU Extension Service	252.98	\$6.30	\$19,491.91	\$18,758.66	\$38,250.58
638	Northern Crops Institute	11.80	\$6.30	\$1,507.79	\$276.37	\$1,784.16
640	NDSU Main Research Center	336.12	\$6.30	\$32,802.31	\$18,019.03	\$50,821.34
649	Agronomy Seed Farm	3.00	\$6.30	\$0.00	\$453.60	\$453.60
670	Racing Commission	2.00	\$6.30	\$302.40	\$0.00	\$302.40
701	State Historical Society	77.00	\$6.30	\$10,646.56	\$995.84	\$11,642.40
709	Council on the Arts	5.00	\$6.30	\$756.00	\$0.00	\$756.00
720	Game & Fish Department	163.00	\$6.30	\$0.00	\$24,645.60	\$24,645.60
750	Department of Parks & Recreation	65.00	\$6.30	\$9,459.38	\$368.62	\$9,828.00
770	State Water Commission	96.00	\$6.30	\$0.00	\$14,515.20	\$14,515.20
801	Department Of Transportation	1054.01	\$6.30	\$0.00	\$159,366.31	\$159,366.31
State Total		16078.69	\$6.30	\$1,336,187	\$1,094,910	\$2,431,098

2017 HOUSE HUMAN SERVICES

HB 1434

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1434
1/30/2017
27613

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Judy Pepple

Explanation or reason for introduction of bill/resolution:

Relating to health insurance coverage for autism-related services; to provide a statement of legislative intent; and to provide for a report to the legislative management.

Minutes:

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21

Chairman Weisz: Called the committee to order.

Attendance taken.

Chairman Weisz: Opened the hearing on HB 1434.
Is there any one with testimony in support of HB 1434?

Thomas Beadle
(Attachment 1)
9:22

Chairman Weisz: Are there any questions from the committee? Seeing none.
Further testimony in support of HB 1434

Rep. Kasper, Health Insurance

I have been in the health insurance business for many years and until I met with folks in Fargo that have a concern about autism I didn't know autism was not covered. When I learned the facts about early intervention and early treatment for these kids. The fact that not only we can save money, but make their lives better. If you can spend a little money now and save a lot of money later, doesn't that make sense. I would urge you to vote for a do pass on HB 1434.

Chairman Weisz: Are there any questions from the committee? Seeing none
Is there more testimony in support of HB 1434?

12:07

Judith Ursitti, CPA and Director of State Government Affairs for Autism Speaks
Mother of a 13 year old with severe autism.

(Attachment 2)

I speak strongly in support of HB 1434 as it is written.

26:05

Chairman Weisz: Are there questions from the committee?

Further testimony in support of HB 1434

Jennifer L. Skjod

(Attachment 3)

29:21

Chairman Weisz: Questions from the committee? Seeing none.

Representative Schneider: What residential options do we even have in ND?

J. Skjod: Right now we are looking at Dakota Boys and Girls Ranch. He is on their waiting list.

Chairman Weisz: Further testimony in support of HB 1434

Dr. Daisha Seyfer, Developmental Behavioral Pediatrician

(Attachment 4)

I drove 7 hours to be here today to talk to you about autism and applied behavior analysis. I can assure you that ABA is not experimental treatment for autism. It is widely known to be the best treatment. Research tells us that when ABA is applied, 47% of children will be able to enter a regular education classroom without an aide by 1st grade. An additional 42% may improve to the point of needing much less special education. That is a huge impact for the children and their families. Studies have shown that children who receive ABA may make significant and sustained gains in IQ, language, functional living skills, academic performance, self-care behaviors and social skills. ABA can address a very wide range of problems including functional living skills, language, reading, social skills, peer interaction and academic engagement. ABA can also address problem behaviors which tend to be an issue for many families. Many well-known national health organizations endorse the use of this treatment for autism. The benefits of ABA are very well documented. It is absolutely the therapy that any one of us would want for our child or other family member with autism spectrum disorder. I have a two year old child and if she ever needed treatment for autism she would absolutely get ABA. If I had to change jobs or move to another state I would do it. I have known many families that have made those decisions and more to access this therapy. That is how important this therapy is. Sadly, the majority of children in this state and others are not able to access ABA and a very big reason is lack of insurance coverage. Clearly there is tremendous need for a law or something to require coverage of this treatment. There has been a huge effort in the last few years to diagnose autism early. The entire reason being so we can treat early, because we know that if we treat early we have better outcomes. The first 5 or 6 years of a child's life is when the brain is growing and developing at it's most rapid pace. So to have the biggest impact we need to act during those early years. Even receiving ABA at a later age can have a positive impact on children. One child that didn't begin treatment until age 8 said his first words at age 8. Also older kids can have great

improvement in behavioral problems with ABA. I have been asked if speech or occupational therapy could take the place of ABA and that is a valid question because those therapies are easier to access. I never know how to answer that question, because all 3 of those therapies have been useful to kids with autism. However, they are 3 totally different therapies. There is a little overlap, but one doesn't take the place of another. In summary I hope that you will consider passing this bill.

37:43

Chairman Weisz: Questions from the committee?

Representative Porter: Inside of this bill it talks about the specific benefit the portion of the bill talks about dollar amounts that are much higher than what other states have done. Like a 30 cent per member mandate, but looking at your state it is limited to \$36,000 up to age 7, \$25,00 between 7 and 13, and \$12,500 between the ages of 14 and 18 with an age cap of 18. Does SD's plan work and is it doing what it is intended to do at those cap levels?

Dr. Seyfer: It depends on what your child's needs are. If it is a specific targeted problem that they want to work on a lower dollar cap is doable, but the families that have very severely affected children such as 2 and 3 year olds that say 0 words and spend the time in the corner of their daycare doing disruptive and repetitive behaviors that is probably not going to be enough. That has been a struggle in my state.

Representative Porter: So part of our problem is that we have to take a whole lot of people that are not affected and put a mandate on their policy to pay for it anyway. We could see employers drop their insurance coverage for their employees and put them on the exchange. We could end up where they would pick a plan that requires a lot more out of pocket expense for them because this was the tipping point for their plan. Inside of our balance as we talk about these things we don't need the Cadillac version, but maybe the Chevy version and work out the details at some other time. Where do we fit into a version that is going to help us the most, but not have negative effects on the other insured populations of the state?

Dr. Seyfer: I am more familiar with SD law and it would be hard for me to answer. There are others that are going to testify that can answer that.

Representative Porter: You are practicing in SD and SD has a law in place. Is it working?

Dr. Seyfer: It is not working as well as I would like to see it.

Vice Chairman Rohr: Since you have worked with this for a long time, is there a federal reimbursement?

Dr. Seyfer: I am not familiar with that.

Representative McWilliams: I am wondering if it would work with a lifetime cap instead of limiting it to an age or limited to a dollar amount per year. That way a family could use more in the early years and then taper off. How would you see that?

Dr. Seyfer: The concern that I sometimes have that if families know that there is a lifetime cap and they knew they had time to use it they would put it off. That doesn't work.

Representative P. Anderson: When you say it could be better in SD, what could be better?

Dr. Seyfer: Only the top tier of analysts is covered by insurance. Often they are the ones supervising the program, but not doing the therapy, so it would not be covered.

Chairman Weisz: Further questions from the committee? Seeing none.

Chairman Weisz: Further testimony in support of HB 1434?

46:46

Chelsea Evenstad, M.S., BCBA, LABA
(Attachment 5)

54:29

Chairman Weisz: Questions from the committee?

Representative P. Anderson: When you describe a family without insurance. How much would it be?

C. Evenstad: \$100/ hour for a behavior analyst, and it would be \$50/hour for the behavior technician.

Representative P. Anderson: Can you give us an average of how many hours we are talking about? How many hours a week or how many hours a month?

C. Evenstad: No I can't. It really depends on the severity of their problems. The ones with more severe problems could be looking at 20-40 hours a week.

Representative Schneider: I see from earlier testimony that there is a service in West Fargo. Is there service available in other parts of the state?

C. Evenstad: No that is the only center of its kind. I don't foresee that more providers will open a practice until something passes like this so that it will pay for the providers to come in.

Representative McWilliams: How many Board Certified practitioners do we have in ND?

C. Evanstad: Right now we currently have about 23.

Representative Skroch: Are there other treatments available in the state?

C. Evanstad: It really is the only treatment that works.

Chairman Weisz: Further Testimony in support of HB 1434?

59:00

Ethan Paul Suda, a child with autism
(Attachment 6)

1:03

Chairman Weisz: Are there any questions from the committee?

Representative Schneider: Do you still have to have therapy?

E. Suda: No, I haven't done it since I was in the second grade.

Chairman Weisz: Further testimony in support of HB 1434?

The Kern Family (Attachment 7)

Charlie
Kenny
Tommy
Jack

Janice
1:15:40

Chairman Weisz: Further testimony in support of HB 1434

Sharbono Family (Attachment 8)

Jens
Kristin
Doug

Chairman Weisz: Are there questions from the committee?

Chairman Weisz: Is there further testimony in support of HB 1434?

1:25

Ted Fogarty, MD
(Attachment 9)

Chairman Weisz: Are there questions from the committee?

Chairman Weisz: Further testimony in support of HB 1434?

Sandy Smith, Exe. Dir. ND Autism Center, Inc.
(Attachment 10)

1:46

Chairman Weisz: Questions from the committee?

Representative Porter: Inside of your business model you deal with a lot of different insurance companies and forms of reimbursements. I am kind of curious about different 3rd party payers and how they participate.

S. Smith: Some of the 3rd party payers are obviously Microsoft and Premiere Blue Cross and Blue Shield. They have always allowed us to bill to them directly. Up until January of 2017, we were unable to bill any out of state insurance through the ND Blues because they didn't offer ABA therapy as a benefit. I believe that is fixed now. We are in the final stages of getting our paperwork completed so we can do that. We are on BC and BS of Illinois. It

does happen to be a self-funded plan. My son does not have therapy anymore because I gave that up. We also have BC and BS of Minnesota which now we will be able to start serving through the ND blues. Tricare which military insurance we do have some clients with that. Other than that the development disabilities waiver has \$5200 of behavior consultation in it. Some of those families have taken advantage of that and engaged us to come in and help them. We work for a local school district that keeps us very busy. If it is not treated it just goes down-hill rapidly. It will continue to be an issue unless the state decides to do something about this problem. I also want you to know there is no money. We are a non-profit. I believe this year after our audit we will end up in the red. It is very difficult to keep staff without having insurance reform.

Representative Kiefert: Are the kids left untreated continuing to stay in that cycle or do they gradually grow out of it. What is your success rate.

Sandy Smith: It depends on the severity. I don't know exact numbers.

Representative Skroch: Have you been able to obtain any data to show the comparison between the early intervention and those not treated and the cost to the state. Like the ones that received early intervention and the ones that did not.

Sandy Smith: I really don't have time to do this. I am the everything at our facility. I do think there are other resources that.

Is there further testimony in support of HB 1434?

Eric Mauch, Father of an autistic child
(Attachment 11)

Chairman Weisz: Questions from the committee?

Chairman Weisz: Further testimony in support of HB 1434?
1:57

Jen Werder, IT Systems Coordinator
(Attachment 12)

Chairman Weisz: Are there questions from the committee?

Chairman Weisz: Is there further testimony in support of HB 1434?
2:03

Samantha Stewart, Mother of a child with autism
(Attachment 13)

Chairman Weisz: Are there questions from the committee?

Chairman Weisz: Is there further testimony in favor of HB 1434?

Jeff Schatz, Supt. Of Fargo Public Schools

I did not plan on testifying today, so I have nothing prepared for you. As I listened to the testimony today I realized that one voice that has not spoken today is the school district. I can tell you that this is a real problem, for these families and for all of us. In society when we don't take care of the neediest when we know there is something to take care of them, in my business we call that educational neglect. I have visited with some of these families. I am not a career superintendent. I am only 5 years into this. I spend 17 years as a high school principal. I worked daily with parents and children that struggled in school and have all sorts of issues when it comes to different types of disabilities. The autism spectrum is impacting our schools greatly. When we know that we could be proactive and provide some kind of therapy that would help our students be better prepared to come to school and to be able to learn and be among their peers and to function in a normal environment then it is incumbent for us to do something about it. I wanted to stand up today to say there is a strong voice in the school to support these parents and all of those affected by this.

Chairman Weisz: questions from the committee?

Representative McWilliams: Is there a way to quantify how much it is costing the schools in working through autism scenarios in the classroom, the principal's office and the disruption it causes to the schools. Is there a way to quantify that?

J. Schatz, In Fargo public schools it costs 29 million dollars a year to provide special education services. What is reimbursed to us and what is not is a difference of 11 million dollars to our general fund. You talk about the number of students here on the spectrum. I will tell you that out of the 1200 students that we have a great number will be effected somehow or some way. The cost to the school district in totality is probably 29 million. Costs to us on a daily rate. The biggest need that we have right now is the one to one support to help in the classroom to deal with those behaviors. We have 298 paraprofessionals in our district and not a week goes by that I don't get a request for another one. A paraprofessional costs us about \$30,000/year. When you look at salary and benefits. I can stand up here and say that at a cost of \$29,000,000 and of that the \$11,000,000 that is not reimbursed that is inadequate.

Representative McWilliams: Would it be fair to say that the state of ND is already paying the cost of this program in other forms and implementing this would end up saving the schools time and resources?

J. Schatz: There are two things we are looking at as a school district right now. We can't just hire a paraprofessional to stand next to someone. They have to be trained and the training is very expensive, but it is necessary!

Chairman Weisz: Further questions in support of HB 1434

Jeanelle Griggs

He receives \$5200/ year for ABA. We tried to do one hour a week. It worked well, but one hour a week didn't go very fast. Then when we ran out of money and we had to stop and so the next year, we decided to do more hours for a shorter part of time. He made great progress, but then we ran out of money and it had to stop. He lost everything he had gained.

Chairman Weisz: Further testimony in support?

Linda Thorson, Speech and Language Pathologist

I have worked at the School for the Deaf and one of my first students there was a young man who was much taller than I. He was a senior and both deaf and autistic. If you can imagine a 19 year old woman beginning as a speech therapist pathologist. I had no clue how to reach this young man, but I want you to know one thing he did. He was 19 years old he still had stressors and the way he worked that out was to attack me. He would run fast and put his arms around my legs. It happened so that the governor was visiting our school that day and thankfully I knew the young man needed to go outside and he followed me. Someone asked if these children out grow this? That is what we are talking about. If we can reach them in the preschool years we see them change. That young man never did leave an institution, because he took a bat to the house and the car where his parents lived. So I am here today that I believe these children are reachable when you give them the opportunity.

Chairman Weisz: Further testimony in support of HB 1434?

Testimony in opposition to HB 1434?

Seeing none, we will close the hearing on HB 1434

Dr. Tracie T. Newman, MD, MPH, FAAP
(Attachment 14)

Stephanie Hanson, MD, FAAP
(Attachment 15)

Pam Gallagher, LSW
(Attachment 16)

Dr. Lisa Faust, Senior Medical Director of Behavioral Health for BCBSND
(Attachment 17)

Brent Bogar, Greater ND Chamber
(Attachment 18)

Christopher H. Tiongson, MD
(Attachment 19)

Dr. Carrie Brower-Breitwieser
(Attachment 20)

Dr. Patrick Welle
(Attachment 21)

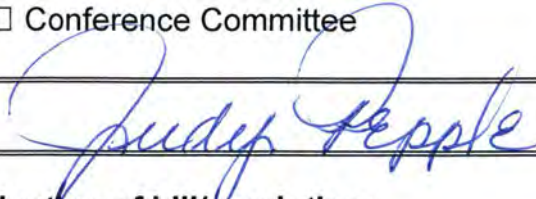
2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1434
2/7/2017
27993

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to health insurance coverage for autism-related services; to provide a statement of legislative intent; and to provide for a report to the legislative management.

Minutes:

1, 2, 3

Chairman Weisz: Called the committee to order.
Attendance was taken.
Opened the discussion on HB 1434

(Attachment 1)

Chairman Weisz: Several sessions ago we passed legislation that said that if any particular bill is declared a mandate, or deemed to be a mandate at the discretion of chair of the Senate and the House, then there has to be an actuarial analysis done and that is what you have here. The first 2 years it would apply only to PERS. The bill in front of you says that it is not a mandate for purposes of that PERS position that the legislature had passed several sessions ago. That doesn't mean that it is not a mandate, it means that it would go into effect right away. It wouldn't run through the normal PERS process.

That is the reason for the Actuarial Analysis in front of you. It is somewhat lengthy, but you can see where they came up with the average per person per month. Both PERS and the insurance department are here. Does either one of you have any comments based on the actuarial analysis?

We did this to see if the actual costs agreed with the what the Actuarial Analysis says.

Representative Porter: I would be interested in hearing from PERS in regards to their fiscal note which shows \$1.87 per policy. The first one came back at \$6 and the second one came back at \$1.87 per policy on the same bill. I would be interested to know what brought it down to that level and then how they plugged it into the bill.

Sparb Collins, Director of PERS

When the bill was originally costed out PERS send the bill to our carrier. Previously we sent it to BC and BS and their actuary costed it out and this time we sent it to Sanford and their actuary costed it out. They originally came up with the \$6 number based upon their underlying assumptions that they had. They had an opportunity to follow up with some other individuals that had worked on the bill, some individuals from other states that had similar legislation in place. As a result of those conversations they were able to update their cost estimate and change some of their underlying assumptions which brings down the cost right now to the \$1.87 per contract. Keep in mind there are two ways these numbers get looked at and \$1.87 is per contract per month. Then there is another way that says it is per member per month. Per member per month is going to be substantially cheaper. For example, in PERS we have about 28,000 contracts and we have about 68,000 members. So if you divide it by the contracts you divide by 28,000 and if you divide by the members, you divide by 68,000. At this point the note that we did our number was \$1.88 per contract per month or \$.75 per member per month. Then I happened to take a look on page 21 and they are coming in at about \$.71 with administrative costs per member per month. So their \$.71 to compare to our \$.75 per member per month. Now concerning the fiscal note. What we do when we come up with a fiscal note is once we get that number we convert it to the per contract and take it times the number of contracts there are in the state in our participating political subdivisions. You will note that the first fiscal note had a fiscal impact in the upcoming biennium and at that time we were assuming that this was a mandate bill, so that would mean it would take effect in PERS immediately. Then we noticed that it was not a mandate bill so that is the reason the fiscal note was updated. How that works is that if it is not a mandate bill it will take effect August 1. It would be effective for contracts after August 1. The PERS contract starts July 1, so our next contract after August 1 would be July 1 of 2019. That is when it would take effect for us. If you change it to a mandate, we would have to update that fiscal note.

Representative Porter: If it is a mandate, what number did you come up with.

S. Collins: The dollar amount that we came up with was 1.3 million in general funds and 1 million in other funds. I am sorry, that is the wrong note. It would be \$397,000 in general and \$325,000 in other funds for the state.

Representative Porter: When would it go into effect?

S. Collins: This assumes that it would be a mandate and it would go into effect with us on July 1. If it is not a mandate, then it wouldn't go into effect until the 2019 – 2021 biennium.

Chairman Weisz: You are assuming the exact same fiscal effect if it went into effect for either biennium.

Representative Porter: On page 3 of the bill on line 6 we set the maximum benefit at \$50,000 and I would guess that was per year. If we would change that to \$25,000 would that cut your fiscal note in half?

S. Collins: No, I am not an actuary, but I answer that from past experience that many times I have applied that to something and it doesn't. It depends on how they change that underlying assumption. This would go down by half if the assumption was that everyone

used \$50,000, but that is not necessarily going to occur. So they will have to build in some assumption and figure it out.

Representative McWilliams: In the bill and the analysis the rates go down at 26 years old. Would the rates go down if that was capped at 10 years old or 12 years old.

S. Collins: That would have to be figured by the actuary. It would have an effect, but I don't know what that would be.

Chairman Weisz: Are there any further questions for Mr. Collins?

Chairman Weisz: What was the PERS recommendation?

S. Collins: They didn't take a position on this. There is a whole process that takes place before they would come forward with a recommendation.

Chrystal Bartuska, Division Director over Forms and Rates in the ND Insurance Dept. In looking at this actuary analysis he does reference in here regarding the \$50,000. He says in here that it is not very common that most people would go to the \$50,000 limit. It is naturally an assumption on his part. I think that if you are considering changing those limits you should go back to the actuary. He could produce those figures quickly.

Chairman Weisz: Are there any questions for the insurance department?

C. Bartuska: Chairman Weisz you and I had talked and we discussed this being a mandate, for those of you that don't know, the Affordable Care Act in 2012 was established was that if the state passed a mandate past a certain time frame it was the responsibility of the state to pay for those costs. I have done some research on that piece of it. This bill actually would not require the state to pay for those costs. The way the Autism Speaks group has gotten this passed at a national level is that they pulled out the ACA plans.

Chairman Weisz: You are sure that it won't come back and make us pay?

C. Bartuska: This has been adopted by 44 other states in some form. Of those 44, 20 of those were after the 2012 mark and the feds have not required any of them to pay for those costs. ACA then allows the caps.

Representative Porter: page 3 lines 29, 30, and 31 is that exemption component that throws out the other plans. So then my question is what plans would this effect?

C. Bartuska: It would affect all grandfathered business and the carriers for all of the grandfathered business in the state are BC and BS and Sanford having the PERS plan and then all large group. Large group encompasses more than just the three carriers that we commonly hear in the state. Medica, Sanford, BC & BS, Aetna, United Health Care, anybody that sells large group plans would then also be required to cover these benefits. The department doesn't take a position on the caps, because we have caps in code now. OPur concern is the cap being based off of this price index. The challenge is that you guys as an insured get your certificate of insurance it tells you what your caps are and your copayments, etc. If this cap changes every year and it is based on a price index that means the carriers

would have to refile those forms every year. There is no fiscal note coming from our department. We would just absorb those costs, but commonly large group carriers once they file their products, they are filed. They don't change a lot of things.

Vice Chairman Rohr: So is there a cost each time that filing is done?

C. Bartuska: Not if you are domestic company. The domestic companies in ND don't have to pay filing charges. But if you are a nondomestic company and your state requires a fee, then they would have to pay a fee to ND.

Representative Skroch: You were referring the section 6 – 9. Would it be possible for us to put a time frame in there like it has to be updated every 6 years or something? Do they update their stuff every so often and maybe we could do it at the same time.

C. Bartuska: It would be up to the carriers. Usually they don't change things through us. Their contracts may stay the same. It depends on the company.

Chairman Weisz: Do you have any idea how many would be under this mandate?

C. Bartuska: No, I don't. In looking at the actual report he did some analysis on page 8 and talks about the autism registry. That would give you more information.

Chairman Weisz: How many plans or people are we talking about under insurance.

C. Bartuska: I actually have those numbers. I can give you a ballpark number. Between grandfathered and large group in the state of ND I would say 100,000 and 150,000, but that is just the 3 carriers that we do stuff on.

Chairman Weisz: Any further questions for Crystal?

Chairman Weisz: Representative Porter had some question about removing the cap.

T .Beadle
(Attachment 2)
He went through his amendment.

Chairman Weisz: Questions

Representative McWilliams: Why are you looking at Texas?

T.Beadle: It was the most easily searchable. I have some other states as well, Ohio, Georgia, Iowa. It was a cleaner statute and they are very similar to us.

Representative McWilliams: Are you aware of what Texas is doing currently with this legislation? On what is being purposed there?

T. Beadle: I don't think they are doing anything currently. They were debating this issue in 2009 and then again in 2013. Gov. Perry at the time was trying to get the cap for under 10 removed, but I don't believe they are currently doing anything to adjust that statute.

33:08

Representative McWilliams: My understanding comes from my cousin who has a degree in ABA in Texas. They are currently looking at putting that cap back down to 10 or 12 for the age cap of ABA services. I think they are looking at bring this cap back down to a lower level to adjust to cost, but to reduce that maximum.

T. Beadle: I had no idea what they are doing. I really don't have any hard feelings as to where we would do a cap. I just know that the younger intervention is what is important.

Chairman Weisz: Ok committee do you have any more questions for those in the room?

Representative Devlin: I am just curious if BC & BS is going to offer this year. Is that true?

Megan Smith Harn: Blue Cross and Blue Shield of North Dakota

Yes, BC & BS of North Dakota has every intention of implementing an ABA benefit on Jan. 1, 2018. They feel that the evidence is at a tipping point. The FEP feels that in certain instances often times age 2 – 12 there is starting to be some outcome for ABA. As the administrator of the federal employee program in ND, for those 8000 plus employees here, we just decided that if the science is coming to a tipping point, we prefer to apply that for our commercial market as well. We cover all of the diagnostic assessments, we cover all of the medication, the psych visits, your physical therapy, speech therapy, your occupational therapy. We already cover all of the evidence based therapies and we always have. We are now saying is that if ABA in various instances is going to be helpful to our members with autism, we think that we should be providing it similar to what is happening with the FEP. We will be doing that on January 1, 2018 and that charge is actually being led by our CEO. The problem that you are going to find here is that we can't really do both. There is cost associated with ABA therapy and when we dive into other blue plans and what is happening in other states. Whether it is \$50,000 or \$36,000 you are grossly underestimating the cost of what ABA therapy is for these children. We have looked into our plan between \$150,000 and \$200,000 annually per child. That is in those instances where it is 2 – 12 and they are receiving a 12- hour assessment. They are getting reevaluated every 6 months. There is a very cohesive plan. They are receiving some after school care which the parents are very involved, because if it is going to be after school hours and more than 8 hours a day the parents need to be engaged as well. All of that is happening, but it does come at a significant cost, but that is something we are looking at doing. It is just that we can't really do both. If we are going to mandate that it needs to be 0 – 26, that \$50,000 cap every year we can't do the FEP program as well. The other concern that we would have is that this is really kind of cherry picking. When we apply something, we apply it to our whole commercial market.

Chairman Weisz: Can you tell me what the terms will be on your contract when you come out with it in 2018?

Megan: It is very specific on age and treatment. It is really based on the provider and the patient. We don't engage in what they receive and what they don't receive. It is kind of the

same as we have it now with our plans with speech and physical therapy and all of that. We will be matching FEP exactly.

Chairman Weisz: Does it follow what we have here?

Megan: I can tell you that I don't believe that it follows what you have here. I think there is some information that we have. We don't have the policy completely outlined, but I can some of it to the committee.

Vice Chairman Rohr: Will this drive up the cost.

Megan: There will be an actuary done in two weeks, based on what we are doing to our commercial market.

Vice Chairman Rohr: You are expecting an increase?

Megan: Yes,

Representative Skroch: Do you have data supporting your testimony about ABA therapy having a much higher cost than what we have estimated. Could you produce that data for us? If you have that data nationwide and if you can show any benefit of that treatment in the long term.

Megan: I think the important thing to note too is that just because we have 45 mandates passed doesn't mean that we have a standardization of care. If you look at the 45 mandates right now they are all different.

Representative Kiefert: So if this bill passes it will limit what you can do? So I am assuming it would be a bad thing.

Megan: Yes. I think that you see historically with BC/BS of ND when we went through the process of selecting the benchmark we had a richer plan that we ended up having to roll back some, because there was a different benchmark selected. I think you would see the same thing here. We anticipate providing a fairly rich benefit to our members and if you did this it would roll it back some.

Representative Kiefert: Do you know of any other insurance companies that are doing this?

Megan: No I don't know, but usually they follow suit to stay competitive.

Chairman Weisz: So to be clear, you are going to be offering this January, 2017 to the federal. If this passes would you say that it would be somewhat or substantially different than your federal program. So do you have two different programs?

Megan: The federal benefit went into effect on January 1, 2017. BC/BS intends to copy that benefit and provide it to our commercial market January 1, 2018. If this mandate passes we won't be able to offer the FEP to our commercial market because those resources will be used to cover this mandate.

Representative McWilliams: Is there a way in this bill that we could set minimums? Like saying instead of being a mandate you could cover up to this amount? If we amend the bill and say that you have to cover at least this amount. Would that open up the market if it wanted to open up different levels of coverage/

Megan: I really leave that to you all to decide. If you are looking at the free market, all I can tell you is that on our own, having studied this over the last several years, because this is not the first time an ABA mandate has come up at the legislature, we are willing to offer it because science is moving and we want to support our members with autism that are seeking this benefit. If you are applying the free market principle, we are doing that without a mandate. The only other caution I have is that when you mandate in state code we have never seen a mandate come off of the books. Like the PSA test that was mandated a few years ago, because it was the scientific evidence then, but now the PSA test has a 50 something percent false positive, however we have never taken the mandate off the books here in ND.

Representative P. Anderson: We did do that with dense breast tissue. It comes off in July of this year.

Representative Kiefert: What is the % of the population in ND have Blue Cross right now?

Megan: I am looking at Chrystal because she has the numbers.

C. Bartuska: In 2015 the market was 75%. That would have been after the PERS change. Prior to that it was at 90%. Once Sanford got PERS, that's when it came down.

Chairman Weisz: Are there any more questions from the committee?

Daniel Hannaher, Sanford Health

No, I don't have that information, but I can get it. I will have a statement from Sanford Health for you on that topic.

Chairman Weisz: We have a bill before us with some suggested amendments. I guess we have heard everything we want to hear or didn't want to hear. What does the committee wish?

Representative Devlin: I have been consistent in my legislative career in not voting for mandates. We got into the study for two years because we were getting this double digit increase in healthcare premiums. We found out that mandates were costing consumers so much money and we put in the two- year test to see if they actually were going to work the way they were intended. If it were a clear mandate bill I would just vote no, but to fix it, I think we need to get rid of sections 2 and 3 and get rid of the mandate.

Chairman Weisz: Ok offer it to the committee>

Representative Devlin: I offer an amendment on HB 1434 to eliminate sections 2 & 3.

Chairman Weisz: Ok committee, the motion is to eliminate section 2 and 3 on page 4 of the bill. Is there a second?

Vice Chairman Rohr: I will second it.

Chairman Weisz: Discussion? I want the committee to be clear about what this does if you have a question on this. This will basically move it back to PERS. It will start immediately.

Representative Devlin: Greater ND association said they don't know what is going to happen to Obama Care and for us to start adding regulatory requirements based on that going to be there is uncertain. We have seen before that the marketplace takes care of it. I think that is what BC is doing. They offer the insurance that the people want. I have never seen where mandates do anything but drive up the cost for all consumers. There is no way I can support this as it is written. I understand the parents and the issues they are going through, but I don't think it is fair to do this to all consumers when we have a better option to study this and then allow us to make an educated decision.

Representative P. Anderson: I think 2 years is too long for some of these families. I think we have to do something. Whether it is a mandate or not or whether it goes away in two years. I just think we need to do something.

Representative McWilliams: Can we put a sunset on this mandate? So we can see what it will do by the next biennium.

Chairman Weisz: We can do it, but it is hard for insurance companies. Once they develop it, get it filed and approved and then in 2 years it goes away? I would guess that is not going to be very popular from that standpoint. Yes, we can do it, good or bad.

Representative Porter: One thing I think we need to keep in mind is that we are not saying that other insurance plans and companies can't adopt all of the same things. States that adopt the federal employee plan as the gold standard of mandates, they are looking at the fact that there is a component of that plan that includes autism coverage. There isn't some kick the can down the road and wait. All we are dealing with here is the PERS plan and seeing how this model works. There are other models out there. This isn't a one size fits all situation. There are other models out there in the private health insurance industry is looking at implementing in the meantime. I think saying that we aren't doing something is not correct. When there are other options out there.

Chairman Weisz: Representative Porter, while you were gone they told us they are offering a plan on January, 2018

Representative Porter: One of my problems with insurance mandates has always been that they are emotionally based and have nothing to do with medicine or science, and when the science changes we never go back and tweak the language of the mandate. We just keep on paying. Like the PSA test. It is outdated.

Chairman Weisz: That came up while you were gone too.

Representative Porter: I would like to see this expanded to the gold standard of the industry rather than have these pieces of emotion come in and pick and choose which one wins and loses each go around.

Representative Kiefert: I would like to ask Rep. Beadle a question. If BC/BS does what they are planning this bill could limit their treatment options to \$36,000/year where it could be close to \$100,000, are we really helping? I think this could actually make things worse.

T. Beadle: That is something we need to consider, but what the families say is that they have been told that we are going to get coverage before and it doesn't happen, so this is kind of a hold their feet to the fires so that we really get what they say we are going to get. That is why this was brought forward. That is why I said we are open to amending this.

Representative Kiefert: So, if we hear that Sanford is going to cover it too, would that be ok.

T. Beadle: They really don't care what you do as long as they get some coverage,

Chairman Weisz: In the FEP it is limited to 12 and that is where some of our discussion has come in.

T. Beadle: There are a couple of differences. The age limit and also I believe that it is very restrictive in the steps you need to take before you get the coverage. The FEP language is very close and tightly covered. In the original bill draft I think the families wanted a little more flexibility in there than what it was. Like going to the dentist's office. If the dentist does it or the hygienists does it the insurance covers them both. They want to be sure whether the therapist or the technician does it that it is covered.

Representative Kiefert: Is there any way that we can have an amendment so if they do provide coverage we are not limiting it.

T. Beadle: We just want something in there that says that they will cover it. The science has fairly well proven this since 2008 or 2009 when we started seeing a lot of these first getting introduced and popping up. In 2013 is when the majority of the states started passing this language. We just want to be sure we do have it there, because since 1987 they have been doing ABA therapy.

Representative Schneider: How critical is that APA component to the folks that are pushing this to pass this bill? It definitely was emotional testimony that we heard, but it was compelling in that we heard that it has a dramatic difference in allowing children that were extremely ill to make them so much better. Parents were all giving credit to ABA therapy for that and if BC/BS is just beginning to cover it and does not cover it to the extent that the bill does. Is that a deal breaker for those families?

T. Beadle: I know that ABA therapy is critical for some of these families, but not everyone is seeing the kinds of results with ABA, but it definitely helps. There are all kinds of new things out there. The ABA therapy really helps.

Representative Schneider: Are you concerned that if we rely on BC/BS to develop their plan that we are going to be missing out?

T. Beadle: I am concerned that if we don't have ABA therapy coverage in the state that we are missing an opportunity to try to benefit some of the most vulnerable citizens. It is a very solid approach and it is different than other therapies.

Representative Devlin: Can you tell me where BC/BS or Sanford has said they would do something and then they didn't?

T. Beadle: I heard it from the families. They have never lied to me. The parents wanting the feet held to the fire. I trust the companies we have in the state. They have never done anything wrong to me. They just want their feet held to the fire.

Representative Devlin: Saying that the parents want their feet held to the fire is different than what you said.

T. Beadle: I didn't intend for it to be different. I see no problem with it. I see no problem if they cover it and it is proven to work. This is something that is going to benefit our state. This is another tool in the toolbox. I would really like to see this done.

D. Hannaher: Sanford does cover ABA in both ND and SD. In SD it is mandated. They passed coverage of \$36,000 of children through the age of 6, \$25,000 from ages 7 – 13, and \$12,500 for ages 14 – 18. Their services must be provided by providers that have masters or doctoral degrees.

Chairman Weisz: Ok committee, there is a motion on the floor.
If there is no further discussion on that, the clerk will call the roll on the motion.

Roll call vote taken on motion to remove sections 2 & 3

Motion carried Yes 7 No 4 Absent 3

Chairman Weisz: We have amendments presented by Rep. Beadle.

Representative Porter: Based on what D. Hannaher gave us on the SD stair step coverage, I like that concept better than what Rep. Beadle is proposing on the first 3 lines of his amendment.

Chairman Weisz: Rep. Beadle would have no limit under age 10 and then a \$36,000 cap through 19.

Representative Porter: Then I guess I like the SD language a little bit better. Is there a way to get that printed out so we can see that?

Chairman Weisz: There probably is, but I would like to take this up before Feb. 23rd.
(Attachment 3)

Representative Porter: In the testimony that came in it was very apparent that the treatments are more intense at the younger ages and then get to a point where they are ineffective after a certain age also. I think based on the science and the testimony it pays to be intense and do the stair step like SD did rather than just kind of a blanket coverage that is being proposed here.

Chairman Weisz: Megan is getting the copies for us. We will take a to minute break while she does that.

Vice Chairman Rohr: D. Hannaher I know you just started this a few years ago, but do you have any data from SD?

D. Hannaher: No, I don't think they would have any data that would be important at this point.

Representative Porter: I would move an amendment on page 2 line 20 change that from 26 years of age to say 19. Then on page 3 lines 5-12 replace that language with "the coverage for ABA shall provide an annual maximum benefit that shall not be less than the following, through age 6 \$36,000, age 7 – 13 \$25,000, age 14 – 18 \$12,500"

Representative B. Anderson: seconded

Chairman Weisz: taking Rep. Beadle's amendment and making it a 3 tier model.

Representative P. Anderson: As I read it they could do more.

Chairman Weisz: Yes, but they have to provide at least that minimum.
Does everyone understand the amendment? If so we will try a voice vote.

Voice vote carried.

Chairman Weisz: Are there any further amendments?

Representative McWilliams: I know that we voted to take out the mandate in section 2, but I make a motion to reinstate section 2 and 3

Representative P. Anderson: second

Chairman Weisz: Is there any discussion on that?

Representative Porter: I am still going to be against that. I think other insurance companies will be working on this and we will be able to see what the effects were over the interim. I think to make this into a mandate when the industry is already working on it now.

Chairman Weisz: Any further discussion? Seeing none, the clerk will call the roll for this motion to reinstate section 2 and section 3 of HB 1434.

Roll call vote taken Yes 4 No 7 Absent 3
Motion failed

Representative Porter: I move that we do pass as amended and rerefer to appropriations.

Vice Chairman Rohr: second.

Chairman Weisz: Now we are back on PERS. Is there any further discussion on the bill?
It is for a do pass as amended and to refer it back to appropriations.

Roll call vote taken on do pass as amended on HB 1434.

Motion carried Yes 9 No 2 Absent 3

Chairman Weisz: do I have a volunteer to carry this bill?
Representative Porter: I will carry it.

February 7, 2017

2/7/17 DLO

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1434

Page 1, line 1, remove "and a new section to"

Page 1, line 2, remove "chapter 54-52.1"

Page 1, line 3, remove "to provide a statement of legislative intent;"

Page 2, line 20, replace "twenty-six" with "nineteen"

Page 3, line 5, remove "Coverage for applied behavior analysis under this section is subject to a maximum"

Page 3, replace lines 6 through 15 with:

"Coverage for applied behavioral analysis must provide an annual maximum benefit that may not be less than:

- a. Thirty-six thousand dollars for individuals under the age of seven;
- b. Twenty-five thousand dollars for individuals between the ages of seven and not yet fourteen; and
- c. Twelve thousand five hundred dollars for individuals between the ages of fourteen and not yet nineteen."

Page 4, remove lines 13 through 20

Renumber accordingly

Date: 2/7/17
Roll Call Vote #: _____

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1434

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Remove Section 2 & 3

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Devlin Seconded By Rep. Rohr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson		✓
Vice Chairman Rohr	✓		Rep. Schneider		✓
Rep. B. Anderson	✓				
Rep. D. Anderson	absent				
Rep. Damschen	✓				
Rep. Devlin	✓				
Rep. Kiefert		✓			
Rep. McWilliams		✓			
Rep. Porter	✓				
Rep. Seibel	absent				
Rep. Skroch	absent				
Rep. Westlind	✓				

Total (Yes) 7 No 4

Absent 3

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2/6/17
Roll Call Vote #: 2

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1434

House Human Services

Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation:

☒ Adopt Amendment

☐ Do Pass

☐ Do Not Pass

☐ Without Committee Recommendation

☐ As Amended

☐ Rerefer to Appropriations

☐ Place on Consent Calendar

Other Actions:

☐ Reconsider

☐ _____

Motion Made By

Porter

Seconded By

B Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. P. Anderson		
Vice Chairman Rohr			Rep. Schneider		
Rep. B. Anderson					
Rep. D. Anderson					
Rep. Damschen					
Rep. Devlin					
Rep. Kiefert					
Rep. McWilliams					
Rep. Porter					
Rep. Seibel					
Rep. Skroch					
Rep. Westlind					

Total

(Yes) _____

No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Change age 26 to 19 on page 2 line 20
Page 3 line 5-12 Replace that language with,
"the coverage for ABA shall provide an annual
maximum benefit that shall not be less than
through age 6, \$36,000; age 7-12, \$25,000; age
14-18 \$12,500."

Date: 2/7/17
Roll Call Vote #: 3

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1434

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Reinstate Sections 2 & 3

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐

Motion Made By Rep. McWilliams Seconded By Rep. P. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz		✓	Rep. P. Anderson	✓	
Vice Chairman Rohr		✓	Rep. Schneider	✓	
Rep. B. Anderson		✓			
Rep. D. Anderson	absent				
Rep. Damschen		✓			
Rep. Devlin		✓			
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter		✓			
Rep. Seibel	absent				
Rep. Skroch	absent				
Rep. Westlind		✓			

Total (Yes) 4 No 7

Absent 3

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3/7/17
Roll Call Vote #: 4

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1434

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 17.0261-01001

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐

Motion Made By Rep. Porter Seconded By Rep. Rohr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz		✓	Rep. P. Anderson	✓	
Vice Chairman Rohr	✓		Rep. Schneider	✓	
Rep. B. Anderson	✓				
Rep. D. Anderson	absent				
Rep. Damschen	✓				
Rep. Devlin	✓	✓			
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter	✓				
Rep. Seibel	absent				
Rep. Skroch	absent				
Rep. Westlind	✓				

Total (Yes) 9 No 2

Absent 3 absent

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1434: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (9 YEAS, 2 NAYS, 3 ABSENT AND NOT VOTING). HB 1434 was placed on the Sixth order on the calendar.

Page 1, line 1, remove "and a new section to"

Page 1, line 2, remove "chapter 54-52.1"

Page 1, line 3, remove "to provide a statement of legislative intent;"

Page 2, line 20, replace "twenty-six" with "nineteen"

Page 3, line 5, remove "Coverage for applied behavior analysis under this section is subject to a maximum"

Page 3, replace lines 6 through 15 with:

"Coverage for applied behavioral analysis must provide an annual maximum benefit that may not be less than:

- a. Thirty-six thousand dollars for individuals under the age of seven;
- b. Twenty-five thousand dollars for individuals between the ages of seven and not yet fourteen; and
- c. Twelve thousand five hundred dollars for individuals between the ages of fourteen and not yet nineteen."

Page 4, remove lines 13 through 20

Renumber accordingly

2017 HOUSE APPROPRIATIONS

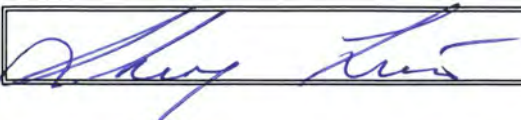
HB 1434

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB1434
2/9/2017
Recording Job# 28158

☐ Subcommittee
☐ Conference Committee



Explanation or reason for introduction of bill/resolution:

Relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:

Representative Weisz: Explained HB1434.

Chairman Delzer: I understand Sanford is already honoring this?

Representative Weisz: Blue Cross Blue Shield, which runs the federal employment, they have that contract. The federal government required, as of January 1, 2017, they'd have to offer coverage for ABA therapy.

Chairman Delzer: 17 or 18?

Representative Weisz: It is 2017 for the federal. As of April they will be covering that and it goes from zero to 12 years of age with no limits. As of January 1, 2018, they plan to roll it out on all the Blue's policies. Because of the mandate in South Dakota, Sanford are instituting that in all their plans.

Chairman Delzer: The Blue's are even above that right now?

Representative Weisz: In the bill it goes to age 21 and they have caps of \$36,000.00, \$25,000.00 and \$12,500.00. The Blue's will have an unlimited cap; but it only goes to age 12.

Representative Weisz continued with his explanation.

Chairman Delzer: My understanding is that employed benefits also reviewed this and came out with an unfavorable recommendation?

Representative Weisz: That's my understanding.

Representative Boehning: I think we've seen the original one. This one wasn't in front of us; because the fiscal note at that time was \$2 million.

Representative Weisz: I think PERS had estimated about \$1.5 million. The fiscal note that we received before we amended the bill was \$396,000.00.

Chairman Delzer: But that one bypassed the two year PERS study part. It mandated it across the board as soon as the bill would become effective.

Representative Weisz: That's correct.

Chairman Delzer: What's the effective date on the bill?

Representative Weisz: The original bill, because it declared it wasn't mandated; had no fiscal effect for the 2017-2019 biennium and the date would have been August 1. Contracts are effective July 1, so it wouldn't apply to the PERS plan for the 2017-2019 biennium.

Chairman Delzer: It would have applied to everyone except PERS?

Representative Weisz: It would apply to everyone except PERS because of the contract dates.

Chairman Delzer: If you put a mandate on, is there an issue where there's a certain amount of time? If they're in a contract with someone for a year, does that wait until that policy is up?

Representative Weisz: Yes. The insurance department did do an analysis from the standpoint of grandfathering with ACA. In this case, it would not affect the grandfathering clause as far as changing our policy.

Chairman Delzer: Either one?

Representative Weisz: Correct.

Representative Monson: The Blue's will cover until age 12? Is there an age limit with PERS?

Representative Weisz: Yes. We have two distinct categories under the bill. The first one is until age 6 and that's \$36,000.00; then it goes to \$25,000.00, and then \$12,500.00; that's through age 18. The limit on this would be through age 18.

Representative Weisz continued with his explanation.

Chairman Delzer: Does this list who can perform those therapies?

Representative Weisz: No. We have discussed that over the last four years.

Chairman Delzer: Does this say who they have to cover? One of the first mandates we ever dealt with was whether you covered chiropractic care. Does this say who can bill insurance and they have to pay for it?

Representative Weisz: That is not specified in this bill.

Chairman Delzer: So it would be wide open; so anybody could charge as long as they had a license of some sort?

Representative Weisz: It's not quite that wide open.

Representative Weisz continued with his explanation.

Chairman Delzer: Under therapeutic care, not many of them are stand-alone individuals. Who would actually bill for it?

Representative Weisz: That would be up to the insured to decide within their codes who's eligible to provide these services. These aren't medical services.

Chairman Delzer: Are there any pre-approval processes in the bill or is it just mandate?

Representative Weisz: This bill just mandates that applied behavioral analysis is covered. It's a very broad range of services in dealing with autistic people.

Chairman Delzer: Do you know of any other place where the insurance companies get into therapeutic care? Are there any kind of restrictions on it as far as who can apply for those and who can't?

Representative Weisz: I guess it could depend on how you want to define that. The feds have come down and said that the federal employment policies have to now add this. There's a controversy within the profession on whether it should be covered and whether it's effective or not.

Representative Monson: When you're talking about licensed speech language pathologists, you're now getting into education services.

Representative Weisz: They're talking about after school care that's all part of the therapy program.

Chairman Delzer: The real question is whether or not you want to mandate this; if it's a South Dakota and federal mandate already, it's a question of whether we want to mandate the South Dakota stuff onto PERS immediately. At the end of two years it automatically takes effect? How does that work?

Representative Weisz: It goes into PERS and then it comes back to the body. Then we have the data from PERS to see what the actual cost is and then it could be introduced to go forward.

Representative Boehning: Was there any discussion with this bill what the cost is if we don't do it to the state? If we don't help them on this end, at some point, what's it going to cost the state to take care of these people?

Representative Weisz: There was testimony that indicated they felt there would be increased burdens on the state; but there are no numbers to prove it.

Chairman Delzer: Closed the discussion.

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB1434
2/13/2017
Recording Job# 28288

☐ Subcommittee
☐ Conference Committee



Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:



Chairman Delzer: Brought the committee to order.

Chairman Delzer discussed the bill.

Representative Martinson: The Blue's will offer it but it won't be a mandate.

Chairman Delzer: Right. Sanford is only a mandate because it's a mandate in South Dakota. This would create a mandate.

Chairman Delzer continued with his discussion.

Chairman Delzer: The employed benefits committee looked at this and gave it an unfavorable recommendation?

Representative Boehning: We did at that time; but that was with a different fiscal note on it. I think it's something we should be covering.

Chairman Delzer: If all the major carriers are going to cover it, why would we want to mandate and have the study on PERS for two years? They're going to be covering it without a mandate.

Representative Boehning: I think the Blue's have been talking about covering this for some time; but they haven't covered it yet.

Representative Streyle: If one's already covering it and one's going to cover it, it seems that we already have this trial in place. I don't see this necessary at all.

Chairman Delzer: I'm very uncomfortable with doing mandates; because they always cost a lot, especially if one's going to be covered.

Representative Boehning: On fiscal note HB1719, which would start in the next biennium; if we don't do anything, our state employees or people covered under PERS won't have the coverage for two years. We're still going to have to pay for that \$1.25 per head; because Sanford is covering it.

Chairman Delzer: It must be figured in. It would have been part of the bid for PERS.

Representative Boehning discussed the language in the fiscal note.

Chairman Delzer: Why would they say they are covering it then? This is to gather the information and bring the information back; because that's what the PERS study does.

Representative Boe: If they're covering it, the fiscal note would have been zero.

Chairman Delzer: You would think so; this does create PERS having to gather the information. This isn't the Sanford cost; this is the PERS cost for doing the study.

Representative Boe: It says that the Sanford health plan estimates the \$1.25.

Representative Boehning: Made a motion for a "Do Pass".

Representative Delmore: Seconded the motion.

Roll Call Vote: 6 Yeas 14 Nays 1 Absent

Motion Failed

Representative Streyle: Made a motion for a "Do Not Pass".

Representative Vigesaa: Seconded the motion.

Roll Call Vote: 16 Yeas 4 Nays 1 Absent

Motion Carried

Representative Streyle will carry the bill

Chairman Delzer: Closed the discussion.

**2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB1434**

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐ _____

Motion Made By Representative Boehning Seconded By Representative Delmore

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer		X	Representative Schatz		X
Vice Chairman Kempenich		X	Representative Schmidt		X
Representative Boehning	X		Representative Streyle		X
Representative Brabandt		X	Representative Vigesaa		X
Representative Brandenburg		X			
Representative Kading		X	Representative Boe	X	
Representative Kreidt	A		Representative Delmore	X	
Representative Martinson		X	Representative Holman	X	
Representative Meier		X			
Representative Monson		X			
Representative Nathe		X			
Representative J Nelson	X				
Representative Pollert		X			
Representative Sanford	X				

Total (Yes) 6 No 14

Absent 1

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

**2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB1434**

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐ _____

Motion Made By Representative Streyle Seconded By Representative Vigesaa

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X		Representative Schatz	X	
Vice Chairman Kempenich	X		Representative Schmidt	X	
Representative Boehning		x	Representative Streyle	X	
Representative Brabandt	X		Representative Vigesaa	X	
Representative Brandenburg	X				
Representative Kading	X		Representative Boe		X
Representative Kreidt	A		Representative Delmore		X
Representative Martinson	X		Representative Holman		X
Representative Meier	X				
Representative Monson	X				
Representative Nathe	X				
Representative J Nelson	X				
Representative Pollert	X				
Representative Sanford	X				

Total (Yes) 16 No 4

Absent 1

Floor Assignment Representative Streyle

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1434, as engrossed: Appropriations Committee (Rep. Delzer, Chairman)
recommends **DO NOT PASS** (16 YEAS, 4 NAYS, 1 ABSENT AND NOT VOTING).
Engrossed HB 1434 was placed on the Eleventh order on the calendar.

2017 SENATE HUMAN SERVICES

HB 1434

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1434
3/6/2017
Job Number 28731

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

McGuire for Maura Quinn

Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:

19 Attachments

Chair J. Lee: Brought the hearing to order, all members were present.

Rep. Thomas Beadle District 27 (1:10-11:) testified in favor, please see attachments #1, 2, 3. Will propose an amendment. Simplify bill, take out under 19 years of age, removes middle sections limit bill, definitions remain in place, remove sub section 4-10 leaving section 11, give the insurance companies more flexibility, closely mimic existing language. Attempt to mitigate some of these adjustments.

Chair J. Lee: What's the impact on self-insured plans?

Rep. Beadle: I'm not fully aware, somebody from insurance will be better to specify that. The language that was written in here regarding the grandfather plan, that is all falls under subsection 10. Someone from the insurance department is more familiar with all the differences of all the plans and could answer that question.

Chair J. Lee: Even if this passes this won't affect all North Dakotans.

Rep. Beadle: You're correct, but it sends a strong message from a state that we value these therapies and want to see them offered and available for our most vulnerable citizens.

Senator Piepkorn: On page 1, bottom family in process, coverage isn't sufficient in their area. What does that mean, what kind of coverage, insurance coverage, or treatment coverage or what?

Rep. Beadle: It's a variety of issues, ND is rural, difficult to provide treatment in all areas. But it's a combination of a few things. One they are consistently paying out of pocket expenses above and beyond what insurance covers. The insurance doesn't currently cover the behavioral therapy treatment that they do receive. So they are paying thousands of

dollars annually out of pocket and so when they couple that with the fact that they are currently having to drive on extensive miles in order to access these treatments, that is all factoring into the move to West Fargo. So part of it comes from the fact that we don't have a lot of providers up in that Langdon, Cavalier area, but the other factor on it they could deal with that and they could deal with riding it. But when their losing thousands of dollars out of pocket a year that coupled with the time ends up being problematic for them.

Senator Piepkorn: They're moving to West Fargo because they are going to have better insurance company there?

Chair J. Lee: No, larger school districts offer better services, school district asks why they're coming, and it's the services. We have the benefit of density.

Rep. Beadle: West Fargo Public school district in particular does a tremendous job and they have ABA licensed therapists within their school district. I know they have a working relationship with the Autism Day Center in Fargo.

Chair J. Lee: We are short of workforce everywhere, help in the recruitment effort.

Rep. Beadle: Drafting get DHS streamline the licensure of ADA therapists throughout the state and that was a tough thing to try to figure out how to do. One of the areas more therapists, as we get more insurance companies covering it might be more of an economic benefit for those licensed individuals.

Chair J. Lee: The state is the largest employer of ADA but in a different format for it because it is for those individuals primarily with intellectual disabilities.

Rep. Jim Casper District 46 in Fargo (19:50) testified in favor, agrees with Rep. Tom Beadle, two I want the committee to know that a representative from Blue Cross about 2.5 weeks ago, in the House chambers after the hearing on the Autism bill said to me, if you pass this bill, we'll cover the minimum that bill requires, but we're planning effective January 1, 2018 to provide coverage for Autism, that sort of mirrors the federal plan that Rep. Beadle outlined. I want to go on the record that I was told that directly from a Blue Cross rep that they will do that.

Senator Heckaman: As a sponsor, I agree with the Reps. I won't take up testimony time.

Chelsea Evenstad, Behavior Support Program Director, ND Autism Center (21:00-27:45) testified in favor, please see attachment #4.

Sandy Smith, Executive Director, Autism Center (28:11-35:45) testified in favor, please see attachment #5.

Catherine Yeager, clinical psychologist, co-owner Assessment and Therapy Associates (36:15-43:40) testified in favor, please see attachment #6.

V-Chair Larsen: Looking at other states, that are allowing it and of those states are any insurance providers in those states going above and beyond that platform or are they tapped out and that's what they are offering?

Ms. Yeager: I'm not sure, I know there's data on it.

V-Chair Larsen: With the new administration's cross state- cross lines policies, with that has traction and gains, will this be necessary if we have cross boarder policies?

Ms. Yeager: Perhaps, the problem in order to use out of state it still goes through, it is processed through North Dakota, and families have had a great deal of difficulty getting it processed through to our local Blue Cross, Blue Shield. So they are not able to use those benefits.

Chair J. Lee: The whole purpose is to open the market place but the problem is the other states don't have same criteria for insurance quality and coverage that North Dakota does. If you have a problem with an insurance coverage and you're in North Dakota and you bought your policy, because it was cheaper from somebody in Mississippi, the Mississippi Department of Insurance is the one who has to deal with your problem. That we think is a big deal. So that is part of the challenge our Department of Insurance regulates closely how policies are written, approve rate changes, agents are licensed and educated, the potential advantage of that out of state policy is dulled by the challenges.

Ms. Yeager: Preauthorization for things outside of just our state. It is hard enough in our state.

Chair J. Lee: We know it isn't perfect but we're accessible enough that usually you can find a person to even if the challenge is bigger than you would like it to be, that there is somebody that you can talk to about it. It is quite as bureaucratic all the time.

Janis and Charlie Kern (47:50-48:50) Testified in favor, please see attachment #7.

Senator Piepkorn: I have difficulty not losing my cool too, perhaps you could give me some pointers.

Dr. Shannon Alexander, practicing psychologist, parent of autistic child (49:50-58:20) testified in favor, please see attachment #8.

V-Chair Larsen: I've been hearing there is no other therapies, this is the newest, in our hospital we have a wing, there's one person who's certified in ABA therapy, they've been dealing with behavioral and mental health issues, they're billing under a different type of therapy, so what other therapies are they using that are as meeting this ABA need prior to this ABA therapy?

Dr. Alexander: It's not new, its 30 years old, I can't speak for others, in the prison, I'm using a modified version of behavior modification. In other states there's occupational therapy, they work with sensory processing needs, he gets speech therapy services to help him try to learn

how to speak, psychotropic medicines, there's many different ways. Applied Behavior Analysis is one of those.

V-Chair Larsen: Those are being covered by insurance currently or are they having to pay out of pocket?

Dr. Alexander: Some are, typically speech therapy, occupational therapy, they are willing to cover those.

Chair J. Lee: The DMS didn't include ABA, as a medically effective treatment at the time that the original North Dakota Legislation was passed which was a very short time ago. The new DSM has a different approach to it which is different. So one of the important things when the Legislature is looking at this as well as insurance companies I am sure, is what is viewed from a medical point of view as being medically effective, because if it isn't regardless of how many years they have been doing it, it isn't something that is likely to be reimbursed. There have been so many changes in a very short period of time, not only in who is included on the spectrum, which is why we have a large increase in numbers, but also in the treatment center seen as valuable depending on what the individual needs might be and a lot of situations are really co-occurring conditions as well, as I think you would acknowledge. Sometimes it might be an intellectual disability as well as autism, or any combination of things like that. So this is with you particularly professionally understand this is a very complicated thing. Each unique individual has his/her own needs and plans and so it is up to the Legislature not to get into the way of treatments being provided that may come out new. I don't care whether its testing for prostate cancer or figuring out what to do with early intervention for children, I think the last thing we want to do is get in the way by saying this is what we're going pay for and as a result that is what you're going to get regardless of what comes out 8 months from now that might prove to be some kind of effective thing. So I am not saying for or against here, I am just saying that the deal. I've been long concerned about legislature getting involved in medical care.

Dr. Alexander: As I testified I feel strongly this should be the domain of experts. If there is empirically support by peer reviewed research, that we should be allowed to utilize that in treating this individual, this is tough work. Being limited in some way about especially when we know that there is a research supported, empirically supported treatment and not being able to utilize that is very frustrating both as a professional and mother knowing that Trey could be further along than he is except for the dollars. It might work at the prison, I've seen what happens when folks don't get the necessary mental health care, that is the worse- case scenario. I've treated individuals with autism on my unit.

Sen. J. Lee: They come out and don't have the community services they need. That is another discussion we've already had.

Senator Clemens: How is ABA unique compared to treatments? List a few things that ABA addresses that other types of treatment wouldn't?

Dr. Alexander: With occupational therapy, it's important, but working with him on diet, vs aba which is going to work with him on reinforcing, you break it down into little steps, you do it over and over. What he's learning through skills training, its different versus the

occupational therapy, where he is learning how to process his different sensory needs. We have a swing and he needs time to swing before he's able to focus on different activities. There's different approaches, the ABA, they look at different deficits, they break it down. And then reinforce him to do those, when a behavior is reinforced, they're more likely to do it again. We know through operant conditioning that when a behavior is reinforced, the more likely to do that behavior again. That is kind of the bare bones look at ABA and how it can be different than giving somebody a medication or giving somebody dietary therapy or speech therapy.

Doug Sharbono (1:07:50-1:11:00) testified in favor, please see attachment # 9.

Holly Johnson ND Licensed Applied Behavior Analyst (1:11:20-1:14:35) testified in favor, please see attachment #10.

