

# NDPERS BOARD SPECIAL MEETING

# Agenda

**Bismarck Location:**  
ND Association of Counties  
1661 Capitol Way  
**Fargo Location:**  
Sanford Health Plan  
1749 38<sup>th</sup> Street South

**September 8, 2016**

**Time: 8:30 a.m.**

- I. Health Plan Renewal – Sparb (Board Action) \* Executive Session
- II. Part D Renewal – Sparb (Board Action)
- III. Telehealth – Sparb (Board Action)

\*Executive Session pursuant to NDCC §44-04-19.1(9) and §44-04-19.2 to discuss negotiating strategy or provide negotiating instructions to its attorney or other negotiator.

---

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



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

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

---

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

# Memorandum

**TO:** PERS Board  
**FROM:** PERS/Deloitte  
**DATE:** September 8, 2016 (Updated September 9, 2016)  
**SUBJECT:** Sanford Health Plan Renewal

\*Executive Session pursuant to NDCC §44-04-19.1(9) and §44-04-19.2 to discuss negotiating strategy or provide negotiating instructions to its attorney or other negotiator.

Pursuant to NDCC 54-52.1-05 (2) we can renew with Sanford Health Plan for the 2017-19 biennium if:

- 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.*
- b. *In making a determination under this subsection, the board shall:*
  - (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) *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.*
  - (3) *Consider any additional information the board determines relevant to making the determination.*
- c. *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.*

To accomplish the above we need to:

- I. Have our consultant do a renewal estimate (b.1 above).
- II. Review the carrier's performance measures, payment accuracy, etc. (b.2 above)

III. Identify and consider other information relevant to making a determination (b.3 above)

Considering what other information we should review during the renewal, last March we looked to the statute for general plan placement criteria and found the following criteria that we decided to use in the renewal as well.

1. The economy to be affected.
2. The ease of administration.
3. The adequacy of the coverages.
4. The financial position of the carrier, with special emphasis as to its solvency.
5. 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.

This last spring we decided:

- a. To contract with Deloitte to help us with the renewal and to do the estimate required in 54-52.1-05 (2)(b)(1).
- b. To have Sanford do a survey of our members (see Exhibit II) and to have Deloitte do an audit of Sanford to help us respond to 54-52.1-05 (2)(b)(2) (see Exhibit III)
- c. To look to the general review criteria 54-52.1-04 for guidance in responding to 54-52.1-05(2)(b)(3). Those criteria are:
  1. The economy to be affected.
  2. The ease of administration.
  3. The adequacy of the coverages.
  4. The financial position of the carrier, with special emphasis as to its solvency.
  5. 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.

At the August 26 meeting Sanford presented to you their renewal proposal (Exhibit I). In this memo staff and Deloitte will review their findings based upon the above statutory guidance. In addition we will provide you some background on some general items relating to the renewal but that are not specifically related to Sanford's performance. The following is the outline for this memo and our presentation on September 8.

1	<i>Review Economic/ Policy Environment</i>
2	<i>Review PERS Funded position and expected funded position</i>
3	<i>Review of Contract Performance Measures</i>
4	<i>Review the Carrier's payment accuracy, claims processing time</i>
5	<i>Review the Carrier's member service center metrics</i>
6	<i>Review the Carrier's wellness participation measures</i>
7	<i>Review the Carrier's special program participation levels</i>
8	<i>Review member survey results</i>

9	a) <i>Use the services of a consultant to concurrently and independently prepare renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.</i>
	b) <i>Administrative Costs</i>
10	<i>Other areas to consider</i>
	a) <i>Pharmacy</i>
	b) <i>Network</i>
	c) <i>Discounts</i>
	d) <i>Member out of pocket</i>
	e) <i>Funding for other programs</i>
	f) <i>Explanation of Benefits (EOB)</i>
	g) <i>Cost effect of ACA fees on fully insured plans</i>
	h) <i>Employer &amp; member participation</i>
11	a) <i>The economy to be affected</i>
	b) <i>The ease of administration.</i>
	c) <i>The adequacy of coverages (see other items the board may want to consider)</i>
	d) <i>The financial position of the Carrier</i>

In reviewing the above areas, we have provided information from the previous carrier's performance and compared it to the existing carrier in order to provide you a perspective on how the transition is progressing. We have utilized this similar approach in the past to provide a perspective on other transitions (dental, vision, life, Companion Plan). Please note that these should not be viewed as direct comparisons since different methodologies and techniques were used by the existing and previous carriers and, therefore while we can get a general perspective from the information it is not an equivalent comparison. PERS/Deloitte staff will also offer an observation by rating each as follows:

- Satisfactory – activities are moving as expected
- Improvement - areas can be improved
- Concern – there are certain issues or activities that are of concern to the future direction of the plan

# GENERAL CONSIDERATIONS RELATING TO THE PERS HEALTH PLAN

## 1. Economic and Policy Environment.

Two general areas of consideration are offered in this area as we contemplate how to move forward with the health plan for 2017-2019 biennium. The first is the economic/fiscal situation of our participating employers/employees and the second is legislative changes that may affect our plan and employers/members going forward.

### Economic Considerations

The fiscal situation for our participating employers has deteriorated substantially in the last six to twelve months. The state has done an across the board general fund reduction of 4.0% followed by another 2.5% reduction. The projections for revenue for the next biennium are not optimistic either. In addition the Governor called a special session of the legislature which used the last \$75 million in the rainy day fund and \$100 million in profits from the Bank of North Dakota to get us through the remainder of this biennium. The following is the forecast for 2015-2017:

### North Dakota General Fund Revenue and Oil and Gas Taxes



Estimated for 2017-19 are being done at this time but are not very optimistic either. Considerable belt tightening is expected.

**STAFF OBSERVATION: Concern:** Strong concern of how this will affect our planning for the plan – existing requirements for plan funding may no longer be applicable.

### Policy Considerations

Two proposed pieces of legislation are expected to be introduced in the next couple of weeks for consideration by interim committees.

The first bill was introduced at the September 1 Legislative Employee Benefits Programs Committee. This bill will require the PERS Board to bid the health plan every two years and would not allow the Board to consider a renewal. By way of history the Board has done the following:

- 2016 – Renewal
- 2014 – Full Bid
- 2012- Fully Insured Bid only
- 2010 - Fully Insured Bid only
- 2008 - Renewal
- 2006 - Renewal
- 2004 – Full Bid

The bill has an emergency provision on it and therefore could become effective this biennium.

The second bill is being submitted to the Legislative Health Care Reform Committee and would eliminate the requirement that the state pay the full cost of employees' single and family premium. Discussion associated with this bill indicate some thinking that the state would freeze its existing funding of the health plan, which would mean that any increase would have to be paid by transfer of costs to employees in premium contributions or increased out of pocket expenses

**STAFF OBSERVATION: Concern:** Strong concern since this will require significant changes in our plan design and our approach to providing this benefit.

## **2. PERS Funded Position and Expected funded position**

### PERS Existing Funded Position - Reserves

Attachment #1 is a detailed discussion of the existing funded position/reserves. The following is a table showing those reserves:

Balance as of:	Health Insurance	Early Retiree Reinsurance Program (ERRP)	Life Insurance
7/1/2007	\$1,540,648	\$0	\$2,155,769
7/1/2009	\$5,581,737	\$0	\$2,421,873
7/1/2011	\$5,943,183	\$1,726,189	\$2,468,533
7/1/2013	\$42,651,594	\$2,735,616	\$2,490,265
7/1/2015	\$42,925,033	\$0	\$2,491,063
7/1/2016 (estimate)	\$41,253,000	\$0	\$2,516,000

PERS has been successful in developing adequate reserves to insure that the program has sound financing going forward.

PERS Expected Funded Position - Reserves

The future expected funded position for PERS is going to deteriorate going forward. Specifically:

\$41,253,000 Estimated balance  
(3,000,000) Less deposit currently held by BCBS for the 2013-15 biennium, at risk until 7/1/2017  
(3,000,000) Less deposit currently held by SHP for the 2015-17 biennium, at risk until 7/1/2019  
(3,000,000) Risk deposit for 2017-19 contract period  
(2,800,000) Retention for administrative expenses for July 2016 – June 2019  
\$29,453,000

The reason for the above is three fold:

1. *ACA Fees* – As discussed at the August Board meeting, the ACA fees for the 2013-2015 biennium are coming in higher than expected. This means we will lose from the our \$3 million deposit currently held by BCBS for the 2013-15 biennium which is at risk until 7/1/2017 plus the \$4 million expected gain for the 2013-15 biennium. In total, the ACA fees are expected to be about \$18 million for the biennium. With the amount included in premium and the above noted redirection of funds, we will be able to pay the ACA fees but it will reduce our available reserves. Please note that when the ACA fees were projected we had little direct information from the Federal Government on what the fees would be and no historical record to look at since they were new.
2. *Gain/ Loss Agreement in Contract.* – We are expected to lose \$3 million this biennium due to the losses Sanford is taking on our plan. Our contract provides that if the plan takes a loss we share 50/50 in first \$6 million. It is expected that Sanford will take a \$40 to \$60 million loss on our plan which means we will lose the full \$3 million. If we look back on the history of how this provision has performed in previous agreements we find:

NDPERS Health Plan Administration and Surpl			
BCBS	Surplus Settlement	BCBS	
		Gain	Loss
1989-1991	First \$1,000,000	\$1,000,000	
1991-1993	First \$2,000,000	\$2,000,000	
1993-1995	First \$500,000	\$500,000	
1995-1997	50% upto \$500,000	\$500,000	
1997-1999	20% upto \$500,000	\$0	\$1,350,000
1999-2001	50% upto \$500,000	\$0	\$2,200,000
2001-2003	50% upto \$500,000	\$500,000	
2003-2005	50% upto \$500,000	\$500,000	
2005-2007	50% upto \$1,500,000	\$1,500,000	
2007-2009	50% upto \$1,500,000	\$0	\$3,100,000
2009-2011	50% upto \$1,500,000	\$1,500,000	
2011-2013	50% upto \$1,500,000	\$1,500,000	
2013-2015 Projected	50% upto \$1,500,000	\$1,500,000	

The above history shows that the largest loss PERS has taken in the past is 50% of the \$3,100,000 which is the largest total loss the plan had taken. In the previous periods it was limited to \$500,000 each. This biennium will be the largest loss the plan has taken under this arrangement.

3. *No Positive Settlement.* If the plan has a gain under our agreement we get funds back. Due to the losses by Sanford this time we will not be getting any funds back which in the past helped our reserves to grow. The history of these settlements is:

A	O
NDPERS Health Plan	
	NDPERS
BCBS	Settlement
1989-1991	
1991-1993	
1993-1995	
1995-1997	\$3,381,000
1997-1999	\$0
1999-2001	\$0
2001-2003	\$3,260,000
2003-2005	\$8,619,000
2005-2007	\$4,048,605
2007-2009	\$0
2009-2011	\$36,605,000
2011-2013	\$9,526,000
2013-2015 Projected	\$4,775,000
SANFORD	
2015-2017 Projected	\$0
Totals	\$70,214,605

Please note that the projected 2013-15 gain on the above table is no longer accurate with the higher than expected ACA fees which would reduce the total to about \$65 million.

Using the projection that Deloitte has done, we asked them what the plan may have gained if we would have been using our old fee schedule instead of the Sanford schedule. The following is that projection:

**North Dakota PERS**

**Claims Projection Summary**

**7/1/14-6/30/15 experience projected to current biennium**

		Total
Experience Period		7/1/14 - 6/30/15
Projection Period		7/1/17 - 6/30/19
Projection Months (midpoint to midpoint)		18
<b>Claims</b>		
Paid Medical and Pharmacy Claims		\$257,068,657
Incurred But Not Reported (IBNR) Completion Factor		1.00000
Completed Medical and Pharmacy Claims		\$257,068,657
Average Member Enrollment		66,026
Medical Claims Cost (PMPM)		\$324.45
Plan Design Change Factor		1.000
Other Adjustment Factors		1.000
Annual Trend Factor <sup>1</sup>		5.90%
Compound Trend		1.0897
Projected Incurred Medical Claims (PMPM)		\$353.57
<b>Total Claims (PMPM)</b>		<b>\$353.57</b>
Average Members		66,026
Average Subscribers		29,143
Projected Incurred Medical/Rx Claims (PEPM)		\$801.05
Current Subscribers (per Sanford Jun-16)		29,220
<b>Projected Total Claims Cost</b>		<b>\$561,757,430</b>

**Notes**

1) Trend assumptions are detailed in the General Information tab

Total net premium to pay claims for the biennium will be approximately \$579,791,000. The difference is \$18 million.

In addition to the above deterioration of PERS Reserves, it is also likely that the State will consider using some or all of our reserves to help pay the cost of the plan for the next biennium. The following is an example of how the reserves could be used:

Reserve Use Option	Approximate savings	Effect on Grandfathered status
Plan remains fully insured – use reserves to buy down the premium for one biennium (would need 3 million to maintain contract leaving about 29.5 million in health (after estimated expenses except ACA fees) and 2.5 million in Life which would require legislation)	.57% for each 5M in buydown	None

**STAFF OBSERVATION: Concern** – Our reserves our dropping instead of increasing. It is also likely that under the fully insured arrangement the State will use some or all of the remaining reserves to fund the plan.

## **REVIEW CRITERIA 54-52.1-05 (2) RELATING TO THE PERS HEALTH PLAN RENEWAL**

### **3. Review of Contract Performance Measures (from the Deloitte Report)**

Deloitte Consulting reviewed 14 performance guarantees agreed to by NDPERS and Sanford. Sanford provided documentation and calculation methodology for each of the guarantees and Deloitte Consulting was given the opportunity to review and ask questions of Sanford's representatives. Additional information was requested for some calculations and Sanford provided the required documentation. Overall, Deloitte Consulting did not have concerns about Sanford's calculation methodology for meeting NDPERS guarantee criteria. Based on the performance guarantee review, Deloitte Consulting found that Sanford had sufficiently exceeded most performance guarantees due thus far and is using acceptable calculation methodology to determine their compliance with each guarantee.

**Staff Observation: Satisfactory** Deloitte review is positive.

### **4. Review of Carrier Payment Accuracy, Claims Processing Time (from Deloitte report)**

Sanford provided documentation for all of the 218 claims requested and Deloitte Consulting evaluated all claims provided. Accuracy rates and turnaround time calculations based on the claims sample are noted in the table below.

There were five payment errors with \$1,139.79 in absolute payment errors. Three overpayments totaled \$1,064.41 and two underpayments totaled \$75.38. One claim had a procedural error which did not affect claim payment. Sanford agrees to all identified errors.

Measurement	Review Result	NDPERS Performance Guarantee	Industry Benchmark
<b>Claims Accuracy</b>			
Financial Accuracy:	99.7%	99%	99%
Payment Accuracy:	97.7%	97%	97%
Procedural Accuracy:	97.3%	-	95%
<b>Claims Turnaround Time*</b>			
Average Days to Process:	5.0 days	-	-
% within 30 Calendar Days:	95.0%	99%	-
Average Days to Payment:	11.1 days	-	-
% within 30 Calendar Days:	92.7%	-	98%

\*Deloitte Consulting's stratified sampling method results in a higher proportion of high dollar claims compared to NDPERS claim population. High dollar claims are more complex and have longer payment approval processes so turnaround time of the sample is expected to be higher than turnaround time of the claim population. Deloitte Consulting does not have concerns about Sanford's claim turnaround time.

#### BCBS Q1 2015 Executive Summary Standards

	Goal	Measure
<b>Operational Performance:</b>		
Claims Financial Accuracy	99%	<b>100%</b>
Payment Incident Accuracy	97%	<b>97%</b>
Claim Timeliness	99%	<b>100%</b>
Average Speed of Answer (in seconds)	30 seconds or less	<b>21</b>
Call Abandonment Rate	5% or less	<b>1%</b>

**Staff Observation:** Satisfactory Claims accuracy meets standards.

## 5. Review of Carrier Member Service Metrics

As noted above this survey information cannot be considered a direct comparison since different methodologies and different sample sizes, etc. were used. Therefore, this should be considered as a general perspective from two different sources of information only.

In contrasting the Sanford call center satisfaction at about 70% compared to BCBS which 94-98% we note a difference but in addition it should be noted that BCBS used a dedicated unit for PERS whereas with Sanford it is handled through a general unit. Also the Sanford information comes from a transition year whereas the BCBS did not.

## MEMBER SERVICES CENTER SURVEY QUESTIONS

**SURVEY QUESTION (#16)**

**How satisfied were you with the service you received when you called member services?**

Use the 10-point scale below to tell us your opinion; 1 is "Not At All Satisfied" and 10 is "Extremely Satisfied."  
Place a (✓) beneath one number.

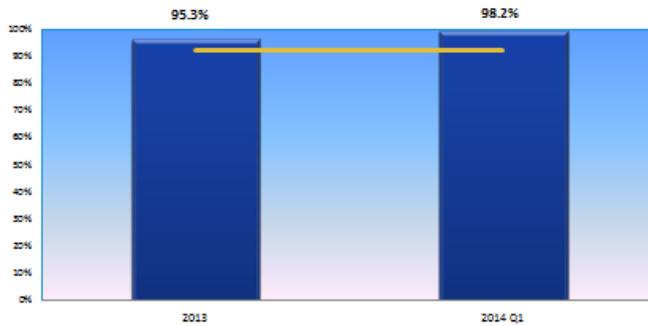
Not at All Satisfied										Extremely Satisfied
1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>										

	SATISFACTION WITH MEMBER SERVICES CALL CENTER SERVICE			
	Responses	Distribution		Average
	n	Satisfied %	Not Satisfied % (n)	out of 10
State Employees	207	64.3%	35.7%	6.4
Medicare Retirees	127	78.7%	21.3%	7.4
Political Subdivisions	57	71.9%	28.1%	6.8
COBRA	9	77.8%	22.2%	6.9
Unidentified	5	80.0%	20.0%	7.6
<b>Raw Totals</b>	<b>405</b>	<b>70.4%</b>	<b>29.6%</b>	<b>6.8/10</b>
<b>Weighted Totals</b>		<b>69.3%</b>	<b>30.7%</b>	<b>6.7/10</b>

**NOTES**

- For purposes of this analysis, values 1 to 5 were considered "Not Satisfied" and values 6 to 10 were considered "Satisfied."

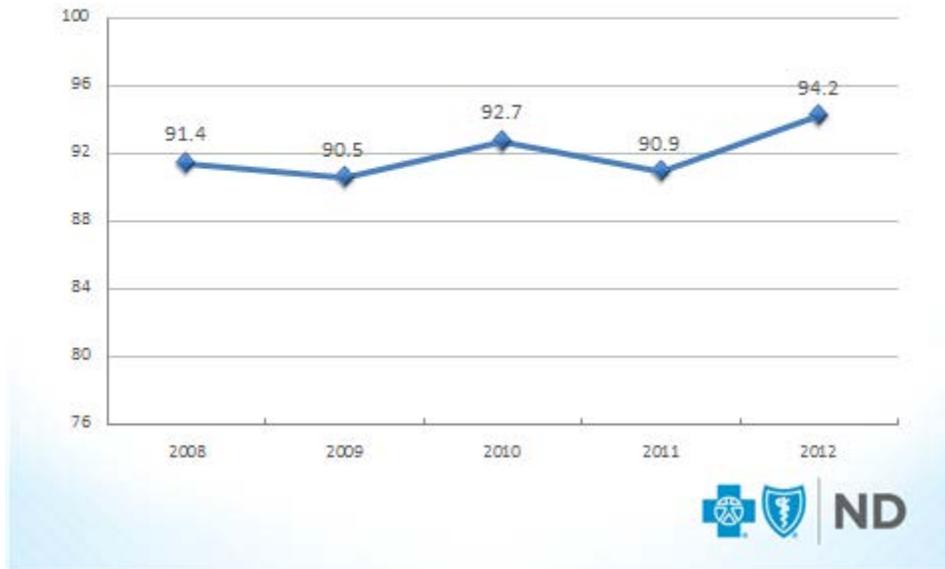
### NDPERS Member Satisfaction ND



**Overall Satisfaction**

- Customers satisfied with the call center experience and the customer service representative. Goal – 92%
  - Based on 451 surveys completed in 2013 and 111 surveys completed in First Quarter 2014.

# Overall Satisfaction with Service



Sanford satisfaction with call center follow-up is at about 68%, compared to 95% for BCBS.

### SURVEY QUESTION (#23)

The customer service representative completed any follow-up that was promised.

Place a (✓) below one of the options below. If your call did not require follow-up, please choose the "N/A" option.

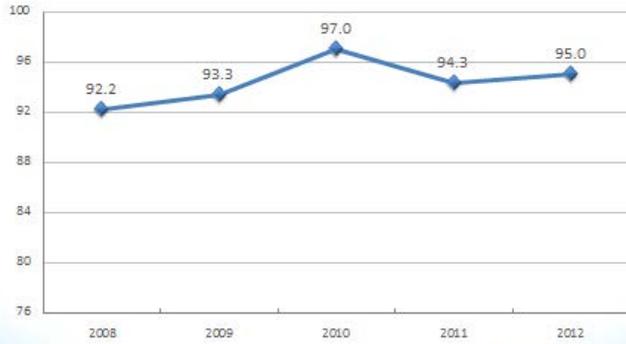
Strongly Disagree				Strongly Agree	N/A
1	2	3	4		
<input type="checkbox"/>					

	REPRESENTATIVE COMPLETED PROMISED FOLLOW-UP			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	101	56.4%	43.6%	2.7
Medicare Retirees	60	86.7%	13.3%	3.4
Political Subdivisions	28	64.3%	35.7%	2.9
COBRA	3	66.7%	33.3%	3.3
Unidentified	4	100%	0%	3.3
<b>Raw Totals</b>	<b>196</b>	<b>67.9%</b>	<b>32.1%</b>	<b>3.0/4</b>
<b>Weighted Totals</b>		<b>65.0%</b>	<b>35.0%</b>	<b>2.9/4</b>

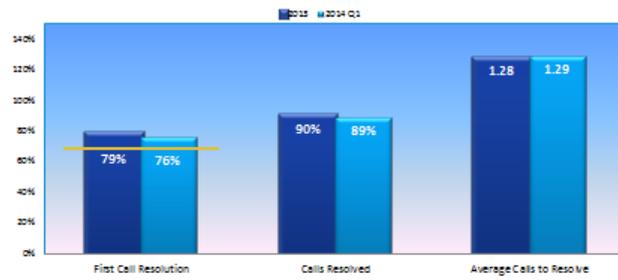
### NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. Use the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

## Completed Follow Up



## Call Resolution



### First Call Resolution

Percentage of customers who had their issue resolved in one call. Goal – 74%

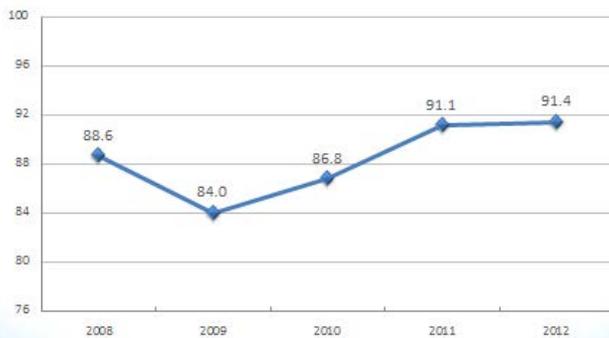
### Calls Resolved

Percentage of customers whose issue was resolved.

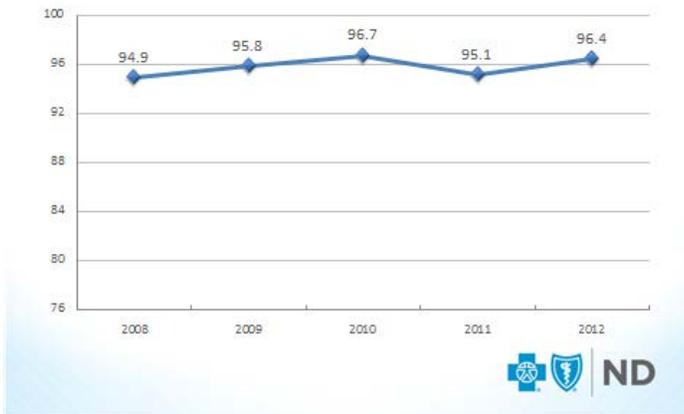
### Average Calls to Resolve

Average number of calls needed to resolve the issue.

## Question Answered/Problem Solved



## Time Reasonable to Resolve Inquiry



Sanford customer service treated member with ‘courtesy’ is at 91% compared to 99% for BCBS.

### SURVEY QUESTION (#20)

**The customer service representative treated you with courtesy and respect.**

Place a (✓) below one of the options below.

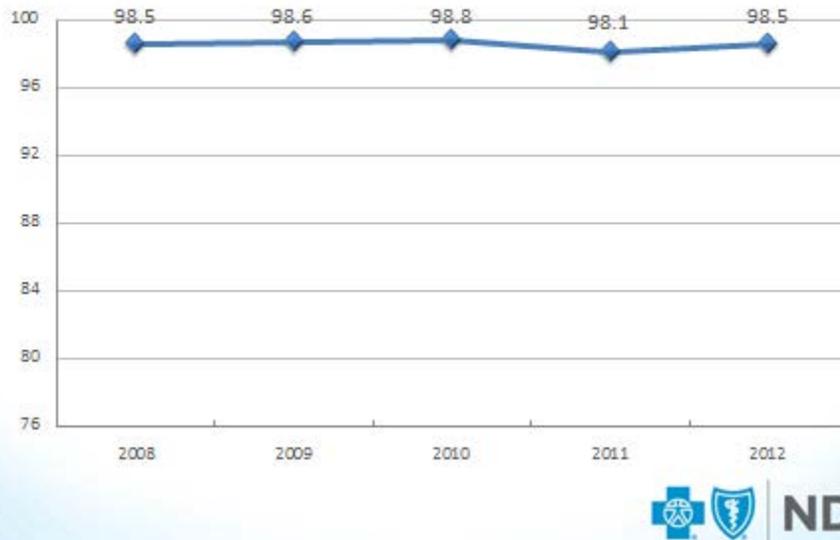
Strongly Disagree				Strongly Agree
1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	REPRESENTATIVE TREATED YOU WITH COURTESY AND RESPECT			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	206	88.8%	11.2%	3.0
Medicare Retirees	129	94.6%	5.4%	3.5
Political Subdivisions	57	89.5%	10.5%	3.1
COBRA	9	100%	0%	3.2
Unidentified	5	80.0%	20.0%	3.4
<b>Raw Totals</b>	<b>406</b>	<b>90.9%</b>	<b>9.1%</b>	<b>3.2/4</b>
<b>Weighted Totals</b>		<b>90.5%</b>	<b>9.5%</b>	<b>3.5/4</b>

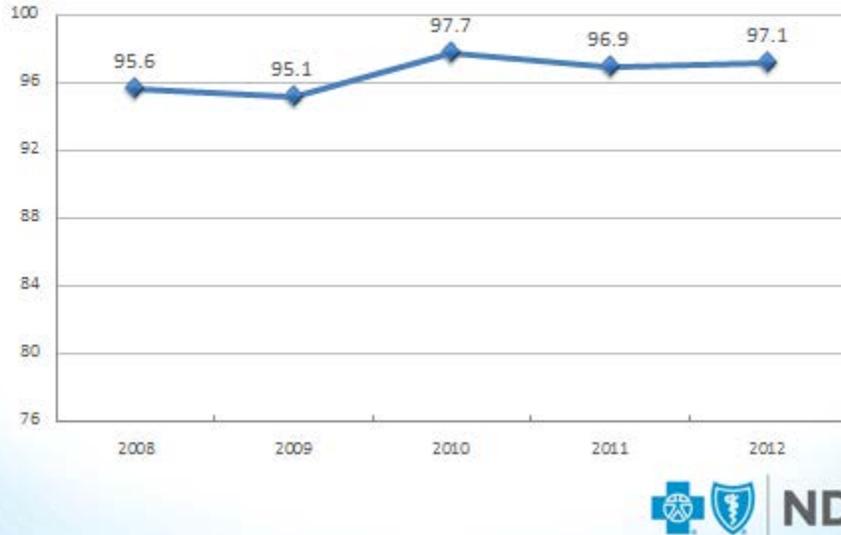
### NOTES

- For purposes of this analysis, values 1 and 2 were considered “Disagree” and values 3 and 4 were considered “Agree.”
- This question was 1 of 4 questions that came after the following survey instructions: “For the next 4 questions, read each statement and rate your experience. Use the 4-point scale to tell us your opinion; 1 is ‘Strongly Disagree’ and 4 is ‘Strongly Agree.’ If the statement doesn’t apply to you, choose the N/A option.”

