

- Today's discussion
  - Self insured vs Fully insured
  - Grandfathered vs Non Grandfathered
    - PERS Update

- Today's discussion

- **Self insured vs Fully insured**

# What is Self-Insurance?

## A self-funded plan...

Is an arrangement in which an employer assumes direct financial responsibility for the costs of enrollees' medical claims. An employer typically contracts with a third-party administrator or insurer to provide administrative services for the plan. In some cases, the employer also buys stop-loss coverage to protect the employer against very large claims.

## A fully insured plan...

Is an arrangement in which the employer contracts with a health plan that assumes full financial liability for the costs of enrollees' medical claims and administrative expenses.

# What is Stop Loss Insurance?

## Stop Loss Insurance

Is a form of insurance that protects employers that self fund their medical plans from the financial impact of catastrophically large claims or an unexpected high volume claims. The employer contracts with an insurance carrier to provide coverage in the event that claims exceed a specified dollar amount over the plan year. There are two types of stop loss coverage: Individual and aggregate.

## Individual Stop Loss

Also referred to as “Specific” stop loss, protects the plan against individual catastrophic claims above a specified level (determined by the employer). Individual stop loss levels vary among employers and depends on their level of comfort with risk and their ability to cope with fluctuating claims experience. (Example: \$250,000 specific stop loss level)

## Aggregate

Aggregate stop loss is used to limit the plan’s exposure to large fluctuations due to an abnormally high incidence of claims. Aggregate stop loss insurance is typically less expensive than specific stop loss insurance. (Example: Aggregate stop loss at 125% of expected claims)

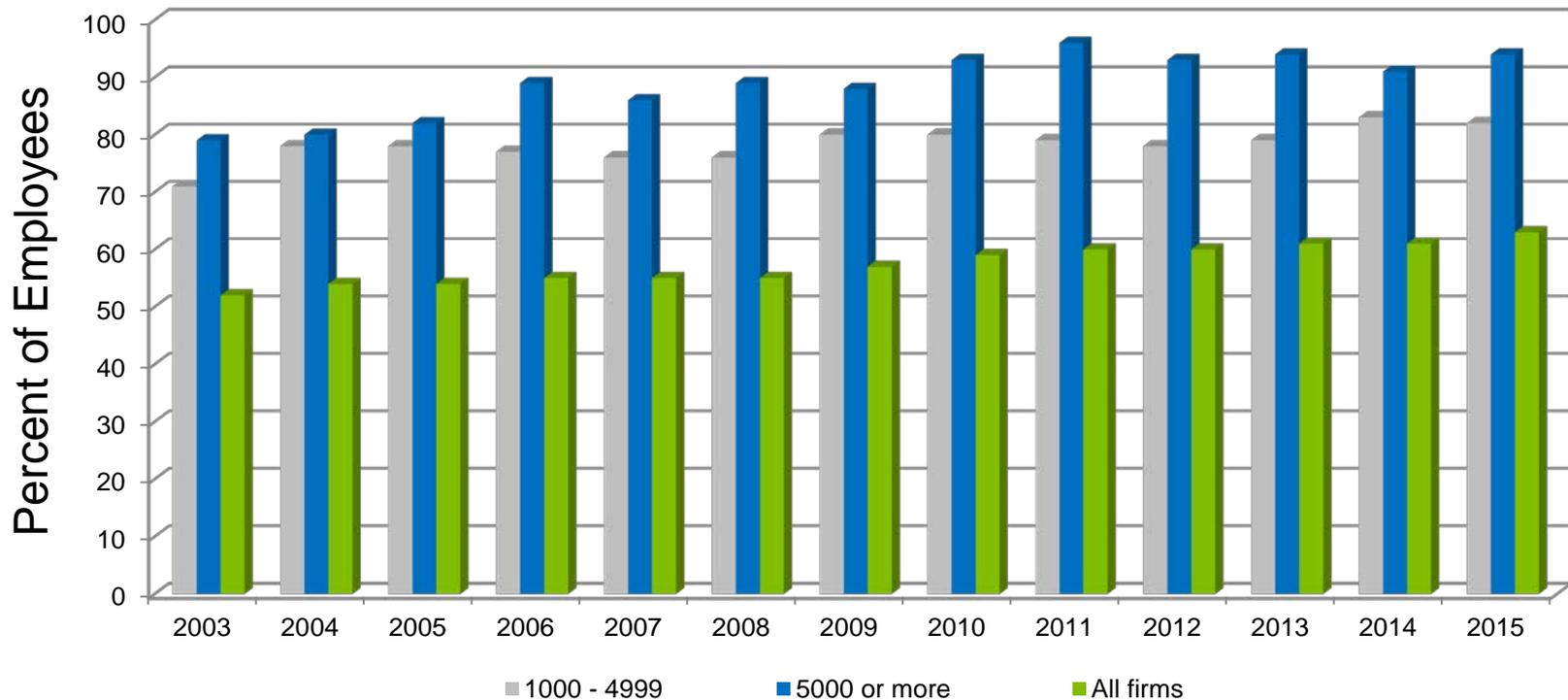
- **54-52.1-04.2. Self-insurance plan for hospital and medical benefits coverage.**

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. 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. **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.** 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.