Britney Hanson (1:14:50-1:18:49) We benefit from the waiver having previously also had very hard to come by autism slot as well. Large companies would be effected. As a consumer, I feel threatened by BCBS statements. There's been no verification of this, there has been no black white, as this is what we are going to do. I feel like when the answers I received as well as we will do this if, there is not a mandate. If there is a mandate, were not going to help you now. We will just do the minimums. This is not a positive relationship to have for the consumer. This is multifaceted, speech, occupational therapies are the main services that a lot of kids with autism or adults or adolescence of autism receive in ND. Sanford doesn't cover speech, OT, PT services on many of their plans to include many of their employee plans. MA pays for all of our rehabilitative services, my senator was told that they do. That's incorrect. We're at a critical point with waivers. Now that secondary payer for many of these families may not be able to get services to that route either, without primary insurance, with many of these service plans. So this bill goes back into that. The providers haven't taken it upon themselves to meet the needs of their consumers, so begging the Legislature to stand up and say you can't keep ignoring the needs of the people. 1 in 5 families with special needs, it insurance would help it might give us a little bit.

Kristin Sharbono (1:19:20-1:20:00) testified in favor, please see attachment #11.

Opposition

Megan Houn Director of Government Relations for Blue Cross, Blue Shield of ND (1:21:20-1) testified in opposition, please see attachment #12, from Elizabeth Faust.

V-Chair Larsen: Mandate at the cost that they are hearing you guys are going to support, what's on the bill now is a little lower than what you guys are talking about is that something that maybe we should just have it at what you guys are saying it's going to be?

Megan Houn: Other mandates across the nation, the cost varies significantly. To provide a robust and comprehensive ABA benefit, the cost will be significantly more than what's included in the bill.

V-Chair Larsen: When I was talking early about areas that people working with autism, they may have someone certified in the ABA, fielding cases, do you think that currently they're

taking those pieces and then just kind of melding them into the cognitive behavior therapy and getting those insurances paid so they can continue to be helping these patients?

Megan Houn: I know there's a comprehensive licensing certification between the Board Certified Behavioral Analysts nationally and also the Board of Psychology here in the state, and as I mentioned previously, we support and reimburse and have for a decade, all of the medical and diagnostic and other therapies, so that might be one that you want to have the doctors stamp.

V-Chair Larsen: I got your brochure, it says you pay 30%, if it's in the DSM it's covered and their charting it, it's paid for right?

Megan Houn: correct.

Senator Heckaman: We've heard that they're not sure about your commitment to the January 1, 2018. Is that an absolute where Blue Cross is coming forward on January 1, 2018 with services?

Megan Houn: To be honest that was a track we were exploring, we are about 8 months out from implementation of that being as we were looking at January 1, 2018. I think that then you start looking at the various routes that we have to take, I think from Pam's statement that we will follow the law

Senator Heckaman: That wasn't my question. Is it an absolute for you on January 1, 2018 that you're telling the families here?

Megan Houn: That depends on what happens here.

Chair J. Lee: Can I rephrase that? How about is January 1, 2018 a realistic goal for the process for which I absolutely understand of actuarial studies and all of the things that have to be done, is that a realistic goal, recognizing how many policies begin on January 1st. That is sort of the big deal.

Megan Houn: The intention was to roll out January 1, 2018, we could not get into our filings as quickly to do a simultaneous roll out with the SEP when it came out on January 1, 2017. Therefore, we needed the extra year, to be able to add that benefit to our filing with the insurance department. Yes, the intention is the Jan 1, 2018.

Chair J. Lee: You still feel that would be a realistic roll, I am not asking you to promise please understand that. We can't ask you to promise that at this point, but I am asking if it's a realistic goal to continue to progress through the process which is a complex one, in order to make sure it adds this to every other benefit considered, completes this process of study and research and medical efficacy and actuarial concerns and what does it do to the premiums and all that good stuff?

Megan Houn: It's a realistic date.

Senator Piepkorn: Have you worked with the proponents to address some of the problems you see with it, or do you just really want to see it stopped in its tracks and then they would trust you then to proceed in everyone's best interest?

Megan Houn: We were willing to work with the bill. We discussed the issues, this was being brought at the hand of constituents, we met since to discuss the issues that we had with the bill, some of the values, mandates, in addition VP actually requested a meeting with Autism Speaks more than once, and never received a response. So the first meeting we were able to get with the proponents was last week Tuesday. So we did meet with them, and we are willing to work with them on some of these issues. There is some pretty significant issues, to one of the questions that was asked earlier, I think by Senator Larson, not only does this mandate not extend these benefits to self-funded groups, the individual plans and the small groups, but it could jeopardize the grandfathered status of the large groups that have been intended to cover. So there are some pretty big issues with this bill as it stands. But yes, we are willing to collaborate. We have been from the start.

Sen. Nicole Poolman District 7 (1:33:50-1:40:10) testified in opposition The Employee Benefits Committee gave unfavorable recommendation. I have been a big advocate for vouchers and waivers that we have used in the past. I am a board member at the Anne Carlson Center and I am a parent raising a beautiful boy with autism for 14 years. I thought I could give my perspective on the bill itself. I think that is where we have to reign this testimony in, is on the bill before us. It came to Employee Benefits long after our deadline. Even though the bill was drafted through the summer. The sponsors were asked to bring it to Employee Benefits and they chose not to. I am concerned that they wanted to keep the argument emotional and not factual based on the bill and the facts before it. That is one concern that we have. The other concern that we had is that we didn't have appropriate time and hearing to hear from providers, to hear from autism organizations. I think that you should notice that there aren't very many providers here. There aren't very many autism organizations here, there absence should be very telling to you. You have a lot of emotional parents here and I understand how emotional that is, I have been there. So, I wanted to talk about employee benefits gave it an unfavorable recommendation twice, both the first time it came and the second. Both times we really believed that this bill as written will do more harm than good. That is really the bottom line. This bill will be more harmful than beneficial. I think when you hear from some of the other providers in testimony today, you'll have them walk through the bill and talk about all the problems with the bill itself. It is not just the fact that it caps it at \$36,000, when we are literally on the cusp of having a market that is going to cover far more than that. There are all sort of issues in terms of whose providing the therapy, how we define it. Someone made an excellent point, I don't think legislators should be getting between doctors and patients in terms of coverage. I would absolutely echo that comment. We don't know enough about ABA as legislators to decide what is appropriate and what is medically necessary and what is medically proven. Just to give you a little bit of my own background, my son is 14, when he was first diagnosed that was well over a decade ago. I had the benefit of being covered by Blue Cross and Blue Shield at that time, and now I am under Sanford. Blue Cross/Blue Shield over a decade ago, covered all of his speech therapy, his occupational therapy, his behavioral health visits, his medications. As we made the switch over to Sanford, the same has been true. They have covered all of his medications, all of his behavioral health therapy, so it's important to note that insurance companies aren't ignoring people with autism. They are covering those services that have been proven to be medically

necessary. A decade ago, ABA was not proven to be medically effective. ABA was compared to within all sorts of new therapies, we had parents putting children in hyperbaric chambers and accidentally killing children with autism, with therapies that they were trying. So I think it is important to note that the science is finally catching up and that's why insurance companies are now catching up. I think that we should allow those insurance companies to do so. This isn't an ideological argument; this is a practical argument before us. The bill before us is written in a way that it is not beneficial, that it will do more harm than good. When you have a provider with 75 % share saying we are about to cover starting January 1, without visit limits, without age limits, this type of therapy because now the science says it is going to work and it's going to be medically necessary. I don't know why we would say we are the government, and we are here to help. We are going to cap that at \$36,000 and we are going to limit to who can provide it, and were going to limit how it's defined. In a nutshell, my experience as we take a look at mandates generally across the country, I would encourage you to read US News and World Report did a study on the impact of mandates across the country. They took a look at all 50 states and the mandates that were implemented and it's nice because it is an objective source. We don't want to look at the insurance companies to see what mandates do. We don't want to look at Autism Speaks to see what mandates do, because they both have skin in the game. But, I would recommend that you read that article, because it does talk about something that has really become obvious to me in my discussions with both Blue Cross/Blue Shield and Sanford Health. That when these mandates go into effect, they aren't really improving access, only on average about 12% more are getting access to services and the reason that is, is because these caps are so low. These providers that are going to provide this early, intensive, 40hour week, service they don't come into those states, because the caps still can't cover the coverage. So it's not improving access nearly as much as we would like too, and I just think capping it at \$36,000 and certainly cutting it off to only state employees for the next 2 years when you look at 75% of the families in North Dakota become eligible January 1, it just is not practical for us to pass the bill at this time. There may have been a time when a mandate would be beneficial, when we would have been so far behind the game and the market had nothing on the horizon. But that is not where we are today.

Senator Heckaman: Are you aware that some amendments are coming forward?

Sen. Poolman: I am not aware.

V-Chair Larsen: You said that you're in the Anne Carlson umbrella are they ABA, are they practicing those therapies?

Sen. Poolman: We do offer those therapies.

V-Chair Larsen: 100% or what is the percentage?

Sen. Poolman: About market share across the state I have no idea what the percent? mixing with other therapies

V-Chair Larson: I am wondering the therapists that are certified to give those services and is it just that or are they mixing it in with other therapies?

Sen. Poolman: Its very common to mix in with other therapies. That you're working in tandem with a number of different therapists, yes.

Senator Piepkorn: If this bill passes it goes into effect August 1? I've heard BCBS would live by the letter of the law. Now is this bill passes, and goes into effect August 1, and if what Blue Cross and Blue Shield eventually intends and hopefully would come up with by January 1st, and it was more comprehensive and didn't have some of the problems that have been pointed out with the current bill, would BCBS go ahead with their new and better plan?

Sen. Poolman: As you look across the country; the mandate becomes what is covered. You can't have a business model where your forced to pay for all of these things of the state has said you have to pay for and then have the freedom to cover the medically necessary and intensive therapy that you wanted to cover because the science says its correct. I wouldn't see BCBS offering their robust plan if you have a \$36,000 cap and you are forcing the language of this bill on to every insurance company in the state.

Senator Piepkorn: You're saying the proposed plan from BCBS that would be rolled out on January 1, 2018 would be better than this bill?

Sen. Poolman: Yes that is what I am saying, significantly better.

Senator Piepkorn: But none the less the people who are here testifying in favor are trusting you to not yield to BCBS to provide this.

Sen. Poolman: Correct.

Chair J. Lee: If the bill goes through, it goes through the PERS system for the first two years so it will be delayed another year for the general public.

RaeAnn Kelsch: (1:44:30-1:45:35) testified in opposition. Small business, National Federation Independent Business (NFIB); on record do not agree with insurance mandates that will cost them more money in providing insurance coverage and health coverage for their employees. It becomes a point where small businesses absorb additional costs.

Dr. Barbara Stanton, Prairie St. John's (1:46:25-1:55:20) testified in opposition, please see attachments #13 and 14.

Chair J. Lee: Accountability we really look at outcomes, and whether or not investments in whatever is happens to be, does have some accountability, can you comment on that?

Dr. Stanton: I work at Prairie St. John's and I worked in a number of different programs including out-patient intensive care day treatment program, and as an out-patient therapist, in the clinic. So I work with what is required by insurance companies. Typically, when I talk about insurance companies, I do understand there needs to be a relationship between those who are providing the funding and those of us who are providing the services. I understand that as a professional that it is critical that I am able to document medical necessity. I have tailored the forms that I use, the intake form, the treatment plans, in order to reflect that, so

that when information does go to the insurance company for reimbursement I don't always get what I want, but sometimes I do. That's part of accountability piece.

Chair J. Lee: May require a report, annually is not enough in my view, that would not be adequate.

Dr. Stanton: I agree with you, as providers, we do have a responsibility not so much to the insurance companies but more to the children and families that we are working with that we are very transparent in the treatments that are providing. That we are able to document progression toward an ultimate treatment goal and that once that we reached that goal, then we reevaluate where are we going next.

Chair J. Lee: The provider can provide a report that the payer cannot require it, so it wouldn't even have to be annual.

Dr. Stanton: This is part of my issue with the bill is that there is so many questions about how that accountability piece is just one part of the language in the bill that I don't believe is specific enough.

Senator Piepkorn: We have to give credit to parents, it's easier to come along after fact point out flaws, why haven't you been involved to come up with something better, it's too easy to point out what's wrong?

Dr. Stanton: That's a good question. I was unaware this bill existed, I'm a part of ND Autism Advocacy Coalition. This is something that has evolved so quickly, we haven't had a lot of time to even talk about it. I'm a board member Emeritus of the Red River Valley Asperger Autism Network. We were not invited to be a part of what was going on. I wasn't a part of it, because I didn't know it existed. Dr. Faust from BC/BS contacted me to talk about their proposed plan rolling out in January of 2018, this was all occurring long before we knew this bill existed. I would have loved to have been a part of this and would've certainly contributed ideas and expertise had I known.

Neutral testimony

Dr. Dan Hannaher: (2:00:50-2:02:20) testified neutral, please see attachment #15.

Senator Heckaman: If Sanford bills a plan that included ABA services or therapies, that cost has to be built in to your monthly benefits, right?

Mr. Hannaher: That's correct

Senator Heckaman: If the plan is more robust than any kind of state mandate would be, it's my perception that those costs per month would be higher?

Mr. Hannher: Yes, that would be an accurate assessment.

Senator Clemens: ABA program, does that include medications, or is it outside of that?

Mr. Hannaher: To my understanding it doesn't involve medications in ABA services.

Sparb Collins, Executive Director, ND Public Employees Retirement System (2:03:45)
Test neutral. There is a question that has arisen about the application date of this bill and whether it goes to PERS first or whether it goes to the general group first. Work with committee to get that clarified in the bill, so that we know what's expected as an agency. There's a lot of details in going through with it. That is essentially the issue that we need to take a look at.

Chair J. Lee: Details because it isn't going to affect audience. Tell us if the mandate remains, or the PERS exposure I should say. The PERS pilot is it included, as it comes to us from the House, tell us what the time table is then for PERS and then for the general public

Sparb Collins: As written, the bill on House side, a provision that excluded it from section that applies to PERS. That was taken out on the House side and based upon that we assumed the bill would apply to PERS first, however the way the statute is worded it may need more affirmative language in there to make sure that it applies to PERS first and that affirmative language isn't there, there's a question as to whether it does to PERS first or goes to the general public. That's the issue that needs some clarification here going forward.

Chair J. Lee: It would go to PERS in the 17-19 biennium the way it's currently written?

Mr. Sparb Collins: I don't know. It would be helpful to get that taken care of.

Senator Heckaman: I don't see any place in here where it says that, that's why I was looking at having our intern look up that Chapter 26.1-36 in which there is an exception, because I didn't see anything in this bill that said a 2- year pilot project for PERS. Am I missing it?

Mr. Sparb Collins: Here, in the past, only one bill has done this. But other bills that haven't have had explicit exclusionary language in it that said it doesn't apply. For example, last session exclusion, this bill had an exclusion, it was taken out. The assumption is if there is no exclusion, then it applies. But as we've looked at this, it may not be as clear as that. That's why the need for clarification.

Senator Piepkorn: You said that we can't make insurance companies promise to do so, I wish it was within our authority to make them promise that by January 1, 2018 we will have a plan in place that exceeds the standards that are put forth by this bill.

Chair J. Lee: If we can decide we can pass that kind of law, we can do that, but that's not what we're talking about this morning.

Senator Piepkorn: I think they should be held accountable and if that's what their plans are, just do it.

Attachments 16-19 were provided for the committee's reference.

Sen. J. Lee: closed the public hearing on HB 1434.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1434
3/14/2017
Job Number 29179

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:

8 Attachments

Chair J. Lee: Brought the meeting to order

Mr. Munson, CEO of Anne Carlsen Center, (0:15-4:30) Stated that the bill wouldn't give them full autism coverage, and that the private market will provide more coverage sooner. The Anne Carlsen Center has been working for increase autism waivers. He doesn't believe the mandate is the way to go.

Chair J. Lee: I agree the market will catch on much faster than the mandate. There are parents who say just raise the amount; it isn't an entitlement. I'm concerned about what happens when the early intervention money is gone. Nobody's going to do more than whatever amount we set.

V-Chair Larsen and Mr. Munson discussed ABA therapies and who is able to provide them. (5:30-8:45)

Committee discussed the January 1, 2018 start date. (8:55-40:45)

Senator Kreun: Sanford Health Plan has been evaluating ABA services using professionals, and have some preliminary ideas about program design for insurance coverage. If that's not a hint that they're going to be participating, that's as close as you're going to get from them. they're still doing the same evaluation that we're going to be doing if we pass the bill. My point of thinking is along the lines if we're going to go through a testing program, or actuarial analysis of this, it's going to be done quicker by BCBS or Sanford, we will take 2 years.

Chair J. Lee: We do need an amendment to clarify the PERS language.

Senator Kreun: Are we going to go for a fiscal note for this too?

Chair J. Lee: It doesn't affect the state; this will be insurance company money.

Senator Kreun: So the rates are going up?

Chair J. Lee: Well maybe the BCBS doesn't have the PERS contract right now.

Senator Kreun: They're not hedging their bets, just by those statements they made publically.

Chair J. Lee: Without being critical, it's just not an unusual process when a new treatment comes along to consider. Story about not legislating between doctors and patients.

Senator Kreun: In the cognitive behavioral intervention program and comprehensive behavioral treatment for young people, is that in this bill? Are we paying for that, did you analyze any of those treatments, so we can say yes, this is what's going to happen? Some of these treatments aren't going to be in this bill and they won't have access to them, is that correct?

Mr. Munson: I'm not sure of the specific reference, the ABA is specifically called for in the bill, and BSBC has researched, they now consider it to be medically necessary. We have considered ABA to be part of a series of interventions you might use on the Spectrum; not every child would be a candidate for ABA, there may be other things that we do. I think that with the addition of ABA coverage by insurers, we probably have a full repertoire of interventions to use.

Senator Kreun: In 1434, does that include what your indicating might be in the BCBS package?

Chair J. Lee: With the DSM-4, ABA wasn't included, the DSM-5 does include it. It provides us with opportunity to move forward.

Senator Kreun: Where is the ND autism center?

Chair J. Lee: Fargo.

Senator Kreun: They've got some information too. I'm trying to figure out avenues of treatment that aren't in this bill.

Senator Heckaman: Did everyone get the email from North Dakota Autism Coalition? Prairie St. John, Anne Carlsen Center P&A, they sent out a memo.

Senator Anderson: That coalition, they supported ABA insurance coverage, they didn't say the supported the bill.

Senator Heckaman: We have amendments before us, 2003 amendments from Rep. Beadle (please see attachment #8), those change the bill quite a bit.

Chair J. Lee: Megan would you answer our question about what the BCBS position is?

Megan Smith-Houn, Director, Government Relations BCBS, There's some confusion about our position, as stated in Dr. Faust's testimony, mandates are not a public policy that we endorse. ABA is at a tipping point in the evidence, the USPSTF has not endorsed it as a best practice. After our meeting with the parents on this issue, it's very clear that they want the mandate. Therefore with this mandate passed and some strengthening on the PERS trial, that is what we will implement.

Chair J. Lee: If we don't implement it, are you going to do what you told us you were going to do a few days ago, and implement the parallel to the FEP on January 1st 2018?

Ms. Smith-Houn: That has been our intention; the January 1 timeline is because we cannot include at present time benefits that have not already been included in our rate filing.

Chair J. Lee: Policies begin January 1.

V-Chair Larsen: Even if we weren't talking about ABA you guys couldn't include anything until you have the plan built.

Ms. Smith-Houn: That's correct we have to include in our benefit plan that are submitted to the Department of Insurance for rate approval by them, all of the benefits that are included. We can't add a benefit until January 1.

Chair J. Lee: We are going to have the amendments that clarify that it goes through PERS. We will continue tomorrow.

Attachments #1-7 were provided for committee reference.

Chair J. Lee: Closed the public hearing.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1434
3/15/2017
Job Number 29233

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:

1 Attachment

Chair J. Lee: Brought the meeting on 1434 to order. All members were present.

Jennifer Clark, Legislative Council

(0:15-9:10) The Committee and Jennifer Clark discussed what the amendments should be. They discussed putting the amendments in the proper section of code, decided that they will need two versions, a Hoghouse and a redrafting of Rep. Beadle's proposed amendment. Federal approval of an insurance mandate was mentioned.

Ms. Clark: If you have the Insurance Department in, ask about putting into PERS for two years, does it affect federal regulation.

(9:30-14:00) discussion about next meeting and fiscal notes.

Senator Clemens: It talks about health insurance in the bill, there is statute that says new insurance has to go to PERS, even though it already says that, you still want it in there?

Chair J. Lee: The House thinks it's in here, and it's not. The original bill was trying to avoid that by saying it's not a mandate. The verbiage they changed in the House they thought would make it clear it was in PERS, it's not. I'm not interested in having it move forward not going to PERS.

Ms. Clark: We know how to draft a law that goes to PERS, and how to draft one that goes to the private market. This looks like neither. Explained law to the committee.

Chair J. Lee: The committee in the House thinks it's required to go to PERS, I talked to the chairman, they believe that it did.

Senator Heckaman: In what I'm understanding, it was specifically written this way; we've got to get it fixed the right way.

General discussion about when to meet. (18:20-20:37)

Senator Piepkorn: What does Sanford think?

Chair J. Lee: It's not the same.

Dan Hannaher: It would be incorporated into the plan.

Senator Kreun: Sanford health has been evaluating services using professionals, and have ideas about program design, so if somebody else does it, they're going to do it.

Chair J. Lee: They are going to do through the processes they have in place, to figure out what's going to be done here.

Senator Kreun: Mentioned a TV segment that talked about a minimum maximum.

Ms. Clark: If you put that PERS policy in Title 54, I think it's reasonable to think they are going to design their plan to specifically meet what we put down here, otherwise the two-year study doesn't do any good. When we put it out to the private market after, that's different setting a floor and you can do anything above it, going into the PERS to 2 years, you are setting the standard. For those 2 years, otherwise the study doesn't do any good.

Attachment #1 provided for committee's reference.

Chair J. Lee: Closed the meeting.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1434
3/15/2017
Job Number 29247

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:

1 Attachment

Crystal Bartuska, Insurance Department, Director forms and rates product filing department

Chair J. Lee: What insurance lives are not going to be covered by this mandate, which we are going to send to PERS, when it talks about non-grandfathered, individual, small group, self-funded, tell us who will be covered and who won't be?

(1:05-13:50) Ms. Bartuska and the committee discussed different types of plans and who will be excluded from this mandate. Please see attachment #1. The mandate exempts individual and small group policies under the scope of ACA. 73,000 not covered there. Erisa plans are exempt, 180,495 covered lives exempt. 358,275 Covered lives will have coverage.

Senator Piepkorn: This bill provides for 2-year study through PERS; what are the possible outcomes?

Chair J. Lee: It will show that it's been effective or not.

Senator Piepkorn: So if it's been determined that it is effective or not effective then what?

Chair J. Lee: Then they decide or decide not to move it forward to the general public.

Senator Piepkorn: If it did not, then what happens?

Chair J. Lee: It goes away.

Senator Anderson: It also gives us numbers and actuarial data.

Chair J. Lee: We don't know what the cost or usage is going to be. PERS is the control group. See how it affects them, we don't want to break the bank down the line.

Chair J. Lee: Closed the hearing.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1434
3/16/2017
Job Number 29359

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Mame Bohannon

Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:

6 attachments

Chair J. Lee: Brought the hearing to order. Senators Clemens and Kreun were absent.

Reviewed the amendments, please see attachments #1, 2, 3.

Chair J. Lee: Are we satisfied with these amendments?

Senator Heckaman: I see from the bill there's a significant change between the 2005 version and the 2007. On the 2nd page section 2 sub c, the change is coverage for ABA must provide for an annual maximum benefit that may not be less than. The original had a floor in it, versions 2005 and 2007 have a ceiling.

(1:20-7:50) The committee and Jennifer Clark discussed the difference between a floor and a ceiling; and what they are directing PERS to do.

Chair J. Lee: The Cost-Benefit Analysis will mess us up if we have to wait 2 weeks.

(9:10-11:05) The committee and Jennifer Clark discussed getting a cost-benefit analysis.

(11:10-18:00) Committee discussed when to meet next.

Senator Anderson: I move to recess until 8:30am tomorrow.

Senator Heckaman: Second.

Jennifer Clark provided information for the committee's reference, please see attachments #4, 5, 6.

Chair J. Lee: Committee recessed until 8:30 tomorrow morning.

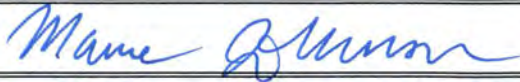
2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1434
3/17/2017
Job Number 29372

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage for autism-related services; and to provide for a report to the legislative management.

Minutes:

2 attachments

Chair J. Lee: Brought the hearing to order, all members present.

Chair J. Lee: Reviewed what the committee discussed in the previous meeting.

Senator Heckaman: Before we move the 2007 amendments, I'd like to **move the 2006 ones.**

V-Chair Larsen: Second.

Senator Heckaman: This takes out the issues we looked at whether it's the floor from the 2000 version, and it takes out some of the other issues with having to look at small market companies on the bottom of page 3 that were concerns, it's in the right section.

Senator Anderson: I think there are additional changes in 2007 that we really want, so I will support that one instead.

A roll call vote was taken.

Motion fails 2-5-0.

V-Chair Larsen: I move adopt .02007

Senator Kreun: Second.

V-Chair Larsen: this amendment puts this bill in the best possible shape to get it out of committee.

Chair J. Lee: And it does include that work by the insurance department that would gather information and data.

A roll call vote was taken.

Motion passes 5-2-0.

V-Chair Larsen: I move Do Not Pass as Amended, and re-refer to Appropriations.

Senator Kreun: Second.

Senator Clemens: The motion is do not pass for the amended bill.

Chair J. Lee: With the market the way it is the purposes will be met more quickly than by waiting through the PERS period.

V-Chair Larsen: I know a mandate is not something that any states want to pursue. As an insurance agent, with the Medicaid Expansion from last session, the information provided was a follow through, I believe this will be a follow through. I know the with the DSM change all of the stuff we've rehashed and rehashed, this is the best way that this need to proceed.

Senator Clemens: I was under the impression we were going to try and move this bill forward with this amendment.

V-Chair Larsen: It's up to the floor, we've made the bill is the best we can make it as a committee, it's good but it isn't good enough.

Senator Anderson: The preponderance of evidence from people that treat autism, the PERS business, to put a mandate on them at this point is a long term negative for the treatment of autism. I'm still not in favor of the mandate, and moving ahead with this approach to requiring autism treatment in PERS or anything else. I think the open market is working, that's the best approach.

Chair J. Lee: Three of the most credible providers of services to children with autism in the state have said that this is not a good bill; because of the things that are limited and not included. It's not an example of a good way to do it. I trust these people, they're all working for insurance companies. I think they're going to get better provision of services, sooner, if we allow the market to do it. The private carriers, one has said they are looking at doing this by the 1st of next year. If it passes, it goes to PERS for 2 years, remember we've got 255,000 people who aren't covered by this bill.

Senator Clemens: I understand that approach, on the other side I've been working with the autism group in Fargo, I will support this, they feel if we don't pass the bill, we're not supporting them.

Chair J. Lee: One of the solutions is additional waiver and voucher slots through the Department programs, we have waiting lists there. We have to make sure our Appropriations people know how important it is for those services too.

Senator Heckaman: Looking at additional waiver and voucher slots, we're going to have minimal results in that this biennium, because the allotments took quite a few away. I don't think there will be more money going into those. In looking at age limits, as these children are receiving services and age out, we've got to address those needs, I'd like to see more slots and extended ages. My concern on allowing this to go to the private market, we do not have that 100% reassurance that they're going to be a plan. There's only one market right now. This would be under PERS, I don't know that this denies anyone else from going to the market, I would encourage those in the gallery to work on those plans. I've been working on this since 2007 and we haven't addressed an insurance mandate. I'm going to vote nay on the motion to Do Not Pass, we're leaving some opportunities behind that could benefit some families right now.

Senator Piepkorn: This is a 2-year trial, the insurance department will be making quarterly surveys of groups involved, at the end of the 2 years, there will be a report at which time it will be determined whether they want to continue. there is nothing in this bill, that prevents

the private market from working on their own coverage, I think they've made it clear they're going to deliver what you ask for. As far as the fear of delay they've been working on it for 10 years, at the end of the trial, I'm sure the people will be back to work on it.

Senator Kreun: In visiting with individuals that want this, I had the opportunity to visit with parents and explain, their position was do it right the first time. They know it will take some time, their issue was don't pass something just to get it done. The other thing, what can it hurt to have it go through, what happens if it doesn't work? Then we're stuck for another year or two, we're going to kick it down the road, just because it might pass this particular time on the floor, doesn't mean it will pass 2 years from now, there is a consequence to this plan. I'm betting on private sector.

Chair J. Lee: It isn't going to keep the insurance people from setting up a plan if we don't pass it either. I believe the carriers recognize how much importance is attached to this; otherwise it's going to be a serious problem two years from now.

A roll call vote was taken.

Motion passes 4-3-0.

Chair J. Lee will carry.

Chair J. Lee: Closed the hearing.

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of autism services; to require a report regarding coverage of autism services; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Coverage of autism services.

1. As used in this section:
 - a. "Applied behavior analysis" has the same meaning as "practice of applied behavior analysis" as defined under section 43-32-01.
 - b. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the "Diagnostic and Statistical Manual of Mental Disorders," American psychiatric association, fifth edition (2013) or a more recent version as identified by the board or as defined by the edition in effect at the time of diagnosis.
 - c. "Behavioral health treatment" means a counseling or treatment program, including applied behavior analysis, that is:
 - (1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
 - (2) Provided or supervised by a licensed behavior analyst or psychologist.
 - d. "Diagnosis of autism spectrum disorder" means any medically necessary assessment, evaluation, or test to diagnose whether an individual has an autism spectrum disorder.
 - e. "Pharmacy care" means a medication prescribed by an individual authorized to prescribe such a medication and any health-related service deemed medically necessary to determine the need or effectiveness of the medication.
 - f. "Psychiatric care" means a direct or consultative service provided by a psychiatrist licensed in the state in which the psychiatrist practices.
 - g. "Psychological care" means a direct or consultative service provided by a psychologist licensed in the state in which the psychologist practices.

- h. "Therapeutic care" means any service provided by a licensed speech language pathologist, occupational therapist, or physical therapist.
 - i. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care is medically necessary, including behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.
2. For all policies that become effective after June 30, 2017, and which do not extend past June 30, 2019, the board shall provide health benefits coverage for the screening for, diagnosis of, and treatment for autism spectrum disorder. Coverage under this section is not subject to limitations on the number of visits a covered individual may make for treatment for autism spectrum disorder.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF AUTISM SERVICES. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-sixth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of autism services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the autism services coverage requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should continue.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly

March 17, 2017

Ch
3/17/17
1 of 3

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

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3/17/17
2 of 3

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 2. For all policies that become effective after June 30, 2017, and which do not extend past June 30, 2019, the board shall provide health benefits coverage for the screening for, diagnosis of, and treatment for autism spectrum disorder in covered individuals under nineteen years of age.
 - a. Coverage under this section is not subject to limitations on the number of visits a covered individual may make for treatment for autism spectrum disorder.
 - b. Except as allowed under subdivision c, coverage under this section is not subject to dollar limits, deductibles, or coinsurance provisions less favorable to a covered individual than the dollar limits, deductibles, or coinsurance provisions that apply to substantially all medical and surgical benefits under the health benefits coverage.
 - c. Coverage for applied behavioral analysis under this section must provide an annual maximum benefit of:
 - (1) Thirty-six thousand dollars for individuals under the age of seven;
 - (2) Twenty-five thousand dollars for individuals between the ages of seven and not yet fourteen; and
 - (3) Twelve thousand five hundred dollars for individuals between the ages of fourteen and not yet nineteen.
 - d. The coverage for applied behavior analysis must include the services of the personnel who work under the supervision of the licensed behavior analyst or psychologist overseeing the program.
 - e. Except for inpatient services, if a covered individual is receiving treatment for an autism spectrum disorder, the coverage may allow for annual review of the treatment plan, unless a more frequent review is necessary. An agreement regarding the right to review a treatment plan more frequently than annually is limited in application to a particular covered individual being treated for an autism spectrum disorder. The cost of obtaining a review or treatment plan must be borne by the policy.
 3. This section does not limit benefits otherwise available to a covered individual under the uniform group insurance program. This section does not affect an obligation to provide services to a covered individual under an individualized family service plan, an individualized education program, or an individualized service plan.

**SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE
OF AUTISM SERVICES.**

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3/17/17
3 of 3

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2. Quarterly during the 2017-18 interim, the insurance commissioner shall survey health insurance carriers in the state to collect data regarding policy coverage and utilization of autism services. The commissioner shall provide this data to the public employees retirement system for inclusion in the report prepared under subsection 1.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly

Date: 3/17 2017Roll Call Vote #: 1

**2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES**

BILL/RESOLUTION NO. 1434Senate Human Services Committee☐ SubcommitteeAmendment LC# or Description: 17. 02 61 . 02006

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____Motion Made By Sen. Heckaman Seconded By Sen. Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)		X	Senator Joan Heckaman	X	
Senator Oley Larsen (Vice-Chair)		X	Senator Merrill Piepkorn	X	
Senator Howard C. Anderson, Jr.		X			
Senator David A. Clemens		X			
Senator Curt Kreun		X			

Total (Yes) 2 No 5Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3/17 2017Roll Call Vote #: 2

**2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES**

BILL/RESOLUTION NO. 1434Senate Human Services Committee☐ SubcommitteeAmendment LC# or Description: 17.0261 .02007

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar
Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Larsen Seconded By Sen. Kreun

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	<u>X</u>		Senator Joan Heckaman		<u>X</u>
Senator Oley Larsen (Vice-Chair)	<u>X</u>		Senator Merrill Piepkorn		<u>X</u>
Senator Howard C. Anderson, Jr.	<u>X</u>				
Senator David A. Clemens	<u>X</u>				
Senator Curt Kreun	<u>X</u>				

Total (Yes) 5 No 2Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3/17 2017Roll Call Vote #: 32017 SENATE STANDING COMMITTEE
ROLL CALL VOTESBILL/RESOLUTION NO. 1439Senate Human Services Committee☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____Motion Made By Sen. Larsen Seconded By Sen. Kreun

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	<u>X</u>		Senator Joan Heckaman		<u>X</u>
Senator Oley Larsen (Vice-Chair)	<u>X</u>		Senator Merrill Piepkorn		<u>X</u>
Senator Howard C. Anderson, Jr.	<u>X</u>				
Senator David A. Clemens		<u>X</u>			
Senator Curt Kreun	<u>X</u>				

Total (Yes) 4 No 3Absent 0Floor Assignment Sen. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1434, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** and **BE REREFERRED** to the **Appropriations Committee** (4 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1434 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of autism services; to require a report regarding coverage of autism services; and to provide an expiration date.

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system shall append to the bill a report regarding the effect of the autism services coverage requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage under this Act, a comparison of the system's coverage of autism services under this Act and the coverage of autism services by North Dakota insurers, and a recommendation regarding whether the coverage under this Act should continue as provided in this Act or should continue with amendments.

2. Quarterly during the 2017-18 interim, the insurance commissioner shall survey health insurance carriers in the state to collect data regarding policy coverage and utilization of autism services. The commissioner shall provide this data to the public employees retirement system for inclusion in the report prepared under subsection 1.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly

2017 TESTIMONY

HB 1434

att. 1 1-30-17
HB 1434

HB 1434
Autism Insurance Reform

Chairman Robin Weisz, House Human Services Committee

Good afternoon Chairman Weisz and members of the House Human Services Committee, for the record, my name is Thomas Beadle, State Representative from District 27 in Fargo. I am here today on behalf of hundreds of families across our state who are leading a grassroots effort pushing Autism Insurance Reform in North Dakota. I will try to be brief in my remarks and in my walk-through of this bill, as there are families and industry professionals here to testify in support of this bill.

As you will hear from those that will speak after me, having a family member on the Autism Spectrum is a life-changing impact, both in terms of cost, and in terms of lifestyle. There is plenty of data on this topic. It is estimated that nationwide, 1 in 68 children are diagnosed with Autism Spectrum Disorder, and it is higher amongst boys at 1 in 42. According to the Harvard School of Public Health, the estimated costs over the lifetime of an Autistic individual is \$3.2 Million dollars. This is a huge issue! And studies show, that early detection, intervention, and therapy support can save \$1 million off of these lifetime costs.

In terms of changing the lifestyle, I have handed out testimony on behalf of my aunt, Heidi Amundson with regards to her experiences with son Zack. Her years of work in advocating for her son has pushed her into going back to school to become a speech pathologist, and has caused them to sell off the farm equipment in order to fund their treatments, and has them moving to West Fargo in order to be closer to the services they need. This is a very needed bill.

A quick summary of the bill itself:

Subsection 1 of the bill is definitions. Referenced definition in subsection 1(a) is below.

43-32-01. Definitions

8. "Practice of applied behavior analysis":

a. Means the application of the principles, methods, and procedures of the experimental analysis of behavior and applied behavior analysis, including principles of operant and respondent learning. The term includes applications of those principles, methods, and procedures to:

- (1) Design, supervise, evaluate, and modify treatment programs to change the behavior of individuals diagnosed with an autism spectrum disorder;
- (2) Design, supervise, evaluate, and modify treatment programs to change the behavior of individuals;
- (3) Design, supervise, evaluate, and modify treatment programs to change the behavior of groups; and
- (4) Consult with individuals and organizations.

Subsection 2 - Institutes an age limit of 26 years old, and makes sure that an autism diagnosis is not grounds for denial of or termination of an insurance contract. Aside from the 8 states that have no Age limit in place, this would be the highest threshold in the nation. One change that I would like to entertain as we continue this discussion, is to look at placing an age threshold in the 18-21 range which is most common across the nation.

Subsection 3 - Prohibits the number of limits on number of visits for treatments

Subsection 4 - Cannot set dollar limits substantially lower than all other medical and surgical benefits in the plan.

Subsection 5 - Not limit other benefits that are available in the plan

Subsection 6 - Coverage for ABA therapy is subject to a maximum of \$50,000 per year

Subsection 7 - Coverage for ABA must include the services of the personnel who work under the supervision of the licensed behavior analyst or psychologist overseeing the program.

Subsection 8 - Allows an insurer to annually review the treatment plan for an insured receiving treatment for Autism spectrum disorder, unless the insurer and the insured's treating physician or psychologist agree to more frequent review as being necessary.

Subsection 9 - This whole section does not affect an obligation to provide services for an individual under an individualized family service plan, an individual educational program or an individualized service plan.

Subsection 10 - This section does not apply to nongrandfathered plans in the individual or small group markets under the ACA.

Subsection 11 - Before August of each even numbered year, the Insurance Commissioner shall submit a biennial report to Legislative Management regarding the implementation of the coverage. This report will give us plenty of data to work with, including the number of diagnosed individuals, costs of claims received, cost per insured for coverage.

Section 2 - Directs ND PERS to include Autism coverage in their plan.

Section 3 - This language is identical to last session when we discussed Oral Chemotherapy. If something is declared to be a mandate, it must be subject to a 2 year review process by PERS before it goes into effect for commercial lines. This language is necessary to bypass that, as it directs autism coverage to be available January 1, 2018 instead.

This language is essentially model language from Autism Speaks, a national organization that is working on behalf of families dealing with these issues, and versions of this language has now passed in 45 states with the remaining states looking at language this year. Someone from Autism Speaks is here and can go in much more depth on this language than I can.

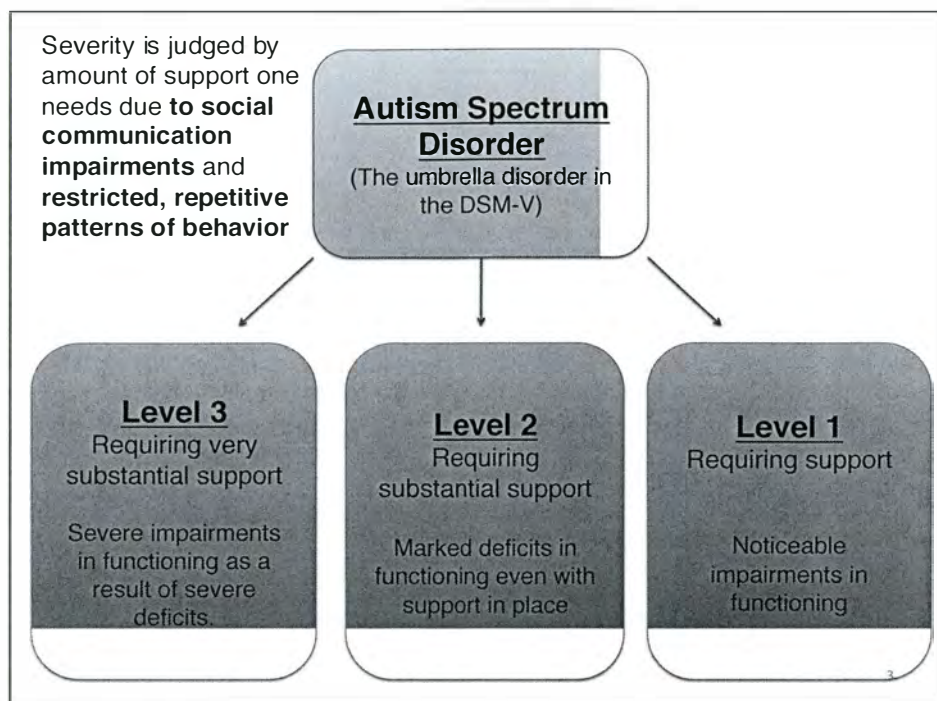
Mr. Chairman, and members of the committee. I strongly believe that our assembly needs to act on this during this legislative session, as we have families that are facing very tough situations and has put some into dire financial need. I ask that you give careful review of this legislation, listen to the families and the experts who will follow me, and adjust this bill if needed so that we can solve some of their issues. This is truly some of the most vulnerable members in our society, and we ought to do what we can to ensure that they are taken care of. I ask for a Do Pass recommendation, and will stand for any questions. Thank you, Mr. Chairman.



Bringing
Meaningful
Autism Insurance
Coverage to
North Dakota

What is Autism?

- Autism and autism spectrum disorder (ASD) are both general terms for a group of complex disorders of brain development.
- Autism affects a person's **communication** abilities and **social skills**, and often causes **repetitive patterns of behavior** and a narrow range of interests.
- Its symptoms range from mild to severe.



Diagnosing Autism

- The American Academy of Pediatrics recommends **screening** every child for autism at their 18 and 24 month checkups.
- Autism is **diagnosed** by a physician; usually by a developmental pediatrician, pediatric neurologist or team of developmental specialists.

Treatment

- Early diagnosis and treatment are critical to a positive outcome for individuals with an autism spectrum disorder (ASD)
- Treatment is prescribed by a licensed physician or licensed psychologist:
 - Behavioral health treatment, including Applied Behavior Analysis (ABA) Therapy
 - Speech, Occupational and Physical Therapy
 - Psychological, Psychiatric, and Pharmaceutical Care

American Academy
of Pediatrics



June 20, 2012

Testimony of
Vera F. Tait MD, FAAP

On behalf of the
American Academy of Pediatrics

Before the
Subcommittee on Personnel,
Senate Armed Services Committee

American Academy of Pediatrics
4025 L Street, NW, Suite 400
Washington, DC 20014-2000
Tel: 800.833.3475 • 1

• "Optimizing medical care and therapy can have a positive impact on the habilitative progress and quality of life for the child. **Medically necessary treatments ameliorate or manage symptoms, improve functioning, and/or prevent deterioration.** Thus, in addition to routine preventive care and treatment of acute illnesses, children with ASDs also require management of sleep problems, obsessive behaviors, hygiene and self-care skills, eating a healthy diet, and limiting self-injurious behaviors.

• Effective medical care and treatment may also allow a child with ASD to benefit more optimally from therapeutic interventions. Therapeutic interventions, including behavioral strategies and habilitative therapies, are the cornerstones of care for ASDs. These interventions address communication, social skills, daily-living skills, play and leisure skills, academic achievement, and behavior."

Applied Behavior Analysis (ABA)

- ABA is the most commonly prescribed **evidence-based** treatment for ASD
- Decades of research demonstrate the effectiveness of ABA therapy for autism
- Many insurers still deny coverage for ABA based on the assertion that ABA therapy is "experimental." *This assertion is simply not supported by science*

American Academy
of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

June 20, 2012
Testimony of
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On behalf of the
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Before the
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- "An example of a demonstrated, effective treatment for ASD is **Applied Behavior Analysis, or ABA**. ABA uses behavioral health principles to increase and maintain positive adaptive behavior and reduce negative behaviors or narrow the conditions under which they occur. ABA can teach new skills, and generalize them to new environments or situations. ABA focuses on the measurement and objective evaluation of observed behavior in the home, school, and community. "

American Academy of Pediatrics • Department of Federal Affairs
601 13th Street NW, Suite 400 North • Washington, DC 20005
Tel: 800.338.5475 • E-mail: ajp@pediatrics.org

American Academy
of Pediatrics
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• "ASD is a medical/
neurodevelopmental condition with
behavioral symptoms that are
directly addressed by applied
behavior analysis methods. ABA has
proved **effective in addressing the
core symptoms of autism as well
as developing skills and improving
and enhancing functioning** in
numerous areas that affect the
health and well-being of people with
ASD."

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Before the
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Senate Armed Services Committee

• "The effectiveness of ABA-based
interventions in ASDs has been well
documented through a long history of
research in university and community
settings. Children who receive early
intensive behavioral treatment have
been shown to make **substantial gains
in cognition, language, academic
performance, and adaptive behavior
as well as some measures of social
behavior**, and their outcomes have
been significantly better than those of
children in control groups."

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5

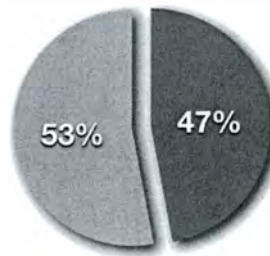
Outcome of Lovaas 1987 UCLA Study

Efficacy of ABA Therapy

Control Group



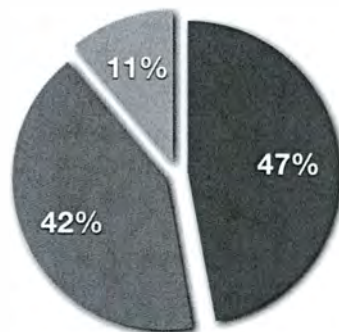
ABA Group



● Achieved Normal IQ ● Did Not Achieve Normal IQ

Outcome of Lovaas 1987 UCLA Study

Educational Placement for Group that Received ABA



● Mainstreamed with No Support
 ● Low-Intensity Special Education Placement (for language delay)
 ● High-Intensity Special Education Placement (for autism or intellectual disability)

ABA endorsements

United States Surgeon General (1999)

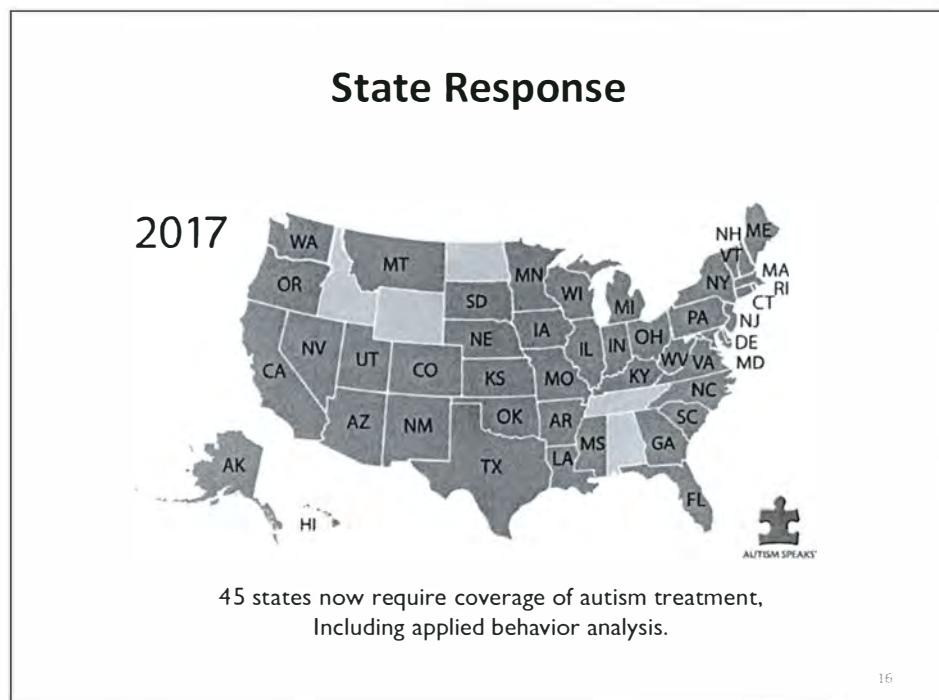
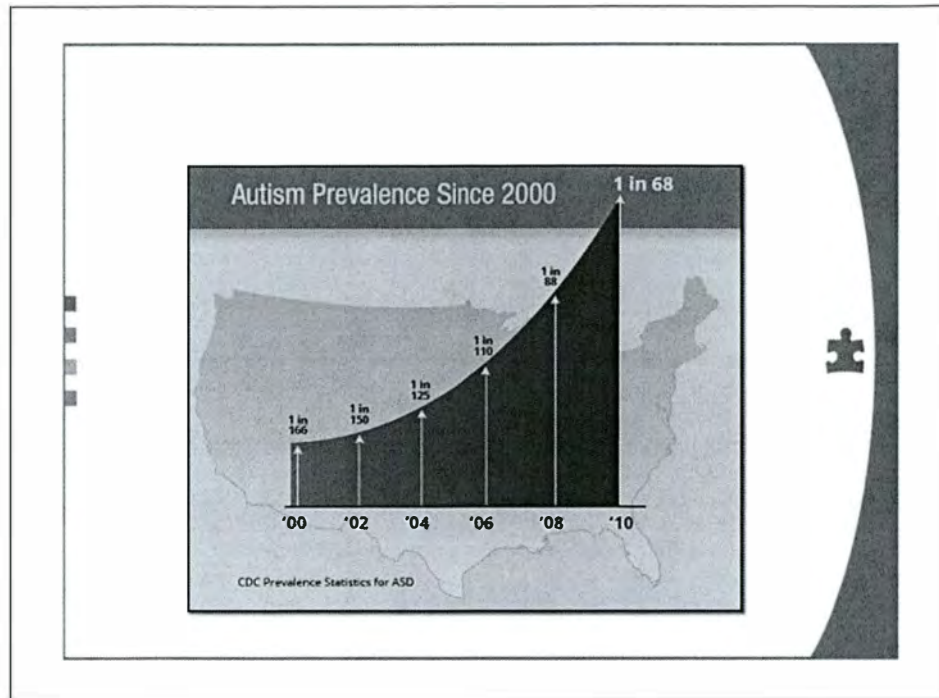
"Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior."

The U.S. Office of Personnel Management (2012)

"The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. **The Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy.** Accordingly, plans may propose benefit packages which include ABA."

Facing Financial Reality

- According to a 2007 study conducted by the Harvard School of Public Health, it costs approximately \$3.2 million to take care of an autistic person over his or her lifetime.
- The Ganz 2007 Harvard study also found that caring for all people with autism over their lifetimes costs an estimated \$35 billion per year in direct and indirect costs.
- Estimated lifetime cost **savings** of providing appropriate treatment are \$1 million per child (Jacobsen et al, 1998)



8

United States Department of Defense



Tricare provides meaningful autism coverage for both active duty and retired military personnel, including behavioral health treatment like applied behavior analysis.



What about the nation's largest employer?

- The Office of Personnel Management, which manages the Federal Employees Health Benefits Program (FEHB) has directed its carriers to cover applied behavior analysis (ABA) starting January 1, 2017.
- The FEHB program is the nation's largest employer-sponsored health benefits program, covering 8.2 million federal employees, retirees and dependents.

"We expect all carriers to offer clinically appropriate and medically necessary treatment for children diagnosed with ASD. "
OPM Letter to Carriers Dated February 26, 2016

In States with Autism Insurance Reform...

- People who have never before been able to receive treatment are making remarkable progress.
- Providers have joined adequate networks of participating providers and negotiated satisfactory reimbursement rates.
- The impact on premiums has been negligible.

Cost of Coverage

If the out of pocket cost of treatment can be as high as \$60,000 per child per year, how can the reported claims data be so low?

- Autism is a **spectrum** and treatment is individualized based on the severity and individual needs of the affected individual.
- **Utilization** of benefits is not 100%

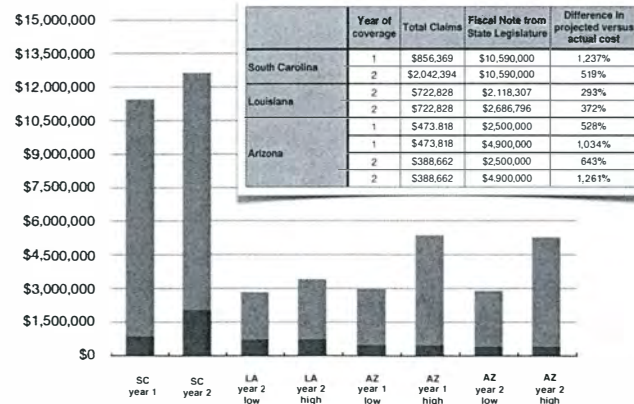
Utilization

- Of the estimated number of affected individuals, how many access treatment?
- Disease Prevalence \neq Treated Prevalence
- Based on claims data collected by Autism Speaks, estimated benefit utilization is 30-50%. (*Minnesota providers report 20%.*)
- Contributing factors?
 - undiagnosed individuals
 - parent choice
 - higher functioning
 - socioeconomic status

21

Projected vs Actual Costs

■ Actual Cost ■ Fiscal Note from State Legislature



The Cost of Autism Insurance Reform – Year Three

	Year of Coverage	Number of Covered Lives	Total Claims Paid	PMPM Cost
South Carolina	3	427,314	2,065,777	\$ 0.40
Illinois	3	208,466	416,741	\$ 0.17
Kansas	3	100,000	326,907	\$ 0.27
Missouri	3	1,443,680	8,289,917	\$ 0.48
Virginia	3	183,407	583,945	\$ 0.27
Iowa	3	79,000	205,573	\$ 0.22
New Jersey	3	597,104	4,482,066	\$ 0.63
Maine	3	29,637	67,384	\$ 0.19
Average Third Year Cost PMPM				\$ 0.45

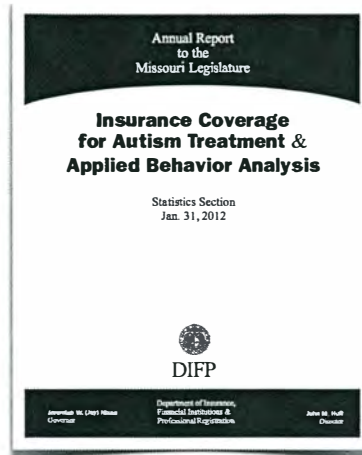
References: Data collected by Autism Speaks from State agencies responsible for administering State Employee Health Benefits Programs (2011); Missouri Department of Insurance, Financial Institutions and Professional Registration (2012); and the Kansas Department of Health and Environment (2012)

The Cost of Autism Insurance Reform – Year Four

	Year of Coverage	Number of Covered Lives	Total Claims Paid	PMPM Cost
Missouri	4	1,634,042	9,804,254	\$ 0.50
Virginia	4	179,634	1,065,180	\$ 0.49
Iowa	4	79,000	175,734	\$ 0.19
Average Fourth Year Cost PMPM				\$ 0.49

References: Data collected by Autism Speaks from State agencies responsible for administering State Employee Health Benefits Programs (2011); Missouri Department of Insurance, Financial Institutions and Professional Registration (2012); and the Kansas Department of Health and Environment (2012)

Effect on Premiums



- Claims incurred for treatment of ASD represent **0.9% of total claims**
- “While claims costs are expected to grow somewhat in the future, it seems very unlikely that costs for autism treatment will have an appreciable impact on insurance premiums.”

The Virginia State Corporation Commission reports to the Virginia General Assembly annually regarding the impact of health insurance mandates on the private health insurance market.



The 2013 report reflects the following:

The average annual claim cost per contract or certificate related to mandated coverage of autism spectrum disorder is \$2.19

This represents .04% of total claims reported and equates a premium impact for policyholders of **18 cents per member per month**

The 2014 report reflects the following:

The average annual claim cost per contract or certificate related to mandated coverage of autism spectrum disorder is \$2.66

This represents .06% of total claims reported and equates a premium impact for policyholders of **22 cents per member per month**

The 2015 report reflects the following:

The average annual claim cost per contract or certificate related to mandated coverage of autism spectrum disorder is \$3.50

This represents .05% of total claims reported and equates a premium impact for policyholders of **29 cents per member per month**

NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

2013 SURVEY TABLES

Percentage of employers providing coverage for autism spectrum disorders:						
	Diagnostic services	Medication management	Speech, occ., physical therapies	Inpatient/outpatient treatment	Intensive behavioral therapies	Autism is not covered
Large employers	74%	63%	68%	56%	36%	18%
BY REGION						
West	74%	64%	70%	57%	41%	14%
Midwest	75	63	66	54	32	20
Northeast	74	61	68	59	39	20
South	74	65	69	56	32	18
BY INDUSTRY						
Manufacturing	79%	65%	69%	48%	29%	15%
Wholesale/Retail	70	51	61	55	26	22
Services	68	57	63	57	31	24
Transport/Communic/Utility	67	62	63	50	38	26
Healthcare	72	63	69	53	37	22
Financial services	87	72	78	76	55	8
Government	69	64	69	60	35	15
BY NUMBER OF EMPLOYEES						
500-999	69%	65%	64%	56%	31%	23%
1,000-4,999	79	64	72	57	39	16
5,000-9,999	70	52	65	47	30	20
10,000-19,999	78	57	70	62	40	13
20,000 or more	71	56	67	51	33	17

Mercer National Survey of Employer Sponsored Health Plans 2013

Self-Funded Plans that Provide Coverage for Autism Treatment

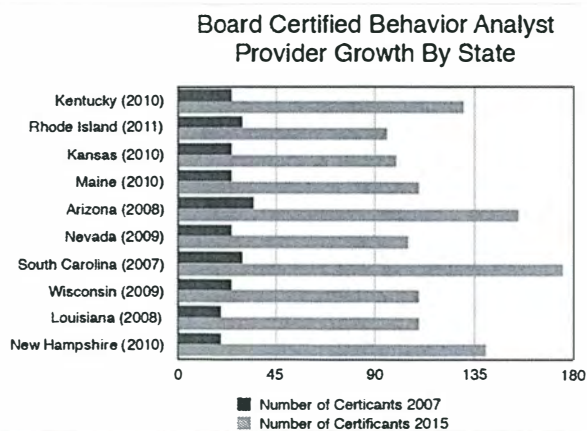
- Microsoft
- AT&T
- Turner Broadcasting
- Georgia Power
- Home Depot
- Arnold & Porter
- Symantec
- Cisco
- Children's Healthcare of Atlanta
- Eli Lilly
- UTC
- Ohio State University
- Time Warner
- John Deere
- MIT
- Blackbaud
- Partners Healthcare
- Deloitte
- White Castle
- Wal Mart
- Bank of America
- JP Morgan Chase
- University of Minnesota
- Progressive Group
- Intel
- DTE Energy
- Emory University
- SunTrust
- Cerner
- Merck
- State Street Corporation
- Children's Mercy
- Capital One
- Yahoo
- Rubbermaid Newell
- Sisters of Mercy Health Systems
- Princeton University
- Wells Fargo
- Jet Blue
- American Airlines
- Southern Baptist Convention
- Northern Trust
- Abbott Labs
- GE
- General Motors
- EMC
- American Express
- Liberty Mutual
- Michelin
- National Grid
- Safeway
- RR Donnelly
- T Rowe Price
- Morgan Stanley
- Price Waterhouse Coopers
- And Many more..

WALL STREET JOURNAL

- More Autism Help... As diagnoses of autism rise, a growing number of families are grappling with the worry and expense of finding treatment for children with the complex developmental disorder, autism. And many are pressing employers and legislators for help. (Wall Street Journal)
<http://online.wsj.com/article/SB10001424052748703867704576183022242647068.html>

- Bernie Marcus, Co-Founder Home Depot ... "The insurance lobbies obviously don't want to cover it and yet **we know the cost is only 32 cents per month per member. And they're fighting it tooth and nail. I put it into Home Depot years ago and I will tell you, it didn't break Home Depot.**"

Job Growth in States with Autism Insurance Reform Laws State/(Year Law Passed)



What Should an Autism Benefit Look Like?

- Coverage should include
 - Applied Behavior Analysis (ABA) Therapy
 - Speech Therapy, Occupational Therapy, and Physical Therapy
 - Psychological, Psychiatric, and Pharmaceutical Care
 - Diagnosis and Assessments

What Should an Autism Benefit Look Like?