## Caller Treated with Courtesy



## Representative Sounded Caring



Sanford customer service is 'knowledgeable' is at 78% compared to 97% for BCBS. Here again it needs to be noted that this was in a transition year for Sanford whereas it was not with BCBS. Also as noted above, BCBS had a dedicated PERS unit with years of experience whereas the Sanford center was a general unit new to PERS.

**SURVEY QUESTION (#21)**

**The customer service representative was knowledgeable.**

Place a (✓) below one of the options below.

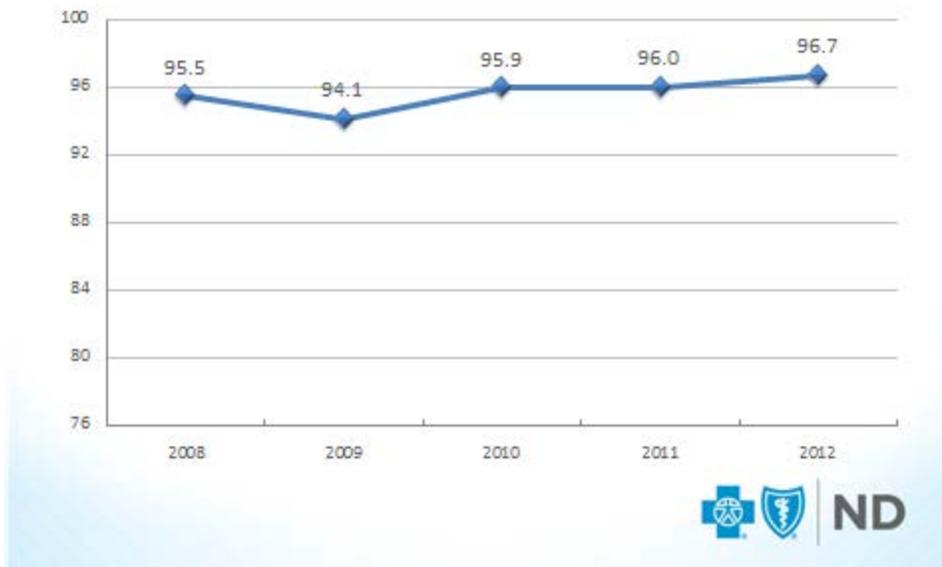
Strongly Disagree				Strongly Agree
1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	REPRESENTATIVE WAS KNOWLEDGEABLE			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	205	72.7%	27.3%	3.0
Medicare Retirees	128	86.7%	13.3%	3.5
Political Subdivisions	57	75.4%	24.6%	3.2
COBRA	9	88.9%	11.1%	3.7
Unidentified	5	100%	0%	3.4
<i>Raw Totals</i>	404	78.2%	21.8%	3.2/4
<b>Weighted Totals</b>		<b>77.0%</b>	<b>23.0%</b>	<b>3.2/4</b>

**NOTES**

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. Use the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

## Representative was Knowledgeable



Sanford customer service is 'clear and complete' is at 77% compared to 97% for BCBS.

**SURVEY QUESTION (#22)**

**The customer service representative answered my questions clearly and completely.**

Place a (✓) below one of the options below.

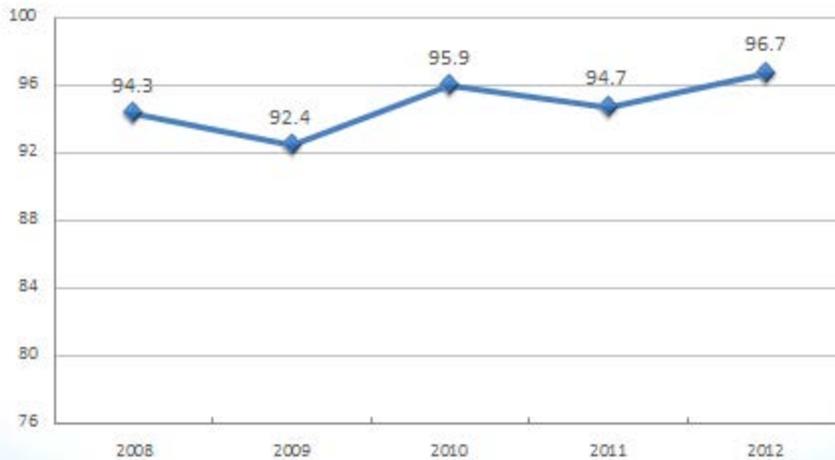
Strongly Disagree			Strongly Agree
1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	REPRESENTATIVE ANSWERS WERE CLEAR AND COMPLETE			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	206	71.8%	28.2%	3.0
Medicare Retirees	127	85.8%	14.2%	3.4
Political Subdivisions	57	73.7%	26.3%	3.1
COBRA	9	77.8%	22.2%	3.6
Unidentified	5	80.0%	20.0%	3.2
<b>Raw Totals</b>	<b>404</b>	<b>76.7% (310)</b>	<b>23.3% (94)</b>	<b>3.2/4</b>
<b>Weighted Totals</b>		<b>75.2%</b>	<b>24.8%</b>	<b>3.1/4</b>

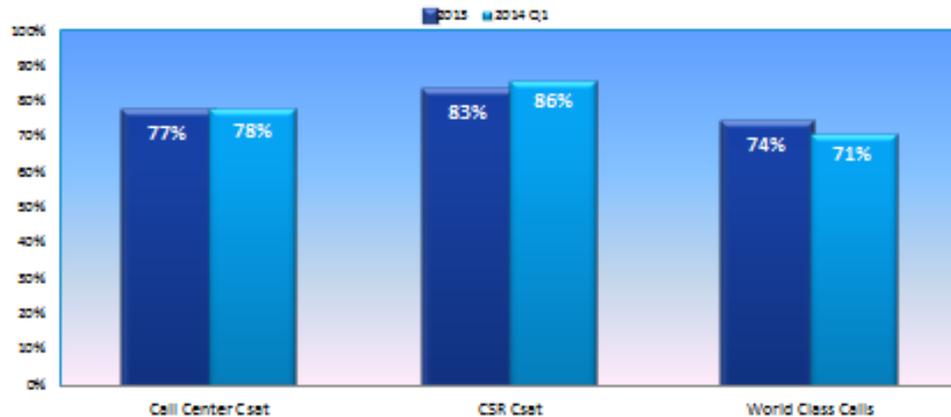
**NOTES**

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. Use the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

## Clear and Complete Answer



## Top Box Satisfaction



### Call Center Csat

Percentage of customers **very** satisfied with their call center experience.

### CSR Csat

Percentage of customers **very** satisfied with the customer service representative.

### World Class Calls

Percentage of customers whose call was resolved and are **very** satisfied with their call center experience and representative.

**Staff Observation: Improvement.** Improvements can be made in this area. Maybe we need to consider going back to a dedicated call center.

## 6. Wellness Participation & Performance

Overall, Sanford has responded to NDPERS requirements related to the NDPERS wellness program, including both the employer based wellness program (1% premium discount) and the employee wellness incentive (\$250 benefit).

Related to the employer based wellness program, SHP has expanded their staffing in their wellness division to include 3 wellness specialists that service both the eastern and western portions of the state. These specialists provide assistance and education to the wellness coordinators designated within the NDPERS wellness employers. They also conduct onsite meetings at employer worksites. Since July 1, they have conducted 229 meetings with 3,318 attendees. In comparison, in 2014, BCBS presented at 132 employer worksites with a total of 3,497 members in attendance. They provide a monthly coordinator update, conduct monthly coordinator webinars and provide flyers/posters for the focus of each month. In June, they conducted their first coordinator summer workshop across the state. There were 9 workshops held with 102 coordinators in attendance. They have also dedicated a communication specialist to prepare employee and employer communications. Overall, they have continued the services that were provided by BCBS to ensure that the employer based wellness program continues to provide services that meet the needs of our

employers. This is reflected in consistent employer wellness participation levels since the transition to SHP.

The employee wellness incentive was transitioned to Sanford with a focus to continue the benefit through the two existing means, the health club credit (renamed fitness center reimbursement) and the online wellness portal. The fitness center reimbursement transitioned with little disruption. However, NDPERS staff did experience comments from the wellness coordinators and members regarding the online wellness portal, bWell, that was available through SHP. The comments were fairly consistent that the membership did not like the new portal, the services offered and felt that it was a step backwards from the previous carrier's portal experience with HealthyBlue. Having heard these concerns, Sanford disabled the bWell platform as of December 31, 2015 and launched a more robust platform, Novu, on April 1, 2016. Initial enrollments indicate that members are utilizing the new portal more. NDPERS has received some member feedback that the former HealthyBlue portal is still preferred, but overall, NDPERS staff feels that the Novu portal provides better services than the former bWell platform. There was an issue following implementation regarding individuals receiving amounts exceeding the \$250 as they redeemed with both BCBS and SHP in 2015, but upon review, SHP identified these individuals and applied the exceeded dollars to 2016 plan year incentives to ensure that the plan did not over-compensate individuals for the benefit.

The following are statistics related to the wellness performance measurements under BCBS as reported on their Q4-2014 Executive Summary:

<b>Measure</b>	<b>Goal</b>	<b>As of 12/31/2014</b>
HRA completions	17%	22%
HRA Score	5% point increase in the 2013 – Goal 55	60
HealthyBlue – incentives paid	10% increase over 2013 incentives paid – Goal = \$581,798	\$722,906
Health Club Credit	10% increase over 2013 member receiving credit – Goal = 2,177	1950 (missed)

In recognition that Sanford would be transitioning the employee wellness incentive mid-year, the performance measures were modified. The following are statistics related to the wellness performance measurements under SHP as reported on their Q4-2015 Executive Summary:

<b>Measure</b>	<b>Goal</b>	<b>As of 12/31/2015</b>
HRA completions	10%	17.7%
bWell participation	10%	10.8%
Fitness Center Reimbursement	1,950	1857 (missed) – final reporting pending

Sanford has provided information related to participation in the new online portal, Novu, since its launch on April 1 and also information on the fitness center reimbursements made in August 2016. The following is as of August 29, 2016:

- 7,664 members have logged onto Novu site

- 6,850 members have completed their HRA (health risk assessment)
- 1,690 members have received fitness center reimbursements (August 2016)

The following information is taken from the Member Survey full report and is regarding results related to wellness questions:

**SURVEY QUESTION (#2)**

**Which health prevention or health screening services do you use?**

Place a (✓) next to every prevention or screening service used by you or any member of your family.

- Annual physical examination
- Immunizations, such as flu shots
- Well Child Care services
- Cancer screening services, such as breast cancer or colon cancer screenings.
- Other (please specify) \_\_\_\_\_
- N/A - Neither I nor my family use prevention or screening services

USE OF PREVENTATIVE HEALTH SERVICES						
	Annual Physical	Flu Shots & Immun.	Well Child Care	Cancer Screening	Other	N/A
State Employees	438	340	76	311	84	25
Medicare Retirees	513	462	4	390	117	26
Political Subdivisions	145	113	28	101	29	10
COBRA	18	11	0	13	5	1
Unidentified	18	16	0	8	2	1
<b>Raw Totals</b>	<b>1,132</b>	<b>942</b>	<b>108</b>	<b>823</b>	<b>237</b>	<b>63</b>

USE OF MULTIPLE PREVENTATIVE HEALTH SERVICES		
(excludes "other" and "N/A" answers)		
	n	%
Uses 1 of 4	249	17.5%
Uses 2 of 4	386	27.2%
Uses 3 of 4	607	42.8%
Uses 4 of 4	42	3.0%

**SURVEY QUESTION (#3)**

**Which NDPERS Dakota Wellness Program benefits do you use?**

Place a (✓) next to every NDPERS Dakota Wellness Program benefit used by you or any member of your family.

- Worksite education or wellness activities (newsletters, book clubs, wellness challenges)
- Fitness Center Reimbursement Program
- Tobacco Cessation, Diabetes Management or Healthy Pregnancy programs
- The Novu online wellness portal, which launched on April 1, 2016
- Other (please specify) \_\_\_\_\_
- N/A - Neither I nor my family use NDPERS Dakota Wellness Program benefits

USE OF WELLNESS SERVICES						
	Worksite Wellness	Fitness Center	Tobacco, Diabetes, or Pregnancy	Novu Wellness Portal	Other	N/A
State Employees	187	127	25	135	8	232
Medicare Retirees	35	95	26	31	18	479
Political Subdivisions	69	26	8	49	2	80
COBRA	1	4	0	2	1	18
Unidentified	3	3	3	3	0	14
<b>Raw Totals</b>	<b>295</b>	<b>255</b>	<b>62</b>	<b>220</b>	<b>29</b>	<b>823</b>

USE OF MULTIPLE WELLNESS SERVICES		
(excludes "other" and "N/A" answers)		
	n	%
Uses 1 of 4	370	26.1%
Uses 2 of 4	163	11.5%
Uses 3 of 4	44	3.1%
Uses 4 of 4	1	0.1%

**Staff Observation: Satisfactory** Sanford has met expectations regarding the employer wellness program and employee wellness incentive.

## 7. Review of Carrier Special Program Participation Levels

	Date Reported*	Carrier	Participants
<b>Tobacco Cessation Program</b>	June 2015	BCBS	122
	August 2016	SHP	89
<b>Accordant Care</b>	March 2015	BCBS	295
	August 2016	SHP	505
<b>About the Patient</b>	June 2015	BCBS	207
	June 2016	SHP	294
<b>Healthy Pregnancy</b>	March 2014	BCBS	210
	August 2016	SHP	497
<b>Life Advocate Program</b>	March 2015	BCBS	15
	August 2016	SHP	90
<b>Medical Home</b>	March 2015	BCBS	90%
	June 2016	SHP	36.5%

\* Participation reported for BCBS is generally based on 24 months of data; the SHP data is based on 12-15 months of data.

Based upon the above:

- Participation in the tobacco cessation program appears to be increasing for the time period reported. This may be due to the implementation of a debit card by SHP for the purchase of prescriptions.
- Medical Home participation is lower; however, for the first year the performance measure was adjusted to 30% which was exceeded and the participation in this program will be continue to be reported to the Board on a quarterly basis for its review and assessment.
- The About the Patient diabetes program appears to be increasing for the time period reported. This may be due to the implementation point-of-sale processing by ESI for diabetic medications and supplies. Previously, members paid for these products out-of-pocket and filed for reimbursement of the copays. Now the copays are waived at the time of purchase which is more convenient and efficient for the member.

**Staff Observation: Satisfactory.** Overall, SHP is exceeding participation levels over the time period reported.

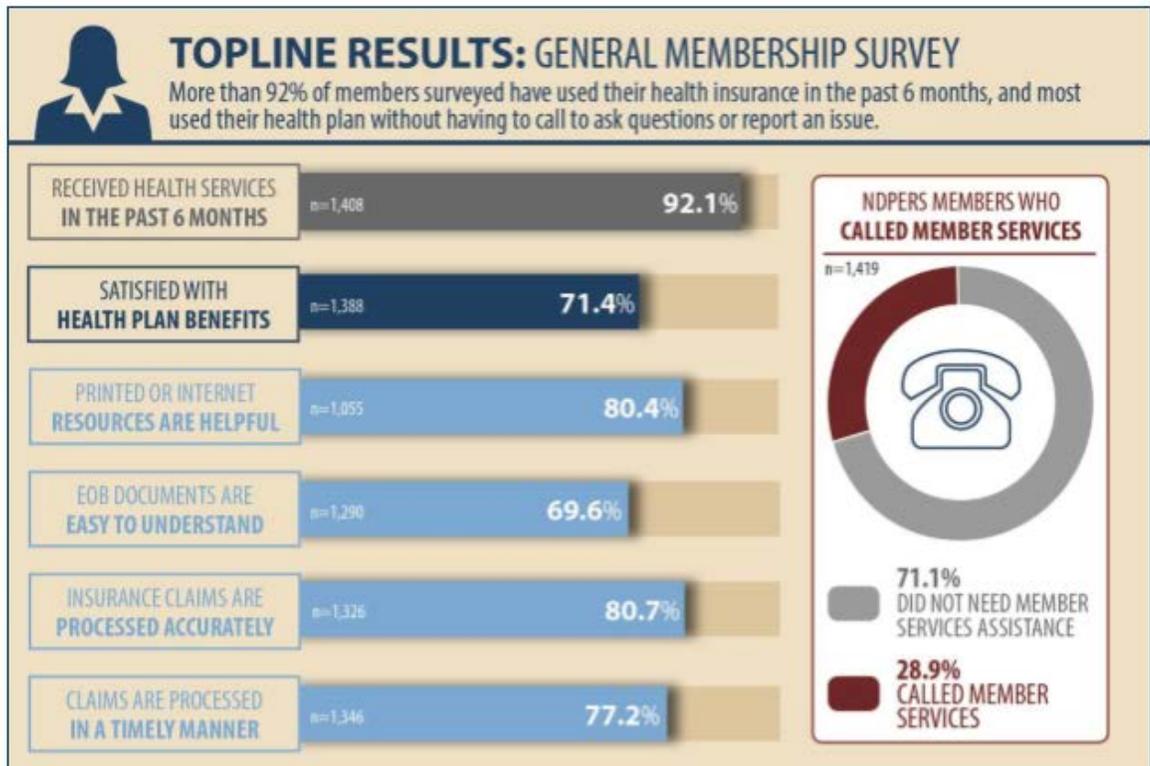
## Member Rebate Program

Administration of this program was included in the RFP. At its December 2015 meeting the NDPERS Board concurred that the program should be re-established and administered by Sanford Health Plan (SHP) effective July 1, 2016. At this time, the program is not place; however, we are continuing conversations with SHP and it will be addressed at future Board meetings. Some additional concerns have been brought forward by Sanford and will be on an upcoming board agenda.

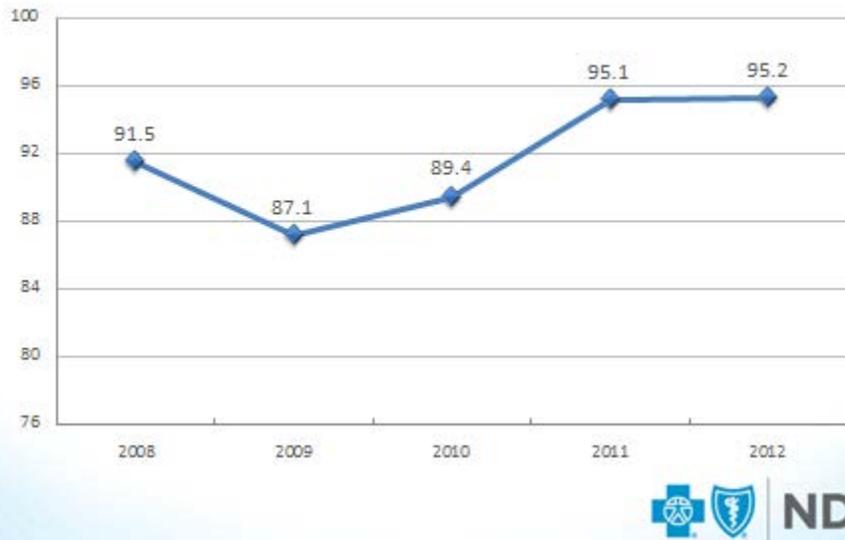
**Staff Observation: Concern.** We are behind schedule.

## 8. Member Survey Results

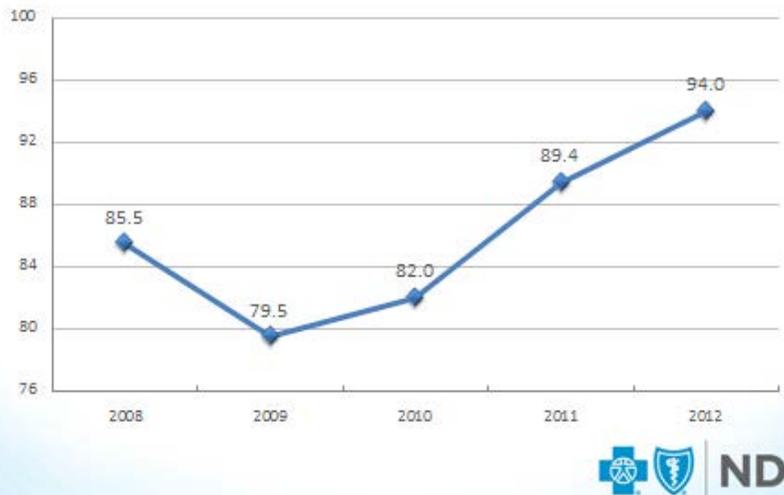
As discussed earlier, the member survey results cannot be considered a direct comparison since different methodologies and different sample sizes, etc. were used. The information in this area is limited. The following is what is available:



## Understandable EOB



## Claim Processed Timely



## BCBS Q1 2015 Executive Summary Standards

	Goal	Measure
<b>Operational Performance:</b>		
Claims Financial Accuracy	99%	100%
Payment Incident Accuracy	97%	97%
Claim Timeliness	99%	100%
Average Speed of Answer (in seconds)	30 seconds or less	21
Call Abandonment Rate	5% or less	1%

	Disagree	Agree
NDPERS Survey ADP Flexcomp 2016		
7. I understand the NDPERS Flexcomp program.	2%	98%
8. I am satisfied with the claim submission options available from ADP.	16%	84%
9. I am satisfied with the online Web Services available from ADP.	16%	84%
14. I am satisfied with the customer service provided by ADP.	21%	79%
15. I am satisfied with the Flexcomp service provided by the NDPERS office.	8%	92%
NDPERS Survey TIAA Deferred Comp 2016		
2. Are you satisfied with the availability of plan information?	12%	88%
7. I am satisfied with the investment education and advice given by TIAA.	19%	81%
8. I am satisfied with the web services and quarterly statements provided by TIAA.	16%	84%
9. I am satisfied with the availability of counselors and advisors from TIAA.	22%	78%
11. I would recommend TIAA to other employees.	17%	83%
12. I am satisfied with the service provided by the NDPERS office.	16%	84%

**Staff Observation: Improvement:** Improvements can be made in this area. We need to get members satisfaction with the health benefits higher. We transferred the flex and Companion plan and those levels have recovered. EOBs are an area of improvement as well which will be discussed later.

## 9. Renewal Projections

### Renewal Projections

This information will be reviewed at the Board meeting.

Information as presented at the September 8 special Board meeting:

### North Dakota PERS 2017-2019 Biennium Claims Projection Summary

#### General Notes

**Scenario 1** - This uses 12 months of completed Sanford claims no other adjustments other than trend

**Scenario 2** - This uses 12 months of completed Sanford claims with adjustments for the new contracts and savings initiatives that will be in place during the next biennium

**Scenario 3** - This uses 12 months of prior claims (7/1/14-6/30/15) with no other adjustments

*NOTE: If the NDPERS PPO discounts (prior carrier) are discontinued, this would increase the claim projection by approximately \$5M per year in Scenario 3*

<b>Projected Annual Trend Rates *</b>				
	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
<b>Medical</b>	6.00%	8.00%	6.00%	6.00%
<b>Pharmacy</b>	8.50%	7.50%	7.00%	7.00%
<b>Medicare Supp</b>	3.20%	3.20%	3.20%	3.20%

*\* Trend Rates were estimated using client experience, trend surveys and national trend projections*

### **Sanford Savings Adjustment Factor**

Sanford provided Deloitte with a list of contracting changes and savings initiatives that will occur between the experience period and the projection period of this analysis. Deloitte did not attempt to verify that these contract changes and other savings initiatives will occur as stated, but we have independently calculated an adjustment factor to apply to the projected claims assuming all are valid. Based on the description of each change, we requested and received sufficient documentation such that we could perform our estimate. The savings percentages associated with these changes are as follows:

Medical non-Medicare: **8.7%**

Pharmacy non-Medicare: **12.8%**

**North Dakota PERS**  
**Claims Projection Summary**  
**Scenario 1 - Sanford claims**

	Medicare (Excluding PDP)	Non-Medicare	Total
Experience Period	7/1/15 - 6/30/16	7/1/15 - 6/30/16	7/1/15 - 6/30/16
Projection Period	7/1/17 - 6/30/19	7/1/17 - 6/30/19	7/1/17 - 6/30/19
<b>Claims</b>			
Paid Medical Claims	\$12,651,869	\$225,684,267	\$238,336,136
Incurred But Not Reported (IBNR) Completion Factor	0.83443	0.86574	0.86402
Completed Medical Claims	\$15,162,372	\$260,682,354	\$275,844,727
Medical Claims Cost (PMPM)	\$146.67	\$372.71	\$343.60
Annual Trend Factor <sup>1</sup>	3.20%	6.00%	5.85%
Projected Incurred Medical Claims (PMPM)	\$158.68	\$431.15	\$396.07
Paid Prescription Drug Claims		\$51,049,004	\$51,049,004
Incurred But Not Reported (IBNR) Completion Factor		0.95696	0.95696
Completed Drug Claims		\$53,344,741	\$53,344,741
Average Member Enrollment		58,286	58,286
Rx Claims Cost (PMPM)		\$76.27	\$76.27
Expected Rx Rebates <sup>2</sup>		(\$6.91)	(\$6.91)
Other Adjustment Factors		1.000	1.000
Annual Trend Factor <sup>1</sup>		7.20%	7.20%
Compound Trend		1.190	1.190
Projected Incurred Rx Claims (PMPM)		\$82.52	\$82.52
Total Claims (PMPM)	\$158.68	\$513.68	\$478.59
Average Members	8,615	58,286	66,901
Average Subscribers	6,416	22,917	29,333
Projected Incurred Medical/Rx Claims (PEPM)	\$213.07	\$1,306.46	\$1,068.18
Current Subscribers (per Sanford Jun-16)	6,368	22,852	29,220
Projected Total Claims Cost	<b>\$32,563,802</b>	<b>\$716,526,541</b>	<b>\$749,090,343</b>
Target Loss Ratio <sup>3</sup>	86%	93%	92%
Required Premium	\$37,864,886	\$772,952,040	\$810,816,926
Monthly Premium PEPM (June 2016 per Sanford)	\$242	\$1,074	\$892.41
Current Premium (June 2016 enrollment)	\$36,943,165	\$588,888,826	\$625,831,991
Required Rate Increase	<b>2.5%</b>	<b>31.3%</b>	<b>29.6%</b>

**Notes**

- 1) Trend assumptions are detailed in the General Information tab
- 2) Expected rebates provided by Sanford Health Plan
- 3) TLR 86% Medicare / 92.7% Non-Medicare provided by Sanford Health Plan

**North Dakota PERS**  
**Claims Projection Summary**  
**Scenario 2 - Sanford claims (adjusted)**

	Medicare (Excluding PDP)	Non-Medicare	Total
Experience Period	7/1/15 - 6/30/16	7/1/15 - 6/30/16	7/1/15 - 6/30/16
Projection Period	7/1/17 - 6/30/19	7/1/17 - 6/30/19	7/1/17 - 6/30/19
<b>Claims</b>			
Paid Medical Claims	\$12,651,869	\$225,684,267	\$238,336,136
Incurred But Not Reported (IBNR) Completion Factor	0.83443	0.86574	0.86402
Completed Medical Claims	\$15,162,372	\$260,682,354	\$275,844,727
Medical Claims Cost (PMPM)	\$146.67	\$372.71	\$343.60
Annual Trend Factor <sup>1</sup>	3.20%	6.00%	5.85%
Projected Incurred Medical Claims (PMPM)	\$158.68	\$394.33	\$363.99
Paid Prescription Drug Claims		\$51,049,004	\$51,049,004
Incurred But Not Reported (IBNR) Completion Factor		0.95696	0.95696
Completed Drug Claims		\$53,344,741	\$53,344,741
Average Member Enrollment		58,286	58,286
Rx Claims Cost (PMPM)		\$76.27	\$76.27
Expected Rx Rebates <sup>2</sup>		(\$6.91)	(\$6.91)
Other Adjustment Factors		0.872	0.872
Annual Trend Factor <sup>1</sup>		7.20%	7.20%
Compound Trend		1.190	1.190
Projected Incurred Rx Claims (PMPM)		\$71.92	\$71.92
Total Claims (PMPM)	\$158.68	\$466.25	\$435.91
Average Members	8,615	58,286	66,901
Average Subscribers	6,416	22,917	29,333
Projected Incurred Medical/Rx Claims (PEPM)	\$213.07	\$1,185.84	\$973.84
Current Subscribers (per Sanford Jun-16)	6,368	22,852	29,220
<b>Projected Total Claims Cost</b>	<b>\$32,563,802</b>	<b>\$650,374,156</b>	<b>\$682,937,958</b>
Target Loss Ratio <sup>3</sup>	86%	93%	92%
Required Premium	\$37,864,886	\$701,590,244	\$739,455,130
Monthly Premium PEPM (June 2016 per Sanford)	\$242	\$1,074	\$892.41
Current Premium (June 2016 enrollment)	\$36,943,165	\$588,888,826	\$625,831,991
Required Rate Increase	<b>2.5%</b>	<b>19.1%</b>	<b>18.2%</b>

**Notes**

- 1) Trend assumptions are detailed in the General Information tab
- 2) Expected rebates provided by Sanford Health Plan
- 3) TLR 86% Medicare / 92.7% Non-Medicare provided by Sanford Health Plan

North Dakota PERS  
 Claims Projection Summary  
 Scenario 3 - (7/1/14-6/30/15) experience

		Total	
Experience Period		7/1/14 - 6/30/15	
Projection Period		7/1/17 - 6/30/19	
<b>Claims</b>			
Paid Medical and Pharmacy Claims		\$257,068,657	
Incurred But Not Reported (IBNR) Completion Factor		1.00000	
Completed Medical and Pharmacy Claims		\$257,068,657	
Average Member Enrollment		66,026	
Medical Claims Cost (PMPM)		\$324.45	
Plan Design Change Factor		1.000	
Other Adjustment Factors		1.000	
Annual Trend Factor <sup>1</sup>		6.54%	
Compound Trend		1.2483	
Projected Incurred Medical Claims (PMPM)		\$405.02	
<b>Total Claims (PMPM)</b>		<b>\$405.02</b>	
Average Members		66,026	
Average Subscribers		29,143	
Projected Incurred Medical/Rx Claims (PEPM)		\$917.62	
Current Subscribers (per Sanford Jun-16)		29,220	
<b>Projected Total Claims Cost</b>		<b>\$643,506,579</b>	
<b>Fixed costs (retention)</b>			
Fixed costs (retention)		\$72,294,973	
Required Premium		\$715,801,552	
Monthly Premium PEPM (June 2016 per Sanford)		\$892	
Current Premium (June 2016 enrollment)		\$625,831,991	
Required Rate Increase		<b>14.4%</b>	
Required Rate Increase (w/loss of NDPER S BCBS discounts) <sup>2</sup>		<b>16.0%</b>	

**Notes**

- 1) Trend assumptions are detailed in the General Information tab
- 2) If the additional BCBS PPO discounts formerly associated with the NDPER S program are discontinued, this could increase the claim projection by approximately \$10M over the biennium

The total fixed costs were calculated using the current enrollment and the administrative and retention rates submitted during the last RFP by the previous health insurer for the current biennium.