# Prevalence of Self-Funded Medical Plans

Larger organizations are more likely to self-fund their medical plans – the larger the group, the more predictable the claims experience

Percent of Employees Covered in a Self-Funded Plan  
By Size of Employer

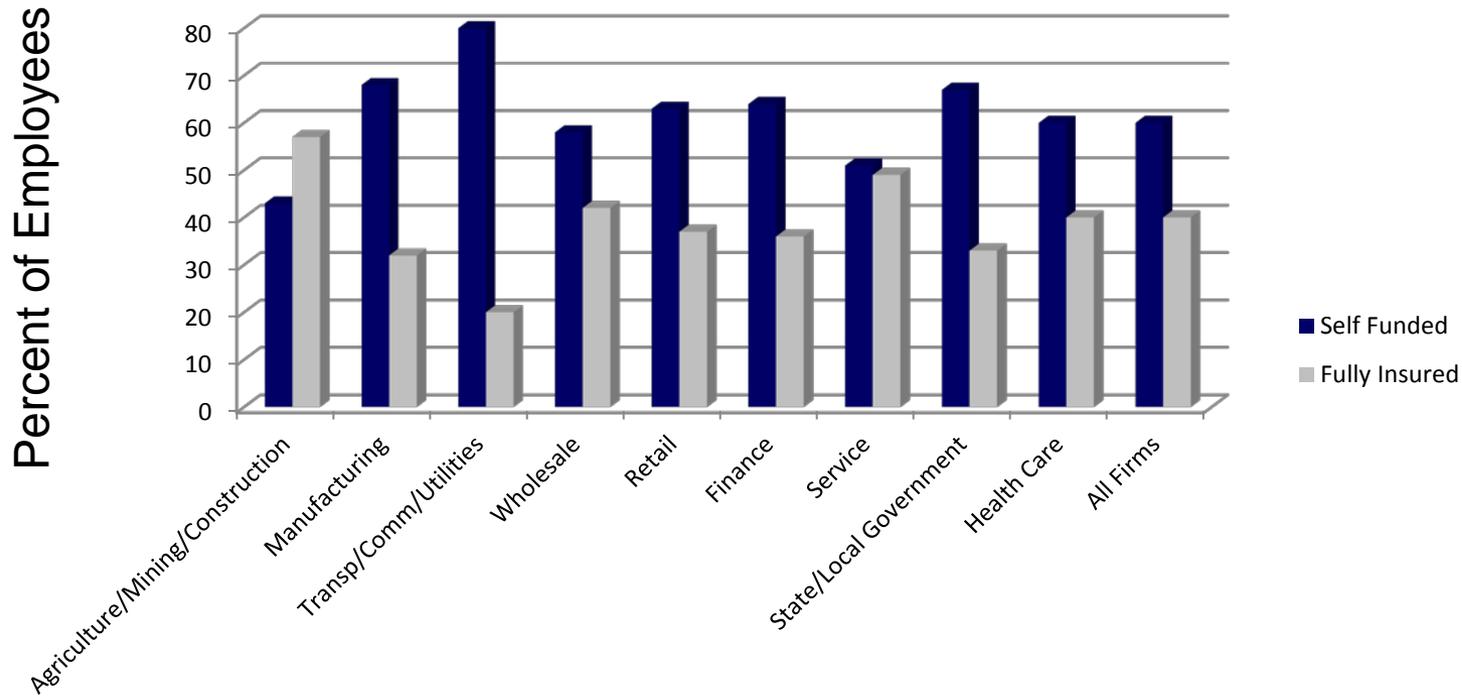


# Prevalence of Self-Funded Medical Plans

The prevalence of self-funding varies by industry

- 67% of State/local government employees nationwide were self-funded in 2011

Percent of Employees Covered in a Self-Funded Plan  
By Industry (2011)



# Advantages of Self Funding (Disadvantages of Fully Insured)

1	Reduction in taxes	Additional taxes are eliminated (HMO, state premium tax, MCHA)
2	Avoid ACA Fees	The Health Insurer tax from the ACA is not required from self-insured plans Estimates are 2-3% For PERS about \$11.5 million (total plan)
3	Administrative fees/risk fees	Some self funded plans see a decrease in administrative fees due to the elimination of built in risk charges Approximately 1 – 2%
4	Reserves/IBNR are held by the employer	Any investment income generated is retained by the employer

# Self insurance Reserve Requirement (54-52.1-04.3 NDCC)

1. 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.