- No denials on the basis that treatment is
 - Habilitative in nature
 - Educational in nature
 - Experimental in nature
- For Applied Behavior Analysis coverage, treatment must be provided or supervised by a behavior analyst who is certified by the Behavior Analyst Certification Board®, or
 - a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience

About Autism Speaks

Autism Speaks is the world's largest autism science and advocacy organization, dedicated to funding research into the causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families.

Autism Votes is an Autism Speaks initiative; a comprehensive grassroots advocacy program, coordinating activist efforts in support of federal and state legislative initiatives.

For more information, please visit www.autismvotes.org and www.autismspeaks.org

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About Autism Speaks

Autism Speaks Autism Speaks is the world's leading autism science and advocacy organization. It is dedicated to funding research into the causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families.

Autism Speaks was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Mr. Wright is the former vice chairman of General Electric and chief executive officer of NBC and NBC Universal. Since its inception, Autism Speaks has committed more than \$500 million to its mission, the majority in science and medical research.

Each year *Walk Now for Autism Speaks* events are held in more than 100 cities across North America. On the global front, Autism Speaks has established partnerships in more than 40 countries on five continents to foster international research, services and awareness.

To learn more about Autism Speaks, please visit www.AutismSpeaks.org



Att. 3
HB1434
1-30-17

Testimony
House Bill 1434
Monday, January 30, 2017
Jennifer L. Skjod (Parent)
(701) 220-7852 / jenniferskjod@gmail.com

Good afternoon, Chairman Weisz and members of the human services committee. My name is Jennifer Skjod, and I am a parent of a 12-year-old child with autism. I am here today to provide information and offer support to House Bill 1434.

House Bill 1434 would establish services required by health insurance companies to cover under their North Dakota policies. North Dakota is one of only a few states that does not encourage this coverage.

Our child was diagnosed in 2011 at age seven with autism. We, like many parents of pre-adolescent and adolescent children in North Dakota, did not have access to early intervention. (You have to be diagnosed to get that.) Neither did we have the benefit of the Medicaid Waiver. Although a step forward in services, our child was past the age limit when that was passed.

Instead, we read enough books and visited enough websites to enable a Ph.D. in this subject! But that knowledge did us little good when we realized that Applied Behavior Analysis or ABA – otherwise known as the gold standard in autism intervention, was unavailable to us. There were simply no providers that offered this practice within a 300-mile radius. (And why would there be if insurance did not cover it.)

Finally, I was over the moon to discover there was a local expert –one person in all of the community that was certified to offer these services. I met with her only to find she was assigned to only work with children on the Medicaid waiver. This is just one long list of cracks our family seemed to slip through, but certainly the most devastating.

With no certified educators in our community and none willing to put up with behaviors we were not successful enough to control on our own, he is on a rather long waitlist for residential care.

I realize coverage for ABA would be an added expense for insurance companies. However, with the reduced need for residential care (which can cost more than \$800 a day), perhaps they would consider this preventive medicine.

I would be happy to answer any questions you have at this time.

Att. 4
HB 1434
1-30-17

Testimony in support of HB 1434: ND House Human Services Committee

Jan. 30, 2017

Good afternoon everyone. Thank you for the opportunity to speak here today. My name is Dr. Daisha Seyfer, and I am trained as a Developmental-Behavioral Pediatrician. That means that after medical school and residency I went on to do a three year fellowship in Developmental-Behavioral Pediatrics at Nationwide Children's Hospital and Ohio State University in Columbus, Ohio.

I spent three years doing focused training in the diagnosis, management, and treatment of autism spectrum disorders. I was very fortunate to be able to do my autism training at the Center for Autism Spectrum Disorders at Nationwide Children's Hospital, which is a very large autism center in central Ohio and is actually an Autism Treatment Network site. I spent two years practicing as a Developmental-Behavioral Pediatrician in Sioux Falls, SD. I drove seven hours from South Dakota to be here and talk to you today about autism and applied behavior analysis.

I can assure you that ABA, or applied behavior analysis, is absolutely not an experimental therapy for autism. Among those in my field and other professionals who are knowledgeable about autism spectrum disorders, ABA is widely considered to be one of the best known therapies for autism. Thirty years of research support its use. You don't have to just take my word for it; I have compiled a sampling of some of the research articles that have been produced over the last three decades that support its use, which you may review at your leisure. Research tells us that when comprehensive ABA therapy is provided at the prescribed intensity to children, 47% of individuals will be able to mainstream into regular education classes without an aide by first grade. An additional 42% may improve such that they require much less intense special education (Lovaas, 1987). That is a HUGE impact, not only for the children themselves but for their families and communities as well.

Studies have shown that kids with autism spectrum disorder who receive ABA may make **significant and sustained** gains in IQ, language, academic performance, self-care behaviors, and social skills (Myers, 2007). ABA can address a wide range of problems, including functional living skills, language, reading, social skills, peer interaction, and academic engagement. ABA can also address problem behaviors such as tantrums, noncompliance, feeding problems, aggression, and self-injury. Notable national health organizations such as the U.S. Surgeon General (Satcher, 1999) and the American Academy of Pediatrics (Myers, 2007) endorse the use of this significant treatment for autism.

The enormous potential benefits of ABA are well-documented in the scientific literature. It is absolutely **the** therapy that any of you would want for your child, grandchild, niece, nephew, or other family member with autism. I am a mother of a two year-old child. If my child were to ever be diagnosed with autism, there is NO WAY that my child would ever go without ABA. And if we had to move to a different state or switch jobs to access it, then so be it. I actually personally know multiple families who have done those exact things- and more- to access ABA for their children. That is how important this is. That's how big a difference this therapy can make in the life of a child.

Sadly, the majority of children in this state who have autism do not receive ABA currently, and a big reason in many cases is lack of insurance coverage. So clearly, there is a tremendous need for a law requiring insurance companies to cover this treatment. You know, there has been great effort in the last few years, both on the part of the American Academy of Pediatrics and public health organizations such as the Centers for Disease Control to get health care providers and communities to recognize the signs of autism early and diagnose it early so that we can treat early. The reason we want to treat as early as possible is because we know that we can have better long term outcomes, or prognosis, the earlier we intervene.

The first 5-6 years of life are the period when the brain is growing and developing at its most rapid pace. In order to have the biggest impact on the future developmental potential of a child, we really need to intervene as early as possible to be able to capitalize on that period of rapid brain growth. However, that's not to say that children won't be able to make any progress if ABA is started later. I personally have seen kids say their first words at age 8 years old and older, but only after beginning to receive intensive ABA therapy. I've also seen older kids make dramatic improvements in some of their behaviors when they begin to receive ABA at an older age. ABA techniques have been shown in the literature to be particularly helpful for adolescents and also adults who have a specific deficits or behavioral problems (Bishop-Fitzpatrick, 2013) (Hagopian, 1996) (Rehfeldt, 2003) (Shabani, 2006).

A question I have been asked by families in the past is whether something like speech therapy or occupational therapy could be as effective as ABA. And I never know quite how to answer that question, because I have seen all three of those therapies be very useful interventions for children with autism. They are three totally different therapies and they all have the potential to be incredibly useful to a child with autism. However, one does not really take the place of another. In the American Academy of Pediatrics' 2007 policy statement on autism (which was reaffirmed in 2011 and 2014), the AAP specifically lists all three interventions (ABA, speech, and OT) as specific recommended strategies to help children with autism enhance communication skills, learn social skills, and reduce problem behaviors (Myers, 2007).

In summary, I hope that you will consider enacting a law to help North Dakota's children with autism to access appropriate therapy, including applied behavior analysis. Thank you very much for your time.

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Ch H. 5
HB 1434
1-30-17

TESTIMONY IN SUPPORT OF HOUSE BILL 1434

INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

January 30, 2017

Ladies and Gentlemen of the Committee:

I am a ND Licensed Board Certified Behavior Analyst (BCBA). I have a bachelor's degree in Psychology and a master's degree in Applied Behavior Analysis and Autism. I have had the privilege of working with children with autism for 10 years. I have been employed at the North Dakota Autism Center for approximately 8 years where I work alongside highly trained behavior technicians and fellow Board Certified Behavior Analysts providing intensive interventions based on the field of ABA. Our team of professionals works daily providing evidence-based interventions to children and adolescents with autism, developmental disabilities, and other related disabilities and behavioral challenges.

Applied Behavior Analysis (ABA) is a discipline devoted to improving the behavior of people in real-world settings (clinics, schools, community, and industry) using evidence-based strategies derived from the field. In general terms, ABA is a field that is dedicated to helping individuals be successful in their everyday lives. When I refer to success, I am not referring to the general public's portrayal of success (money, raises, and promotions); I am referring to critical life changing skills. We are focused on teaching patients how to communicate when they are hungry, how to get a glass of water when they are thirsty, how to use the bathroom independently, how to respond to the directions of others (i.e. "Stop" "Hot" "Dangerous), how to communicate with others, and the list of skills goes on and on. Not only are we focused on teaching new skills, but we are also focused on reducing unwanted behavior(s) that can be detrimental to the patients. When I refer to unwanted behavior(s), I am referring to life altering behaviors such as reducing a patient's engagement in self-injurious behavior (i.e. a patient harming him/herself), physical aggression towards others, destruction of property, tantrums, and dangerous behaviors such as running away from caregivers or climbing on high surfaces.

In summary, the field of ABA teaches patients the skills that many people develop naturally and then take for granted on a daily basis. For example, the skills that you and I utilize every day that can seem so basic and routine such as taking a shower, getting dressed, brushing our teeth, problem solving, navigating social situations, practicing safety skills (i.e. crossing the street), using calming techniques to stay in control are the same skills that that these incredible, hard-working patients may not develop "naturally" and have to work exceptionally hard to learn. Applied behavior analysis makes that possible.

Learning what the field of ABA is and what it does is only half the battle to understanding why making ABA services available is so critical to helping these individuals. The other half is learning ABA is a safe treatment that has scientifically been shown to be effective. The successful and effective use of ABA-based procedures to increase wanted behavior and decrease unwanted behavior has been documented across 40 years of extensive research and is well documented in scientific literature. Research showing that ABA-based procedures are empirically supported treatments can be found in both behavioral and non-behavioral journals. Thousands of studies utilizing different research designs have been published since the 1960s and the results of these studies can best be seen in the multiple review papers conducted on ABA-based interventions. For example, the *Journal of Pediatrics*, in a review of scientifically supported and unsupported interventions for childhood psychopathology concluded that: "*The most efficacious psychosocial treatment for autism is applied behavior analysis.*" (Lillienfeld, 2005,

p. 762) In addition, systematic evaluations of ABA-based procedures have been conducted based on standards put in place to determine if a particular intervention can be characterized as “empirically supported” or “established.” Multiple evaluations of ABA-based procedures have concluded that ABA interventions are “well established” or “evidence-based.” (Wong et al., 2013) Finally, in an overview and summary of scientific support for ABA, Hagopian and colleagues (2015) highlight the many scientific, government, and professional agencies that have concluded that ABA-based procedures represent best practice as a result of the overwhelming empirical evidence provided by the field of ABA:

- **Autism Speaks** states that “*ABA is widely recognized as a safe and effective treatment for autism*”; and “*Behavior analysis is a scientifically validated approach to understanding behavior and how it is affected by the environment.*”
- **The American Association on Intellectual and Developmental Disabilities** (formerly the American Association on Mental Retardation), the oldest and largest interdisciplinary organization of professionals concerned with intellectual disability and related disabilities, designated ABA-based procedures for the treatment of behavioral problems with individuals with intellectual disability and related disorders as “highly recommended” (Rush & Frances, 2000).
- **American Academy of Child and Adolescent Psychiatry** concluded: “*ABA techniques have been repeatedly shown to have efficacy for specific problem behaviors, and ABA has been found to be effective as applied to academic tasks, adaptive living skills, communication, social skills, and vocational skills*” (Volkmar et al., 2014).
- **Organization For Autism Research** (“The Best of the OARacle”; see page 10) stated that “*...[ABA] is distinguished from other interventions because it has been proven effective in promoting skill development in persons with autism.*”
- **National Autism Center’s National Standards Report** (2009) noted that behavioral interventions based on ABA were found to have an *established level of evidence* to support their use. Examples include behavioral packages, antecedent packages, comprehensive behavioral treatment for young children, modeling, schedules, pivotal response training, and self-management packages.
- **The Association for Science in Autism Treatment (ASAT)** found that “*...ABA is effective in increasing behaviors and teaching new skills....ABA is effective in reducing problem behavior...and also indicates that, when implemented intensively (more than 20 hours per week) and early in life (beginning prior to the age of 4 years), ABA may produce large gains in development and reductions in the need for special services.*”
- **The Centers for Disease Control** (see types of treatment) indicated that a “*... notable treatment approach for people with an ASD is called applied behavior analysis (ABA). ABA has become widely accepted among health care professionals and is used in many schools and treatment clinics....*”
- **The National Institute of Mental Health (NIMH)** noted that ABA has become widely recognized as an effective treatment for individuals with autism (see treatment options section).

- **The National Institute of Child Health and Human Development** stated that "... *applied behavior analysis (ABA), [is] a widely accepted approach that tracks a child's progress in improving his or her skills...*"
- **The Surgeon General of the United States** stated, "*Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior*" (1999).

My personal experience with this field and what these interventions are capable of are testimony to its effectiveness. At just 20 months old, a young boy was referred to me by his doctor as he was nonverbal and failing to meet his milestones. This patient had just received a diagnosis of autism, and his parents were motivated to get him the services he needed. Assessment of this patient revealed he was unable to engage in many of the expected skills for his age (request for wanted or needed items, follow the directions of others, label/name things in his environment, imitate the actions or sounds of others, or engage socially with peers or adults). Using evidence-based strategies derived from the field of ABA, a tailored intervention package was developed for this patient and was implemented 25 hours per week. At 46 months when this patient was reassessed, he had gained most of the skills of his current age matched peers. Today this patient is enrolled in a general education school and spends his day in the general education classroom and is no longer receiving ABA services.

In a similar example, a family of a 39-month-old boy requested an intake as their son was diagnosed with autism, and since both parents were medical doctors, they understood the importance of ABA and getting their child services. Before services started, this patient's assessment revealed high areas of skill deficits and engagement in barrier skills. After 3 years of receiving ABA services for 10 – 25 hours a week, the patient is now enrolled in a general education school where he spends his day in the general education classroom with his age matched peers and receives minimal support.

I have also seen firsthand the implementation of evidence based ABA-procedures teach an 8-year-old boy with a severe genetic disorder to be independent in the bathroom, eliminate the severe self-injurious behavior of head-banging in a 9-year-old, teach a nonverbal 6-year-old girl with a brain disorder how to communicate using pictures, a 14-year-old male how to independently engage in self-help skills and engage in numerous job skills in the home and community, and reduce the intense physical aggression of a 7-year-old girl to ensure her continued access to peers and family. These are only a few examples that highlight the effectiveness and significance of ABA services.

In closing, I would like to share with you a situation that I encounter far more frequently than necessary . A concerned parent calls the center and explains to me that their son or daughter is engaging in a serious behavior and is unable to engage in some of the most fundamental skills. The parent proceeds to tell me how hard it is to see their loved one struggle every day and how powerless they feel as parents, as they do not know what to do to help their child. They proceed to tell me that their doctor referred them to us, and they have read and researched all about the field of ABA and how it can help. I listen to the parent and think about all of the evidence-based procedures that I have seen time and time again be successful with the same information the parent is sharing with me. I hear the hope and the desperation in that parent's voice, but instead of being optimistic about the chance of being able to teach this child the skills he/she needs, I sit on the other end of the line dreading the next question I have to ask and silently hope that this family does not live in North Dakota or they have out of state insurance. I ask the parent, "What insurance do you have?", and undoubtedly have to spend the next part of the conversation explaining to this parent in desperate need that we have the evidence-based strategies that could be the

answer to their problems, but unless they can pay out of pocket, I cannot help them because no North Dakota insurance companies cover ABA, the service that was prescribed by their doctor. Now, the family has to make the impossible decision of giving their child the opportunity to learn the skills that so many of us take for granted and potentially putting their family in financial ruin, watch their child struggle daily knowing they could be receiving help but are not financially capable, or move to one of the other 45 states where ABA coverage is available.

I strongly support House Bill 1434, Autism Insurance Reform for North Dakota Families and ask that you vote in support this legislation. Thank you for your time and consideration of this significant matter. If I can be of any assistance during this time of deliberation, please do not hesitate to contact me.

Sincerely,

Chelsea Evenstad, M.S., BCBA, LABA
Behavior Support Program Director
North Dakota Autism Center
West Fargo, ND 58078

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Att. 6
HB 1434
1-30-17

Good Afternoon, Chairman Weisz and representatives of the Human Service Committee:

My name is Ethan Paul Suda. I am 13 years old and in the 7th grade. I am from Grafton, North Dakota.

Currently, Autism affects 1 in 68 children, 1 in 42 boys and is still on the rise. I am here today representing all children with Autism; however I am only one voice, one child affected by Autism. I am a boy, a son, a grandson, a brother, a cousin and a friend. This disorder does not discriminate. It affects everyone.

I am one of those 42 boys.

In October 2005, at the age of 2, I was diagnosed with Autism. Any skills I had learned, I had lost by 18 months. I cried a lot, I banged my head on the floor & the door, spun in circles over and over again. I avoided eye contact, had no speech, I acted deaf, didn't know how to imitate play and completely obsessed and perseverated about specific interests.

I was gone. Lost. Trapped in my own body. For my parents, it was like a death. They lost the child they once had.

When I was diagnosed, my doctor said that the only researched based therapy that would help me was Applied Behavior Analysis or ABA. She said I needed 40 hours a week of ABA therapy. We were also told that nobody in North Dakota offered it and most importantly, nobody pays for it.

In 2006, My mom quit her job, which was a loss of income. We also lost our employer self-funded health insurance plan and had to pay for it 100% out of pocket. And my parents paid 100% for all of my ABA therapy. **You see, I was one of the lucky ones.** My entire family sacrificed in order for me to receive it. My mom, along with her friend Janice dove in 100% to make this therapy possible. They received help from a grad student at the University of North Dakota who was from Canada and she trained a team of people in our community to help me and my friend Charlie get to where we are today. My siblings became mini therapists too, always making me work for a reward, helping me reach my goals. This was a family mission and I will be forever grateful to all who helped me along the way. I am confident in saying that without ABA therapy, I would not be standing up here today asking all of you for your support.

I have a 4 point GPA, I am independent in school, participate in football, musicals, basketball, & baseball. I too am a representative (of student council that is!). This would not be possible without the proper techniques that have been taught to me over the years through many countless hours of therapy.

I am grateful that I have a voice. I love to draw and have a dream of becoming a cartoon animator for Pixar or Disney.

Now imagine me as your son, or your grandson.... a part of your family in some way. Think about how you would feel having someone you love diagnosed and knowing they would not get the 1 treatment they needed to help them. It is devastating.

Picture what I would be like today as if I never received ABA therapy. Think about what life would be like for me if I would have never gotten the chance. I think we can all agree after hearing my testimony that YES, I AM one of the lucky ones.

As legislators YOU have the ability to change that. YOU have the voice for so many that do not, YOU can make a difference. YOU have the power to give children the therapy that they need. YOU can vote YES.

I am asking for your support to pass House Bill #1434 to give children a voice, the chance to get the skills and independence they need to live happy, fulfilling lives.

To each and every one of you, I Thank you from the bottom of my heart for hearing me speak today, a voice for so many. Kids like me need your help.



Mr. Chairman and committee members,

My name is **Charlie Kern**. I am 15 years old. I'm standing here talking to you because I got better.

It hasn't been easy but some things I can do now are

I can talk. Can you hear me?

I can deal with changes in my schedule without **freaking out**. Like today.

I can **be cool**.

I have **friends**.

I can tell my brothers to **leave me alone**.

I know I should also tell them **thank you**. They're **great** brothers and have helped me a lot.

Vote yes today and I'll thank **YOU** too.



A.H. 7
HB 1434
1-30-17 2

Chairman Wiesz and committee members

My name is **Kenny Kern**. I'm here because young men like me are affected by House Bill 1434.

My brother Charlie has autism. There are 4 boys in our family and I...am first
or as **I like to say, #1**.

One of the treatments that has really helped my brother is ABA therapy. That's why I'm here.

ABA Therapy was, and still is, a big part of our family's life. It's worth it.

We talk about Charlie's future just like we talk about mine - - - because he **definitely** has a future.

Charlie can talk to me. He can also hug me, high five me, hang out with me and BUG me. Even young guys like me know the importance of brothers hugging **AND bugging** each other.

It used to be that Charlie couldn't be around sounds. He couldn't be in music class or school programs. We couldn't play music in our house. Because of treatment, Charlie is in piano lessons, high school band and has played for our church.

It used to be that we couldn't even say certain words in our house because certain words would start a nightmare of behavior for Charlie and we would all be miserable. One of the big words in our house was **FROZEN**. And as you can see, Charlie is not panicking now when I say this.

All the pieces of progress might sound small but put them together, they are **life changing**.

We can leave **home** now and Charlie is **safe**. He doesn't wander.

Before Charlie COULD TALK or answer to his OWN name, we needed help from POLICE to find him. It was scary to not be able to find him. Charlie has been helped by a lot of people but a 5 year old shouldn't need help from THE POLICE for his family to find him in their own neighborhood.

Please vote **yes** for House Bill 1434
so more people **like my brother** can
have a big future AND.....

so more guys like me
can be a part of that
future.



Chairman Wiesz and committee members

My name is Tommy Kern. I am almost 14 years old. I'm here because of **House Bill 1434** and want to encourage you to vote **yes** on it.

This bill will help families like mine. I am brother # 3 in a family of 4 boys. The #2 in our family is Charlie and he was diagnosed with autism right **after I was born**.

I know how hard Charlie works for lots of things that come easily for me. ABA therapy has not been easy for him or for our family. But it has been worth it.

Being able to talk was something I just *did*. Talking to other people is something I just *do*. For Charlie, he needed treatment to be able to do these things that come so easily to me. He now talks to me, to our parents and to anyone else in his life. Especially if the topic is **Star Wars**.

One of the **successes** Charlie has had involves **me**. We are both on the **High School Cross Country Team**. I'm glad Charlie can ride the team bus, on his own, **without** our parents. Because if Charlie needed our parents to ride the bus with him, that would mean **I** would be riding the bus with our parents too. Autism takes **enough** fun out of our life, we don't want parents riding our team bus on top of it.

I know our family is one of the lucky ones to be able to find this treatment for Charlie and pay for it. **But it shouldn't take luck to make this happen for families like mine and brothers like Charlie.** When more than 5 doctors in one year agree that a person needs ABA therapy like they did for my brother, they should be able to have it. And they should be able to use their insurance to pay for it.

You have the opportunity to change lives with House Bill 1434. Not just the lives of children with autism like my brother. But the lives of brothers like me. And families like mine. Take this opportunity.

Vote yes.

Thank you for your time.



Chairman Wiesz and committee members

My name is Jack Kern. I am 11 years old, in the 5th grade. I'm *also* here because of House Bill 1434 and want to encourage you to vote **yes** on it. I'm the fourth and final brother.

I like to think we've saved the best for last!

This is what I know. My brother's doctors recommended ABA Therapy. My parents started this when I was born. My life has revolved around a schedule of appointments for my brother since as long as I can remember. And I know this is a good thing.

Even as an 11 year old, I've been around long enough to know, **this treatment** has helped my brother and our entire family in a big way. Kenny, Charlie, Tommy and I can't share with you the hardest times and Charlie's biggest challenges. It's hard to talk about. Maybe we think it's a little embarrassing. I wouldn't want Charlie to share with you **my** hardest challenges so I won't do that to Charlie either.

Charlie is one of 68. I'm one of **thousands** of brothers wanting treatments to **be** available for the Charlies of North Dakota. When it's time to say yes or no, **SAY YES**. I will personally shake your hand when you do.

Thank you very much.



Mr. Chairman Weisz and Human Services Committee

I am Janice Kern. My husband and I have four children. Our 15 year old son was diagnosed with **autism** at the age of 2.

I would like to ask for your support in passing House Bill #1434 dealing with autism insurance reform. Our son Charlie is covered by **3** insurance policies, one of which I have been paying premiums into for 26 years, a second personal plan, as well as state medicaid. Yet he is unable to have coverage for evidence-based treatment referred to as ABA Therapy, even though it has been recommended by numerous doctors and non-physician providers since the day he was diagnosed.

Fortunately, my son was able to access ABA and because of it, his independence level is much higher than if he had gone without. **He** is one of the lucky ones. Even with **2 insurance policies and state medicaid**, our family had to pay out-of-pocket to obtain this treatment. Most families, even the most resourceful and creative ones, are unable to afford this at the cost of \$5,000 - \$50,000 per year.

Without ABA Therapy, we don't know where we would be. I would never want to know. **But**, it is likely that without this treatment, Charlie would speak very little, require special education, need full-time care and 1:1 supervision. This would force my husband or myself to stop working, force our family of 6 to reconsider future plans of Charlie's siblings, put us back into the days of not hearing our child's voice and the list of challenges goes on.

Because of ABA Therapy, Charlie is able to attend regular ed classes at public school. He rides his bike across town, safely and independently, to school. He can speak full sentences and engage in conversations. He can participate in sports including riding the team bus to sporting events without his parents.

These successes and more, have allowed for my husband to stay in the workforce and myself to re-enter the workforce. These changes have allowed his three brothers to maintain their roles as **brothers** rather than caregivers. These changes have allowed our family of 6 to be a part of our small North Dakota community. The impact of ABA has not only changed my son's outcome, it has changed the lives of all six people in our family.



When it is time to decide yes or no, I hope you're a **yes** with House Bill 1434.

Thank you

5

A.H. 8
HB 1434
1-30-17

Hello my name is Jens Sharbono. I love Super Mario and I am pretty lucky sometimes. Things are harder because I have autism. Please vote yes.



January 30, 2017

Dear Chairman Weisz and Committee,

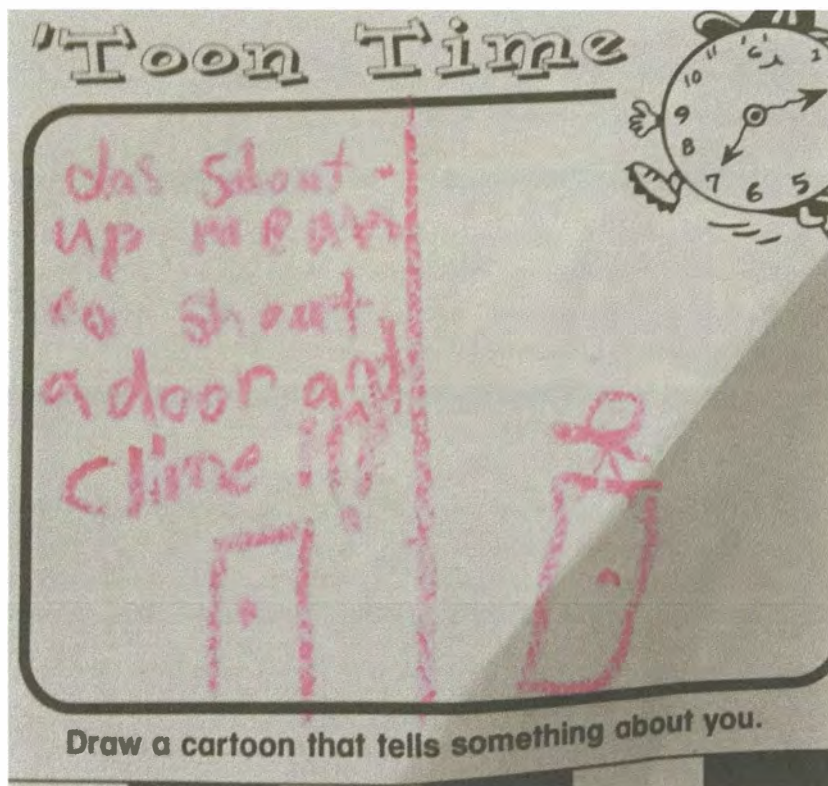
I want to start by thanking you for your dedication and service to the state of North Dakota. I have always taken pride in growing up in ND and felt that I was providing my children with an advantage by choosing to raise them in ND. While I continue to feel that ND has a lot to offer it is been a huge disadvantage to my 2 children on the autism spectrum. My children need assistance to obtain skills that most of us take for granted. One of the most obvious examples of this occurred when my daughter was in the third grade. She started a new school and came home excited about 2 weeks into the start of school excited because she had finally talked to someone at recess. I asked the obvious question that most of ask "What was her name". My daughter responded "I don't know, why would I ask her that?" How many times do you use your own name or the name of others as a way of communicating? It was another realization to me of how different her world is. This is a basic skill that most children learn at a very young age. This is a very concrete example of why autism services are so important. Specific autism services able to break down, explain, and teach these everyday skills. My daughter is very capable of learning and has a lot to teach the rest of us but basic skills of interaction do not come naturally for her. A person does not grow out of autism or get "cured" so it is necessary for these services to be available into high school and beyond. She will continue to face new social situations and they will only become more complex. It is medically necessary for her to receive autism specific services for her to reach her fullest potential and be a contributing member of our community.

My son has different needs then my daughter. He has always been fascinated by people's names because he has been able to read them since the age of 3. It has been a strength that he has used to interact with others. This skill has gotten him a long way but now at the age of 8 he needs other skills to help him to be able to participate in activities that other kids enjoy. He enjoys a lot of physical contact and is naturally strong. His need for increased need for physical contact is due to a sensory processing disorder that is frequently a part of autism. We felt wrestling was a natural fit so we signed him up. He loves it but it also is a source of great frustration for him because he does not understand the rules and how to score points. It is hard to watch; something that brings him joy also brings him so much frustration. It takes someone with skills and knowledge to teach these things in a way that is useful to him. With assistance, wrestling has the potential to be an appropriate way to get his increased need for physical

2

contact to get met instead of getting into physical fights with others at school. His need to learn new skills will end at a certain age. How will he handle walking through the crowded halls of high school or in a store if others bumping into him is perceived as an invitation to wrestling or worse yet is interpreted as a threat instead of a simple mistake due to it being crowded? Autism services are essential to help him tolerate these circumstances and many more.

A direct impact that I have seen in my children from not having services that they desperately need are struggles with mental health issues. Imagine how you would feel if people rarely understood what you were trying to explain; or if when in a group of peers you couldn't make sense of what was being said. My childrens' literal thinking is a unique way of looking at the world but also makes communicating with others challenging. This is a cartoon that my daughter drew:



Does shut up mean to shut a door and climb it?

Although autism will always be a part of their lives meaningful autism services will help that to reach their full potential. My family and I ask you to think about what you would want for your loved one if they had a medical condition that had proven (evidenced based) treatments that would greatly improve their quality of life even though there isn't a cure. Please vote yes. Individuals with autism that live in North Dakota deserve the same quality of life that is offered in most states.

Sincerely,

Kristin Sharbono

January 30, 2017

Human Services Committee
HB1434

Testimony of Doug Sharbono
2419 9th St. S.
Fargo, ND 58103
(701) 212-3944

Mr. Chairman and Committee Members,
Thank you for your service to the State of North Dakota. You have a substantial time commitment to your work here in Bismarck.

My name is Doug Sharbono, Fargo, ND. I am testifying in support of HB1434. I have five children, four currently living with us, and a wonderful wife. Two of my children are on the autism spectrum. I have been a North Dakotan most of my life, growing up on a grain and cattle farm in north-central North Dakota, and later educated at NDSU compliments of the North Dakota National Guard. I became a practicing structural engineer, eventually becoming involved in ownership of a small company that has recently celebrated its 50th year in continuous business.

I support HB1434 because currently our medical insurance does not cover autism therapy and medical care. Our son has received some services through the developmental delay waiver. Even so, we have paid for some services out-of-pocket that were not covered by this. As an example, toilet training was not accomplished until age 5 with us paying specialists from the North Dakota Autism Center to spend a week in the bathroom with our son. We have also paid for treatment out of our own pocket for our daughter who does not have a developmental disability waiver. Her speech therapy, some portions of her occupational therapy, and social skills class have been paid out-of-pocket. We have discontinued some of this therapy due to cost considerations. Our insurance also does not pay for any ABA related therapy.

With two autistic children, our household is very chaotic and busy. Often, the chaos and rigid thinking of our children with autism, places tremendous

(Over)



stress on two of our other children who do not have autism. We currently need to periodically bring these children to therapy for mental health treatment to sort out the hurt feelings, differences in treatment, and other complications. This expense currently covered by insurance treats the symptoms, but does not at all address the cause. We would like the insurance to work on the root of the issue so that other symptoms currently present in other family members are not present to even treat.

I have at times heard some say that autism was not around until recently. I do not believe this is true. Being currently fully immersed in an autistic world with autism that runs in our immediate family, I have the benefit (or burden) of looking back into prior family history. Back in the 1970's and 1980's, autism was understood very little. I watched relatives during this timeframe that I now know to have had autistic tendencies. One particular family, who were also neighbors to us, struggled severely. Unfortunately back then, society did not look onto them kindly. They did not have any therapy or insurance coverage available to deal with their many issues of speech delays, poor social behavior, incessant screaming, and learning delays. Society, including us, incorrectly chalked these issues up to bad parenting. Currently, one of the adult children of this family is out of prison, another is also out of prison looking to get onto disability, and the other has at times been institutionalized for mental health issues. With what I now know about early intervention, this could have been a drastically different story that would have had less cost impact.

On a more positive note, autism has some very strong positives. Some of the more amazing strengths observed in our autistic children is very strong math skills and strong visual-spatial skills. My autistic son runs roughshod over those who play Farkle with him adding combinations of numbers in his head with ease, and he can almost beat me at checkers. My daughter has a strong photographic memory and amazing music skills. I would like these strengths cultivated and some of the challenges removed that would prevent them from using these strong skills in the real world. I believe approval of HB1434 would be effective in giving our autistic children the tools they need to become productive, tax paying citizens at very little extra cost to the State of North Dakota.

Thank you, Doug Sharbono

Att. 9
HB 1434
1-30-17

House Human Services Committee

HB1434

January 30, 2017

Committee Members, I am a practicing physician and father of a child with autism. My wife Carolyn was appointed to the Governor's Autism Task Force when now Senator Hoeven was in the Governor's office. I have many hats as my testimony to the committee last week demonstrated. My grassroots efforts in researching how to better help our society deal with the difficulties of autism are a key thread of research that has led me to the board of the Institute for Pure and Applied Knowledge. I am currently working on a public policy implementation of "ethical vaccinomics" that may have merit here in the macroeconomics of this bill. It is a concept of cost savings in one area of healthcare that can be used in another for a budget neutral approach.

Autism is costing society much more than the policy numbers show, these are big numbers and growing every year. The syndrome is more complicated than cancer in its genetic and exposure risk assessments. Even my specialty of radiology may be playing a role in exposures as my written testimony last week described research in non-human mammals showing in utero exposure to ultrasound can induce autism-like behaviors after birth. The President of the United States, Mr. Donald J. Trump and many others in society are well aware we have an epidemic on our hands. Toxins that immunostimulators are playing a role in this epidemic, neuroimmunological hyper-stimulation is a key common thread in the development of autism. By ALARA principles, which the state's radiology technologists discussed last week, we

should never expose our most vulnerable children to genetic or autoimmune induction agents unnecessarily. Unfortunately, federal health policies enacted in the 1980's and promoted by the CDC have created a particularly illogical situation in vaccine schedules that now should be looked at for some thoughtful changes and resulting in cost savings for insurance systems and state governments.

In the long standing progressive increase of vaccine distribution to our children beginning in the 1980's, there is one vaccine in the guidelines that is an overstep of glaring nature into the realm of ethics, consent, autonomy, and respect for first amendment rights even. That is the first year of life dosing of a vaccine for a sexually transmitted or body fluids transmitted disease. By the ALARA principle, because of its use on day one of life in newborn babies Hepatitis B vaccine is particularly problematic. However, it is the area of greatest cost savings in a titer-checked CDC vaccine protocol modification.

By using a real world scenario of North Dakota birth statistics with regards to a Hep B titer check protocol, we can see a resource savings as well as a diversion of resources from global pharmaceutical companies into the individualized care needs for North Dakota families and a diagnostics shift of resources that has not previously been realized. In 2015 we had a little over 11,000 births in ND. Making the math a little simpler by round numbers, the following economic analysis shows the derived resource changes:

10,000 ND Births in a 4 shot Hep B protocol at \$50 per shot leads to cost outlay of \$2 million.

10,000 ND Births in a Titer-checked protocol at \$50 for the shot and \$50 for the lab (titers) will follow the basic bioeconomometrics on the appended email to my research colleague, James

Lyons-Weiler, MD. After doing the math, we see a 19.4% cost savings in the titer check protocol over the standard approach. The resource shift from pharmaceutical companies to North Dakota hospitals for the lab work is in addition to that cost savings, and in the first round of labs it is \$500,000 into hospitals, the additional rounds of labs providing lesser derived resource transfer since we are culling the need for many boosters as the 19.4% savings in the protocol. A 20% savings on \$2 million is \$400,000.

This is but one example of where we can save money, improve care, rely on our local resources and do the right thing for our future generations of North Dakotans. There are others in the CDC schedule, but this is the logical one to define the new art and practice. Dr. Todd Twogood and I have performed whole schedule titer check protocols for several families in Bismarck and the benefits across the whole schedule in this hand for of cases is an approximately 50% reduction of vaccine boosting across the whole schedule. This is precession medicine and it saves money, builds rapport between families and pediatricians in a political climate where our dear president is going to clean up the up the swamp in Atlanta, Georgia known as the CDC.

Long story short, just as my Bismarck Tribune letter to the editor from 9 years ago states, we can do this better here because of our social fabric, professional kinship and common sense values. Funding the behavioral neuro-plastics medical exercise of the current generation of children with what an old ND veterinarian once described to me as vaccinosis through this pathway will make our state a leader in crossroads of civics and health policy. Thank you for your time and attention. If there are any questions I would be grateful to have the opportunity to respond.

Ted Fogarty, MD

Att. 10
HB 1434
1-30-17

TESTIMONY IN SUPPORT OF HOUSE BILL 1434 - INSURANCE COVERAGE FOR AUTISM
SPECTRUM DISORDERS

Sandy Smith
Executive Director
North Dakota Autism Center, Inc.
647 13th Ave E, Ste A
West Fargo, ND 58078
701-367-9855

Chairman Weisz, committee members, my name is Sandy Smith. I am the Executive Director of the North Dakota Autism Center Inc. (NDAC) and I am testifying in favor of House Bill 1434. My oldest daughter and I founded the NDAC after her brother, my son, Tyler was diagnosed with autism at twenty-two months old. When Tyler was diagnosed, I worked at Microsoft and was able to take advantage of the autism therapy benefit their out of state insurance plan offered and he started applied behavior analysis therapy (ABA) when he was two years old. The journey to open an autism center began in December 2004 as a home daycare that my daughter ran so Tyler had a place to go that would allow all of this therapists to come in and provide the therapy he needed. We officially founded the NDAC in December 2006 and opened for business in November 2008. The NDAC currently works with approximately 125 children across various different programs.

Our Behavior Services Team is a team of Licensed Board Certified Behavior Analysts (BCBA's) and highly trained Behavior Technicians that provide one on one ABA therapy programs for several children that have out of state insurance, TriCare insurance or have parents that have the means to privately pay. The team also provides autism therapy services for seven children who are on one of the forty-seven ND Autism Waivers that are currently being funded. However, a significant amount of the work being done by this team is Behavior Consultation for families of children and adolescents and for children and adolescents in local school districts who have very challenging behaviors such as self-injurious behavior, physical aggression, destruction of property, tantrums, and dangerous behaviors such as eloping. Behavior Consultation is funded primarily through the ND Developmental Disabilities Waiver and by local school districts. It involves doing a functional behavior assessment, developing a behavior intervention plan and training families and school personnel to implement the programs. It sounds pretty straight forward. However, this is some of the hardest and most challenging work that the team does.

Our Family Support Services Team is licensed by the ND Developmental Disabilities Division to provide In Home Family Support Services for children and adolescents who qualify for the ND Developmental Disabilities Home and Community Based Waiver. We serve individuals with various disabilities but over 95% of the individuals have autism and most have not had access to ABA therapy. Families come to us because we specialize in autism. Developmental Disabilities Program Managers from the Regional Human Service Center determine the number of authorized hours for the in home support families receive. From our experience, the number of hours authorized for individuals with autism is often driven by the significance of their behavioral challenges. The number of hours can range from about 20 up to 300 hours per month. Providing staff for individuals with these challenges can also prove very difficult and requires a great deal of staff training.

Lastly our AuSome Kids Day Program is a licensed childcare center. This program was developed for children who did not have access to ABA therapy. We operate with a very low child to staff ratio (3 to 1) and staff have specialized training. Many of the children enrolled have not been successful in other daycares because of significant behavioral challenges and were asked to leave. They were "childcareless" before they came to us. Using positive behavior supports, structure and routine we are able to reduce challenging behaviors significantly. Unfortunately, we only have 28 slots available in this program because the fees we charge cover only half the cost we incur to provide the service. We depend heavily on donations, grants and fundraising events to continue operating this program. This is clearly a group of children and families that is falling through the cracks and the waiting list for this program is long.

Back to my son, Tyler. As I mentioned he is fourteen years old, six feet tall and weighs 220 pounds. We call him our gentle giant. His official diagnosis is Autism Level III formerly Autistic Disorder. This would be considered low functioning autism. He was non-verbal and had significant behavioral issues such as aggression and massive tantrums. With the help of ABA therapy and the evidence based techniques it employs he has learned to speak and communicate his wants and needs thus reducing the behavioral issues to almost non-existent. He can read and write sentences. He is very good at math and he has learned to independently engage in self-help skills and engage in numerous job skills in the home, at school and in the community. He is a happy, healthy young man who is amazing his high school job coach. His job coach tells me he wishes Tyler was already sixteen so he could get a job because he is more than capable of having one. I can very confidently say he already has been and will continue to be less dependent on North Dakota tax payers than others with his diagnosis because he received the early intervention using ABA that others have not. In addition, both his and our family's quality of life has been improved.

We founded the NDAC with the intention of being able to provide children with early intervention using the evidence based procedures of ABA. As I write this testimony I have just come to the realization that we have done much less early intervention than I had originally envisioned because families can't access it without insurance reform. Instead we are overwhelmed with work because of the downstream effects of children not receiving the behavioral interventions and the ABA therapy they need. These children get older and they go to preschool, kindergarten, elementary school, middle school, high school and into adulthood. Without intervention the challenges become bigger every step of the way and the cost to families, school districts and tax payers just continues to grow.

In closing, I want to address questions you may have about the number of providers in the state. Prior to opening the NDAC there was one Board Certified Behavior Analyst in North Dakota that number has grown to 24 in a state with no insurance reform which I believe is very remarkable. The NDAC has two Licensed BCBA's and there are at least 6 more employees who are in various stages of pursuing their certification. With passage of this legislation recruiting BCBA's from other states would become much more realistic as well. I am confident all ND providers would do their best to ensure we have adequate numbers of ABA professionals in the state.

I strongly support House Bill 1434 and urge you to vote in support this legislation. Thank you for the opportunity to testify before you today. I would be happy to answer any questions.

QH. 11
HIB 1434
1-30-17

Testimony for Public Hearing
Human Services Committee
January 30, 2017

Eric Mauch
5507 Sunflower Lane S.
Fargo, ND 58104

HOUSE BILL NO. 1434 – An Act to create and enact a new section to chapter 26.1-36 and a new section to chapter 54-52.1 of the North Dakota Century Code, relating to health insurance coverage for autism-related services; to provide a statement of legislative intent; and to provide for a report to the legislative management.

Good Afternoon Chairman Weisz and Human Services Committee Members. My name is Eric Mauch and I am father of an autistic child. My 6-year-old son Brody was diagnosed with autism shortly after turning 3. Over the past 3 years Brody has been one of the rare lucky children to receive some Applied Behavioral Analysis (ABA). ABA therapy has had a tremendous impact on Brody and our family.

Ask any parent of a typically developing child and most will tell you they enjoy picking up their kids after work or coming home to see their family, before Brody received ABA therapy I did not. Brody severely struggled with simple life skills most parents take for granted, such as waiting for an adult to turn on a favorite TV program, fetch a snack or find a lost toy. Every day I dreaded coming home and scrambling throughout our house while Brody screamed for whatever he currently needed; this was our nightly routine. On one occasion, I picked Brody up after work and he screamed for a treat prior to arriving at home. In the 3-mile drive to our house I counted 112 times that he asked for a treat, this had occurred numerous times.

Outings with friends and family were worse. Christmas gatherings, outings at the lake, and trips to local events meant my wife or I would spend most of the time away from the rest of the group with a child that would not stop screaming and crying. I had no enjoyment participating in these outings as my son would melt down every time.

Addressing behavioral issues were at the top of the list when Brody began ABA therapy. Throughout the course of ABA therapy, Brody has shown control over his urge to melt down and throw tantrums. Going home after work to see my family is now routine I enjoy. ABA therapy has also turned outings with friends and family to an enjoyable experience. Meltdowns and tantrums still occur but on a much more infrequent basis and he understands the directions we give him.

ABA therapy has given my family hope and experiences most other families take for granted. I urge you to consider all other families with children on the autism spectrum and give them the opportunity to make the best of each and every day.

Thank you for your time and consideration.

Sincerely,

Eric Mauch

Testimony of Jen Werder, parent of an autistic child
In support of HB 1434
January 26, 2017

att. 12
HB 1434
1-30-17

Chairman Weisz, and Members of the Human Services Committee:

My name is Jen Werder; I grew up in Dickinson, attended DSU, and have been living and working in Bismarck since 2002. I have been the IT Systems Coordinator for one of Bismarck's largest employers since 2008. My husband, Andy, is a native Minnesotan that attended NDSU and now works as a Civil Engineer with one of the nation's top 500 design firms.

We are a typical middle-class family: two working parents, three kids, a dog, a cat, a mortgage. We attend events in Bismarck frequently. We support local organizations and businesses, and we volunteer our time and money to provide opportunities that others in our community may benefit from.

Fifteen years ago, my husband and I were the young professionals that North Dakota was working diligently to recruit and retain. I stayed in ND, and Andy moved to ND, because ND offered us a quality of life that was unmatched.

We love our home, neighborhood, and community. We love our jobs and the school system. We've made wonderful friendships, and we are only short drives away from our families.

It's breaking my heart that we are considering giving this all up to move out of state.

This is Laeken, my five year old son

He's adventurous. He's brilliant. He's curious.
He's honest, humorous, and helpful.
He's defiant. He's daring.
He's defiantly daring.
He's silly, opinionated, strong, outgoing, perceptive,
entertaining, talkative, and affectionate.
And, he has autism.



If you meet Laeken, your first impression will be that he is extraordinarily intelligent and energetic, but otherwise a typical five year old boy. But here is the rest of Laeken's story:

He has difficulty processing external stimuli like noises, movement, and lights, and will become agitated and defensive in the wrong environment.

He has a strong adherence to sameness, and the smallest change or unexpected occurrence in his daily routine results in anxiety and a meltdown.

He does not understand danger or how his actions affect other people. He can recite rules, but he doesn't correlate them to his own behavior. For example, he will tell you that you need to look for cars before crossing a road, but he routinely runs into the street without a pause or glance.

He can't carry on a back-and-forth conversation. While he has superior language skills and a vocabulary years beyond his age, he only recites answers he has pre-programmed himself with, or has learned from television or books. He doesn't comprehend questions that can't be answered with a fact or canned response, especially questions that begin with "why".

There are many other autistic characteristics that give Laeken his own unique, quirky personality, but these particular traits that I listed are the challenges that can be debilitating to him later in life if he doesn't gain the skills to identify and manage these behaviors.

When Laeken was first diagnosed with autism almost two years ago, we were presented with options. We were told that he could benefit from occupational therapy (OT) and speech therapy. Our insurance covered a portion of those visits, but at a cost of \$800/month for less than 10 hours of therapy, we decided to go a different route and enrolled Laeken in Early Childhood Special Ed (ECSE) classes at a preschool that included half an hour each of speech and OT weekly.

Laeken has had a lot of ups and downs through the past school year, but continually made progress until last spring when he started to falter. He began to struggle with behavior problems and we received daily reports from both his preschool and daycare regarding undesirable actions, including defiance, meltdowns, and verbal and physical outbursts. These behaviors were also present at home, and it was wearing us all down.

I felt helpless and hopeless.

And I felt frustrated and angry, because there was a solution suggested to us, but it was out of our reach.

Applied Behavior Analysis, or ABA, is evidence-based therapy that has been used since the 1960's for the treatment of autism, and is the most widely accepted therapy for children with autism spectrum disorder. ABA helps teach social, motor, and verbal behaviors, as well as reasoning skills, and works to manage challenging behavior. ABA therapy is intensive and ongoing, from 10 to 40 hours a week, and the family is heavily involved. ABA therapy is expensive, ranging from \$30,000 to \$50,000+ per year. Our insurance doesn't cover ABA. In fact, there are no health insurance plans in ND that cover ABA. The high cost of ABA paired with the lack of insurance coverage also equates to a shortage of providers in this area.

ABA works best when introduced as an early intervention, preferably before the age of five, although it benefits children of all ages. With therapy, Laeken could learn to self-regulate, self-advocate, and become a successful, independent adult.

Laeken, and the many other autistic children like him, are the out-of-the-box thinkers that could be the next great innovators of our society, the people that could change the world. Without support from a young age, many of these kids will never leave their parent's home, never graduate college, and will have difficulty holding a job.

I envision Laeken having a remarkable future, but I know it's going to take a lot of work to get there. Time is of the essence; Laeken's formative years are passing us quickly. One in every 68 kids is now diagnosed with Autism. Laeken, and many other children in our community just like him, are depending on HB 1434. My family's future in North Dakota depends on HB 1434.

ah. 13
HB 1434
1-30-17

Good Afternoon Chairman Weisz and the Human Services Committee,

My name is Samantha Stewart, and this is my husband Anthony and we are here as parents of a child with Autism. We live and work in Fargo, and have two small children. Our daughter, Phayme, is 6 and attends kindergarten through Fargo Public Schools. Our son, Chevelle, is 5 and attends preschool through the Early Childhood Special Education program through Fargo Public Schools.

When Chevelle was about 18 months old we started to realize that he wouldn't make eye contact, or respond to his name. He didn't seem content in his body and we could no longer communicate with him. He had no words, and had no desire to use words. We didn't know how to connect with him and we didn't know where to turn for help. We were referred for a speech, occupational therapy, and physical therapy evaluation and the results were alarming. Our son was stationary or regressing in all areas. He was no longer meeting his milestones, in fact, he was going backwards in social/communication areas. The next step was to start therapy and try to get a diagnosis. We did that. We started OT and Speech 3 times a week for each. We were placed on a waiting list for an appointment to get a diagnosis for 3 months. We made very little progress in those three months, we felt hopeless.

Once we finally got in for our diagnosis, we received the news we were expecting, Chevelle had Autism and Sensory Processing Disorder. These two things together were making it very challenging for our son to progress to his full potential. We asked questions about what we could do and where we could turn. They told us we were doing a great job having him in therapy, but there was one therapy in particular that we needed. Ideally we needed ABA (Applied Behavior Analysis). That was the therapy that was prescribed to us and would have the most positive impact for Chevelle. We were also told in that same meeting that it would be nearly impossible to do here. That there was no funding for it, it was very expensive, no insurance company covered it, and if we wanted it, we would need to find it elsewhere. I was heartbroken. I needed answers. He was already in the therapies that were available to us, but we needed more!

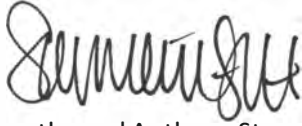
We were fortunate to get Chevelle into the day program at the North Dakota Autism Center. They are a specialized daycare for children with Autism and other special healthcare needs. Chevelle has flourished there. I believe it is because they use many of the ABA principles throughout their day. That small amount of exposure proves to me that if we had this therapy works and it will work for my son. It proves to me that his prescription has merit and we should be utilizing those services to meet his potential, wherever that might be.

Access to this therapy is so important for our children. ABA therapy has been proven to work and endorsed by the American Academy of Pediatrics and the US Surgeon General. It is time that our families are able to utilize our insurance for the therapies that our children need and are prescribed. Our son has made many gains since his diagnosis. We have continued with the therapy that we have access too and we have gotten by. But, we can only imagine where he would be if we had access to the adequate amount and type of therapy that is prescribed as medically necessary for his diagnosis.

Chevelle will start Kindergarten in the fall. We want what every parent wants for their child. We want him to be as happy, independent, and successful as he can be. If Chevelle has access to ABA therapy, we believe he can do great things. He can be a productive member of society as an adult. He can have meaningful relationships. He can live on his own. He can attend college. He can do all these things with the adequate support. We want to be able to provide our child with the tools he needs to lead a successful life. We want ND insurance companies to recognize the severity of our situation, and cover what is medically necessary for our child to meet his potential.

45 other states have shown us how important this is. They have paved the way for their residents' future to be bright. All of their residents. We are here, we are asking, pleading, we need help. We need our insurance companies to support us. We need you to support us. We need coverage. Please vote DO PASS on HB 1434 and give our families the peace of mind we have gone so long without.

Thank you for your time.



Samantha and Anthony Stewart



Att. 14
HB 1434
1-30-17

To Whom it May Concern:

This is a letter stating my strong support for House Bill 1434 which is an Autism insurance reform bill. As a pediatrician in our state and a mother of a child on the autism spectrum, I can tell you first hand the importance of this bill.

As you know, the CDC now estimates that 1 in 68 children have autism. Coverage for evidence-based therapies for these children, which are supported by the American Academy of Pediatrics and other medical organizations, are routinely denied by insurance companies. To date, 45 states in our county have passed similar legislation mandating such coverage. Not only is Autism treatment highly efficacious and cost-effective, it is what the children of our great state of North Dakota deserve. This only works to create a better, more productive society for the future.

Please see the enclosed informational sheet and feel free to contact me personally with any questions.

Thank you in advance for your time in this vital matter,

Dr. Tracie T. Newman, MD, MPH, FAAP

Sanford Children's Southwest Clinic

2701 13th Ave S

Fargo, ND 58103

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Please Support House Bill 1434 Autism Insurance Reform for North Dakota Families



FACTS ABOUT AUTISM

- According to the CDC, autism now affects **1 in 68 children and 1 in 42 boys**.
- Coverage for evidence-based treatments, endorsed by the American Academy of Pediatrics and the U.S. Surgeon General, is routinely denied by health insurers.
- **Forty-five states** have passed autism insurance reform legislation and a majority of the remainder are currently pursuing passage.
- The US Military (TRICARE), Federal Employee Health Plan (with 8 million members nationwide) and almost 40% of self funded plans also provide coverage.

2017



WHAT DOES HOUSE BILL 1434 DO?

Requires state regulated plans to cover evidence based autism treatment for individuals under the age of 26 when prescribed by a licensed physician or licensed psychologist as medically necessary including:

- Therapeutic Services (speech therapy, occupational therapy, physical therapy)
- Psychological, psychiatric and pharmacy care.
- Behavioral health treatment (including Applied Behavior Analysis up to \$50,000 per year)

AUTISM INSURANCE REFORM IS FISCALLY CONSERVATIVE

- **Actual claims data** from other states that have required similar coverage for multiple years indicates an **average premium impact of 31-49 cents per member per month** -- less than a cost of a postage stamp.
- Approximately **250,000 covered lives in North Dakota** have private health insurance regulated by state law. These families and their employers have **no** access to meaningful autism coverage, even though they pay their health insurance premiums every month.
- According to the Harvard School of Public Health, **the incremental cost of caring for someone with autism over their lifetime is \$3.2 million**. The costs of treatments covered could be expected to be recovered through reductions in educational and medical expenditures alone. (Oliver Wyman, 2011) **State estimated lifetime cost savings of providing appropriate treatment are \$1 million per child**. (Jacobsen et al, 1998)

For additional information please contact
judith.ursitti@autismspeaks.org or NDAutismReform@gmail.com

 [@NDAutismReform](https://twitter.com/NDAutismReform)

Att. 15
HB 1434
1-30-17

January 27, 2017

North Dakota House of Representatives

RE: support for House Bill 1434, Autism Insurance Reform for North Dakota Families

To Whom It May Concern:

My name is Dr. Stephanie Hanson, and I am a general pediatrician with Sanford Health in Fargo. I am Service Chair for Ambulatory Pediatrics in the Fargo region.

I am writing today in support of House Bill 1434, Autism Insurance Reform for North Dakota Families.

Current statistics from the Centers for Disease Control find that 1:68 of our children are affected by Autism Spectrum Disorder. There are a number of evidence based treatments endorsed by the American Academy of Pediatrics as well as the U.S. Surgeon General. Unfortunately, these treatments are routinely denied by health insurers. These treatments may include occupational therapy, speech therapy, physical therapy, psychiatry/psychology care, pharmaceuticals and behavioral care including Applied Behavioral Analysis therapy. As a pediatrician, I have seen firsthand the positive impact of these therapies on the health of my patients with autism and their families.

45 states in our country have already passed legislation in support of this reform, and the remaining states are all pursuing passage at this time. Both TRICARE and the Federal Employee Health Plan provide this coverage, as well as 40% of self-funded plans.

According to the Harvard School of Public health, the incremental cost of caring for an individual with autism is \$3.2 million over the lifetime. With appropriate treatment, this cost is estimated to reduce by \$1 million per individual (Jacobsen et al 1998).

I ask that you vote in to support this legislation, and appreciate the time and effort spent considering this important issue. Our North Dakota children deserve to receive quality, evidence based care to improve their health, the health of their families and the health of their schools and communities.

Sincerely,

Stephanie Hanson, MD FAAP

Sanford Children's Service Chair

Fargo, ND 58103

A.H. 16
HB 1434
1-30-17

To the ND State Legislators:

I am writing this letter of support to pass House Bill 1434

I have had the privilege to work with many families in ND that have children with autism. I have seen firsthand how vital intervention and services are for the treatment and improved outcomes for children with autism. It can make the difference of success to independence as an adult.

Therapeutic services such as speech, occupational therapy, physical therapy, psychological, psychiatric, pharmacy, behavioral therapy/applied behavior analysis are medically necessary. The requirement for state regulated plans to cover this evidence based autism treatments in this House Bill will provide an ultimate lifetime cost savings.

I encourage you to vote for House Bill 1434.

Sincerely,

Pam Gallagher LSW

Auth. 17
HB 1434
1-30-17

Human Services Committee
HB 1434
January 30, 2017

Chairman Weisz and members of the Human Services Committee, my name is Elizabeth Faust. I am the Senior Medical Director for Behavioral Health for Blue Cross Blue Shield North Dakota (BCBSND). BCBSND appreciates the opportunity to provide this committee with information regarding its current benefit coverage for autism and share our analysis of HB 1434 as it relates to evidence-based treatment.

Autism spectrum disorders (ASDs) are believed to arise from a number of different causes, none of which are yet well understood. They are frequently associated with a variety of neurological, genetic and behavioral health disorders, as well as intellectual disabilities. Because of the complexity and the potential for associated medical, psychiatric and intellectual problems to be present, initial assessment of an individual with suspected ASDs must be comprehensive and individualized in nature and include screening for potential neurological, genetic, psychiatric and medical conditions which may complicate treatment and long term outcome. BCBSND currently provides coverage for the full range of diagnostic assessments, including physical evaluations, specialty evaluations, psychiatric and psychological evaluations, sensory testing, imaging and laboratory testing that may be necessary for a comprehensive medical evaluation. BCBSND also provides coverage for a full range of medically appropriate treatments including occupational therapy, physical therapy, speech therapy and behavior therapy for conditions identified during comprehensive assessment.

House Bill 1434 creates an unnecessary requirement for availability of this full range of services which are already basic components of our members' benefit plans. The introduction of such narrow and artificially specific requirements will potentially hamper or obstruct future access of our members to treatments that may emerge and become evidence based but are not yet anticipated or developed.

As research into autism spectrum disorders has progressed, evidence and consensus regarding which treatments are known to be beneficial is becoming more clear. There is now expert consensus regarding a number of interventions and practices known to be effective in the treatment of ASDs. The National Professional Development Center on Autism Spectrum Disorders currently identifies 27 evidence based practices, some of which are based on the principles of applied behavioral analysis (ABA). Of note, 15 of these interventions are not based on ABA principles.