**Administration costs**

Sanford is currently charging **\$11.60** per member per month for administration. The renewal proposes an increase of **44.5%** to **\$16.76** per member per month. The BCBS cost in the prior bid was \$16.37 per member per month.

**Staff Observations: Concern** – We do note that this was a topic of discussion when originally proposed. At the time we questioned the administration costs. It was indicated then that it was sufficient. We notice that since then they hired less staff than they were

proposing. Consequently, what we are seeing here is higher administration fees for less people. This may be a topic for further discussion. We also note that administration fees have been a historical concern for the Board and an area we had considerable disagreement with BCBS.

## 10. Other items the Board may want to consider

In this area we will examine eight items (pharmacy, network, discounts, member out of pockets, funding of other programs, EOB's, ACA fees and employer and member participation). These topics, while being examined in this section, also relate to the general criterion – Adequacy of Coverages.

### Pharmacy

Mike Schwab with the ND Pharmacy Association will update the Board on how things are going. Attachment 2 is a letter from him with his observations.

**Staff Observations: Improvement.** The Board did discuss the option of a transparent PBM relationship and Sanford has developed information on that for your consideration.

### Network

Sanford provided the following table relating to contracting activity:

<b>Summary of Provider Contracting Activity</b>		
<b>All Providers</b>	<b>Count</b>	<b>Percent</b>
Active Providers in Legacy NDPERS Network	6,285	100%
Active Providers in SHP NDPERS Network	6,241	99.3%
Active Providers Not Contracted	44	.7%
<b>Breakout</b>		
<b>Institutional Providers</b>		
Active Providers in Legacy NDPERS Network	301	100%
Active Providers in SHP NDPERS Network	298	99.0%
Active Providers Not Contracted	3	1.0%
List of Non Contracted		
- Free Standing Dialysis	1	
- IHS/Military Hospitals	2	
<b>Professional Providers</b>		
Active Providers in Legacy NDPERS Network	5,984	100%
Active Providers in SHP NDPERS Network	5,943	99.3%
Active Providers Not Contracted	41	.7%
List of Non Contracted Active Providers		

- Chiropractors	25	
- Behavioral Health	2	
- Vision	6	
- MD/DO/NP/PA	3	
- Other	5	
Active providers are those that had claim activity.		

Based upon the above reporting, Sanford has filled out the network in North Dakota. However, one area concern is the recent action of Sanford dropping out of the Dakota Care Network (Attachment 3). While the reason seems to be understandable the concern is that the decision was based upon not allowing Sanford Health to be a part of the Dakota Care Network and not what is best for the Sanford Health Plan members.

Concerning the out of state or wrap network we have few complaints from members on that. One issue has arisen about how those claims are identified and staff/Sanford is working on that at this time.

**Staff Observation: Satisfactory** While we have had some complaints about the missing providers overall the network has been reasonably developed.

Discounts

This seems to be the area that has presented significant challenges to the Sanford Health Plan in the past year and resulted in substantial losses to them and losses to the PERS plan (as discussed under Funded Position of PERS). We also note that Sanford has recognized this and presented PERS in the renewal with how they plan to approach resolving this in the future.

## Operational Savings



Total annual improvement of **\$30 million** achieved from contracting and claims management implementation.

The primary savings in the above plan is to get steeper provider discounts. This was identified in the review last year and that time we felt they were behind BCBS by about 7%. They have not been able to make this up thus far and consequently the losses to us and them. While the plan appears to address the issue there is no quantitative way that staff or Deloitte can validate the plan. The only way to judge this will be based upon the experience of the plan. Our risk is the loss of another \$3 million, any gain we could have gotten with more favorable experience and if Sanford Health Plan can continue to operate if losses continue (discussed later).

**Staff Observation: Concern** Sanford does have a plan to address these losses, however, with no quantitative way to assure its success this remains a significant risk to our reserves and Sanford Health Plan.

## Member Out of Pocket

NDPERS Active Health Insurance Out-Of-Pocket									
Jan-Dec Calendar Year ending:									
	2009	2010	2011	2012	2013	2014	2015 (1-6)	2015 (7-12)	2015
Active Contracts	19,317	19,728	20,016	20,940	21,203	21,530	21,907	21,433	21,670
Deductibles	\$9,290,919	\$9,816,469	\$10,073,095	\$10,967,963	\$11,328,815	\$11,374,638	\$7,839,134	\$4,082,148	\$11,921,282
Coinsurance	\$11,832,668	\$12,712,265	\$13,059,708	\$13,930,488	\$14,614,079	\$15,478,868	\$9,440,939	\$4,952,382	\$14,393,321
Sanctions	\$2,138,358	\$2,414,573	\$2,471,455	\$2,650,929	\$3,976,577	\$3,461,110	\$2,060,789	\$0	\$2,060,789
Copayments	\$10,295,041	\$11,464,880	\$11,696,304	\$12,214,972	\$12,396,682	\$12,336,376	\$6,476,564	\$8,708,884	\$15,185,448
Exclusions	\$5,604,131	\$4,497,621	\$5,851,646	\$9,056,696	\$10,857,602	\$20,948,164	\$11,878,567	\$9,240,469	\$21,119,036
<b>TOTAL</b>	<b>\$39,161,117</b>	<b>\$40,905,808</b>	<b>\$43,152,208</b>	<b>\$48,821,048</b>	<b>\$53,173,755</b>	<b>\$63,599,156</b>	<b>\$37,695,993</b>	<b>\$26,983,883</b>	<b>\$64,679,876</b>
Per Contract	\$2,027	\$2,073	\$2,156	\$2,331	\$2,508	\$2,954	\$1,721	\$1,259	\$2,985
State Classified									
Average Salary	\$42,382	\$44,698	\$46,057	\$48,554	\$50,942	\$53,297	\$55,231	\$55,231	\$55,231
Percent	4.8%	4.6%	4.7%	4.8%	4.9%	5.5%	3.1%	2.3%	5.4%

**Staff Observation: Satisfactory** It is hard to analyze the variation from Jan-Jun and Jul-Dec of 2015 since the member deductible and coinsurance reset at the beginning of the year. 2015 total active member out of pocket appears to be in line with the prior periods.

## Funding For Other Programs

We are currently partnering with the ND pharmacists to offer the About the Patient Diabetes Management Program, pursuant to NDCC 54-52.1-16 and 54-52.1-17.

### **54-52.1-16. Uniform group insurance program - Collaborative drug therapy program - Continuing appropriation.**

1. The board may establish a collaborative drug therapy program 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 in identified health populations and to manage health care expenditures.
2. Under the program, the board may involve physicians, pharmacists, and other health professionals to coordinate health care for individuals in identified health populations in order to improve health outcomes and reduce spending on care for the identified health problem. Under the program, pharmacists and other health professionals may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals in the identified health population. To encourage enrollment in the plan, the board may provide incentives to covered individuals in the identified health population which may include waived or reduced copayment for related treatment drugs and supplies.
3. The board may request the assistance of the North Dakota pharmacists association or a specified delegate to implement a formalized disease management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize chronic disease care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.
4. The board may seek and accept private contributions, gifts, and grants-in-aid from the federal government, private industry, and other sources for a collaborative drug

therapy program for identified health populations. Any funds that may become available through contributions, gifts, grants-in-aid, or other sources to the board for a collaborative drug therapy program are appropriated to the board on a continuing basis.

**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.

At the July 2016 meeting, the Board heard a presentation from Dr. Wendy Brown on the About the Patient Hypertension-control pilot program and at the August 2016 meeting, Jane Myers from the ND Department of Health provided the Board with an overview of the National Diabetes Prevention Program (NDPP). As part of the renewal process, the Board may want to consider whether to continue the About the Patient Diabetes program and whether to include funding for the Hypertension program and/or the NDPP.

Following are the estimated costs for each of these programs for the next biennium:

<b>Program</b>	<b>July 2017-June 2019</b>
About the Patient – Diabetes (See Exhibit IV)	\$210,000
About the Patient – Hypertension (See Exhibit IV)	\$288,500
National Diabetes Prevention Program (See Exhibit V) *based on 50% enrollment and 70% completion	\$607,300*

Currently, the About the Patient Diabetes program is funded through our existing reserves. If the Board would like to add these new programs, it would be necessary to retain an additional \$900,000 - \$1,000,000 of the current reserve balance to fund these programs.

The other consideration provided by statute is to fund the programs by adding up to a two dollar per month charge on the health premium.

**Staff Observation Concern. Declining reserves will mean that funding for existing or new programs will need to be added to premium.**

Explanation Of Benefits (EOB)

SHP processes EOBs different than BCBS and NDPERS has received comment regarding these differences from the membership. Specifically, the following items have been noted:

- Dependent claims data is sent as an EOB addressed to the policy holder at the policy holder address unless the dependent has requested to have an alternative address used. BCBS sent the EOB in the dependent’s name to the policy holder’s address unless the dependent requested to have the EOB sent to a different address. SHP has indicated that their process is federally compliant as well as HIPAA and ND law compliant. They have also indicated they are reviewing their EOB business practice and looking to modify the current process for a better member experience.
- SHP does not provide a Quarterly Prescription Drug Summary to members. BCBS previously provided this summary. SHP has estimated the cost to have these generated and sent to the membership would be approximately \$38,000 per quarter.
- Staff has brought confusing language and timing of EOB’s to Sanford’s attention.
- Members do not rate EOB’s very high.

**SURVEY QUESTION (#7)**

**Explanation of Benefits (EOB) documents are easy to understand.**

Place a (✓) below one of the options below. If you have not received an explanation of benefits, please choose the "NA" option.

Strongly Disagree				Strongly Agree	N/A
1	2	3	4		
<input type="checkbox"/>					

	EOBs ARE EASY TO UNDERSTAND			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	525	63.8%	36.2%	2.7
Medicare Retirees	553	80.3%	19.7%	3.1
Political Subdivisions	171	70.8%	29.2%	2.9
COBRA	22	77.3%	22.7%	2.9
Unidentified	19	94.7%	5.3%	3.2
<b>Raw Totals</b>	<b>1,290</b>	<b>72.5%</b>	<b>27.5%</b>	<b>2.9/4</b>
<b>Weighted Totals</b>		<b>69.6%</b>	<b>30.4%</b>	<b>2.8/4</b>

**NOTES**

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. Use the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

**Staff Observation:** Improvement - Staff requested many changes, but we are not aware of any being made. SHP has also acknowledged that based on feedback in the member survey, they have targeted this as an area for improvement.

Cost Effect of ACA Fees on Fully Insured Plans

At the August meeting we reviewed the initial settlement with BCBS relating to the ACA fees for fully insured plans. The actual cost of the fees (subject to our audit) is \$19,279,366. Of those fees the transitional reinsurance fee goes away by 2017. That was \$5.2 million of the \$19 million. Presently Sanford ACA fee is approximately \$685,000 a month of what we pay in premiums. With the total premium being approximately \$26 million the ACA fee is 2.6%% of premium or about \$31 per contract. This is a significant cost for the plan.

**Staff Observation: Concern** This is a significant cost to the plan.

Employer & Member Participation

Since July 1, 2015, NDPERS has had 19 employers discontinue participation in the NDPERS health plan. Of these employers, 14 have discontinued as they are no longer eligible due to ACA compliance requirements. The remaining 5 have elected to discontinue their participation. These 5 employers had a total of 163 covered employees.

The following provides an overall picture of the number of members enrolled in the health plan prior to the transition (as of June 2015) compared to July 2016, with a breakout of actives vs. retirees & COBRA participants:

	June 2015	July 2016
Active employees	21,464	21,540
Retirees & COBRA	8,039	7,666

**Staff Observation: Satisfactory** Enrollment has not changed significantly. The decrease in retiree participation is likely due to the RHIC portability.

## GENERAL AWARD CRITERIA

The Economy to the affected

Staff sees no affect in this area

**Staff Observation: Satisfactory**

The ease of administration

In evaluating the ease of administration, NDPERS staff reviewed both the transition to SHP from BCBS and the ongoing administration of the plan. To transition the plan, SHP

dedicated key subject matter experts within each area to work with the NDPERS team. As issues arose, SHP was responsive in addressing the concerns and problem solving to meet the needs of the NDPERS membership with as little disruption as possible. NDPERS staff found that this dedication of staff and resources has continued beyond implementation and applies to on-going operations. Some of the specific areas to note are:

- Member communications - ID cards, Certificate of Insurance, Summary of Benefits & Coverage and other required member communications were available and provided prior to the July 1 effective date.
- Closed formulary – shortly after implementation, it was determined that SHP and ESI had inadvertently coded our 3<sup>rd</sup> tier of prescription benefits as a “Closed” formulary. Upon discussion with NDPERS, this was quickly corrected.
- Health Savings Account (HSA) administration – SHP administers the HSA for NDPERS members who enroll in the High Deductible Health Plan; under BCBS, this was contracted out to a separate vendor. Having the health savings account administration integrated with the health carrier has allowed for a more seamless process for both NDPERS and our members when establishing the HSA.
- Staffing - SHP has experienced turnover in their leadership staff. However, NDPERS staff has not experienced an impact as a result. In addition, we have noted that overall staffing has been increased in order to meet the needs of the NDPERS population.
- Enrollment process - Some enrollment issues occurred for members who transferred employment between NDPERS covered employers or changed participation between plans. Upon review, SHP made modifications to their data system to resolve the issue within a timely manner. NDPERS staff has found the IT staff and business system used by SHP to be flexible and able to be modified to meet the needs of our member records. SHP has also provided a direct contact for our enrollment team to resolve day to day issues.
- Integrated data system – Because SHP is part of an integrated health system, we experienced unique issues with member demographic data. There were some issues with ID cards and correspondence going out to old addresses or with wrong names because SHP was using existing data instead of updated data from NDPERS. Upon review, SHP has recently made changes to their business process to insure that the correct demographic information is used when issuing ID cards and mailings to NDPERS members.
- Claims data - Claims data files have not been received within the timeframe expected by NDPERS staff and have not provided complete and accurate information as required. This continues to be a work in progress.
- Coordination of Benefits - Issues have been reported by members regarding coordination of benefits, specifically when there are 2 SHP coverages and also

related to pharmacy. Sanford has reviewed issues and also developed member communications to address concerns of members impacted.

- Premium reconciliation - SHP is providing timely monthly billing reconciliations and has provided a direct contact for our billing team to resolve issues.
- ACA compliance - SHP conducted the annual ACA minimum contribution testing. This testing proved to be a difficult process and was not conducted within the timeframes that NDPERS staff typically experienced with BCBS. However, NDPERS has met with SHP to discuss concerns and ensure the process runs smoother in the future. SHP provided covered individuals the 1094B within the specified timeframe required by the IRS. In addition, SHP provided files to the NDPERS employers regarding covered employees to assist them in preparing the required 1095C employer reporting form.
- Medicare Part D - Medicare Part D was a concern prior to implementation as SHP did not have experience in this area. SHP brought forward ESI as a partner to administer the program for NDPERS. This resulted in a change in how NDPERS has handled the Part D product. Previously the health carrier was the liaison between NDPERS and the Part D vendor, acting as the communicator between the two parties. With this change, NDPERS contracted directly with ESI and Sanford has remained more of a consultant and assistant when NDPERS needs to raise issues to ESI. ESI has significant experience with and knowledge of Part D plans. ESI has provided direct contacts for NDPERS staff to resolve member enrollment and billing issues. NDPERS staff note that the change in how we do business related to the Part D product has resulted in more understanding, flexibility and compliance to CMS requirements.

Reporting – SHP is providing all monthly, quarterly and annual reporting as requested by NDPERS

**Staff Observation: Satisfactory** – Overall, Sanford Health Plan has performed very well in this area considering the magnitude of the transition and has continued to be very responsive whenever issues have been raised.

*The financial position of the carrier*

**This information will be reviewed at the Board meeting.**

**Information as presented at the September 8 special Board meeting:**

Attachment 4 is the Quarterly Statement filed with the State Insurance Commissioner as of March 31, 2016. Of note is:

1. For the year ended December 31 the plan shows a net loss of \$73,243,122
2. For the YTD (as of March 31) the plan shows a net loss of \$7,418,297
3. In 2015 the amount of surplus that was added or “paid in” was \$110,512,000
4. An additional amount is anticipated to be paid in 2016

5. Sanford Operations are not providing sufficient revenue to support the cost of plan operations or benefit payments. Sanford Health Plan relies on Sanford Health for funding to keep operating but does have a plan to be self sufficient in 2017.

Operations:

- First quarter underwriting (loss) of \$8.7 million
- Loss includes all lines of business
- We anticipate mitigating our overall losses from operation improvements
- Plan to have favorable operating results in CY17 for all lines of business

Balance Sheet:

- Cash and investments grew from \$81.9 million to \$95.4 million
- Assets of \$225 million
- Liabilities of \$180 million
- No material changes on balance sheet and cash flow statement

Ratios:

- RBC level @ 200% - Above Company Action Level
- All ratios in compliance with DOI standards

In recognition of this, staff mentioned to Sanford during our discussions on information for the renewal that it would be beneficial to have some commitment from Sanford Health that they would continue to provide funds to insure its operation for the 2017-19 biennium. After discussion with Jan and Ice Miller, we had suggested some sort of written document that could be between PERS and Sanford Health or between Sanford Health Plan and Sanford Health that PERS would be a party to. What was provided in this renewal was a jointly signed letter from Mr. Kelly Krabbenhoft, President and CEO of Sanford Health, and Mr. Kirk Zimmer, Executive Vice President, Sanford Health Plan. In that letter it states:

*Sanford Health is dedicated to the work of health and healing and delivering the highest quality care. Sanford Health Plan shares that commitment and is supported by the strength of the \$4 billion Sanford Health organization.*

This is what was given.

**Staff Observation: Concern** Given the above financial portrait, the Board should consider seeking a guarantee that Sanford Health will continue to support Sanford Health Plan for the 2017-19 biennium if the plan is renewed. While what was provided is noteworthy, it does not represent a firm financial commitment to continue to cover losses that could occur if Sanford's plan does not work for 2017-2019.

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.

**Staff Observation: Satisfactory**

<b>Review Areas</b>		<b>Staff Observation</b>
1	Review Economic/ Policy Environment	Concern
2	Review PERS Funded position and expected funded position	Concern
3	Review of Contract Performance Measures	Satisfactory
4	Review the carrier's payment accuracy, claims processing time,	Satisfactory
5	Review the carrier's member service center metrics	Improvement
6	Review the carrier's wellness participation measures	Satisfactory
7	Review the carrier's special program participation levels	Satisfactory
8	Review member survey results	Improvement
9	a) Use the services of a consultant to concurrently and independently prepare renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.	Concern
	b) Administrative Costs	Concern
10	Other areas reviewed by the Board	
	a) Pharmacy	Improvement
	b) Network	Satisfactory
	c) Discounts	Concern
	d) Member out of pocket	Satisfactory
	e) Funding for other programs	Concern
	f) EOB	Improvement
	g) Cost effect of ACA on fully insured plans	Concern
h) Employer & member participation	Satisfactory	
11	a) The economy to be affected	Satisfactory
	b) The ease of administration.	Satisfactory
	c) The adequacy of coverages (see other items the board may want to consider)	(See above #10)
	d) The financial position of the carrier, with special emphasis as to its solvency	Concern
	e) 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.	Satisfactory

# SANFORD RENEWAL

---

PERS Board Meeting  
September 8, 2016

PURSUANT TO NDCC 54-52.1-05 (2) WE CAN  
RENEW WITH SANFORD HEALTH PLAN FOR  
THE 2017-19 BIENNIUM

---

This is the question for us at this point.

# Next Steps

- **Renewal Steps (54-52.1-05(2):**
  - **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.**

# Next Steps

## • **Renewal Steps:**

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.**

# Renewal

- *Received by the PERS Board at its August 25<sup>th</sup> Meeting*



 NORTH DAKOTA  
PUBLIC EMPLOYEES  
RETIREMENT SYSTEM

Health Insurance Renewal

**SANFORD**  
HEALTH PLAN

# Next Steps

## • **Renewal Steps:**

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.**

# Next Steps

## •Renewal Steps:

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.**

# Next Steps – Other Matters

- To look to the general review criteria 54-52.1-04 for guidance in responding to 54-52.1-05(2)(b)(3). Those criteria are:
  1. The economy to be affected.
  2. The ease of administration.
  3. The adequacy of the coverages.
  4. The financial position of the carrier, with special emphasis as to its solvency.
  5. 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.

# Sanford Renewal

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. **#9**

2. 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. **#3,4,5,6,7,8,10**

3. **11 (General Criteria)**

1	Review Economic/ Policy Environment
2	Review PERS Funded position and expected funded position
3	Review of Contract Performance Measures
4	Review the carrier's payment accuracy, claims processing time,
5	Review the carrier's member service center metrics
6	Review the carrier's wellness participation measures
7	Review the carrier's special program participation levels
8	Review member survey results
9	a) Use the services of a consultant to concurrently and independently prepare renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.
	b) Administrative Costs
	Other areas reviewed by the Board
10	a) Pharmacy
	b) Network
	c) Discounts
	d) Member out of pocket
	e) Funding for other programs
	f) EOB
	g) Cost effect of ACA on fully insured plans
	h) Employer & member participation
11	a) The economy to be affected
	b) The ease of administration.
	c) The adequacy of coverages (see other items the board may want to consider)
	d) The financial position of the carrier, with special emphasis as to its solvency
	e) 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.