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- ***PERS presently has a \$40,000,000 reserve***
  - ***This equates to just over 2 months based on the average monthly paid claims prior to 3/1/14 \****
- ***We would meet the initial requirement without adding to premium***

*\* Average monthly paid medical and pharmacy claims for the period 3/1/13-2/28/14 was \$19,700,000*

# Self insurance Reserve Requirement (54-52.1-04.3 NDCC)

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2. **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. (Last biennium was about \$ 20 million to 30 Million)**

# Self insurance Reserve Requirement (54-52.1-04.3 NDCC)

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2. 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. ( Last biennium was about \$ 20 million to 30 Million)
3. **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.**

# Advantages of Self Funding (Disadvantages of Fully Insured)

1	Reduction in taxes	Additional taxes are eliminated (HMO, state premium tax, MCHA)
2	Avoid ACA Fees	The Health Insurer tax from the ACA is not required from self-insured plans Estimates are 2-3%
3	Administrative fees/risk fees	Some self funded plans see a decrease in administrative fees due to the elimination of built in risk charges Approximately 1 – 2%
4	Reserves/IBNR are held by the employer	Any investment income generated is retained by the employer
5	<b>Flexibility</b>	<b>Allows for greater flexibility in plan design, incentive arrangements and contractual provisions (health plans are not limited to filed plans)</b>
6	<b>Pass through savings</b>	<b>Employer benefits from provider discounts, rebates and other favorable reimbursement mechanisms with full disclosure</b>
7	<b>Mandates</b>	<b>Do not have to comply with state mandates</b>

# Disadvantages to self insurance

## Advantages of Fully Insured

1	Risk	Employer is at risk for financial Losses
2	Employer must retain IBNR	Additional liability for IBNR on the balance sheet
3	Employer must have a reserve account	Employer must maintain and fund a reserve account
4	Must maintain cash flow	Uneven cash flow due to fluctuation of claims from month to month - Potential that claims may be higher than funding
5	Employer is directly responsible for some administrative responsibilities	Self funding will result in some additional administrative requirements for the employer <ul style="list-style-type: none"><li>• Plan document, summary plan description</li><li>• Accounting/finance requirements</li><li>• Management of fiduciary responsibility</li></ul>

# Self insured vs Fully insured NDPERS

- PERS is technically a fully insured plan
- However, PERS is not a traditional fully insured plan
- Due to our size, we have been able to negotiate a fully insured plan that incorporates many of the advantages of a self insured plan and avoids many of the disadvantages of a fully insured plan.
- Consequently, our plan is a hybrid fully insured plan that incorporates the advantages of self and fully insured

<b>Advantages of Self Insurance</b> (Disadvantages of being fully insured)	<b>PERS Hybrid Fully Insured Plan</b>
1. <b>Reduction in Taxes</b>	State Statute exempts PERS from Insurance Premium Tax
1. <b>No ACA tax (estimated at about \$5.5 million per year)</b>	
1. <b>Administrative/ risk fees</b>	This is offset to a certain extent by having to pay for stop-loss insurance when self insured.
1. <b>Reserves/IBNR held by the employer</b>	PERS gets interest on cash flow as part of settlement process if the plan has a gain and PERS gets all earnings reserves
1. <b>Flexibility</b>	PERS determines plan design based upon funding
1. <b>Pass through savings</b>	PERS gets savings less 1.5 million
1. <b>Mandates</b>	Under state law PERS does have to comply with state mandates

## Disadvantages of Self insurance

(advantages of being fully insured)

## PERS Hybrid Fully Insured Plan

### 1. Financial Risk

PERS Plan limits employer loss to 50% of first 6 million or a total of 3 million

### 1. Employer must retain IBNR (Incurred by not reported)

Insurance company is responsible and at risk for IBNR

### 1. Employer needs a reserve account

Insurance company is responsible for maintaining and at risk for reserve account

### 1. Must maintain cash flow

Insurance company is responsible for cash flow

### 1. Employer is directly responsible for some administrative responsibilities

Insurance company is directly responsible.

- Today's discussion

- Self insured vs Fully insured
- **Grandfathered vs Non Grandfathered**

# What Does it Mean to be a Grandfathered Health Plan?

Grandfathered group health plans do not have to comply with some of the ACA's group health plan mandates.

Mandate	Applies to Grandfathered Plans?	
	Yes	No
Ban on Lifetime Dollar Limits for EHBs	★	
Ban on Annual Dollar Limits for EHBs	★	
Dependent Eligibility until Age 26	★	
Preventive Care		★
Summary of Benefits and Coverage	★	
External Review of Claims Determinations		★
90-day Maximum Waiting Periods	★	
Nondiscrimination Rules for Fully-Insured Plans		★
Ban on Preexisting Condition Exclusions	★	
Quality of Care Reporting		★
Patient Protections		★