As a reflection of this advancement of research, outcome studies, and expert consensus in the treatment of ASDs, the Federal Employee Plan (FEP), which is administered by BCBS, with the assessment completed by an MD such as a Family Practice, Pediatrician, Psychiatrist, has now incorporated the use of specific evidence-based ABA interventions for the treatment of ASDs into the FEP benefit plan as of 01/01/17. FEP is widely regarded as a "gold standard" in terms of evidence-based benefit design. BCBSND is following suit with development of ABA benefits that will mirror the FEP benefit design for inclusion across the BCBSND commercial lines of business.

What this means, in essence, is that the evidence for use of specific interventions, including specific ABA-based procedures, has now emerged to a "tipping point", a degree of confidence that warrants inclusion of these treatments into the menu of treatments and services available for clinicians to select from as they develop individualized treatment planning for individuals with ASDs.

Although HB 1434 specifically states that it is not a mandate, there is clearly an artificial delineation of a specific menu of services based on a current-state understanding of ABA-based treatments and entirely ignoring the other evidence-based behavioral treatments currently available. The bill specifies an arbitrary age delineation for services that is not based on current scientific evidence. As research continues to clarify evidence in the treatment of ASDs, it is inevitable that new treatments, population-specific best practices, optimal age ranges, etc., will evolve. The unintended consequence of legislation mandating specific treatments, specific ages, and even specific monetary maximums based on today's understanding of science is limiting and shortsighted. It will create barriers to the adoption of evidence based treatments as those evolve based on tomorrow's science.

We are also greatly concerned with Section 2 and 3 of this bill, which states that this bill is not a mandate and therefore not be subject to section 54-03-28, which requires that the public employee's retirement system would conduct a cost/benefit analysis on the ABA treatment coverage included in the bill for a two-year trial. This bill clearly mandates coverage of ABA up to age 26, with significant cost implications to the state. The two-year cost/benefit analysis has proven to be a highly beneficial requirement and the removal of this section runs contrary to the desire to hold health care costs down for North Dakota taxpayers.

I greatly appreciate the opportunity to share this information with your committee as you seek solutions on these challenging issues. Please feel free to contact me with any additional questions you may have.

Respectfully submitted,

Dr. Lisa Faust

2

Testimony of Brent Bogar
Greater North Dakota Chamber
HB 1434
January 30, 2017

Mr. Chairman and members of the committee, my name is Brent Bogar. I am here representing the Greater North Dakota Chamber (GNDC), the champions for business in North Dakota. GNDC is working on behalf of our more than 1,100 members to build the strongest business environment in North Dakota. As a group, we stand in opposition of HB 1434.

The Greater North Dakota Chamber supports the appropriate coverage and health care for all individuals in North Dakota. This issue is about the state taking a position to require insurance to cover a certain disorder, or a mandate to provide coverage. GNDC believes that market forces should help to determine the best products and services available, and that through competition the marketplace can and will develop appropriate solutions.

The bill as it stands also provides for exclusions of certain classes of plans. By creating a system in which certain plans are required to meet new requirements and others do not HB 1434 is creating an unequal position in the marketplace for coverage. It is not clear whether those plans that are exempted from the requirement of coverage would also not make the premium payment adjustment, or would those plans then see the premium increase and not receive the benefits? This type of discrepancy will create confusion for those people that change plans, as well as for the providers of coverage.

Currently, as a nation we are seeing dialogue for changes at the federal level regarding health care coverage. The uncertainty of any changes to the Affordable Care Act, or "Obamacare," also should cause pause to the state adding additional regulatory requirements. Any time that there is uncertainty in the marketplace, costs become unknown and difficult for businesses to manage cost and expenses.

Thank you for allowing me to appear before you in opposition to HB 1434. I know this can be an emotional issue, but when the emotion is removed and the issues as discussed are reviewed, we hope this committee understands the need for the State of North Dakota to minimize mandates and requirements on businesses. The Greater North Dakota Chamber urges a Do Not Pass on HB 1434.

AH.19
HB 1434
1-30-17

In Support of:
North Dakota House Bill 1434
Autism Insurance Reform for North Dakota Families

January 27, 2017


As a pediatrician in practice for over 20 years, having dedicated many of those years to caring for kids with autism and their families, I've known how families struggle and strive to do all they can for their child on the autism spectrum. I've seen and assisted families in finding the best evidence-based treatments to improve the essential skills of communication, social interaction, emotional and psychological well-being. The medical literature is clear; early intervention is the best intervention. What parent or grandparent wouldn't go to the ends of the earth for their child? I knew that in my head, but didn't know it in my heart until my own family was touched by autism.

Why are medically-necessary, evidence-based proven treatments for autism (like Applied Behavioral Analysis, Speech Therapy, Occupational Therapy) when prescribed by a licensed physician or psychologist treated differently by the State of North Dakota when compared to other common chronic conditions like asthma or diabetes? Our state would never dream of creating financial or bureaucratic barriers to children getting inhalers or insulin. All children with chronic medical conditions need to have an equal opportunity to access appropriate, standard, proven treatments—that's one reason why I support House Bill 1434 as a pediatrician and a father.

Another reason I support this bill as a taxpayer, is that I can see the cost-effectiveness of early intervention with proven therapies for autism. Not only is early intervention more effective medically, it is also more effective fiscally. Intervening now to improve the ability of our kids with autism to live and work in the world reduces their dependence on other taxpayer supported social, housing, and vocational services. Improving skills early in childhood is one of the most important ways to have adults with autism with more independence.

With the introduction of this bill, the Legislature is offered an opportunity as a public servant to balance a duty to care for and protect those citizens most vulnerable and in need (like our children with autism and their families) with a duty of fiscal stewardship to the taxpayers of the North Dakota. For me it is clear. As a pediatrician, a father, and a citizen of North Dakota, I whole-heartedly support passage of House Bill 1434.

Sincerely,



Christopher H. Tiongson, MD
3117 38th Ave S
Fargo, ND 58104

Att. 20
HB1434
1-30-17

January 27, 2017

North Dakota House of Representatives

RE: Support for House Bill 1434, Autism Insurance Reform for North Dakota Families

To Whom It May Concern:

My name is Dr. Carrie Brower-Breitwieser, and I am pediatric psychologist with Sanford Health in Fargo. I am the Clinical Director of the Pediatric Feeding Disorders program at Sanford Health, and I serve as a member of the Developmental Evaluation multidisciplinary team.

I strongly support House Bill 1434, Autism Insurance Reform for North Dakota Families. I deeply regret that I cannot testify in person today, as I am currently out of the country attending an international conference highlighting the evidence supporting the use of Applied Behavior Analysis (ABA) as the treatment of choice for autism spectrum disorders.

Autism is a complex developmental disorder that impacts an estimated 1:68 children. Individuals diagnosed with autism spectrum disorders have deficits in communication, socialization, and self-help skills. They are at significantly increased risk for elopement and wandering, as individuals diagnosed with an autism spectrum disorder often lack a sense of safety or danger. Data from the National Autism Association suggests that 92% of children diagnosed with autism wander, which can result in serious injury or death. Individuals diagnosed with autism spectrum disorders are also more likely to have co-morbid behavioral problems, and engage in much higher rates of aggression, self-injury (e.g., head banging, skin picking, etc.), or meltdowns than individuals who do not have a diagnosis of an autism spectrum disorder.

According to the Harvard School of Public Health, the incremental cost of caring for an individual with autism is \$3.2 million over the lifetime. With appropriate treatment, this cost is estimated to reduce by \$1 million per individual (Jacobsen et al 1998). Decades worth of rigorous research has demonstrated that ABA therapy is highly effective at treating the symptoms associated with an autism spectrum disorder. The science of applied behavior analysis is evidence based, and is considered medically necessary for the treatment of autism. Applied Behavior Analysis is endorsed by the American Academy of Pediatrics, the U.S., Surgeon General, as well as the Association for Applied Behavior Analysis. Research has shown that with early intervention and treatment, almost 50% of individuals diagnosed with an autism spectrum disorder recover typical function, and another 40% make significant progress toward their treatment goals. Those nearly 50% of individuals can go on to attend post-secondary training and education, and can become vital parts of our state's workforce.

Thankfully for most families in the United States, appropriate and medically necessary treatment for autism spectrum disorders is available and has insurance funding. As of today, 45 states in our country have already passed legislation in support of this reform, and the remaining states are all pursuing passage at this time. Both TRICARE and the Federal

Employee Health Plan provide this coverage, as well as 40% of self-funded plans. As a provider, I cannot tell you all how difficult it is to sit across from a family and inform them that their child meets criteria for a diagnosis of an autism spectrum disorder, and then, while the family is processing this new reality, explain to them that they will likely not be able to afford the medically necessary treatment that their child so deserves. I should not have to breathe a sigh of relief when I discover that the patient in my clinic lives out of state, or has a parent who serves in our military. All children should be afforded the equal opportunity to participate in highly effective therapy. If our great state cannot provide the necessary care that our children need, families will indeed leave this state, taking with them productive (as well as future productive) members of our workforce and society.

I ask that you vote in to support this legislation, and appreciate the time and effort spent considering this important issue.

Sincerely,

Carrie Brower-Breitwieser, PhD, BCBA-D

Pediatric Feeding Disorders, Clinical Director

Sanford Health

Fargo, ND 58102



PEDS SOUTHWEST SC
SANFORD CHILDREN'S SOUTHWEST CLINIC
2701 13 Ave So
Fargo ND 58103-3602
701-234-3620

Att. 21
HB 1434
1-30-17

January 29, 2017

No Recipients

Dear Legislators:

When I trained in pediatrics at the University of Minnesota in the early 1980's I did not encounter a single patient with autism my entire three year training program. Conditions are much different now and it is not unusual to see several patients with autism in a single day . For practicing pediatricians , the current prevalence of autism at 1 in 68 children is a daily fact of life. I have additional contact with autistic individuals at the Sanford Developmental Evaluation Center where patients with autism are often first formally diagnosed . I have staffed this clinic for over 10 years.

The pediatric community now systematically screens children for autism at their periodic health maintenance visits with proven diagnostic instruments . Individuals are now being identified more often and at earlier ages . When a diagnosis of autism is made, we recommend intensive behavioral and educational services. To my knowledge there is no convince evidence that one particular program is superior , but all the proven effective programs have the core attributes of 1:1 staff ratio, practitioners with appropriate training and expertise , functional analysis of behavioral problems and a minimum of 25 hours per week of services. Behavioral based intervention programs have evidence based efficacy and are in my opinion an established standard of care.

There have been 2 very significant obstacles to acquiring theses services for my autistic patients. The first obstacle of adequately trained clinicians is finally being solved in ND with the arrival of many well trained behavioral specialists . The second obstacle is lack of funding. I do hope that this problem can be mitigated with mandated insurance coverage for behavioral therapy for autistic individuals.

From my personal experience, I can anecdotally attest to the improvement in daily function , communication and quality of life that behavioral therapy can provide to autistic individuals . More importantly , these types of gains have been documented in well controlled clinical trials. I truly believe that this therapy is the established core of any treatment plan for individuals with an autistic spectrum disorder.

Sincerely,
Dr Patrick Welle MD
Sanford Pediatrician
Clinical Professor UND School of Med
Attending Physician Sanford Children's Developmental Evaluation Clinic

Patrick Welle MD

CH. 1 HB 1434
2-7-17

2017

ACTUARIAL ANALYSIS Of HB 1434

By Acumen Actuarial

For the State of North Dakota

**APPLIED BEHAVIORAL ANALYSIS (ABA) and
TREATMENTS for AUTISM SPECTRUM DISORDERS (ASD)**

Daniel Bailey, FSA, MAAA

FEBRUARY 2, 2017

TABLE OF CONTENTS:

1. PREFACE
2. EXECUTIVE SUMMARY
3. INTRODUCTION
4. DATA and INFORMATION
5. OBSERVATIONS and FINDINGS
6. CALCULATIONS
7. CONCLUSION
8. LIMITATIONS OF USE and QUALIFICATIONS

PREFACE

This report was created by Acumen Actuarial for the state of North Dakota. It provides Acumen's analysis of HB 1434, a Bill for an Act to create new sections relating to health insurance coverage for autism-related services, to provide a statement of legislative intent, and to provide for a report to the legislative management.

Section I of the Bill defines terms. Among its eleven points, it also stipulates that:

- Health insurance policies will cover the screening for, diagnosis of, and treatment of autism spectrum disorder for insureds under 26 years of age, and must not deny enrollment or terminate it on the basis of an ASD diagnosis or prior treatment
- There is no limit to the number of services an individual may receive per year, but the total cost for Applied Behavior Analysis is limited to \$50,000. This amount will be indexed to Medical CPI in future years to raise the \$50,000 annual maximum for ABA services
- The insurance commissioner will issue a biennial report to legislative management concerning the cost of the bill and use of treatments for ASD. Moreover, health insurers and health benefit plans will provide the data needed for the report.

The intent of this actuarial study is to analyze the ASD benefit coverage with respect to its possible medical and administrative cost, as well as its impact on expected premium level. The Bill is examined in relation to the public employees health insurance plan and public employees retiree health insurance plan. It is also examined in relation to all those insureds who are covered by health insurance in ND other than those in the public employees plans.

In 2011, an actuarial analysis was carried out for a similar ND bill, SB2268. Over the past decade, many states have enacted legislation mandating that individual and group health policies issued in their state include coverage for ASD. Some states have already mandated a biennial or annual report on the use of services for the treatment of ASD and the overall cost of the mandate. The author has made use of current data and information where possible. There is actually a scarcity of reliable data available on the use and cost of ASD screening, diagnosis, and treatment. Many reports calculate an expected cost based on specific assumptions. This report from Acumen Actuarial provides its own calculation of the use and cost for North Dakota. It makes use of prior studies as well as emerging data and information. This report and cost estimate take into consideration the characteristics of North Dakota that may affect use and cost of ASD services such that they may be different than in other states.

EXECUTIVE SUMMARY

Any requirement to add new medical services to insurance coverage that were not previously required is likely to increase the use of those newly required services and the overall cost of care. Treatments for autism spectrum disorder (ASD) including Applied Behavior Analysis (ABA) are no exception. The question is how much the use and incremental cost will be over a multi-year horizon. The coverage of the screening, diagnosis, and treatment for ASD is relatively new, and there is a scarcity of reliable data about its use and cost in other states.

When the expense of ASD coverage is spread over all insureds, the requirement for screening, diagnosis, and treatment of ASD including ABA is likely to cost approximately 1% or less of the overall cost of health coverage per year for Active employees. During the first year of implementation, it is likely to cost less than 0.5% of premium or overall claims. Over the course of several years, it could ramp up to over 0.5% of overall cost before the utilization of ASD services eventually levels off at its *ultimate* level.

On a per capita cost basis, the incremental cost will be greater for the ND Active Employees Health Insurance plan than the Retired because there are far more children younger than 26 years of age per contract in the Active plan.

The overall health care cost per member per month for all Active employees was \$453 per member per month (PMPM) in Q2 2016. (This includes state employees and all political subdivisions.) A reasonable estimate of the expected average cost of screening, diagnosis, and treatment of ASD including ABA in the initial year of implementation is approximately 0.13% of overall cost, which is \$0.58 per member per month (PMPM) on a 2016 basis when spread across all members. A similar medical expense can be expected for the commercial coverage of the general insured ND population beyond the ND employees health insurance plans for Active employees and their dependents. This 2016 claim cost of \$0.58 PMPM can be reasonably expected for both non-PERS commercial group health insurance plans and “individual” coverage.

If the mandate is not implemented until 2018, the annual trend in claims cost will likely affect both the cost of ASD services as well as the overall cost of all health care services. Although it may give a false sense of precision, it is reasonable to trend this 2016 per member cost estimate by approximately 5% per year to reflect the ongoing cost increases that are in keeping with the medical consumer price index. Hence, on a 2017 basis, the cost estimate is projected to be \$0.61 PMPM. For 2018, it is \$0.64 PMPM. This is the estimated first year claims cost. In reality, there is a wide margin of error in any projection of the cost of the ASD coverage, and it would be misleading to assert with certainty that this point estimate is accurate to within pennies. It is possible that actual year one cost will be greater or less than this amount. Given

the logistic challenge of getting ABA therapists to more rural locations in North Dakota, the actual cost in 2017 could be less than \$0.61 PMPM.

On a per **contract** per month basis, the cost for the NDPERS active plan would be \$1.61 PCPM. (\$1.61 = \$0.61 PMPM x 2.64 members per contract in the NDPERS active plan as of Jan 2017.)

Many factors affect the use and overall cost of ASD services, especially in year one of coverage, but also beyond. If the supply of certified providers is low in ND in the initial year of implementation, this could result in lower use and spending than the estimate above, which is 0.13% of overall claims. Provider supply in relation to patient demand will also affect the level of use over time. There may be an insufficient number of certified applied behavior therapists initially, which would suppress utilization below the level of actual patient demand, but if the supply increases significantly in subsequent years, year five could experience utilization of ASD services that is considerably greater than year one.

The use of and expense for ASD treatment can be expected to increase over a period of several years as families and providers become more accustomed to the use of these services. Other actuarial studies and reports have shown a range of expected medical cost in the neighborhood of 0.1% to 1% of total cost for ASD services including ABA. The use and cost are typically greater on an "ultimate" basis several years after the initial implementation. The increase in the annual use and overall cost from initial to ultimate is important to consider. That is, there will likely be an increase from the year of implementation to a point in time three, four, or five years later when the ASD coverage requirement has ramped up to a mature level.

There is likely to be little effect on administrative activity; however, administrative cost is often expressed as a percent of premium or claims cost. Hence it is reasonable to gross up the expected claims cost to reflect incremental administrative cost. This done by dividing the expected claim cost by 1 minus the administrative cost as a percent of premium.

The requirement that insurers supply data for the biennial report is an administrative activity that insurers and plans are not currently obliged to carry out, and this will require some effort, albeit relatively minor compared with all the other activity associated with running a health insurance plan. The 2017 cost with incremental administrative expense is $\$0.61 + \$0.10 = \$0.71$ PMPM. [$\$0.71 = \$0.61 / (1 - 0.14)$]. This assumes administrative cost is 14% of premium, which is reasonable.

Often, the health insurers and other payers who are financially responsible for the cost of a new mandate are apprehensive about it prior to implementation. These payers find the new benefit is most difficult to price in the first year (or few years) of coverage because they have no prior internal data upon which to rely. This adds to the insurer's risk of underpricing the mandate as well as the overall cost of care, which is never known with certainty in advance.

The proposed ABA benefit under HB1434 has an annual limit of \$50,000. In actual practice, it is unlikely that many of those receiving ABA will incur a full \$50,000 of cost per year. Most can be expected to have total annual cost below \$50,000. The annual maximum cost limit is intended to assure that individuals with high need and high cost can obtain services. However, maximum annual limits in health plans also have a “sentinel” effect that serves to reduce possible overuse, gaming of the system, or potential overcharging for unnecessary services.

It is important to note that some ASD services and support, including ABA, are already provided by school systems under IDEA, Sections B and C. There is some overlap between services provided by the public and private sector. Under the Individuals with Disabilities Education Act, Sections B and C, children to 21 years of age are provided with Free Appropriate Public Education. This applies to children with any of 13 named disabilities, one of which is autism and another is communication disorders. These services may include treatment for autism spectrum disorders; however, the purpose of these ASD treatment services provided through the school system is to help the child to be more functional in the educational environment, but not necessarily at home or in the community at large. Be that as it may, it is important to recognize that some ASD support is provided by the school system for children with ASD, and this includes ABA. Moreover, the amount of ASD treatment already provided to children from the public sector may decrease the ASD services to be provided in the private sector through health insurance coverage. Hence, insurance coverage is not the sole source of funding for ASD treatment, services, and support. This may be one of the reasons that helps explain why the actual average cost for children receiving ABA and ASD treatment is significantly less than the maximum annual amount, according to the limited actual data currently available on the use and cost of ASD services provided to children.

KEY COST STATISTICS FROM EXECUTIVE SUMMARY

HB 1434—Expected first year per member per month 2017 claims cost only for:

- ND Health Insurance Plan for Active Employees is \$0.61 PMPM
- All other ND insureds covered (other than in public plans) is also \$0.61 PMPM.

Expected first year incremental 2017 premium cost with administrative expense for:

- ND Health Insurance Plan for Active Employees is \$0.71 PMPM
- All other ND insureds covered (other than in public plans) is also \$0.71 PMPM.

On a per **contract** per month basis, the expected first year 2017 claims cost is \$1.61 PCPM for the ND Health Insurance Plan for Active Employees.

The cost is expected to be significantly less for the public **Retiree** Health Insurance Plan because there are far fewer children under 26 years of age per contract in the Retiree plan. The expected claims cost of HB 1434 is expected to be *de minimis* for the Retiree plan.

INTRODUCTION

HB 1434 requires health insurers to cover the screening, diagnosis, and treatment of autism spectrum disorder (ASD) including behavior-based therapy, such as Applied Behavior Analysis (ABA). The bill is limited to fully insured health coverage of major medical plans that cover a comprehensive range of services. It is not applicable to limited plans, such as hospital indemnity, mini-med, Medicare Supplement, or other such plans with limited benefits. For further information about the purview of the bill and the types of coverage to which it applies, see subsection 10 under Section 1. The bill applies to the North Dakota Public Employees Health Insurance Plans for Active and Retired Employees and their dependents. In the event that the public employees plan switches from a fully insured to self-insured basis, the bill would continue to apply.

Subsection 2 of the bill requires insurers to cover ASD, and it forbids them to deny issue or continuation of coverage to those who are diagnosed with or have received treatment for ASD. Subsection 6 stipulates that ABA Services will be covered to a maximum limit of \$50,000 per year. The amount of the maximum is required to be increased annually in accordance with the increase in the medical consumer price index. This will assure that the maximum keeps pace with the increasing cost of living in future years. Some states have different maximum amounts. Some states vary the amount by age. The logic behind varying the maximum amount by age is that behavioral therapy tends to be more effective on younger people. This is consistent with actual practice where higher intensity of service (more hours per week) is more common for younger children with autism.

In actual practice, it is unlikely that many of those receiving ABA will incur a full \$50,000 of cost per year. Most can be expected to have total annual cost below \$50,000. The annual maximum cost limit is intended to assure that individuals with high need and high cost can obtain services. However, maximum annual limits in health benefit plans traditionally also have a “sentinel” effect that serves to reduce possible overuse, gaming of the system, or potential overcharging for unnecessary services.

Subsection 11 of the bill requires the insurance commissioner to submit a biennial report to the legislative management covering cost and use of services under the bill. Insurers subject to the bill will be required to provide data for this report. This can be a helpful follow-up activity subsequent to the implementation of the bill because it provides the legislative management a

clearer understanding of the true emerging use and cost of the bill in the state. To the extent the insurer data is reliable, this report could be a useful basis for future revisions to the bill.

The bill requires insurers to cover the cost of screening for ASD in children under 26. Screening identifies the presence of disease in a particular population that has not been diagnosed with it. In the case of ASD, young children are observed in well-child pediatrician visits and may be identified for diagnosis; this screening may involve consultation with the child's parents or caregiver. In some cases, a pre-school can recommend a child for evaluation. It is possible that the bill will encourage better and more complete screening of ASD in medical visits, but this is not billed separately in pediatric office visits, so no material cost is expected to be added for additional screening.

The bill requires coverage of diagnosis of ASD. It is possible that, over time, more children will be referred for diagnosis, but that too is not expected to materially affect overall use and cost.

The incremental use and cost is expected to come from additional treatment provided to children with ASD.

One of the key drivers of the use of ASD treatment is the number of children diagnosed with ASD. The prevalence rate of ASD in children has been increasing over the past ten or fifteen years according to reliable sources such as the Center for Disease Control (CDC). Part of this increase involves the evolution of the definition in the DSM manual that is used by clinicians to diagnose children with ASD.

A number of other factors contribute to use of ASD treatment. Not all children who are diagnosed with ASD will receive treatment for ASD in any given year under the bill. Some children with ASD whose behavior is more severely affected by it will tend to receive more hours per week of treatment. Children who need more hours of treatment per week do not necessarily continue to receive that level of treatment for an indefinite period of time. It often tapers off over time. The goal is for the individual with ASD to become more functional in their day-to-day life at home and outside the home.

Children with ASD often receive services and supports in their public education environments per the Individuals with Disabilities Education Act (IDEA), sections B and C. This is generally part of an Individual Education Plan that helps the child achieve educational goals and become more functional in the educational environment. Although these skills are transferable to environments outside of school, the intent of ASD support provided in the educational environment is focused on improving the child's ability to learn. This may include improving social and communication skills, which have benefits to the child beyond the classroom.

There may be some overlap in ASD services provided in the public and private sectors. For example, children with less severe ASD might not require additional ASD services beyond those they already receive in the educational environment.

In terms of the use of ASD services under HB 1434, there are multiple additional factors that will affect use over time:

- Availability of trained providers in relation to the demand for their services—if there are fewer qualified ASD service providers than patient demand requires, use will be reduced
- General awareness of ASD and ASD treatments among parents, and the degree to which parents seek treatment for their children—parents may hold back and be more tentative about seeking treatment for their children in early years and more assertive in later years when the benefits of obtaining ASD treatment are more broadly recognized. This can be expected to drive up the use of services over time.
- Logistics of providing services. North Dakota is a large state geographically with several population centers and many counties with low population density. Issues pertaining to rural medicine in sparsely populated counties could make it more difficult to provide services to children with ASD in more remote locations. It is possible that, at some future time, some parental coaching and support may be available using telehealth.

In the course of Acumen's research for this project, data on the prevalence of autism and autism spectrum disorder was reviewed. With respect to geography, race, or ethnicity, there is little variation in the prevalence rate among children. Gender, however, is different—male children are approximately four times as likely to be diagnosed with ASD. North Dakota is expected to be similar to the rest of the nation in this respect.

North Dakota has an autism registry maintained by the state Department of Health, but it is not yet an all-inclusive list of children with autism throughout the state. It went live on February 8, 2016 and seems to be a work-in-progress. As of October 2016, there were 186 children included in the registry. At present, there are 302 children. The North Dakota Autism Registry is still growing, and it is incomplete. For example, as of December 2015, however, there were 1,031 children on the Department of Public Instruction's list of children with an educational determination of autism. These two sources are not expected to be exactly identical, but the large difference helps us understand that the ND Autism Registry has not yet captured all those children with ASD that it eventually will. Yet another data source is the 2016 State Autism Profiles for North Dakota prepared by Easterseals, Inc. and distributed November 2016. It shows 939 children with autism in ND from age 3 through 21.

In the course of this research, report author, Daniel Bailey, spoke with individuals associated with NDPERS, Sanford Health Plan, and the ND Department of Public Instruction. He spoke with Judith Ursitti at Autism Speaks. And he also conferred with an expert on ABA, John Molteni, who is the Director of the Institute for Autism Behavioral Studies at the University of Saint Joseph in West Hartford, CT. Acumen wishes to thank all those who shared their knowledge or otherwise assisted in this project and report.

DATA AND INFORMATION

Many states have estimated the cost of similar bills that require insurers to cover the cost of screening, diagnosis, and treatment for ASD. Few states, however, have produced reports on the actual cost of those services after the insurance mandate has gone into effect. Little detail is provided with those reports about that data; and researchers generally find it difficult to assess the reliability of that data.

Prior to implementation of an ASD mandate, many states have evaluated the expected cost of ASD coverage using a prevalence and expected unit cost approach. That is the approach used in this report from Acumen Actuarial, which has taken into consideration the characteristics particular to North Dakota.

Although North Dakota's population declined somewhat from 2000 to 2004, it has grown steadily since then, more so in the past several years. This will have little if any effect on the per capita cost of ASD services, but the increase in population *will* affect the overall total cost of care because more individuals will obtain care. However, the cost of ASD services as a percent of overall premium is not expected to change as a result of the increase in North Dakota's population.

Acumen received demographic data for the ND Employees Health Insurance Plans for Actives and Retirees and their dependents. Among the active members' plan, children under 26 represented 38.6% of all members. It is assumed that this same proportion of children under 26 applies to the general population of insureds in ND. (A slight difference will not affect the cost estimate materially). State-specific data was obtained from the Kaiser Family Foundation website, such as the percent of insureds by coverage type and a North Dakota age distribution.

Acumen checked the Behavior Analyst Certification Board (BACB) website for information and data about the number of certified BACB therapists in ND relative to other states. In Missouri, where the ASD mandate has been in place for a few years, there is 1 qualified BACB therapist per 17,000 people in the general population. In North Dakota, there is 1 therapist per 33,000 people.

State-specific emerging actual claims data on ASD use and cost was reviewed during this study. It should be pointed out that this data is generally self-reported by participating insurers and HMOS, some of which may be delayed or remiss in their self-reporting altogether. It is not typically audited by an external party. Moreover, in year one, not all plans are necessarily fully phased-in to coverage under the mandate. Hence, year one use and cost may be materially less than year two and beyond.

The state of GA recently produced a report with state-specific 2016 ASD costs under its mandate requiring ASD coverage by private insurance. Ten of twenty carriers provided data. These findings were reported:

20,266,939	Number of member-months reported for all members
16,953	Number of member-months for those diagnosed with ASD subject to mandate
1,841	Number of members for those diagnosed with ASD subject to mandate
9.2 months	Average # of months/ yr / member diagnosed with ASD (Acumen calculated)
0.084%	Percent of member months diagnosed with ASD among all insureds
\$0.32	PMPM Cost of ASD services spread across all members
\$0.18	PMPM Cost of ABA only spread across all members (a subset of above).

Again, this data is not guaranteed to be 100% reliable nor is it highly credible in terms of volume. Moreover, there is likely some under-reporting of the true PMPM claims cost because the requirement to cover ASD was phased in over the first year and not in effect for every plan for every month of 2016. We do not know what this \$0.32 PMPM amount would be if all members were covered under the ASD mandate in GA all year.

One noteworthy point is that the 2016 occurrence rate in the GA insured population is 0.084%. This is significantly less than the occurrence rate Acumen obtained when multiplying 38.6% x 1% ASD prevalence rate among 0 – 26 year olds. The 38.6% represents children under 26 years of age as a percentage of the entire insured population of all members; this is based on NDPERS data for active employees and dependents as of Jan 2017. When 38.6% is multiplied by 1%, we obtain the expected occurrence rate in the overall insured population determined by Acumen. This occurrence rate developed by Acumen is 0.386%, and it is much greater than the actual occurrence rate reported in the GA data of 0.084%. Note that 0.386% is 4.6 times as much as .084%. Whereas the GA occurrence rate is based on actual data, the Acumen rate was projected from demographic and prevalence data. Again the GA data may be under-reported, but it is also possible that the Acumen occurrence rate is overstated. This may be off-set by similar but opposite under-statement of Acumen's "take-up" rate among children diagnosed with ASD, as further explained on page 14 of this report.

A report was published in JAMA Pediatrics in July 2016, Volume I, Issue 12, titled "Effects of Autism Spectrum Disorder Insurance Mandates on the Treated Prevalence of Autism Spectrum Disorder, Diagnosis Rates Increase, but Shortfalls Remain." The key finding is, "State mandates requiring commercial health plans to cover services for children with autism spectrum disorder increased the number of children diagnosed with the disorder. However, diagnosis rates remain much lower than community estimates, suggesting that many commercially insured children

with ASD remain undiagnosed or are insured through public plans.” This finding is consistent with the GA data.

Missouri has had an ASD coverage mandate in place for health insurance for several years and published annual statistics on use and cost of ASD services from 2011 through 2015. The table below is from page 2 of the Annual Report to the Missouri Legislature—“Insurance Coverage for Autism Treatment & Applied Behavior Analysis”, Statistics section, February 1, 2016.

MISSOURI ASD STATS

	2011	2012	2013	2014	2015
% Total Losses	0.10%	0.16%	0.20%	0.21%	0.25%
Monthly Cost for Indiv for Autism Treatment	\$143	\$222	\$255	\$278	\$357
Cost PMPM					
All Autism Treatments	\$0.25	\$0.38	\$0.48	\$0.50	\$0.60
ABA Services only	\$0.06	\$0.17	\$0.22	\$0.26	\$0.30
Annual COST Trend--Calculated					
All Autism Treatments		52%	26%	4%	20%
ABA Services only		183%	29%	18%	15%
Number of Autism related claims			43,372	51,855	61,457
Number of ABA claims			14,505	25,291	32,997
Annual Claim # Trend--Calculated					
All Autism Treatments				20%	19%
ABA Services only				74%	30%

Note that the ASD mandate in MO is not identical to HB 1434. The MO mandate requires ABA to an annual maximum of \$41,263 for children up to age 19.

A VA mandate study showed a cost of \$3.50 per contract per year, which is \$0.29 per contract per month. Assuming 2.5 members per contract; that is equivalent to \$0.11 PMPM. The VA mandate, however, covers children 2 to 6. Hence, it too is different than HB 1434 because VA covers a smaller percentage of its privately insured population due to the age restriction.

In producing this report, other sources were referenced for reasonability. The scarcity of actual ASD treatment use and cost data makes all these preliminary cost estimates more speculative prior to implementation of the mandate. However, the emerging actual ASD data is also not without problems. Adjustments need to be considered when using other states’ estimated (projected) or actual data.

OBSERVATIONS AND FINDINGS

As described earlier, there are a number of different factors and forces that will affect the use and cost of ASD under HB 1434 in the first year of implementation as well as subsequent years. The future extent of these different factors or forces is difficult to accurately estimate in the present. Sensitivity testing of these individual forces shows that the initial estimate could be considerably less or more than the point estimate provided in this report. That is, in advance of the implementation of HB 1434, there is a wide margin of error for the point estimate and a wide range in which the true actual cost could result.

Most reports in advance of implementation in other states show an expected cost of 0.1% to 1% of annual premium or claims cost. The eligibility criteria under any mandate for ASD treatment may affect its use and cost. Some states have different eligibility standards for ASD services than in HB 1434. For example, some states:

- Limit coverage to ages 0 – 21 or other younger age groups
- Reduce the annual maximum for ABA for older children, such as \$50,000 for 0 – 6 years of age; \$40,000 for 7 – 12 years of age; and \$30,000 for 13 – 18. The rationale behind such a step-wise decrease is that behavior is easier to change in young children than older children and intensive ABA (more hours / week) is more effective in younger children than older.

HB 1434 does not reduce the ABA annual maximum with age. If it did, the expected cost could lower than the point estimate already provided in this report; however, that is also not certain. Similarly, if HB 1434 restricted eligibility to children younger than 21 years of age, that could also reduce expected cost. Nonetheless, the highest use (in terms of hours / week) is expected to be associated with younger children; and, it is expected that children age 21 through 25 years of age will obtain fewer services for ASD treatment, at lower cost annually, than younger children. Hence, if HB 1434 were limited to children younger than 21, the expected cost would not necessarily be 21/26 of the original point estimate. Those with ASD in the 21 through age 25 range are expected to use fewer ASD treatment services annually than young children, especially those younger than age 9.

States often implement ASD coverage mandates that differ somewhat with respect to eligibility and benefits. For this reason, caution should be exercised in comparing results of emerging data across different states.

CALCULATIONS

Acumen estimates that first year claims cost for ASD services in 2017 under HB 1434 would be \$0.61 per member per month (PMPM). This is a point estimate, and the true actual amount could be considerably more or less than the point estimate. If the availability of behavior therapists and other ASB providers is low, the use and cost will be less than expected. Similarly, if public knowledge of HB 1434 is limited and ND residents remain unaware that ASD is covered under private health insurance, it too could depress the initial use of ASD services. Moreover, children with ASD, who live in remote rural locations in the state, may have lower use of ASD treatment than expected. Similarly, unforeseen circumstance and factors could contribute to use and cost that is greater than \$0.61 PMPM in year one. This estimate assumes all members are covered all year with no reduction for phase-in. In order to establish the initial year claim cost in **2016**, Acumen created the following cost projection model shown below:

Table 1—Development of Expected Average Per Member Per Month (PMPM) Claims Cost

CALCULATIONS, Yr 1 Claims Cost, 2016 Basis

The factors chosen below are expected values.
They are not known for certain in advance.

	Behavioral Therapy (may include ABA)	All Other ASD Service & Treatments
Occurrence Rate in General Pop		0.00386
Take-Up Among All Diagnsd	5%	18%
Average # Hrs/Month	29.0	
Avg Cost / Hr	\$52.50	
		\$5,000 Avg Annual Cost for Children Treated
2016 PMPM Claims Cost, spread over all insureds	\$0.29	\$0.29
TOTAL	\$0.58	
Q2 2016 CLAIM COST		
NDPERS ACTIVES, PMPM		\$453
% of Claim Cost		0.13%

This 2016 amount was calculated first. To obtain the 2017 amount, the 2016 expected claims cost was trended by 5% to reflect a 2017 basis of **\$0.61 PMPM**.

$$\$0.61 = \$0.58 \times 1.05.$$

The \$0.58 PMPM expected starting point was developed as shown in Table 1. The expected cost of behavioral services for children under 26 diagnosed with ASD was developed separately from the cost of **non**-behavioral based ASD services. This amount is spread over all members to obtain a PMPM cost for each service track. The two PMPMs were then summed to obtain the total 2016 expected cost of \$0.58 PMPM for HB 1434 when spread over all insured members.

In the Acumen model, there is an interplay between the occurrence rate and the take-up rate. The former describes the relative frequency with which children with ASD are represented in the overall insured population. The take-up rate represents the portion of children with ASD who actually receive treatment in either of the two services categories—Behavioral treatment (which includes ABA) and non-Behavioral treatment. It is important to consider cost of these two service tracks in tandem. In the Acumen model, it is possible that the occurrence rate is understated and the take-up rate is overstated. However, these are offsetting if the one is understated commensurate with the overstatement of the other.

The Acumen model splits the calculation into the two different service categories or “tracks”—Behavioral services and non-Behavioral. A separate PMPM is calculated for each. The “non-Behavioral” track is estimated using an expected average frequency times expected average cost per person treated per year. This is then converted to a per member per month basis, and the cost is spread over all insured members.

After the separate claims cost is developed for each track and the two are summed, a percent of total claims cost number is then calculated based on the overall Medical cost of \$453 PMPM using the Q2 2016 PMPM for the NDPERS health insurance plan active employees and dependents, which includes both state employees and those of political sub-divisions. On a 2016 basis, the \$0.58 claims cost is 0.13% of the overall health claims cost of \$453 PMPM. For 2017, it would be expected to be the same 0.13% of overall cost.

Note that the claim costs for the two service tracks (Behavioral and non-Behavioral) are approximately equivalent. This is reasonable and consistent with the emerging ASD cost data from the state of Missouri.

After developing the model for expected average year one cost as a point estimate, a five year *pro forma* was developed that projects the expected values over the next four years under different assumed growth rates. The year one expected costs in the 5 year model are based on the year one point estimate. It becomes the medium initial cost estimate, and two additional scenarios are shown for year one cost representing a low and a high estimate.

FIVE YEAR COST MODEL--

In establishing a *pro forma* with expected annual cost for the first five years, three growth-rate scenarios are considered in combination with three initial use and cost scenarios.

- SCENARIOS for Initial Use and Cost—Low, Medium, High
- SCENARIOS for Annual Growth Rate—Slow, Medium, Fast

The initial year 2017 claims cost estimate of \$0.61 PMPM corresponds to the “medium” initial use and cost scenario. Over a five year horizon, different results occur under the different combinations of scenarios. The low and high, and the slow and fast, are not meant to represent best-case or worst-case scenarios.

Low Initial Use and Cost combined with Slow Growth Rate leads to the lowest use and cost in year 5. Oppositely, High Initial Use and Cost combined with Fast Growth Rate leads to the highest use and cost in year 5. This is shown in the table below:

Table 2

Annual Growth Rate	INITIAL USE AND COST		
	Low	Medium	High
SLOW	Lowest Yr 5		
MEDIUM		Expected	
FAST			Highest Yr 5

Again, these are not best and worst-case scenarios. They are the lowest or highest of the various combinations of initial cost in year one and growth rate over future years.

In the next table, Table 3, we see a five year *pro forma* of expected cost over the first five years under the nine different combinations of 3 initial use and cost scenarios vs. 3 growth rates. The low initial use and cost (\$0.24) is based on 40% of the expected (medium) \$0.61 PMPM. The **high** initial use and cost (\$0.92) is based on **150%** of the expected \$0.61. These year one costs are then trended forward to years two through five at the three different rates of annual growth. The growth rates correspond to ASD treatment services under HB 1434, which are expected to increase more quickly than overall health spending because ASD coverage is a new requirement subject to different utilization trend forces than general health spending.

The slow growth rate corresponds to 5% annually. The medium growth rate corresponds to 15%, and the fast to 30%. Note that the slow growth rate of 5% is the same as the trend rate

used to establish the initial cost of ASD services under HB 1434 for 2017 and 2018 for whichever is the initial year of implementation. This is appropriate. The 5% trend of the expected 2016 ASD cost was used to establish the initial year cost only relative to the projection which was centered on 2016. In order to estimate the initial year cost of HB 1434 in 2017 or 2018, a trend factor needed to be used to increase that cost relative to 2016. Once HB 1434 is in place, however, it is expected that the use and cost of ASD services will increase annually at a faster rate than the overall cost of health care. This is primarily due to a faster increase in the utilization of ASD services and not a faster increase in the unit cost of ASD services.

The use of the different scenarios helps the reader to understand the range of cost that may occur over the course of the first five years, and even in year one. It would be misleading for this report to represent the cost estimate for any year as highly accurate, even under the medium scenario for both initial cost and growth rate. Although the numbers are shown to two decimal places, the two decimal digit representation does not mean that the actual cost of ASD services under HB 1434 (once all is known at some future time) will be exactly the same as the two decimal amounts shown here.

Note that the yellow-highlighted column in the center of the medium growth rate represents the years 1 – 5 claims cost of ASD services under HB 1434 assuming medium initial use and cost and a medium annual growth rate over the next four years. This is in the second box of Table 3. Here again, it is possible that the expected first year cost of \$0.61 may be high (overstated) compared with the ultimate actual cost, but the 5th year actual cost could be considerably more than the expected \$1.07 (understated) for reasons that cannot be fully anticipated at this time.

Emerging ASD claims data from other states, despite its potential shortcomings in credibility and reliability, seems to show significant increases from year one to year three in some cases. Hence, the fast growth rate costs are shown in the last box of table 3. Under the fast growth scenario, the \$0.61 claims cost in year one becomes a \$1.75 PMPM cost in year five.

Note also that the year one costs are identical in all three boxes reflecting different growth rates—slow, medium, and fast annual growth rates.

In year five, there is a wide range of estimated claims costs based on the nine combinations of the three scenarios. At the low end is \$0.30 based on low initial cost and slow growth. At the high end is \$2.62 based on high initial cost and fast growth. Neither is a best or worst-case scenario.

Table 3—Claims Cost Only (PMPM)**SCENARIOS FOR INITIAL USE & COST vs GROWTH**

Assumes implementation in 2017

SLOW GROWTH-- Assumes 5% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.24	\$0.61	\$0.92
2	\$0.26	\$0.64	\$0.96
3	\$0.27	\$0.67	\$1.01
4	\$0.28	\$0.71	\$1.06
5	\$0.30	\$0.74	\$1.12

MEDIUM GROWTH RATE--Assumes 15% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.24	\$0.61	\$0.92
2	\$0.28	\$0.70	\$1.06
3	\$0.32	\$0.81	\$1.21
4	\$0.37	\$0.93	\$1.40
5	\$0.43	\$1.07	\$1.61

FAST GROWTH RATE--Assumes 30% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.24	\$0.61	\$0.92
2	\$0.32	\$0.80	\$1.19
3	\$0.41	\$1.03	\$1.55
4	\$0.54	\$1.34	\$2.02
5	\$0.70	\$1.75	\$2.62

The numbers contained in the next table, Table 4, show the expected cost of HB 1434 over five years with the incremental administrative cost included in addition to the expected claims cost for ASD services.

Table 4—Includes Both Claims Cost and Administrative Cost (PMPM)

**TOTAL INCREMENTAL COST INCLUDING BOTH CLAIMS
and ADMIN COST PMPM OVER TIME UNDER DIFFERENT
SCENARIOS FOR INITIAL USE & COST vs GROWTH**

Assumes implementation in 2017

SLOW GROWTH-- Assumes 5% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.28	\$0.71	\$1.07
2	\$0.30	\$0.75	\$1.12
3	\$0.31	\$0.78	\$1.18
4	\$0.33	\$0.82	\$1.24
5	\$0.35	\$0.87	\$1.30

MEDIUM GROWTH RATE--Assumes 15% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.28	\$0.71	\$1.07
2	\$0.33	\$0.82	\$1.23
3	\$0.38	\$0.94	\$1.41
4	\$0.43	\$1.08	\$1.62
5	\$0.50	\$1.24	\$1.87

FAST GROWTH RATE--Assumes 30% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.28	\$0.71	\$1.07
2	\$0.37	\$0.93	\$1.39
3	\$0.48	\$1.20	\$1.80
4	\$0.63	\$1.56	\$2.35
5	\$0.81	\$2.03	\$3.05

CONCLUSION

In many states that have contemplated implementing bills similar to HB 1434, there has been preliminary concern about the potential high cost of covering ABA and other treatments for ASD. This concern is further heightened when those estimating the future cost (and those who will pay for it) learn that ABA can potentially cost \$50,000 per year and that an increasing number of children are diagnosed with autism spectrum disorder. In reality, not all children diagnosed with ASD will receive treatment, and, of those who receive treatment, many will receive some form of evidence-based ASD treatment other than ABA or some other form of behavioral treatment. Very few children will receive \$50,000 of ABA per year. Assuming that most children with ASD will receive \$50,000 of ABA per year would be incorrect and would substantially overstate the true cost of HB 1434. It would be similar to assuming that every person under the treatment of a cardiologist needs to have a heart transplant.

Relative to some other states, especially states that already mandate the coverage of ASD in health insurance, ND may have a scarcity of trained providers who can provide ASD services, support, and treatment to children with ASD. Based on the comparison of BACB certified behavior therapists in Missouri vs. North Dakota, it seems there are fewer providers in North Dakota per 1,000 people in the general population. This deficit in provider supply could reduce the use and cost in the initial year of implementation of HB 1434, and this could continue beyond year one until there are enough qualified providers throughout the state to meet the demand for services for children with ASD.

The estimated first year claims cost of providing ASD services in ND under HB 1434 is \$0.61 PMPM in 2017. This is an approximate point estimate within a wider range of possible cost outcomes. It is possible that the actual cost could be less than half of that. It is also possible that it could cost 50% more than \$0.61. The wide range of potential cost is reasonable. It would be unreasonable to assert that the estimate of \$0.61 PMPM is precise to the penny and the actual cost will be exactly that.

On a per **contract** per month basis, the \$0.61 PMPM is equivalent to \$1.61 per contract per month for the NDPERS health insurance plan for active employees and their dependents. This PCPM amount is calculated using 2.64 members per contract based on the actual January enrollment data for members and contracts.

While some services and support are already provided for children with ASD in the school setting under the Individuals with Disabilities Education Act, sections B and C, this is not a substitute or replacement for treatment for children with ASD in the home or community, outside of the school setting. The extent to which a child with ASD needs services in the home

or community under private health insurance will often be similar to the need that child has in school. However, there are some children with ASD who have need for services in the school system but do not need services outside school. Oppositely, there are children with ASD who have need for treatment outside school but not in school. And then there are those who receive services both in school and out, in varying amounts.

Some children with ASD are high functioning and never use any ABA in their lifetimes either in the school setting or privately under health coverage. Other children who are at the other end of the spectrum may have more need for ASD services including ABA. These services, especially behavioral approaches, seem to be more effective when children are young and their brains and behavior are more malleable. In terms of hours per week of needed ASD services, children at one end of the spectrum have the most need, and children at the other end have the least need.

When ASD services are provided in school, they are part of the child's Individual Education Plan. The intent is to help the child with ASD become more functional in the educational environment for the purpose of learning. Some of the behavioral training the child receives in the school setting is transferrable to the home or community, but it is not necessarily a substitute for it. Whether in the school system or outside it, some of the ASD training is directed toward parental coaching. This is intended to give parents strategies and approaches to alter and improve the autistic child's behavior everywhere, including at home and in the community at large. In severe cases, it may begin with teaching the parents effective strategies to stop the child from self-injury or other behaviors that may adversely affect the siblings and parents in the home.

Subsection 11 of the HB1434 requires the ND Insurance Commissioner to submit a biennial report to the legislative management on concerning implementation of HB 1434, and the use and cost of ASD services under private health insurance plans covered by the bill. This is important because it will help the state measure the use and cost of ASD services under HB 1434 going forward.

Subsection 11 requires the reporting of the number of members who are children less than 26 years of age diagnosed with autism spectrum disorder. It does not require reporting of the total number of member months for all members. However, this would be a helpful requirement because it would allow the state to track the children under 26 diagnosed with ASD as a percentage of total members over time, which was referred to as the "occurrence rate" in the calculations section of this report.

It is difficult to draw conclusions about the true actual cost of ASD services from these state-specific reports, especially in year one. The mandate may be phased-in in such a way that the first year numbers are understated because some plans are subject to the mandates for only part of the year. The data in these reports is based on self-reported numbers from participating

insurers. Typically, the data is not audited. There may be issues with the credibility and reliability of the data. The credibility issues arise as a function of small numbers since ASD cost is less than 1% of total health spending.

When administrative cost is added to the expected claims cost using 14% of premium, the total incremental effect on premium in year one is expected to be \$0.71 PMPM in 2017 for the NDPERS health insurance plan for active employees and their dependents.

$$(\$0.71 = \$0.61 / (1 - .14)).$$

The same cost is expected to apply to the commercial insured population to which HB 1434 applies (outside of the members in the NDPERS health insurance plan for Active employees and dependents).

For the NDPERS health insurance plan for Retired employees and dependents, the incremental 2017 claims cost of HB 1434 is expected to be *de minimis*--less than \$0.05 PMPM. This is substantially less than for the Active plan because the Retiree plan has far fewer children under 26 years of age as a percent of all members. Despite the provision for coverage of grandchildren under special circumstances, HB 1434 will have far less effect on the PMPM cost of the Retiree plan, if any. Given the very low percentage of children covered by the Retiree plan, the claims cost (even with administrative cost added) is expected to be pennies only. That said, the smaller Retiree plan has far fewer members than the Active plan, and its actual results will be subject to more statistical fluctuation.

Similarly, when the effects of HB 1434 are observed on health claims data in future years, some insurers or plan-specific data may show actual cost that deviates significantly from the expected. This is a common problem when health cost data is sliced and diced into multiple cells of relatively small credibility. The numbers prepared in this report are intended to represent the average expected cost across all members in North Dakota.

QUALIFICATIONS AND LIMITATIONS:

This actuarial report is intended for the state of North Dakota for the purpose of its evaluation of the proposed legislation under HB 1434. It provides an estimate of the uncertain future cost of ASD services to be provided under HB 1434. This report summarizes Acumen's review and provides data, information, and Acumen's analytical findings.

The use and discussion of this document is limited to North Dakota and Acumen Actuarial. This report is not to be used for any other application or purpose. It was developed specifically for the state of North Dakota as it applies to the actuarial evaluation of HB 1434 at this point in time. The contents of this report are not intended for any other use or purpose. If the distribution of this report is not prohibited by public records law, this report should not be distributed to third parties without Acumen's prior permission. This report shall be released only in whole, and it shall not be released in part to any party.

This review is limited in time and scope. It is not a guarantee that ND's future actual ASD services cost under HB 1434 will equal those shown in this report. In conducting my work, I have reviewed various data. In addition to publically available data and information, I have been supplied with and relied upon data and information provided by the state of ND.

This report does not recommend a specific course of action. The intent of this review and report is to provide objective facts and findings that the state of ND Legislative Council can use to evaluate HB 1434 with respect to the expected future cost and use of ASD services in private health insurance as required under the bill. It is not a legal opinion and does not provide legal advice on matters of law pertaining to the legislation.

I, Daniel Bailey, am a consulting health actuary and owner of Acumen Actuarial LLC. I am a fellow of the Society of Actuaries and member of the American Academy of Actuaries, and in good standing with both organizations. I meet the Qualification Standards to render the opinion contained herein. If you have questions, please contact me at bailey-d-1@comcast.net. My office phone is 860-986-4052.

Daniel Bailey, FSA, MAAA



Page 2 Line 20 replace "twenty-six" with "nineteen"

Page 3 Line 5 replace "Coverage" with "For an insured over the age of 10, coverage"

Page 3 Line 6 replace "fifty" with "thirty-six"

Page 3 Line 6 remove "Beginning January 1, 2018, and on an annual"

Page 3 remove Lines 7 through 12

Texas Statute

Sec. 1355.015. REQUIRED COVERAGE FOR CERTAIN ENROLLEES.

(a) At a minimum, a health benefit plan must provide coverage for screening a child for autism spectrum disorder at the ages of 18 and 24 months.

(a-1) At a minimum, a health benefit plan must provide coverage for treatment of autism spectrum disorder as provided by this section to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis, only if the diagnosis was in place prior to the child's 10th birthday.

(b) The health benefit plan must provide coverage under this section to the enrollee for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. An individual providing treatment prescribed under this subsection must be:

(1) a health care practitioner:

(A) who is licensed, certified, or registered by an appropriate agency of this state;

(B) whose professional credential is recognized and accepted by an appropriate agency of the United States; or

(C) who is certified as a provider under the TRICARE military health system; or

(2) an individual acting under the supervision of a health care practitioner described by Subdivision (1).

(c) For purposes of Subsection (b), "generally recognized services" may include services such as:

(1) evaluation and assessment services;

(2) applied behavior analysis;

(3) behavior training and behavior management;

(4) speech therapy;

(5) occupational therapy;

(6) physical therapy; or

(7) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

(c-1) The health benefit plan is not required to provide coverage under Subsection (b) for benefits for an enrollee 10 years of age or older for applied behavior analysis in an amount that exceeds \$36,000 per year.

(d) Coverage under Subsection (b) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

(e) Notwithstanding any other law, this section does not apply to a standard health benefit plan provided under Chapter 1507.

(f) Subsection (a) does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter requires the qualified health plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by this subchapter.

(g) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this section that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

AN ACT

Att. 3
HB 1434
2-7-17

ENTITLED, An Act to clarify health coverage for applied behavior analysis, and to establish the
Applied Behavior Analysis Provider Workgroup.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as
follows:

Terms used in this Act mean:

- (1) "Applied behavior analysis," the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;
- (2) "Autism spectrum disorder," a complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior;
- (3) "Behavioral health treatment," evidence-based interventions that:
 - (a) Achieve specific improvements in functional capacity of a person; and
 - (b) Are provided by a licensed or certified practitioner as provided in section 6 of this Act;
- (4) "Treatment," evidence-based care which is prescribed or ordered for a person diagnosed with an autism spectrum disorder by a licensed physician or psychologist, including:
 - (a) Behavioral health treatment;
 - (b) Pharmacy care; and
 - (c) Therapeutic care.

Section 2. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as

follows:

Nothing in this Act applies to nongrandfathered plans in the individual and small group markets that are required to include essential health benefits under the federal Patient Protection and Affordable Care Act of 2010, as in effect on January 1, 2015, or to Medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care, major medical policies with a limited duration of less than twelve months, or other limited benefit hospital insurance policies, or any plan or coverage exempted from state regulation by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 18, as in effect on January 1, 2015.

Section 3. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as follows:

Except as provided in section 2 of this Act, this Act applies to all individual and group health insurance policies, contracts, and certificates issued by health carriers as defined in subdivision 58-17H-1(19) and self-funded nonfederal governmental plans with the exception of the state employee health plan sponsored by the State of South Dakota.

Section 4. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as follows:

Every policy, contract, certificate, or plan subject to the provisions of this Act shall provide coverage for applied behavior analysis for the treatment of autism spectrum disorders consistent with this Act.

Section 5. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as follows:

Coverage for an applied behavior analysis may be subject to pre-authorization, prior approval, and other care management requirements including limits on the number of individual visits a person may make for applied behavior analysis subject to the general care management provisions of the

plan, and may be subject to dollar limits, deductibles, copayments, or coinsurance provisions that apply to other medical or surgical services covered under the policy. The coverage for applied behavior analysis shall provide an annual maximum benefit that may not be less than the following:

- | | | |
|-----|-----------------------|----------|
| (1) | Through age 6 | \$36,000 |
| (2) | Age 7 through age 13 | \$25,000 |
| (3) | Age 14 through age 18 | \$12,500 |

Section 6. Any person who performs applied behavior analysis shall:

- (1) Be licensed by the South Dakota Board of Medical and Osteopathic Examiners or the Board of Examiners of Psychologists; or
- (2) Have a master's degree or a doctoral degree and be certified by the National Behavior Analyst Certification Board with a designation of board certified behavior analyst.

Supervisory services performed by such practitioners are not required to be covered.

Section 7. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as follows:

A health carrier or plan provider subject to this Act shall have the right to request a review of the treatment that a person is receiving not more than once every three months unless the insurer and the person's licensed physician or licensed psychologist execute an agreement that a more frequent review is necessary. Any agreement regarding the right to review a treatment plan more frequently applies only to a particular person receiving applied behavior analysis and may not apply to all persons receiving applied behavior analysis by a licensed physician, licensed psychologist, or board certified behavior analyst. The cost of obtaining a review under this section shall be paid by the health carrier or plan.

Section 8. Nothing in this Act may be construed to affect any obligation to provide services to a person under an individualized family service plan, an individualized education program, or an

individualized service plan.

Section 9. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as follows:

The effective date of this Act is the first plan year, policy year, or renewal date on or after January 1, 2016.

Section 10. There is hereby established the Applied Behavior Analysis Provider Workgroup, operated under the Department of Human Services, to advise and make recommendations to the Governor and the Legislature regarding the certification and licensure of applied behavior analysis therapy providers.

The workgroup shall consist of the following members appointed by the Governor by July 1, 2015: two members of the Senate; two members of the House of Representatives; two persons who have a family member with autism spectrum disorder; two persons who are behavior analysts certified by the National Behavior Analyst Certification Board, including one at a supervisory level; one licensed healthcare provider who provides other medical or therapy services to children with autism spectrum disorder; one representative from the Department of Human Services; one representative from the Department of Social Services; one representative from the Department of Education; one representative from the Department of Labor and Regulation; two persons representing health insurance carriers who offer health coverage in the state of South Dakota; and one person who serves as an executive director of a medical or therapy licensing board. The Department of Human Services representative will chair the workgroup.

The workgroup shall make a final report including a record of its discussions and recommendations to the Governor and to the Legislature by December 1, 2015.

An Act to clarify health coverage for applied behavior analysis, and to establish the Applied Behavior Analysis Provider Workgroup.

I certify that the attached Act
originated in the

SENATE as Bill No. 190

Secretary of the Senate

President of the Senate

Attest:

Secretary of the Senate

Speaker of the House

Attest:

Chief Clerk

Senate Bill No. 190
File No. _____
Chapter No. _____

Received at this Executive Office
this _____ day of _____,

20____ at _____ M.

By _____
for the Governor

The attached Act is hereby
approved this _____ day of
_____, A.D., 20____

Governor

STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____, 20____
at _____ o'clock ____ M.

Secretary of State

By _____
Asst. Secretary of State

6 March 2017

HB 1434 - Autism Insurance Reform

Senate Human Services Committee

Good morning Chairwoman Lee and members of the Senate Human Services Committee. For the record, my name is Thomas Beadle, State Representative from District 27 in Fargo. I am here today on behalf of hundreds of families across our state who are leading a grassroots effort pushing Autism Insurance Reform in North Dakota.

Having a family member on the Autism Spectrum is a life changing event, and has massive impacts financially, and on the family's quality of life. There is plenty of data on this topic, with an estimated 1 in 68 children being diagnosed as autistic, including 1 in 42 boys. According to the Harvard School of Public Health, the estimated costs of care over the lifetime of an Autistic individual is \$3.2 Million dollars. Studies over the last few decades have consistently shown that early detection, early intervention, and therapies can save over \$1 Million off these lifetime costs. Additionally, the long term savings to county social services, K12 resources and taxpayers at all levels should more than offset the PERS fiscal impact. Dr. Jeff Schatz testified to this effect in the House Human Services Committee. Fargo Public schools has given me some data on this, showing that during the 2014-15 school year, the actual costs for special education services was \$22.1 Million in Fargo Public, with a significant chunk of this being used by students on the autism spectrum. They feel, that if we can have more intervention and detection at a young age and we get therapies including ABA therapy, which this bill does, than they can see significant savings to the school district and the local tax base.