# Review

- In reviewing the above areas, we have provided information from the previous carrier's performance and compared it to the existing carrier in order to provide you a perspective on how the transition is progressing. We have utilized this similar approach in the past to provide a perspective on other transitions (dental, vision, life, Companion Plan). Please note that these should not be viewed as direct comparisons since different methodologies and techniques were used by the existing and previous carriers and, therefore while we can get a general perspective from the information it is not an equivalent comparison. PERS/Deloitte staff will also offer an observation by rating each as follows:
  - **Satisfactory** – activities are moving as expected
  - **Improvement** - areas can be improved
  - **Concern** – there are certain issues or activities that are of concern to the future direction of the plan

# 1. REVIEW ECONOMIC/ POLICY ENVIRONMENT

---

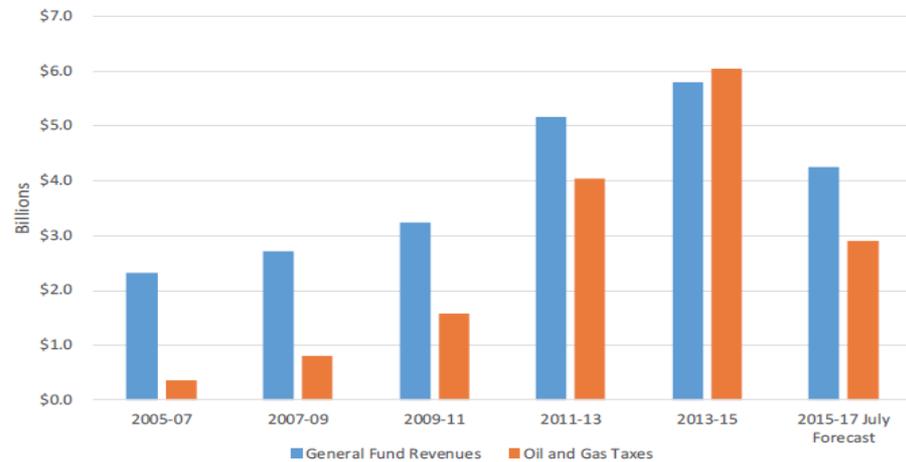
## Economic Considerations

# State Fiscal Situation

## *Concern*

- 4% allotment
- 2.5% allotment
- Rainy day fund
- \$100 million BND

North Dakota General Fund Revenue  
and Oil and Gas Taxes



## Economic Considerations

## Policy Considerations

## *Concern*

- Require PERS to Bid every 2 years
  - 2016 – Renewal
  - 2014 – Full Bid
  - 2012- Fully Insured Bid only
  - 2010 - Fully Insured Bid only
  - 2008 - Renewal
  - 2006 - Renewal
  - 2004 – Full Bid
- Eliminate the requirement that the state pay the full cost of employees' single and family premium

# **Economic/ Policy Environment**

Staff Observation: *Concern*

# 2. PERS FUNDED POSITION & EXPECTED POSITION

---

# PERS Existing Funded Position

Balance as of:	Health Insurance	Early Retiree Reinsurance Program (ERRP)	Life Insurance
7/1/2007	\$1,540,648	\$0	\$2,155,769
7/1/2009	\$5,581,737	\$0	\$2,421,873
7/1/2011	\$5,943,183	\$1,726,189	\$2,468,533
7/1/2013	\$42,651,594	\$2,735,616	\$2,490,265
7/1/2015	\$42,925,033	\$0	\$2,491,063
7/1/2016 (estimate)	\$41,253,000	\$0	\$2,516,000

# PERS EXPECTED FUNDED POSITION

- The future expected funded position for PERS is going to deteriorate going forward. Specifically:
  - 
  - \$41,253,000 Estimated balance
  - (3,000,000) Less deposit currently held by BCBS for the 2013-15 biennium, at risk until 7/1/2017
  - (3,000,000) Less deposit currently held by SHP for the 2015-17 biennium, at risk until 7/1/2019
  - (3,000,000) Risk deposit for 2017-19 contract period
  - (2,800,000) Retention for administrative expenses for July 2016 – June 2019
  - \$29,453,000

# REASONS FOR DECLINE

- ACA FEES – Higher than expected
- No Positive Settlement

A	O
NDPERS Health Plan	
	NDPERS Settlement
BCBS	
1989-1991	
1991-1993	
1993-1995	
1995-1997	\$3,381,000
1997-1999	\$0
1999-2001	\$0
2001-2003	\$3,260,000
2003-2005	\$8,619,000
2005-2007	\$4,048,605
2007-2009	\$0
2009-2011	\$36,605,000
2011-2013	\$9,526,000
2013-2015 Projected	\$4,775,000
SANFORD	
2015-2017 Projected	\$0
Totals	\$70,214,605

- Gain/ Loss Agreement

Have generally had no to minimal losses – this time we will lose \$3 million

NDPERS Health Plan Administration and Surpl		BCBS	
BCBS	Surplus Settlement	Gain	Loss
1989-1991	First \$1,000,000	\$1,000,000	
1991-1993	First \$2,000,000	\$2,000,000	
1993-1995	First \$500,000	\$500,000	
1995-1997	50% upto \$500,000	\$500,000	
1997-1999	20% upto \$500,000	\$0	\$1,350,000
1999-2001	50% upto \$500,000	\$0	\$2,200,000
2001-2003	50% upto \$500,000	\$500,000	
2003-2005	50% upto \$500,000	\$500,000	
2005-2007	50% upto \$1,500,000	\$1,500,000	
2007-2009	50% upto \$1,500,000	\$0	\$3,100,000
2009-2011	50% upto \$1,500,000	\$1,500,000	
2011-2013	50% upto \$1,500,000	\$1,500,000	
2013-2015 Projected	50% upto \$1,500,000	\$1,500,000	

# What if:

- \$3M No loss
- \$1M Claims gain
- \$15M ACA fees

## North Dakota PERS

### Claims Projection Summary

*(7/1/14-6/30/15) experience projected to current biennium*

Experience Period
Projection Period

Total
7/1/14 - 6/30/15
7/1/15 - 6/30/17

### Claims

Paid Medical and Pharmacy Claims	\$257,068,657
Incurred But Not Reported (IBNR) Completion Factor	1.00000
Completed Medical and Pharmacy Claims	\$257,068,657
Average Member Enrollment	66,026
Medical Claims Cost (PMPM)	\$324.45
Plan Design Change Factor	1.000
Other Adjustment Factors	1.000
Annual Trend Factor <sup>1</sup>	8.00%
Compound Trend	1.1224
Projected Incurred Medical Claims (PMPM)	\$364.16
Total Claims (PMPM)	\$364.16
Average Members	66,026
Average Subscribers	29,143
Projected Incurred Medical/Rx Claims (PEPM)	\$825.03
Current Subscribers (per Sanford Jun-16)	29,220
<b>Projected Total Claims Cost</b>	<b>\$578,576,397</b>

### Notes

1) Trend assumptions are detailed in the General Information tab

# Use of Reserves for fully insured premium

Reserve Use Option	Approximate savings	Effect on Grandfathered status
Plan remains fully insured – use reserves to buy down the premium for one biennium (would need 3 million to maintain contract leaving about 29.5 million in health (after estimated expenses except ACA fees) and 2.5 million in Life which would require legislation)	.57% for each 5M in buydown	None

# PERS Funded Position & Expected Position

Staff Observation: *Concern*

# **3. REVIEW CONTRACT PERFORMANCE MEASURES**

---

# Review Contract Performance Measures

- Deloitte Consulting reviewed 14 performance guarantees
- Sanford provided documentation & calculation methodology for each guarantee
- Deloitte Consulting found that Sanford had sufficiently exceeded most performance guarantees due thus far and is using acceptable calculation methodology to determine their compliance with each guarantee

**Staff Observation: Satisfactory**

# 4. REVIEW CARRIER PAYMENTS

---

# Deloitte Review

Measurement	Review Result	NDPERS Performance Guarantee	Industry Benchmark
<b>Claims Accuracy</b>			
Financial Accuracy:	99.7%	99%	99%
Payment Accuracy:	97.7%	97%	97%
Procedural Accuracy:	97.3%	-	95%
<b>Claims Turnaround Time*</b>			
Average Days to Process:	5.0 days	-	-
% within 30 Calendar Days:	95.0%	99%	-
Average Days to Payment:	11.1 days	-	-
% within 30 Calendar Days:	92.7%	-	98%

\*Deloitte Consulting's stratified sampling method results in a higher proportion of high dollar claims compared to NDPERS claim population. High dollar claims are more complex and have longer payment approval processes so turnaround time of the sample is expected to be higher than turnaround time of the claim population. Deloitte Consulting does not have concerns about Sanford's claim turnaround time.

# Review Carrier Payments

Staff Observation: Satisfactory

# **5. REVIEW OF CARRIER MEMBER SERVICE METRICS**

---

# Review of Carrier Member Service Metrics

## MEMBER SERVICES CENTER SURVEY QUESTIONS

### SURVEY QUESTION (#16)

How satisfied were you with the service you received when you called member services?

Use the 10-point scale below to tell us your opinion; 1 is "Not At All Satisfied" and 10 is "Extremely Satisfied."

Place a (✓) beneath one number.

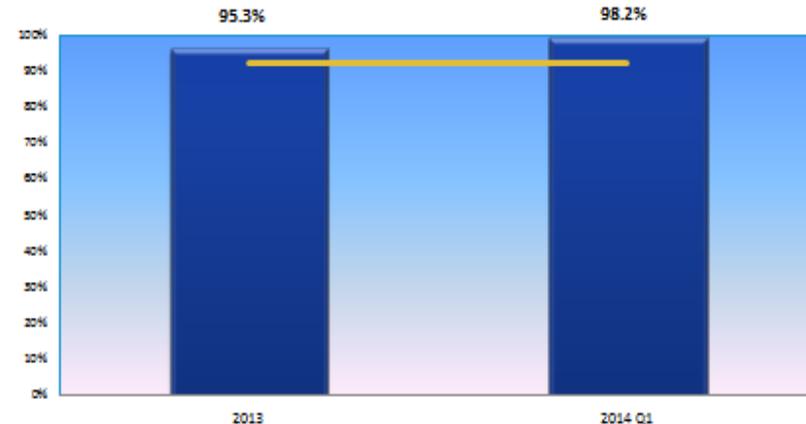
Not at All Satisfied											Extremely Satisfied
	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>										

	SATISFACTION WITH MEMBER SERVICES CALL CENTER SERVICE			
	Responses	Distribution		Average
	n	Satisfied %	Not Satisfied % (n)	out of 10
State Employees	207	64.3%	35.7%	6.4
Medicare Retirees	127	78.7%	21.3%	7.4
Political Subdivisions	57	71.9%	28.1%	6.8
COBRA	9	77.8%	22.2%	6.9
Unidentified	5	80.0%	20.0%	7.6
<b>Raw Totals</b>	<b>405</b>	<b>70.4%</b>	<b>29.6%</b>	<b>6.8/10</b>
<b>Weighted Totals</b>		<b>69.3%</b>	<b>30.7%</b>	<b>6.7/10</b>

### NOTES

- For purposes of this analysis, values 1 to 5 were considered "Not Satisfied" and values 6 to 10 were considered "Satisfied."

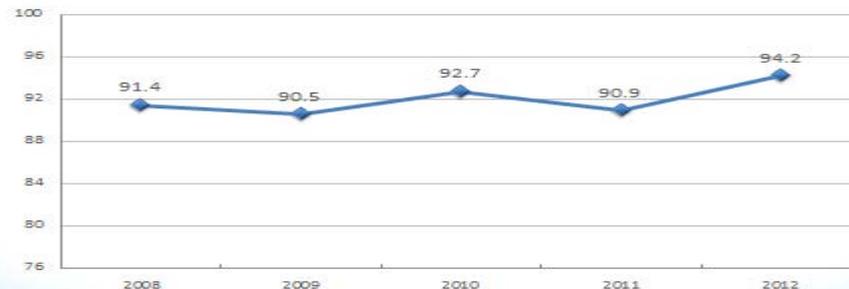
## NDPERS Member Satisfaction



### Overall Satisfaction

- Customers satisfied with the callcenter experience and the customer service representative. Goal – 92%
  - Based on 451 surveys completed in 2013 and 111 surveys completed in First Quarter 2014.

## Overall Satisfaction with Service



# Review of Carrier Member Service Metrics

## SURVEY QUESTION (#21)

The customer service representative was knowledgeable.

Place a (✓) below one of the options below.

Strongly Disagree				Strongly Agree
1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	REPRESENTATIVE WAS KNOWLEDGEABLE			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	205	72.7%	27.3%	3.0
Medicare Retirees	128	86.7%	13.3%	3.5
Political Subdivisions	57	75.4%	24.6%	3.2
COBRA	9	88.9%	11.1%	3.7
Unidentified	5	100%	0%	3.4
<b>Raw Totals</b>	<b>404</b>	<b>78.2%</b>	<b>21.8%</b>	<b>3.2/4</b>
<b>Weighted Totals</b>		<b>77.0%</b>	<b>23.0%</b>	<b>3.2/4</b>

### NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. Use the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

## SURVEY QUESTION (#20)

The customer service representative treated you with courtesy and respect.

Place a (✓) below one of the options below.

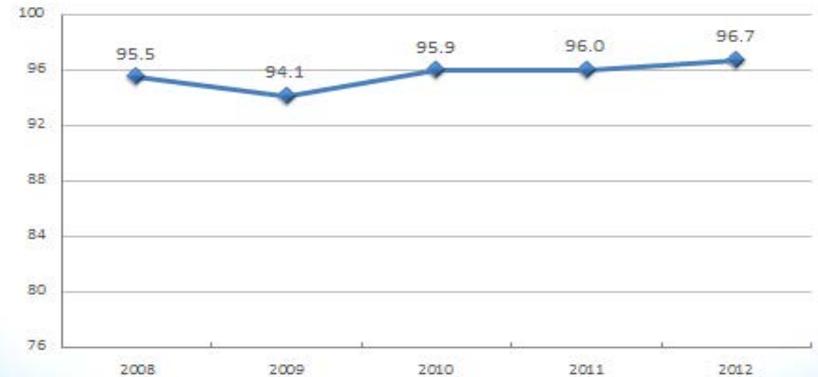
Strongly Disagree				Strongly Agree
1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	REPRESENTATIVE TREATED YOU WITH COURTESY AND RESPECT			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	206	88.8%	11.2%	3.0
Medicare Retirees	129	94.6%	5.4%	3.5
Political Subdivisions	57	89.5%	10.5%	3.1
COBRA	9	100%	0%	3.2
Unidentified	5	80.0%	20.0%	3.4
<b>Raw Totals</b>	<b>406</b>	<b>90.9%</b>	<b>9.1%</b>	<b>3.2/4</b>
<b>Weighted Totals</b>		<b>90.5%</b>	<b>9.5%</b>	<b>3.5/4</b>

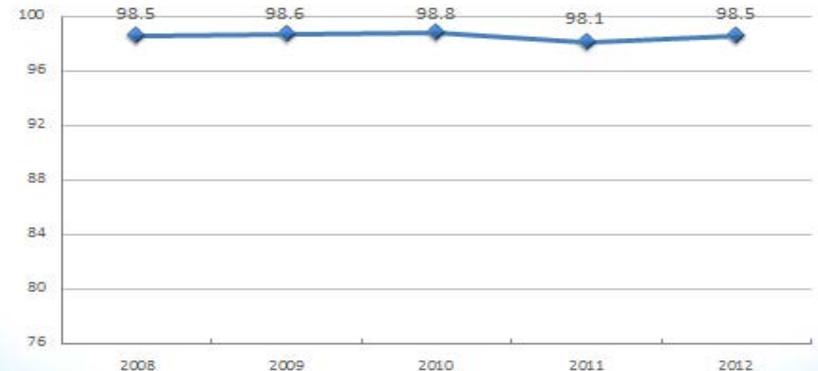
### NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. Use the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

## Representative was Knowledgeable



## Caller Treated with Courtesy



# Review of Carrier Member Service Metrics

## Staff Observation: Improvement

We should use caution in directly comparing across different surveys. Variations may be due to the survey instrument, sampling, timing, etc. With that in mind, we do notice a difference and as Sanford indicated in their survey presentation there is room for improvement. One thing is that maybe we need to consider going back to a dedicated NDPERS call center.

# **6. WELLNESS PARTICIPATION & PERFORMANCE**

---

# Wellness Participation & Performance

- Employer Based Wellness Program
  - 1% Premium Discount
  - Benefit Funding Program
- Employee Wellness Incentive/\$250 benefit
  - Fitness Center Reimbursement
  - Online Wellness Portal

# Wellness Participation & Performance

- Employer Based Wellness Program
  - Staffing to support employer & wellness coordinator education and assistance
  - Onsite worksite member education since July 2015
    - 229 meetings conducted with 3,318 attendees
  - Monthly coordinator webinars
  - Monthly coordinator newsletters
  - Monthly member newsletters
  - Monthly flyers/posters
  - Summer coordinator workshops held in June 2016
    - 9 workshops statewide with 102 coordinators in attendance

# Wellness Participation & Performance

- Employee Wellness Incentive/\$250 Benefit
  - Fitness Center Reimbursement
    - Transitioned with little disruption
  - Online Wellness Portal (bWell)
    - Concerns voiced by coordinators & members regarding bWell
      - Sanford disabled bWell as of December 31, 2015
    - Implemented new, more robust portal on April 1, 2016
      - Novu

# Wellness Participation & Performance

The following are statistics related to the wellness performance measurements under BCBS as reported on their Q4-2014 Executive Summary:

Measure	Goal	As of 12/31/2014
HRA completions	17%	22%
HRA Score	5% point increase in the 2013 – Goal 55	60
HealthyBlue – incentives paid	10% increase over 2013 incentives paid – Goal = \$581,798	\$722,906
Health Club Credit	10% increase over 2013 member receiving credit – Goal = 2,177	1950 (missed)

The following are statistics related to the wellness performance measurements under SHP as reported on their Q4-2015 Executive Summary:

Measure	Goal	As of 12/31/2015
HRA completions	10%	17.7%
bWell participation	10%	10.8%
Fitness Center Reimbursement	1,950	1857 (missed) – final reporting pending

# Wellness Participation & Performance

## 2016 Participation Details:

- Since launch of Novu on April 1, 2016:
  - 7,664 members have logged onto Novu site
  - 6,850 members have completed their HRA (health risk assessment)
- Fitness Center Reimbursement:
  - 1,690 members have received fitness center reimbursements (August 2016)

# Wellness Participation & Performance

Staff Observation: Satisfactory

# 7. REVIEW OF CARRIER SPECIAL PROGRAM PARTICIPATION LEVELS

---

This represents programs that add value by promoting wellness initiatives, prevention and health care management.

# Participation Levels

	<b>Date Reported*</b>	<b>Carrier</b>	<b>Participants</b>
<b>Tobacco Cessation Program</b>	June 2015	BCBS	122
	August 2016	SHP	89
<b>Accordant Care</b>	March 2015	BCBS	295
	August 2016	SHP	505
<b>About the Patient</b>	June 2015	BCBS	207
	June 2016	SHP	294
<b>Healthy Pregnancy</b>	March 2014	BCBS	210
	August 2016	SHP	497
<b>Life Advocate Program</b>	March 2015	BCBS	15
	August 2016	SHP	90
<b>Medical Home</b>	March 2015	BCBS	90%
	June 2016	SHP	36.5%

*\* Participation reported for BCBS is generally based on 24 months of data; the SHP data is based on 12-15 months of data.*

# Staff Observations

Based upon the above:

- Participation in the tobacco cessation program appears to be increasing.
  - Implementation of a debit card by SHP for the purchase of prescriptions.
- Medical Home participation is lower; however, for the first year the performance measure was adjusted to 30% which was exceeded and the participation in this program will be continue to be reported to the Board on a quarterly basis for review and assessment.
- The About the Patient diabetes program appears to be increasing.
  - Implementation point-of-sale processing for diabetic medications and supplies. Previously, paid out-of-pocket and member filed for reimbursement of the copays.
  - Now copays are waived at the time of purchase.
  - Convenient and efficient.

Staff Observation: Satisfactory

# Member Rebate Program

- Administration of this program was included in the RFP.
- NDPERS Board approved re-establishing the program effective July 1, 2016.
- Currently, program is not in place.
- Staff is continuing conversations with SHP and some concerns have been brought forward by Sanford which will be on an upcoming board agenda.

Staff Observation: Concern. We are behind schedule.

# 8. MEMBER SURVEY RESULTS

---

# Member Survey Results



## TOPLINE RESULTS: GENERAL MEMBERSHIP SURVEY

More than 92% of members surveyed have used their health insurance in the past 6 months, and most used their health plan without having to call to ask questions or report an issue.

RECEIVED HEALTH SERVICES  
IN THE PAST 6 MONTHS

n=1,408

92.1%

SATISFIED WITH  
HEALTH PLAN BENEFITS

n=1,388

71.4%

PRINTED OR INTERNET  
RESOURCES ARE HELPFUL

n=1,055

80.4%

EOB DOCUMENTS ARE  
EASY TO UNDERSTAND

n=1,290

69.6%

INSURANCE CLAIMS ARE  
PROCESSED ACCURATELY

n=1,326

80.7%

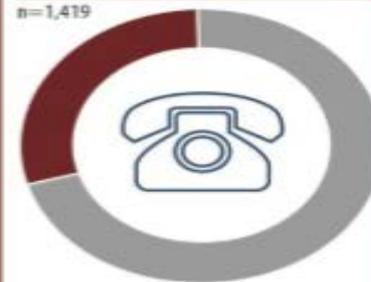
CLAIMS ARE PROCESSED  
IN A TIMELY MANNER

n=1,346

77.2%

### NDPERS MEMBERS WHO CALLED MEMBER SERVICES

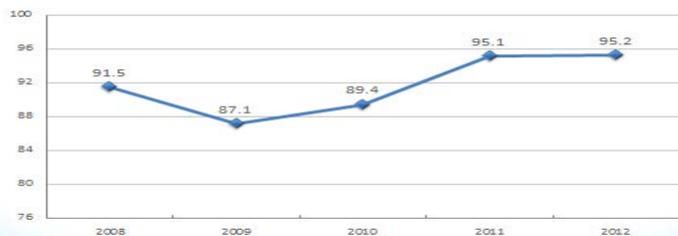
n=1,419



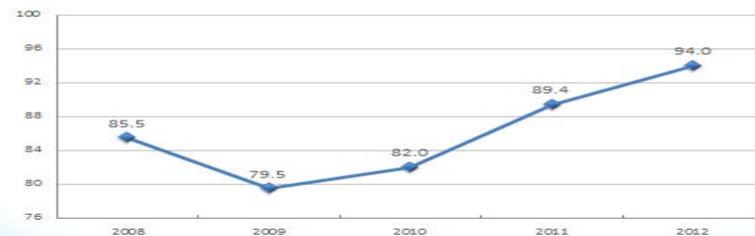
71.1%  
DID NOT NEED MEMBER  
SERVICES ASSISTANCE

28.9%  
CALLED MEMBER  
SERVICES

### Understandable EOB



### Claim Processed Timely



# Member Survey Results

While it is not a direct comparison to our other plans/vendors, we do have survey results for some of our other plans. We know that when issues are addressed survey results can improve.

NDPERS Survey ADP Flexcomp 2016	Disagree	Agree
7. I understand the NDPERS Flexcomp program.	2%	98%
8. I am satisfied with the claim submission options available from ADP.	16%	84%
9. I am satisfied with the online Web Services available from ADP.	16%	84%
14. I am satisfied with the customer service provided by ADP.	21%	79%
15. I am satisfied with the Flexcomp service provided by the NDPERS office.	8%	92%
NDPERS Survey TIAA Deferred Comp 2016		
2. Are you satisfied with the availability of plan information?	12%	88%
7. I am satisfied with the investment education and advice given by TIAA.	19%	81%
8. I am satisfied with the web services and quarterly statements provided by TIAA.	16%	84%
9. I am satisfied with the availability of counselors and advisors from TIAA.	22%	78%
11. I would recommend TIAA to other employees.	17%	83%
12. I am satisfied with the service provided by the NDPERS office.	16%	84%

# Member Survey Results

## Staff Observation: Improvement

Improvements can be made in this area. We need to get members satisfaction with the health benefits higher.

# 10. OTHER ITEMS FOR BOARD CONSIDERATION

---

## Pharmacy



August 31, 2023

To: NDPhA Board of Trustees and Staff

From: North Dakota Pharmacists Association

Re: NDPhA Health Plan Renewal

Dear NDPhA Board of Trustees and Staff,

As per request, we have prepared some comments for consideration as you move forward in your discussion regarding your health plan renewal. First, we truly appreciate your willingness to listen to our concerns. Thank you for your help in facilitating discussions to take place between all parties who provide services under the NDPhA health plan. It is no secret that we have noted some concerns during the first year of implementation.

We would like to thank Sanford Health Plan and NDPhA for addressing two immediate issues that were brought forward last year with the initial roll-out of the plan. The first issue was the request by NDPhA to look at all of rates for providers compared to the previous carrier. Thank you. The second issue was Sanford Health Plan not enabling or meeting that HD has over 300 pharmacists authorized to provide immunizations. This was not included as providers of those services when the plan was rolled out. After notifying Sanford Health Plan regarding this oversight, changes were made in September of 2022.

During multiple NDPhA Board meetings, we have discussed additional concerns our members have brought forward. Below I have listed some of the shared concerns.

### MAC Comments:

We continue to hear from our members that Maximum Allowable Cost (MAC) reimbursement as set forth by Express Scripts is more aggressive than the previous carrier. A MAC set to what a PBM uses to pay pharmacies for generic drugs. This has caused numerous prescriptions to be filled before the cost of doing business and in some cases below the actual acquisition cost that a pharmacy can even buy the prescription. This causes the pharmacy to actually lose money when providing certain generic prescriptions to NDPhA beneficiaries. In some cases, pharmacies are losing from a couple of dollars to literally hundreds of dollars on certain prescriptions. In these situations, the pharmacy still serves the NDPhA beneficiaries however the pharmacy cannot deliver services to the patient and the pharmacy hopes to make up for it on future prescriptions.

- Maximum Allowable Cost
  - ND pharmacists would appreciate a more equitable MAC list
- Specialty Drugs
  - Have ND pharmacies paid the same as ESI mail order pharmacy
- Copayments
  - Require pharmacy be due \$5 copay.

Staff Observation:  
Improvement

## Network

Staff Observation:  
**Satisfactory** but keep  
 up effort to get those  
 that have not signed.

<b>All Providers</b>	<b>Count</b>	<b>Percent</b>
Active Providers in Legacy NDPERS Network	6,285	100%
Active Providers in SHP NDPERS Network	6,241	99.3%
Active Providers Not Contracted	44	.7%
<b>Breakout</b>		
<b>Institutional Providers</b>		
Active Providers in Legacy NDPERS Network	301	100%
Active Providers in SHP NDPERS Network	298	99.0%
Active Providers Not Contracted	3	1.0%
List of Non Contracted		
- Free Standing Dialysis	1	
- IHS/Military Hospitals	2	
<b>Professional Providers</b>		
Active Providers in Legacy NDPERS Network	5,984	100%
Active Providers in SHP NDPERS Network	5,943	99.3%
Active Providers Not Contracted	41	.7%
List of Non Contracted Active Providers		
- Chiropractors	25	
- Behavioral Health	2	
- Vision	6	
- MD/DO/NP/PA	3	
- Other	5	
Active providers are those that had claim activity.		

## Member out of pocket

**Staff Observation:**  
**Satisfactory** It is hard to analyze the variation from Jan-Jun and Jul-Dec of 2015 since the member deductible and coinsurance reset at the beginning of the year. 2015 total active member out of pocket appears to be in line with the prior periods.

NDPERS Active Health Insurance Out-Of-Pocket									
Jan-Dec Calendar Year ending:									
	2009	2010	2011	2012	2013	2014	2015 (1-6)	2015 (7-12)	2015
Active Contracts	19,317	19,728	20,016	20,940	21,203	21,530	21,907	21,433	21,670
Deductibles	\$9,290,919	\$9,816,469	\$10,073,095	\$10,967,963	\$11,328,815	\$11,374,638	\$7,839,134	\$4,082,148	\$11,921,282
Coinsurance	\$11,832,668	\$12,712,265	\$13,059,708	\$13,930,488	\$14,614,079	\$15,478,868	\$9,440,939	\$4,952,382	\$14,393,321
Sanctions	\$2,138,358	\$2,414,573	\$2,471,455	\$2,650,929	\$3,976,577	\$3,461,110	\$2,060,789	\$0	\$2,060,789
Copayments	\$10,295,041	\$11,464,880	\$11,696,304	\$12,214,972	\$12,396,682	\$12,336,376	\$6,476,564	\$8,708,884	\$15,185,448
Exclusions	\$5,604,131	\$4,497,621	\$5,851,646	\$9,056,696	\$10,857,602	\$20,948,164	\$11,878,567	\$9,240,469	\$21,119,036
TOTAL	\$39,161,117	\$40,905,808	\$43,152,208	\$48,821,048	\$53,173,755	\$63,599,156	\$37,695,993	\$26,983,883	\$64,679,876
Per Contract	\$2,027	\$2,073	\$2,156	\$2,331	\$2,508	\$2,954	\$1,721	\$1,259	\$2,985
State Classified									
Average Salary	\$42,382	\$44,698	\$46,057	\$48,554	\$50,942	\$53,297	\$55,231	\$55,231	\$55,231
Percent	4.8%	4.6%	4.7%	4.8%	4.9%	5.5%	3.1%	2.3%	5.4%

## Funding for other programs

**Staff Observation Concern.** Declining reserves will mean that funding for existing or new programs will need to be added to premium.

Program	July 2017-June 2019
About the Patient – Diabetes (See Exhibit IV)	\$210,000
About the Patient – Hypertension (See Exhibit IV)	\$288,500
National Diabetes Prevention Program (See Exhibit V)	\$607,300*

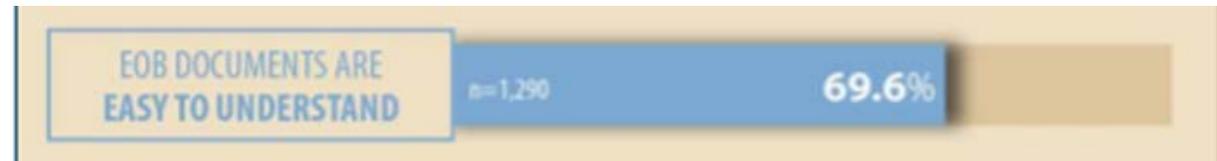
\*based on 50% enrollment and 70% completion

# EOB

Differences in processing of EOBs between SHP and previous carrier has caused feedback from our membership.