# Impact of Losing Grandfather Status

The following provisions must be added when a plan loses its Grandfather Status

ACA Provision	Description	Applies to Self-Funded Plans?	Pros		Cons	
			Member	Employer	Member	Employer
<b>First-dollar coverage of preventive health benefits (§2713)</b>	<ul style="list-style-type: none"> <li>No deductibles, copays, coinsurance, or other cost-sharing can be applied to in-network preventive care services.</li> <li>Benefits are defined by the US Preventative Services Task Force with an "A" or "B" rating. See Attachment A.</li> <li>Immunizations for children, adolescents and adults recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC Advisory Committee) See Figure 1.</li> <li>With respect to infants, children, and adolescents, evidence-informed preventive care and screenings recommended by the Health Resources and Services Administration (HRSA). See Figure 1.</li> </ul>	Yes	Increased member satisfaction in added benefits.	Increased member satisfaction in added benefits.	None	Cost
<b>Prohibition of discrimination based upon salary (§2716).</b>	Plans cannot discriminate in favor of highly compensated individuals (to be implemented for plan years after future regulations are issued).	Yes	Benefit and eligibility equality.	None	None	Must do discrimination testing.
<b>Medical Loss Ratio requirement and rebates to consumers (§2718).</b>	Requires loss ratio reporting to HHS and rebates to consumers for MLR below required levels (80% small group and individual, 85% large group).	No	Possible rebates.	None	None	None.
<b>Internal and external appeals (§2719)</b>	Carriers required to establish internal and external appeals process and must continue coverage/payment of claims pending outcome.	Yes	More expansive appeal rights.	None	None	None

# Impact of Losing Grandfather Status

The following provisions must be added when a plan loses its Grandfather Status

ACA Provision	Description	Applies to Self-Funded Plans?	Pros		Cons	
			Member	Employer	Member	Employer
<b>Patient protections (§2719A).</b>	Members must be given opportunity to choose their own participating PCP, pediatrician, OB/Gyn (without a referral). Carrier must cover out-of-network emergency services and without pre-authorization.	Yes	PERS already complies.	None	None	None
<b>For small groups, federal PMPM rating rules apply. (§ 2701).</b>	Must follow rating limitations (rating based on: tobacco use 1.5:1, age 3:1, rating area, and coverage for individual versus family). No two families will pay the same premium.	No	Some member may pay less.	None	Some members may pay more.	Challenge in reconciling premium billing.
<b>Guaranteed Availability/Issue (§ 2702).</b>	Must offer coverage to and accept every employer or individual who applies for coverage. Exceptions allow carrier to restrict enrollment in coverage to: 1) open and special enrollment periods, 2) employers with eligible individuals who live, work, or reside in the service area of a network plan, and 3) for situations involving limited network capacity and limited financial capacity.	No	Members have an opportunity to enroll annually at a minimum.	PERS already complies.	None	None
<b>Guaranteed renewability (§2703)</b>	Must renew or continue in force at the option of the plan sponsor. Exceptions to this requirement include the failure to meet minimum participation or contribution standards in the small group market.	No	None	Guarantee Renewal	None	None
<b>For small groups, Comprehensive health insurance coverage for Essential Health Benefits (EHB) (§2707)</b>	Must include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all group health plans to comply with limitations on allowable cost sharing.	No	Richer benefits.	None	Cost	Cost
<b>Coverage for individuals participating in approved clinical trials (§2709)</b>	Must include coverage for individuals participating in approved clinical trials. Prohibits health insurance issuers from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Carriers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.	Yes	PERS already complies	None	None	Cost

**Table 1: Summary of Selected Preventive Services for Adults Covered by Non-Grandfathered Private Plans without Cost Sharing**