For me, this is an issue that we need to pay attention to as a state. My cousin Zach was diagnosed with autism a few years ago. He was considered a fussy baby, and he developed milestones a slower rate than his peers. It wasn't until he was 3 or 4 years old before he was officially diagnosed with autism. They put him into Speech and Occupational Therapy programs, and started to get some treatment for him, but they ran into roadblocks with insurance coverage. When he was 4, they ended up paying over \$11,500 out of their own pockets, plus their monthly insurance premium of \$1000. They have started behavior therapy programs with him, and have gotten some success. As an example, one of the things they do with him is video his surroundings and put him in the video, which is a therapy called "social stories" as part of ABA therapy. They've gone from the Langdon school district to the Cavalier district while trying to provide for Zack, and drive 80 miles round trip for Zack daily to try and provide for his needs. What we currently have isn't enough. They are now in the process of purchasing a home in West Fargo, and will be leaving the family farm because coverage isn't sufficient in their area and they are accumulating significant debt in trying to care for Zack.

1434
#1
3/6
pg. 2

Their story isn't unique, it isn't even the worst case scenario that some families are faced with, but that's why we need bills like this. Our job is to help protect the most vulnerable in our state, and I contend that this bill does that.

45 states have passed a version of this bill. The language here is a combination of South Dakota, Texas and Ohio. This bill ensures that providers cover medically prescribed, evidence-based treatments for Autism Spectrum Disorder. Decades of research demonstrate the effectiveness of ABA therapy, yet many insurance providers still deny coverage for ABA saying that it is experimental. That does seem to be changing now, and the insurers are saying that they will try and cover ABA therapy in the next few years. Well, this bill puts a floor in place, and says that if they say they are going to do it, then we should hold their feet to the fire and ensure it is going to happen. If they say they will do it, then we should ensure that they focus on early detection, intervention, and ensure that they cover therapies that are medically proven to be effective. This bill does that. While currently, most of our insurers in the state will help cover expenses for Speech and Physical Therapies, they do not cover one of the most widely diagnosed therapies, Applied Behavioral Analysis treatment.

This bill is different than it was initially introduced on the House side. Initially, we had a 26 years old age limit that coincided with the ACA limit of kids on their parent's plan, and it initially had a cap on coverage of \$50k annually. This was done to offset the fiscal impact of the longer term of coverage and to help mitigate against opposition from the insurers. Knowing that some patients, especially in the early stages of treatment, require extensive care that can easily exceed \$100k in expenses, the House committee, led by Rep. Porter amended the language so that it matched up with South Dakota, and included a floor of coverage that should in no way limit insurers from offering coverage above and beyond these levels. Additionally, that committee lowered the age limit to ensure coverage of individuals through high school, but this should again not preclude an insurer from offering coverage above that threshold. This bill was initially drafted to bypass the PERS trial and go straight to commercial plans, but that language was amended out. BCBS had requested this and members of the House committee thought it was good policy to stick to the trial that we legislatively set up. Interestingly, Sparb Collins from ND PERS testified on the House side, and their position was that if this had the bypassing language in it, then they wouldn't need to include it in their plan until they rebid the contract, which meant that it wouldn't have a fiscal note for this biennium. Since we no longer have that language in here, the fiscal note was adjusted to reflect that.

Before I conclude, I will do a quick walkthrough on the bill itself.

Subsection 1 of the bill is definitions. These definitions were prepared by Autism Speaks, a national advocacy group that operates on behalf of Autism impacted families.

1434
#1
3/6
PS-3

The referenced definition in subsection 1(a) is as follows.

43-32-01. Definitions

8. "Practice of applied behavior analysis":

a. Means the application of the principles, methods, and procedures of the experimental analysis of behavior and applied behavior analysis, including principles of operant and respondent learning. The term includes applications of those principles, methods, and procedures to:

- (1) Design, supervise, evaluate, and modify treatment programs to change the behavior of individuals diagnosed with an autism spectrum disorder;
- (2) Design, supervise, evaluate, and modify treatment programs to change the behavior of individuals;
- (3) Design, supervise, evaluate, and modify treatment programs to change the behavior of groups; and
- (4) Consult with individuals and organizations.

Subsection 2 - Institutes an age limit of 19 years old, and makes sure that an autism diagnosis is not grounds for denial of or termination of an insurance contract. 8 states currently have no age limit in place, and this puts us into the age limits that are most common across the country.

Subsection 3 - Prohibits the number of limits on number of visits for treatments

Subsection 4 - Cannot set dollar limits substantially lower than all other medical and surgical benefits in the plan.

Subsection 5 - Not limit other benefits that are available in the plan

Subsection 6 - This language mimics South Dakota, and places minimum thresholds for coverage at \$36,000 for individuals under 7, \$25,000 for individuals between 7 and 14, and \$12,500 for individuals 14 until they turn 19

Subsection 7 - Coverage for ABA must include the services of the personnel who work under the supervision of the licensed behavior analyst or psychologist overseeing the program. This is to ensure that insurance covers therapy overseen by a licensed provider, much like how we cover work by a dental hygienist that is overseen by a dentist.

Subsection 8 - Allows an insurer to annually review the treatment plan for an insured receiving treatment for Autism spectrum disorder, unless the insurer and the insured's treating physician or psychologist agree to more frequent review as being necessary.

1434
#1
3/6
Pg. 4

Subsection 9 - This whole section does not affect an obligation to provide services for an individual under an individualized family service plan, an individual educational program or an individualized service plan.

Subsection 10 - This section does not apply to nongrandfathered plans in the individual or small group markets under the ACA.

Subsection 11 - Before August of each even numbered year, the Insurance Commissioner shall submit a biennial report to Legislative Management regarding the implementation of the coverage. This report will give us plenty of data to work with, including the number of diagnosed individuals, costs of claims received, cost per insured for coverage.

One of the Insurers in the state has stated throughout discussion on the House side that they will be including ABA therapy as part of their commercially available plans in 2018. Supposedly, this coverage will be without age limits and without dollar limits. Per the Federal guidelines for federal employee coverage, the initial evaluation and diagnosis will not need prior insurance approval, but ABA therapy coverage would need prior approval. I believe that BCBS, the one insurer that has mentioned they intend to cover this, will use FEP language as a baseline for the coverage. I have included the text from BCBS's email to me with the summary of FEP guideline language as a part of this testimony. While I find this encouraging, it is important for us to remember that there is more than one insurer in the state, though one insurer is all that has even expressed an intention to start covering ABA therapy. Additionally, even if Sanford does follow suit, those two insurers still do not cover all North Dakotans.

This is an important issue for hundreds of families across North Dakota. If you check out the Facebook group "North Dakotans for Autism Insurance Reform", you will find nearly 550 North Dakotans that have joined this movement since September of last year. These are families that have been struggling with out of pocket expenses in caring for their loved ones. These are families that can tell you from experience, that they have been given the run around by their insurers, where they have been told that therapies were going to be covered soon, and yet they have had to wait and wait. These are families that have coverage through their work from insurers in other states, such as BCBS Indiana, and have tried to get therapies covered in ND only to have the local provider put up roadblocks to passing that coverage along. It is important for us to remember, that despite this mandate existing in 45 states, our insurers that are forced to cover this therapy elsewhere have so far refused to cover it here. Only once other states have had mandates implemented have they provided the coverage. All of our surrounding states have this mandate, including South Dakota, Minnesota, and Montana, and yet the free market has not yet provided a solution in North Dakota. Sometimes, the state needs to step in and ensure that we allow every tool to be made

available in the toolbox for our citizens and their loved ones... This bill is an attempt to do that.

Madam Chair, this is an important issue and one that we have people passionately supporting that will follow me with their stories. Inaction, or waiting and hoping that insurance companies step up and do the right thing in the future, means years lost in treatments that are exponentially more effective when implemented at an early age. I strongly ask this committee to give them a good hearing, and for this committee to give this bill a Do Pass recommendation.

Thank you!

1434
#1
3/6
pg. 6

Hi Representative Beadle,

After some serious digging, the language that most easily outlines the FEP benefit is included below:

- FEP allows
 - Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder. Prior approval is required for ABA and related services, including assessments, evaluations and treatment. Benefits are not available for ABA for any other condition.
- FEP does not allow
 - Marital, family, educational, or other counseling or training services, or applied behavior analysis (ABA), when performed as part of an educational class or program
- FEP has general exclusions for
 - Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder,
 - applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system

FEP does provide guidance for the administration of the FEP benefit per the below:

- ABA is a medical (habilitative) benefit
- Prior approval is not required for the diagnostic evaluation
- Prior approval is required for the initial assessment visit and for all ABA therapy
- Prior approval is based on the medical necessity of the individuals care and is reviewed as clinically appropriate.
- Services are allowed based on clinical need and evidence based practice,
- Family/guardian involvement in treatment is required.
- Benefits will not be available for telemedicine ABA therapy

Benefits

Federal employee program benefit changes for 2017

- An autism spectrum evaluation and diagnosis needs to be made prior to a referral for ABA. The comprehensive evaluation needs to be completed by a licensed provider working within their scope of practice. This does not require prior approval.
- Prior approval is required for the following ABA services:
 - The initial assessment visit (i.e., functional behavioral assessment (FBA) to develop the ABA treatment plan).
 - All ABA therapy.

Potential amendment for simplification and flexibility for the Insurers:

Page 2 Line 20 after "disorder" insert "."

Page 2 Line 20 remove "under nineteen years of age."

Page 2 remove lines 30 and 31

Page 3 remove lines 1 and 2

Page 3 remove lines 5 through line 30

Renumber accordingly



The Pew Charitable Trusts / Research & Analysis /
Stateline / Coverage for Autism Treatment Varies by State

STATELINE

Coverage for Autism Treatment Varies by State

February 19, 2016

By Jen Fifield



At the Autism Academy of South Carolina in Columbia, Kristen Bettencourt helps 6-year-old Brooke Sharpe assemble a Mr. Potato Head. Health insurance coverage for behavior analysis treatment is hit or miss across the country, despite

1434
#2
3/6
Pg. 2

requirements in 44 states.

This story has been updated throughout.

COLUMBIA, South Carolina — All morning at the Autism Academy of South Carolina, 6-year-old Brooke Sharpe has been doing what her therapist tells her to do: build a Mr. Potato Head; put together a four-piece puzzle of farm animals; roll a tennis ball.

Now it's Brooke's turn to choose. She touches an icon of Elsa from the movie "Frozen" on her iPad. When "Let It Go" begins to play, she swings her braids to the music. For Brooke, who has a severe form of autism and doesn't speak, this is progress: Last year, unable to express a preference, she might have just flailed to the floor in tears, said Kristen Bettencourt, her therapist.

The treatment Brooke is receiving, "applied behavior analysis," has been proven to help children with autism learn new skills, develop good behaviors and stop bad ones. It is the method known to work best for treating autism, but health insurance doesn't always cover it.

Since 2001, 44 states have begun requiring some insurance plans to cover ABA for children diagnosed with autism spectrum disorder. But the rules are all different, making for uneven coverage across states. Autism Speaks, a national nonprofit, estimates that 36 percent of Americans have access to autism coverage.

The mandates don't apply to those companies, often large, that insure their own workers. In some states, small businesses are not required to offer coverage. Depending on the state, coverage may be available to state employees, Medicaid recipients and people purchasing insurance in the marketplaces created under the Affordable Care Act.

The breadth of the coverage also varies. Some states only require coverage up to a set dollar amount per year or a set number of hours of treatment per week, or only require the coverage until a child reaches a certain age, ranging from 8 to 21.

The highest annual cap was set at \$50,000. That's the cap in South Carolina, where coverage is required until age 16. Only California, Indiana, Massachusetts and Minnesota require the plans to cover the therapy without any limits on age, cost or frequency.

The disparities among states have sent families, such as Brooke's, packing. Her parents, Alicia and Edwin Sharpe, sold their "gorgeous house" in Florida, left their jobs, and took \$30,000 pay cuts to come to South Carolina, knowing that the state requires some employers to cover the Autism Academy's full-time treatment program.

After the move, Alicia had to switch jobs twice to find coverage. Without insurance, Brooke's program, which is full-day, five days a week, costs \$50,000 a year.

1434
#2
3/6
Pg. 4

Insurance Coverage for Autism Treatment

Are some plans required
to cover treatment?

6,681 views [more by this author](#)

View

State lawmakers who want to require insurers to cover the treatment say doing so will save their states money in the long run. The lifetime costs of each person with autism is estimated to be \$3.2 million, including medical and treatment costs for families, and costs to society, such as loss of productivity. ABA therapy can reduce those costs, as children who receive the treatment early have less trouble adapting, allowing them to potentially hold a job and pay taxes in the future.

Many insurance companies and business groups oppose the mandates, arguing that they would result in steep premium increases. But, for some insurance companies, increases have been less than expected, at less than half of 1 percent.

National Movement

Autism is the fastest-growing developmental disability in children in the nation, according to the Centers for Disease Control and Prevention. About one in 68 children was reported to have autism spectrum disorder in 2010, up from 1 in 150 in 2002, according to the CDC.

Autism advocates say the national movement to expand coverage really started with one boy: Ryan Unumb. Ryan was diagnosed with autism in 2003, just before his second birthday.

His parents, Lorri and Dan Unumb, are attorneys. They pushed South Carolina to become the second state (Indiana was the first, in 2001) to require coverage of the therapy. Autism Speaks hired the couple to push for similar laws in other states. The Unumbs also are the founders of the Autism Academy.

In ABA, board certified behavior analysts and other therapists teach children using requests, repetition and rewards. Brooke knows activities by their one-word prompts, such as "building," "standing" and "rolling."

Ryan, now 14, is learning prepositions. At the academy, his therapist, Courtney Lindler, tells him to stand behind something, or on top of it. This way, he will know how to stand in a line somewhere else. The two do push-ups, lunges and squats together — physical activity lessens his aggression.

The laws have come as more people have started to recognize the benefits of ABA therapy for autism, said David Mandell, director of the Center for Mental Health Policy and Services Research at the University of Pennsylvania. He said there is often resistance to covering conditions that doctors diagnose based on behavior, such as autism. Mandell expects mandates to be an easier sell once researchers can find biological markers for autism.

"If we were talking about pediatric cancer, we wouldn't be having this discussion," he said.

1434
#2
3/6
pg. 6

The six states that do not require that insurers cover the therapy are Alabama, Idaho, North Dakota, Oklahoma, Tennessee and Wyoming. Oklahoma and Alabama are considering bills that would mandate coverage.

Of the 44 states with requirements, 42 passed laws mandating the coverage; in Washington, coverage is required as a result of litigation; and in Ohio it is required because of an executive order from Republican Gov. John Kasich. In both Ohio and Iowa, the rules only apply to health plans for state employees.

Since 2012, 10 states with coverage requirements have expanded them, and Iowa, Nebraska, Ohio and South Carolina are considering doing so this year.

In Ohio, Republican state Rep. Cheryl Grossman has introduced a bill that would expand the coverage requirement to private employers. She said she knows the children who get treatment have a better chance of entering public schools, and achieving independence.

"I'm looking at it as an investment on behalf of these children, and a very meaningful way to help them succeed in their lives," Grossman said.

But her bill is facing opposition from business groups and insurers.

In Ohio, plans offered on the Affordable Care Act marketplace cover the treatment, so people not happy with their employer's coverage have the option of getting an individual plan there, said Keith Lake of the Ohio Chamber of Commerce.

Lake said his organization is sympathetic to the plight of families with autistic children. But, he said, Grossman's bill would increase insurance premiums for small businesses that can ill afford it — especially as the Legislature weighs similar coverage requirements for hearing aids and contraception.

"Anything that the Legislature does that further increases those premiums is a problem," Lake said.

1434
#2
3/6
pg. 7

But premiums have increased less than expected.

In Missouri, where the coverage for treatment was capped at \$40,000 a year until age 19, the state found that, in 2015, the mandate cost 30 cents per member per month. That's at the lower end of the expected cost, said John Huff, director of the Missouri Department of Insurance.

The department estimated the mandate would increase claim payments by 0.2 to 0.5 percent. In 2015, 32,997 claims were filed and the mandate had raised premiums by 0.25 percent, on the low end of expectations.

"As much as anything it is an educational process" for lawmakers, Grossman said, "because we aren't talking huge numbers here, but we are talking huge successes."

Roadblocks

But even in states that require coverage, families can have a hard time getting it.

After the law passed in New York in 2011, families couldn't get the coverage for two years due to a licensing problem. The state Department of Financial Services was telling therapists they needed to get an ABA license in order to receive insurance reimbursement, yet the state had no ABA license available. In 2014, the Legislature amended the law, creating a licensing procedure.

In states such as New Jersey, some families have trouble finding therapists who will take their insurance, said Peter Bell, CEO of Eden Autism Services, a nonprofit there. Bell said some insurers' plans reimburse therapists so little for the therapy that Eden cannot afford to accept them.

Medicaid reimbursement rates also are low in some states. In South Carolina, for example, Medicaid pays up to \$15 an hour for therapists who normally charge \$50 an hour and \$58 for board certified behavior analysts who typically charge \$125, Unumb said.

1434
#2:
3/6
pg. 8

In a handful of states, such as Massachusetts, there is better access to coverage. The Massachusetts mandate includes small businesses and individual plans, and there are no caps. In addition, 62 percent of people working for companies that insure their own workers, which aren't subject to the mandate, have coverage because their employers have chosen to offer it, according to Amy Weinstock, director of the Autism Insurance Resource Center at the University of Massachusetts, which helps families find coverage.

While the state hasn't released information about the cost of the mandates, Weinstock said premiums have not gone up much. The law allows insurers to opt out if premiums increase more than 1 percent, and that isn't happening, she said.

Brooke's parents said the sacrifices they made to find coverage were worth it. Before they came here, autism had put their only daughter into a "zombie mode" — she wouldn't even acknowledge them. Now, when they pick her up from the academy, she runs up to shower them with hugs and kisses.

"In the end, you have to do what you need to do for your child," Edwin Sharpe said. "Because no one is going to care for your child the way you are."

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SUBMIT

North Dakota families fighting for access to life-changing autism services

By Catherine Ross on Feb 16, 2017 at 11:01 p.m.



1 / 2

FARGO — Some are calling North Dakota one of the worst states in the country to live with autism.

One in 68 kids will be diagnosed the disorder and the state does not currently cover the primary treatment.

This week, legislation to mandate coverage failed in the North Dakota House on Tuesday, but received a re-vote and passed Wednesday. It now awaits its turn in the Senate.

Brody Mauch, 6, walks into a therapy room at the North Dakota Autism Center with a child-sized tool belt tied around his waist and plastic wrench in his fist.

"What seems to be the problem?" Brody playfully asks his therapist, Paige Davis.

"Look, my house is a disaster," Davis says, gesturing to a messy dollhouse. "Can you help me fix it?"

To Brody, it feels like playing pretend, but the games are actually specialized therapy called Applied Behavioral Analysis (ABA).

It's now the No. 1 prescribed method for working with someone on the autism spectrum.

1434
#2
3/6
pg. 11

h autism when he was a toddler.

His mother, Beth Mauch, says, "He would scream and scream, basically just not stop screaming."

He's now 6 years old and the ABA therapy is teaching him critical behavior skills.

Role-playing with two monster hand puppets, Davis uses a monster voice and directs him to find yellow and red laminated cards from a line of colors.

When he picks up the correct cards and feeds them to his monster hand, she says, "You found yellow and red! Do they taste good?"

Brody's mother says the therapy has improved his communication skills and behavior.

"He relaxes, we're able to all sit down at the dinner table," she says.

The Mauchs consider themselves lucky because their out-of-state health insurance covers the therapy.

But for many in North Dakota, an autism diagnosis is more than just a lifestyle change.

Recalling her son's prognosis from specialists, Mauch says, "They tell you you could either leave the state or make some huge life changes."

Forty-five other U.S. states require insurance companies to cover ABA therapy.

Sandy Smith from the North Dakota Autism Center says, "Unfortunately North Dakota was one of the five worst states to live in if you have a child with autism."

The services are available at places like the North Dakota Autism Center or the Anne Carlsen Center, but out-of-pocket, ABA alone can cost between \$30,000 to \$60,000.

The state offers autism vouchers, but there are only a few dozen up for grabs and the waiting list stretches almost five years.

Even on the waiver, Samantha Stewart's son used most of the funds for one potty-training class.

"It's not OK," Stewart says. "We need to have these things available to these children."

Christina McNeal moved from Valley City to West Fargo for specialized treatment.

Her 3-year-old son Lennon is on the waiver waiting list.

McNeal says, "The difference between having services and not having services is their level of functioning and ability when they're adults."

The McNeals have been considering another move out of state if North Dakota doesn't start covering ABA.

"We need it," McNeal says. "Why should we be one the last few people in the entire nation that are offered a medically necessary treatment for our children?"

Other families agree they can't wait much longer.

Stewart says, "If we don't act on this now, we're going to have a whole generation of kids that had the potential to reach independence and success and they simply didn't get what they needed."

WDAY reached out to North Dakota's primary insurance companies.

d to covering ABA unless the bill passes.

Blue Cross Blue Shield and Sanford both say they're working with doctors and patients to determine future benefits coverage.

**Catherine Ross**

Catherine joined the WDAY 6 News team as a reporter and photographer in April of 2014 and is honored to bring you stories from around the Red River Valley. She grew up in a suburb of Minneapolis and got her first taste of the news industry during a high school mentorship at Fox 9 in the Twin Cities. Catherine graduated from Emerson College in Boston where she participated in the student-run TV station WEBN and spent a semester in Washington, DC working at Voice of America. Those opportunities gave her a front-row seat to the 2012 Presidential election cycle, reporting at the Iowa Caucuses, Republican National Convention and President Obama's second inauguration. Now happy to be back closer to family, Catherine enjoys exploring the nature and culture of the upper Midwest. She's an avid runner, novice foodie and lifelong Twins fan. If you have any story ideas or just want to say hello, Catherine would love to hear from you!

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ADVERTISEMENT

1434
#2
3/6
Pg. 12

HB 1434
#3
3/6
Pg. 1

Terms of State Autism Reform Laws

State	Enacted	Annual Cap on Applied Behavior Analysis	Age cap
INDIANA	2001	None	None
SOUTH CAROLINA	2007	\$50K	16
TEXAS	2007	None: 0-10, \$36K: >10	None
ARIZONA	2008	\$50K: 0-8; \$25K: 9-16	16/17
FLORIDA	2008	\$36K	18
ILLINOIS	2008	\$36K	21
LOUISIANA	2008	\$36K	21
PENNSYLVANIA	2008	\$36K	21
COLORADO	2009	None	19
CONNECTICUT	2009	\$50K: 0-8 \$35K: 9-12 \$25K: 13-14	15
MONTANA	2009	\$50K: 0-8; \$20K: 9-18	18
NEVADA	2009	\$36K	18 (22 if school)
NEW JERSEY	2009	\$36K	21
NEW MEXICO	2009	\$36K	19 (22 if school)
WISCONSIN	2009	\$50K for 4 yrs; \$25K after	None
IOWA	2010	\$36K	21
KANSAS	2010	25 hours per week for 4 years from diagnosis then 10	
KENTUCKY	2010	\$50K: 0-7; \$1,000/mo: 7-21	1-21
MAINE	2010	\$36K	10
MASSACHUSETTS	2010	None	None
MISSOURI	2010	\$40K	19

1434
#3
3/6
Pg. 2

Terms of State Autism Reform Laws

State	Enacted	Annual Cap on Applied Behavior Analysis	Age cap
NEW HAMPSHIRE	2010	\$36 from 0-12/\$27 from 13-21	21
VERMONT	2010	None	21
ARKANSAS	2011	\$50K	18
CALIFORNIA	2011	No dollar cap	None
NEW YORK	2011	\$45K	None
RHODE ISLAND	2011	\$32K	15
VIRGINIA	2011	\$35K	10
WEST VIRGINIA	2011	\$30K for 3 yrs; \$24K thru 18	3-18
ALASKA	2012	None	21
DELAWARE	2012	\$36K	21
MICHIGAN	2012	\$50K: 0-6, \$40K: 7-12, \$30K: 13-18	19
MINNESOTA	2013	None	None
OREGON	2013	25 hours of ABA per week	9
MARYLAND	2014	25 hours of ABA per week through age 5, then 10	19
NEBRASKA	2014	25 hours of ABA per week	21
UTAH	2014	\$36k to age 9, \$18K to age 18	18
SOUTH DAKOTA	2015	\$36k to age 7, \$25K age 7-13, \$12.5K age 14-18	18
MISSISSIPPI	2015	25 hours of ABA per week	8
GEORGIA	2015	\$35K	None
HAWAII	2015	\$25K	14
NORTH CAROLINA	2015	\$40K	18

028-14

TESTIMONY IN SUPPORT OF HOUSE BILL 1434

INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

March 6, 2017

Ladies and Gentlemen of the Committee:

I am a ND Licensed Board Certified Behavior Analyst (BCBA). I have a bachelor's degree in Psychology and a master's degree in Applied Behavior Analysis and Autism. I have had the privilege of working with children with autism for 10 years. I have been employed at the North Dakota Autism Center for approximately 8 years where I work alongside highly trained behavior technicians and fellow Board Certified Behavior Analysts providing intensive interventions based on the field of ABA. Our team of professionals works daily providing evidence-based interventions to children and adolescents with autism, developmental disabilities, and other related disabilities and behavioral challenges.

Applied Behavior Analysis (ABA) is a discipline devoted to improving the behavior of people in real-world settings (clinics, schools, community, and industry) using evidence-based strategies derived from the field. In general terms, ABA is a field that is dedicated to helping individuals be successful in their everyday lives. When I refer to success, I am not referring to the general public's portrayal of success (money, raises, and promotions); I am referring to critical life changing skills. We are focused on teaching patients how to communicate when they are hungry, how to get a glass of water when they are thirsty, how to use the bathroom independently, how to respond to the directions of others (i.e. "Stop" "Hot" "Dangerous), how to communicate with others, and the list of skills goes on and on. Not only are we focused on teaching new skills, but we are also focused on reducing unwanted behavior(s) that can be detrimental to the patients. When I refer to unwanted behavior(s), I am referring to life altering behaviors such as reducing a patient's engagement in self-injurious behavior (i.e. a patient harming him/herself), physical aggression towards others, destruction of property, tantrums, and dangerous behaviors such as running away from caregivers or climbing on high surfaces.

In summary, the field of ABA teaches patients the skills that many people develop naturally and then take for granted on a daily basis. For example, the skills that you and I utilize every day that can seem so basic and routine such as taking a shower, getting dressed, brushing our teeth, problem solving, navigating social situations, practicing safety skills (i.e. crossing the street), using calming techniques to stay in control are the same skills that these incredible, hard-working patients may not develop "naturally" and have to work exceptionally hard to learn. Applied behavior analysis makes that possible.

Learning what the field of ABA is and what it does is only half the battle to understanding why making ABA services available is so critical to helping these individuals. The other half is learning ABA is a safe treatment that has scientifically been shown to be effective. The successful and effective use of ABA-based procedures to increase wanted behavior and decrease unwanted behavior has been documented across 40 years of extensive research and is well documented in scientific literature. Research showing that ABA-based procedures are empirically supported treatments can be found in both behavioral and non-behavioral journals. Thousands of studies utilizing different research designs have been published since the 1960s and the results of these studies can best be seen in the multiple review papers conducted on ABA-based interventions. For example, the *Journal of Pediatrics*, in a review of scientifically supported and unsupported interventions for childhood psychopathology concluded that: "*The most efficacious psychosocial treatment for autism is applied behavior analysis.*" (Lillienfeld, 2005,

1434
#4
3/6
pg. 2

p. 762) In addition, systematic evaluations of ABA-based procedures have been conducted based on standards put in place to determine if a particular intervention can be characterized as “empirically supported” or “established.” Multiple evaluations of ABA-based procedures have concluded that ABA interventions are “well established” or “evidence-based.” (Wong et al., 2013) Finally, in an overview and summary of scientific support for ABA, Hagopian and colleagues (2015) highlight the many scientific, government, and professional agencies that have concluded that ABA-based procedures represent best practice as a result of the overwhelming empirical evidence provided by the field of ABA:

- **Autism Speaks** states that “*ABA is widely recognized as a safe and effective treatment for autism*”; and “*Behavior analysis is a scientifically validated approach to understanding behavior and how it is affected by the environment.*”
- **The American Association on Intellectual and Developmental Disabilities** (formerly the American Association on Mental Retardation), the oldest and largest interdisciplinary organization of professionals concerned with intellectual disability and related disabilities, designated ABA-based procedures for the treatment of behavioral problems with individuals with intellectual disability and related disorders as “highly recommended” (Rush & Frances, 2000).
- **American Academy of Child and Adolescent Psychiatry** concluded: “*ABA techniques have been repeatedly shown to have efficacy for specific problem behaviors, and ABA has been found to be effective as applied to academic tasks, adaptive living skills, communication, social skills, and vocational skills*” (Volkmar et al., 2014).
- **Organization For Autism Research** (“The Best of the OARacle”; see page 10) stated that “...[ABA] is distinguished from other interventions because it has been proven effective in promoting skill development in persons with autism.”
- **National Autism Center’s National Standards Report** (2009) noted that behavioral interventions based on ABA were found to have an *established level of evidence* to support their use. Examples include behavioral packages, antecedent packages, comprehensive behavioral treatment for young children, modeling, schedules, pivotal response training, and self-management packages.
- **The Association for Science in Autism Treatment (ASAT)** found that “...ABA is effective in increasing behaviors and teaching new skills....ABA is effective in reducing problem behavior...and also indicates that, when implemented intensively (more than 20 hours per week) and early in life (beginning prior to the age of 4 years), ABA may produce large gains in development and reductions in the need for special services.”
- **The Centers for Disease Control** (see types of treatment) indicated that a “... notable treatment approach for people with an ASD is called applied behavior analysis (ABA). ABA has become widely accepted among health care professionals and is used in many schools and treatment clinics....”
- **The National Institute of Mental Health (NIMH)** noted that ABA has become widely recognized as an effective treatment for individuals with autism (see treatment options section).

1434
#4
3/6
Pg.3

- **The National Institute of Child Health and Human Development** stated that "... *applied behavior analysis (ABA), [is] a widely accepted approach that tracks a child's progress in improving his or her skills...* "
- **The Surgeon General of the United States** stated, "*Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior*" (1999).

My personal experience with this field and what these interventions are capable of are testimony to its effectiveness. At just 20 months old, a young boy was referred to me by his doctor as he was nonverbal and failing to meet his milestones. This patient had just received a diagnosis of autism, and his parents were motivated to get him the services he needed. Assessment of this patient revealed he was unable to engage in many of the expected skills for his age (request for wanted or needed items, follow the directions of others, label/name things in his environment, imitate the actions or sounds of others, or engage socially with peers or adults). Using evidence-based strategies derived from the field of ABA, a tailored intervention package was developed for this patient and was implemented 25 hours per week. At 46 months when this patient was reassessed, he had gained most of the skills of his current age matched peers. Today this patient is enrolled in a general education school and spends his day in the general education classroom and is no longer receiving ABA services.

In a similar example, a family of a 39-month-old boy requested an intake as their son was diagnosed with autism, and since both parents were medical doctors, they understood the importance of ABA and getting their child services. Before services started, this patient's assessment revealed high areas of skill deficits and engagement in barrier skills. After 3 years of receiving ABA services for 10 – 25 hours a week, the patient is now enrolled in a general education school where he spends his day in the general education classroom with his age matched peers and receives minimal support.

I have also seen firsthand the implementation of evidence based ABA-procedures teach an 8-year-old boy with a severe genetic disorder to be independent in the bathroom, eliminate the severe self-injurious behavior of head-banging in a 9-year-old, teach a nonverbal 6-year-old girl with a brain disorder how to communicate using pictures, a 14-year-old male how to independently engage in self-help skills and engage in numerous job skills in the home and community, and reduce the intense physical aggression of a 7-year-old girl to ensure her continued access to peers and family. These are only a few examples that highlight the effectiveness and significance of ABA services.

In closing, I would like to share with you a situation that I encounter far more frequently than necessary . A concerned parent calls the center and explains to me that their son or daughter is engaging in a serious behavior and is unable to engage in some of the most fundamental skills. The parent proceeds to tell me how hard it is to see their loved one struggle every day and how powerless they feel as parents, as they do not know what to do to help their child. They proceed to tell me that their doctor referred them to us, and they have read and researched all about the field of ABA and how it can help. I listen to the parent and think about all of the evidence-based procedures that I have seen time and time again be successful with the same information the parent is sharing with me. I hear the hope and the desperation in that parent's voice, but instead of being optimistic about the chance of being able to teach this child the skills he/she needs, I sit on the other end of the line dreading the next question I have to ask and silently hope that this family does not live in North Dakota or they have out of state insurance. I ask the parent, "What insurance do you have?", and undoubtedly have to spend the next part of the conversation explaining to this parent in desperate need that we have the evidence-based strategies that could be the

1434
#4
3/6
Pg. 4

answer to their problems, but unless they can pay out of pocket, I cannot help them because no North Dakota insurance companies cover ABA, the service that was prescribed by their doctor. Now, the family has to make the impossible decision of giving their child the opportunity to learn the skills that so many of us take for granted and potentially putting their family in financial ruin, watch their child struggle daily knowing they could be receiving help but are not financially capable, or move to one of the other 45 states where ABA coverage is available.

I strongly support House Bill 1434, Autism Insurance Reform for North Dakota Families and ask that you vote in support this legislation. Thank you for your time and consideration of this significant matter. If I can be of any assistance during this time of deliberation, please do not hesitate to contact me.

Sincerely,

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1434
#4
3/6
Pg. 5

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1434
#4
3/6
pg. 6

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1434
#4
3/6
Pg. 7

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1434
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3/6
pg. 8

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1434
#4
3/6
Pg. 9

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TESTIMONY IN SUPPORT OF HOUSE BILL 1434 - INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

Sandy Smith, Executive Director
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701-367-9855

Madam Chairwoman Lee and Senate Human Services Committee Members, my name is Sandy Smith. I am first the parent of a child with autism and the Executive Director of the North Dakota Autism Center Inc. (NDAC) and I am testifying in favor of House Bill 1434. My oldest daughter and I founded the NDAC in 2006 as a result of her brother, my son, Tyler being diagnosed with autism in 2004 when he was just twenty-two months old. The NDAC specializes in autism and is one of the largest providers of autism services in the state.

We founded the NDAC with the intention of being able to provide children early intervention using evidence based procedures of applied behavior analysis (ABA). However, over the nine years we have been in operation the number of children that have been able to receive ABA therapy is a very small fraction of the individuals served. This is because most families can't access it unless they have out of state insurance, Tricare insurance which is offered to active duty and retired military personnel, have parents that have the means to pay privately, were lucky enough to get on one of the forty-seven ND Autism Waivers or as of January 2017 have a parent who is a federal government employee. Instead, the NDAC is completely overwhelmed with work because of the downstream effects of children not receiving the behavioral interventions and the ABA therapy they need. The deficits in social, emotional and communication skills, problems with repetitive behaviors, the different ways of learning, paying attention or reacting often lead children with autism to develop very challenging behaviors such as physical aggression towards family members, peers and school staff, destruction of property, tantrums, and dangerous behaviors affecting their safety. These challenges follow them to daycare, preschool, all the way through high school and into adulthood. Without intervention the challenges become bigger every step of the way and the cost to families, school districts and tax payers just continues to grow.

The state is already experiencing the growing costs and with the state budget challenges it is time for North Dakota to join the forty-five other states in the nation who passed meaningful autism insurance reform. In 2016, the NDAC was paid approximately \$1.4 million by taxpayers of North Dakota to provide services through the ND Developmental Disabilities Home and Community Based Waiver, School Districts and the ND Autism Waiver and Voucher Program. Unfortunately, less than \$200,000 of that was for providing one on one ABA therapy through the ND Autism Waiver. Much of the remaining \$1.2 million was for providing services to families and school districts that are faced with the challenges of trying to raise and educate children with autism who have had no or very little intervention. This bill would provide access to ABA therapy that would reduce the burden on ND taxpayers by requiring ND insurance companies to provide ABA therapy benefits. In addition, it will improve outcomes, improve quality of life and reduce the amount of support individuals with autism will need later in life.

I also want to call to your attention another significant issue that will put even more pressure on the state budget and ND tax payers. In July 2014 the Centers for Medicare & Medicaid Services (CMS) released federal guidance for states on Medicaid coverage of therapies for autism, and that guidance indicates states are expected to adhere to long-standing EPSDT (Early and Periodic Screening, Diagnostic and Treatment Benefit) obligations for individuals from birth to age 21, including providing medically necessary services available for the treatment of autism. Applied behavior analysis is a medically necessary therapy and is being prescribed by medical professionals across the state. North Dakota is currently not in compliance with this federal guidance. However, the ND Department of Human Services has drafted and submitted a State Plan Amendment to CMS

HB 1434
5
3/6
Pg. 1

in June 2016. I have included a copy in my testimony. The anticipated implementation date was November 2016. It is not implemented today but it is only a matter of time because families are being denied services and are already filing claims with ND Protection & Advocacy. What this means is that any individual with autism under age 21 who qualifies for Medicaid either because of income or because they are on the ND Autism Waiver or the ND Developmental Disabilities Waiver should be receiving this medically necessary therapy.

I believe the impact this will have on the state budget is significant enough to put language back into HB1434 to exempt this bill from North Dakota Century Code section 54-03-28 which requires health insurance mandates be limited to the public employee health insurance program (PERS) for two years before being offered to the general public.

The group of advocates that spearheaded this bill have worked tirelessly since July. We and the legislators that have introduced and sponsored this bill know no legislation is perfect. We are very open to amendments and have had legislative counsel draft some possible amendments for you to consider.

The group of advocates is also firm in its conviction to ensure that all North Dakota insurance companies include ABA therapy in their policies. Without this bill there is no guarantee that any ND insurance company will offer this benefit whether legislators are being told in one on one conversations with insurance lobbyists or not. Even if they do offer something there is no guarantee they will offer adequate coverage and could decide after a year to significantly reduce the benefit or even end it. After hearing House Representatives state during the House debate that BCBS had told them they were planning to offer better coverage than stated in the bill starting January 2018, a group of advocates met with BCBS executives on Tuesday, February 28, 2017 in Fargo. Advocates in attendance were myself, Beth Mauch, Kirsten Sharbano and Judith Ursitti from Autism Speaks. BCBS attendees were Jacquelyn Walsh, Dr. Lisa Faust, Pam Gulleeson and Megan Houn. Barb Stanton of Prairie St. Johns also attended. We expressed our willingness to work with BCBS and Barb Stanton to make changes to the bill to ensure all their concerns were addressed. Our intention is not to interfere or exclude any providers currently providing services for children and adults with autism. We asked what the BCBS plan would look like and if they could confirm the implementation date of January 2018. They said they were "hoping" to mirror the Federal Employee Plan but would not commit to any specifics or give a definitive "Yes" that they would begin coverage in January 2018. When asked about House Representatives stating on the record that BCBS told them they were starting coverage in January 2018 there was some discussion but no admission from BCBS that anyone had told Representatives that. When asked if they would go ahead on January 2018 with their planned coverage whether the bill passed or not, Pam Gulleeson stated, "If the bill passes we will follow the law. It is our policy to follow the law". There is absolutely no reason except an internal policy that would stop them from going ahead with their planned coverage in January 2018.

Families of children and adults with autism have been waiting a very long time for ND insurance companies to do the right thing and include this medically necessary therapy in their plans. The state of ND cannot continue to bear the costs alone. I urge you to do what it takes to pass HB1434 and get it implemented as soon as possible. I sincerely thank you for your time today.

13(c). Preventive Services

(2) Services to Treat Autism Spectrum Disorders Pursuant to EPSDT

A. Service Description

General Description. Services to treat autism spectrum disorders (ASD) pursuant to EPSDT are provided only to Medicaid beneficiaries (defined below as individual or individuals) under age twenty-one. Pursuant to 42 C.F.R. § 440.130(c), these services are provided as preventive services and are recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency.

If the Level of Support Determination is signed by a qualified practitioner and recommends services consistent with a requested comprehensive diagnosis to pursue development of the behavioral plan of care or ASD treatment services, as applicable, then such evaluation report is the licensed practitioner's recommendation of the services pursuant to 42 C.F.R. § 440.130(c).

1. Screenings Prior to Receiving ASD Treatment Services. These screenings are covered under the Physician Services, Other Licensed Practitioner, or Clinic benefit category, as applicable.

Service	Service Description	Qualified Practitioners
Medical Screening	A review of the individual's overall medical and physical health, hearing, speech, and vision, including relevant information and must include an ASD screening tool as approved by the state agency. The screening is also designed to rule out medical or behavioral conditions other than ASD, including those that may have behavioral implications and/or may co-occur with ASD.	Medical Doctor (MD, OD)
		Physician's Assistant (PA)
		Nurse Practitioner (NP) or
		Advanced Practice Registered Nurse (APRN)

The individual must receive a Medical Screening Evaluation indicating the possibility of an ASD before receiving a comprehensive Autism Diagnostic Evaluation, behavior assessment, or ASD treatment services including development of a behavioral plan of care.

1434
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13(c). Preventive Services
Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

2. Autism Diagnostic Evaluation:

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Tools Required
Autism Spectrum Disorders Diagnostic Evaluation	<p>Purpose: Determine ASD diagnosis and medical necessity of services</p> <ul style="list-style-type: none"> Collaborate with the family to determine the professionals best suited for the child's Evaluation and Diagnostic Team (EDT). The Evaluation and Diagnostic Team (EDT) will conduct a coordinated multidisciplinary assessment using multiple tools to evaluate and diagnose (or confirm the diagnosis of) ASD. The evaluation will incorporate relevant medical information and identify the child's strengths, needs, interests, and challenges as related to the child's daily routines. Evaluations will also include an environmental assessment in order to determine interventions, supports, and resources that are appropriate for the child, as well as his or her family. 	<p><u>Clinical Oversight</u> (The individual's primary care provider OR one of the following to Administer Diagnostic Evaluation - Required)</p> <ul style="list-style-type: none"> Licensed Psychologist (PhD, PsyD, EDD) Clinical Psychiatrist (MD) Pediatrician (MD) Licensed Independent Clinical Social Workers (LICSW) Psychiatric Clinical Nurse Specialist (CNS) Psychiatric Nurse Practitioner (NP) <p><u>Speech-Language Pathologist</u> (Required)</p> <ul style="list-style-type: none"> Speech and Language Pathology - Certificate of Clinical Competence (SLP-CCC) Speech and Language Pathology with Audiology Specialty (A-SLP-CCC) <p><u>Occupational Therapist (OT)</u> (Required if no PT)</p> <ul style="list-style-type: none"> Licensed Occupational Therapist (OTRL) Certified Occupational Therapy Assistant (COTA) <ul style="list-style-type: none"> Licensed Occupational Therapist (OT) supervision required 	<ul style="list-style-type: none"> ADOS-2 (for determining ASD) Vineland II (Behavior Assessment Tool for determining Medical Necessity)

13(c). Preventive Services

Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Tools Required
	<ul style="list-style-type: none"> The Evaluation and Diagnostic Team (EDT) will produce a collaborative report based upon findings of the initial evaluation including a Level of Support determination form (Attachment A). 	<u>Licensed Physical Therapist (PT) (Required if no OT)</u> <ul style="list-style-type: none"> Licensed Physical Therapist (PT) Licensed Physical Therapist Aide (PTA) <ul style="list-style-type: none"> Licensed Physical Therapist (PT) supervision required 	
		Additional practitioners may incorporated, as determined by the clinical oversight, as optional additions to a diagnostic team in the event that other possible disorders or conditions must be ruled out to successfully diagnose Autism	

The individual must receive a Medical Screening Evaluation and an Autism Diagnostic Evaluation determining medical necessity before receiving ASD treatment services.

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pg. 6

13(c). Preventive Services

Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

B. Service Components

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Care Plan Tools Allowed	Practices Required
Behavioral Program Design and Monitoring (BPDM)	<p>The BPDM is:</p> <ul style="list-style-type: none"> Behavior Assessment; a clinical compilation of observational data, behavior rating scales, and reports from various sources (<i>e.g.</i>, schools, family, pediatricians, and other sources) designed to identify the individual's current strengths and needs across developmental and behavioral domains Development of a Care Plan including the following: <ul style="list-style-type: none"> measurable goals and expected outcomes to determine if ASD treatment services are effective; specific description of the recommended amount, type, 	<p>Behavioral Interventionist</p> <ul style="list-style-type: none"> Board Certified Behavior Analyst-Doctoral (BCBA-D) Board Certified Behavior Analyst (BCBA) Registered Behavior Analyst (RBA) <ul style="list-style-type: none"> <u>RBA oversight required:</u> <ul style="list-style-type: none"> BCBA-D, BCBA, Licensed Psychologist (PhD, PsyD, EDD) Licensed Psychologist (PhD, PsyD, EDD) Social Worker <ul style="list-style-type: none"> Licensed Clinical Social Worker (LCSW) Licensed Independent Clinical Social Worker (LICSW) 	<ul style="list-style-type: none"> Essentials for Living The Assessment of Basic Language and Learning Skills - Revised (ABLLS-R) CARD assessment Individualized Goal Selection Curriculum VB-MAPP: Verbal Behavior Milestones Assessment and Placement Program Social Skills Solutions: A Hands-On Manual Autism Spectrum Rating Scale 	<p>Evidence-based practices based upon national standards set by the Autism Evidence-Based Practice Review Group, University of North Carolina at Chapel Hill.</p>

13(c). Preventive Services

Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Care Plan Tools Allowed	Practices Required
	<p>frequency, setting and duration of ASD treatment services;</p> <ul style="list-style-type: none"> Amount and type of caregiver (defined below) ongoing participation in the ASD treatment services necessary to maximize the success of the services. Trains and oversees the Skills Trainers who work directly with the participant on implementing their specific training plan protocol. The formal Care Plan is written in accordance with the objectives specified in the individual's Participant Service Plan. Meet with the participant's Skills Trainer and the parents at least monthly for the purpose 		<ul style="list-style-type: none"> Gilliam Asperger Disorder Scale Social Communication Questionnaire Wechsler Intelligence Scale for Children Stanford Binet Wechsler Individual Achievement Test II Yale Brown Obsessive Compulsive Scale Peabody Individual Achievement Test Kaufman Brief Intelligence Test 2 Revised Children's Manifest Anxiety Scale 2 	

13(c). Preventive Services
Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Care Plan Tools Allowed	Practices Required
	of reviewing progress on the formal training objectives and reviewing the need for changes in the formal Care Plan.		<ul style="list-style-type: none"> Children's Depression Inventory UCLA Post Traumatic Stress Disorder RI AFLS®- The Assessment of Functional Living Skills 	
Skills Training (ST)	<ul style="list-style-type: none"> The Skills Training (ST) professional will train the parent(s) on implementing interventions across multiple settings as long as it is for the direct benefit of the child. ST provides hands-on training, to parents and others, as needed, for the direct benefit of the child, using evidence-based behavioral intervention methods as directed by the Behavioral Program Design and Monitoring Professionals. 	<p>Practitioners providing Skills Training (ST) services that are not enrolled with ND Medicaid to provide Behavioral Program Design and Monitoring (BPDM) services must be under the supervision of a practitioner that is enrolled to provide BPDM and will follow the specific training protocols developed in the Care Plan.</p> <p>Behavioral Analyst</p> <ul style="list-style-type: none"> Board Certified Behavior Analyst - Doctoral (BCBA-D) Board Certified Behavior Analyst 	N/A	Evidence-based practices based upon national standards set by the Autism Evidence-Based Practice Review Group, University of North Carolina at Chapel Hill.

13(c). Preventive Services
Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Care Plan Tools Allowed	Practices Required
	<ul style="list-style-type: none"> ST may also provide general assistance and support on interventions to individuals who provide unpaid support, training, companionship or supervision to participants. ST professionals will meet with the participant's Behavioral Program Design and Monitoring Professional and the parents at least monthly for the purpose of reviewing progress on the formal training objectives and reviewing the need for changes in the Care Plan. 	(BCBA) <ul style="list-style-type: none"> Registered Behavior Analyst(RBA) Registered Behavior Technician (RBT) Psychology <ul style="list-style-type: none"> Licensed Psychologist (PhD, PsyD, EDD) Licensed Professional Clinical Counselor (LPCC) Licensed Professional Counselor (LPC) Psychiatric Triage Therapist Licensed Marriage and Family Therapist (LMFT) General psychology degree (BA, BS) Nursing <ul style="list-style-type: none"> Psychiatric Clinical Nurse Specialist (CNS) Registered Nurse (RN) Licensed Practical Nurse (LPN) Psychiatric Nurse Practitioner (NP) Social Worker		

1434
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3/6
pg. 9

1434
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3/6
pg. 10

13(c). Preventive Services
Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Care Plan Tools Allowed	Practices Required
		<ul style="list-style-type: none"> Licensed Independent Clinical Social Worker (LICSW) Licensed Clinical Social Worker (LCSW) Licensed Social Worker (LSW) Masters in Social Work (MSW) Occupational Therapy <ul style="list-style-type: none"> Licensed Occupational Therapist (OTRL) Certified Occupational Therapy Assistant (COTA) Physical Therapist <ul style="list-style-type: none"> Licensed Physical Therapist (PT) Licensed Physical Therapist Aide (PTA) Speech-Language Pathologist <ul style="list-style-type: none"> Speech and Language Pathology - Certificate of Clinical Competence (SLP-CCC) Speech and Language Pathology with Audiology Specialty (A-SLP-CCC) Education <ul style="list-style-type: none"> Special Education 		

13(c). Preventive Services
Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

Service	Service Description	Qualified Practitioners including Credential/ Licensure and Required Supervision (if applicable)	Care Plan Tools Allowed	Practices Required
		<ul style="list-style-type: none"> • Elementary Education • Secondary Education • Early Childhood Development 		

ASD Services Framework

1. Care plan goals will be outcome based and progress toward goals will be monitored by training data. ASD Preventative Services seek to develop, maintain or restore skills and functioning in all areas (including):
 - a. Social Skills, and related skills to enhance participation across all environments (school, home and community settings) and relationships, including imitation, initiation of social interactions with both adults and peers, reciprocal exchanges, parallel and interactive play with peers and siblings;
 - b. A functional communication system which may include expressive verbal language, receptive language and nonverbal communication skills and augmentative communication;
 - c. Increased engagement and flexibility in the exhibition of developmentally appropriate behaviors, including: play behavior, attending behavior, responding to environmental cues (including cues from the training staff and others) and cooperation with instructions;
 - d. Replacement of inappropriate behaviors with more conventional and functional behaviors;
 - e. Working with caregivers and others in the environment to promote the participant's competence and positive behavior;
 - f. Fine and gross motor skills used for age-appropriate, functional activities, as needed;
 - g. Cognitive skills related to play activity and academic skills;
 - h. Adaptive behavior and self-care skills to enable the participant to become more independent and/or;

1434
#5
3/6
pg. 1

13(c). Preventive Services

Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

- i. Independent exhibition of organizational skills including completing a task independently, asking for help, giving instructions to peers and following instructions from peers, following routines, self-monitoring and sequencing behavior.
2. Participation by Caregiver in ASD Treatment Services: Over half of all interventions must involve the primary caregiver to ensure generalization of skills
3. Presence / Availability of Caregiver: A caregiver shall be present or available at all times in or around the home when services are being provided in the home. For services provided outside of the home, a caregiver shall be present or available as necessary based on the ASD treatment services provider's clinical judgment.
4. Supervision of Skills Trainers. Skills Trainers requiring supervision by a qualified provider (described above). Such supervision must:
 - a. Be with the supervising provider and documented on an ongoing basis.
 - b. Be at least ten percent of the amount of hours that the Skills Trainer is providing ASD treatment services to each individual.

C. Limitations

1. Total ASD treatment services under this authority may only be the amount medically necessary for each individual as determined by the Vineland II scores. These limits may be exceeded due to medical necessity.
2. The department shall not pay for program services or components of services that:
 - a. Are of an unproven, experimental, cosmetic or research nature.
 - b. Do not relate to the individual's diagnosis, symptoms, functional limitations or medical history.
 - c. Are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms.
 - d. Are solely educational, vocational, recreational, or social.

13(c). Preventive Services

Services to Treat Autism Spectrum Disorders Pursuant to EPSDT (continued)

- e. Are not coverable within the preventive services benefit category, such as respite care, child care, or other custodial services
- f. Duplicate other State Plan Services.

D. Teletherapy

- a. Nothing in this state plan is intended to prohibit or restrict the use of telehealth services to deliver services under this amendment.

E. Free Choice of Provider

Individuals eligible to receive ASD services described in this section have a free choice of any available provider qualified to perform the services. Providers must be enrolled as a Medicaid provider.

Good morning Chairperson Lee and members of the committee.

My name Catherine Yeager and I am clinical psychologist and co-owner of Assessment and Therapy Associates of Grand Forks. I have been licensed in North Dakota since 2002 and I specialize in the diagnosis and management of autism spectrum disorders.

Autism has historically been characterized as a static, lifelong condition; however, studies beginning in the 1980s strongly suggest that autism is a treatable disorder and that significant reduction in symptom expression is very possible with appropriate treatment. In addition, "normalization" of overall behavior to the extent that diagnostic criteria for autism are no longer met and the child can function independently is also possible with early intensive behavioral intervention, also known as Applied Behavior Analysis or ABA. Along with reducing impairment, use of this therapy can also offset, or in some cases negate, the potentially enormous costs of future social and financial assistance required by these children as they become adults. Although initially expensive, assuming an investment of \$33,000 per year for three years, research suggests that the average lifetime *savings* of providing intensive, high-quality ABA for a very young child with autism ranges from \$1.6 to \$2.8 million dollars. This savings is largely to the state programs that typically provide funds for services, care, and housing for adults with disabilities.

Despite these facts, which have been well-known in the national and international autism community for decades, no North Dakota-based insurance company currently covers this therapy. They have suggested as recently as a few years ago that ABA is "experimental," when in fact it is a well-established treatment for autism with studies demonstrating moderate to large treatment effects dating back to 1987. I have heard it said that it is a questionable treatment because it does not help all children, but the reality is that no treatment is perfect – for example, chemotherapy does not cure all cancers – and this is simply not an appropriate metric by which to judge a treatment. Science tells us that this is by far the best treatment we have for autism, a fact that has been echoed by the Surgeon General of the United States, the American Academy of Child and Adolescent Psychiatry, the National Institute of Mental Health, the Federal Agency for Healthcare Research and Quality, Center for Medicaid and Medicare Services, the American Academy of Pediatrics, and the American Psychological Association to name only a few.

North Dakota has shown clear dedication to our individuals with autism and as a result, we have programs that make early identification of autism spectrum disorders possible. We have also begun to individually license ABA providers so that they are available to provide treatment without redundant supervision. Despite these efforts, most children with autism in North Dakota still do not receive what is most important - empirically-validated treatment. Although ABA is available to children who receive funds through North Dakota's Autism Waiver, this program is full and the waiting list estimated to be several years long. Because North Dakota insurance companies do not cover autism treatment, parents of children with autism are often left to either allow their child to go without treatment, pay for therapy themselves, or move to another state where

1434
#6
3/6
Pg 2

treatment is mandated. I have seen all of these scenarios play out in my practice, but most often, children simply do not receive treatment.

I believe that all involved in the care of kids with autism believe that this is unacceptable and would like to see treatment offered as a part of medical insurance; however, many question whether this coverage should be or needs to be mandated. This may be related to the fact that reportedly, Blue Cross Blue Shield of North Dakota recently indicated that they intend to provide a comprehensive treatment package for children with autism without such a mandate. If accurate, this is, of course, a very welcome development. However, at this point this seems to be no more than a rumor - there has been no confirmation of this by any specific individual at BCBS, there is no contact person, and no specific plan. BCBSND has developed a written policy for ABA that can be found on their website; however, this policy is stated to apply to federal employees only.

More importantly, if it is indeed BCBS's intent to eventually broaden ABA coverage to include all subscribers, there is simply nothing in this bill that would prevent them from doing that - the bill actually states "this section does not limit benefits that are otherwise available to an insured under a health insurance policy." As such, assuming their plan meets the minimum requirements, BCBS is free to proceed with their plan regardless of the status of this bill. In fact, doing so prior to the implementation of a mandate would simply prove their dedication to treating children with autism. However, not all children are insured by BCBSND and even those who are now may be subject to insurance changes down the road - at the beginning of each year as many as a third of patients who receive services in our clinic have changes in their insurance providers even with stable employment. This mandate would ensure that all children in the state can access ABA therapy and that services are not interrupted when insurance plans change. Early treatment would also very likely improve the functioning of children with autism over the course of their lives, reducing the need for services and funding by the state in adulthood.

More detailed information is provided in my handout for anyone who is interested and I am happy to take any questions.

1934
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3/6
Pg 3

TREATMENT FOR AUTISM IN NORTH DAKOTA

Prepared by Catherine Yeager, PhD
Assessment and Therapy Associates of Grand Forks, PLLC

I. DESCRIPTION OF AUTISM

Autism is a developmental syndrome characterized by a specific set of problems and symptoms which typically become apparent during the toddler years. Early signs of autism may include atypicalities in behavior as well as problems in the development of language, social relatedness, and play skills. Specific symptoms of autism often include delayed or absent language, or, if language is present, the child may demonstrate abnormal language usage (i.e., a child with autism may "echo" what is said to him but be unable to ask or answer questions or respond to his name). Socially, children with autism are often disinterested in those around them or may even be unaware of the presence of others. Because their ability to relate with others is markedly impaired, children with autism demonstrate limited use of gestures (i.e., pointing, waving), imitation skills, and eye contact. Children with autism may also lack the capacity to form bonds with their parents and other caregivers and may dislike physical affection. Play skills are significantly impaired and play is often "sensory" as opposed to symbolic or imaginary in nature (e.g., a child with autism may prefer to line up play cars or spin their wheels as opposed than playing with them in a typical fashion). Children with autism also often demonstrate odd, stereotypical and/or self-stimulatory behaviors such as "hand flapping," jumping, spinning, and toe-walking (APA, 2013).

Many children with autism appear to have limited cognitive potential and most are assumed to have some degree of mental retardation. However, given the above described developmental problems, thorough intellectual assessment a child with autism is difficult and results may have limited validity. That said, given the extent of the developmental problems present, without treatment most children with autism function in a similar manner to children with mild to moderate mental impairments and require extensive services and support throughout the lifespan.

II. INCIDENCE AND COST OF CARE

Autism is increasingly common. In the 1970s the prevalence of the full spectrum of autistic disorders was approximately 5 to 10 per 10,000 births. Currently data from the CDC suggest that 1 in 68 children has an autism spectrum disorder. In North Dakota the prevalence of autism spectrum disorders is also increasing whereas the incidence of other developmental disabilities remains stable (Hollenbeck, 2004).

As mentioned above, without early autism-specific intervention, most children with autism require lifelong care. The lifetime per capita cost of autism is estimated to be \$3.2 million or \$35 billion for an entire birth cohort of individuals with autism. Assuming a child with autism continues to be impaired throughout his lifespan, care in adulthood is the largest of all lifetime costs, costing approximately five times more than care in childhood (Ganz, 2007).

III. SCIENTIFICALLY VALID TREATMENT OTIONS FOR AUTISM

Although autism has historically been characterized as a static, lifelong condition, studies beginning in the 1980s strongly suggest that autism is a treatable disorder and that significant reduction in symptom expression and is very possible with appropriate treatment. In addition, "normalization" of overall behavior to the extent that diagnostic criteria for autism are no longer met and the child can function independently is also possible with intensive behavioral treatment (Lovaas, 1987).

Currently, the most efficacious treatments for autism have their roots in Applied Behavior Analysis (ABA) theory (often also referred to as Early Intensive Behavioral Intervention). ABA-based treatments emphasize skill development through repeated positive reinforcement of desired behaviors and should

1434
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3/6
B4

begin immediately after diagnosis. Treatment begins with an assessment of the individual child's current skill set and deficits and is customized with regard to teaching methods, pace, skill sequences, and reinforcers. Problems in all skill domains (i.e., language, play, social skills, behavior) are addressed systematically and close monitoring is required to ensure appropriate progress. Direction and supervision of such programs is provided by a psychologist or another highly trained individual with extensive experience in behavior analysis (Guralnick, 1998). Ideally treatment is intensive (i.e., 25-40 hours per week) and therefore several therapists or "trainers" (who are supervised by the behavior analyst or psychologist) are required to provide daily treatment.