- Dependent claims data is sent as an EOB addressed to the policy holder at the policy holder address unless the dependent requested an alternative address. BCBS sent the EOB in the dependent's name to the policy holder address unless an alternative address was requested
- SHP does not provide a Quarterly Prescription Drug Summary to members
- Confusing language and timing of EOB's
- Survey results indicate our members do not find the EOB as easy to understand

Staff Observation:  
**Improvement –**



Sanford has also identified this as an area for improvement in their survey results:

**Explanation of Benefits documents (EOBs) are a candidate for targeted improvement.** It may be most effective to start improvement efforts by focusing on the smaller share of members who believe EOBs are not easy to understand (30.4%). The most frequent service-related open-ended statement shared a perception that EOBs do not contain enough detail or are hard to understand (3.2% of all statements), and unclear EOBs may explain why 38.9% of call center volume is attributed to claim or EOB questions. Considering members who call for that reason are already less satisfied with their benefits (50.5% satisfied), improving EOB clarity may reduce call center volumes and improve the member experience.

## Employer & Member Participation

### **Staff Observation: Satisfactory.**

Enrollment has not changed significantly. The decrease in retiree participation is likely due to the RHIC portability.

	June 2015	July 2016
Active employees	<b>21,464</b>	<b>21,540</b>
Retirees & COBRA	<b>8,039</b>	<b>7,666</b>

# 11. GENERAL AWARD CRITERIA

---

*The Economy  
to be affected*

*Staff  
Observation:*  
**Satisfactory**

- Staff sees no affect in this area with a renewal

## Ease of Administration

*Staff*

*Observation:*

**Satisfactory** –

Performed very well

considering the magnitude of the transition.

Continues to be responsive whenever issues are raised.

- Member communications
- Formulary
- HSA's
- Staffing
- Enrollment
- Data System
- Claims data
- COB
- Premium Reconciliation
- ACA compliance
- Part D
- Reporting

Financial  
position of the  
carrier

## General

- For the year ended December 31 the plan shows a net loss of \$(73,243,122)
- For the YTD (as of March 31) the plan shows a net loss of \$(7,418,297)
- In 2015 the amount of surplus that was added or “paid in” was \$110,512,000
- An additional amount is anticipated to be paid in 2016
- Sanford operations are not providing sufficient revenue to support the cost of plan operations or benefit payments at this time. Sanford Health Plan relies on Sanford Health for funding but has a plan to be self sustaining by 2018

# Financial position of the carrier

Operations

Balance Sheet

Ratios

## Operations:

- First quarter underwriting (loss) of \$8.7 million
- Loss includes all lines of business
- We anticipate mitigating our overall losses from operation improvements
- Plan to have favorable operating results in CY17 for all lines of business

## Balance Sheet:

- Cash and investments grew from \$81.9 million to \$95.4 million
- Assets of \$225 million
- Liabilities of \$180 million
- No material changes on balance sheet and cash flow statement

## Ratios:

- RBC level @ 200% - Above Company Action Level
- All ratios in compliance with DOI standards

Financial  
position of the  
carrier

Staff  
Observation:  
**Concern**

- Given the previous financial portrait the consideration to seeking a guarantee that Sanford Health will continue to support Sanford Health Plan for the 2017-19 Biennium if the plan is renewed may be supportive.

*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*

- **Staff Observation: Satisfactory**

# 9A. PROJECTIONS

---

- Projection based on Sanford History
- Projection based on Sanford History with Modifications supplied by Sanford
- Projection based on PERS History trended forward

# Claims Projection Methodology

*Prior claims data is adjusted and projected forward using trend data to the new projection period in order to estimate premium rates and rate increases.*

## Define Base Experience Data

- This data is used to project forward to the new period
- Most recent available data should be used
- 2 years for small groups, 1 year is sufficient for larger groups
- Full calendar years are necessary to avoid seasonality distortions

## Adjustments to Base Data

- Apply a factor for incomplete claims (e.g. claims incurred but not yet reported or paid)
- Adjust for other factors causing differences between base and experience period (contract changes, plan design changes, mandated coverage, population/risk changes, etc)
- Convert claims to per member per month (PMPM)

## Apply Trend Factors

- Accounts for inflation in cost of services & amount of care/utilization
- Separate factors should be used for medical and pharmacy
- Amount of trend depends on the number of months between the midpoints of the base period and the experience period

## Convert Claims to Premiums

- Add in known fixed fees (administrative fees, ACA fees, premium tax, risk charge, etc)
- If actual fees are not known, apply an estimated loss ratio (claims as a percent of premium)
- Multiply by current membership to project total costs
- Compare new estimated premium rates to prior period's

# Claims Projection Scenarios

## Scenario #1 Sanford Unadjusted

- Scenario 1 uses Sanford PERS claims from July 1, 2016 to June 30, 2016 paid through July 31, 2016.
- The claims are adjusted for IBNR and trended to the projection period.
- There are no other adjustments made to the data for known changes (provider contracts, operational, etc.) that occurred or will occur between the base period and experience period.

## Scenario #2 Sanford Adjusted

- Scenario #2 base period data and trend applied are the same as Scenario #1
- Adjustments have been made to the medical and pharmacy data for contractual changes and operational improvements occurring between the base and experience period.
- These changes include no 2017 cost trend for several providers, new Outpatient services contracts (APC-based) and a new contract with Express Scripts (PBM), new pre-auth system for high-tech imaging, and others.

## Scenario #3 Prior Claims

- Scenario #3 uses prior claims from July 1, 2014 to June 30, 2016 paid through July 31, 2016.
- The claims are adjusted for IBNR and trended to the projection period (same '17-'18 trend rates as Scenario #1-2, BCBS book of business trend for '15-'16)
- No other adjustments were made to the data. There were PPO discounts that may have been PERS specific and would not apply in the projection period. The impact is noted in the footnote of the projection.

**North Dakota PERS**  
**Claims Projection Summary**  
**Scenario 1 - Sanford claims**

	Medicare (Excluding PDP)	Non-Medicare	Total
Experience Period	7/1/15 - 6/30/16	7/1/15 - 6/30/16	7/1/15 - 6/30/16
Projection Period	7/1/17 - 6/30/19	7/1/17 - 6/30/19	7/1/17 - 6/30/19
<b>Claims</b>			
Paid Medical Claims	\$12,651,869	\$225,684,267	\$238,336,136
Incurred But Not Reported (IBNR) Completion Factor	0.83443	0.86574	0.86402
Completed Medical Claims	\$15,162,372	\$260,682,354	\$275,844,727
Medical Claims Cost (PMPM)	\$146.67	\$372.71	\$343.60
Other Adjustment Factors <sup>1</sup>	1.000	1.000	1.000
Annual Trend Factor <sup>1</sup>	3.20%	6.00%	5.85%
Projected Incurred Medical Claims (PMPM)	\$158.68	\$431.15	\$396.07
Paid Prescription Drug Claims		\$51,049,004	\$51,049,004
Incurred But Not Reported (IBNR) Completion Factor		0.95696	0.95696
Completed Drug Claims		\$53,344,741	\$53,344,741
Rx Claims Cost (PMPM)		\$76.27	\$76.27
Expected Rx Rebates <sup>2</sup>		(\$6.91)	(\$6.91)
Other Adjustment Factors		1.000	1.000
Annual Trend Factor <sup>1</sup>		7.20%	7.20%
Projected Incurred Rx Claims (PMPM)		\$82.52	\$82.52
Total Claims (PMPM)	\$158.68	\$513.68	\$478.59
Projected Incurred Medical/Rx Claims (PEPM)	\$213.07	\$1,306.46	\$1,068.18
Current Subscribers (per Sanford Jun-16)	6,368	22,852	29,220
<b>Projected Total Claims Cost</b>	<b>\$32,563,802</b>	<b>\$716,526,541</b>	<b>\$749,090,343</b>
Target Loss Ratio <sup>3</sup>	86%	93%	92%
Required Premium	\$37,864,886	\$772,952,040	\$810,816,926
Monthly Premium PEPM (June 2016 per Sanford)	\$242	\$1,074	\$892.41
Current Premium (June 2016 enrollment)	\$36,943,165	\$588,888,826	\$625,831,991
Required Rate Increase	2.5%	31.3%	29.6%

## Discounts

Level of discounts have contributed to losses this year. While plan appears to address the issue, there is no quantitative way that staff or Deloitte can validate the plan.

### **Staff Observation:**

Concern —Sanford does have a plan to address these losses; however, with no quantitative way to assure its success this remains a significant risk to our reserves and Sanford Health Plan.

### Operational Savings



Total annual improvement of **\$30 million** achieved from contracting and claims management implementation.

**North Dakota PERS**  
**Claims Projection Summary**

**Scenario 2 - Sanford claims (adjusted)**

	Medicare (Excluding PDP)	Non-Medicare	Total
Experience Period	7/1/15 - 6/30/16	7/1/15 - 6/30/16	7/1/15 - 6/30/16
Projection Period	7/1/17 - 6/30/19	7/1/17 - 6/30/19	7/1/17 - 6/30/19
<b>Claims</b>			
Paid Medical Claims	\$12,651,869	\$225,684,267	\$238,336,136
Incurred But Not Reported (IBNR) Completion Factor	0.83443	0.86574	0.86402
Completed Medical Claims	\$15,162,372	\$260,682,354	\$275,844,727
Medical Claims Cost (PMPM)	\$146.67	\$372.71	\$343.60
Other Adjustment Factors <sup>1</sup>	1.000	0.915	0.919
Annual Trend Factor <sup>1</sup>	3.20%	6.00%	5.85%
Projected Incurred Medical Claims (PMPM)	\$158.68	\$394.33	\$363.99
Paid Prescription Drug Claims		\$51,049,004	\$51,049,004
Incurred But Not Reported (IBNR) Completion Factor		0.95696	0.95696
Completed Drug Claims		\$53,344,741	\$53,344,741
Rx Claims Cost (PMPM)		\$76.27	\$76.27
Expected Rx Rebates <sup>2</sup>		(\$6.91)	(\$6.91)
Other Adjustment Factors		0.872	0.872
Annual Trend Factor <sup>1</sup>		7.20%	7.20%
Projected Incurred Rx Claims (PMPM)		\$71.92	\$71.92
Total Claims (PMPM)	\$158.68	\$466.25	\$435.91
Projected Incurred Medical/Rx Claims (PEPM)	\$213.07	\$1,185.84	\$973.84
Current Subscribers (per Sanford Jun-16)	6,368	22,852	29,220
<b>Projected Total Claims Cost</b>	<b>\$32,563,802</b>	<b>\$650,374,156</b>	<b>\$682,937,958</b>
Target Loss Ratio <sup>3</sup>	86%	93%	92%
Required Premium	\$37,864,886	\$701,590,244	\$739,455,130
Monthly Premium PEPM (June 2016 per Sanford)	\$242	\$1,074	\$892.41
Current Premium (June 2016 enrollment)	\$36,943,165	\$588,888,826	\$625,831,991
Required Rate Increase	2.5%	19.1%	18.2%

**North Dakota PERS**  
**Claims Projection Summary**  
**Scenario 3 - [7/1/14 - 6/30/15] experience**

Experience Period
Projection Period

Total	
7/1/14 - 6/30/15	
7/1/17 - 6/30/19	

**Claims**

Paid Medical and Pharmacy Claims
Incurred But Not Reported (IBNR) Completion Factor
Completed Medical and Pharmacy Claims
Medical Claims Cost (PMPM)
Other Adjustment Factors
Annual Trend Factor <sup>1</sup>
Projected Incurred Medical Claims (PMPM)
<b>Total Claims (PMPM)</b>
Projected Incurred Medical/Rx Claims (PEPM)
Current Subscribers (per Sanford Jun-16)
<b>Projected Total Claims Cost</b>

\$257,068,657
1.00000
\$257,068,657
\$324.45
1.000
6.54%
\$405.02
\$405.02
\$917.62
29,220
<b>\$643,506,579</b>

Fixed costs (retention)
Required Premium
Monthly Premium PEPM (June 2016 per Sanford)
Current Premium (June 2016 enrollment)
Required Rate Increase
Required Rate Increase (w/loss of NDPERS BCBS discounts) <sup>2</sup>

\$72,294,973
\$715,801,552
\$892
\$625,831,991.35
<b>14.4%</b>
<b>16.0%</b>

# Observations

- Sanford's renewal amount is less than that projected by Deloitte for Sanford with operational changes
- If Sanford performs going forward based upon its history PERS will lose 3 million plus any possible gain.
- If Sanford performs going forward as projected with the Sanford modifications the PERS plan would lose .8% (difference between Sanford Renewal and Deloitte).
- If the PERS historical claims trended forward would be achieved in a bid the PERS increase could be 14.4%. This would be lower than the renewal bid by 3.0% points.
- If PERS was to self fund:
  - Not paying the ACA fees would save about 2.6% off the above scenarios. After consideration for Stop-Loss coverage and extra administration it would be about \$10 million or 1.6% of premium.
  - No risk charge from the carrier would be 1% savings.

## ACA Fees

### **Staff**

### **Observation:**

**Concern** –This is a significant cost to the plan.

- Presently Sanford ACA fee is approximately \$685,000 of our monthly premium payment.
- With the total premium being approximately \$26 million the ACA fee is 2.6% of premium or about \$31 per contract.
- Not a cost if self insured

# Observations

- Likely outcome if PERS is to renew with Sanford is that claims would come in between the Sanford bid amount (17.4%) and the Deloitte Sanford projections (29.6%) and PERS will likely lose the \$3 million risk sharing amount.
- Possible outcome in a rebid is that:
  - Sanford could consider lowering its bid slightly.
  - We could get a lower bid possibly around 14.4%
  - Self insured could be as low as 11.8%

# Projections

Staff Observation: Concern

# 9B. ADMINISTRATIVE COSTS

Sanford is currently charging **\$11.60** per member per month for administration. The renewal proposes an increase of **44.5%** to **\$16.76** per member per month. The BCBS cost in the prior bid was \$16.37 per member per month.

---

- Administration was a topic of discussion with proposal.
- Fewer employees than originally proposed?
- Historically an area for concern and focus for the NDPERS Board.

**Staff Observation: Concern**

# Observations

- Sanford has done satisfactory in many areas:
  - Meeting the Performance Criteria
  - Payment accuracy
  - Payment processing time
  - Wellness
  - Special programs
    - Accordant Care, About the Patient, Health Pregnancy, Life Advocate
  - Development of the Network
  - Member out of pocket
  - Economy to be effected
  - Employer and Member Participation
  - Ease of administration

# Observations

- Areas of Improvement that have been identified for Sanford:
  - Service Metrics
  - Member survey results
  - Pharmacy relations
  - Medical Home
  - EOB (Explanation of benefits)

# Observations

- Areas of Concern:
  - Discounts
  - Administrative Cost increase
  - Member Rebate Accounts
  - Financial position of carrier
    - Sustainability due to losses
    - While a plan is in place to reverse losses it can will only be proven in implementation
    - What if plan is not 100% successful will Sanford Health continue to support Sanford Health Plan?
  - Renewal Premium

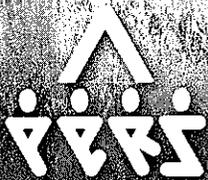
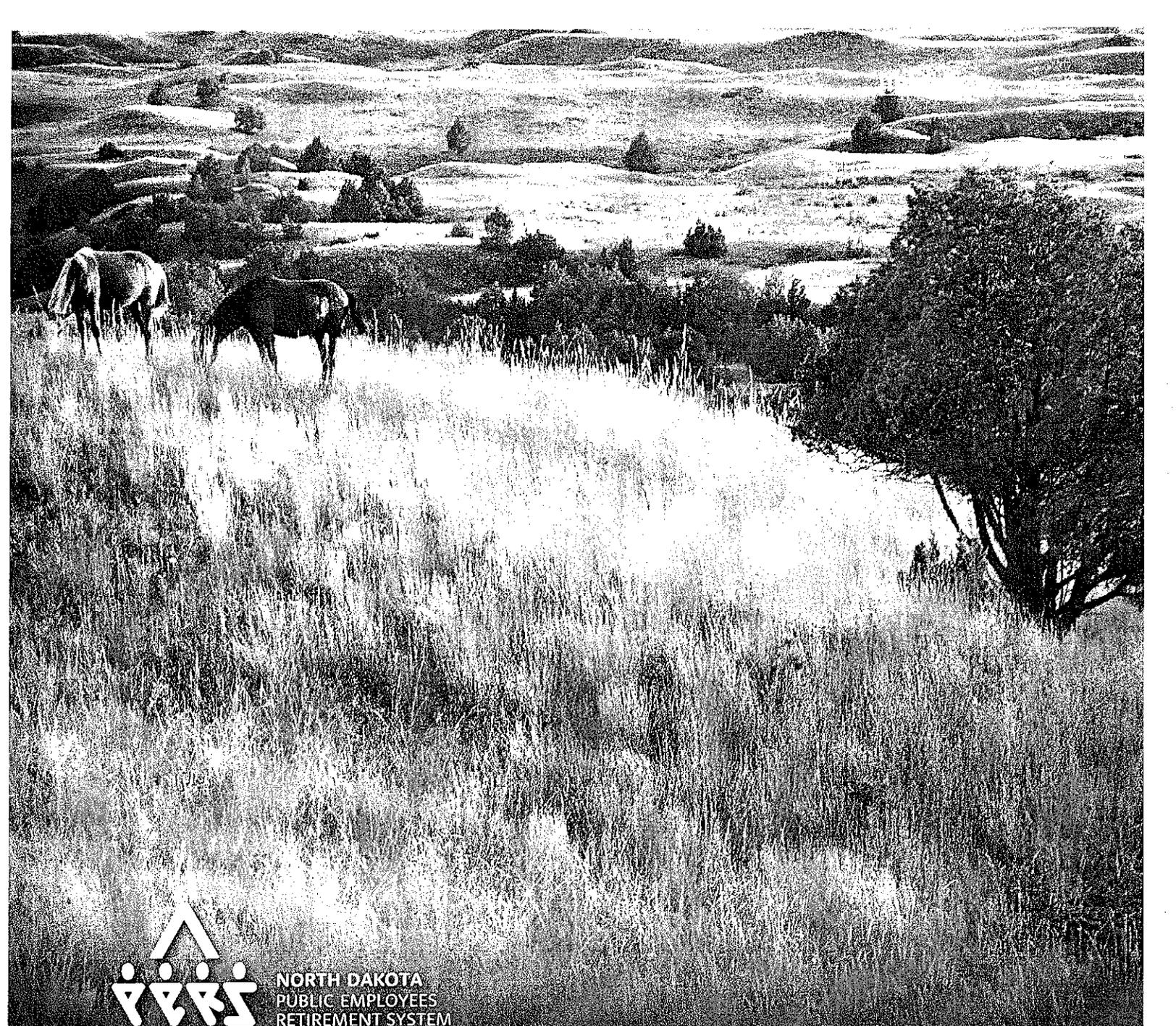
# Observations

- Concerns focus on financial performance & renewal amount
  - Numbers indicate
    - In a rebid a fully insured bid could be offered in the 14% to 16% range
    - If we renew it is possible that we would lose another 3 million since we have no way to measure the success of the operational savings plan. If it is not fully successful the plan will lose money
    - If we are to renew it would be beneficial to get some additional guarantees from Sanford Health and consider changing the risk sharing
    - Likely would be cheaper to self insure by about 2.5% from any of the projections
  - This information today is only estimates; the only way to confirm is to bid
  - If we elect to bid you may want to consider other options for consideration (topics for another meeting)
    - EPO
    - More than one carrier

# Observations

- This information today is only estimates; the only way to confirm is to bid
- Our first decision is if we should go to bid or not
  - If not
    - Do we want to consider other options in the bid
      - EPO
      - Multiple fully insured plans
      - ?

	<b>Review Areas</b>	<b>Staff Observation</b>
1	Review Economic/ Policy Environment	Concern
2	Review PERS Funded position and expected funded position	Concern
3	Review of Contract Performance Measures	Satisfactory
4	Review the carrier's payment accuracy, claims processing time,	Satisfactory
5	Review the carrier's member service center metrics	Improvement
6	Review the carrier's wellness participation measures	Satisfactory
7	Review the carrier's special program participation levels	Satisfactory
8	Review member survey results	Improvement
9	a) Use the services of a consultant to concurrently and independently prepare renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.	Concern
	b) Administrative Costs	Concern
10	Other areas reviewed by the Board	
	a) Pharmacy	Improvement
	b) Network	Satisfactory
	c) Discounts	Concern
	d) Member out of pocket	Satisfactory
	e) Funding for other programs	Concern
	f) Medical Home	Improvement
	g) EOB	Improvement
	h) Cost effect of ACA on fully insured plans	Concern
General Evaluation Criteria		
	i) Employer & Member participation	Satisfactory
	j) Member Rebate Account	Concern
11	a) The economy to be affected	Satisfactory
	b) The ease of administration.	Satisfactory
	c) The adequacy of coverages (see other items the board may want to consider)	(See above #10)
	d) The financial position of the carrier, with special emphasis as to its solvency	Concern
	e) 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.	Satisfactory
	1 & 2 above are not related to Sanford	



NORTH DAKOTA  
PUBLIC EMPLOYEES  
RETIREMENT SYSTEM

# Health Insurance Renewal

**SANFORD**  
HEALTH PLAN

**SANFORD<sup>®</sup>**  
HEALTH PLAN



**Dear NDPERS Board Members,**

Sanford Health and Sanford Health Plan are honored to provide health insurance coverage to state employees of North Dakota, both active and retired. It's a responsibility and a commitment we do not take lightly.

Sanford Health is dedicated to the work of health and healing and delivering the highest quality care. Sanford Health Plan shares that commitment and is supported by the strength of the \$4 billion Sanford Health organization.

Since its inception nearly two decades ago, Sanford Health Plan has a proven record of integrity and adeptness in providing comprehensive insurance coverage to all our members. We honor our promises and leave no stone unturned in serving our members. Sanford and NDPERS share the same geographic footprint and population, which further reinforces our commitment to serve this area.

A sincere thank you to the board and staff of NDPERS who worked side by side with us this past year during the transition. It was a significant undertaking after 37 years with a legacy provider. We remain firm in our commitment to do everything in our power to provide the best member experience and service possible and to address any issues or concerns quickly and efficiently.

This book highlights the past year's performance, the robust provider network, the sustainability of the plan, examples of our support for NDPERS members and renewal details. Today, we are pleased to show we've honored our promises, managed a significant transition and delivered on performance, all while increasing access.

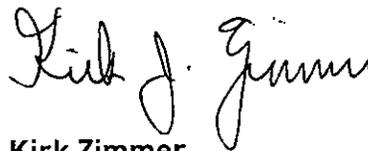
Our continued partnership with you will be necessary as we move forward and seek opportunities to keep insurance affordable and sustainable for all members.

Thank you for choosing Sanford Health Plan. We look forward to the opportunity to serve you for many years to come.

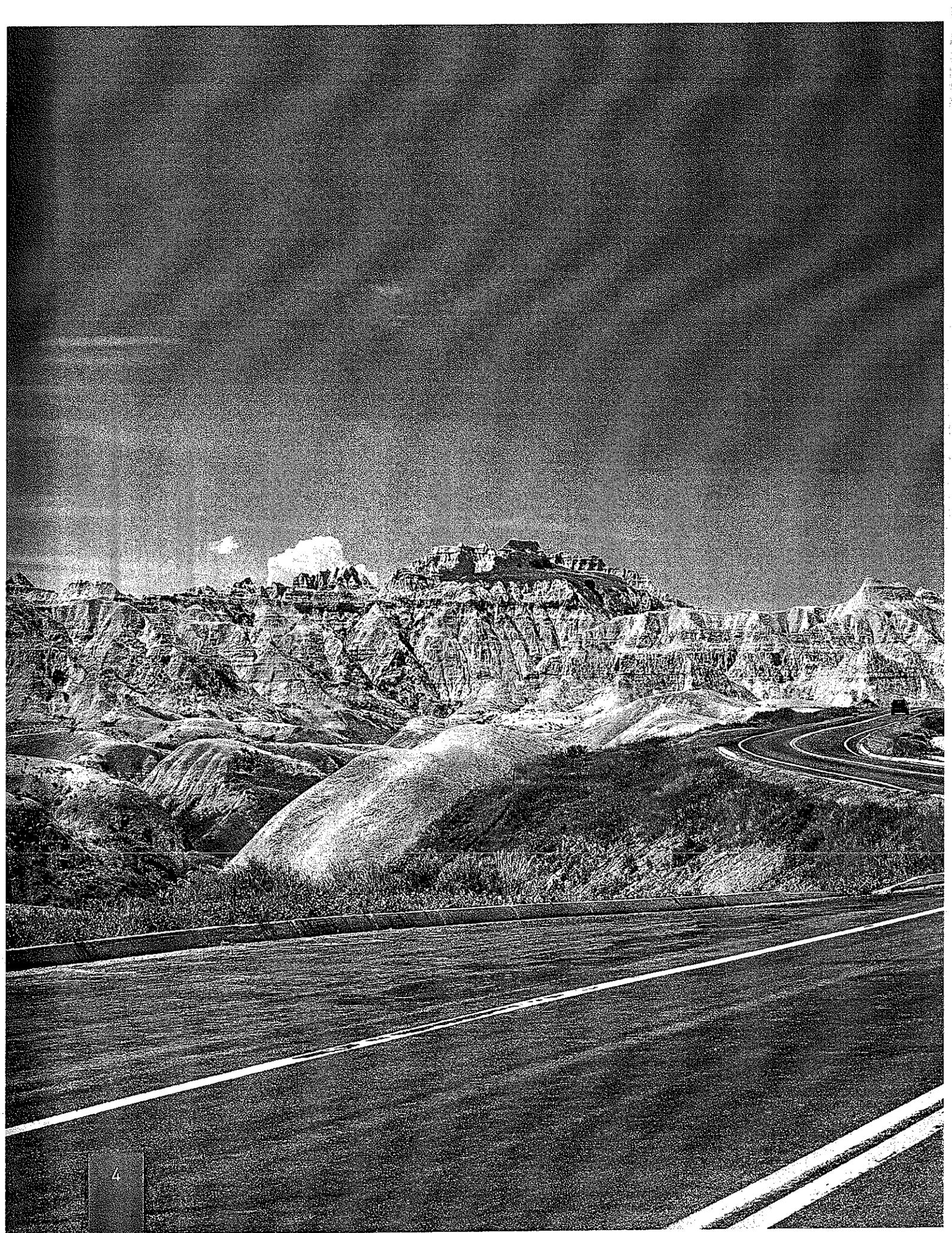
Sincerely,



**Kelby Krabbenhoft**  
President and CEO  
Sanford Health



**Kirk Zimmer**  
Executive Vice President  
Sanford Health Plan



# TABLE OF CONTENTS

<b>Executive Summary</b>	<b>6</b>	<b>Renewal</b>	<b>16</b>
<b>Access</b>	<b>8</b>	<b>Cost Savings</b>	<b>18</b>
<b>Performance</b>	<b>10</b>	<b>In Summary</b>	<b>20</b>
<b>Sustainability</b>	<b>14</b>		

# EXECUTIVE SUMMARY

## Milestones Reached:

- 1 Opened **TWO** North Dakota offices
- 2 Hired **85 NEW STAFF**
- 3 Provided a **DEDICATED ACCOUNT EXECUTIVE** to NDPERS
- 4 Hired a **DEDICATED ASSOCIATE CHIEF MEDICAL OFFICER**
- 5 **LED THE SEAMLESS TRANSITION** from a 37 year legacy provider
- 6 Held **72 FACE-TO-FACE** member transition meetings **IN 18 CITIES**
- 7 **EXPANDED THE NETWORK** of providers and pharmacies
- 8 Created a **NEW WEB PORTAL**, with provider directory, and communication avenues for members
- 9 Launched a **ROBUST WELLNESS PORTAL**
- 10 **MET PERFORMANCE GOALS** ahead of schedule to date



**“Every Sanford person I have dealt with or spoke to has been just wonderful!”**

ANNE H., DAKOTA GRANDFATHERED ACTIVE

### Accomplishments:



**67,248** ID cards printed



**67,971** Member calls received



**13,689** Members logged in to mySanfordHealthPlan

### Claims paid:



**1,008,022** Total claims

**\$254,724,441** Total claim dollars

**490,250** Prescription claims

### Dakota Wellness Program



Health assessments completed

- **8,145** Completed July 1 - Dec. 31, 2015
- **5,790** Completed April 1 - June 30, 2016



**21,847** Members engaged in non-health assessment activities



Redemption Center Orders

- **3,563** Orders July 1 - Dec. 31, 2015
- **2,259** Orders April 1 - June 30, 2016

# ACCESS

Sanford Health Plan wants to ensure NDPERS members have access to a comprehensive network of providers. During this year, we achieved our goal of building a robust and complete network of providers across the region for you and your members.