Cancer	Chronic Conditions	Immunizations	Health Promotion	Pregnancy-Related**	Reproductive Health
<ul style="list-style-type: none"> <li>• Breast cancer                             <ul style="list-style-type: none"> <li>- Mammography (women 40+<sup>4</sup>)</li> <li>- Genetic (BRCA) screening and counseling (women at high risk)</li> <li>- Preventive medication (women at high risk)</li> </ul> </li> <li>• Cervical cancer                             <ul style="list-style-type: none"> <li>- Pap testing (women 21+ with cervix)</li> <li>- HPV DNA testing<sup>2</sup> (women 30-65 with normal pap results)</li> </ul> </li> <li>• Colorectal cancer                             <ul style="list-style-type: none"> <li>- Fecal occult blood testing, sigmoidoscopy, and/or colonoscopy. (adults 50-75)</li> </ul> </li> <li>• Lung cancer screening                             <ul style="list-style-type: none"> <li>- Annual tomography (adults 55- 80 with history)</li> </ul> </li> <li>• Skin cancer                             <ul style="list-style-type: none"> <li>- Counseling (adults 18- 24)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening (men 65- 75 who have ever smoked)</li> <li>• Cardiovascular health                             <ul style="list-style-type: none"> <li>- Hypertension screening</li> <li>- Blood pressure</li> <li>- Lipid disorders screenings (high risk women 20+; at risk men 20-35; all men 35+)</li> <li>- Aspirin (men 45- 79; women 55- 79)</li> <li>- Behavioral Counseling (overweight or obese adults with CVD risk factors)</li> </ul> </li> <li>• Diabetes (Type 2) screening (adults with elevated blood pressure)</li> <li>• Depression screening (adults when follow up supports available)</li> <li>• Hepatitis B screening (adults at high risk for infection)</li> <li>• Hepatitis C screening (high risk adults; one time screening for adults born between 1945 and 1965)</li> <li>• Obesity Screening and Management (all adults via body mass index (BMI))                             <ul style="list-style-type: none"> <li>- Referral for intervention for adults ≥ BMI of 30 kg/m<sup>2</sup></li> </ul> </li> <li>• Osteoporosis screening (all women 65+; high risk women &lt;60)</li> </ul>	<ul style="list-style-type: none"> <li>• Haemophilus influenzae type b (adults 18+ with risk factors)</li> <li>• Hepatitis A (adults with risk factors)</li> <li>• Hepatitis B (adults with risk factors)</li> <li>• HPV (women 18- 26 and men 18- 21 not previously vaccinated; at risk men 22- 26)</li> <li>• Influenza (yearly)</li> <li>• Meningococcal (adults 18+ with risk factors)</li> <li>• Measles, Mumps and Rubella (adults 18- 49; 50+ with risk factors)</li> <li>• Pneumococcal (adults 19- 64 with risk factors; adults 65+)</li> <li>• Td booster, Tdap</li> <li>• Varicella</li> <li>• Zoster (adults 60+)</li> </ul>	<ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling (risk assessment all adults)</li> <li>• Fall Prevention Counseling and Preventive Medication (community-dwelling adults 65+)</li> <li>• Intimate partner violence screening, counseling<sup>2</sup> (women)</li> <li>• Tobacco counseling and cessation interventions</li> <li>• Well-woman visits<sup>2</sup> (women 18- 64; visits for recommended preventive services, preconception care, and/or prenatal care)</li> </ul>	<ul style="list-style-type: none"> <li>• Alcohol misuse screening and counseling</li> <li>• Breastfeeding supports                             <ul style="list-style-type: none"> <li>- Counseling</li> <li>- Consultations with trained provider<sup>2</sup></li> <li>- Equipment rental<sup>2</sup></li> </ul> </li> <li>• Folic acid supplements (women with reproductive capacity)</li> <li>• Gestational diabetes screenings<sup>2</sup> (after 24 weeks gestation)</li> <li>• Iron deficiency anemia screening</li> <li>• Preeclampsia preventive medicine (pregnant women at high risk)</li> <li>• Low-dose aspirin (at risk women after 12 weeks of gestation)</li> <li>• Screenings for pregnant women                             <ul style="list-style-type: none"> <li>- Hepatitis B</li> <li>- Chlamydia (women ≤24 years; older women at risk)</li> <li>- Gonorrhea</li> <li>- Syphilis</li> <li>- Bacteriurea</li> </ul> </li> <li>• Tobacco counseling and cessation interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Contraception (all women with reproductive capacity)<sup>2</sup> *                             <ul style="list-style-type: none"> <li>- All FDA-approved contraceptive methods as prescribed</li> <li>- Sterilization procedures</li> <li>- Patient education and counseling</li> <li>- Services related to follow-up, management of side effects, and device removal</li> </ul> </li> <li>• Screenings                             <ul style="list-style-type: none"> <li>- Chlamydia (sexually active women ≤24 years old, older women at risk)</li> <li>- Gonorrhea ((sexually active women ≤24 years old, older women at risk)</li> <li>- Syphilis (adults at high risk)</li> <li>- HIV (adults 15- 65; at-risk younger adolescents and older adults)</li> </ul> </li> <li>• STI and HIV counseling (adults at high risk; all sexually-active women<sup>2</sup>)</li> </ul>

**Notes:** Unless noted, applicable age for the recommendations is age 18+. Pregnancy-related applies to pregnant women. Age ranges are meant to encompass the broadest range possible. Each service may only be covered for certain age groups or based on risk factors. \*The ACA defines the recommendations of the USPSTF regarding breast cancer services to "the most current other than those issued in or around November 2009." Thus, coverage for mammography is guided by the 2002 USPSTF guideline. \*\*Services in this column apply to all pregnant or lactating women, unless otherwise specified. \*\*\*Certain religious employers exempt from this requirement. <sup>2</sup>Recommendation from HRSA Women's Preventive Services; coverage for these services without cost sharing in "non-grandfathered" plans began August 1, 2012. Coverage without cost sharing for all other services went into effect Sep. 23, 2010.

**Sources:** CMS, [Affordable Care Act Implementation FAQ's Set 18](#). CMS, [Preventive Health Services for Adults](#). More information about each of the items in this table, including details on periodicity, age, risk factors, and specific tests and procedures are available at the following websites: [USPSTF](#); [ACIP](#); [HRSA Women's Preventive Services](#).

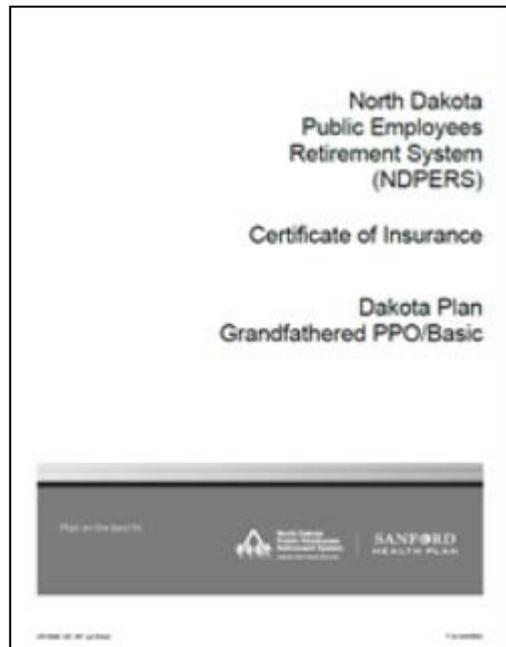
**Table 2: Summary of Selected Preventive Services for Children Covered by Non-Grandfathered Private Plans without Cost Sharing**