Although sometimes considered to be "experimental" or unproven by insurance companies, the fact is that ABA-based therapies are nationally and internationally regarded as effective treatments for autism spectrum disorders. In fact, the first study of ABA-based therapies suggested that 47% of children with autism receiving intensive ABA for several years beginning in preschool were able to function independently in the classroom setting by kindergarten. Additionally, these children's intellectual skills increased from the range of moderate mental retardation to the average range with intensive treatment over a two to three year period. Another 40% of the children in this initial study made substantial gains but continued to require some special education, and only 10% of the children in this study continued to be significantly impaired after intensive ABA therapy (Lovaas, 1987). Many studies have replicated these findings (Anderson, et al., 1987; Birnbrauer & Leach, 1993; McEachin, Smith, & Lovaas, 1993; Sallows & Graupner, 2005), and as such, there is little doubt that ABA can significantly improve functioning and decrease the need for specialized services later in childhood and adult life.

Lastly, although it is certainly true that not every child will respond to this therapy, this fact should not be used as a means by which to deny ABA to all children with autism. We do not deny treatment to children afflicted with cancer because of variable treatment responses, and we should not deny ABA to children with autism because some will benefit less than others. The fact remains that ABA is an established treatment for autism and recommended by the Surgeon General of the United States, the American Academy of Child and Adolescent Psychiatry, the National Institute of Mental Health, the Federal Agency for Healthcare Research and Quality, Center for Medicaid and Medicare Services, the American Academy of Pediatrics, and the American Psychological Association (Terdal, 2013).

IV. COST AND IMPACT OF TREATMENT

The cost of intensive ABA-based treatment programs typically range from \$25,000 to \$50,000 per child annually with treatment typically spanning a two to four year period beginning at the time of identification.

Assuming an initial investment of \$100,000 (i.e., \$33,000 per year for three years), research suggests that the average lifetime *savings* of providing intensive, high-quality ABA for a very young child with autism ranges from \$1,686,061 to \$2,816,535, depending on the effectiveness of ABA on the child's level of functioning (Jacobson et al., 1998).

V. CURRENT SERVICES FOR AUTISM IN NORTH DAKOTA

North Dakota provides free, in-home developmental screening of infants and young children through the Right Tracks program. Other systems, such as the Infant Development program, also make early identification of autism spectrum disorders possible in North Dakota. However, once identified securing treatment, which should begin immediately to have maximum impact, is extremely difficult.

Although autism specific treatments, such as ABA, are available to children who receive funds through North Dakota's Autism Waiver, this program is full and the waiting list estimated to be several years long. Because North Dakota insurance companies do not provide reimbursement for autism treatment, parents of children with autism must pay for therapy themselves. Because this is often not financially feasible, most children simply go without treatment.

1434
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Pg. 5

I believe that all involved in the care of kids with autism believe that this is unacceptable and would like to see treatment offered as a part of medical insurance; however, many question whether this coverage should be or needs to be mandated. This may be related to the fact that reportedly, Blue Cross Blue Shield of North Dakota recently indicated that they intend to provide a comprehensive treatment package for children with autism without a mandate. If accurate, this is, of course, a very welcome development. However, at this point this seems to be no more than a rumor and there has been no confirmation of this by any individual at BCBS, there is no contact person, and no specific plan. BCBSND has developed a written policy for ABA that can be found on their website; however, this policy is stated to apply to federal employees only.

More importantly, if it is indeed BCBS's intent to eventually broaden ABA coverage to include all subscribers, there is simply nothing in this bill that would prevent them from doing that - the bill actually states "this section does not limit benefits that are otherwise available to an insured under a health insurance policy." As such, assuming their plan meets the minimum requirements, BCBS is free to proceed with their plan regardless of the status of this bill. In fact, doing so prior to the implementation of a mandate would simply prove their dedication to treating children with autism. However, not all children are insured by BCBSND and even those who are now may be subject to insurance changes down the road. This mandate would ensure that all children in the state can access ABA therapy and that services are not interrupted when insurance plans change.

VI. CONCLUSION

Autism is a potentially debilitating and lifelong disorder; however, ameliorative therapies are available. Although the initial investment in ABA for children with autism may appear large, providing treatment for these children is not only the ethically-sound course of action, but it could also offset, or in some cases negate, the potentially enormous costs of future social and financial assistance required by these children as they become adults. Investing in treatment for children with autism through insurance mandates requiring reimbursement for such treatment is likely to be extremely beneficial not only for children with autism and their families, but also for the various service agencies charged with the care of the disabled over the lifespan. Ultimately, the most expensive option is to continue to fail to provide ABA-based treatment for children with autism.

1994
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Pg. 6

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My name is Charlie Kern. I have had autism since I was 2 years old. I am now 15 and in 9th grade in Grafton.

I am standing here talking to you because I got better.

One of the reasons I got better is ABA therapy.

A few things ABA has done for me:

I can talk.

We are worried that if more kids can't get ABA, they won't talk like me.

I can deal with changes in my schedule without losing my cool. Like today. I'm missing school. I'm in a new place. I'm wearing a tie around my neck, and I'm **not** losing my cool.

Losing your cool makes everything really hard. We are worried that if more kids don't get ABA, they won't keep their cool.

I have relationships. I know people. And people know me.

Autism is tough. Without ABA, it's even tougher.



HB 1434
8
3/6
Pg. 1

HB 1434 Testimony
Shannon Alexander, Ph.D.
3/6/17

Hello. Thank you for the opportunity to speak with you about the topic of health insurance reform as it pertains to services for individuals on the autism spectrum. This is of vital importance to many children and families in our state and an issue that is a personal passion.

My name is Dr. Shannon Alexander. I am a practicing psychologist in the state of North Dakota, working with the most severely mentally ill and behaviorally challenged individuals in the public sector.

I am in the unique position of being a psychologist with specialized training in applied behavior analysis as well as being a mother to a child on the spectrum. The combination of my training as a scientist and clinician and my family situation has provided me with an unusual perspective. I have been afforded the opportunity to experience what it is like to sit "on the other side of the desk", to see what this is like as a family member. Researching options, making hundreds of phone calls, going to the innumerable appointments and evaluations, fighting for your child's needed services, and being repeatedly turned down or denied. Being told over and over, that, yes, he requires services but there is simply no funding source available. Over the past 2 years, I have spent a tremendous amount of time fighting to get my son the services he requires. There has been a great deal of frustration and tears knowing that my son could be benefitting from applied behavior analysis. Knowing that there was a treatment available but not being able to access it. No one expects to have a child with special needs and there is no way of being able to financially or emotionally prepare for it ahead of time.

My son, Trey, was diagnosed with moderate-severe autism shortly after his third birthday, although, in hindsight, there were clear indicators by 18 months. Our family life revolves around Trey and his needs. There is no such thing as a simple task when it is new or unexpected. Every day is planned out in advance. Something as simple as driving into the daycare parking lot from the east rather than the west is sufficiently overwhelming to result in a meltdown. It takes multiple specially trained caregivers to assist us throughout the day. Trey is now 5 ½ years old. He will be going into kindergarten this fall. He is essentially non-verbal, being able to communicate in 1-2 word sentences. He continues to need diapers as he is not toilet trained. He demonstrates echolalia (repeating words), has limited interests, and little interest in interacting with others. He eats approximately 5 food items and requires therapy to address his dietary issues. He becomes overwhelmed easily, which results in frequent meltdowns that can include self-injury, aggression, and destruction of property. He has no sense of danger, is known to bolt away from caregivers, and is attracted to water. I have accrued \$18,000 worth of debt while attempting to cover his medically necessary treatments on my own. I work 65-70

hours per week in order to cover his many expenses and his past medical bills.

In the course of pursuing my education, I lived in Arkansas, California, and Texas. I made the decision to return to North Dakota to raise my children due to family support, low crime, and good neighbors. As you are aware, North Dakota is far behind almost every other state in mandating insurance coverage for medically necessary treatments for autism. I have been repeatedly instructed to relocate out-of-state in order to get my child the services he needs; that the state of North Dakota makes it impossible to raise a child on the spectrum here due to limited waiver slots and an unwillingness to mandate that insurance companies cover services. I grew up on a family farm by Carrington. North Dakota is what me and my children know. I refuse to believe that the citizens of North Dakota would be okay with this situation in which insurance companies have been allowed to avoid their responsibility to cover medically necessary services for developmentally disabled children.

There are multiple treatments that have been demonstrated empirically to improve functioning among individuals with autism, one of these being applied behavior analysis. There is an abundance of empirical support for applied behavior analysis providing moderate to large positive outcomes in areas such as intellectual functioning, language development, acquisition of daily living skills and social functioning among children on the spectrum (Virues-Ortega, 2010; Neeley et al., 2016; Debodinance et al., 2017). It is my firm belief that any treatment that has the support of the professional community, as a result of passing the rigors of peer reviewed research, should be covered by insurance companies. It should be the domain of the experts, the treating providers, to make the determination of what treatment approach will be most effective in treating this particular patient. Within the autism label, there is a wide variety of presentations within autism spectrum disorder (Roane, Fisher, & Carr, 2016) and the provider needs the flexibility to tailor the treatment program to that specific individual's needs. This should not be dictated by the legislature or be solely a business decision from an insurance companies. Applied behavior analysis is simply outside the scope of being financially feasible for the majority of families, including my own. It is difficult to accept that my son would likely be functioning at a higher level if I had been able to afford the 30-40 hours of ABA therapy per week that research supports as being most effective.

I understand that BCBS-ND has expressed a willingness to now voluntarily cover these services. I have serious reservations regarding this proposal. As a state employee, my family is covered under the Sanford plan. There are many children who would continue to not be covered, including those of state employees. These same insurance companies fought for years to not be required to cover autism services; their assurance to do so now when there is a push to move towards requiring it should give us pause. If this bill is not passed and there is no requirement to provide coverage, I feel confident that these children and families

will be back in the same position of having their claims denied, in short order. Having a child with special needs has many challenges associated with it. They should not be required to face further stress, financial hardship, and bankruptcy to simply get their child the needed treatment. Without these services, children on the spectrum will grow into adults that require much more support and services from the state of North Dakota. Let me repeat that. Without the necessary interventions as children, these individuals will require high levels of supervision, assistance with living costs, and costly treatment as adults. In my work, I see the effect of not addressing mental health needs early on. Mandating that insurance companies assist in covering these services will pay off in the moderate to long term as these children will have a higher level of functioning, requiring less assistance from taxpayers.

Up until this point, the state of North Dakota has placed families with children with autism in an unenviable and precarious position by not following the other 45 states in mandating coverage of services. It is my sincere hope that this legislative session will correct this now by passing HB 1434. Thank you for your time and for listening to my thoughts.

HB 1434
#9
3/6
Pg. 1

March 6, 2017
Senate Human Services Committee
HB1434

Testimony of Doug Sharbono
2419 9th St. S.
Fargo, ND 58103
(701) 212-3944

Madam Chairman and Committee Members,
Thank you for your service to the State of North Dakota. You have a substantial time commitment to your work here in Bismarck.

My name is Doug Sharbono, Fargo, ND. I am testifying in support of HB1434. I have five children, four currently living with us, and a wonderful wife. Two of my children are on the autism spectrum. I have been a North Dakotan most of my life, growing up on a grain and cattle farm in north-central North Dakota, and later educated at NDSU compliments of the North Dakota National Guard. I became a practicing structural engineer, eventually becoming involved in ownership of a small company recently celebrating its 50th year in continuous business.

I support HB1434 because currently our medical insurance does not cover autism therapy and medical care. Our son has received some services through the developmental delay waiver. Even so, we have paid for some services out-of-pocket that were not covered by this. As an example, toilet training was not accomplished until age 5 with us paying specialists from the North Dakota Autism Center to spend a week in the bathroom with our son. We have also paid for treatment out of our own pocket for our daughter who does not have a developmental disability waiver. Her speech therapy, some portions of her occupational therapy, and social skills class has been paid out-of-pocket. We have discontinued some of this therapy due to cost considerations. Our insurance also does not pay for any ABA related therapy.

HB1434 is a mandate for insurance providers to provide coverage for autism related services, specifically Applied Behavior Analysis, a science proven method of treatment. Mandates are nothing new to the North Dakota Legislature. They have historically embraced them when they make sense. Last session many of you supported HB1072, legislation relating to insurance coverage of cancer treatment medications. North

(Over)

1434
#9
3/6
Pg. 2

Dakota has set minimum standards for various industries, whether agriculture, construction, oil, transportation, or healthcare. That some argue the State of North Dakota shouldn't interfere with the free market can be an appealing statement. However, it isn't what is actually practiced. That some argue we must take a free market ideological stance on this current issue of autism insurance reform is quite puzzling in light of the fact we have a beautiful State Mill and Elevator.

The North Dakota State Mill and Elevator is a beautiful structure that supports the concept of "value added agriculture". Whether you agree with a state owned mill or not, I think we can learn some lessons from the state mill. We currently have a crop of children that will either be producers or consumers. I would prefer that they become producers, and we can support a concept of "value added children" by giving them the skills they need to be self-sufficient. With autistic children, certain therapies have been proven to be beneficial including ABA therapy. We think their medical condition of autism should be treated so these kids have the ability to be producers. A yes vote on HB 1434 will assist in this goal.

I have heard the House floor arguments that if we set a floor to the coverage, the insurance companies will provide only that level of coverage and no more. If we are to take those comments at face value, the current floor for ABA services has historically by default been at \$0, which correlates to the coverage of \$0 offered by the insurance companies for ABA treatments. So, in that view, these arguments are affirmed. If HB1434 does not pass, we should expect the insurance company's coverage for ABA services to remain at the floor of \$0.

If the insurance coverage limits on this bill are considered too low, then I encourage the committee to amend the coverage limits to what the insurance companies are supposedly proposing at the higher level. In this manner, this coverage is available to all children in our state with passage of HB1434.

Self-insured companies are unaffected by this legislation. Whether this bill passes or not, the self-insured companies can choose to cover ABA services. Currently, 40% of these companies cover ABA therapy.

In closing, I believe approval of HB1434 would be effective in giving our autistic children the tools they need to become productive, tax paying citizens at very little extra cost to the State of North Dakota.

Thank you, Doug Sharbono

TESTIMONY IN SUPPORT OF HOUSE BILL 1434

INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

March 6, 2017

Chairman Lee, Ladies, and Gentlemen of the Senate Human Services Committee:

My name is Holly Johnson, and I am a North Dakota Licensed Applied Behavior Analyst (LABA) and nationally Board Certified Behavior Analyst (BCBA) located in Minot, ND. I have a bachelor's degree in Rehabilitation & Human Services and a master's degree in Applied Behavior Analysis and Autism. I have been working with adults and children with autism for the past 11 years. I currently serve people with autism and intellectual disabilities, and other developmental disabilities (who don't have autism) using strategies of applied behavior analysis (ABA), ranging in age from 1-82 across northern areas of ND. The geographical area I provide ABA services covers Williston to Devils Lake, to New Rockford to Watford City, and rural communities in between, including Native American Reservations. I work daily providing evidence-based interventions to children, adolescents, and adults with autism, developmental disabilities, and other related disabilities and behavioral challenges.

My personal experience with this field and what these interventions are capable of are testimony to its effectiveness. I changed my career path from physical therapy to ABA because of its long-standing success for people with autism spectrum disorders and because of the lack of highly trained professionals in ND. Through my fieldwork experience and graduate education program, I learned of its success and benefits to a broader range of people. Not only is it an evidence-based intervention for people with autism, but an evidence-based practice for all disabilities and abilities. When I began in applied behavior analysis, there were three professionals in the state, and it was important to me to stay here to grow the field, and it is a commitment I continue to hold. Currently, we have 23 BCBAs, including 3 BCBA-Ds (doctorate level board certified behavior analysts), but the demand for more in ND is immense. My caseload is currently serving approximately 50 individuals, mostly through reducing problematic and dangerous behaviors (like self-injury, physical aggression, criminal behavior, addiction, and even sexual offending) that people with disabilities display in their home, community, and work environments. I serve school districts as well, for children with autism in public school settings and in their parents' homes.

Testimony before mine spoke to the positive impact of providing ABA services early in life after an autism diagnosis, and my experience lies in providing services to those who did not receive ABA services in their childhood. The adults with autism I serve have longer behavior and learning histories that impact much of their day-to-day activities, and many times with negative, problematic, and even dangerous behavior(s). This in turn makes behavior change slower and more difficult to correct, but not impossible with ABA. The impact of missing this medically necessary and critical service early in life increases the long-term cost of services. I end up spending and providing a greater amount of time to change their behavior and teach adaptive skills, which in turn costs them, their families, the state, and taxpayers more money. By missing critical access to ABA at an early age, the end result is increased costs for my services for those individuals as adults, other professionals' services, and support professionals to manage these individuals as adults; which is something that could be decreased and help cut long-term costs. Early services through autism insurance coverage for the most empirically supported science for behavior that exists is imperative to long-term success.


HB 1434
#10
3/6
Pg. 2

As a past Board Member-at-Large (2014-2016) and current Board President (2016-present) for the North Dakota Association for Behavior Analysis and the ND Liaison (2016-present) for the Minnesota Northland Association for Behavior Analysis (MNABA) based in Minnesota, I hear first-hand testimony from our professionals across the state. ND is being significantly held back in bringing more professionals to our area due to the lack of insurance coverage for our services, especially for people and children with autism. Many BCBAs will go to our neighbors to the east, and start up or join private practices in MN that can ensure insurance coverage for this population. This is unfortunate for those of us practicing in the state, with a commitment to stay located here, because demand only continues to grow, yet there are not enough properly trained professionals (BCBAs) to keep up with demand. My current practice only serves those with an intellectual disability (IQ below 75), because of the lack of insurance coverage for ABA and autism. However, I still have to tell people with autism, especially children's parents, that they cannot access me, because their child does not have an intellectual disability. Many children with autism don't have a low IQ score, which excludes them from accessing me. If I didn't have those professional boundaries, my caseload would be even larger. I believe, through conversations with other ND Licensed BCBAs, and my personal opinion, that if ND had mandated insurance coverage for applied behavior analysis and autism, more of us would open private practices, more BCBAs would move to the state because of the high demand, and more students would pursue a degree in this field and stay in ND.

In closing, I would like to share with you a situation that I encounter often. I get contacted by a BCBA out of state, or a young professional wanting to enter the field of applied behavior analysis. I discuss with them the job opportunities in the state, and ultimately lose their interest after explaining the great demand we have does not have the insurance support to cover our interventions. Current professionals are reluctant to move here, and interested college students are worried about furthering their education with an unknown future and unknown job market. Just last week, I met with a student from Dickinson, who drove to Minot to meet with me in person to discuss ABA. She is currently an Occupational Therapist, who sees the great need for the knowledge of ABA in her practice and that part of the state. After breaking the news that she wouldn't currently be able to bill private insurers in ND, something she is already comfortable with as an OT, she left very certain it would not be practical for her to begin training, which again, leaves us with one less potential professional who has a commitment to stay in ND.

I strongly support House Bill 1434, Autism Insurance Reform for North Dakota Families and ask that you vote in support this legislation. Thank you for your time and consideration of this significant matter. If I can be of any assistance during this time of deliberation, please do not hesitate to contact me.

Sincerely,



Holly E. Johnson, M.S., BCBA, LABA
Licensed Board Certified Behavior Analyst
Board President, North Dakota Association for Behavior Analysis (NDABA)
Minot, ND 58701



March 6, 2017

Dear Chairman Lee and Committee,

I want to start by thanking you for your dedication and service to the state of North Dakota. I have always taken pride in growing up in ND and felt that I was providing my children with an advantage by choosing to raise them here. While I continue to feel that ND has a lot to offer it is been a huge disadvantage to my 2 children on the autism spectrum 45 other states mandate autism insurance coverage. My children need assistance to obtain skills that most of us take for granted. One of the most obvious examples of this occurred when my daughter was in the third grade. She started a new school and came home excited about 2 weeks into it because she had finally talked to someone at recess. I asked the obvious question that most of ask, "What was her name". My daughter responded "I don't know, why would I ask her that?" How many times do you use your own name or the name of others as a way of communicating? It was another realization to me of how different her world is. This is a basic skill that most children learn at a very young age. Specific autism services are able to break down, explain, and teach these everyday skills.

My son has different needs then my daughter. He enjoys a lot of physical contact and is naturally strong. His need for increased physical contact is due to a sensory processing disorder that is frequently a part of autism. We felt wrestling was a natural fit so we signed him up. He loves it but it also is a source of great frustration for him because he does not understand the rules and how to score points. It takes someone with skills and knowledge to teach these things in a way that is useful to him. With assistance, wrestling has the potential to be an appropriate way to get his increased need for physical contact to get met instead of getting into physical fights with others at school.

I have been following this bill and have heard the majority of testimony and debate associated with it. On the floor of the House of Representatives it was not a question of whether the services were needed but if a mandate should be put on insurance companies. I appreciate the value of less government but not at the expense of protecting citizens. Article 1 section 2 of the ND constitution states: Government is instituted for the protection, security and benefit of the people, and they have a right to alter or reform the same whenever the public good may require.

1434
#11
3/6
pg. 2

As a result of this we have many laws/regulations that are put into place to protect children in our state: children are required to wear seat belts, there are mandates that are put on professionals to report abuse, parents are required to bring their children to school, etc. Children with autism need the "protection" of the government in the form of mandated coverage for autism related services. The government stepping in to provide this protection for my children does not interfere with the rights of others.

As a parent I am required to bring my children to school. This is very hard to do when your child is being restrained and put "in jail" as my son calls it. His outbursts at school are a direct result of not having the training needed so that he can handle being in the mainstream classroom or be able to let others know when he is feeling too overwhelmed to be there. Education is a basic right given to all citizens of the state of ND in article 8 of our constitution. Not having this medically necessary treatment interferes in the education of my children.

Although autism will always be a part of their lives meaningful autism services will help them to reach their full potential. My family and I ask you to think logically think about the actions and statements made by BCBS representatives. They are spending money and time in order to convince the legislative body that as a private insurance company they want to give their policy holders more coverage then what is being asked. Historically this has not been their way of doing business. Please vote yes. Individuals with autism that live in North Dakota deserve the same quality of life that is offered in most states.

Sincerely,

Kristin Sharbono

HB1434
#12
3/6
Pg 1

**Testimony of Elizabeth Faust
H.B. 1434
Senate Human Services Committee
March 6, 2017**

Madam Chair and committee members, my name is Elizabeth Faust. I am the Senior Medical Director for Behavioral Health for Blue Cross Blue Shield North Dakota (BCBSND). BCBSND appreciates this opportunity to provide testimony regarding our current benefit coverage for autism spectrum disorders and to share our analysis of HB1434 as it relates to evidence-based treatment.

Autism spectrum disorders (ASDs) are believed to arise from a number of different causes, not yet well understood. They are frequently associated with a variety of neurological, genetic and behavioral health disorders, as well as intellectual disabilities. Because of the complexity and potential for associated problems to be present, initial assessment of an individual with suspected ASDs must be comprehensive and individualized in nature to include screening for potential conditions which may complicate treatment and long term outcome. BCBSND currently provides coverage for the full range of diagnostic assessments, including physical evaluations, specialty evaluations, psychiatric and psychological evaluations, sensory testing, imaging and laboratory testing that may be necessary for a comprehensive medical evaluation to fully assess the individual's needs. BCBSND also provides coverage for a full range of medically appropriate treatments including habilitative and behavior therapy for conditions identified during comprehensive assessment. BCBSND has not covered ABA based services in the past because

1434
#12
3/6
Pg. 2

the scientific evidence was not sufficiently robust regarding their effectiveness for ASD conditions.

Research in autism spectrum disorders has progressed; evidence and consensus regarding which treatments are known to be beneficial has become far more clear over the past decade. There is now expert consensus regarding a number of behavioral interventions and practices known to be effective in the treatment of ASDs. A number of these are based on the principles of ABA. (The National Professional Development Center on Autism Spectrum Disorders currently identifies 27 evidence based practices. 12 of these are based on the principles of applied behavioral analysis (ABA). 15 of these interventions are not based on ABA principles.) What this means, in essence, is that the evidence for use of specific interventions, including some specific ABA-based services, has now emerged to a “tipping point”, a degree of confidence that warrants consideration of inclusion of these treatments into the menu of services available for clinicians to select from as they develop individualized treatment planning for those with ASDs. As a reflection of this advancement in research, evidence-based ABA services are now covered through the Federal Employee Benefit Program (FEP) as of January 2017.

It is the standard of BCBSND that we consider all potential benefit additions objectively according to a standard process, measured against rigorous research standards and based on empirical studies of efficacy. We are guided by the scientific evidence and we hold all potential benefits to the same standard. We are committed to assuring that all of our members receive safe and effective treatments and that we are responsible stewards of their health care dollars. That includes our members who have autism spectrum disorders. We will be carefully assessing

1434
#12
3/6
Pg. 3

the potential benefits and premium impacts of additional benefits for ABA services, and balancing those according to our standard process.

Proponents of HB1434 describe the proposed mandate as providing choice for families with afflicted children. In reality, HB1434 sets up a benefit with winners and losers. Large grandfathered employer groups are included, but non-grandfathered individual and small group businesses are excluded. BCBSND believes coverage should be offered as widely as possible and when we apply a benefit, we offer it across all of our eligible member groups.

Proponents also say that North Dakota should be embarrassed to be one of only 5 states without an autism mandate. There are currently 45 states with 45 different mandates for 45 different non-standardized, non-evidence-based approaches to ABA coverage. BCBSND believes North Dakota is fortunate that we do not have an ABA mandate. We have much better confidence today as we move forward with evaluation and development of rational benefit design to support evidence-based treatments for ASDs than we had a decade ago, or even five years ago. BCBSND goes where the evidence leads us, and we hold all potential benefits to the same evidentiary standards. When the clinical evidence emerges clearly, we move forward in our standard process for consideration of benefit additions.

HB 1434 spells out an artificial delineation of a specific menu of services based on a current-state understanding of ABA-based treatments and entirely ignores the other evidence-based behavioral treatments currently available. The bill specifies an arbitrary age delineation for services that is not based on current scientific evidence. As research continues to clarify evidence in the treatment of ASDs, it is inevitable that new treatments, population-specific best practices, optimal age ranges, etc., will evolve. The unintended consequence of legislation

1434
#12
3/6
pg. 4

mandating specific treatments, specific ages, and even specific monetary maximums based on today's understanding of science is limiting and shortsighted. It will create barriers to the adoption of evidence based treatments as those evolve based on tomorrow's science. It will create "one size fits no one" treatment planning with under-allocation of resource for some who need more, and over-allocation of resource for others who may not benefit.

BCBSND believes this mandate is unnecessary and frankly regressive. A mandate that supersedes evidence-based benefit design does not serve our citizens responsibly. We respectfully recommend that you not support moving this mandate into law.

Respectfully submitted,

Elizabeth Faust, M.D.

BCBSND

HB 1434
#13
3/6
Pg. 1

Testimony for:

HB 1434: Senate Human Services Committee

March 6, 2017

Madame Chairman Lee and members of the Senate Human Services Committee,

I am Dr. Barbara Stanton. I am employed at Prairie St. John's as an outpatient therapist specializing in autism spectrum disorders (ASDs). I conduct diagnostic assessments, do individual and family therapy and provide consultation, collaboration and case management services.

I appreciate the work that the sponsors and co-sponsors put into this bill. I appreciate the hard work of the advocates who are supporting this bill. I also appreciate that autism is again before the North Dakota legislature. I have been and will continue to be a strong advocate to address the significant needs of individuals on the autism spectrum and their families. Every day I talk to North Dakota families who are unable to access needed supports and services for a variety of reasons. Unfortunately, I believe this bill does not address most of those needs.

I am submitting this testimony to express my concerns regarding HB 1434. My concerns are as follows:

Section 1.

Subsection 1a. Applied behavior analysis (ABA) is a theoretical orientation that is used in a number of different settings and applications. It is not one set of procedures or interventions. The National Professional Development Center on Autism Spectrum Disorder developed a list of Evidence Based Practices for Autism Spectrum Disorders. They identify 27 evidenced based practices. Those practices are approved by the North Dakota Department of Human Services for reimbursement. There are 6 intervention categories that are based primarily on the principles of ABA. There are 6 interventions that can be considered ABA or other theoretical applications. There are 15 interventions not based in ABA. How will these interventions be covered under this bill? To identify only one

intervention serves to limit the access to care to those for whom ABA may not be an effective or appropriate intervention.

We know that those with an ASD are diverse and unique. It is important to have variety in the choice of interventions as we know that treatment must be eclectic to target the person's challenges. Some interventions are only evidence based for subcategories of individuals and take into account age and development. Providers must have the ability to utilize all interventions.

Many who have used consequence or aversive based interventions, including forms of ABA, no longer considered them acceptable. One of the primary reasons for their paradigm shift was recognizing that alternative developmental interventions result in quicker and more long lasting positive behavioral changes tailored to the individual's specific needs.

Applied behavior analysis is the only scientific discipline mentioned or defined in this bill. Other states with similar language in their mandates have found that, despite intent, providers are limited to this specific category of interventions. Lack of access to the right services is the same as a lack of access to any services at all.

Subsection 1b. The definition of "autism spectrum disorder" is from the Diagnostic and Statistical Manual (DSM) IV TR not the latest DSM 5 edition which states that Autism Spectrum Disorder is a serious neurodevelopmental disorder that impairs a child's ability to communicate and interact with others. It also includes restricted repetitive behavior, interests and activities. These issues cause significant impairment in social, occupational and other areas of functioning.

Subsection 1d(2). I am not sure what is meant by the term "behavioral health treatment" and "counseling and treatment programs". In my profession, "behavioral health treatment" including counseling and other treatment programs is considered mental health care. This is critical to comprehensive care

1434
#13
3/6
Pg. 3

for individuals with an ASD and their caregivers and should be provided by those who are educated and licensed to perform those services. This includes Licensed Independent Clinical Social Workers (LICSW), Licensed Professional Clinical Counselors (LPCC) and Licensed Marital and Family Therapists (LMFT). To limit the professionals providing care in a state with few qualified providers will serve to further limit the access of treatment to individuals with an Autism Spectrum Disorder (ASD). Licensed Behavior Analysts are not able to provide counseling even with the supervision of a psychologist. Those of us who are independently licensed must receive supervision in accordance with our licensure standards.

Subsection 1g. This section excludes other medical doctors, nurse practitioners and others who are educated and licensed to prescribe psychotropic medications. This will significantly limit access for individuals.

Subsection 1i. The term "therapeutic care" is vague and should be defined. Those providing behavioral health services also use the term "therapeutic care" to describe their services yet those professionals are excluded from in this bill. Would individuals who currently have these valuable services covered in their insurance policies be limited to the scope of this bill?

Subsection 1j. "Treatment for autism spectrum disorder", specifically behavioral health care, is provided by many other professions besides physicians or psychologists. Licensed Independent Clinical Social Workers (LICSW), Licensed Professional Clinical Counselors (LPCC) and Licensed Marital and Family Therapists (LMFT) are trained and licensed to provide evidence based care, develop treatment plans, and determine medically necessary and appropriate services. Insurance companies recognize these professions and provide reimbursement for some services to individuals on the spectrum.

Subsection 6. This bill states that there will be a maximum benefit which varies based on age. Age does not necessarily correlate to need. States with insurance mandates, including those with higher caps, consistently report that these

1434
#13
3/6
pg. 4

amounts are inadequate. The cap listed in this bill is one of the lowest in the nation.

Subsection 7. The language in this subsection is also vague. It is unclear what type of programming is being referred to other than ABA. How are other evidence based practices going to be provided/covered and who can provide them and supervise. In most professions supervision is typically not a reimbursable service covered under an insurance plan.

Subsection 8. I believe that there needs to be greater oversight than is listed. As a provider understand the reality of prior approval for services and welcome reviews so there is accountability to the child and their caregivers. I understand and support the need to document medical necessity.

There should be consistency in training at a state level to insure that all providers are adequately qualified to provide their services to individuals with an ASD; whether direct care or supervision.

Subsection 10. What will happen if the Affordable Care Act is repealed? Many of my current clients have relied on ACA benefits for assistance. This bill does not address the supports offered in the ACA that could be lost.

Subsection 11. It is unclear what information/data will be in the report and what will be done with the report.

We know that mandates are rigid and this bill is no exception. I am concerned that as the research into ASDs continues to expand, especially neurobiological research, we must have the flexibility to utilize new evidence based practices/interventions and those that are emerging so we are providing the best care possible.

While I fully support the expansion of services and coverage of services for those with an ASD, this bill does not do that. The AMA Journal of Ethics (2015; 17, 4, pgs. 328-341) stated that "to create fiscally responsible action plans that focus on achieving and maintaining sustainable, long-term results, we must construct meaningful data sets by

melding evidence-based research from multiple disciplines including medicine, mental health, economics, accounting, sociology, policy, and law. Until silos are broken down and professionals in many disciplines are willing to work together in ways they perhaps never have before, ASD will unduly challenge the lives of patients and those who love and care for them." Mandates with the limitations of this one do not accomplish this. There are insurance plans, such as the Federal Employee Plan, that offers better coverage. This is what children in North Dakota deserve.

People have said that a little is better than nothing. I do not believe that when the risks are so high. Without significant changes and clarifications in the language of this bill, inclusion of all evidence based and emerging interventions, inclusion of all providers who are qualified to provide treatment, and a significant increase in the cap without age limits this bill presents a high risk.

Thank you for your time in consideration of my testimony. I will answer any questions.

Summary of Evidence Based Practices for Autism Spectrum Disorders

There are 3 national organizations that review the literature and determine evidence based practices for those with an Autism Spectrum Disorder (ASD). While there are similarities, there are also differences in what is considered "evidence based" as determined by the strength and quality of the research. Each organization has their own standards.

In order to avoid confusion the terminology must be very clear. Many experts adapt the term "intervention" as opposed to "therapy".

In order to be effective there should be a number of elements combined within a behavior reduction or skill acquisition treatment plan. This can be challenging to providers. Inappropriate or ineffective services may not only cause delays in developing necessary skills but the use of "aversive" behavioral interventions or interventions that focus on compliance rather than skill development can cause lasting harm.

National statistics state that 1 in 68 children meet the criteria for an Autism Spectrum Disorder. We know that those with an ASD are diverse and unique. It is important to have variety in the choice of interventions as we know that treatment must be eclectic in order to target the person's specific challenges. Some interventions are only evidence based for subcategories of individuals and take into account age and development. For example, Cognitive Behavior Therapy is evidence based for children age 6 – 19 while Discrete Trial Training is evidence based for children ages 3 – 5 and 6 – 11.

The Agency for Healthcare Research and Quality (2014)

The Agency for Healthcare Research and Quality (AHRQ) which is run by the US Department of Health and Human Services evaluated systematic reviews. One common finding is that interventions based on the principles of applied behavior analysis do have a track record of effectiveness when incorporated in a well-designed program for individuals who are on the autism spectrum. A well-designed program requires professionals to implement the framework of evidence-based practices. The framework includes research findings, professional judgment, values and preferences of the parents/care providers/individual on the spectrum, and the ability a parent/care provider/educators/practitioners to correctly implement an intervention. Without an intervention provided with integrity even a well-designed program is the useless. Capacity also must be considered with regard to the modality of treatment (individual, family, or group), whether or not parents/caregivers can implement the intervention in home, and is there adequate time and money to implement an intervention appropriately.

National Standards Project (2015)

In Phase 2 of the National Standards Project done by the National Autism Center, categories of established interventions, emerging interventions, and unestablished interventions are listed.

Established interventions for individuals under age 22 include:

Behavioral interventions *

1434
#14
3/6
Pg. 2

Cognitive behavioral interventions **

Comprehensive behavioral treatment for young children ***

Language training

Modeling

Natural teaching strategies

Parent training, peer training

Pivotal response training

Schedules

Scripting

Self-management

Social skills package

Story based interventions.

*Behavioral interventions include several subcategories of interventions. Most of them are not "stand alone" evidence-based interventions. Some may have four or more identified components. Some of these components may be based in theoretical foundation of applied behavior analysis and some may not.

**Cognitive behavioral interventions are typically what you would consider in a traditional therapy session. It will need to be modified for individuals with an ASD. There are some manual lysed packages that maybe you specifically with those with an ASD.

***Comprehensive behavioral treatment for young children is typically what we think of with intensive service delivery, typically 25–40 hours per week for 2–3 years, and are based on the principles of applied behavior analysis. Comprehensive behavioral treatment also includes a range of interventions to target specific essential skills which define or are associated with an ASD. These interventions can include discrete trial teaching, incidental teaching, shaping, modeling and other interventions derived from ABA. These interventions are considered effective for children under age 9.

The other interventions listed above are not considered to be derived from ABA.

There are currently 18 interventions that are considered to be emerging. Studies suggest that they may produce favorable outcomes but there needs to be additional high-quality studies that consistently show their effectiveness for individuals who are on the autism spectrum.

There are 13 interventions consider to be unestablished. However, some of these interventions such as DIR and Floortime are being used consistently and effectively in many programs in other states. Other reviews include them in evidence based/emerging interventions. Special education teachers in the Fargo public school district are trained in Social Thinking interventions even though it is considered to be unestablished.

Best Practice Review Group

The Evidence – Best Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder was compiled by the Autism Evidence – Best Practice Review Group at the University of North Carolina.

They list the following as evidence-based practices:

Differential reinforcement of alternative, incompatible or other behavior
Discrete trial training
Extinction
Reinforcement
Task analysis
Time delay

Antecedent based intervention
Functional communication
Parent implemented intervention
Picture exchange communication system
Pivotal response training
Prompting
Response interruption/redirection
Scripting

Exercise
Cognitive behavior therapy
Functional behavior assessment
Modeling
Naturalistic intervention
Peer mediated instruction
Self-management
Social narratives
Social skills
Structured play groups
Technology aided instruction and intervention
Video modeling
Visual supports

Interventions derived primarily from the principles of ABA

Interventions can be derived from ABA principles and/or other theories

Interventions not based in principles of ABA

HB 1434
#15
3/6
pg.1

Testimony on HB 1434

Health Insurance Coverage for Autism Related Services

Senate Human Services Committee

March 6, 2017

Chairman Lee and members of the Senate Human Services Committee, I am Dan Hannaher, Senior Legislative Affairs Specialist with Sanford Health. I'm here today to provide neutral testimony on House Bill 1434 related to Health Insurance Coverage for Autism related services.

In North Dakota, Sanford Health Plan covers medical services for kids with autism including (but not limited to) physical therapy, occupational therapy and speech therapy services as well as psychology and psychiatric services. Sanford Health Plan operates in other states where ABA services for autism is already mandated, some with restrictions on age limits and dollar limits. We will continue to monitor the impact ABA services has on the populations we serve in North Dakota. Sanford Health Plan has been evaluating ABA services using professionals who are board-certified in ABA, and we have some preliminary ideas about program design for insurance coverage. We continue to analyze evidence-based medicine whose effectiveness has been demonstrated in a convincing body of well-designed studies. Before we build the cost of new services into our benefit plans for all members to pay, we must ensure the services (procedures, drugs, and technologies) improve health outcomes of the patient, such as length of life, quality of life and functional ability.

Thank you, Chairman Lee and committee members. I will stand for questions or at least endeavor to find answers to any inquiries.

NDLA, S HMS - Johnson, Marne



Sent:

To:

Subject:

Attachments:

Judy Lee <judylee1822@gmail.com>

Saturday, March 04, 2017 12:27 PM

NDLA, S HMS - Johnson, Marne

FW: HB 1434 Employee Benefits Committee 2017.docx

HB 1434 Employee Benefits Committee 2017.docx

HB 1434
#16
3/6
Pg. 1

CAUTION: This email originated from an outside source. Do not click links or open attachments unless you know they are safe.

Marne –

Please make copies of this testimony for all of us, along with Dr. Faust's message explaining it.

From: Lisa Faust [mailto:]

Sent: Saturday, March 4, 2017 12:13 PM

To: Judy Lee <judylee1822@gmail.com>

Subject: HB 1434 Employee Benefits Committee 2017.docx

Hi Senator Lee,

Thank you for taking time out of your hectic weekend to chat with me today. As promised, I am attaching my testimony that Blue Cross submitted regarding 1434 when it was before Employee Benefits. Just for clarity, this commentary was regarding the version of the bill containing language attempting to exempt from the PERS pilot requirement, and also claimed "this is not a mandate", both of which were subsequently removed.

Best regards,

Lisa

Confidentiality Notice: This communication and any attachments are for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, distribution or copying is prohibited. If you are not the intended recipient(s), please contact the sender by replying to this e-mail and destroy/delete all copies of this e-mail message.

1434
#16
3/6
Pg. 2

Employee Benefits Committee

HB 1434

January 27, 2017

Madam Chair and committee members, my name is Elizabeth Faust. I am the Senior Medical Director for Behavioral Health for Blue Cross Blue Shield North Dakota (BCBSND). BCBSND appreciates the opportunity to provide this committee with information regarding its current benefit coverage for autism and share our analysis of HB 1434 as it relates to evidence-based treatment.

Autism spectrum disorders (ASDs) are believed to arise from a number of different causes, none of which are yet well understood. They are frequently associated with a variety of neurological, genetic and behavioral health disorders, as well as intellectual disabilities. Because of the complexity and the potential for associated medical, psychiatric and intellectual problems to be present, initial assessment of an individual with suspected ASDs must be comprehensive and individualized in nature and include screening for potential neurological, genetic, psychiatric and medical conditions which may complicate treatment and long term outcome. BCBSND currently provides coverage for the full range of diagnostic assessments, including physical evaluations, specialty evaluations, psychiatric and psychological evaluations, sensory testing, imaging and laboratory testing that may be necessary for a comprehensive medical evaluation. BCBSND also provides coverage for a full range of medically appropriate treatments including occupational therapy, physical therapy, speech therapy and behavior therapy for conditions identified during comprehensive assessment.

House Bill 1434 creates an unnecessary requirement for availability of this full range of services which are already basic components of our members' benefit plans. The introduction of such narrow and artificially specific requirements will potentially hamper or obstruct future access of our members to treatments that may emerge and become evidence based but are not yet anticipated or developed.

As research into autism spectrum disorders has progressed, evidence and consensus regarding which treatments are known to be beneficial is becoming more clear. There is now expert consensus regarding a number of interventions and practices known to be effective in the treatment of ASDs. The National Professional Development Center on Autism Spectrum Disorders currently identifies 27 evidence based practices, some of which are based on the principles of applied behavioral analysis (ABA). Of note, 15 of these interventions are not based on ABA principles.

1434
#16
3/6
Pg. 3

As a reflection of this advancement of research, outcome studies, and expert consensus in the treatment of ASDs, the Federal Employee Plan (FEP), which is administered by BCBS, with the assessment completed by an MD such as a Family Practice, Pediatrician, Psychiatrist, has now incorporated the use of specific evidence-based ABA interventions for the treatment of ASDs into the FEP benefit plan as of 01/01/17. FEP is widely regarded as a "gold standard" in terms of evidence-based benefit design. BCBSND is following suit with development of ABA benefits that will mirror the FEP benefit design for inclusion across the BCBSND commercial lines of business.

What this means, in essence, is that the evidence for use of specific interventions, including specific ABA-based procedures, has now emerged to a "tipping point", a degree of confidence that warrants inclusion of these treatments into the menu of treatments and services available for clinicians to select from as they develop individualized treatment planning for individuals with ASDs.

Although HB 1434 specifically states that it is not a mandate, there is clearly an artificial delineation of a specific menu of services based on a current-state understanding of ABA-based treatments and entirely ignoring the other evidence-based behavioral treatments currently available. The bill specifies an arbitrary age delineation for services that is not based on current scientific evidence. As research continues to clarify evidence in the treatment of ASDs, it is inevitable that new treatments, population-specific best practices, optimal age ranges, etc., will evolve. The unintended consequence of legislation mandating specific treatments, specific ages, and even specific monetary maximums based on today's understanding of science is limiting and shortsighted. It will create barriers to the adoption of evidence based treatments as those evolve based on tomorrow's science.

We are also greatly concerned with Section 2 and 3 of this bill, which states that this bill is not a mandate and therefore not be subject to section 54-03-28, which requires that the public employee's retirement system would conduct a cost/benefit analysis on the ABA treatment coverage included in the bill for a two-year trial. This bill clearly mandates coverage of ABA up to age 26, with significant cost implications to the state. The two-year cost/benefit analysis has proven to be a highly beneficial requirement and the removal of this section runs contrary to the desire to hold health care costs down for North Dakota taxpayers.

I greatly appreciate the opportunity to share this information with your committee as you seek solutions on these challenging issues. Please feel free to contact me with any additional questions you may have.

Respectfully submitted,

Dr. Lisa Faust

NDLA, S HMS - Johnson, Marne

HB 1434
17
3/6
Pg. 1



Sent: Lee, Judy E.
Saturday, March 04, 2017 12:20 PM
To: -Grp-NDLA Senate Human Services; NDLA, S HMS - Johnson, Marne; NDLA, Intern 02 - Arendt, Ian
Subject: FW: Yes on HB 1434

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: Rachel Haman [mailto:
Sent: Saturday, March 4, 2017 8:25 AM
To: Lee, Judy E. <jlee@nd.gov>
Subject: Yes on HB 1434

CAUTION: This email originated from an outside source. Do not click links or open attachments unless you know they are safe.

Senator,

I write this letter in regards to the ND House Bill 1434 that involves insurance coverage for applied behavior therapy (ABA) for children with Autism. I have worked in the ND public schools for the past 9 years, previously in Mandan and now West Fargo, serving a variety of ages and disability areas. A significant portion of my time has been working in Early Childhood Special Education (ECSE) classrooms as a Speech Language Pathologist. I choose to work with the preschool population because I strongly believe and advocate for early intervention for our preschooler students.

I have spent my career learning, researching, and implementing the best practices available in terms of speech therapy and various curriculum or programs. This year, I have had an amazing opportunity to gain exposure to a treatment that is relatively new to me, Applied Behavior Analysis (ABA). I have been extremely fortunate to collaborate with two Board Certified Behavior Analysts, one within the school district and one contracted from the North Dakota Autism Center to assist our school team in completing intensive functional behavior assessments and positive behavior support plans for our students with the most intensive needs.

Currently, the West Fargo School District pays for consultation for two of my students from Chelsea Evenstad, a Board Certified Behavior Analyst (BCBA) from the ND Autism Center. This woman's skillset and what she can do with behavior and programming for children with Autism is truly remarkable! There are a multitude of research articles you can read to support the evidence-base of ABA in your own time, but when you have the chance to see this approach be successful right in front of your eyes, with children you have attempted intervention you can think of... that is when you know the research is REAL LIFE!

1434
#17
3/6
Pg. 2

I have learned that the high level of technical training and expertise the BCBAs receive plays a critical role in the programming they develop for our students. One of these tools is the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP). Our consulting BCBA, Chelsea, assists in providing the assessment and designing specific programming for each student. The VB-MAPP programming focuses on teaching the foundational skills that many children with autism have not acquired. It is not easy. Nevertheless, behavior analysts write these intensive detailed programs using small stepping-stones with consistent prompting, reinforcement, task analysis, and errorless learning. This is all a part of ABA therapy.

Both of my students receiving this programming have made huge improvements over the short time they have had access to it this school year. One child, in particular, has had his day changed from continuous wandering, climbing, refusal, dropping to the ground, fleeing the classroom and some self-injurious behavior to an intensely structured day. Due to this structure, he does not have many opportunities to have those "behavior" moments, and instead he is engaged with staff who are teaching him individualized play skills, imitation, functional language, and even sitting at a table to complete "work and therapy tasks."

I know in my heart that this is what early intervention is all about, and I only wish that more families could access this support and service. By tackling this behavior at such a young age, we are allowing children to achieve so much more over the course of their development.

Please consider a YES vote on ND House Bill 1434.

Sincerely,
Rachel Haman
Speech Language Pathologist at West Fargo Public Schools

SUPPLEMENTAL REPORT

Concerning First Engrossment to HB 1434

(Supplemental to Original **ACTUARIAL ANALYSIS**
of **HB 1434**)

By **Acumen Actuarial**

For the **State of North Dakota**

APPLIED BEHAVIORAL ANALYSIS (ABA) and
TREATMENTS for AUTISM SPECTRUM DISORDERS (ASD)

Daniel Bailey, FSA, MAAA

FEBRUARY 26, 2017

1434
#18
3/6
Pg. 2

TABLE OF CONTENTS:

1. PREFACE
2. EXECUTIVE SUMMARY
3. CONTENTS & CONCLUSION
4. LIMITATIONS OF USE and QUALIFICATIONS

1434
#18
3/6
Pg. 3

PREFACE

This supplemental actuarial report from Acumen Actuarial dated February 26, 2017 is an addendum to our original actuarial report issued on February 2, 2017 titled "Actuarial Analysis of HB 1434". In the original report, Acumen presented its findings and conclusions relative to the original version of HB 1434.

In this addendum, Acumen Actuarial presents its findings related to the revisions to HB 1434 proposed February 9, 2017 by the North Dakota Legislative Council. These revisions are contained in "**First Engrossment, Engrossed House Bill Number HB 1434.**"

1434
#18
3/6
Pg. 4

EXECUTIVE SUMMARY

The modifications to the original bill are not extreme; however, they are expected to have a small but material impact on the expected average cost of the autism spectrum disorder mandate originally proposed in the initial version of HB 1434.

There are two fundamental modifications to the original bill that may affect the expected average claims cost for 2017—1) the limitation of ASD benefits to children up to age 19 rather than to age 26, and 2) the reduction in the amount of annual Applied Behavioral Analysis (ABA) maximums depending on age-bracket.

In the initial year of the mandate, 2017, the revised HB 1434 could be expected to cost approximately 5% less than the original bill. The range of expected cost reduction relative to the original is 0% to 15%. The expected average claim cost for 2017 was \$0.61 PMPM under the original bill. This becomes \$0.58 PMPM under the revised bill.

With the cost of administrative services added, the original cost estimate was \$0.71 PMPM. Under the revised bill, it is \$0.67 PMPM, with rounding.

It is not the author's intention to imply a false sense of precision. The direction of the cost change is known; the exact magnitude is not. The revisions to the mandate are not expected to increase the cost. However, the extent to which they decrease the cost relative to the original is uncertain.

The cost reduction from the original to the revised version of HB 1434 could be described as small but material. As previously mentioned in the original report, the annual maximum on ABA services may have some sentinel effect and limit utilization that would have otherwise exceeded the revised maximums. That is to say the annual ABA maximums may function as a deterrent to ABA utilization, especially the lower maximums for children of older ages—7 through 13 years of age, and 14 through age 18.

1434
#18
3/6
Pg. 5

CONTENT and CONCLUSION

As it pertains to Acumen's original cost estimate, there are two fundamental revisions to HB 1434 in the First Engrossment that may affect the future cost:

1. The first change to consider is the limitation of the ASD mandate to children less than 19 years of age. (The original version covered children less than age 26.)
2. The second fundamental change is the revision in the annual benefit maximum that applies to Applied Behavior Analysis services. (In the original version, an annual ABA maximum of \$50,000 for ABA services was applicable to children up to age 26.) In the revised version of HB 1434, the ABA annual maximum is as follows:
 - a. \$36,000 for children less than age 7
 - b. \$25,000 for children from age 7 through age 13
 - c. \$12,500 for children from age 14 through age 18.

The revised bill stipulates that the annual maximum cannot be less than these amounts, but it does not preclude insurers from establishing their own annual maximums for ABA services that exceed the amounts shown. Whether any insurers will choose to cover more than the ABA maximums shown is unknown at this time, but in the past, health insurers have tended not to exceed annual statutory maximums for specific benefits.

In Acumen's original report, the average expected cost of the original version of HB 1434 was \$0.61 PMPM for initial year 2017 claim cost. Given the revisions in the First Engrossment, Acumen expects the 2017 initial year cost would be approximately 0% to 15% less than the original estimate. Acumen's point estimate is an expected 5% reduction to the original cost-estimate. This projected cost differential is an approximation. It reduces the original \$0.61 PMPM claims cost to **\$0.58 PMPM** in the **revised** bill. (The original cost-estimate in Acumen's original report was described as approximate and not a guarantee that the actual future cost would be exactly the same as the cost-estimate. The cost estimate of the revision is also.)

The expected average cost of the original bill with administrative cost added was \$0.71 PMPM. Acumen's estimate for the cost of the **revised** bill with administrative cost is **\$0.67 PMPM** with rounding.

In both cases, the expected reduction in cost is approximately three or four cents. While it is clear that the cost of the revised bill should not be greater than the original, the extent to which it is less than the original is quite difficult to ascertain with certitude.

The logic behind this estimate reflects the fact that ASD services tend to be utilized more by younger children with ASD than older children and young adults. There is insufficient data to calculate the cost reduction with pinpoint precision. However, reducing the age to which the

1434
#18
3/6
pg. 6

ASD mandate applies and reducing the amounts of the ABA annual maximums will certainly not increase the future cost. The extent to which these revisions will reduce the cost relative to the original is unclear. It is possible that no children over 18 and less than 26 would have received ASD care if the original version of HB 1434 would have been implemented. If that were the case, the reduction in the cost would be 0%. However, on a state-wide basis, it is possible that some children from age 19 up to age 26 would have utilized ASD services if the original bill were implemented.

Concerning the reductions in the annual maximum from \$50,000 to:

- a. \$36,000 for children less than age 7
- b. \$25,000 for children from age 7 through age 13
- c. \$12,500 for children from age 14 through age 18.

Under the original bill, some children may have received more ABA services than these revised maximums but less than the original \$50,000. Data was provided by North Dakota's Autism Registry for the original actuarial report. It showed that symptoms of ASD tend to be noticed at a very young age, and only 3% of children with ASD had their symptoms first noticed after age 20. 84% were first noticed before age 4. Although the data was limited, 2 years was the median age at which ASD symptoms were first noticed, and 7 years of age was the median age of diagnosis.

The organization Autism Speaks reports that ABA techniques are effective for building important life skills in teens and adults with autism. They also report that there are many unknowns concerning the benefits of intensive ABA programs for teens and adults. ASD and ABA programs for younger children seem to be better studied in the academic literature than those for teens and adults. While many experts agree that behavior is easier to modify in young children, many programs nonetheless assert that ABA is effective for older children. Hence, it is difficult to say whether the maximums for each age-bracket are consistent with current ABA utilization levels or whether older children will more frequently have their ABA services limited by the revised annual maximums under the First Engrossment.

By using a regressive approach to the annual maximums for ABA by age-bracket, there may be increased pressure on ASD providers and professionals to diagnose earlier, and parents and families may seek ABA treatment earlier. When all children with ASD can receive up to \$50,000 of ABA services at any age prior to 26, as under the original version of the bill, there is less pressure for parents and families to obtain ABA treatment before the child ages into the next age-bracket with a lower maximum. The tendency to diagnose and treat earlier is not expected to occur instantly in year one, but it may increase over the first several years of the mandate as families and providers become accustomed to it.

If there are children whose ABA is limited by the annual maximum, it is more likely that it will be those who are 7 to 10 and 14 to 16. These are children at the younger end of these two age brackets. This assumes that the number of hours of ABA used per child per year declines with

age from age 5 to 26, which is consistent with the limited data and information about ABA use. Similarly, in terms of total hours of ASD services used per year, the annual use of ASD services in general is likely greater for children less than 10 years of age than those over 20, which is also consistent with the limited data and information about the use of ASD services.

One thing is clear: It would be inappropriate to estimate the reduced cost of the revised bill by simply scaling down the original estimate to reflect the two fundamental changes (reduced age and reduced annual ABA maximums by age-bracket). This would overstate the value of the cost reduction stemming from the revisions contained in the First Engrossment. Assuming a uniform distribution of children by age, the limitation to age 19 alone may reduce the number of eligible children and young adults by 27%, but it would not cut cost by the same amount.

[$- 27\% = (19 / 26) - 1$]. Again, those in the age 19 through 25 bracket are expected to use fewer ASD services and ABA annually than younger children. Hence, a 27% reduction is unlikely. Based on the ND PERS data provided for Active employees and dependents, the number of children to age 19 represent 69.3% of the children to age 26, which is 30.7% reduction. This 69% is slightly lower than the 73% because there are slightly more children in the 19 through 25 age range, especially ages 24 and 25. This demographic 'bump' could be a consequence of the fact that it is more cost-effective to keep children on the parents' policy to age 26 than for the children to buy their own separate individual coverage.

One other issue to note with the revised version of HB 1434 (as described in the First Engrossment) is interstate equity. This was not discussed in the original report from Acumen Actuarial, but since the parameters of the revised HB 1434 were taken from South Dakota legislation, North and South Dakota's ASD benefits will be equivalent. This would eliminate the incentive for parents of children with ASD to relocate from one state to another in order to obtain significantly more generous ASD benefits in one state than another. It is unclear if and to what extent this is already happening from state to state. There are so many other factors that come into play when it comes to interstate family relocation that it seems unlikely that it plays a material role in the cost of the mandate itself.

The cost estimate in this supplemental report is an adjustment to the cost estimate in the original report. In so doing, the margin of error is increased. Projecting the cost change produced by the revisions to HB 1434 in the First Engrossment requires some mathematical hair-splitting. We can be confident that the two fundamental revisions to HB 1434 reduce the cost of the original bill slightly, but we cannot determine exactly how much. The estimated reduction of 5% is reasonable. Although the original cost of HB 1434 is less than \$1.00 PMPM, this 5% reduction cannot be ignored as entirely immaterial or *de minimis*. Hence the analysis in this supplemental report. Nonetheless, the 5% reduction is, in fact, small, and it amounts to pennies per person per month when spread over all insureds.

1434
#18
3/6
pg. 8

LIMITATIONS OF USE AND QUALIFICATIONS

This supplemental actuarial report is intended for the state of North Dakota for the purpose of its evaluation of the revised legislation under HB 1434 as described in the First Engrossment dated February 9, 2017. It provides an estimate of the uncertain future cost of ASD services to be provided under the revised version HB 1434 relative to the cost of the original version. This supplemental report is not intended as a stand-alone report. It is a supplement to the report issued February 2, 2017 by Acumen Actuarial; that original report concerns the original version of HB 1434.

The use and discussion of this document is limited to North Dakota and Acumen Actuarial. This supplemental report is not to be used for any other application or purpose. It was developed specifically for the state of North Dakota as it applies to the actuarial evaluation of the revised version of HB 1434 at this point in time. It is intended for use in conjunction with the original report. The contents of this report are not intended for any other use or purpose. If the distribution of this report is not prohibited by public records law, this report should not be distributed to third parties without Acumen's prior permission. Like the original report, this supplemental report shall be released only in whole, and it shall not be released in part to any party.

This review is limited in time and scope. It is not a guarantee that ND's future actual ASD services cost under HB 1434 will equal those shown in this report. This report does not recommend a specific course of action. The intent of this review and supplemental report is to provide objective facts and findings that the state of ND Legislative Council can use to evaluate the revised version of HB 1434 with respect to the expected future cost and use of ASD services in private health insurance as required under the bill. It is not a legal opinion and does not provide legal advice on matters of law pertaining to the legislation.

I, Daniel Bailey, am a consulting health actuary and owner of Acumen Actuarial LLC. I am a fellow of the Society of Actuaries and member of the American Academy of Actuaries, and in good standing with both organizations. I meet the Qualification Standards to render the opinion contained herein. If you have questions, please contact me at bailey-d-1@comcast.net. My office phone is 860-986-4052.

Daniel Bailey, FSA, MAAA

Daniel Bailey

Dear Senators-

I hope this email finds you well. I'm sure you are very busy now, so I won't take much of your time. Today I want to talk to you about the Autism Insurance Reform for the State of North Dakota. We have submitted a bill, HB 1434, and would like to reach out to you and ask for your support in our efforts to provide medically necessary therapies for our population with Autism.

My daughter recently benefitted from a clinic (Sanford) in Fargo to address a feeding disorder. It was very successful for us but we had to separate our family for 7 weeks while my daughter and I lived in Fargo to receive this care. Not all families would be able to do this. See her picture below. Amelia is 10 years old and is a nonverbal autistic child.