---

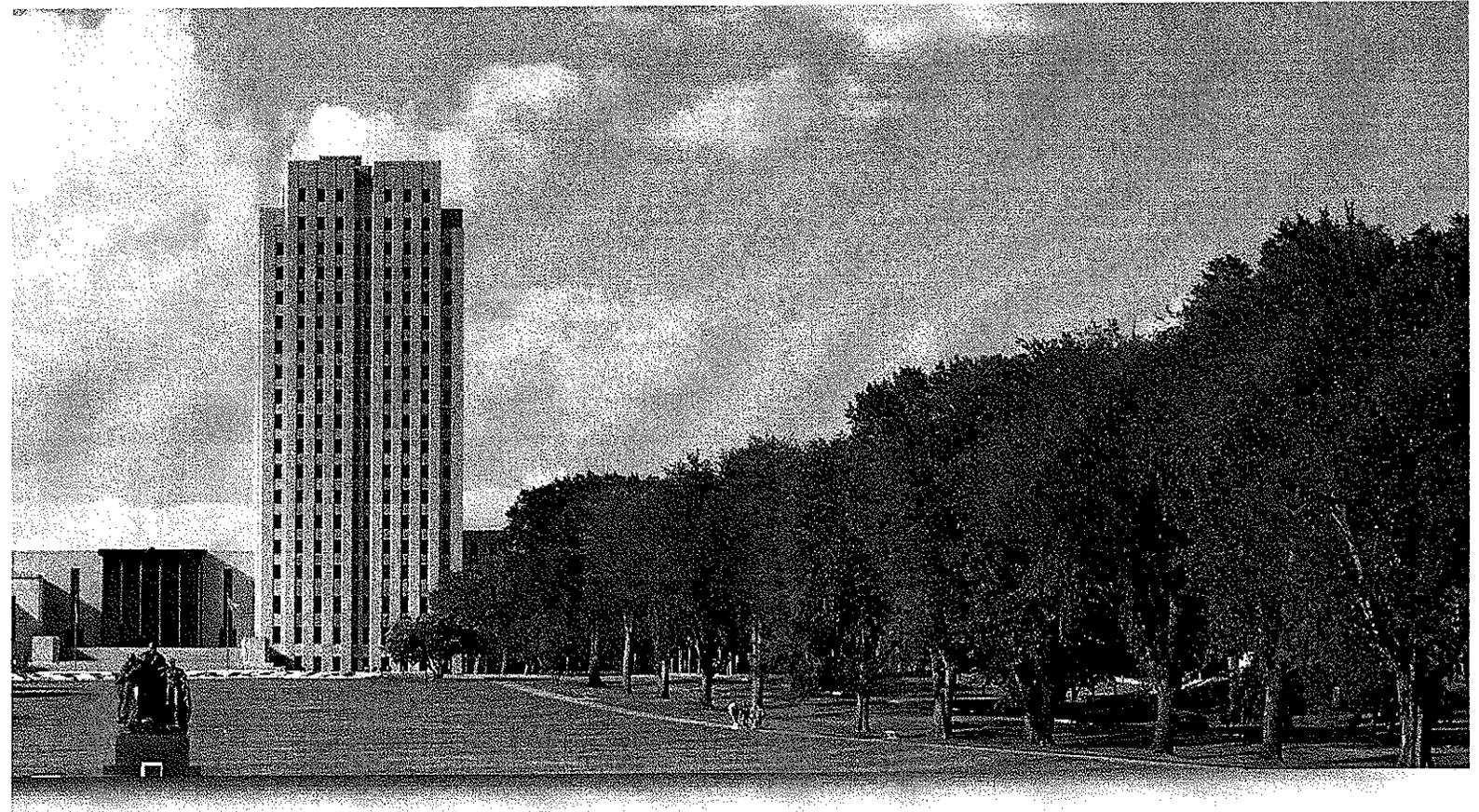


- 99%** Previous NDPERS providers are contracted
- 853** New provider contracts since February 2015
- 214** Additional providers not offered by legacy carrier

Our team continues to work with Express Scripts, Inc. (ESI) and the ND pharmacy board for better pharmacy coverage.



- 194** Pharmacies in-network
- 43** Rural pharmacies recontracted to achieve a complete at-market rural network

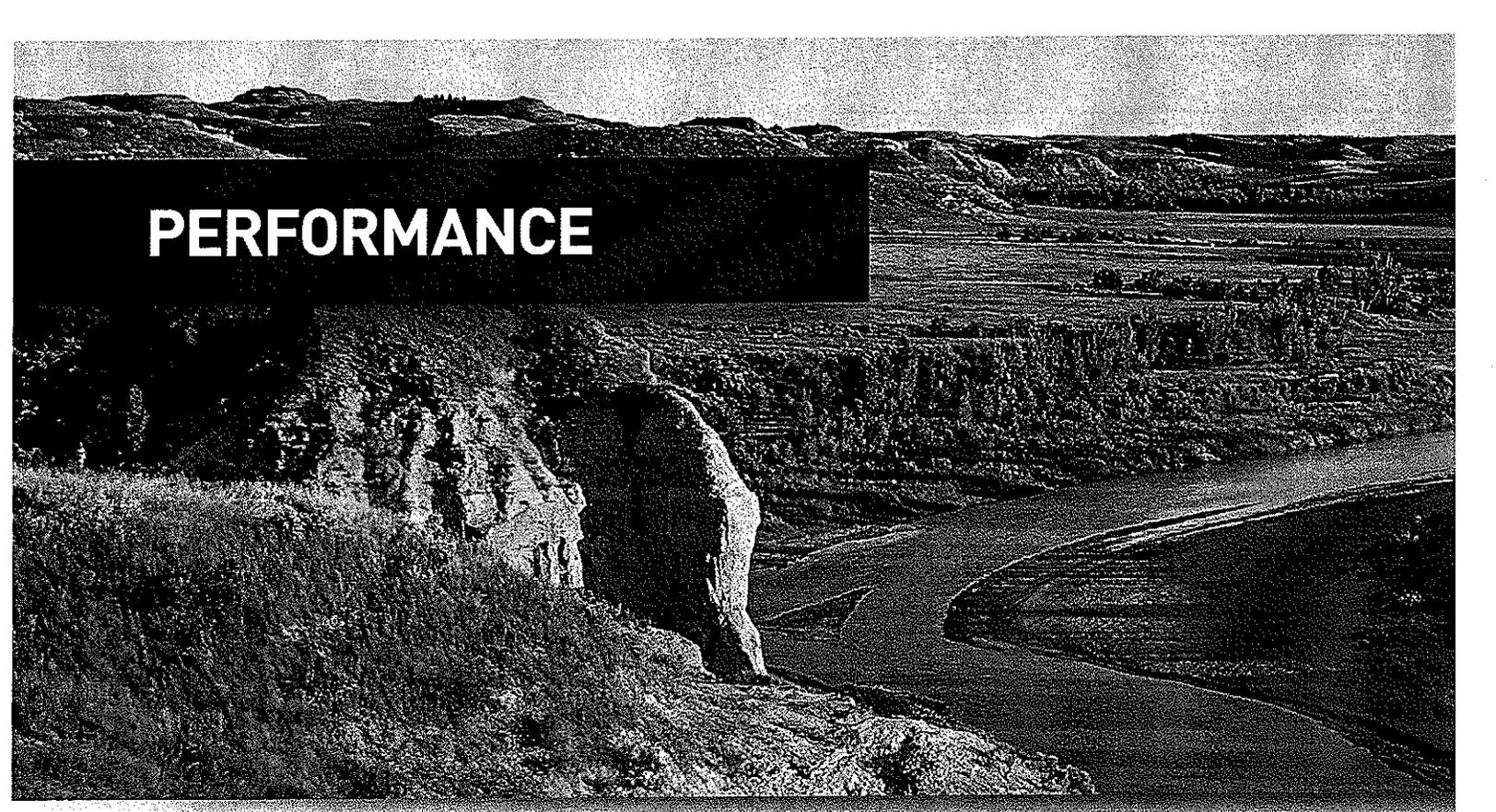


**The Sanford Health Plan NDPERS Network Encompasses:**

- 99% Facilities
- 99% Professional providers
- 96% Pharmacy network

**“I am thoroughly impressed with Sanford Health Plan thus far. Your automatic voice in your queue stated it would be a long hold time, however I got a member services representative within 30 seconds. You guys are pleasant to work with.”**

MARY M., RETIREE MEDICARE SUPPLEMENT



# PERFORMANCE

Our goal is to not only meet, but exceed NDPERS' expectations of our performance.

- An independent consultant performed an operational review validating our performance and performance guarantees.
- We have met or exceeded four performance guarantees due on or before July 1, 2016.
- A survey of our performance with your membership was completed, and results show high member satisfaction with Sanford Health Plan.

**“Everyone I have spoken to has been very helpful and kind. I feel reassured the transition is going to work out fine.”**

MARILYN B., RETIREE MEDICARE SUPPLEMENT



## Performance Levels

An independent operational review was performed and encompassed audit claims, contract configurations and performance guarantees. Today, five of the six performance goals have been met, and the Sanford Health Plan team is tracking data and will bring our 97.25 percent claims timeliness status to the 99 percent goal by the deadline next July.

Operational Review Executive Summary	Goal	Current Status Level*
Claims financial accuracy	≥ 99%	99.73%
Claims payment incident accuracy	≥ 97%	97.71%
Claims paid timeliness	≥ 99%	97.25%
Minimum provider discount from in-network providers	≥ 30%	34.5%
Average speed of call answered	≤ 45 sec.	41.4 sec.
Call abandon rate	≤ 7%	5.70%

\*All measures due at the biennium.

**“What a great job the customer service team did, even going out of their way to get the pharmacy on the phone to get my situation straightened out.”**

BRANDY Z., DAKOTA GRANDFATHERED ACTIVE

### Performance Guarantees

Five performance guarantees were due on or before July 1, 2016.

Measure	Goal	Outcome Reporting Date	Outcome
Health Risk Assessment	≥ 10%	Dec. 31, 2015	17.7%
Hospitals and Physicians within Network	Hospital ≥ 85% MDs & DOs ≥ 85%	Dec. 31, 2015	Hospital=94% MDs & DOs=87%
bWell Participation	≥ 10%	Dec. 31, 2016	10.8%
Health Club Credit	≥ 1,950	July 1, 2016	1,857*
Medical Home Enrollment	≥ 30%	July 1, 2016	36.5%

\*Vendor expects to submit Health Club Reimbursements to Sanford Health Plan within three months to determine final outcome.

## NDPERS Member Experience Survey

From June to early July 2016, a random sampling of the NDPERS membership was surveyed on their experience. Less than one year following the transition from the NDPERS long-term health insurance provider, most members are satisfied with their service from Sanford Health Plan.

### General Survey:

- **80.7%** Agree that their health insurance claims are processed accurately.
- **77.2%** Agree that their claims are processed in a timely manner.
- **80.4%** Agree that the printed materials or internet resources are helpful.

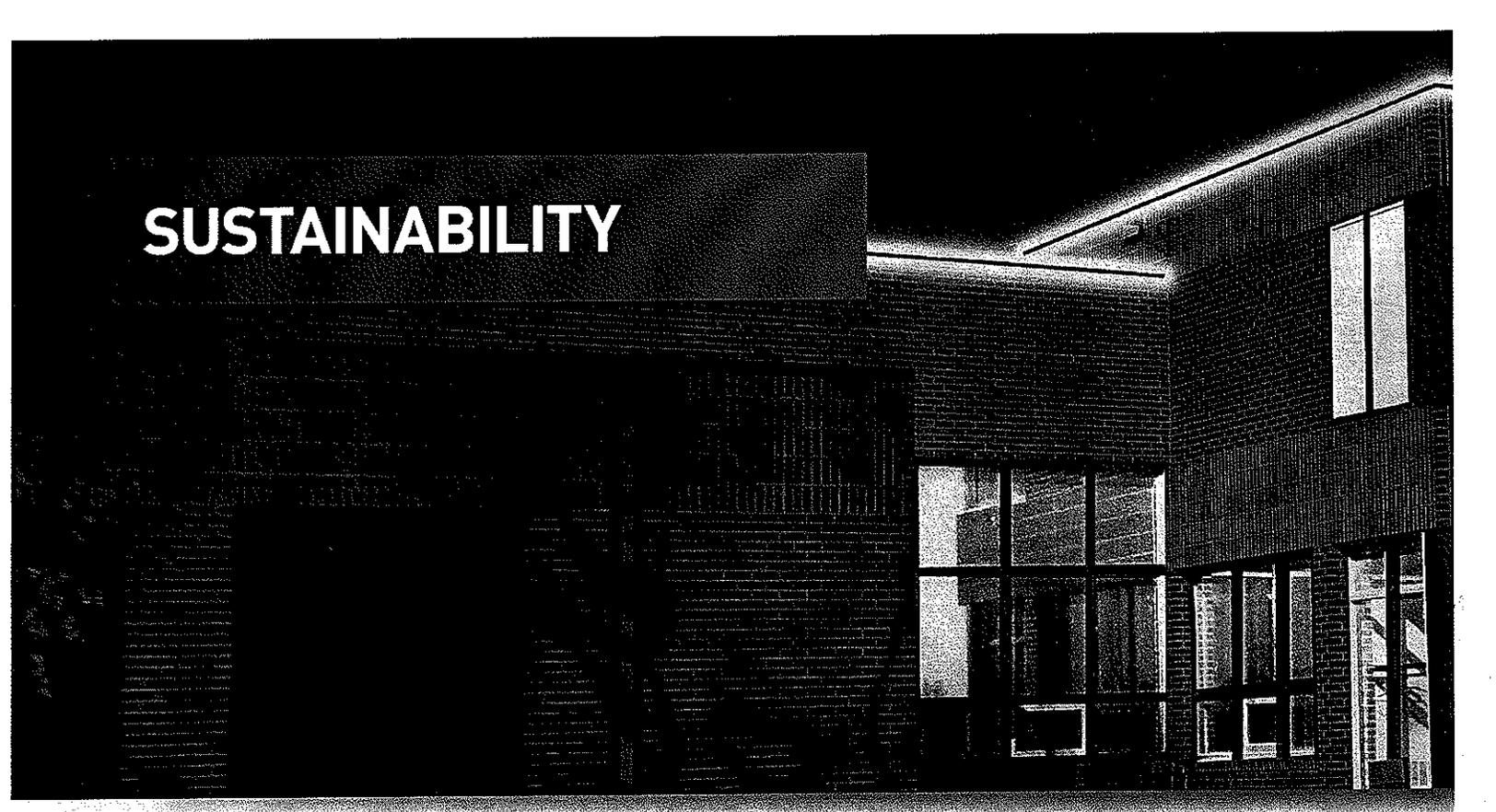
### Member Services:

- **86.9%** Reported that their issue was resolved, including 61.3 percent who reported that the information or help they needed was provided during the initial call.
- **69.3%** Of Sanford Health Plan Member Services callers are satisfied with the service received when they called.
- **90.5%** Agree that the service representative was courteous and respectful.

**“Change is hard for people my age,  
but so far you are doing an amazing job.”**

KATHLEEN S., RETIREE MEDICARE SUPPLEMENT

# SUSTAINABILITY



Sanford Health Plan is committed to a long-term partnership with NDPERS. During the bidding process, we developed a proposal based on limited trend information and detailed claims assumptions.

We have learned a great deal about the NDPERS membership since becoming your provider and that has better enabled us to develop a sustainable, renewal proposal. As part of Sanford Health, we are prepared to meet that long-term commitment to you.

---

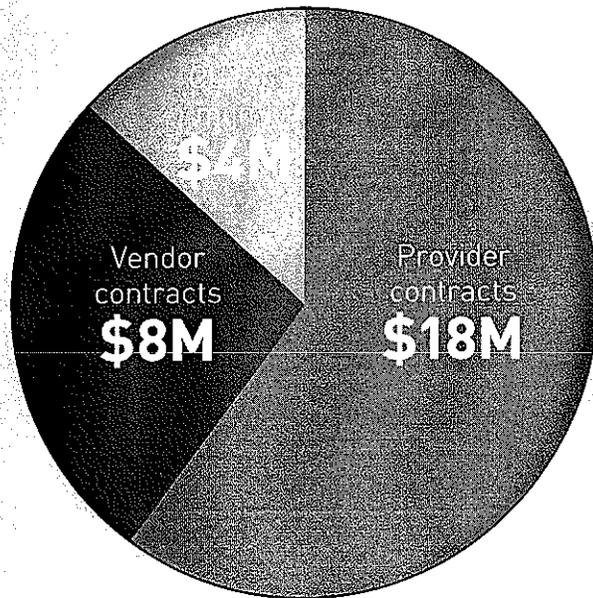
## Financial Opportunities

- New market-based contracts with providers
- Claims management software
- Vendor contracts re-negotiation:
  - o Pharmacy Benefit Management
  - o National Wrap Network

# SANFORD HEALTH PLAN

1749

## Operational Savings



Total annual improvement of **\$30 million** achieved from contracting and claims management implementation.

# RENEWAL



In 2014, we submitted a bid comparable to the legacy insurer. That bid was developed using national trend data and assumptions on historical NDPERS utilization. Today, based on increased understanding of your memberships' trends this past year, we are bringing forward solutions in order to provide you and your members affordable and quality coverage.

---

## Trends

- Trend assumptions were analyzed to determine a **6.0 percent increase for medical** and **12.0 percent increase for prescriptions** per year (7.0 percent weighted average).
- Over the last twelve years, the average NDPERS premium trend is an increase of **7.3 percent** per year. This trend is driven by price (e.g. specialty drugs, etc.) and not utilization.

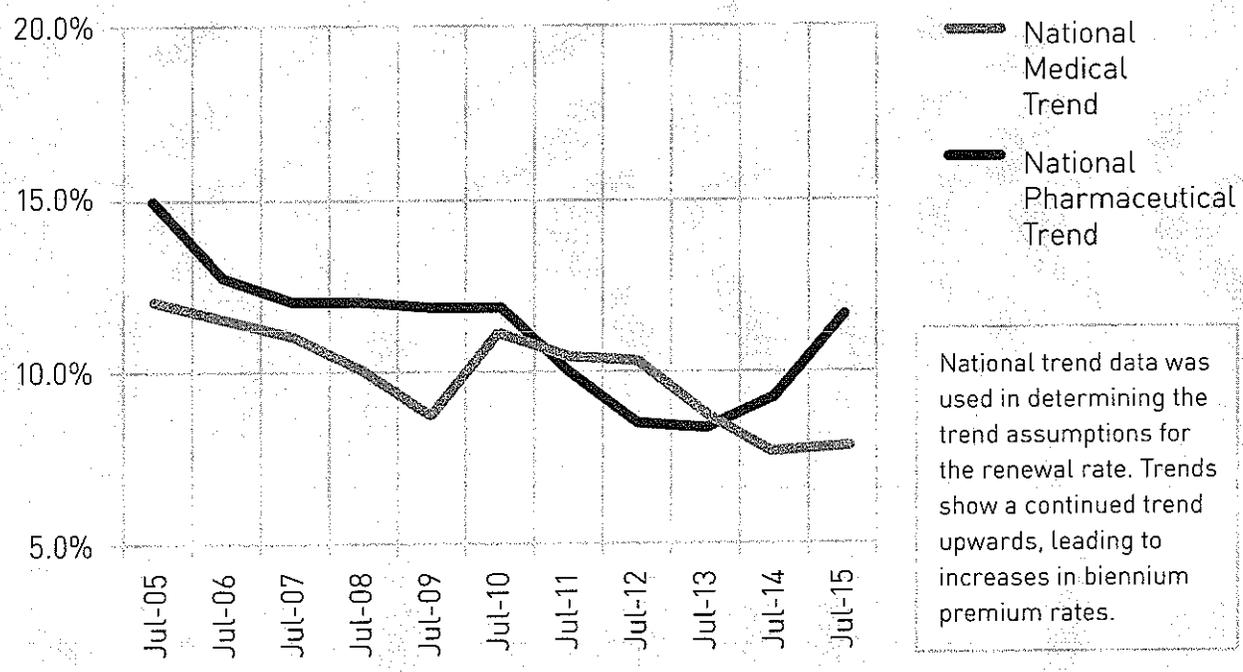
## Renewal Rate

Using these national medical and pharmacy trends, along with information we have learned this past year as your insurer, we propose these renewal rates for the next biennium.

- A NDPERS renewal increase of **17.4 percent**, or **8.7 percent per year**.
- A Medicare supplement increase of **6.5 percent** based on 5.0 percent trend.



### Benchmark Medical/Pharmaceutical Trend



## NDPERS Alternative Innovative Options

### In-State Network

An in-state network benefits NDPERS by keeping the renewal rate as low as possible. This option gives members access to quality providers in North Dakota, where this network includes 99 percent of the providers within the state.

It also keeps more dollars in the state. According to NDPERS claim data, an estimated \$40 million dollars leaves the state due to care provided outside of North Dakota.

	<b>Current Services</b>	<b>Next Biennium In-State Services</b>	<b>Next Biennium Out-of-State Services</b>
Deductible			
• Individual	\$500	\$500	\$2,500
• Family	\$1,500	\$1,500	\$5,000
Coinsurance	80%	80%	50%
Out of pocket maximum			
• Single	\$1,500	\$1,500	\$5,000
• Family	\$3,500	\$3,500	\$10,000

## Summary of Cost Savings

Options	Estimated PPO Change Percentage	Savings for State Employees (Millions)	Savings for Political Subs & Retirees (Millions)
<b>Annual Premium Reduction for Pharmaceutical Changes</b>	1.1%	\$2.8	\$1.0
*From \$5 to \$10 change in generic copay			
*From \$20 to \$25 change in formulary brand copay			
*From \$25 to \$30 copay in non-formulary copay			
*From \$1,000 coinsurance to \$1,200 coinsurance			
<b>Increase in Office Visit/Emergency Room Copays</b>	0.9%	\$2.3	\$0.8
*From \$25 to \$30 copay in office visit			
*From \$50 to \$60 copay in emergency room copay			
<b>Annual Premium Reduction to Deductible</b>	0.6%	\$1.5	\$0.6
*From \$400 single/\$1,200 family to \$500 single/\$1,500 family			
<b>Annual Premium Reduction to Change in Coinsurance Maximum</b>	1.8%	\$4.5	\$1.7
*Change from \$750/\$1,500 to \$1,000/\$2,000			
<b>SUB-TOTAL Grandfathered Savings</b>	<b>4.4%</b>	<b>\$11.1</b>	<b>\$4.2</b>
<b>Create In-State Network</b>	5.0%	\$12.6	\$4.7
<b>Change to Non-Grandfathered Option of \$1,500</b>	7.6%	\$19.1	\$7.2
<b>Include Grandfathered Plan Design Changes</b>	4.4%	\$11.1	\$4.2
<b>Loss of Grandfathered status</b>	-3.0%	-\$7.5	-\$2.8
*Includes 100% preventative care			
*Includes other grandfathered option changes above			
<b>SUB-TOTAL Non-Grandfathered Savings</b>	<b>14.0%</b>	<b>\$35.3</b>	<b>\$13.3</b>
<b>Add 5% to Employee Contribution to Premium</b>	5.0%	\$12.6	\$4.7
<b>TOTAL OPPORTUNITY (Non-Grandfathered)</b>	<b>19.0%</b>	<b>\$47.9</b>	<b>\$18.0</b>

# IN SUMMARY

The team at Sanford Health Plan is prepared and committed to continued service to the members of NDPERS and the State of North Dakota. State statute requires validation and review of certain criteria, and we are proud to have met all specified performance expectations during our first year as your provider.

- ✓ A review of performance guarantees revealed five of six goals were met ahead of schedule.
- ✓ A comprehensive member survey showed high member satisfaction with Sanford Health Plan.
- ✓ A robust and comprehensive network of providers was developed to increase access across the region.
- ✓ Opened two new North Dakota offices with dedicated staff and chief medical officer.
- ✓ Launched new communication and wellness portals for members.

Sanford Health Plan is dedicated to a long-term partnership with NDPERS. With the resources and financial backing of Sanford Health, we expect continued growth within the State of North Dakota. Our Sanford Health Plan team looks forward to serving as your insurance provider for the next two years and many years to come.

**SANFORD**  
HEALTH PLAN

# NDPERS MEMBER EXPERIENCE SURVEY

## **Executive Summary and Detailed Topline Report**

August 2016

Jointly Commissioned by the North Dakota Public Employees Retirement System & Sanford Health Plan

*Prepared by: Sanford Health Market Insights*

**SANFORD**  
HEALTH PLAN

**Dear NDPERS Board Members,**

Sanford Health Plan is pleased to provide the results of the 2016 NDPERS Member Experience Survey. The survey serves as a milestone in our relationship with NDPERS members and as a foundation for our efforts to continually improve member experience.

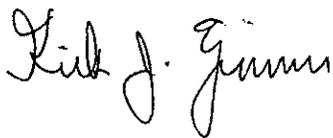
We are grateful that the NDPERS Board of Directors recommended expanding the effort beyond the small-scale call center surveys that were done by the legacy provider. While expanding the reach of the survey, we also raised the bar by asking more meaningful questions and strengthening the survey methodology. Ultimately, we gathered valuable feedback from more than 1,400 NDPERS members, resulting in the most comprehensive, accurate, credible and transparent survey of the NDPERS membership to date.

The Sanford Health Plan leadership team is confident that the results of the 2016 survey set the baseline from which future performance will be measured. We also believe current results are more meaningful than surveys conducted by the legacy insurance provider. Here's why.

- **Sanford Health Plan made sure results are accurate.**  
Strong survey methodology produces accurate results, and Sanford Health Plan used transparent, best-practice methodologies to send surveys and analyze responses. Surveys conducted by the legacy insurance provider do not show which NDPERS members received or completed surveys, which means we don't know how accurate historical results are.
- **We surveyed many more NDPERS members, so the results are much more credible.**  
Sanford Health Plan devoted the time and resources to a large-scale member survey so we could deliver highly credible, actionable results. We cast a much wider net and gave NDPERS members the option to conveniently return a paper survey or complete the survey online. Those adjustments led to results backed by 1,419 total members and more than 410 Member Services callers, significantly more than the 250 surveys gathered in 2012.

Executing a member experience survey of this magnitude and complexity requires expertise, and Sanford Health Plan was able to rely on Sanford Health's team of professionals who are dedicated to consumer and market research. The effort underscores the commitment that both Sanford Health Plan and Sanford Health have to our relationship with NDPERS.

Sincerely,



**Kirk Zimmer**  
Executive Vice President  
Sanford Health Plan

## EXECUTIVE SUMMARY: NDPERS MEMBER EXPERIENCE

Less than one year following a change in their health plan service providers, a strong majority of NDPERS members are satisfied with their Dakota Health Plan Benefits and with the customer service provided by Sanford Health Plan. This executive summary details topline results, presents key insights from analysis, provides survey methodology notes and presents a summary of open-ended comments.

### ABOUT THE RESULTS

- **Survey Response:** A random, representative sample of 7,500 NDPERS members was invited to participate. Results are based on 1,419 returned surveys, a response rate of 18.9%.
- **Margin of Error:** The full sample has a margin of error of  $\pm 3\%$ , and the sub-sample of Member Services Call Center callers (n=410) has a margin of error  $\pm 5\%$ .
- **Time Frame:** Responses were gathered from June 1 to July 7, 2016.

### TOPLINE RESULTS: GENERAL MEMBERSHIP SURVEY

General membership survey results are based upon 1,419 returned surveys, and the number of valid responses is reported for each question.