Chronic Conditions	Immunizations	Health Promotion	Reproductive Health	Development and Behavioral Health
<ul style="list-style-type: none"> <li>• <b>Cardiovascular health</b> <ul style="list-style-type: none"> <li>- Blood pressure (screening for at risk newborn children - 3 years; children 3 years+)</li> <li>- Lipid disorders screenings (children 2 years+ risk assessment/ screening)</li> </ul> </li> <li>• <b>Depression screening</b> (adolescents 11 years+)</li> <li>• <b>Hepatitis B screening</b> (adolescents at high risk for infection)</li> <li>• <b>Skin cancer counseling</b> (children 10 years+)</li> <li>• <b>Obesity</b> <ul style="list-style-type: none"> <li>- Screening (children 2 years+ via body mass index (BMI))</li> <li>- Counseling and behavioral interventions (obese children 6 years+)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>DTaP</b> (children 2 months- 6 years)</li> <li>• <b>Haemophilus influenzae type b</b> (children 2 months - 4 years)</li> <li>• <b>Hepatitis A</b> ( children 1 year+; 2 years+ with risk factors)</li> <li>• <b>Hepatitis B</b> (at birth; then newborn+)</li> <li>• <b>HPV</b> (children 11 years+)</li> <li>• <b>Inactivated Poliovirus</b> (children 2 months+)</li> <li>• <b>Influenza (yearly)</b> (children 6+ months+)</li> <li>• <b>Meningococcal</b> (children 11 years+; 2 months+ with risk factors)</li> <li>• <b>Measles, Mumps and Rubella</b> (children 1 year+)</li> <li>• <b>Pneumococcal</b> <ul style="list-style-type: none"> <li>- Pneumococcal conjugate (children 2 months - 4 years; 5 years+ with risk factors)</li> <li>- Pneumococcal polysaccharide (children 2 years+ with risk factors)</li> </ul> </li> <li>• <b>Td booster, Tdap</b> (children 7 years+)</li> <li>• <b>Varicella</b> (children 1 year+)</li> <li>• <b>Rotavirus</b> (children 2- 6 months)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Anemia screening, supplements</b> (children 6 months+ iron supplements for high risk 6 - 12 months)</li> <li>• <b>Dental caries prevention</b> <ul style="list-style-type: none"> <li>- Fluoride varnish (infants and children at age of primary teeth eruption)</li> <li>- Fluoride supplements(children 6+ months without fluoride in water source)</li> </ul> </li> <li>• <b>Gonorrhea prophylaxis treatment</b> (newborn)</li> <li>• <b>History and physical exams</b> (prenatal+)</li> <li>• <b>Measurements:</b> <ul style="list-style-type: none"> <li>- Length/height and weight (children newborn- adolescence)</li> <li>- Head circumference, weight for length (newborn - 2 years)</li> <li>- Body mass index (BMI) (children 2 years+)</li> <li>- Blood pressure (risk assessment at birth; children 3 years+)</li> </ul> </li> <li>• <b>Oral health: risk assessment, referral to dental home</b> (children 6 months - 6 years)</li> <li>• <b>Screenings</b> <ul style="list-style-type: none"> <li>- Blood screening(newborn- 2 months)</li> <li>- Critical congenital health defect (newborn)</li> <li>- Lead screening(children risk assessment and/or test 6 months - 6 years)</li> <li>- Metabolic/hemoglobin, phenylketonuria, sickle cell, congenital hypothyroidism screenings (newborn+)</li> <li>- Tuberculin (children risk assessment 1 month+)</li> </ul> </li> <li>• <b>Tobacco counseling and cessation interventions</b> (children 5 years- adolescence)</li> <li>• <b>Vision and hearing screenings/assessment</b> (children newborn+)</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Contraception</b> (all women with reproductive capacity)<sup>2*</sup> <ul style="list-style-type: none"> <li>- All FDA-approved contraceptive methods as prescribed</li> <li>- Sterilization procedures</li> <li>- Patient education and counseling</li> <li>- Services related to follow-up, management of side effects, and device removal</li> </ul> </li> <li>• <b>STI and HIV counseling</b> (sexually-active adolescents)</li> <li>• <b>Screenings</b> <ul style="list-style-type: none"> <li>- Chlamydia (sexually active females)</li> <li>- Gonorrhea (sexually active females)</li> <li>- HIV (adolescents and at risk children; screening ages 16- 18)</li> <li>- STIs (risk assessment for adolescents; screening ages 16- 18)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Alcohol misuse screening and counseling</b> (risk assessment adolescents 11 years+)</li> <li>• <b>Autism screening:</b> (infants 18- 24 months)</li> <li>• <b>Developmental screenings and surveillance</b> (newborn+)</li> <li>• <b>Psychosocial/ behavioral assessment</b> (newborn+)</li> </ul>

**Notes:** Age ranges are meant to encompass the broadest range possible, up to age 21. Each service may only be covered for certain age groups or based on risk factors. For specific details on recommendations, please consult the websites listed below. \*Certain religious employers exempt from this requirement. <sup>2</sup>Recommendation from HRSA Women's Preventive Services; coverage for these services without cost sharing in "non-grandfathered" plans began August 1, 2012. Coverage without cost sharing for all other services went into effect Sep. 23, 2010.

