STUDY OF STATE CONTRIBUTIONS TO STATE EMPLOYEE HEALTH INSURANCE PREMIUMS - BACKGROUND MEMORANDUM

STUDY RESPONSIBILITIES

Section 39 of House Bill No. 1015 (attached as an appendix) provides for a study of the state contribution to the cost of state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution. The responsibility for this study was assigned to the Government Finance Committee by the Legislative Management.

BACKGROUND INFORMATION

North Dakota Century Code Chapter 54-52.1 provides group medical insurance is available to any employee who meets the eligibility requirements of being a permanent employee of the state. To be eligible, an employee must be at least 18 years of age, occupy a regularly funded position, work a minimum of 20 hours per week, and work at least 20 weeks each year. Temporary employees who work a minimum of 20 hours per week and 20 weeks per year may purchase health insurance at their own expense or the employing agency may pay the premium.

The 1963 Legislative Assembly enacted Chapter 52-12 which authorized state agencies, either individually or jointly with other agencies, to enter a group hospitalization and medical care plan and group life insurance plan for each agency's employees. The agencies were required to pay $5 per month for each participating employee's insurance premium. An employee could elect to participate in either a single or family plan. The 1971 Legislative Assembly repealed Chapter 52-12 and enacted Chapter 54-52.1 establishing the uniform group insurance program. The program was placed under the authority of the Public Employees Retirement Board. The board was required to solicit bids and contract for the provision of insurance benefits coverage with an insurance carrier determined by the board.

From 1971 to 1983, Blue Cross Blue Shield of North Dakota provided and administered the health insurance benefits plan for public employees. In 1983 the Retirement Board was authorized by Section 54-52.1-04.2 to establish a plan of self-insurance for providing health benefits coverage under an administrative services-only contract or a third-party administrator contract if the board determined during any biennium that a self-insured plan is less costly than the lowest bid submitted by an insurance carrier. The board exercised the option to implement a self-insurance health benefits plan and administered the program in that manner from July 1, 1983, through June 30, 1989.

Rising health care costs in the state were the primary reason for the cashflow difficulties experienced in the health benefits plan. In the 1985-87 biennium, the Legislative Assembly appropriated funds for a 20 percent premium increase, and claims costs increased 42 percent.

Although the Retirement Board began its administration of the self-insured health benefits plan on July 1, 1983, with reserves of $2,143,880, claim expenditures and other expenses of the program exceeded premium income and other revenue in 1984. By June 1987 the fund balance, as indicated in audited financial statements of the plan, was a negative $4,759,963 with estimated outstanding claims payable of $4,600,000.

In 1987 the Retirement Board incorporated various cost-containment components into the health benefits plan which included:

1. Implementation of a program of concurrent review of inpatient hospitalizations designed to eliminate unnecessary treatment or prolonged hospital stays and to allow consideration of less expensive appropriate treatment for long-term medical care.
2. Implementation of a program of mandatory second surgical opinions for certain elective surgeries. (This program did not generate anticipated results and after a one-year trial period was discontinued.)
3. Expansion of contract deductibles to include all inpatient, outpatient, and physician services.
4. Increase in the coinsurance base from the first $2,000 in charges to the first $4,000 in charges.
5. Implementation of a preferred pharmacy program.
6. Establishment of a separate premium rate for retirees, based on retiree claims experience.
7. Introduction of a $25 copayment for each hospital emergency room visit.
8. Adjustment of the Medicare coordination of benefits formula applied to retiree members of the plan.

Due to the introduction of these cost-containment initiatives and the availability to public employees of a number of attractive health maintenance organization plans, approximately 3,350 membership contracts constituting 23 percent of the total contracts of the health benefits plan were lost during the 1987 open enrollment period, resulting in a decrease of approximately $563,000 per month in premium income.

The decision by the Medcenter One HMO, a health maintenance organization that had the largest Public Employees Retirement System (PERS) eligible enrollment, to discontinue its participation agreement with PERS as of July 1, 1988, and substantial increases in premiums charged by other health maintenance organizations resulted in a substantial number of public employees choosing the PERS health benefits plan during the 1988 open enrollment period.

In January 1989 the Retirement Board voted to end the state-funded health insurance program and buy the coverage from Blue Cross Blue Shield of North Dakota. Officials of PERS predicted the state would end the 1987-89 biennium with a $3.5 million deficit and would need to increase premium rates by 65 percent in 1989-91. The Blue Cross Blue Shield bid of about $35 million to fund state employees' health insurance for the 1989-91 biennium included provisions that the company would absorb about $5 million in unpaid claims when it took over in July 1989.

Senate Bill No. 2026 (1989) appropriated $1.2 million from the fund for unemployment compensation claims to PERS for the state group health program for the period beginning January 1, 1989, and ending June 30, 1991.