- 92.1% report receiving health services the past 6 months (n=1,408).
- 71.4% are satisfied with their NDPERS Dakota Health Plan Benefits (n=1,388).
- 80.4% agree that printed materials or internet resources are helpful (n=1,055).
- 80.7% agree that health insurance claims are processed accurately (n=1,326).
- 77.2% agree that claims are processed in a timely manner (n=1,346).
- 69.6% agree that EOBs are easy to understand (1,290).

### TOPLINE RESULTS: MEMBER SERVICES CALL CENTER

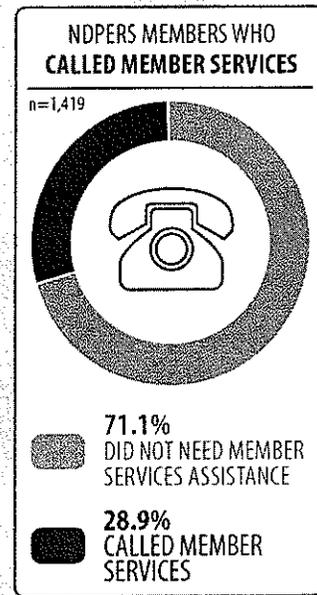
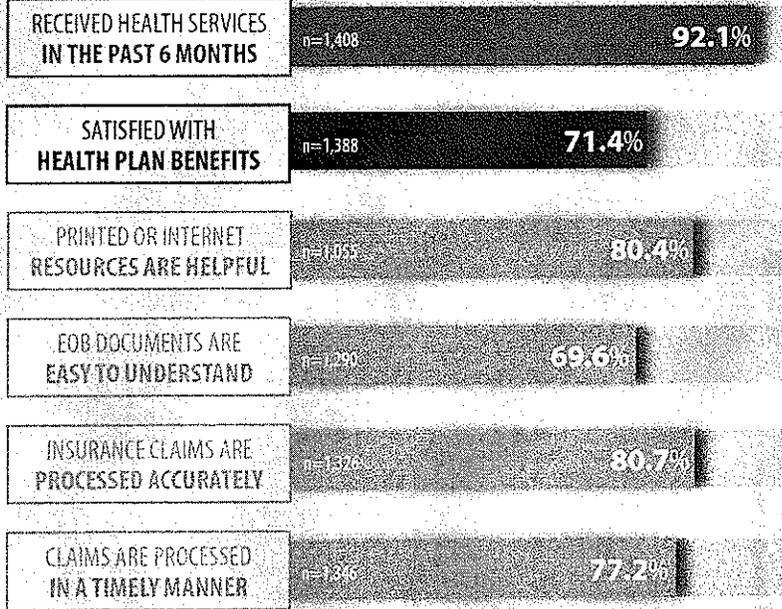
Member Services Call Center results are based on 410 returned surveys, and the number of valid responses is reported for each question.

- 28.9% of members report calling Member Services in the past six months (n=410), a percentage that tracks well with actual Sanford Health Plan statistics that show 32.4% of policy holders called Member Services in the past six months.
- 61.7% of Member Services callers are satisfied with their NDPERS Dakota Health Plan Benefits (n=405).
- 69.3% of Member Services callers are satisfied with the service they received when they called member services (n=405).
- 86.9% of callers reported receiving the help or information they needed, including 68.7% who were helped within 24 hours and another 18.2% where resolution came between 24 hours and 3 weeks (n=405).
- 90.5% agreed that the service representative was courteous and respectful (n=406).
- 77.0% agreed that the service representative was knowledgeable (n=404).
- 75.2% agreed that questions were answered clearly and completely (n=404).
- 65.0% agreed that the service representative completed any promised follow-up (n=196).
- 40.2% called the call center to get information about coverage or benefits, and 38.9% called to ask a question about a health insurance claim or explanation of benefits (EOB).
- 74.1% waited 2 minutes or less to talk to a representative, and 1.7% hung-up before the call was answered (n=406).



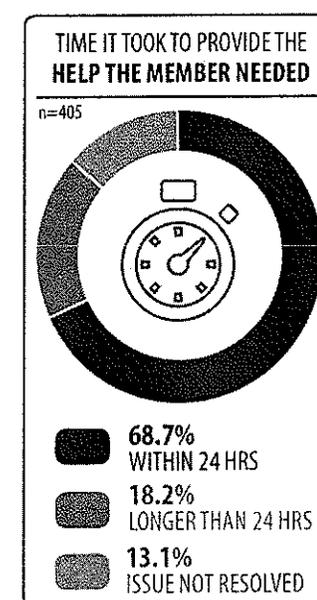
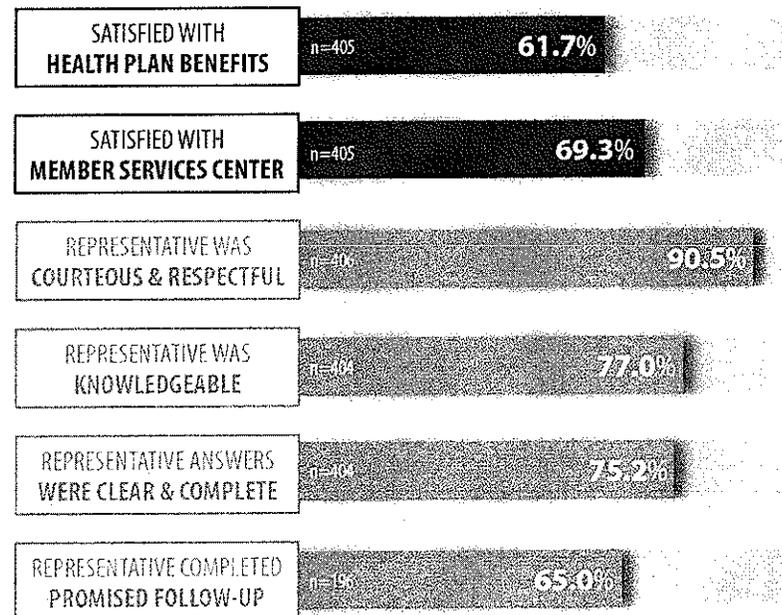
## TOPLINE RESULTS: GENERAL MEMBERSHIP SURVEY

More than 92% of members surveyed have used their health insurance in the past 6 months, and most used their health plan without having to call to ask questions or report an issue.



## TOPLINE RESULTS: MEMBER SERVICES CALL CENTER SURVEY

Less than 30% of members surveyed reported calling the call center, but those members said they are more satisfied with their service experience than they are with their health plan benefits.



## ANALYSIS: SIX KEY MEMBER EXPERIENCE INSIGHTS

Topline results are useful for benchmarking, but analysis connects data to form narratives that better explain member experience results. This executive summary contains six key insights taken from the full set of survey responses, including responses to both closed-ended and open-ended questions.

### **For more than 71% of members, the health plan works as expected.**

The percent of members who did not call Sanford Health Plan Member Services (71.1%) tracks closely with overall satisfaction with health plan benefits (71.4%). The relationship is noteworthy given nearly all (92.1%) members reported filing a claim in the past six months, making the “did not call” metric a representation of NDPERS members who use services without needing to ask questions or report problems. In other words, members are satisfied when their health plan works as expected and without their intervention.

### **Member Services is helpful, but members are happier when they don't have to call.**

A strong majority of individuals who call Member Services receive the help they need (86.9% have their issue resolved) and are satisfied with call center service (69.3%), but the fact that they had to call at all has a negative impact on overall health plan benefits satisfaction. There is a 14-point difference in health plan benefits satisfaction between people who did not call Sanford Health Plan Member Services (76.0% satisfied) and those who placed a call in the past 6 months (61.7% satisfied).

### **Satisfaction with the Member Services Call Center hinges on quick issue resolution.**

It's generally assumed that customers want problems solved quickly, and Member Services call center survey data shows how valuable quick resolutions are. Overall call center satisfaction (69.3%) and the percent of people who got help within 24 hours (68.7%) are closely aligned, and call center satisfaction drops the longer an issue lingers. In cases when a caller's issue is not or cannot be resolved (13.1% of all calls, but 3.5% of all members), call center satisfaction plummets (14.0% satisfied).

### **Explanation of Benefits documents (EOBs) are a candidate for targeted improvement.**

It may be most effective to start improvement efforts by focusing on the smaller share of members who believe EOBs are not easy to understand (30.4%). The most frequent service-related open-ended statement shared a perception that EOBs do not contain enough detail or are hard to understand (3.2% of all statements), and unclear EOBs may explain why 38.9% of call center volume is attributed to claim or EOB questions. Considering members who call for that reason are already less satisfied with their benefits (50.5% satisfied), improving EOB clarity may reduce call center volumes and improve the member experience.

### **Open-ended comments reveal clear cost frustrations.**

When asked to explain their level of satisfaction with their health plan benefits, nearly 1 in 5 members made a statement related to the cost of their benefits. Of those, 75% were negative, with most (11.5% of all statements) reflecting a perception that premiums, deductibles, or co-pays are increasing. The remaining negative cost comments (2.2% of all statements) were directed at costs of prescription drugs or specific medical services.

### **Comment diversity shows the challenges of delivering health insurance that works.**

Nearly 60% of open-ended statements ranged across 16 separate topics related to coverage nuances or the multiple aspects of plan service, resulting in several infrequently mentioned topics as opposed to broader, more obvious themes. The diversity of responses reflects the complexity of health insurance delivery, which includes coordination across multiple customer touch points. In addition, open-ended comments related to plan coverage or plan customer service were often offset by a similar number of statements reporting the opposite experience. For example, there were 42 positive statements (2.9%) related to medical benefits coverage, while 35 statements on the same topic were negative (2.5%).

## METHODOLOGY: FIELDING THE SURVEY AND PREPARING RESULTS

Sanford Health Market Insights conducts consumer and market research for Sanford Health's various service divisions and partners. Survey goals, methodology and questions for this effort were developed in cooperation with Sanford Health Plan and NDPERS leadership.

### FIELDING THE SURVEY: SURVEY SAMPLING AND DISTRIBUTION

To generate accurate, credible and actionable results, the survey effort focused on asking the right questions to the right people.

- **Survey Sample:** Using policy holder lists provided by Sanford Health Plan, 7,500 members were randomly selected to participate in the survey. Invitations were sent in proportion to how NDPERS members receive benefits - 54.3% of surveys were sent to state employees, 22.0% to Medicare retirees, 20.5% to members of political subdivisions and 3.2% to COBRA participants.
- **Survey Distribution:** Surveys were sent via postal mail, and members had the option of returning a paper survey or completing the survey online by visiting [www.surveyndpers.com](http://www.surveyndpers.com).
- **Unique Survey IDs:** To track survey participation, eliminate the possibility of double-participation and allow for data entry validation, each survey was assigned a unique survey ID number.
- **Survey Collection:** Surveys were received by Sanford Health Market Insights between June 1 and July 7. Paper surveys were returned via pre-paid envelopes, and completing the survey online required a survey password and survey ID.
- **Survey Questions:** The 23-question survey included 15 questions asked to all members, including 5 demographic questions. An additional 8 questions were asked to individuals who had called Sanford Health Plan Member Services in the past six months.

### PREPARING RESULTS: ANALYZING AND REPORTING RESULTS

Due to the nature of the survey effort, preparing survey results involved establishing consistent analysis and reporting methods.

- **General Membership Survey - Survey Participation and Response Weighting:** Medicare retirees accounted for 45.2% of general membership responses but only represent 21.9% of NDPERS members. To account for uneven response rates, overall totals were weighted to ensure results accurately reflect the membership as a whole. In effect, weighting adjusted raw totals downward.

	GENERAL MEMBERSHIP SURVEY PARTICIPATION				
	All Policy Holders	Surveys Sent		Survey Responses	
	%	%	n	%	n
State Employees	54.7%	54.3%	4,070	38.5%	546
Medicare Retirees	21.9%	22.0%	1,649	45.2%	642
Political Subdivisions	20.3%	20.5%	1,539	13.0%	185
COBRA	3.1%	3.2%	242	1.6%	23
Unidentified				1.6%	23
<b>Total Members</b>			<b>7,500</b>		<b>1,419</b>
<b>Total Possible</b>			<b>29,013</b>		<b>7,500</b>
<b>% of Total Possible</b>			<b>25.9%</b>		<b>18.9%</b>

- **Member Services Survey - Survey Participation and Response Weighting:** Medicare retirees accounted for 32.2% of Member Services Call Center Survey responses but only represent 19.2% of all individuals who called Member services in the past six months. To account for uneven response rates, overall totals were weighted to accurately reflect call center volumes. In effect, weighting adjusted raw totals downward.

MEMBER SERVICES CALL CENTER SURVEY PARTICIPATION				
	Actual Member Services Call Volume		Survey Responses (Yes to Q15)	
	%	n	%	n
State Employees	56.6%	5,331	50.5%	207
Medicare Retirees	19.2%	1,812	32.2%	132
Political Subdivisions	19.2%	1,805	13.9%	57
COBRA	5.0%	471	2.2%	9
Unidentified			1.2%	5
<b>Total Callers</b>		<b>9,419</b>		<b>410</b>
<b>Total Possible</b>		<b>29,013</b>		<b>1,419</b>
<b>% of Total Possible</b>		<b>32.4%</b>		<b>28.9%</b>

- **Satisfied/Not Satisfied Totals:** Satisfaction questions asked members to use a 1 to 10 scale, with 10 representing "Extremely Satisfied." Answers values from 1 to 5 are reported as "Not Satisfied" and answers from 6 to 10 are reported as "Satisfied."
- **Agree/Disagree Totals:** Agreement questions asked members to use a 1 to 4 scale, with 4 representing "Strongly Agree." Answer values of 1 and 2 are reported as "Disagree" and values 3 and 4 are reported as "Agree."
- **Number of Responses Per Question:** Not all survey questions were answered by all survey responders. Responses for each question may vary based on whether the question was skipped or had an "N/A" option.
- **Detailed Topline Results:** This executive summary includes responses to key survey questions. A full and detailed accounting of each question asked - including demographic and questions - is available from Sanford Health Plan.

## OPEN-ENDED COMMENTS: METHODOLOGY AND SUMMARY

The survey included one open-ended question asking NDPERS members to explain their overall satisfaction with NDPERS Dakota Health Plan Benefits. This section provides two brief summary charts and a short explanation of open-ended comment methodology.

- **Comments and Statements:** A total of 1,112 open-ended comments were separated into 1,427 separate statements for analysis. For example, a comment such as "I am happy with the benefits and processing of claims, but I think premiums should be lower" is 1 comment that would be separated into 3 statements.
- **Statement Groupings:** Statements were separated into 1 of 4 categories, grouped by topic within each category, and assigned either a positive, negative or neutral tone. In total, open ended comment analysis included reviewing and sorting comments into approximately 50 separate "category / topic / tone" groupings.
- **Statement Examples:** Charts on the following page provide examples of statements for each grouping. Examples are illustrative only, and are not necessarily verbatim member comments.

OPEN-ENDED COMMENT SUMMARY					
Category	# of Statements	% of Total	% Positive	% Negative	% Neutral
Benefits Generally	318	22.3%	71.4%	8.2%	20.4%
Benefits Cost	280	19.6%	25.0%	75.0%	N/A
Benefits Coverage	489	34.3%	40.1%	59.9%	N/A
Benefits Service	340	23.8%	43.2%	56.7%	N/A
<b>Total</b>	<b>1,427</b>				

TOP OPEN-ENDED STATEMENT GROUPINGS			
Category / Topic / Tone	n	%	Example
Benefits / General / Positive	175	12.3%	"I have had no problems with the plan."
Coverage / General / Positive	117	8.2%	"I think the coverage is good."
Cost / General / Negative	83	5.8%	"Because out-of-pocket costs keep going up."
Coverage / Change in Carrier / Negative	82	5.7%	"Coverage is not the same as the previous plan."
Cost / Change in Carrier / Negative	82	5.7%	"I am paying more out of pocket since the switch."
Benefits / General / Neutral	65	4.6%	"I haven't used them enough to rate them."
Cost / General / Positive	49	3.4%	"Deductibles and copays are reasonable."
Service / EOBs / Negative	46	3.2%	"The EOBs are not detailed and hard to understand."
Coverage / Wellness / Negative	44	3.1%	"The wellness portal is confusing and hard to use."
Coverage / Medical / Positive	42	2.9%	"My recent hospital stay was covered well."
Service / Timeliness / Positive	41	2.9%	"Payments are made promptly."
Coverage / Medical / Negative	35	2.5%	"The medical coverage is not adequate."
Service / General / Positive	30	2.1%	"Service has been excellent."
Coverage / General / Negative	29	2.0%	"It seems the plan covers less and less."
Coverage / Network / Negative	28	2.0%	"I've had trouble finding out-of-state providers."
Benefits / Change in Carrier / Positive	28	2.0%	"We didn't notice any change when we switched."
Coverage / Authorizations / Negative	28	2.0%	"The plan wouldn't allow a test my doctor ordered."
Cost / Pharmacy / Negative	27	1.9%	"Prescription prices have gone up."
Service / Timeliness / Negative	27	1.9%	"EOBs sometimes come months later."
Service / Accuracy / Negative	27	1.9%	"Coding errors have caused me problems."
Service / Accuracy / Positive	26	1.8%	"Claims are being paid as I expect them to be paid."
Coverage / Other / Negative	25	1.8%	"The plan doesn't cover birth control."
<b>Total Statements Represented</b>	<b>961</b>	<b>67.3%</b>	

## Exhibit III



Deloitte Consulting LLP  
Suite 2800  
50 South Sixth Street  
Minneapolis, MN 55402-1538  
U.S.A.

Tel: (612) 397-4051  
Fax: (612) 692-4051  
www.deloitte.com

August 1, 2016

Ms. JoAnn Kunkel  
Chief Financial Officer  
Sanford  
1305 West 18<sup>th</sup> Street  
P.O. Box 5039  
Sioux Falls, SD 57117

Re: NDPERS Claim Review Results and Comments on Performance Guarantees

Dear Ms. Kunkel,

Thank you for providing Deloitte Consulting LLP ("Deloitte Consulting") with the opportunity to work with Sanford Health Plan ("Sanford") and its client, North Dakota Public Employees Retirement System ("NDPERS"), on a medical claims review and examination of performance guarantees in the contract between Sanford and NDPERS.

Deloitte Consulting reviewed a random sample of 218 claims for NDPERS members in order to validate performance guarantees related to claims processing and payment.

Results of the claim review were positive and Sanford met the financial and payment accuracy performance guarantees for NDPERS during the evaluation period, at 99.7% and 97.7%, respectively. There were five payment errors with \$1,139.79 in absolute dollars and one processing error that did not affect claim payment. Sanford agreed to all identified errors. While the payment issues identified were relatively small dollar amounts, several errors were the result of system setup issues so the payment of claims not reviewed in the sample may have been impacted.

The results of the NDPERS claims review compare favorably with results of similar reviews performed at other health plans, both regional and national. Sanford surpassed industry benchmarks for financial, payment, and procedural accuracy. While there were no significant payment errors, Deloitte Consulting identified areas where Sanford should review quality controls and processes in place, particularly around provider contracting.

The following section provides further detail on the claim review scope, methodology, review standards, findings, and recommendations.

### Claim Review

The following highlights processes and findings of the onsite claim review conducted July 18 - July 21, 2016. Additional detail is included in the attached worksheet "NDPERS – Sanford Claim Review Financials.xlsx."

#### Scope and Objective

Sanford engaged Deloitte Consulting to conduct a claims transaction review of NDPERS plans administered by Sanford. The review covered medical claims paid from July 1, 2015 through May 31, 2016. All NDPERS

plans were considered in-scope of the review: Grandfathered PPO/Basic, Non-Grandfathered PPO/Basic, Non-Grandfathered High Deductible Health Plan PPO/Basic, Medicare Supplement Retiree Plan.

The objective of this review was to evaluate the financial, payment and procedural accuracy and determine the average turnaround time for the selected sample of claims and validate the related performance guarantees. Deloitte Consulting also reviewed the sample with a focus on identifying potential systematic errors in processing, errors in plan design set-up or any other issues that may exist with respect to the adjudication of NDPERS' claims.

## Methodology

Deloitte Consulting reviewed a sample of 218 claims with a total paid amount of \$7,198,173, or about 3.27% of the total \$219,826,423 paid during the evaluation period. The claim sample was selected using a stratified (by paid dollar amount) random sample approach. Strata were determined based on the actual distribution of claims and the individual claims within each stratum were randomly selected. This random, stratified approach produces a sample that is representative of the population and contains claims from all paid dollar ranges. Claims are stratified by paid amount because claims are typically processed similarly based on their complexity, which correlates to the dollar amount. This results in a review of both large and small claims. The sample size selected is statistically significant and can be used to measure overall administrator performance.

Each claim was reviewed first against NDPERS' plan designs, then according to Sanford's policies/procedures and finally with respect to industry standards and practices.

Claims were evaluated for the following:

- Timeliness of processing
- Member/provider eligibility
- Appropriateness of charges
- Interpretation of charges
- Claim entry procedure
- Examiners handling of claim
- Completeness of documentation
- Coordination of benefits
- Interpretation of plan provisions
- Cost-share accumulation
- Application of contract terms
- Application of medical management
- State surcharge calculations
- System edit application
- Assignment of benefits
- Subrogation/third-party liability

Any questions regarding each claim were recorded by Deloitte Consulting. The claims and any applicable documentation were reviewed with Sanford's assigned representatives. Sanford was given an opportunity to respond to all claim questions and provide additional information/comments and was also asked to confirm any errors identified.

## Review Standards

Errors are defined as either financial or procedural.

- A financial error occurs when the amount paid is incorrect, is paid to a wrong party, or is paid under an incorrect claimant's file.
- A procedural error occurs when (1) a financial error occurs or (2) there is no financial error but the claims administrator's own claims payment guidelines are not followed. In this case, the processing error recorded for a claim did not result in a measurable financial amount.

Deloitte Consulting measures three performance criteria.

- Financial accuracy rate is calculated by dividing the absolute value of overpayments plus underpayments by the total dollars paid per strata for the sample and then subtracting the resulting number from one to develop a percentage accuracy measure.

- Payment accuracy rate (incidence) is calculated by dividing the total number of claims paid correctly by the total number of claims reviewed.
- Procedural accuracy rate is calculated by dividing the total number of procedurally correct claims by the total number of claims reviewed.

## Findings

Sanford provided documentation for all of the 218 of the claims requested and Deloitte Consulting evaluated all claims provided. Accuracy rates and turnaround time calculations based on the claims sample are noted in the table below followed by summarized findings. Detailed findings and recommendations are included in the attached spreadsheet.

There were five payment errors with \$1,139.79 in absolute payment errors. Three overpayments totaled \$1,064.41 and two underpayments totaled \$75.38. One claim had a procedural error which did not affect claim payment. Sanford agrees to all identified errors.

Measurement	Review Result	NDPERS Performance Guarantee	Industry Benchmark
<b>Claims Accuracy</b>			
Financial Accuracy:	99.7%	99%	99%
Payment Accuracy:	97.7%	97%	97%
Procedural Accuracy:	97.3%	-	95%
<b>Claims Turnaround Time*</b>			
Average Days to Process:	5.0 days	-	-
% within 30 Calendar Days:	95.0%	99%	-
Average Days to Payment:	11.1 days	-	-
% within 30 Calendar Days:	92.7%	-	98%

\*Deloitte Consulting's stratified sampling method results in a higher proportion of high dollar claims compared to NDPERS claim population. High dollar claims are more complex and have longer payment approval processes so turnaround time of the sample is expected to be higher than turnaround time of the claim population. Deloitte Consulting does not have concerns about Sanford's claim turnaround time.

Payment Errors:

### *NDPERS Plan Design Setup*

- Sample #83: An office visit claim was underpaid \$65.38 because one lab test was applied to the deductible rather than the \$200 wellness services benefit due to a system setup issue. The member overpaid \$65.38 but Sanford indicated that the claim has been adjusted to pay correctly.
- Sample #151: An ER facility bill was overpaid \$160.92 because, at the time the claim was processed, the system was not set up to apply the member coinsurance to the claim line to which a \$50 copay was applied. There is no payment impact for the member because their out-of-pocket maximum was met on a later claim.

### *Provider Contract Pricing*

- Sample #108: A well child visit was overpaid \$19.33 because the incorrect contracted provider discount rate was set up in the system and applied to immunizations on the claim. There was no member payment impact.
- Sample #200: A \$10.00 underpayment occurred because the contract rate for one procedure on the claim was keyed into the system incorrectly.

- Sample #203: A transplant claim was overpaid \$884.16 because Sanford applied the incorrect contracted provider discount to the case. The provider sent back a refund for most of the original overpayment, but the case remains overpaid \$884.16. There is no payment impact for the member.

#### Procedural Errors:

- Sample #139: The provider associated with this claim is set up in the claims system to pay services at Sanford's default discount off charges, which does not align with the percent of Medicare fee schedule language in the provider contract. Sanford indicated that this is due to a system limitation when the provider was initially set up a number of years ago and the contract would be re-negotiated to clearly define reimbursement rates. A procedural error was charged because the system payment method does not match the contract language.

#### Additional Findings/Comments:

- Sample #134: When anesthesia services are billed by both a CRNA and a supervising anesthesiologist, industry standard practice is to split the allowed amount between the two providers. Sanford's procedure is to pay each provider the full contracted amount with no reduction. There is no error on this claim, but Sanford may consider a change to provider contracting to align with industry standard practice.
- Sample #199: An out-of-area facility was paid billed charges of \$51,941 because Optum, Sanford's third party vendor, was unable to negotiate a discount. It was later determined that the provider was contracted with PHCS and Sanford requested a refund of \$17,141 from the provider. There is no error on this claim, but Sanford may consider updating processes for out-of-area claims so PHCS status is validated prior to sending to Optum.
- Sample #218: Member's eligibility detail had the incorrect termination date for the member's primary insurance. This was a manual data entry error but did not affect the sample claim so no error was charged on this sample.

#### Recommendations

For those payment errors that were determined to be system setup issues (#83, #108, #151), Sanford should run impact reports to identify affected claims. Where NDPERS members are affected, Sanford and NDPERS should determine whether claims should be adjusted.

NDPERS and Sanford should review the \$200 wellness services benefit to confirm that all inclusions are defined and claims are being processed in accordance with the plan intent.

Several issues were due to provider contracts. Sanford should review provider contract management processes and the frequency of internal contract audits.

For issues caused by manual adjudication errors, additional training should be provided to the claims processors.

#### Performance Guarantees

In addition to a claims transaction review, Deloitte Consulting reviewed 14 other performance guarantees agreed to by NDPERS and Sanford. Sanford provided documentation and calculation methodology for each of the guarantees and Deloitte Consulting was given the opportunity to review and ask questions of Sanford's representatives. Additional information was requested for some calculations and Sanford provided the required documentation.

Overall, Deloitte Consulting does not have concerns about Sanford's calculation methodology for meeting NDPERS guarantee criteria. Comments and/or recommendations are noted below where appropriate.

### **Comments and Recommendations**

*Guarantee: By Dec. 31, 2015, 10% of NDPERS members will have created a mySanfordHealthPlan account where they can access the bWell Health Management Tool and the incentive program. (Performance Guarantee based on bWell participation and utilization of wellness activities)*

Sanford met this guarantee and Deloitte Consulting does not have concerns about the calculation. This guarantee is not ongoing but if a similar wellness program utilization guarantee is put in place in the future, language should be updated to more clearly indicate the criteria needed to meet the guarantee.

*Guarantee: By July 1, 2016 the annual percentage average of NDPERS members receiving the Health Club Credit will meet the 2014 annual NDPERS rate.*

Sanford did not meet this guarantee based on actual average number of members receiving the Health Club Credit. BCBSND reported 1,950 average members utilizing the benefit while Sanford reported 1,857 average members reporting the benefit during the 12-month period. The lower number reported by Sanford may be due in part to the transitional period as members switched from BCBSND to Sanford reporting system, Sanford's data shows that utilization was low in July 2015 but increased steadily in the following months.