**Sources:** CMS, [Affordable Care Act Implementation FAQ's Set 18](#). CMS, [Preventive health services for children](#). More information about each of the items in this table, including details on periodicity, age, risk factors, and specific tests and procedures are available at the following websites: [USPSTF](#); [Bright Futures and American Academy of Pediatrics](#); [ACIP](#); [HRSA Women's Preventive Services](#).

# PERS Plan Document



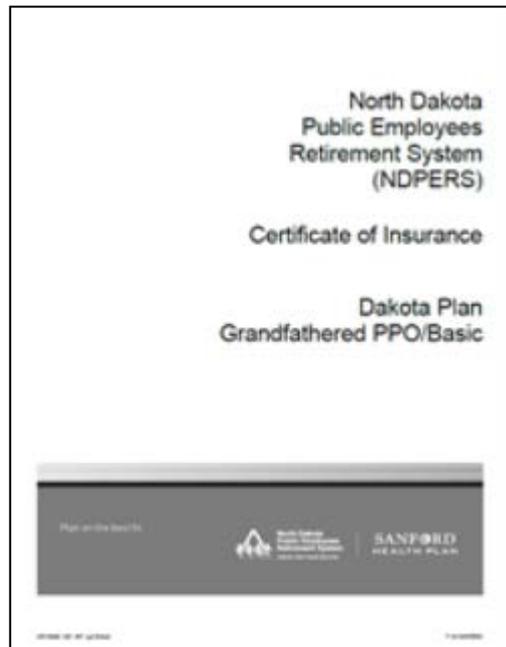
## *Grandfathered vs NonGrandfather benefits*

- *100% coverage*
- *Scope of Benefits*

# PERS Plan Comparison

Covered Services	PROVIDER OF SERVICE		Covered Services	PROVIDER OF SERVICE	
	Basic Plan After Deductible Amount	PPO Plan After Deductible Amount		Basic Plan After Deductible Amount	PPO Plan After Deductible Amount
<b>Grandfathered plan</b>			<b>Non Grandfathered Plan</b>		
<ul style="list-style-type: none"> <li><b>Routine Pap smear</b>  Related Office Visit</li> <li><b>Prostate Cancer Screening</b>  Related Office Visit</li> <li><b>Fecal Occult Blood Testing for Colorectal Cancer Screening</b></li> <li><b>Dilated Eye Examination (for diabetes related diagnosis)</b></li> <li><b>Colorectal Cancer Screening</b></li> <li><b>Immunizations other than Well Child Care</b></li> </ul>	<p>100% of Allowed Charge. Deductible Amount is waived. Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period.</p> <p>\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. Additional benefits will be available for Pap smears when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 5(a).</p> <p>75% of Allowed Charge. Deductible Amount is waived. Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for the following: an asymptomatic male age 50 and older; a male age 40 and older of African American descent; and a male age 40 with a family history of prostate cancer.</p> <p>\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived. Additional benefits will be available for prostate cancer screening when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider.</p> <p>100% of Allowed Charge. Deductible Amount is waived. Benefits are available for Members age 50 and older, subject to a Maximum Benefit Allowance of 1 test per Benefit Period.</p> <p>\$30 Copayment Amount, then 75% of Allowed Charge. Deductible Amount is waived. Benefits are subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period.</p> <p>Deductible Amount is waived. Benefits are available for Members age 50 and older, subject to a Maximum Benefit Allowance of 1 test per Benefit Period.</p> <p>100% of Allowed Charge. Deductible Amount is waived. Covered immunizations are those that have been published as policy by the Centers for Disease Control, including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles</p>	<p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>\$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p> <p>80% of Allowed Charge. Deductible Amount is waived.</p> <p>\$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p> <p>\$25 Copayment Amount, then 80% of Allowed Charge. Deductible Amount is waived.</p> <p>100% of Allowed Charge. Deductible Amount is waived.</p>	<p><b>Preventive Screening Services for Members ages 18 and older</b></p> <ul style="list-style-type: none"> <li><b>Routine Preventive Wellness (Physical) Examination</b> Preauthorization is not required when using a participating provider. Your annual preventive services do not need to be scheduled 12 months apart. For example, if your services were done July last year, it is okay to schedule them before July this year.</li> <li><b>Routine Diagnostic Screenings</b></li> </ul>	<p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>100% of Allowed Charge. Deductible Amount is waived. Office visit exam includes health advice and counseling on blood pressure, counseling and interventions on tobacco use, screening and counseling for alcohol use, sun exposure, screening for depression, obesity screening with referral for behavioral interventions for patients with a body mass index of 30 or higher and referrals to intensive behavioral counseling to promote a healthful diet and physical activity to decrease cardiovascular risk in adults that are overweight or obese and with cardiovascular disease risk factors. During the visit, you may receive immunizations/screenings based on your practitioner's recommendation.</p> <p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>100% of Allowed Charge. Deductible Amount is waived. Screenings include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>Abdominal Aortic Aneurysm Screening, Lifetime Maximum Benefit Allowance of one (1) ultrasound screening per male Member ages 65 through 75 with a history of smoking</li> <li>Anemia screening – Hemoglobin or Hematocrit (one or the other), one (1) per Member per year.</li> <li>Basic Metabolic Panel, one (1) per Member per year.</li> <li>Cholesterol Screening, coverage for frequency of Lipid Profile is dependent on Member age. Additional tests, such as comprehensive metabolic panels will be applied to your deductible/coinsurance.</li> <li>Diabetes Screening, benefit allowance of one (1) per Member per year.</li> <li>Hepatitis B Virus infection screening.</li> <li>Hepatitis C Virus (HCV) infection screening, Lifetime Maximum Benefit Allowance of either: one (1) screening for Members born between 1945-1965; or one (1) screening for Members at risk.</li> <li>Lung Cancer Screening, benefit allowance of one (1) per Member ages 55 through 80 who: 1) have a 30 pack-year smoking history; 2) currently smoke; or 3) have quit smoking within the past 15 years.</li> <li>Osteoporosis Screening for female Members ages 65 and older, or younger if at increased risk.</li> <li>Sexually Transmitted Disease (STD) Screening, one (1) per Member per year.</li> <li>Genetic counseling and evaluation for BRCA Testing and BRCA lab screening</li> </ul>	