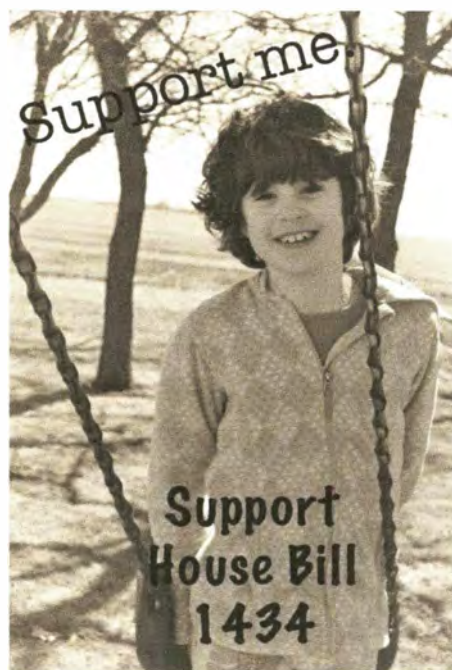
This therapy is the only one of its ABA kind that I've found in my research that is covered and it took our doctor to have a special arrangement with BCBS and Sanford. We waited under this doctor's care for many years to be able to be one of the first 12 children to go through this program. She went from eating only 3 foods to now over 30!! Without this intensive program, her health, brain growth and probably her life would have been compromised as she became an adult.

Programs like this need to be funded by insurance companies in order for families to keep themselves out of bankruptcy. We all have a responsibility to our communities to get our children help when they are young and as they grow. These children need to become positive members of society because if the help is not there, they could become a challenge as adults in this world.

We need your help to move this forward on a pace that gets children the help they need now, not "down the road". Thank you for support and for taking the time to read my email. We really appreciate all you do.

Donna and Rolan Bye

Minot, ND



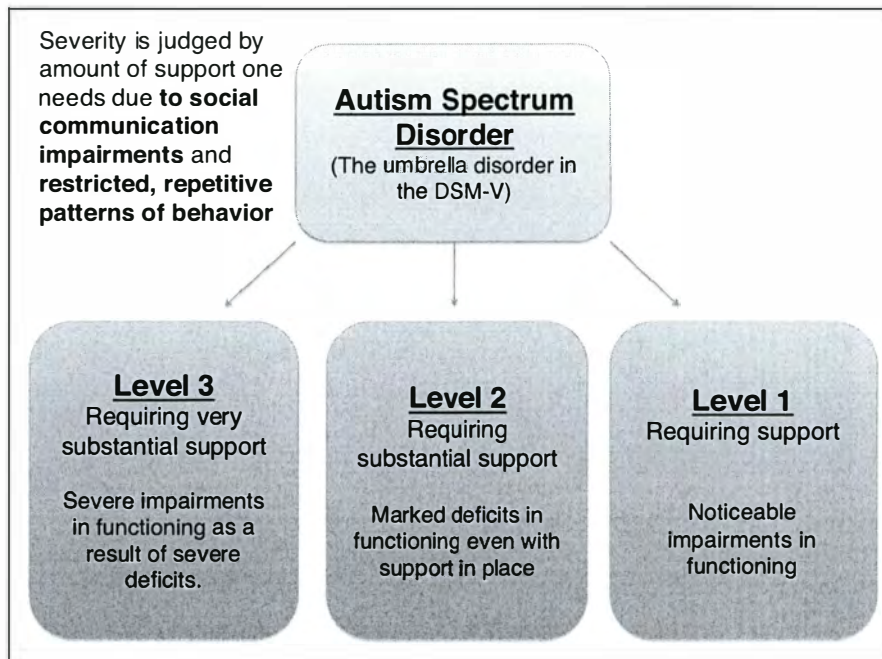


Bringing
Meaningful
Autism Insurance
Coverage to
North Dakota

What is Autism?

- Autism and autism spectrum disorder (ASD) are both general terms for a group of complex disorders of brain development.
- Autism affects a person's **communication** abilities and **social skills**, and often causes **repetitive patterns of behavior** and a narrow range of interests.
- Its symptoms range from mild to severe.

1434
#1
3/14



Diagnosing Autism

- The American Academy of Pediatrics recommends **screening** every child for autism at their 18 and 24 month checkups.
- Autism is **diagnosed** by a physician; usually by a developmental pediatrician, pediatric neurologist or team of developmental specialists.

Treatment

- Early diagnosis and treatment are critical to a positive outcome for individuals with an autism spectrum disorder (ASD)
- Treatment is prescribed by a licensed physician or licensed psychologist:
 - Behavioral health treatment, including Applied Behavior Analysis (ABA) Therapy
 - Speech, Occupational and Physical Therapy
 - Psychological, Psychiatric, and Pharmaceutical Care



American Academy
of Pediatrics



June 20, 2012

Testimony of
Vera F. Tait MD, FAAP

On behalf of the
American Academy of Pediatrics

Before the
Subcommittee on Personnel,
Senate Armed Services Committee

• "Optimizing medical care and therapy can have a positive impact on the habilitative progress and quality of life for the child. Medically necessary treatments ameliorate or manage symptoms, improve functioning, and/or prevent deterioration. Thus, in addition to routine preventive care and treatment of acute illnesses, children with ASDs also require management of sleep problems, obsessive behaviors, hygiene and self-care skills, eating a healthy diet, and limiting self-injurious behaviors.

• Effective medical care and treatment may also allow a child with ASD to benefit more optimally from therapeutic interventions. Therapeutic interventions, including behavioral strategies and habilitative therapies, are the cornerstones of care for ASDs. These interventions address communication, social skills, daily-living skills, play and leisure skills, academic achievement, and behavior."

American Academy of Pediatrics
505 15th Street NW, Suite 900
Washington, DC 20005-4000
Tel: 202 638 3475



1434
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3/14

Applied Behavior Analysis (ABA)

- ABA is the most commonly prescribed **evidence-based** treatment for ASD
- Decades of research demonstrate the effectiveness of ABA therapy for autism
- Many insurers still deny coverage for ABA based on the assertion that ABA therapy is "experimental." *This assertion is simply not supported by science*



American Academy
of Pediatrics



PRESENTED TO THE SENATE OF THE UNITED STATES

June 20, 2012

Testimony of
Vera F. Tait MD, FAAP

On behalf of the
American Academy of Pediatrics

Before the
Subcommittee on Personnel,
Senate Armed Services Committee

- "An example of a demonstrated, effective treatment for ASD is Applied Behavior Analysis, or ABA. ABA uses behavioral health principles to increase and maintain positive adaptive behavior and reduce negative behaviors or narrow the conditions under which they occur. ABA can teach new skills, and generalize them to new environments or situations. ABA focuses on the measurement and objective evaluation of observed behavior in the home, school, and community."



American Academy of Pediatrics • Department of Federal Affairs
601 20th Street NW, Suite 400 North • Washington, DC 20005
Tel: 800 368 5473 • Email: HHSaffairs@aap.org

1434
#1
3/14

American Academy
of Pediatrics
PEDIATRIC SOCIETY OF THE UNITED STATES OF AMERICA

June 20, 2012
Testimony of
Vera F. Tall MD, FAAP
On behalf of the
American Academy of Pediatrics
Before the
Subcommittee on Personnel,
Senate Armed Services Committee

• "ASD is a medical/
neurodevelopmental condition with
behavioral symptoms that are
directly addressed by applied
behavior analysis methods. ABA has
proved effective in addressing the
core symptoms of autism as well
as developing skills and improving
and enhancing functioning in
numerous areas that affect the
health and well-being of people with
ASD."

American Academy of Pediatrics • Department of Federal Affairs
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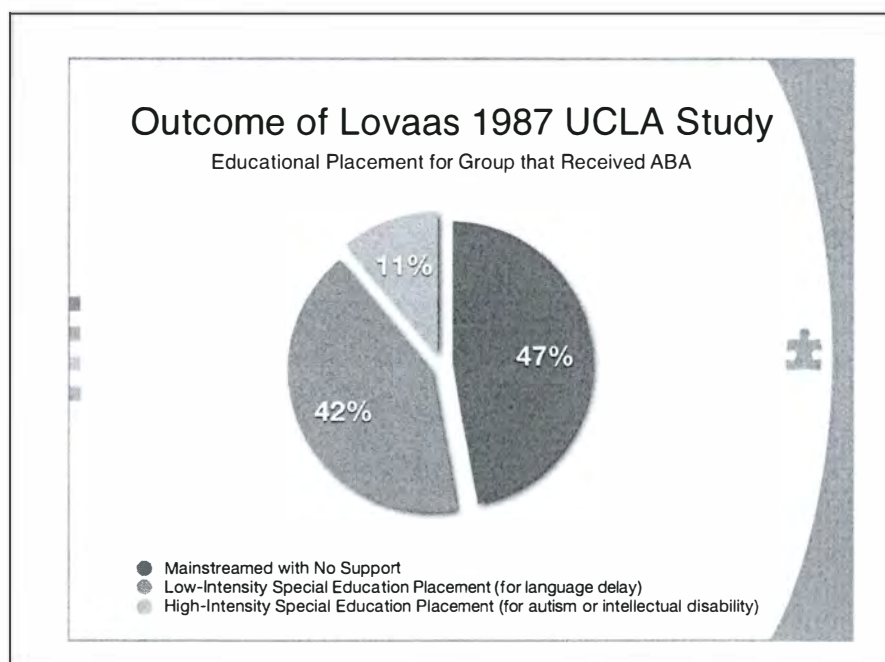
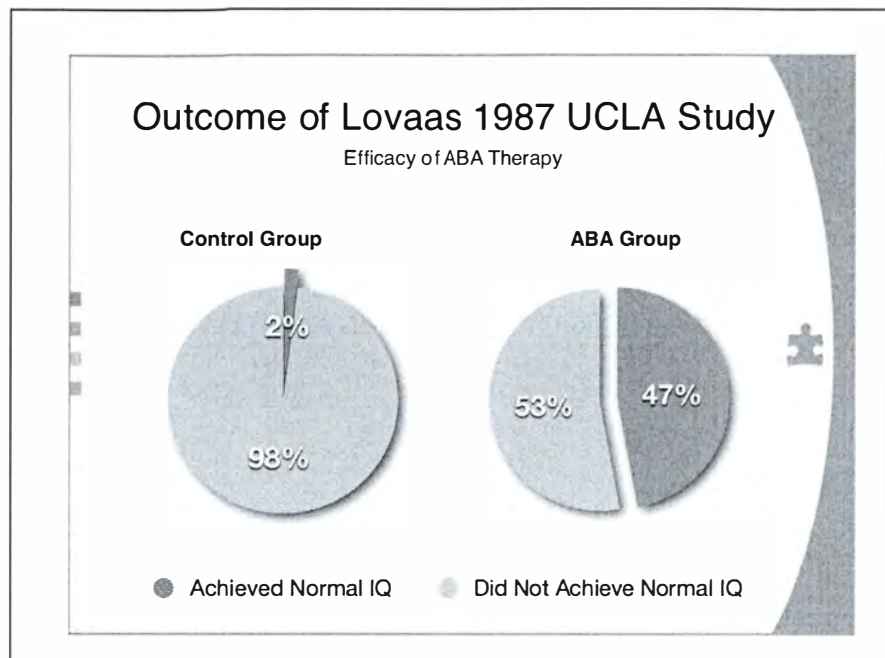
American Academy
of Pediatrics
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June 20, 2012
Testimony of
Vera F. Tall MD, FAAP
On behalf of the
American Academy of Pediatrics
Before the
Subcommittee on Personnel,
Senate Armed Services Committee

• "The effectiveness of ABA-based
interventions in ASDs has been well
documented through a long history of
research in university and community
settings. Children who receive early
intensive behavioral treatment have
been shown to make substantial gains
in cognition, language, academic
performance, and adaptive behavior
as well as some measures of social
behavior, and their outcomes have
been significantly better than those of
children in control groups."

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1434
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3/14



ABA endorsements

United States Surgeon General (1999)

"Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior."

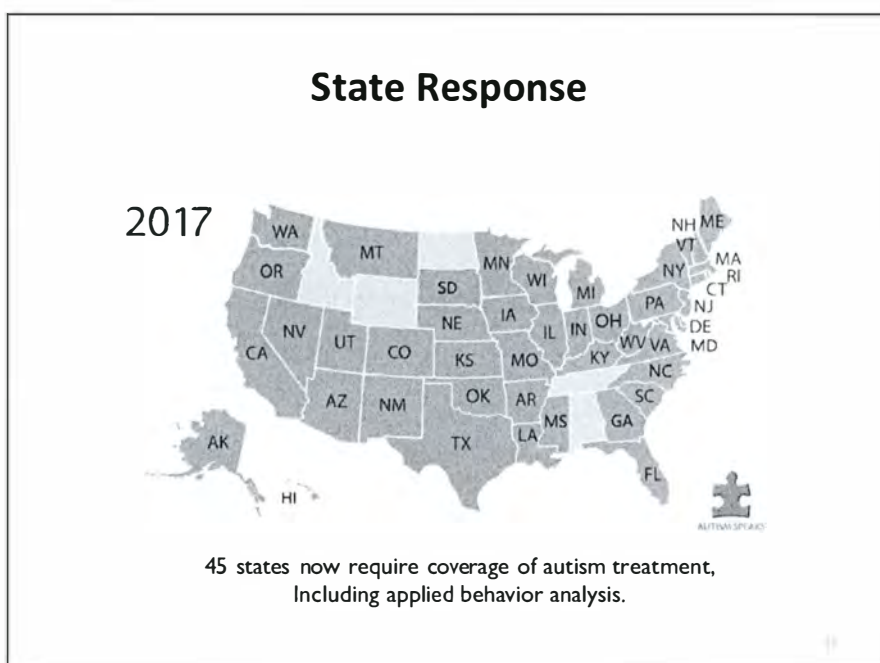
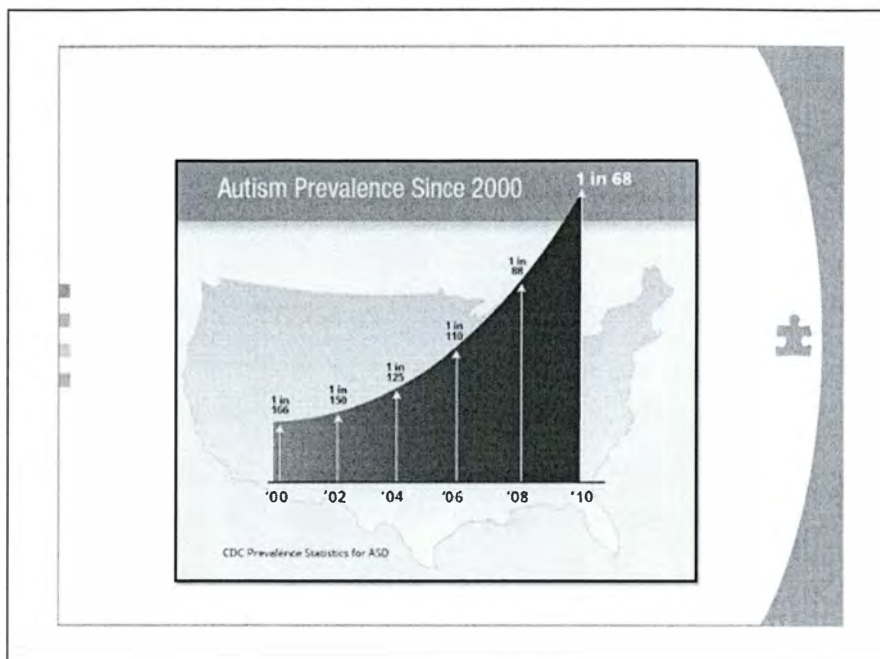
The U.S. Office of Personnel Management (2012)

"The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. The Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy. Accordingly, plans may propose benefit packages which include ABA."

Facing Financial Reality

- According to a 2007 study conducted by the Harvard School of Public Health, it costs approximately \$3.2 million to take care of an autistic person over his or her lifetime.
- The Ganz 2007 Harvard study also found that caring for all people with autism over their lifetimes costs an estimated \$35 billion per year in direct and indirect costs.
- Estimated lifetime cost **savings** of providing appropriate treatment are \$1 million per child (Jacobsen et al, 1998)

1434
#1
3/14



1434
#1
3/14

United States Department of Defense



Tricare provides meaningful autism coverage for both active duty and retired military personnel, including behavioral health treatment like applied behavior analysis.



What about the nation's largest employer?

- The Office of Personnel Management, which manages the Federal Employees Health Benefits Program (FEHB) has directed its carriers to cover applied behavior analysis (ABA) starting January 1, 2017.
- The FEHB program is the nation's largest employer-sponsored health benefits program, covering 8.2 million federal employees, retirees and dependents.



"We expect all carriers to offer clinically appropriate and medically necessary treatment for children diagnosed with ASD. "
OPM Letter to Carriers Dated February 26, 2016

In States with Autism Insurance Reform...

- People who have never before been able to receive treatment are making remarkable progress.
- Providers have joined adequate networks of participating providers and negotiated satisfactory reimbursement rates.
- The impact on premiums has been negligible.

Cost of Coverage

If the out of pocket cost of treatment can be as high as \$60,000 per child per year, how can the reported claims data be so low?

- Autism is a **spectrum** and treatment is individualized based on the severity and individual needs of the affected individual.
- **Utilization** of benefits is not 100%

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3/4

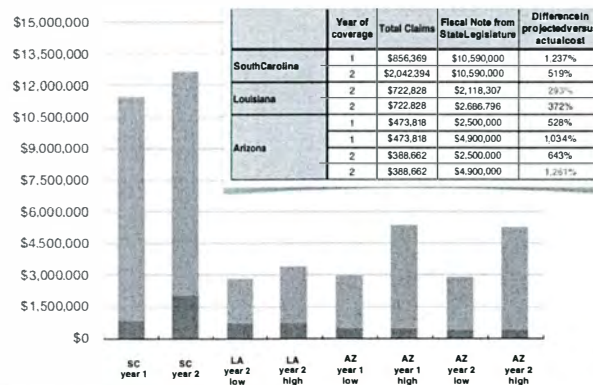
Utilization

- Of the estimated number of affected individuals, how many access treatment?
- Disease Prevalence \neq Treated Prevalence
- Based on claims data collected by Autism Speaks, estimated benefit utilization is 30-50%. (*Minnesota providers report 20%.*)
- Contributing factors?
 - undiagnosed individuals
 - parent choice
 - higher functioning
 - socioeconomic status

28

Projected vs Actual Costs

■ Actual Cost ■ Fiscal Note from State Legislature



1434
#1
3/14

The Cost of Autism Insurance Reform – Year Three

	Year of Coverage	Number of Covered Lives	Total Claims Paid	PMPM Cost
South Carolina	3	427,314	2,065,777	\$ 0.40
Illinois	3	208,466	416,741	\$ 0.17
Kansas	3	100,000	326,907	\$ 0.27
Missouri	3	1,443,680	8,289,917	\$ 0.48
Virginia	3	183,407	583,945	\$ 0.27
Iowa	3	79,000	205,573	\$ 0.22
New Jersey	3	597,104	4,482,066	\$ 0.63
Maine	3	29,637	67,384	\$ 0.19
Average Third Year Cost PMPM				\$ 0.45

References: Data collected by Autism Speaks from State agencies responsible for administering State Employee Health Benefits Programs (2011); Missouri Department of Insurance, Financial Institutions and Professional Registration (2012); and the Kansas Department of Health and Environment (2012)

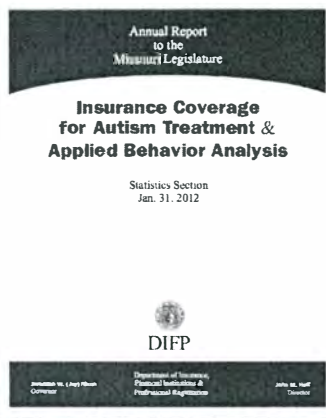
The Cost of Autism Insurance Reform – Year Four

	Year of Coverage	Number of Covered Lives	Total Claims Paid	PMPM Cost
Missouri	4	1,634,042	9,804,254	\$ 0.50
Virginia	4	179,634	1,065,180	\$ 0.49
Iowa	4	79,000	175,734	\$ 0.19
Average Fourth Year Cost PMPM				\$ 0.49

References: Data collected by Autism Speaks from State agencies responsible for administering State Employee Health Benefits Programs (2011); Missouri Department of Insurance, Financial Institutions and Professional Registration (2012); and the Kansas Department of Health and Environment (2012)

1434
#1
3/14

Effect on Premiums



- Claims incurred for treatment of ASD represent **0.9% of total claims**
- “While claims costs are expected to grow somewhat in the future, it seems very unlikely that costs for autism treatment will have an appreciable impact on insurance premiums.”

The Virginia State Corporation Commission reports to the Virginia General Assembly annually regarding the impact of health insurance mandates on the private health insurance market.



The 2013 report reflects the following:

The average annual claim cost per contract or certificate related to mandated coverage of autism spectrum disorder is \$2.19

This represents .04% of total claims reported and equates a premium impact for policyholders of **18 cents per member per month**

The 2014 report reflects the following:

The average annual claim cost per contract or certificate related to mandated coverage of autism spectrum disorder is \$2.66

This represents .06% of total claims reported and equates a premium impact for policyholders of **22 cents per member per month**

The 2015 report reflects the following:

The average annual claim cost per contract or certificate related to mandated coverage of autism spectrum disorder is \$3.50

This represents .05% of total claims reported and equates a premium impact for policyholders of **29 cents per member per month**

1434
#1
3/4

NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 2013 SURVEY TABLES

Percentage of employers providing coverage for autism spectrum disorders.

	Diagnostic services	Medication management	Speech, occ., physical therapies	Inpatient/outpatient treatment	Intensive behavioral therapies	Autism is not covered
Large employers	74%	63%	66%	56%	36%	18%
BY REGION						
West	74%	64%	70%	57%	41%	14%
Midwest	75	63	66	54	32	20
Northeast	74	61	68	59	39	20
South	74	65	69	56	32	18
BY INDUSTRY						
Manufacturing	79%	65%	69%	48%	29%	15%
Wholesale/Retail	70	51	61	55	26	22
Services	68	57	63	57	31	24
Transport/Communic./Utility	67	62	63	50	38	26
Healthcare	72	63	69	53	37	22
Financial services	87	72	78	76	55	8
Government	69	64	69	60	35	15
BY NUMBER OF EMPLOYEES						
500-999	69%	65%	64%	56%	31%	23%
1,000-4,999	79	64	72	57	39	16
5,000-9,999	70	52	65	47	30	20
10,000-19,999	78	57	70	62	40	13
20,000 or more	71	56	67	51	33	17

Mercer National Survey of Employer Sponsored Health Plans 2013

Self-Funded Plans that Provide Coverage for Autism Treatment

- Microsoft
- AT&T
- Turner Broadcasting
- Georgia Power
- Home Depot
- Arnold & Porter
- Symantec
- Cisco
- Children's Healthcare of Atlanta
- Eli Lilly
- UTC
- Ohio State University
- Time Warner
- John Deere
- MIT
- Blackbaud
- Partners Healthcare
- Deloitte
- White Castle
- Wal Mart
- Bank of America
- JP Morgan Chase
- University of Minnesota
- Progressive Group
- Intel
- DTE Energy
- Emory University
- SunTrust
- Cerner
- Merck
- State Street Corporation
- Children's Mercy
- Capital One
- Yahoo
- Rubbermaid Newell
- Sisters of Mercy Health Systems
- Princeton University
- Wells Fargo
- Jet Blue
- American Airlines
- Southern Baptist Convention
- Northern Trust
- Abbott Labs
- GE
- General Motors
- EMC
- American Express
- Liberty Mutual
- Michelin
- National Grid
- Safeway
- RR Donnelly
- T Rowe Price
- Morgan Stanley
- Price Waterhouse Coopers
- And Many more..

WALL STREET JOURNAL

- More Autism Help... As diagnoses of autism rise, a growing number of families are grappling with the worry and expense of finding treatment for children with the complex developmental disorder, autism. And many are pressing employers and legislators for help.

(Wall Street Journal)

[http://online.wsj.com/article/](http://online.wsj.com/article/SB10001424052748703867704576183022242647068.html)

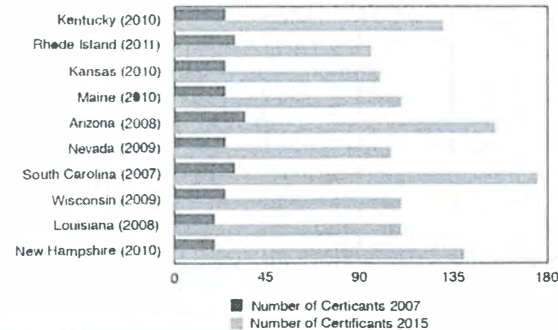
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- Bernie Marcus, Co-Founder Home Depot ... "The insurance lobbies obviously don't want to cover it and yet **we know the cost is only 32 cents per month per member. And they're fighting it tooth and nail. I put it into Home Depot years ago and I will tell you, it didn't break Home Depot.** "

Job Growth in States with Autism Insurance Reform Laws

State/(Year Law Passed)

Board Certified Behavior Analyst Provider Growth By State



What Should an Autism Benefit Look Like?

- Coverage should include
 - Applied Behavior Analysis (ABA) Therapy
 - Speech Therapy, Occupational Therapy, and Physical Therapy
 - Psychological, Psychiatric, and Pharmaceutical Care
 - Diagnosis and Assessments

What Should an Autism Benefit Look Like?

- No denials on the basis that treatment is
 - Habilitative in nature
 - Educational in nature
 - Experimental in nature
- For Applied Behavior Analysis coverage, treatment must be provided or supervised by a behavior analyst who is certified by the Behavior Analyst Certification Board®, or
 - a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience

1434
#1
3/14

About Autism Speaks

Autism Speaks is the world's largest autism science and advocacy organization, dedicated to funding research into the causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families.

Autism Votes is an Autism Speaks initiative; a comprehensive grassroots advocacy program, coordinating activist efforts in support of federal and state legislative initiatives.

For more information, please visit www.autismvotes.org and www.autismspeaks.org

Contact Information

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Michael Wasmer, DVM, DACVIM

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Director State Government Affairs
Autism Speaks
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About Autism Speaks

Autism Speaks Autism Speaks is the world's leading autism science and advocacy organization. It is dedicated to funding research into the causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families.

Autism Speaks was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Mr. Wright is the former vice chairman of General Electric and chief executive officer of NBC and NBC Universal. Since its inception, Autism Speaks has committed more than \$500 million to its mission, the majority in science and medical research.

Each year *Walk Now for Autism Speaks* events are held in more than 100 cities across North America. On the global front, Autism Speaks has established partnerships in more than 40 countries on five continents to foster international research, services and awareness.

To learn more about Autism Speaks, please visit www.AutismSpeaks.org



HB1434
#2
3/4

Testimony of Brent Bogar
Greater North Dakota Chamber
HB 1434
March 6, 2017

Madam Chairwoman and members of the committee, my name is Brent Bogar. I am here representing the Greater North Dakota Chamber (GNDC), the champions for business in North Dakota. GNDC is working on behalf of our more than 1,100 members to build the strongest business environment in North Dakota. As a group, we stand in opposition of HB 1434.

The Greater North Dakota Chamber supports the appropriate coverage and health care for all individuals in North Dakota. This issue is about the state taking a position to require insurance to cover a certain disorder, or a mandate to provide coverage. GNDC believes that market forces should help to determine the best products and services available, and that through competition the marketplace can and will develop appropriate solutions.

The bill as it stands also provides for exclusions of certain classes of plans. By creating a system in which certain plans are required to meet new requirements and others do not HB 1434 is creating an unequal position in the marketplace for coverage. It is not clear whether those plans that are exempted from the requirement of coverage would also not make the premium payment adjustment, or would those plans then see the premium increase and not receive the benefits? This type of discrepancy will create confusion for those people that change plans, as well as for the providers of coverage.

Currently, as a nation we are seeing dialogue for changes at the federal level regarding health care coverage. The uncertainty of any changes to the Affordable Care Act, or "Obamacare," also should cause pause to the state adding additional regulatory requirements. Any time that there is uncertainty in the marketplace, costs become unknown and difficult for businesses to manage cost and expenses.

Thank you for allowing me to appear before you in opposition to HB 1434. I know this can be an emotional issue, but when the emotion is removed and the issues as discussed are reviewed, we hope this committee understands the need for the State of North Dakota to minimize mandates and requirements on businesses. The Greater North Dakota Chamber urges a Do Not Pass on HB 1434.



Please Support House Bill 1434 Autism Insurance Reform for North Dakota Families



HB1434
#3
3/14

AUTISM INSURANCE REFORM IS FISCALLY CONSERVATIVE

- **Actual claims data** from other states that have required similar coverage for multiple years indicates an **average premium impact of 31-49 cents per member per month** -- less than a cost of a postage stamp.
- Approximately **250,000 covered lives in North Dakota** have private health insurance regulated by state law. These families and their employers have *no* access to meaningful autism coverage, even though they pay their health insurance premiums every month.
- According to the Harvard School of Public Health, **the** lifetime per capita incremental societal cost of autism is **\$3.2 million**. Lost productivity and adult care are the largest components of costs. The distribution of costs over the life span varies by cost category. Although autism is typically thought of as a disorder of childhood, its costs can be felt well into adulthood. The substantial costs resulting from adult care and lost productivity of both individuals with autism and their parents have important implications for those aging members of the baby boom generation approaching retirement, including large financial burdens affecting not only those families but also potentially society in general. (Ganz, 2007)
- The financial implications of the increased prevalence of autism, though rarely discussed, are extremely important to society. Chasson compared the costs associated with 18 years of special education to the costs associated with the implementation of an average of 3 years of Discrete Trial Training as an Early Intensive Behavioral Intervention (EIBI) in an effort to minimize the need for special education. **Results indicate that the state of Texas would save \$208,500 per child across eighteen years of education with EIBI. When applied to the conservative estimate of 10,000 children with autism in Texas, the State would save a total of \$2.09 billion with EIBI.** (Chasson, 2007)
- **State estimated lifetime cost savings of providing appropriate treatment are \$1 million per child.** At varying rates of effectiveness and in constant dollars, estimated cost savings range from \$187,000 to \$203,000 per child for ages 3±22 years, and from \$656,000 to \$1,082,000 per child for ages 3±55 years. (Green, Jacobsen et al, 1998)
- The costs of treatments covered could be expected to be recovered through reductions in educational and medical expenditures alone. (Oliver Wyman, 2011)

For additional information please contact
judith.ursitti@autismspeaks.org or NDAutismReform@gmail.com

 [@NDAutismReform](https://twitter.com/NDAutismReform)



HB1434
#4
3/14
pg. 1

March 6, 2017

North Dakota Senate
Human Services Committee
Bismarck, North Dakota

Re: House Bill 1434

Madam Chair and Members of the Human Services Committee:

I write to you today in strong support of House Bill 1434 which would simply require North Dakota regulated health insurance plans to cover basic, evidence-based autism treatment. I do not write representing any providers or business interest, but rather in support of North Dakota families struggling with the challenges of autism in every corner of the state.

As you likely are already aware, autism is a spectrum disorder which affects a person's communication abilities and social skills and often causes repetitive patterns of behavior and a narrow range of interests. Its symptoms can range from mild to quite severe. The CDC estimates that 1 in 68 children in the United States are now diagnosed with this disorder.

Recognizing the importance of early intervention, The American Academy of Pediatrics recommends screening every child for autism at their 18 and 24 month checkups. Autism is subsequently diagnosed, based on strict criteria found in The Diagnostic and Statistical Manual of Mental Disorders.

Early diagnosis and treatment are critical to a positive outcome for individuals with autism. Treatment is prescribed by a licensed physician or licensed psychologist. As reflected in the current version of House Bill 1434, current evidence-based treatment for autism includes:

- Behavioral health treatment (including Applied Behavior Analysis)
- Speech, Occupational and Physical Therapy
- Psychological, Psychiatric and Pharmaceutical Care

1434
#4
3/14
pg. 2

Applied Behavior Analysis (ABA) is the most commonly prescribed, evidence-based treatment for autism. Decades of research demonstrate the effectiveness of ABA therapy for the challenges of autism. Unfortunately, state-regulated insurers still deny coverage for ABA, frequently based on the assertion that ABA therapy is "experimental." This assertion is simply not supported by science.

The American Academy of Pediatrics, for example, states that

ASD is a medical/neurodevelopmental condition with behavioral symptoms that are directly addressed by applied behavior analysis methods. ABA has proved effective in addressing the core symptom of autism as well as developing skills and improving and enhancing functioning in numerous areas that affect the health and well-being of people with ASD.

The effectiveness of ABA interventions in ASD's has been well documented through a long history of research in university and community settings. Children who receive early intensive behavioral treatment have ben shown to make substantial gains in cognition, language, academic performance and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups.

Without this critical intervention, however, individuals with autism may never learn to speak or connect with the world around them. From a personal perspective, this is a devastating consequence for the individual and their family. From a fiscal perspective, the implication for the North Dakota taxpayer is dire.

According to a 2007 study from the Harvard School of Public Health, it costs about \$3.2 million to care for an individual with autism over their lifetime. In contrast, estimated lifetime cost savings of providing appropriate treatment is \$1 million per child. (Please see attached information.)

Because in great part of the fiscal implications, over the past decade states have taken action to require health insurers to cover basic, evidence-based treatment for autism. To date, 45 states have done so. In addition, the US Department of Defense has offered coverage of ABA to their active-duty and retirees for many years. The nation's largest employer, the Federal Employee Health Plan, has also been rolling out coverage over the last couple of years to their 8 million employees.

In the 45 states where autism insurance reform legislation has been passed, people who have never before been able to receive treatment are making remarkable progress. Providers have joined networks, building the workforce.

1434
#4
3/14
pg.3

(See workforce graphic in attached information.) The impact on premiums, which is of great concern, has also been negligible.

Average claims impact reported by state employee health plans and state bureaus of insurance indicate a range of 31-49 cents per member per month. (See attached handout.) This moderate impact reflects the reality that autism is a spectrum and treatment is individualized based on severity. Similar to other health conditions, utilization is not 100%.

Because of the efficacy of the treatment and the growing number of states requiring coverage over the years, many self-funded employers (which are federally regulated and can't be regulated by the states) are now offering coverage as well. According to the Mercer National Survey of Employer-Sponsored Health Plans, almost 40% of self-funded plans now cover autism treatment, including intensive behavioral therapies like ABA. This number continues to grow. Some examples of self-funded companies that cover ABA are Wells Fargo, Microsoft, United Technologies and John Deere. (A list of more examples is included in the attached information.)

In closing, it has been my honor and privilege to provide support to your constituents in North Dakota over the years, as they work to ensure their children with autism are simply treated fairly. They work hard and pay their health insurance premiums. Basic, evidence-based treatment for autism is broadly covered around the nation. It is their hope (and mine as well) that North Dakota legislators will work to find a viable, meaningful solution. It is my assertion that common-sense solution lies in the passage of House Bill 1434, which simply requires coverage of evidence-based treatment.

Please know that this community has and will continue to communicate with North Dakota health plans, who have most recently told us they are *considering* the addition of coverage *at some point*. The lack of specificity (nothing in writing and no timeline provided) warrants concern and action by the legislature. How many human lives will be impacted by this ambiguity?

North Dakotans for Autism Reform is also working with providers to ensure that North Dakota licensed-practitioners providing evidence-based therapy for autism are included in the legislation. The reflected age caps and dollar caps on Applied Behavior Analysis in House Bill 1434 were placed there by amendment in the House Human Services Committee. They are certainly negotiable as it is important that this legislation require meaningful coverage of *all* health plans that are regulated by the state of North Dakota. Amendments are available for your consideration to address concerns.

North Dakota children with autism, their families, and ultimately the taxpayers of North Dakota who will bear the financial burden of caring for individuals who haven't received adequate, medically necessary care, are looking to you for

1434
#4
3/14
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common sense leadership on this issue. Please move House Bill 1434 with a "Do Pass" recommendation out of your committee this year.

Respectfully,

Judith Ursitti, CPA
Director – State Government Affairs

Attachments

1434
#5
3/14

NEWS

Board revokes license of Fargo doctor who ran clinics in Minnesota

By **ASSOCIATED PRESS** |

PUBLISHED: August 27, 2008 at 11:01 pm | UPDATED: November 14, 2015 at 4:27 am

BISMARCK, N.D. — North Dakota's medical watchdog panel has revoked a Fargo doctor's medical license.

Dr. Rodney Lee's license was revoked Wednesday by the state Board of Medical Examiners. The panel accused Lee of sloppy handling of addictive painkillers and overbilling the state's Medicaid program.

The board suspended Lee's medical license last month. Judge Allen Hoberg made a recommendation last week to revoke Lee's license. The board says it followed Hoberg's recommendation, and ordered Lee to pay the cost of prosecution.

Lee ran RapidCare clinics in Fargo and Grand Forks in North Dakota, and in Moorhead and Detroit Lakes in Minnesota.

Lee's attorney, John Goff, told the that Lee accepted responsibility for his actions, but never intended to harm anyone.



Associated Press



As you comment, please be respectful of other commenters and other viewpoints. Our goal with article comments is to provide a space for civil, informative and constructive conversations. We reserve the right to remove any comment we deem to be defamatory, rude, insulting to others, hateful, off-topic or reckless to the community. See our full terms of use [here](#).

VIEW COMMENTS

MFCU Statistical Data for Fiscal Year 2016

State	Investigations ¹			Indicted/Charged			Convictions			Civil Settlements and Judgments	Recoveries ²				Expenditures ⁴		Staff on Board
	Total	Fraud	Abuse/ Neglect	Total	Fraud	Abuse/ Neglect	Total	Fraud	Abuse/ Neglect		Total Recoveries	Criminal Recoveries	Civil Recoveries		MFCU	Medicaid	
													Global ³	Other			
Alabama	64	43	21	23	7	16	20	3	17	11	\$17,034,541	\$113,178	\$16,921,363	\$0	\$1,379,111	\$5,657,488,854	8
Alaska	141	140	1	18	18	0	29	29	0	11	\$3,093,089	\$1,804,185	\$1,288,904	\$0	\$1,394,058	\$1,929,110,081	10
Arizona	171	133	38	76	46	30	75	61	14	11	\$10,525,172	\$6,514,601	\$4,010,571	\$0	\$2,770,174	\$11,343,767,402	21
Arkansas	147	118	29	22	16	6	27	20	7	26	\$9,266,817	\$204,922	\$8,085,098	\$976,797	\$2,437,992	\$6,337,245,143	16
California	1,735	1,169	566	231	147	84	173	98	75	32	\$136,201,028	\$27,240,288	\$103,375,056	\$5,585,684	\$32,469,156	\$86,608,583,280	185
Colorado	226	223	3	7	7	0	12	12	0	97	\$14,617,470	\$899,190	\$9,304,300	\$4,413,980	\$2,178,699	\$8,289,970,721	14
Connecticut	82	81	1	3	3	0	6	6	0	19	\$20,786,363	\$63,457	\$18,029,857	\$2,693,048	\$2,135,726	\$7,790,671,895	11
Delaware	635	603	32	20	5	15	19	11	8	10	\$2,012,900	\$197,534	\$1,615,472	\$199,894	\$1,989,706	\$2,003,364,878	16
D.C.	129	126	3	1	1	0	7	6	1	10	\$91,207,067	\$83,344,915	\$1,710,850	\$6,151,303	\$2,812,205	\$2,935,002,292	20
Florida	664	606	58	78	61	17	51	41	10	21	\$165,545,718	\$101,059,813	\$58,413,444	\$6,072,461	\$17,316,568	\$22,457,578,621	156
Georgia	495	479	16	19	17	2	15	14	1	18	\$31,571,210	\$2,634,624	\$12,686,801	\$16,249,785	\$4,719,262	\$10,283,904,205	44
Hawaii	441	405	36	6	6	0	5	4	1	13	\$1,856,104	\$91,071	\$1,765,033	\$0	\$1,622,502	\$2,271,886,352	14
Idaho	116	110	6	3	3	0	3	3	0	9	\$2,655,166	\$15,126	\$2,640,039	\$0	\$833,297	\$1,794,759,439	7
Illinois	329	281	48	71	53	18	57	46	11	13	\$35,478,915	\$4,605,086	\$30,223,829	\$650,000	\$7,137,131	\$20,172,293,337	41
Indiana	1,745	1,264	481	27	18	9	47	37	10	27	\$36,928,401	\$2,739,336	\$32,724,220	\$1,464,844	\$6,484,688	\$10,901,014,576	58
Iowa	309	267	42	80	42	38	63	37	26	22	\$10,656,073	\$230,695	\$7,023,005	\$3,402,374	\$1,133,997	\$4,914,249,752	10
Kansas	158	141	17	6	6	0	7	7	0	11	\$9,274,992	\$47,736	\$8,927,256	\$300,000	\$1,337,183	\$3,421,881,490	14
Kentucky	117	77	40	30	26	4	19	10	9	16	\$47,635,513	\$131,735	\$23,279,694	\$24,224,084	\$3,415,842	\$9,893,628,407	30
Louisiana	492	406	86	86	64	22	75	69	6	16	\$40,374,660	\$10,770,898	\$18,323,027	\$11,280,735	\$5,710,826	\$8,837,228,184	54
Maine	88	74	14	9	2	7	3	0	3	12	\$24,387,068	\$650	\$24,386,418	\$0	\$910,641	\$2,636,443,851	8
Maryland	381	294	87	7	2	5	9	5	4	20	\$10,396,359	\$129,969	\$9,930,035	\$336,355	\$3,843,664	\$10,819,233,860	33
Massachusetts	485	437	48	15	15	0	4	4	0	35	\$82,844,082	\$54,616	\$77,975,202	\$4,814,263	\$5,394,276	\$17,865,505,404	40
Michigan	511	472	39	19	14	5	24	14	10	26	\$32,312,718	\$191,390	\$30,681,104	\$1,440,225	\$5,053,299	\$17,438,676,650	32
Minnesota	397	392	5	65	62	3	42	42	0	12	\$26,129,645	\$1,181,413	\$24,945,482	\$2,750	\$2,367,287	\$11,544,958,884	24
Mississippi	527	101	426	54	14	40	64	6	58	14	\$19,821,844	\$7,814,578	\$11,476,226	\$531,040	\$3,406,068	\$5,563,413,438	35
Missouri	171	153	18	23	21	2	21	20	1	16	\$13,494,876	\$479,804	\$12,488,713	\$526,359	\$2,215,566	\$10,201,941,673	24
Montana	55	46	9	7	4	3	6	4	2	13	\$1,593,763	\$45,403	\$1,548,360	\$0	\$679,021	\$1,446,698,958	6
Nebraska	99	92	7	9	7	2	12	10	2	21	\$19,443,143	\$15,080,673	\$3,341,351	\$1,021,119	\$934,567	\$2,092,993,865	9
Nevada	417	413	4	14	14	0	14	14	0	15	\$2,389,471	\$593,799	\$1,730,172	\$65,500	\$2,093,050	\$3,520,421,319	19
New Hampshire	66	32	34	2	0	2	1	0	1	9	\$2,058,999	\$8,214	\$2,050,785	\$0	\$770,510	\$2,076,589,333	8
New Jersey	404	379	25	14	8	6	25	21	4	13	\$47,320,818	\$1,269,801	\$46,051,017	\$0	\$3,899,420	\$15,080,356,828	35
New Mexico	184	181	3	6	6	0	6	6	0	15	\$6,205,203	\$50,413	\$3,465,867	\$2,688,923	\$2,190,671	\$5,537,037,048	21
New York	707	589	118	113	71	42	120	88	32	80	\$228,866,107	\$157,846	\$145,266,934	\$83,441,327	\$47,018,833	\$62,909,519,309	298
North Carolina	387	378	9	20	15	5	25	22	3	23	\$80,416,129	\$11,875,419	\$63,043,469	\$5,497,242	\$5,944,944	\$12,821,165,394	51
Ohio	1,460	1,017	443	122	102	20	126	110	16	16	\$64,010,493	\$23,031,251	\$40,365,343	\$613,899	\$11,278,343	\$22,485,693,773	94
Oklahoma	254	206	48	37	28	9	25	15	10	16	\$21,469,407	\$1,642,636	\$13,974,669	\$5,852,102	\$2,433,434	\$4,698,727,448	23
Oregon	94	87	7	30	28	2	30	24	6	13	\$10,312,944	\$937,896	\$8,962,548	\$412,500	\$2,380,639	\$8,814,205,907	16
Pennsylvania	486	451	35	85	83	2	81	81	0	11	\$42,140,800	\$1,722,619	\$40,418,181	\$0	\$7,415,937	\$28,220,307,793	46
Rhode Island	90	76	14	15	5	10	10	2	8	12	\$6,373,535	\$9,003	\$6,090,923	\$273,609	\$1,326,223	\$2,626,681,914	12
South Carolina	195	146	49	13	6	7	15	9	6	16	\$16,495,835	\$793,391	\$15,168,293	\$534,152	\$1,704,531	\$6,230,510,941	16
South Dakota	46	40	6	3	3	0	1	1	0	20	\$2,319,912	\$1,094	\$2,009,259	\$309,560	\$438,343	\$875,472,076	5
Tennessee	273	242	31	35	22	13	40	21	19	22	\$105,835,521	\$1,451,883	\$93,223,123	\$11,160,515	\$4,828,604	\$9,928,469,426	36
Texas	1,367	1,236	131	109	97	12	60	51	9	21	\$128,257,249	\$53,618,692	\$73,682,086	\$956,471	\$18,832,570	\$41,068,187,142	165
Utah	134	106	28	7	1	6	4	0	4	29	\$10,033,408	\$53,620	\$2,123,664	\$7,856,124	\$2,056,785	\$2,251,931,573	13
Vermont	61	53	8	10	8	2	16	15	1	17	\$7,907,487	\$271,096	\$6,806,872	\$928,535	\$1,768,236,337	\$7	7
Virginia	412	409	3	43	40	3	42	38	4	21	\$33,889,093	\$2,499,780	\$25,868,433	\$5,520,880	\$11,445,452	\$8,927,198,595	92
Washington	201	193	8	7	6	1	10	9	1	17	\$55,306,211	\$122,620	\$52,435,513	\$2,748,078	\$4,534,668	\$11,458,035,943	36
West Virginia	158	143	15	20	19	1	10	6	4	21	\$5,271,732	\$488,454	\$3,556,154	\$1,227,123	\$1,257,637	\$3,813,616,346	16
Wisconsin	367	344	23	0	0	0	7	7	0	18	\$81,071,820	\$104,688	\$20,967,132	\$60,000,000	\$1,342,631	\$8,026,421,926	12
Wyoming	57	55	2	1	0	1	1	1	0	11	\$1,435,973	\$107,632	\$1,328,341	\$0	\$493,574	\$637,273,743	4
Grand Total	18,730	15,509	3,221	1,721	1,249	472	1,564	1,160	404	998	\$1,876,532,842	\$368,498,733	\$1,225,709,487	\$282,324,622	\$258,698,147	\$571,229,555,606	1,965

¹ Investigations are defined as the total number of open investigations at the end of the fiscal year.

² Recoveries are defined as the amount of money that defendants are required to pay as a result of a settlement, judgment, or pre-filing settlement in criminal and civil cases and may not reflect actual collections. Recoveries may involve cases that include participation by other Federal and State agencies.

³ "Global" recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

⁴ MFCU and Medicaid Expenditures include both State and Federal expenditures. In previous years, these expenditures were entitled "MFCU Grant" and "Total Medicaid" respectively.

Information in this chart was reported to OIG by the 50 State MFCUs, except Total Medicaid Expenditures. Abuse/Neglect cases are defined to include "patient funds" cases.

All information is current as of January 26, 2017.

HB 1434
#6
3/14

NDLA, S HMS - Johnson, Marne

HB1434
7
3/14
Pg. 1

From: Lee, Judy E.
Sent: Tuesday, March 14, 2017 8:36 PM
To: NDLA, S HMS - Johnson, Marne
Subject: Fwd: HB1434

Copies, please

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Phone: 701-282-6512
e-mail: jlee@nd.gov

Begin forwarded message:

From: Lisa Faust <jlee@nd.gov>
Date: March 14, 2017 at 8:33:45 PM CDT
To: "Judy Lee (jlee@nd.gov)" <jlee@nd.gov>
Cc: Pam Gulleon <Pam.Gulleon@bcbsnd.com>, Megan Houn <Megan.Houn@bcbsnd.com>
Subject: HB1434

CAUTION: This email originated from an outside source. Do not click links or open attachments unless you know they are safe.

Hi Senator Lee,

This is in follow up to your questions about FEP. While the Federal Employee Program does not allow us to reproduce the benefit, I thought it might be helpful to give you our internal interpretation information:

ABA is covered in 2017 as a habilitative benefit for FEP plans. To qualify for this benefit the individual must have a diagnosis of autism.

- A comprehensive evaluation for autism spectrum disorder with a diagnosis of autism spectrum disorder needs to be performed prior to a referral for ABA. Recommendation for a functional behavioral assessment must be made by the diagnosing provider. The comprehensive evaluation needs to be completed by a licensed provider working within their scope of practice. This assessment does not require preauthorization.
- Prior Approval is required for the following:
 - The initial assessment visit (i.e. functional behavioral assessment (FBA) to develop ABA treatment Plan)
 - All ABA therapy.

For purpose of the FEP benefit, accepted ABA therapies include: UCLA/Lovas Method, Discrete Trial Teaching, Pivotal Response Training, Treatment and Education of Autistic & Communication related handicapped Children (TEACCH), Early Start Denver Model (ESDM), Picture exchange Communication System (PECS) Functional Communication training and Verbal Behavior,

1434
#7
3/14
PA2

Developmental individual difference, Relationship based model (DIR), Social commination, Emotional regulation and Transactional supports (SCERTS).

In addition, the website for FEP is available for public viewing or copying:

https://media.fepblue.org/-/media/PDFs/Brochures/2017_SBP_%20Brochure.pdf

The references to ABA are on Pages 16, 22, 55,65, 88 and 132.

I hope this is of some benefit.

Best regards,

Lisa

Elizabeth Faust, MD
Senior Medical Director
Behavioral Health
Blue Cross Blue Shield North Dakota
701.277.2477(work) | 701.306.1217(cell)
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HB 1434
8
3/4

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

Page 1, line 2, remove "and"

Page 1, line 3, after "management" insert "; and to provide for application"

Page 2, line 20, remove "in insureds under nineteen years of age."

Page 2, remove lines 21 through 23

Page 2, line 24, remove "amended, adjusted, or renewed in this state"

Page 2, remove lines 30 and 31

Page 3, remove lines 1 and 2

Page 3, line 3, replace "5." with "4."

Page 3, remove lines 5 through 30

Page 4, line 1, replace "11." with "5."

Page 4, after line 9, insert:

"SECTION 2. APPLICATION. This Act applies to health insurance policies
issued or renewed after the effective date of this Act."

Renumber accordingly

HB 1434
#1
3/15
Pg. 1

North Dakota Autism Spectrum Disorder Advocacy Coalition (NDASDAC)

March 12, 2017

RE: HB 1434

To: ND Senate Human Services Committee

From: The North Dakota Autism Spectrum Disorder Advocacy Coalition

Chairperson Lee and Committee Members, please accept this testimony on behalf of the North Dakota Autism Spectrum Disorders Advocacy Coalition (NDASDAC).

Formed in early 2013, the Coalition members were initially at odds over an array of proposed autism-related services. Advocates came together to attempt agreement on the best approaches for people with autism spectrum disorders. We found that, collectively, we had much more in common than we had anticipated. Through a series of consensus-based decision-making meetings, the organizations comprising the Coalition have reached agreement on key program elements of Autism Spectrum Disorders services for the people of North Dakota.

The Coalition meets monthly following our mission of *advocating for improved, informed, and appropriate public policies and superior service provision for all people on the autism spectrum statewide.*

The NDASDAC supports and recognizes the importance of insurance coverage in accessing the services needed by people on the autism spectrum. As one of only a few states without such coverage, this issue is a priority for the Coalition and for the people of North Dakota. Thank you for your time.

North Dakota Autism Spectrum Disorder Advocacy Coalition 2017



Family Voices of North Dakota
312 2nd Ave. W – PO Box 163
Edgeley, ND 58433
701.493.2634



Anne Carlsen Center
701 3rd Ave. NW – PO Box 8000
Jamestown, ND 58402
701.252.3850



Red River Valley
Asperger - Autism Network
701.566.1675



North Dakota Protection & Advocacy
Project
400 E. Broadway Ave. – Suite 409
Bismarck, ND 58501
701.328.2950



The Arc of Bismarck
PO Box 2081
Bismarck, ND 58502
701.222.1854



ND Federation of Families
For Children's Mental Health
PO Box 3061
Bismarck, ND 58502
701.222.3310



Prairie St. John's
510 4th Street South
Fargo, ND 58103
701.476.7200

North Dakota Insurance Department

Data Call as of 8/1/2016- Cumulative data for BCBS, Sanford, Medica and NDPer's

ND PERS			NOTES
	Contracts (Employees)	Covered Lives	
	29,125	66,690	Require Coverage
Small Group- Fully Insured only			
	Contracts (Employees)	Covered Lives	
Non-GRF (ACA & Transitional plans)			Exempt from coverage
Total	16,725	31,100	
Grandfathered			Require Coverage
Total	16,289	31,811	
Individual- Fully Insured only			
	Contracts (Employees)	Covered Lives	
Non-GRF (ACA & Transitional plans)			Exempt from coverage
Total	25,494	43,669	
Grandfathered			Require Coverage
Total	3,691	7,673	
Large group- Fully Insured only			
	Contracts (Employees)	Covered Lives	
Non-GRF (ACA & Transitional plans)			Require Coverage
Total	63,522	134,511	
Grandfathered			Require Coverage
Total	55,252	116,280	
Self-Funded plans			Exempt from coverage
	Contracts (Employees)	Covered Lives	
TOTAL	83,841	180,495	

Totals of required coverage by 1434	167,879	356,965
Totals of NO required coverage by 1434	126,060	255,264

Please NOTE- Transitional plans referenced above would be required to provide the Autism benefit. This chart is intended to show the non-Grandfathered plans in ND. The transitional plans in the state are 1713 covered lives, so that number can be subtracted from exempt total and added to the required total.

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of autism services; to require a report regarding coverage of autism services; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Coverage of autism services.

1. As used in this section:
 - a. "Applied behavior analysis" has the same meaning as "practice of applied behavior analysis" as defined under section 43-32-01.
 - b. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the "Diagnostic and Statistical Manual of Mental Disorders," American psychiatric association, fifth edition (2013) or a more recent version as identified by the board or as defined by the edition in effect at the time of diagnosis.
 - c. "Behavioral health treatment" means a counseling or treatment program, including applied behavior analysis, that is:
 - (1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
 - (2) Provided or supervised by a licensed behavior analyst or psychologist.
 - d. "Diagnosis of autism spectrum disorder" means any medically necessary assessment, evaluation, or test to diagnose whether an individual has an autism spectrum disorder.
 - e. "Pharmacy care" means a medication prescribed by an individual authorized to prescribe such a medication and any health-related service deemed medically necessary to determine the need or effectiveness of the medication.
 - f. "Psychiatric care" means a direct or consultative service provided by a psychiatrist licensed in the state in which the psychiatrist practices.
 - g. "Psychological care" means a direct or consultative service provided by a psychologist licensed in the state in which the psychologist practices.

- h. "Therapeutic care" means any service provided by a licensed speech language pathologist, occupational therapist, or physical therapist.
- i. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care is medically necessary, including behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.

2. For all policies that become effective after June 30, 2017, and which do not extend past June 30, 2019, the board shall provide health benefits coverage for the screening for, diagnosis of, and treatment for autism spectrum disorder in covered individuals under nineteen years of age.

a. Coverage under this section is not subject to limitations on the number of visits a covered individual may make for treatment for autism spectrum disorder.

b. Except as allowed under subdivision c, coverage under this section is not subject to dollar limits, deductibles, or coinsurance provisions less favorable to a covered individual than the dollar limits, deductibles, or coinsurance provisions that apply to substantially all medical and surgical benefits under the health benefits coverage.

c. Coverage for applied behavioral analysis under this section must provide an annual maximum benefit of:

(1) Thirty-six thousand dollars for individuals under the age of seven;

(2) Twenty-five thousand dollars for individuals between the ages of seven and not yet fourteen; and

(3) Twelve thousand five hundred dollars for individuals between the ages of fourteen and not yet nineteen.

d. The coverage for applied behavior analysis must include the services of the personnel who work under the supervision of the licensed behavior analyst or psychologist overseeing the program.

e. Except for inpatient services, if a covered individual is receiving treatment for an autism spectrum disorder, the coverage may allow for annual review of the treatment plan, unless a more frequent review is necessary. An agreement regarding the right to review a treatment plan more frequently than annually is limited in application to a particular covered individual being treated for an autism spectrum disorder. The cost of obtaining a review or treatment plan must be borne by the policy.

3. This section does not limit benefits otherwise available to a covered individual under the uniform group insurance program. This section does not affect an obligation to provide services to a covered individual under an individualized family service plan, an individualized education program, or an individualized service plan.

1434
#1
3/16
Pg. 3

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF AUTISM SERVICES. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-sixth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of autism services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the autism services coverage requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should continue.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of autism services; to require a report regarding coverage of autism services; and to provide an expiration date.

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 - c. "Behavioral health treatment" means a counseling or treatment program, including applied behavior analysis, that is:
 - (1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
 - (2) Provided or supervised by a licensed behavior analyst or psychologist.
 - d. "Diagnosis of autism spectrum disorder" means any medically necessary assessment, evaluation, or test to diagnose whether an individual has an autism spectrum disorder.
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 - f. "Psychiatric care" means a direct or consultative service provided by a psychiatrist licensed in the state in which the psychiatrist practices.
 - g. "Psychological care" means a direct or consultative service provided by a psychologist licensed in the state in which the psychologist practices.

1434
#2
3/16
Pg. 2

- h. "Therapeutic care" means any service provided by a licensed speech language pathologist, occupational therapist, or physical therapist.
 - i. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care is medically necessary, including behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.
2. For all policies that become effective after June 30, 2017, and which do not extend past June 30, 2019, the board shall provide health benefits coverage for the screening for, diagnosis of, and treatment for autism spectrum disorder. Coverage under this section is not subject to limitations on the number of visits a covered individual may make for treatment for autism spectrum disorder.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF AUTISM SERVICES. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-sixth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of autism services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the autism services coverage requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should continue.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly

March 16, 2017

HB 1434
#3
3/16
pg. 1

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact section a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of autism services; to require a report regarding coverage of autism services; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Coverage of autism services.

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 - c. "Behavioral health treatment" means a counseling or treatment program, including applied behavior analysis, that is:
 - (1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
 - (2) Provided or supervised by a licensed behavior analyst or psychologist.
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 - f. "Psychiatric care" means a direct or consultative service provided by a psychiatrist licensed in the state in which the psychiatrist practices.
 - g. "Psychological care" means a direct or consultative service provided by a psychologist licensed in the state in which the psychologist practices.

- 17.0261.02007

**SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE
OF AUTISM SERVICES.**

1. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-sixth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of autism services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the autism services coverage requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage under this Act, a comparison of the system's coverage of autism services under this Act and the coverage of autism services by North Dakota insurers, and a recommendation regarding whether the coverage under this Act should continue as provided in this Act or should continue with amendments.
2. Quarterly during the 2017-18 interim, the insurance commissioner shall survey health insurance carriers in the state to collect data regarding policy coverage and utilization of autism services. The commissioner shall provide this data to the public employees retirement system for inclusion in the report prepared under subsection 1.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly

1161434
#3
3/16
Pg. 3

NDLA, S HMS - Johnson, Marne

From: Clark, Jennifer S.
Sent: Thursday, March 16, 2017 3:39 PM
To: Lee, Judy E.; Anderson, Jr., Howard C.; Larsen, Oley L.; Clemens, David; Kreun, Curt E.; Heckaman, Joan M.; Piepkorn, Merrill
Cc: NDLA, Intern 02 - Arendt, Ian; NDLA, S HMS - Johnson, Marne; Sandness, Sheila M.
Subject: FW: HB 1434 - Autism
Attachments: Acumen Report_HB 1434_Feb 2 2017_Final (002).pdf; Supplemental Actuarial Report.pdf

Committee Members-

Attached, please find the original and supplemental actuarial reports on HB 1434.

The law addressing your duties regarding health insurance mandates is NDCC 54-03-08, which provides (emphasis added):

54-03-28. Health insurance mandated coverage of services Cost-benefit analysis requirement.

1. A legislative measure mandating health insurance coverage of services or payment for specified providers of services may not be acted on by any committee of the legislative assembly unless the measure is accompanied by a cost-benefit analysis provided by the legislative council. Factors to consider in this analysis include:

- a. The extent to which the proposed mandate would increase or decrease the cost of the service.
- b. The extent to which the proposed mandate would increase the appropriate use of the service.
- c. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds.
- d. The impact of the proposed mandate on the total cost of health care.