Until 1993 the health insurance program charged premiums based on each employee's election of a single or family plan. Beginning in the 1993-95 biennium, the Retirement Board began to charge a combination rate that is a blended rate per employee whether a single or family plan is chosen. The blended rate enables agencies to budget the same premium rate for all employees; therefore, an agency's budget is not adversely affected if an employee electing to receive single health insurance coverage quits and is replaced by an employee electing to receive family coverage. The schedule below shows the premiums charged since the program began in 1963.

Biennium	Single Plan	Percentage Change	Family Plan	Percentage Change	Combination Rate	Percentage Change
1963-65	$5.00		$21.00			
1965-67	$8.55	71.0%	$21.50	2.4%		
1967-69	$10.75	25.7%	$25.00	16.3%		
1969-71	$14.45	34.4%	$34.90	39.6%		
1971-73	$15.95	10.4%	$41.90	20.1%		
1973-75	$14.46	(9.3%)	$41.90	0.0%		
1975-77	$19.50	34.9%	$59.95	43.1%		
1977-79	$25.50	30.8%	$67.42	12.5%		
1979-81	$34.84	36.6%	$87.40	29.6%		
1981-83	$42.68	22.5%	$107.07	22.5%		
1983-85	$50.28	17.8%	$140.28	31.0%		
1985-87	$60.00	19.3%	$168.00	19.8%		
1987-89	$68.28	13.8%	$191.28	13.9%		
1989-91	$99.82	46.2%	$280.39	46.6%		
1991-93	$108.00	8.2%	$304.00	8.4%		
1993-95					$254.00	
1995-97					$265.00	4.3%
1997-99					$301.00	13.6%
1999-2001					$349.72	16.2%
2001-03					$409.09	17.0%
2003-05					$488.70	19.5%
2005-07					$553.95	13.4%
2007-09					$658.08	18.8%
2009-11					$825.66	25.5%
2011-13					$886.62	7.4%
2013-15					$981.69	10.7%

From 1963 through 1969, the state contributed $5 per month toward the cost of health insurance for state employees. State employees paid any additional amount for single or family coverage. During the 1969-71 biennium, the state contributed $7.50 per month. For the period 1973 through 1979, the state paid the cost of a single health insurance plan. Employees choosing a family plan paid any additional cost. Since 1979 the state has paid the full cost of either a single or family plan for eligible state employees.

The schedule below provides information on health insurance premiums and the cost of health insurance increases since the 1997-99 biennium.

State Employee Health Insurance Increases (Excluding Higher Education)						
Biennium	Monthly Premium	Increase From Previous Biennium	Percentage Increase	General Fund	Special Funds	Total
1997-99	$301	$36	13.6%	$7,026,674	$3,619,802	$10,646,476
1999-2001	$350	$49	16.2%	$6,989,537	$3,858,174	$10,847,711
2001-03	$409	$59	17.0%	$11,182,551	$6,001,252	$17,183,803
2003-05	$489	$80	19.5%	$8,027,122	$8,258,216	$16,285,338
2005-07	$554	$65	13.4%	$5,335,798	$7,903,870	$13,239,668
2007-09	$658	$104	18.8%	$9,115,817	$12,346,031	$21,461,848
2009-11	$826	$168	25.5%	$15,889,790	$20,215,824	$36,105,614
2011-13	$887	$61	7.4%	$7,179,809	$5,995,847	$13,175,656
2013-15	$982	$95	10.7%	$11,127,312	$9,700,989	$20,828,301

High-Deductible Health Plan

Section 54-52.1-18, as enacted by the 2011 Legislative Assembly, requires the Public Employees Retirement Board to develop and implement a high-deductible health plan with a savings account as an alternative to the regular health insurance plan. The section requires the difference between the cost of single and family health plan for state employees to be deposited in a health savings account for the benefit of the participating employee. The high-deductible health plan has higher annual deductibles and larger out-of-pocket costs which are partially offset by the employer contribution to the health savings account. The health savings account is not subject to federal income tax at the time of deposit and funds may be carried over and used in subsequent years.

As of April 2013, there were 15,262 state contracts for the regular health insurance benefit, and 122 employees were enrolled in the high-deductible health plan.

STUDY PLAN

The following is a proposed study plan for the committee's consideration in its study of the state contributions for state employee health insurance premiums:

1. Receive information from the Legislative Council regarding historical costs for state employee health insurance premiums and estimated future premium costs.
2. Receive information from the Legislative Council regarding expected employee out-of-pocket costs paid through deductibles, coinsurance, copays, and pharmaceutical costs based on the current state employee health insurance plan.
3. Receive information from the Legislative Council on the state's available high-deductible health plan, including an explanation of plan components and the number of participants in the plan.
4. Receive and review information from the Legislative Council staff regarding state contributions for state employee health insurance premiums in other states, private employer health insurance premium contributions for private sector employees, and associated employee out-of-pocket costs.
5. Receive information from PERS on the process used for determining health insurance premiums each biennium.
6. Receive testimony from interested persons regarding the study.
7. Develop recommendations and any bill drafts necessary to implement the recommendations.
8. Prepare a final report for submission to the Legislative Management.

ATTACH:1