# PERS Plan Document



## *Grandfathered vs NonGrandfather benefits*

- *100% coverage*
- *Scope of Benefits*
- ***Fiscal implication***
  - **Our current state premium of \$1130.22 would increase by about \$34 (3%) if the plan lost Grandfathered status.**
  - **This \$34 times the 12,000 state contracts would be \$408,000 a month (\$4.9 million a year or \$9.8 million a biennium).**

# What About the Employer?

Employers sponsoring grandfathered group health plans must comply with all of the following ACA requirements:

- Employer Shared Responsibility Rules (“Play-or-Pay”)
- Mandatory Automatic Enrollment
- W-2 Reporting of Employer-Provided Health Benefits
- Notice of Exchanges
- Information Reporting to IRS
- PCORTI Fee
- Transitional Risk Reinsurance Fee
- High-Value Excise Tax

# Is Grandfather Status Forever?

Theoretically, yes. But any of the following changes will cause a grandfathered plan to permanently lose that status:

- Eliminating all or substantially all benefits for diagnosing or treating a particular condition
- Adding new annual limits or reducing existing ones
- Decreasing the employer's premium contribution rate by more than 5 percentage points
- Increasing coinsurance requirements by any amount
- Increasing deductibles or out-of-pocket limits by more than medical inflation + 15 percentage points
- Increasing copays by more than the greater of –
  - Medical inflation + 15 percentage points; or
  - \$5

# For employer

Advantages	Disadvantages
About 3% lower premium cost	Limited ability to make plan design changes
Less benefit requirements	Less preventive benefits for members
Less administrative requirements	More administrative requirements relating member provisions

- Biggest challenge is paying the additional premium on top of medical inflation. If employer cannot pay the cost burden it is then passed on to the employee.

- Today's discussion

- Self insured vs Fully insured
  - Grandfathered vs Non Grandfathered

- **PERS Update**

# Next Steps

- Renewal Steps:

1. Solicit a renewal from the existing vendor

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  - 2. The consultant will be required to estimate the required premiums for the group health insurance program for a twenty-four (24) month period beginning July 1, 2017 and ending June 30, 2019. The consultant will be supplied the proposed plan of benefits by July 2016. The consultant must have completed the estimates by August 1, 2016. The purpose of this effort is to provide the Board an estimate to be used in analyzing the merits of renewing with the existing carrier**

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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.**

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  - 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.**

# Timeline

- **July, 2016** – Consultant will prepare premium renewal estimate. Submit Medicare Part D & Health RFP to PERS Board.
- **August, 2016** - Review proposed health and Part D renewals and report findings to the Board.
- **September, 2016** - Issue Medicare Part D and/or Health RFP if so determined by the PERS Board..
- **December, 2016** - Review analysis of health bids if necessary and provide recommendations to the PERS board. The consultant should be available either by teleconference or video conference.
- **January, 2017** - Follow-up with PERS Board on any issues from the December meeting, conduct interviews if necessary.
- **February, 2017** - PERS Board selects health carrier if necessary.

# Legislative Directions

- **NDCC 54-52.1-04** – Prepare bids, distribute, advertise, use a consultant
  - The economy to be affected.
  - The ease of administration.
  - The adequacy of the coverage's.
  - 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.
- **NDCC 54-52.1-04.2** – allows the board to self insure the plan if it is more competitive than fully insured