2. A legislative measure mandating health insurance coverage of services or payment for specified providers of services may not be acted on by any committee of the legislative assembly unless the measure as recommended by the committee provides:

a. The measure is effective through June thirtieth of the next odd-numbered year following the year in which the legislative assembly enacted the measure, and after that date the measure is ineffective.

b. The application of the mandate is limited to the public employees health insurance program and the public employee retiree health insurance program. The application of such mandate begins with every contract for health insurance which becomes effective after June thirtieth of the year in which the measure becomes effective.

c. That for the next legislative assembly, the public employees retirement system shall prepare and request introduction of a bill to repeal the expiration date and to extend the mandated coverage or payment to apply to accident and health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the mandated coverage or payment on the systems health insurance programs. The report must include information on the utilization and costs relating to the mandated coverage or payment and a recommendation on whether the coverage or payment should continue. For purposes of this section, the bill is not a legislative measure mandating health insurance coverage of services or payment for specified providers of services, unless the bill is amended following introduction so as to change the bills mandate.

1434
#4
3/16
Pg. 2
3. A majority of the members of the committee, acting through the chairman, has sole authority to determine whether a legislative measure mandates coverage of services under this section.

4. Any amendment made during a legislative session to a measure which mandates health insurance coverage of services may not be acted on by a committee of the legislative assembly unless the amendment is accompanied by a cost-benefit analysis provided by the legislative council.

5. The legislative council shall contract with a private entity, after receiving one or more recommendations from the insurance commissioner, to provide the cost-benefit analysis required by this section. The insurance commissioner shall pay the cost of the contracted services to the entity providing the services.

Source:

S.L. 2001, ch. 471, 1; 2003, ch. 240, 6.

Good luck-

Jenn

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ACTUARIAL ANALYSIS Of HB 1434

By Acumen Actuarial

For the **State of North Dakota**

**APPLIED BEHAVIORAL ANALYSIS (ABA) and
TREATMENTS for AUTISM SPECTRUM DISORDERS (ASD)**

Daniel Bailey, FSA, MAAA

FEBRUARY 2, 2017

1434
#5
3/16

TABLE OF CONTENTS:

1. PREFACE
2. EXECUTIVE SUMMARY
3. INTRODUCTION
4. DATA and INFORMATION
5. OBSERVATIONS and FINDINGS
6. CALCULATIONS
7. CONCLUSION
8. LIMITATIONS OF USE and QUALIFICATIONS

PREFACE

This report was created by Acumen Actuarial for the state of North Dakota. It provides Acumen's analysis of HB 1434, a Bill for an Act to create new sections relating to health insurance coverage for autism-related services, to provide a statement of legislative intent, and to provide for a report to the legislative management.

Section I of the Bill defines terms. Among its eleven points, it also stipulates that:

- Health insurance policies will cover the screening for, diagnosis of, and treatment of autism spectrum disorder for insureds under 26 years of age, and must not deny enrollment or terminate it on the basis of an ASD diagnosis or prior treatment
- There is no limit to the number of services an individual may receive per year, but the total cost for Applied Behavior Analysis is limited to \$50,000. This amount will be indexed to Medical CPI in future years to raise the \$50,000 annual maximum for ABA services
- The insurance commissioner will issue a biennial report to legislative management concerning the cost of the bill and use of treatments for ASD. Moreover, health insurers and health benefit plans will provide the data needed for the report.

The intent of this actuarial study is to analyze the ASD benefit coverage with respect to its possible medical and administrative cost, as well as its impact on expected premium level. The Bill is examined in relation to the public employees health insurance plan and public employees retiree health insurance plan. It is also examined in relation to all those insureds who are covered by health insurance in ND other than those in the public employees plans.

In 2011, an actuarial analysis was carried out for a similar ND bill, SB2268. Over the past decade, many states have enacted legislation mandating that individual and group health policies issued in their state include coverage for ASD. Some states have already mandated a biennial or annual report on the use of services for the treatment of ASD and the overall cost of the mandate. The author has made use of current data and information where possible. There is actually a scarcity of reliable data available on the use and cost of ASD screening, diagnosis, and treatment. Many reports calculate an expected cost based on specific assumptions. This report from Acumen Actuarial provides its own calculation of the use and cost for North Dakota. It makes use of prior studies as well as emerging data and information. This report and cost estimate take into consideration the characteristics of North Dakota that may affect use and cost of ASD services such that they may be different than in other states.

EXECUTIVE SUMMARY

Any requirement to add new medical services to insurance coverage that were not previously required is likely to increase the use of those newly required services and the overall cost of care. Treatments for autism spectrum disorder (ASD) including Applied Behavior Analysis (ABA) are no exception. The question is how much the use and incremental cost will be over a multi-year horizon. The coverage of the screening, diagnosis, and treatment for ASD is relatively new, and there is a scarcity of reliable data about its use and cost in other states.

When the expense of ASD coverage is spread over all insureds, the requirement for screening, diagnosis, and treatment of ASD including ABA is likely to cost approximately 1% or less of the overall cost of health coverage per year for Active employees. During the first year of implementation, it is likely to cost less than 0.5% of premium or overall claims. Over the course of several years, it could ramp up to over 0.5% of overall cost before the utilization of ASD services eventually levels off at its *ultimate* level.

On a per capita cost basis, the incremental cost will be greater for the ND Active Employees Health Insurance plan than the Retired because there are far more children younger than 26 years of age per contract in the Active plan.

The overall health care cost per member per month for all Active employees was \$453 per member per month (PMPM) in Q2 2016. (This includes state employees and all political subdivisions.) A reasonable estimate of the expected average cost of screening, diagnosis, and treatment of ASD including ABA in the initial year of implementation is approximately 0.13% of overall cost, which is \$0.58 per member per month (PMPM) on a 2016 basis when spread across all members. A similar medical expense can be expected for the commercial coverage of the general insured ND population beyond the ND employees health insurance plans for Active employees and their dependents. This 2016 claim cost of \$0.58 PMPM can be reasonably expected for both non-PERS commercial group health insurance plans and "individual" coverage.

If the mandate is not implemented until 2018, the annual trend in claims cost will likely affect both the cost of ASD services as well as the overall cost of all health care services. Although it may give a false sense of precision, it is reasonable to trend this 2016 per member cost estimate by approximately 5% per year to reflect the ongoing cost increases that are in keeping with the medical consumer price index. Hence, on a 2017 basis, the cost estimate is projected to be \$0.61 PMPM. For 2018, it is \$0.64 PMPM. This is the estimated first year claims cost. In reality, there is a wide margin of error in any projection of the cost of the ASD coverage, and it would be misleading to assert with certainty that this point estimate is accurate to within pennies. It is possible that actual year one cost will be greater or less than this amount. Given

the logistic challenge of getting ABA therapists to more rural locations in North Dakota, the actual cost in 2017 could be less than \$0.61 PMPM.

On a per **contract** per month basis, the cost for the NDPERS active plan would be \$1.61 PCPM. (\$1.61 = \$0.61 PMPM x 2.64 members per contract in the NDPERS active plan as of Jan 2017.)

Many factors affect the use and overall cost of ASD services, especially in year one of coverage, but also beyond. If the supply of certified providers is low in ND in the initial year of implementation, this could result in lower use and spending than the estimate above, which is 0.13% of overall claims. Provider supply in relation to patient demand will also affect the level of use over time. There may be an insufficient number of certified applied behavior therapists initially, which would suppress utilization below the level of actual patient demand, but if the supply increases significantly in subsequent years, year five could experience utilization of ASD services that is considerably greater than year one.

The use of and expense for ASD treatment can be expected to increase over a period of several years as families and providers become more accustomed to the use of these services. Other actuarial studies and reports have shown a range of expected medical cost in the neighborhood of 0.1% to 1% of total cost for ASD services including ABA. The use and cost are typically greater on an "ultimate" basis several years after the initial implementation. The increase in the annual use and overall cost from initial to ultimate is important to consider. That is, there will likely be an increase from the year of implementation to a point in time three, four, or five years later when the ASD coverage requirement has ramped up to a mature level.

There is likely to be little effect on administrative activity; however, administrative cost is often expressed as a percent of premium or claims cost. Hence it is reasonable to gross up the expected claims cost to reflect incremental administrative cost. This done by dividing the expected claim cost by 1 minus the administrative cost as a percent of premium.

The requirement that insurers supply data for the biennial report is an administrative activity that insurers and plans are not currently obliged to carry out, and this will require some effort, albeit relatively minor compared with all the other activity associated with running a health insurance plan. The 2017 cost with incremental administrative expense is $\$0.61 + \$0.10 = \$0.71$ PMPM. [$\$0.71 = \$0.61 / (1 - 0.14)$]. This assumes administrative cost is 14% of premium, which is reasonable.

Often, the health insurers and other payers who are financially responsible for the cost of a new mandate are apprehensive about it prior to implementation. These payers find the new benefit is most difficult to price in the first year (or few years) of coverage because they have no prior internal data upon which to rely. This adds to the insurer's risk of underpricing the mandate as well as the overall cost of care, which is never known with certainty in advance.

1434
#5
3/16

ACUMEN ACTUARIAL

The proposed ABA benefit under HB1434 has an annual limit of \$50,000. In actual practice, it is unlikely that many of those receiving ABA will incur a full \$50,000 of cost per year. Most can be expected to have total annual cost below \$50,000. The annual maximum cost limit is intended to assure that individuals with high need and high cost can obtain services. However, maximum annual limits in health plans also have a "sentinel" effect that serves to reduce possible overuse, gaming of the system, or potential overcharging for unnecessary services.

It is important to note that some ASD services and support, including ABA, are already provided by school systems under IDEA, Sections B and C. There is some overlap between services provided by the public and private sector. Under the Individuals with Disabilities Education Act, Sections B and C, children to 21 years of age are provided with Free Appropriate Public Education. This applies to children with any of 13 named disabilities, one of which is autism and another is communication disorders. These services may include treatment for autism spectrum disorders; however, the purpose of these ASD treatment services provided through the school system is to help the child to be more functional in the educational environment, but not necessarily at home or in the community at large. Be that as it may, it is important to recognize that some ASD support is provided by the school system for children with ASD, and this includes ABA. Moreover, the amount of ASD treatment already provided to children from the public sector may decrease the ASD services to be provided in the private sector through health insurance coverage. Hence, insurance coverage is not the sole source of funding for ASD treatment, services, and support. This may be one of the reasons that helps explain why the actual average cost for children receiving ABA and ASD treatment is significantly less than the maximum annual amount, according to the limited actual data currently available on the use and cost of ASD services provided to children.

KEY COST STATISTICS FROM EXECUTIVE SUMMARY

HB 1434—Expected first year per member per month 2017 claims cost only for:

- ND Health Insurance Plan for Active Employees is \$0.61 PMPM
- All other ND insureds covered (other than in public plans) is also \$0.61 PMPM.

Expected first year incremental 2017 premium cost with administrative expense for:

- ND Health Insurance Plan for Active Employees is \$0.71 PMPM
- All other ND insureds covered (other than in public plans) is also \$0.71 PMPM.

On a per **contract** per month basis, the expected first year 2017 claims cost is \$1.61 PCPM for the ND Health Insurance Plan for Active Employees.

The cost is expected to be significantly less for the public **Retiree** Health Insurance Plan because there are far fewer children under 26 years of age per contract in the Retiree plan. The expected claims cost of HB 1434 is expected to be *de minimis* for the Retiree plan.

INTRODUCTION

HB 1434 requires health insurers to cover the screening, diagnosis, and treatment of autism spectrum disorder (ASD) including behavior-based therapy, such as Applied Behavior Analysis (ABA). The bill is limited to fully insured health coverage of major medical plans that cover a comprehensive range of services. It is not applicable to limited plans, such as hospital indemnity, mini-med, Medicare Supplement, or other such plans with limited benefits. For further information about the purview of the bill and the types of coverage to which it applies, see subsection 10 under Section 1. The bill applies to the North Dakota Public Employees Health Insurance Plans for Active and Retired Employees and their dependents. In the event that the public employees plan switches from a fully insured to self-insured basis, the bill would continue to apply.

Subsection 2 of the bill requires insurers to cover ASD, and it forbids them to deny issue or continuation of coverage to those who are diagnosed with or have received treatment for ASD. Subsection 6 stipulates that ABA Services will be covered to a maximum limit of \$50,000 per year. The amount of the maximum is required to be increased annually in accordance with the increase in the medical consumer price index. This will assure that the maximum keeps pace with the increasing cost of living in future years. Some states have different maximum amounts. Some states vary the amount by age. The logic behind varying the maximum amount by age is that behavioral therapy tends to be more effective on younger people. This is consistent with actual practice where higher intensity of service (more hours per week) is more common for younger children with autism.

In actual practice, it is unlikely that many of those receiving ABA will incur a full \$50,000 of cost per year. Most can be expected to have total annual cost below \$50,000. The annual maximum cost limit is intended to assure that individuals with high need and high cost can obtain services. However, maximum annual limits in health benefit plans traditionally also have a "sentinel" effect that serves to reduce possible overuse, gaming of the system, or potential overcharging for unnecessary services.

Subsection 11 of the bill requires the insurance commissioner to submit a biennial report to the legislative management covering cost and use of services under the bill. Insurers subject to the bill will be required to provide data for this report. This can be a helpful follow-up activity subsequent to the implementation of the bill because it provides the legislative management a

1434
#5
3/16

ACUMEN ACTUARIAL

clearer understanding of the true emerging use and cost of the bill in the state. To the extent the insurer data is reliable, this report could be a useful basis for future revisions to the bill.

The bill requires insurers to cover the cost of screening for ASD in children under 26. Screening identifies the presence of disease in a particular population that has not been diagnosed with it. In the case of ASD, young children are observed in well-child pediatrician visits and may be identified for diagnosis; this screening may involve consultation with the child's parents or caregiver. In some cases, a pre-school can recommend a child for evaluation. It is possible that the bill will encourage better and more complete screening of ASD in medical visits, but this is not billed separately in pediatric office visits, so no material cost is expected to be added for additional screening.

The bill requires coverage of diagnosis of ASD. It is possible that, over time, more children will be referred for diagnosis, but that too is not expected to materially affect overall use and cost.

The incremental use and cost is expected to come from additional treatment provided to children with ASD.

One of the key drivers of the use of ASD treatment is the number of children diagnosed with ASD. The prevalence rate of ASD in children has been increasing over the past ten or fifteen years according to reliable sources such as the Center for Disease Control (CDC). Part of this increase involves the evolution of the definition in the DSM manual that is used by clinicians to diagnose children with ASD.

A number of other factors contribute to use of ASD treatment. Not all children who are diagnosed with ASD will receive treatment for ASD in any given year under the bill. Some children with ASD whose behavior is more severely affected by it will tend to receive more hours per week of treatment. Children who need more hours of treatment per week do not necessarily continue to receive that level of treatment for an indefinite period of time. It often tapers off over time. The goal is for the individual with ASD to become more functional in their day-to-day life at home and outside the home.

Children with ASD often receive services and supports in their public education environments per the Individuals with Disabilities Education Act (IDEA), sections B and C. This is generally part of an Individual Education Plan that helps the child achieve educational goals and become more functional in the educational environment. Although these skills are transferable to environments outside of school, the intent of ASD support provided in the educational environment is focused on improving the child's ability to learn. This may include improving social and communication skills, which have benefits to the child beyond the classroom.

There may be some overlap in ASD services provided in the public and private sectors. For example, children with less severe ASD might not require additional ASD services beyond those they already receive in the educational environment.

In terms of the use of ASD services under HB 1434, there are multiple additional factors that will affect use over time:

- Availability of trained providers in relation to the demand for their services—if there are fewer qualified ASD service providers than patient demand requires, use will be reduced
- General awareness of ASD and ASD treatments among parents, and the degree to which parents seek treatment for their children—parents may hold back and be more tentative about seeking treatment for their children in early years and more assertive in later years when the benefits of obtaining ASD treatment are more broadly recognized. This can be expected to drive up the use of services over time.
- Logistics of providing services. North Dakota is a large state geographically with several population centers and many counties with low population density. Issues pertaining to rural medicine in sparsely populated counties could make it more difficult to provide services to children with ASD in more remote locations. It is possible that, at some future time, some parental coaching and support may be available using telehealth.

In the course of Acumen's research for this project, data on the prevalence of autism and autism spectrum disorder was reviewed. With respect to geography, race, or ethnicity, there is little variation in the prevalence rate among children. Gender, however, is different—male children are approximately four times as likely to be diagnosed with ASD. North Dakota is expected to be similar to the rest of the nation in this respect.

North Dakota has an autism registry maintained by the state Department of Health, but it is not yet an all-inclusive list of children with autism throughout the state. It went live on February 8, 2016 and seems to be a work-in-progress. As of October 2016, there were 186 children included in the registry. At present, there are 302 children. The North Dakota Autism Registry is still growing, and it is incomplete. For example, as of December 2015, however, there were 1,031 children on the Department of Public Instruction's list of children with an educational determination of autism. These two sources are not expected to be exactly identical, but the large difference helps us understand that the ND Autism Registry has not yet captured all those children with ASD that it eventually will. Yet another data source is the 2016 State Autism Profiles for North Dakota prepared by Easterseals, Inc. and distributed November 2016. It shows 939 children with autism in ND from age 3 through 21.

In the course of this research, report author, Daniel Bailey, spoke with individuals associated with NDPERS, Sanford Health Plan, and the ND Department of Public Instruction. He spoke with Judith Ursitti at Autism Speaks. And he also conferred with an expert on ABA, John Molteni, who is the Director of the Institute for Autism Behavioral Studies at the University of Saint Joseph in West Hartford, CT. Acumen wishes to thank all those who shared their knowledge or otherwise assisted in this project and report.

1434
#5
3/16

DATA AND INFORMATION

Many states have estimated the cost of similar bills that require insurers to cover the cost of screening, diagnosis, and treatment for ASD. Few states, however, have produced reports on the actual cost of those services after the insurance mandate has gone into effect. Little detail is provided with those reports about that data; and researchers generally find it difficult to assess the reliability of that data.

Prior to implementation of an ASD mandate, many states have evaluated the expected cost of ASD coverage using a prevalence and expected unit cost approach. That is the approach used in this report from Acumen Actuarial, which has taken into consideration the characteristics particular to North Dakota.

Although North Dakota's population declined somewhat from 2000 to 2004, it has grown steadily since then, more so in the past several years. This will have little if any effect on the per capita cost of ASD services, but the increase in population *will* affect the overall total cost of care because more individuals will obtain care. However, the cost of ASD services as a percent of overall premium is not expected to change as a result of the increase in North Dakota's population.

Acumen received demographic data for the ND Employees Health Insurance Plans for Actives and Retirees and their dependents. Among the active members' plan, children under 26 represented 38.6% of all members. It is assumed that this same proportion of children under 26 applies to the general population of insureds in ND. (A slight difference will not affect the cost estimate materially). State-specific data was obtained from the Kaiser Family Foundation website, such as the percent of insureds by coverage type and a North Dakota age distribution.

Acumen checked the Behavior Analyst Certification Board (BACB) website for information and data about the number of certified BACB therapists in ND relative to other states. In Missouri, where the ASD mandate has been in place for a few years, there is 1 qualified BACB therapist per 17,000 people in the general population. In North Dakota, there is 1 therapist per 33,000 people.

State-specific emerging actual claims data on ASD use and cost was reviewed during this study. It should be pointed out that this data is generally self-reported by participating insurers and HMOS, some of which may be delayed or remiss in their self-reporting altogether. It is not typically audited by an external party. Moreover, in year one, not all plans are necessarily fully phased-in to coverage under the mandate. Hence, year one use and cost may be materially less than year two and beyond.

1434
#5
3/16

The state of GA recently produced a report with state-specific 2016 ASD costs under its mandate requiring ASD coverage by private insurance. Ten of twenty carriers provided data. These findings were reported:

20,266,939	Number of member-months reported for all members
16,953	Number of member-months for those diagnosed with ASD subject to mandate
1,841	Number of members for those diagnosed with ASD subject to mandate
9.2 months	Average # of months/ yr / member diagnosed with ASD (Acumen calculated)
0.084%	Percent of member months diagnosed with ASD among all insureds
\$0.32	PMPM Cost of ASD services spread across all members
\$0.18	PMPM Cost of ABA only spread across all members (a subset of above).

Again, this data is not guaranteed to be 100% reliable nor is it highly credible in terms of volume. Moreover, there is likely some under-reporting of the true PMPM claims cost because the requirement to cover ASD was phased in over the first year and not in effect for every plan for every month of 2016. We do not know what this \$0.32 PMPM amount would be if all members were covered under the ASD mandate in GA all year.

One noteworthy point is that the 2016 occurrence rate in the GA insured population is 0.084%. This is significantly less than the occurrence rate Acumen obtained when multiplying 38.6% x 1% ASD prevalence rate among 0 – 26 year olds. The 38.6% represents children under 26 years of age as a percentage of the entire insured population of all members; this is based on NDPERS data for active employees and dependents as of Jan 2017. When 38.6% is multiplied by 1%, we obtain the expected occurrence rate in the overall insured population determined by Acumen. This occurrence rate developed by Acumen is 0.386%, and it is much greater than the actual occurrence rate reported in the GA data of 0.084%. Note that 0.386% is 4.6 times as much as .084%. Whereas the GA occurrence rate is based on actual data, the Acumen rate was projected from demographic and prevalence data. Again the GA data may be under-reported, but it is also possible that the Acumen occurrence rate is overstated. This may be off-set by similar but opposite under-statement of Acumen's "take-up" rate among children diagnosed with ASD, as further explained on page 14 of this report.

A report was published in JAMA Pediatrics in July 2016, Volume I, Issue 12, titled "Effects of Autism Spectrum Disorder Insurance Mandates on the Treated Prevalence of Autism Spectrum Disorder, Diagnosis Rates Increase, but Shortfalls Remain." The key finding is, "State mandates requiring commercial health plans to cover services for children with autism spectrum disorder increased the number of children diagnosed with the disorder. However, diagnosis rates remain much lower than community estimates, suggesting that many commercially insured children

1434
#5
3/16

ACUMEN ACTUARIAL

with ASD remain undiagnosed or are insured through public plans.” This finding is consistent with the GA data.

Missouri has had an ASD coverage mandate in place for health insurance for several years and published annual statistics on use and cost of ASD services from 2011 through 2015. The table below is from page 2 of the Annual Report to the Missouri Legislature—“Insurance Coverage for Autism Treatment & Applied Behavior Analysis”, Statistics section, February 1, 2016.

MISSOURI ASD STATS

	2011	2012	2013	2014	2015
% Total Losses	0.10%	0.16%	0.20%	0.21%	0.25%
Monthly Cost for Indiv for Autism Treatment	\$143	\$222	\$255	\$278	\$357
Cost PMPM					
All Autism Treatments	\$0.25	\$0.38	\$0.48	\$0.50	\$0.60
ABA Services only	\$0.06	\$0.17	\$0.22	\$0.26	\$0.30
Annual COST Trend--Calculated					
All Autism Treatments		52%	26%	4%	20%
ABA Services only		183%	29%	18%	15%
Number of Autism related claims			43,372	51,855	61,457
Number of ABA claims			14,505	25,291	32,997
Annual Claim # Trend--Calculated					
All Autism Treatments				20%	19%
ABA Services only				74%	30%

Note that the ASD mandate in MO is not identical to HB 1434. The MO mandate requires ABA to an annual maximum of \$41,263 for children up to age 19.

A VA mandate study showed a cost of \$3.50 per contract per year, which is \$0.29 per contract per month. Assuming 2.5 members per contract; that is equivalent to \$0.11 PMPM. The VA mandate, however, covers children 2 to 6. Hence, it too is different than HB 1434 because VA covers a smaller percentage of its privately insured population due to the age restriction.

In producing this report, other sources were referenced for reasonability. The scarcity of actual ASD treatment use and cost data makes all these preliminary cost estimates more speculative prior to implementation of the mandate. However, the emerging actual ASD data is also not without problems. Adjustments need to be considered when using other states' estimated (projected) or actual data.

OBSERVATIONS AND FINDINGS

As described earlier, there are a number of different factors and forces that will affect the use and cost of ASD under HB 1434 in the first year of implementation as well as subsequent years. The future extent of these different factors or forces is difficult to accurately estimate in the present. Sensitivity testing of these individual forces shows that the initial estimate could be considerably less or more than the point estimate provided in this report. That is, in advance of the implementation of HB 1434, there is a wide margin of error for the point estimate and a wide range in which the true actual cost could result.

Most reports in advance of implementation in other states show an expected cost of 0.1% to 1% of annual premium or claims cost. The eligibility criteria under any mandate for ASD treatment may affect its use and cost. Some states have different eligibility standards for ASD services than in HB 1434. For example, some states:

- Limit coverage to ages 0 – 21 or other younger age groups
- Reduce the annual maximum for ABA for older children, such as \$50,000 for 0 – 6 years of age; \$40,000 for 7 – 12 years of age; and \$30,000 for 13 – 18. The rationale behind such a step-wise decrease is that behavior is easier to change in young children than older children and intensive ABA (more hours / week) is more effective in younger children than older.

HB 1434 does not reduce the ABA annual maximum with age. If it did, the expected cost could lower than the point estimate already provided in this report; however, that is also not certain. Similarly, if HB 1434 restricted eligibility to children younger than 21 years of age, that could also reduce expected cost. Nonetheless, the highest use (in terms of hours / week) is expected to be associated with younger children; and, it is expected that children age 21 through 25 years of age will obtain fewer services for ASD treatment, at lower cost annually, than younger children. Hence, if HB 1434 were limited to children younger than 21, the expected cost would not necessarily be 21/26 of the original point estimate. Those with ASD in the 21 through age 25 range are expected to use fewer ASD treatment services annually than young children, especially those younger than age 9.

States often implement ASD coverage mandates that differ somewhat with respect to eligibility and benefits. For this reason, caution should be exercised in comparing results of emerging data across different states.

1434
#5
3/16

ACUMEN ACTUARIAL

CALCULATIONS

Acumen estimates that first year claims cost for ASD services in 2017 under HB 1434 would be \$0.61 per member per month (PMPM). This is a point estimate, and the true actual amount could be considerably more or less than the point estimate. If the availability of behavior therapists and other ASB providers is low, the use and cost will be less than expected. Similarly, if public knowledge of HB 1434 is limited and ND residents remain unaware that ASD is covered under private health insurance, it too could depress the initial use of ASD services. Moreover, children with ASD, who live in remote rural locations in the state, may have lower use of ASD treatment than expected. Similarly, unforeseen circumstance and factors could contribute to use and cost that is greater than \$0.61 PMPM in year one. This estimate assumes all members are covered all year with no reduction for phase-in. In order to establish the initial year claim cost in **2016**, Acumen created the following cost projection model shown below:

Table 1—Development of Expected Average Per Member Per Month (PMPM) Claims Cost

CALCULATIONS, Yr 1 Claims Cost, 2016 Basis

The factors chosen below are expected values.
They are not known for certain in advance.

	Behavioral Therapy (may include ABA)	All Other ASD Service & Treatments
Occurrence Rate in General Pop	0.00386	
Take-Up Among All Diagnsd	5%	18%
Average # Hrs/Month	29.0	
Avg Cost / Hr	\$52.50	
		\$5,000 Avg Annual Cost for Children Treated
2016 PMPM Claims Cost, spread over all insureds	\$0.29	\$0.29
TOTAL	\$0.58	
Q2 2016 CLAIM COST		
NDPERS ACTIVES, PMPM	\$453	
% of Claim Cost	0.13%	

This 2016 amount was calculated first. To obtain the 2017 amount, the 2016 expected claims cost was trended by 5% to reflect a 2017 basis of **\$0.61** PMPM.

$$\$0.61 = \$0.58 \times 1.05.$$

The \$0.58 PMPM expected starting point was developed as shown in Table 1. The expected cost of behavioral services for children under 26 diagnosed with ASD was developed separately from the cost of **non**-behavioral based ASD services. This amount is spread over all members to obtain a PMPM cost for each service track. The two PMPMs were then summed to obtain the total 2016 expected cost of \$0.58 PMPM for HB 1434 when spread over all insured members.

In the Acumen model, there is an interplay between the occurrence rate and the take-up rate. The former describes the relative frequency with which children with ASD are represented in the overall insured population. The take-up rate represents the portion of children with ASD who actually receive treatment in either of the two services categories—Behavioral treatment (which includes ABA) and non-Behavioral treatment. It is important to consider cost of these two service tracks in tandem. In the Acumen model, it is possible that the occurrence rate is understated and the take-up rate is overstated. However, these are offsetting if the one is understated commensurate with the overstatement of the other.

The Acumen model splits the calculation into the two different service categories or “tracks”—Behavioral services and non-Behavioral. A separate PMPM is calculated for each. The “non-Behavioral” track is estimated using an expected average frequency times expected average cost per person treated per year. This is then converted to a per member per month basis, and the cost is spread over all insured members.

After the separate claims cost is developed for each track and the two are summed, a percent of total claims cost number is then calculated based on the overall Medical cost of \$453 PMPM using the Q2 2016 PMPM for the NDPERS health insurance plan active employees and dependents, which includes both state employees and those of political sub-divisions. On a 2016 basis, the \$0.58 claims cost is 0.13% of the overall health claims cost of \$453 PMPM. For 2017, it would be expected to be the same 0.13% of overall cost.

Note that the claim costs for the two service tracks (Behavioral and non-Behavioral) are approximately equivalent. This is reasonable and consistent with the emerging ASD cost data from the state of Missouri.

After developing the model for expected average year one cost as a point estimate, a five year *pro forma* was developed that projects the expected values over the next four years under different assumed growth rates. The year one expected costs in the 5 year model are based on the year one point estimate. It becomes the medium initial cost estimate, and two additional scenarios are shown for year one cost representing a low and a high estimate.

1434
#5
3/16

ACUMEN ACTUARIAL

FIVE YEAR COST MODEL--

In establishing a *pro forma* with expected annual cost for the first five years, three growth-rate scenarios are considered in combination with three initial use and cost scenarios.

- SCENARIOS for Initial Use and Cost—Low, Medium, High
- SCENARIOS for Annual Growth Rate—Slow, Medium, Fast

The initial year 2017 claims cost estimate of \$0.61 PMPM corresponds to the “medium” initial use and cost scenario. Over a five year horizon, different results occur under the different combinations of scenarios. The low and high, and the slow and fast, are not meant to represent best-case or worst-case scenarios.

Low Initial Use and Cost combined with Slow Growth Rate leads to the lowest use and cost in year 5. Oppositely, High Initial Use and Cost combined with Fast Growth Rate leads to the highest use and cost in year 5. This is shown in the table below:

Table 2

Annual Growth Rate	INITIAL USE AND COST		
	Low	Medium	High
SLOW	Lowest Yr 5		
MEDIUM		Expected	
FAST			Highest Yr 5

Again, these are not best and worst-case scenarios. They are the lowest or highest of the various combinations of initial cost in year one and growth rate over future years.

In the next table, Table 3, we see a five year *pro forma* of expected cost over the first five years under the nine different combinations of 3 initial use and cost scenarios vs. 3 growth rates. The low initial use and cost (\$0.24) is based on 40% of the expected (medium) \$0.61 PMPM. The **high** initial use and cost (\$0.92) is based on **150%** of the expected \$0.61. These year one costs are then trended forward to years two through five at the three different rates of annual growth. The growth rates correspond to ASD treatment services under HB 1434, which are expected to increase more quickly than overall health spending because ASD coverage is a new requirement subject to different utilization trend forces than general health spending.

The slow growth rate corresponds to 5% annually. The medium growth rate corresponds to 15%, and the fast to 30%. Note that the slow growth rate of 5% is the same as the trend rate

used to establish the initial cost of ASD services under HB 1434 for 2017 and 2018 for whichever is the initial year of implementation. This is appropriate. The 5% trend of the expected 2016 ASD cost was used to establish the initial year cost only relative to the projection which was centered on 2016. In order to estimate the initial year cost of HB 1434 in 2017 or 2018, a trend factor needed to be used to increase that cost relative to 2016. Once HB 1434 is in place, however, it is expected that the use and cost of ASD services will increase annually at a faster rate than the overall cost of health care. This is primarily due to a faster increase in the utilization of ASD services and not a faster increase in the unit cost of ASD services.

The use of the different scenarios helps the reader to understand the range of cost that may occur over the course of the first five years, and even in year one. It would be misleading for this report to represent the cost estimate for any year as highly accurate, even under the medium scenario for both initial cost and growth rate. Although the numbers are shown to two decimal places, the two decimal digit representation does not mean that the actual cost of ASD services under HB 1434 (once all is known at some future time) will be exactly the same as the two decimal amounts shown here.

Note that the yellow-highlighted column in the center of the medium growth rate represents the years 1 – 5 claims cost of ASD services under HB 1434 assuming medium initial use and cost and a medium annual growth rate over the next four years. This is in the second box of Table 3. Here again, it is possible that the expected first year cost of \$0.61 may be high (overstated) compared with the ultimate actual cost, but the 5th year actual cost could be considerably more than the expected \$1.07 (understated) for reasons that cannot be fully anticipated at this time.

Emerging ASD claims data from other states, despite its potential shortcomings in credibility and reliability, seems to show significant increases from year one to year three in some cases. Hence, the fast growth rate costs are shown in the last box of table 3. Under the fast growth scenario, the \$0.61 claims cost in year one becomes a \$1.75 PMPM cost in year five.

Note also that the year one costs are identical in all three boxes reflecting different growth rates—slow, medium, and fast annual growth rates.

In year five, there is a wide range of estimated claims costs based on the nine combinations of the three scenarios. At the low end is \$0.30 based on low initial cost and slow growth. At the high end is \$2.62 based on high initial cost and fast growth. Neither is a best or worst-case scenario.

1434
#5
3/16

ACUMEN ACTUARIAL

Table 3—Claims Cost Only (PMPM)

SCENARIOS FOR INITIAL USE & COST vs GROWTH

Assumes implementation in 2017

SLOW GROWTH-- Assumes 5% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.24	\$0.61	\$0.92
2	\$0.26	\$0.64	\$0.96
3	\$0.27	\$0.67	\$1.01
4	\$0.28	\$0.71	\$1.06
5	\$0.30	\$0.74	\$1.12

MEDIUM GROWTH RATE--Assumes 15% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.24	\$0.61	\$0.92
2	\$0.28	\$0.70	\$1.06
3	\$0.32	\$0.81	\$1.21
4	\$0.37	\$0.93	\$1.40
5	\$0.43	\$1.07	\$1.61

FAST GROWTH RATE--Assumes 30% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.24	\$0.61	\$0.92
2	\$0.32	\$0.80	\$1.19
3	\$0.41	\$1.03	\$1.55
4	\$0.54	\$1.34	\$2.02
5	\$0.70	\$1.75	\$2.62

The numbers contained in the next table, Table 4, show the expected cost of HB 1434 over five years with the incremental administrative cost included in addition to the expected claims cost for ASD services.

1434
#5
3/16

Table 4—Includes Both Claims Cost and Administrative Cost (PMPM)

**TOTAL INCREMENTAL COST INCLUDING BOTH CLAIMS
and ADMIN COST PMPM OVER TIME UNDER DIFFERENT
SCENARIOS FOR INITIAL USE & COST vs GROWTH**

Assumes implementation in 2017

SLOW GROWTH-- Assumes 5% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.28	\$0.71	\$1.07
2	\$0.30	\$0.75	\$1.12
3	\$0.31	\$0.78	\$1.18
4	\$0.33	\$0.82	\$1.24
5	\$0.35	\$0.87	\$1.30

MEDIUM GROWTH RATE--Assumes 15% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.28	\$0.71	\$1.07
2	\$0.33	\$0.82	\$1.23
3	\$0.38	\$0.94	\$1.41
4	\$0.43	\$1.08	\$1.62
5	\$0.50	\$1.24	\$1.87

FAST GROWTH RATE--Assumes 30% Annual Trend			
YEAR	Initial Use and Cost		
	Low	Medium	High
1	\$0.28	\$0.71	\$1.07
2	\$0.37	\$0.93	\$1.39
3	\$0.48	\$1.20	\$1.80
4	\$0.63	\$1.56	\$2.35
5	\$0.81	\$2.03	\$3.05

1434
#5
3/16

CONCLUSION

In many states that have contemplated implementing bills similar to HB 1434, there has been preliminary concern about the potential high cost of covering ABA and other treatments for ASD. This concern is further heightened when those estimating the future cost (and those who will pay for it) learn that ABA can potentially cost \$50,000 per year and that an increasing number of children are diagnosed with autism spectrum disorder. In reality, not all children diagnosed with ASD will receive treatment, and, of those who receive treatment, many will receive some form of evidence-based ASD treatment other than ABA or some other form of behavioral treatment. Very few children will receive \$50,000 of ABA per year. Assuming that most children with ASD will receive \$50,000 of ABA per year would be incorrect and would substantially overstate the true cost of HB 1434. It would be similar to assuming that every person under the treatment of a cardiologist needs to have a heart transplant.

Relative to some other states, especially states that already mandate the coverage of ASD in health insurance, ND may have a scarcity of trained providers who can provide ASD services, support, and treatment to children with ASD. Based on the comparison of BACB certified behavior therapists in Missouri vs. North Dakota, it seems there are fewer providers in North Dakota per 1,000 people in the general population. This deficit in provider supply could reduce the use and cost in the initial year of implementation of HB 1434, and this could continue beyond year one until there are enough qualified providers throughout the state to meet the demand for services for children with ASD.

The estimated first year claims cost of providing ASD services in ND under HB 1434 is \$0.61 PMPM in 2017. This is an approximate point estimate within a wider range of possible cost outcomes. It is possible that the actual cost could be less than half of that. It is also possible that it could cost 50% more than \$0.61. The wide range of potential cost is reasonable. It would be unreasonable to assert that the estimate of \$0.61 PMPM is precise to the penny and the actual cost will be exactly that.

On a per **contract** per month basis, the \$0.61 PMPM is equivalent to \$1.61 per contract per month for the NDPERS health insurance plan for active employees and their dependents. This PCPM amount is calculated using 2.64 members per contract based on the actual January enrollment data for members and contracts.

While some services and support are already provided for children with ASD in the school setting under the Individuals with Disabilities Education Act, sections B and C, this is not a substitute or replacement for treatment for children with ASD in the home or community, outside of the school setting. The extent to which a child with ASD needs services in the home

or community under private health insurance will often be similar to the need that child has in school. However, there are some children with ASD who have need for services in the school system but do not need services outside school. Oppositely, there are children with ASD who have need for treatment outside school but not in school. And then there are those who receive services both in school and out, in varying amounts.

Some children with ASD are high functioning and never use any ABA in their lifetimes either in the school setting or privately under health coverage. Other children who are at the other end of the spectrum may have more need for ASD services including ABA. These services, especially behavioral approaches, seem to be more effective when children are young and their brains and behavior are more malleable. In terms of hours per week of needed ASD services, children at one end of the spectrum have the most need, and children at the other end have the least need.

When ASD services are provided in school, they are part of the child's Individual Education Plan. The intent is to help the child with ASD become more functional in the educational environment for the purpose of learning. Some of the behavioral training the child receives in the school setting is transferrable to the home or community, but it is not necessarily a substitute for it. Whether in the school system or outside it, some of the ASD training is directed toward parental coaching. This is intended to give parents strategies and approaches to alter and improve the autistic child's behavior everywhere, including at home and in the community at large. In severe cases, it may begin with teaching the parents effective strategies to stop the child from self-injury or other behaviors that may adversely affect the siblings and parents in the home.

Subsection 11 of the HB1434 requires the ND Insurance Commissioner to submit a biennial report to the legislative management on concerning implementation of HB 1434, and the use and cost of ASD services under private health insurance plans covered by the bill. This is important because it will help the state measure the use and cost of ASD services under HB 1434 going forward.

Subsection 11 requires the reporting of the number of members who are children less than 26 years of age diagnosed with autism spectrum disorder. It does not require reporting of the total number of member months for all members. However, this would be a helpful requirement because it would allow the state to track the children under 26 diagnosed with ASD as a percentage of total members over time, which was referred to as the "occurrence rate" in the calculations section of this report.

It is difficult to draw conclusions about the true actual cost of ASD services from these state-specific reports, especially in year one. The mandate may be phased-in in such a way that the first year numbers are understated because some plans are subject to the mandates for only part of the year. The data in these reports is based on self-reported numbers from participating

1434
#5
3/16

ACUMEN ACTUARIAL

insurers. Typically, the data is not audited. There may be issues with the credibility and reliability of the data. The credibility issues arise as a function of small numbers since ASD cost is less than 1% of total health spending.

When administrative cost is added to the expected claims cost using 14% of premium, the total incremental effect on premium in year one is expected to be \$0.71 PMPM in 2017 for the NDPERS health insurance plan for active employees and their dependents.

$$(\$0.71 = \$0.61 / (1 - .14)).$$

The same cost is expected to apply to the commercial insured population to which HB 1434 applies (outside of the members in the NDPERS health insurance plan for Active employees and dependents).

For the NDPERS health insurance plan for Retired employees and dependents, the incremental 2017 claims cost of HB 1434 is expected to be *de minimis*--less than \$0.05 PMPM. This is substantially less than for the Active plan because the Retiree plan has far fewer children under 26 years of age as a percent of all members. Despite the provision for coverage of grandchildren under special circumstances, HB 1434 will have far less effect on the PMPM cost of the Retiree plan, if any. Given the very low percentage of children covered by the Retiree plan, the claims cost (even with administrative cost added) is expected to be pennies only. That said, the smaller Retiree plan has far fewer members than the Active plan, and its actual results will be subject to more statistical fluctuation.

Similarly, when the effects of HB 1434 are observed on health claims data in future years, some insurers or plan-specific data may show actual cost that deviates significantly from the expected. This is a common problem when health cost data is sliced and diced into multiple cells of relatively small credibility. The numbers prepared in this report are intended to represent the average expected cost across all members in North Dakota.

1434
#5
3/16

QUALIFICATIONS AND LIMITATIONS:

This actuarial report is intended for the state of North Dakota for the purpose of its evaluation of the proposed legislation under HB 1434. It provides an estimate of the uncertain future cost of ASD services to be provided under HB 1434. This report summarizes Acumen's review and provides data, information, and Acumen's analytical findings.

The use and discussion of this document is limited to North Dakota and Acumen Actuarial. This report is not to be used for any other application or purpose. It was developed specifically for the state of North Dakota as it applies to the actuarial evaluation of HB 1434 at this point in time. The contents of this report are not intended for any other use or purpose. If the distribution of this report is not prohibited by public records law, this report should not be distributed to third parties without Acumen's prior permission. This report shall be released only in whole, and it shall not be released in part to any party.

This review is limited in time and scope. It is not a guarantee that ND's future actual ASD services cost under HB 1434 will equal those shown in this report. In conducting my work, I have reviewed various data. In addition to publically available data and information, I have been supplied with and relied upon data and information provided by the state of ND.

This report does not recommend a specific course of action. The intent of this review and report is to provide objective facts and findings that the state of ND Legislative Council can use to evaluate HB 1434 with respect to the expected future cost and use of ASD services in private health insurance as required under the bill. It is not a legal opinion and does not provide legal advice on matters of law pertaining to the legislation.

I, Daniel Bailey, am a consulting health actuary and owner of Acumen Actuarial LLC. I am a fellow of the Society of Actuaries and member of the American Academy of Actuaries, and in good standing with both organizations. I meet the Qualification Standards to render the opinion contained herein. If you have questions, please contact me at bailey-d-1@comcast.net. My office phone is 860-986-4052.

Daniel Bailey, FSA, MAAA



HB 1434
#6
3/16
Pg. 1

2017

SUPPLEMENTAL REPORT

Concerning First Engrossment to HB 1434

(Supplemental to Original ACTUARIAL ANALYSIS
of **HB 1434**)

By Acumen Actuarial

For the **State of North Dakota**

**APPLIED BEHAVIORAL ANALYSIS (ABA) and
TREATMENTS for AUTISM SPECTRUM DISORDERS (ASD)**

Daniel Bailey, FSA, MAAA

FEBRUARY 26, 2017

1434
#6
3/16
PA.2

TABLE OF CONTENTS:

1. PREFACE
2. EXECUTIVE SUMMARY
3. CONTENTS & CONCLUSION
4. LIMITATIONS OF USE and QUALIFICATIONS

PREFACE

This supplemental actuarial report from Acumen Actuarial dated February 26, 2017 is an addendum to our original actuarial report issued on February 2, 2017 titled "Actuarial Analysis of HB 1434". In the original report, Acumen presented its findings and conclusions relative to the original version of HB 1434.

In this addendum, Acumen Actuarial presents its findings related to the revisions to HB 1434 proposed February 9, 2017 by the North Dakota Legislative Council. These revisions are contained in "**First Engrossment, Engrossed House Bill Number HB 1434.**"

1434
#6
3/16
pg. 4

EXECUTIVE SUMMARY

The modifications to the original bill are not extreme; however, they are expected to have a small but material impact on the expected average cost of the autism spectrum disorder mandate originally proposed in the initial version of HB 1434.

There are two fundamental modifications to the original bill that may affect the expected average claims cost for 2017—1) the limitation of ASD benefits to children up to age 19 rather than to age 26, and 2) the reduction in the amount of annual Applied Behavioral Analysis (ABA) maximums depending on age-bracket.

In the initial year of the mandate, 2017, the revised HB 1434 could be expected to cost approximately 5% less than the original bill. The range of expected cost reduction relative to the original is 0% to 15%. The expected average claim cost for 2017 was \$0.61 PMPM under the original bill. This becomes \$0.58 PMPM under the revised bill.

With the cost of administrative services added, the original cost estimate was \$0.71 PMPM. Under the revised bill, it is \$0.67 PMPM, with rounding.

It is not the author's intention to imply a false sense of precision. The direction of the cost change is known; the exact magnitude is not. The revisions to the mandate are not expected to increase the cost. However, the extent to which they decrease the cost relative to the original is uncertain.

The cost reduction from the original to the revised version of HB 1434 could be described as small but material. As previously mentioned in the original report, the annual maximum on ABA services may have some sentinel effect and limit utilization that would have otherwise exceeded the revised maximums. That is to say the annual ABA maximums may function as a deterrent to ABA utilization, especially the lower maximums for children of older ages—7 through 13 years of age, and 14 through age 18.

CONTENT and CONCLUSION

As it pertains to Acumen's original cost estimate, there are two fundamental revisions to HB 1434 in the First Engrossment that may affect the future cost:

1. The first change to consider is the limitation of the ASD mandate to children less than 19 years of age. (The original version covered children less than age 26.)
2. The second fundamental change is the revision in the annual benefit maximum that applies to Applied Behavior Analysis services. (In the original version, an annual ABA maximum of \$50,000 for ABA services was applicable to children up to age 26.) In the revised version of HB 1434, the ABA annual maximum is as follows:
 - a. \$36,000 for children less than age 7
 - b. \$25,000 for children from age 7 through age 13
 - c. \$12,500 for children from age 14 through age 18.

The revised bill stipulates that the annual maximum cannot be less than these amounts, but it does not preclude insurers from establishing their own annual maximums for ABA services that exceed the amounts shown. Whether any insurers will choose to cover more than the ABA maximums shown is unknown at this time, but in the past, health insurers have tended not to exceed annual statutory maximums for specific benefits.

In Acumen's original report, the average expected cost of the original version of HB 1434 was \$0.61 PMPM for initial year 2017 claim cost. Given the revisions in the First Engrossment, Acumen expects the 2017 initial year cost would be approximately 0% to 15% less than the original estimate. Acumen's point estimate is an expected 5% reduction to the original cost-estimate. This projected cost differential is an approximation. It reduces the original \$0.61 PMPM claims cost to **\$0.58 PMPM** in the **revised** bill. (The original cost-estimate in Acumen's original report was described as approximate and not a guarantee that the actual future cost would be exactly the same as the cost-estimate. The cost estimate of the revision is also.)

The expected average cost of the original bill with administrative cost added was \$0.71 PMPM. Acumen's estimate for the cost of the **revised** bill with administrative cost is **\$0.67 PMPM** with rounding.

In both cases, the expected reduction in cost is approximately three or four cents. While it is clear that the cost of the revised bill should not be greater than the original, the extent to which it is less than the original is quite difficult to ascertain with certitude.

The logic behind this estimate reflects the fact that ASD services tend to be utilized more by younger children with ASD than older children and young adults. There is insufficient data to calculate the cost reduction with pinpoint precision. However, reducing the age to which the

1434
#6
3/6
pg. 6

ASD mandate applies and reducing the amounts of the ABA annual maximums will certainly not increase the future cost. The extent to which these revisions will reduce the cost relative to the original is unclear. It is possible that no children over 18 and less than 26 would have received ASD care if the original version of HB 1434 would have been implemented. If that were the case, the reduction in the cost would be 0%. However, on a state-wide basis, it is possible that some children from age 19 up to age 26 would have utilized ASD services if the original bill were implemented.

Concerning the reductions in the annual maximum from \$50,000 to:

- a. \$36,000 for children less than age 7
- b. \$25,000 for children from age 7 through age 13
- c. \$12,500 for children from age 14 through age 18.

Under the original bill, some children may have received more ABA services than these revised maximums but less than the original \$50,000. Data was provided by North Dakota's Autism Registry for the original actuarial report. It showed that symptoms of ASD tend to be noticed at a very young age, and only 3% of children with ASD had their symptoms first noticed after age 20. 84% were first noticed before age 4. Although the data was limited, 2 years was the median age at which ASD symptoms were first noticed, and 7 years of age was the median age of diagnosis.

The organization Autism Speaks reports that ABA techniques are effective for building important life skills in teens and adults with autism. They also report that there are many unknowns concerning the benefits of intensive ABA programs for teens and adults. ASD and ABA programs for younger children seem to be better studied in the academic literature than those for teens and adults. While many experts agree that behavior is easier to modify in young children, many programs nonetheless assert that ABA is effective for older children. Hence, it is difficult to say whether the maximums for each age-bracket are consistent with current ABA utilization levels or whether older children will more frequently have their ABA services limited by the revised annual maximums under the First Engrossment.

By using a regressive approach to the annual maximums for ABA by age-bracket, there may be increased pressure on ASD providers and professionals to diagnose earlier, and parents and families may seek ABA treatment earlier. When all children with ASD can receive up to \$50,000 of ABA services at any age prior to 26, as under the original version of the bill, there is less pressure for parents and families to obtain ABA treatment before the child ages into the next age-bracket with a lower maximum. The tendency to diagnose and treat earlier is not expected to occur instantly in year one, but it may increase over the first several years of the mandate as families and providers become accustomed to it.

If there are children whose ABA is limited by the annual maximum, it is more likely that it will be those who are 7 to 10 and 14 to 16. These are children at the younger end of these two age brackets. This assumes that the number of hours of ABA used per child per year declines with

age from age 5 to 26, which is consistent with the limited data and information about ABA use. Similarly, in terms of total hours of ASD services used per year, the annual use of ASD services in general is likely greater for children less than 10 years of age than those over 20, which is also consistent with the limited data and information about the use of ASD services.

One thing is clear: It would be inappropriate to estimate the reduced cost of the revised bill by simply scaling down the original estimate to reflect the two fundamental changes (reduced age and reduced annual ABA maximums by age-bracket). This would overstate the value of the cost reduction stemming from the revisions contained in the First Engrossment. Assuming a uniform distribution of children by age, the limitation to age 19 alone may reduce the number of eligible children and young adults by 27%, but it would not cut cost by the same amount.

[$- 27\% = (19 / 26) - 1$]. Again, those in the age 19 through 25 bracket are expected to use fewer ASD services and ABA annually than younger children. Hence, a 27% reduction is unlikely. Based on the ND PERS data provided for Active employees and dependents, the number of children to age 19 represent 69.3% of the children to age 26, which is 30.7% reduction. This 69% is slightly lower than the 73% because there are slightly more children in the 19 through 25 age range, especially ages 24 and 25. This demographic 'bump' could be a consequence of the fact that it is more cost-effective to keep children on the parents' policy to age 26 than for the children to buy their own separate individual coverage.

One other issue to note with the revised version of HB 1434 (as described in the First Engrossment) is interstate equity. This was not discussed in the original report from Acumen Actuarial, but since the parameters of the revised HB 1434 were taken from South Dakota legislation, North and South Dakota's ASD benefits will be equivalent. This would eliminate the incentive for parents of children with ASD to relocate from one state to another in order to obtain significantly more generous ASD benefits in one state than another. It is unclear if and to what extent this is already happening from state to state. There are so many other factors that come into play when it comes to interstate family relocation that it seems unlikely that it plays a material role in the cost of the mandate itself.

The cost estimate in this supplemental report is an adjustment to the cost estimate in the original report. In so doing, the margin of error is increased. Projecting the cost change produced by the revisions to HB 1434 in the First Engrossment requires some mathematical hair-splitting. We can be confident that the two fundamental revisions to HB 1434 reduce the cost of the original bill slightly, but we cannot determine exactly how much. The estimated reduction of 5% is reasonable. Although the original cost of HB 1434 is less than \$1.00 PMPM, this 5% reduction cannot be ignored as entirely immaterial or *de minimis*. Hence the analysis in this supplemental report. Nonetheless, the 5% reduction is, in fact, small, and it amounts to pennies per person per month when spread over all insureds.

1434
#6
3/16
pg. 8

LIMITATIONS OF USE AND QUALIFICATIONS

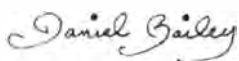
This supplemental actuarial report is intended for the state of North Dakota for the purpose of its evaluation of the revised legislation under HB 1434 as described in the First Engrossment dated February 9, 2017. It provides an estimate of the uncertain future cost of ASD services to be provided under the revised version HB 1434 relative to the cost of the original version. This supplemental report is not intended as a stand-alone report. It is a supplement to the report issued February 2, 2017 by Acumen Actuarial; that original report concerns the original version of HB 1434.

The use and discussion of this document is limited to North Dakota and Acumen Actuarial. This supplemental report is not to be used for any other application or purpose. It was developed specifically for the state of North Dakota as it applies to the actuarial evaluation of the revised version of HB 1434 at this point in time. It is intended for use in conjunction with the original report. The contents of this report are not intended for any other use or purpose. If the distribution of this report is not prohibited by public records law, this report should not be distributed to third parties without Acumen's prior permission. Like the original report, this supplemental report shall be released only in whole, and it shall not be released in part to any party.

This review is limited in time and scope. It is not a guarantee that ND's future actual ASD services cost under HB 1434 will equal those shown in this report. This report does not recommend a specific course of action. The intent of this review and supplemental report is to provide objective facts and findings that the state of ND Legislative Council can use to evaluate the revised version of HB 1434 with respect to the expected future cost and use of ASD services in private health insurance as required under the bill. It is not a legal opinion and does not provide legal advice on matters of law pertaining to the legislation.

I, Daniel Bailey, am a consulting health actuary and owner of Acumen Actuarial LLC. I am a fellow of the Society of Actuaries and member of the American Academy of Actuaries, and in good standing with both organizations. I meet the Qualification Standards to render the opinion contained herein. If you have questions, please contact me at bailey-d-1@comcast.net. My office phone is 860-986-4052.

Daniel Bailey, FSA, MAAA



PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of autism services; to require a report regarding coverage of autism services; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Coverage of autism services.

1. As used in this section:
 - a. "Applied behavior analysis" has the same meaning as "practice of applied behavior analysis" as defined under section 43-32-01.
 - b. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the "Diagnostic and Statistical Manual of Mental Disorders," American psychiatric association, fifth edition (2013) or a more recent version as identified by the board or as defined by the edition in effect at the time of diagnosis.
 - c. "Behavioral health treatment" means a counseling or treatment program, including applied behavior analysis, that is:
 - (1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
 - (2) Provided or supervised by a licensed behavior analyst or psychologist.
 - d. "Diagnosis of autism spectrum disorder" means any medically necessary assessment, evaluation, or test to diagnose whether an individual has an autism spectrum disorder.
 - e. "Pharmacy care" means a medication prescribed by an individual authorized to prescribe such a medication and any health-related service deemed medically necessary to determine the need or effectiveness of the medication.
 - f. "Psychiatric care" means a direct or consultative service provided by a psychiatrist licensed in the state in which the psychiatrist practices.
 - g. "Psychological care" means a direct or consultative service provided by a psychologist licensed in the state in which the psychologist practices.

- h. "Therapeutic care" means any service provided by a licensed speech language pathologist, occupational therapist, or physical therapist.
 - i. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care is medically necessary, including behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.
2. For all policies that become effective after June 30, 2017, and which do not extend past June 30, 2019, the board shall provide health benefits coverage for the screening for, diagnosis of, and treatment for autism spectrum disorder. Coverage under this section is not subject to limitations on the number of visits a covered individual may make for treatment for autism spectrum disorder.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF AUTISM SERVICES. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-sixth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of autism services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the autism services coverage requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should continue.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly

March 16, 2017

HB 1434
#2
3/17

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1434

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact section a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employees retirement system uniform group insurance coverage of autism services; to require a report regarding coverage of autism services; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Coverage of autism services.

1. As used in this section:
 - a. "Applied behavior analysis" has the same meaning as "practice of applied behavior analysis" as defined under section 43-32-01.
 - b. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the "Diagnostic and Statistical Manual of Mental Disorders," American psychiatric association, fifth edition (2013) or a more recent version as identified by the board or as defined by the edition in effect at the time of diagnosis.
 - c. "Behavioral health treatment" means a counseling or treatment program, including applied behavior analysis, that is:
 - (1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
 - (2) Provided or supervised by a licensed behavior analyst or psychologist.
 - d. "Diagnosis of autism spectrum disorder" means any medically necessary assessment, evaluation, or test to diagnose whether an individual has an autism spectrum disorder.
 - e. "Pharmacy care" means a medication prescribed by an individual authorized to prescribe such a medication and any health-related service deemed medically necessary to determine the need or effectiveness of the medication.
 - f. "Psychiatric care" means a direct or consultative service provided by a psychiatrist licensed in the state in which the psychiatrist practices.
 - g. "Psychological care" means a direct or consultative service provided by a psychologist licensed in the state in which the psychologist practices.

- h. "Therapeutic care" means any service provided by a licensed speech language pathologist, occupational therapist, or physical therapist.
- i. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care is medically necessary, including behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.
- For all policies that become effective after June 30, 2017, and which do not extend past June 30, 2019, the board shall provide health benefits coverage for the screening for, diagnosis of, and treatment for autism spectrum disorder in covered individuals under nineteen years of age.
- a. Coverage under this section is not subject to limitations on the number of visits a covered individual may make for treatment for autism spectrum disorder.
- b. Except as allowed under subdivision c, coverage under this section is not subject to dollar limits, deductibles, or coinsurance provisions less favorable to a covered individual than the dollar limits, deductibles, or coinsurance provisions that apply to substantially all medical and surgical benefits under the health benefits coverage.
- c. Coverage for applied behavioral analysis under this section must provide an annual maximum benefit of:
- (1) Thirty-six thousand dollars for individuals under the age of seven;
- (2) Twenty-five thousand dollars for individuals between the ages of seven and not yet fourteen; and
- (3) Twelve thousand five hundred dollars for individuals between the ages of fourteen and not yet nineteen.
- d. The coverage for applied behavior analysis must include the services of the personnel who work under the supervision of the licensed behavior analyst or psychologist overseeing the program.
- e. Except for inpatient services, if a covered individual is receiving treatment for an autism spectrum disorder, the coverage may allow for annual review of the treatment plan, unless a more frequent review is necessary. An agreement regarding the right to review a treatment plan more frequently than annually is limited in application to a particular covered individual being treated for an autism spectrum disorder. The cost of obtaining a review or treatment plan must be borne by the policy.
- This section does not limit benefits otherwise available to a covered individual under the uniform group insurance program. This section does not affect an obligation to provide services to a covered individual under an individualized family service plan, an individualized education program, or an individualized service plan.

1434
#2
3/17

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - COVERAGE OF AUTISM SERVICES.

1. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-sixth legislative assembly to repeal the expiration date for section 1 of this Act and to extend the coverage of autism services to apply to all group and individual health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the autism services coverage requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage under this Act, a comparison of the system's coverage of autism services under this Act and the coverage of autism services by North Dakota insurers, and a recommendation regarding whether the coverage under this Act should continue as provided in this Act or should continue with amendments.
2. Quarterly during the 2017-18 interim, the insurance commissioner shall survey health insurance carriers in the state to collect data regarding policy coverage and utilization of autism services. The commissioner shall provide this data to the public employees retirement system for inclusion in the report prepared under subsection 1.

SECTION 3. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2019, and after that date is ineffective."

Renumber accordingly