Deloitte Consulting recommends two modifications to this performance guarantee. First, because total plan enrollment may fluctuate over time, using percentage of average members rather than actual average members would provide a more accurate comparison from one measurement period to another. Second, because members can receive the \$250 wellness benefit through multiple channels, NDPERS may consider changing this measurement to incorporate all activities instead of measuring health club utilization only.

*Guarantee: By Dec. 31, 2016, NDPERS will have a 5% point increase in the NDPERS group aggregate HRA wellness score.*

The intent of this guarantee is to measure the change in HRA wellness score from July 1, 2015. On April 1, 2016, Sanford changed wellness providers so a different HRA is now being used. Because the assessments are from different providers, the two scores cannot be accurately compared.

Deloitte Consulting recommends that NDPERS consider moving the guarantee period back six-months so that the members' assessment data can be compared from 2016 to 2017. In order to monitor the change from 2015 to 2016, Sanford may work on normalizing the two different assessments so that the scores can be meaningfully, if not exactly, compared. While this comparison would not be precise, it may provide NDPERS with an understanding of the movement of the group's aggregate wellness score.

*Guarantee: HEDIS-like measures: breast cancer screening rates will be at least 80%; cervical cancer screening rates will be at least 80%; colorectal cancer screening rates will be at least 60%.*

Sanford's methodology for determining these preventive care compliance rates are appropriate. Given that Sanford has limited medical history of NDPERS members, assumptions are made to extrapolate these rates across the population. These measures will become more accurate over time as Sanford builds claims history on NDPERS members.

### **Conclusion**

Based on the claim transaction and performance guarantee review, Deloitte Consulting finds that Sanford has sufficiently exceeded most performance guarantees due thus far and is using acceptable calculation methodology to determine their compliance with each guarantee. Sanford is actively working to improve

performance and is open to recommendations for improvements to their processes so they can best serve NDPERS.

Please feel free to contact us if you should have any questions concerning our observations.

Carolyn Heisler  
Deloitte Consulting LLP

Cc: Patrick Pechacek, Deloitte Consulting LLP  
Josh Johnson, Deloitte Consulting LLP



Level of Service July 2015-June 2017

<b>Diabetes</b>		<b>July 2015-June 2017</b>
Direct Program Cost		
Provider Visits		\$132,000.00
Patient Incentives		\$43,000.00
<b>Subtotal</b>		<b>\$175,000.00</b>

Administration Costs		
<b>Subtotal</b>		<b>\$20,000.00</b>

Marketing Costs		
Direct to consumer mailings		\$5000.00
In-pharmacy marketing		
<b>Subtotal</b>		<b>\$5000.00</b>

<b>Biennial Expenses</b>		<b>\$200,000.00</b>
--------------------------	--	---------------------

<b>Hypertension</b>		<b>Oct. 2016-June 2017</b>
Direct Program Cost		
Provider Visits		\$39,200.00
Patient Incentives		\$10,000.00
<b>Subtotal</b>		<b>\$49,200.00</b>

Administration Costs		
<b>Subtotal</b>		<b>ND DoH Grant</b>

Marketing Costs		
Direct to consumer mailings		ND DoH Grant
In-pharmacy marketing		
<b>Subtotal</b>		

<b>Estimated Expenses</b>		<b>\$49,200.00</b>
---------------------------	--	--------------------

<b>TOTAL Biennial Expenses</b>		<b>\$249,200.00</b>
--------------------------------	--	---------------------

Expense estimates are for serving ~200 patients (~5% participation rate) over the next biennium. Each patient would be eligible to receive a Comprehensive Medication Review (CMR-\$400.00) and up to 2 Targeted Medication Reviews (TMR-\$80.00) the first year and one CMR (\$200.00) and one TMR (\$80.00) in for any subsequent years of participation in the program.

Within the first year of the biennium we have exceeded anticipated enrollment for program. We still anticipate staying within the budget as participation rates trend to decrease in the second year. As discussed, we feel it is mainly because there is no direct marketing in year two.

Expense estimates are for serving ~70 patients state wide (~1% participation rate) October 2016 to June 2017 (9 months). Each patient would be eligible to receive a Comprehensive Medication Review (CMR-\$400.00) and 2 Targeted Medication Reviews (TMR-\$80.00) during this pilot period.

In-kind from NDPhA and NDSU: Telephone (maintaining toll free direct number for patients), office space, office supplies, Training/Credentialing/Certification of providers, patient curriculum, Clinical Coordinator, Data Analysis



Level of Service July 2017-June 2019

<b>Diabetes</b>		<b>July 2017-June 2019</b>
Direct Program Cost		
Provider Visits		\$140,000
Patient Incentives		\$ 45,000
<b>Subtotal</b>		<b>\$185,000</b>

Administration Costs	
<b>Subtotal</b>	<b>\$20,000.00</b>

Marketing Costs	
Direct to consumer mailings	\$5,000.00
In-pharmacy marketing	
<b>Subtotal</b>	<b>\$5,000.00</b>

<b>Biennial Expenses</b>	<b>\$210,000.00</b>
--------------------------	---------------------

<b>Hypertension</b>		<b>July 2017-June 2019</b>
Direct Program Cost		
Provider Visits		\$231,000
Patient Incentives		\$ 40,000
<b>Subtotal</b>		<b>\$271,000</b>

Administration Costs	
<b>Subtotal</b>	<b>\$10,000.00</b>

Marketing Costs	
Direct to consumer mailings	\$7,500.00
In-pharmacy marketing	
<b>Subtotal</b>	<b>\$7,500.00</b>

<b>Biennial Expenses</b>	<b>\$288,500.00</b>
--------------------------	---------------------

Expense estimates are for serving ~500 patients (~200 Diabetes and ~300 hypertension) at an 5%-7% participation rate over the next biennium. Each patient would be eligible to receive a Comprehensive Medication Review (CMR-\$400.00) and up to 2 Targeted Medication Reviews (TMR-\$80.00) the first year and one CMR (\$200.00) and one TMR (\$80.00) for any subsequent years of participation in the program.

In-kind from NDPhA and NDSU: Telephone (maintaining toll free direct number for patients), office space, office supplies, Training/Credentialing/Certification of providers, patient curriculum, Clinical Coordinator, Data Analysis

# Cost/Savings of NDPP

Average cost per participant: \$450

Approximately 10% of prediabetes is diagnosed

**NDPERS: If 10% diagnosed with prediabetes: 1,928**

- ▶ If 10 - 50% enrollment: 385 - 964 participants
- ▶ If 40-70% complete

Anticipated Enrollment	Cost for 40% to Complete	Cost for 70% to Complete	Savings
If 10% (385)	\$69,300	\$121,500	\$408,100 - \$715,500
If 50% (964)	\$173,250	\$303,660	\$1,022,900-\$1,788,750



## History of PERS Health Insurance Reserves

<i>Balance as of:</i>	<i>Health Insurance</i>	<i>Early Retiree Reinsurance Program (ERRP)</i>	<i>Life Insurance</i>
7/1/2007	\$1,540,648	\$0	\$2,155,769
7/1/2009	\$5,581,737	\$0	\$2,421,873
7/1/2011	\$5,943,183	\$1,726,189	\$2,468,533
7/1/2013	\$42,651,594	\$2,735,616	\$2,490,265
7/1/2015	\$42,925,033	\$0	\$2,491,063
7/1/2016 (estimate)	\$41,253,000	\$0	\$2,516,000
<b>Available reserve</b>	<b>\$29,400,000*</b>		<b>\$2,516,000</b>

\*The amount of the 7/1/2016 estimated balance for the health insurance funds that would be available to buydown the health premiums for the 17-19 biennium is approximately \$29.4 million, which is arrived at as follows:

\$41,253,000 Estimated balance

(3,000,000) Less deposit currently held by BCBS for the 2013-15 biennium, at risk until 7/1/2017

(3,000,000) Less deposit currently held by SHP for the 2015-17 biennium, at risk until 7/1/2019

(3,000,000) Risk deposit for 2017-19 contract period

(2,800,000) Retention for administrative expenses for July 2016 – June 2019

\$29,453,000

Recap of use of funds from 7/1/2007 through 6/30/2015:

For the 2013-15 biennium, the health insurance and ERRP funds were used to buydown the health insurance premiums by approximately 2%. This amounted to \$5,437,457 for the 1st year of the biennium and \$5,512,668 for the 2nd year of the biennium. The health insurance funds are also used for the \$3,000,000 deposit that is held by the health carrier for the risk corridor pursuant to the contract, administrative expenses, fees for the disease management program established under NDCC 54-52.1-17, and wellness programs. No funds were used from the life insurance reserve.

Brief description of how funds accumulate:

**Health Insurance.** The contract with the health insurance carrier includes a gain sharing provision if premiums paid exceed claims incurred during the biennium. The final accounting for the biennium is completed 24 months after the end of the contract period. The health plan experienced gains for the 2005-07 biennium, 2009-11 biennium and for the 2011-13 biennium. At this time, the projected gain for the 2013-2015 biennium and a portion of the \$3 million deposit will be offset by the amount of actual

ACA fees paid by BCBS that were higher than estimated. We are not expecting to have any funds returned; however, this will be determined after July 1, 2017. The other source of funds is interest income.

**Early Retiree Reinsurance Program.** The federal health care reform bill provided for a pre-Medicare retiree reinsurance provision for employer plans that reimbursed employers by providing reinsurance for 80% of retiree claims between \$15,000 and \$90,000. This program became effective June 1, 2010 and employer eligibility was determined through an application process submitted by the employer to the Department of Health and Human Services. The program required that the funds be used to (1) reduce the sponsor's health benefit premiums or health benefit costs, (2) reduce health benefit premium contributions, copayment, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, for plan participants, or (3) reduce any combination of the costs in (1) and (2). The NDPERS Board determined that any reimbursements received under this program be used to help reduce health care costs for members of the Uniform Group Insurance Program. NDPERS submitted an application and was determined to be an eligible employer. Reimbursements were received during fiscal year 2011 and 2012. No further reimbursements were received as funding for this program is no longer available.

**Life Insurance.** Prior to the 2005-07 biennium, the contract with the life insurance carrier had a gain sharing provision. The balance in the life insurance account reflects gains that were accumulated as part of contract settlements before July 2005. The other source of funds is interest income.



August 31, 2016

To: NDPERS Board of Trustees and Staff

From: North Dakota Pharmacists Association

**Re: NDPERS Health Plan Renewal**

Dear NDPERS Board of Trustees and Staff,

At your request, we have prepared some comments for consideration as you move forward in your discussions regarding your health plan renewal. First, we truly appreciate your willingness to listen to our concerns. Thank you for your help in facilitating discussions to take place between all parties who provide services under the NDPERS health plan. It is no secret that we have aired some concerns during the first year of implementation.

We would like to thank Sanford Health Plan and NDPERS for addressing two immediate issues that were brought forward last year with the initial roll out of the plan. The first issue was the request by NDPERS to look at rural rates for providers compared to the previous carrier. Thank you. The second issue was Sanford Health Plan not realizing or missing that ND has over 300 pharmacists authorized to provide immunizations. They were not included as providers of those services when the plan was rolled out. After notifying Sanford Health Plan regarding this oversight, changes were made in September of 2015.

During multiple NDPERS Board meetings, we have shared additional concerns our members have brought forward. Below I have listed some of the shared concerns.

**MAC Comments:**

We continue to hear from our members that Maximum Allowable Cost (MAC) reimbursement or lack thereof by Express Scripts is more aggressive than the previous carrier. A MAC list is what a PBM uses to pay pharmacies for generic drugs. This has caused numerous prescriptions to be filled below the cost of doing business and in some cases below the actual acquisition costs that a pharmacy can even buy the prescription. This causes the pharmacy to actually lose money when providing certain generic prescriptions to NDPERS beneficiaries. In some cases, pharmacies are losing from a couple of dollars to literally hundreds of dollars on certain prescriptions. Even in these situations, the pharmacy still serves the NDPERS beneficiary because the pharmacy cannot deny services to the patient and the pharmacy hopes to make up for it on future prescriptions.

If you recall, we asked Express Scripts if they pay themselves through their mail order owned pharmacies off of the same MAC list that they reimburse the community pharmacies. To our recollection, Express Scripts Senior Management stated they pay themselves off of a different MAC list. They also use a different MAC list when billing NDPERS than they use when paying the pharmacies. This would be consistent with comments made by Express Scripts during a PBM transparency hearing related to MAC issues held during the 2013 ND Legislative session. Our members would appreciate a more equitable MAC list be used for the NDPERS health plan. To the benefit of NDPERS, a request should be made of Express Scripts to use the same MAC list for all drugs dispensed and paid for under the NDPERS plan.

#### **Specialty Drugs:**

It is no secret that “specialty drugs” are the fastest growing and most expensive area of the pharmacy market. As reported by Sanford Health Plan, 2% of NDPERS prescription claims volume represents over 30% of total prescription claim spending. In some areas of NDPERS population it is even higher. As discussed previously, there currently is no Federal definition of what constitutes a specialty drug nor are there any State definitions on what constitutes a specialty drug. The PBMs, in this case, Express Scripts, is the one who defines what drugs are deemed “specialty”. This list continues to grow rapidly and with a large number of the drugs there is nothing “special” about the drug(s) except the price.

Even though NDPERS has been asked to move to a mandatory mail order program for specialty drugs owned by Express Scripts, we appreciate NDPERS Board position that “access” and “choice” is important for their beneficiaries. Of course, Express Scripts has stated NDPERS will save money if they use the specialty mail order program that they own. We respectfully request that if there are any future discussions around this topic, we be invited to participate in such discussions. This will ensure the conversation stays honest and not one sided. Also, we ask that NDPERS keep in mind that Express Scripts is the one who gets to create the invoices back to NDPERS. They pay the pharmacy one price and then create a “spread price” back to NDPERS to make it appear the community pharmacy is charging NDPERS more for the specialty drug than Express Scripts mail order owned pharmacies.

If Express Scripts mail order pharmacies are truly going to save money for NDPERS, we have a suggestion that will benefit NDPERS and the State while still maintaining a high level access and choice for their beneficiaries. Simply require that a ND pharmacy must be paid at the same rate that Express Scripts pays themselves for the mail order pharmacies that they own. If it is truly cheaper to use Express Scripts mail order pharmacies that they own, they should welcome our offer. The same offer stands for the MAC issue noted above.

#### **Copayments to Pharmacy Providers:**

We have brought this issue up on a number of occasions. The previous carrier provided a good faith effort to make sure pharmacies were treated fairly when it came to collecting copayments from NDPERS beneficiaries. The previous carrier had a minimum reimbursement level that a pharmacy would be paid per prescription. This was not included by NDPERS when the carrier change was made. For example, NDPERS has a generic drug copayment structure of \$5.00 for

their beneficiaries. There are times when the beneficiary doesn't have to pay the \$5.00 copayment to the pharmacy because Express Scripts determines what price they are going to reimburse the pharmacy. In some cases, a pharmacy's net reimbursement can be \$.80, \$1.25, \$2.25, \$3.25, etc. This hardly covers the cost of the prescription vial and label and is nowhere close to the cost of doing business for a pharmacy. At a minimum, the pharmacy provider should be able to collect the \$5.00 copayment established by NDPERS. If the Usual and Customary price set by a pharmacy is less than the copayment, than the pharmacy is required by law to bill for the usual and customary price. NDPERS could require that a pharmacy provider is due the \$5.00 copayment unless the pharmacies usual and customary price is less.

A question for NDPERS is if a pharmacy is only being reimbursed \$0.80 for prescription, is that what NDPERS is being billed for that same drug?

**Conclusion:**

NDPhA is committed to providing a high level of service, high level of access and helping to reduce costs for NDPERS and its beneficiaries. Our members appreciate the opportunity to serve NDPERS beneficiaries. We also appreciate the request to submit any concerns or comments that we have related to the NDPERS health plan renewal for consideration.

We value the partnership with NDPERS and have served NDPERS beneficiaries since its establishment. Our members look forward to continuing our partnership to benefit you, your members and the State.

Respectfully Submitted,



Mike Schwab  
EVP NDPhA

## Attachment 3

# Sanford to leave DakotaCare after negotiations with Avera fall through

Jonathan Ellis, jonellis@argusleader.com 7:58 a.m. CDT August 24, 2016

Sanford Health(Photo: logo)

Sanford Health says it will leave DakotaCare next year after Sanford and Avera Health Plans failed to reach a deal in which Sanford could offer a broad health plan that included Avera's physicians.

The decision will affect thousands of consumers who will open enroll for health insurance later this year, and it ensures that only one health insurer – Wellmark – will be able to offer a broad insurance network in South Dakota that includes most of the state's health providers.

And it means that consumers in some communities might have to drive longer distances for in-network care or that longstanding health providers will suddenly no longer be in DakotaCare's network.

Laurie Gill, the commissioner for the South Dakota Bureau of Human Resources, notified the state's more than 12,000 employees – the biggest member group in DakotaCare – that Sanford's decision does not require immediate changes.

“We will work with our partners to continue to provide services for our members and will keep you informed as new information becomes available,” Gill wrote.

The decision was set in motion last year when Avera bought DakotaCare, which offered the only other broad network plan in the state. Avera's acquisition meant it owned an insurance plan that offered access to Sanford's providers. Prior to the acquisition, Avera's health plan generally did not include networks with Sanford providers, and Sanford did not offer plans with Avera providers.

Earlier this year, Sanford officials say they approached Avera about extending access to Sanford Health Plans to Avera physicians, a move that would have created a third broad network plan in the state and one that would have put Sanford on an equal footing with Avera's DakotaCare plan. But Avera countered with a proposal that Sanford buy an equity share in DakotaCare.

Paul Hanson, the executive vice president of Sanford Health, said Sanford balked at Avera's proposal based on philosophical and regulatory concerns. Hanson said he didn't think it was

realistic for two competing health systems to own an insurance company, and he said the move might have raised anti-trust problems with the two owning a single insurer.

Hanson said the decision means that Sanford will have to develop new insurance plans that will be attractive and competitive in the new marketplace. It also means that Sanford, at least in the short-term, will lose millions of dollars by leaving DakotaCare.

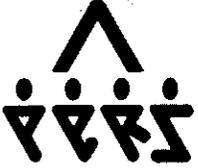
“Is it going to be easy? No. This is going to be a long road, but it’s the high road for us to take,” Hanson said.

Rob Bates, the senior vice president of Avera Health, called Sanford’s decision to leave DakotaCare “unfortunate,” and one meant to cause “maximum noise in the marketplace.” He predicted that it would be disruptive to some of DakotaCare’s members.

Bates said that Avera offered ownership stakes in DakotaCare to Sanford and other health providers across the state. Avera bought DakotaCare with the intent of preserving a broad-network plan that was owned by more than just Avera. He said Sanford rejected multiple offers to buy into DakotaCare, and he said he didn’t agree that there were anti-trust problems with Sanford and Avera owning DakotaCare.

Bates also said Avera could not come to terms with Sanford about allowing Avera providers to participate in Sanford’s plans because Sanford’s terms and conditions were too “onerous,” a charge that Sanford officials dismissed.

Ultimately, Sanford said that it will provide continuity of care for DakotaCare members who are undergoing treatment for various ailments when the change occurs



**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](mailto:NDPERS-info@nd.gov) • [www.nd.gov/ndpers](http://www.nd.gov/ndpers)

# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 7, 2016  
**SUBJECT:** Part D Renewal

At the last meeting we discussed the Part D renewal (Attachment #1 is the Board memo from last time). As discussed in that memo the proposed premium for the same plan design for 2017 is \$90.33 which is a 10.16% increase or \$8.33 per month per person.

It was decided to delay action to this meeting to give Deloitte a chance to review the proposed increase. Attachment # 2 is the memo from Deloitte. Their conclusion is:

Based on our review, we believe reasonable and appropriate actuarial methodologies and assumptions were utilized by ESI in the 2017 rate development. We recommend enhancements and refinements be made for 2018 rate development as ESI will have a calendar year of historical allowed claims and member months and actual payments received from CMS for this population. We recommend NDPERS to consider contract negotiations for pharmacy rebates and discounts to determine if better rebates with fewer discounts would benefit their rate development. We also recommend NDPERS and ESI consider formulary and utilization management techniques to help lower member premium.

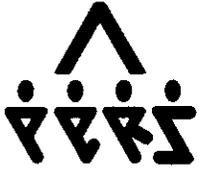
We did get some contract language suggestions from Linda Cahn that we can propose relating to the above.

**Board Action Requested:**

Renew with ESI or go to bid.

**Staff Recommendation:**

Renew



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

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

---

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

# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** August 18, 2016  
**SUBJECT:** Part D Renewal

Attachment #1 is the proposed Renewal from Sanford with some optional plan changes to mitigate the premium increase. You will note in the attached that the premium for 2016 is \$82 per person. The proposed premium for the same plan design for 2017 is \$90.33 which is a 10.16% increase or \$8.33 per month per person.

Attachment #2 is a powerpoint presentation that was reviewed with PERS Retiree Committee on August 16. Pages 2-11 is information on the plan metrics. Page 12 is the **ESI summary and recommendation which is to move to Option #4 on Attachment #1.**

Attachment #3 is the retiree committee meeting minutes. **You will note that retiree committee recommendation is to renew the existing plan design and to study options #3 and #4 for consideration next year.** The goal of the study would be to develop information on who would be affected by the changes, the cost implication to those members, the cost benefit to other members and other information so these options can be fully considered next year if necessary.

Attachment #4 is the review by Deloitte.

Attachment #5 is a RFP if you should decide to go to bid on this product. This will be sent via email prior to the Board meeting.

Staff Recommendation:

Staff Agrees with the Retiree Recommendation

Board Action Requested.

Determine if PERS should 1) renew with ESI 2) if we are to renew for the existing plan or one of the options or 3) if PERS should issue the RFP.

# ESI Part D Renewal

Existing premiums \$82  
 Increase \$8.33  
 Approx: 10.16%

	<b>Scenario 1: Current Plan Design, Formulary &amp; Network</b>
<b>Deductible</b>	\$0
<b>Initial Coverage</b>	Same as Current
<b>Coverage Gap</b>	All
<hr/>	
<b>2017 Premium Estimate PMPM*</b>	\$90.33

Optional plan designs and cost implications (scenario 1 is the existing plan design)

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 2: Same as Current Plan Design, Formulary & Network. Add \$100 Deductible	Scenario 3: Same as Current Plan Design, Formulary & Network. Coverage Gap option is Generic Only
Deductible	\$0	\$100	\$0
Initial Coverage	Same as Current	Same as Current	Same as Current
Coverage Gap	All	All	Generic Only
<hr/>			
2017 Premium Estimate PMPM*	\$90.33	\$86.73	\$81.29
	Scenario 4: Same Plan Design & Network. Move to a Closed Formulary	Scenario 5: Same as Current Plan Design & Formulary. Move to a Preferred Network	Scenario 6: Current Network & Formulary. Move to CMS Defined Standard Plan Design.
Deductible	\$0	\$0	\$400
Initial Coverage	Same as Current	Same as Current	CMS Defined Standard (25%)
Coverage Gap	All	All	CMS Defined Standard Minimum
<hr/>			
2017 Premium Estimate PMPM*	\$88.95	\$89.86	\$68.26

# NDPERS EGWP

Performance Metrics January-June 2016

PERS Retiree Meeting  
August 2016



EXPRESS SCRIPTS®

1

# Top Line Performance Metrics

- Generic Fill Rate (GFR) is 87.6%
- Formulary Compliance Rate is 98.6%

NDPERS EGWP	
Description	1-16 - 6-16
Avg Members per Month	8,526
Number of Unique Patients	8,067
Pct Members Utilizing Benefit	94.6%
Total Days	6,096,726
Total Rxs	135,250
Average Member Age	74.8
Nbr Rxs PMPM	2.64
Generic Fill Rate	87.6%
Home Delivery Utilization	1.0%
Member Cost %	23.3%
Specialty Percent of Plan Cost	26.4%
Formulary Compliance Rate	98.6%

# Top Line Performance Metrics: Specialty

- There are 175 unique specialty patients

NDPERSEGWP			
Description	All Drugs	Non-Specialty	Specialty
Avg Members per Month	8,526	8,526	8,526
Number of Unique Patients	8,067	8,067	175
Pct Members Utilizing Benefit	94.6%	94.6%	2.1%
Total Days	6,096,726	6,082,417	14,309
Total Rx's	135,250	134,720	530
Member Cost %	23.3%	27.1%	10.5%

# Top 10 Indications

**REPRESENT  
69.3%  
OF YOUR TOTAL  
PLAN COST**

- Diabetes represents 15.1% of your total Plan Cost

Top Indications by Plan Cost						
1-16 - 6-16						
AUM Strategy	Rank	Indication	Rxs	Patients	Generic Fill Rate	
ST/PA/DQM	1	DIABETES	8,634	1,577	44.8%	
ST/PA/DQM	2	CANCER	1,030	325	85.8%	
ST/PA/DQM	3	HIGH BLOOD CHOLESTEROL	12,645	4,491	87.4%	
ST/DQM	4	HIGH BLOOD PRESS/HEART DISEASE	32,645	5,954	98.0%	
ST/PA/DQM	5	ASTHMA	3,461	1,020	26.6%	
ST/PA/DQM	6	MULTIPLE SCLEROSIS	69	18	26.1%	
ST/PA/DQM	7	PAIN/INFLAMMATION	9,371	2,461	92.5%	
ST/DQM	8	URINARY DISORDERS	4,895	1,335	90.1%	
ST/PA/DQM	9	INFLAMMATORY CONDITIONS	289	90	51.6%	
PA	10	ANTICOAGULANT	3,400	895	77.9%	
Total Top 10:			76,439		84.5%	

# Top 25 Drugs

- Represent 41.1% of your total Plan Cost and comprise 13 indications
- 8 of your top 25 are specialty drugs

Top Drugs by Plan Cost						
1-16-6-16						
AUM Strategy	Rank	Brand Name	Indication	Rxs	Pts.	
PA	1	REVLIMID*	CANCER	47	9	
N/A	2	LANTUS SOLOSTAR	DIABETES	962	306	
ST/DQM	3	CRESTOR	HIGH BLOOD CHOLESTEROL	1,075	476	
ST/PA/DQM	4	ZYTIGA*	CANCER	35	7	
N/A	5	HUMALOG KWIKPEN U-100	DIABETES	506	209	
PA/DQM	6	GLEEVEC*	CANCER	22	5	
PA/DQM	7	ADVAIR DISKUS	ASTHMA	651	222	
ST/PA	8	ZEMAIRA*	ALPHA 1 DEFICIENCY	13	2	
ST/DQM	9	JANUVIA	DIABETES	422	128	
DQM	10	SPIRIVA	COPD	504	156	
ST	11	ZETIA	HIGH BLOOD CHOLESTEROL	483	170	
DQM	12	ATORVASTATIN CALCIUM	HIGH BLOOD CHOLESTEROL	4,706	1,835	
ST	13	LYRICA	PAIN/INFLAMMATION	432	103	
N/A	14	LEVEMIR FLEXTOUCH	DIABETES	306	99	
PA	15	XARELTO	ANTICOAGULANT	341	106	
PA/DQM	16	SYMBICORT	ASTHMA	453	159	
N/A	17	METOPROLOL SUCCINATE	HIGH BLOOD PRESS/HEART DISEASE	3,236	1,188	
PA/DQM	18	FORTEO*	OSTEOPOROSIS	51	14	
ST/PA/DQM	19	HUMIRA PEN*	INFLAMMATORY CONDITIONS	22	5	
N/A	20	LANTUS	DIABETES	316	86	
PA/DQM	21	GLATORA*	MULTIPLE SCLEROSIS	17	4	
PA	22	ELIQUIS	ANTICOAGULANT	298	94	
ST/PA/DQM	23	VICTOZA 3-PAK	DIABETES	145	39	
DQM	24	ROSUVASTATIN CALCIUM	HIGH BLOOD CHOLESTEROL	327	266	
N/A	25	EXJADE*	IRON TOXICITY	6	1	
Total Top 25:				15,376		

\*Specialty Drugs

# Top 10 Specialty Indications

Top Specialty Indications by Plan Cost				
1-16 - 6-16				
AUM Strategy	Overall Rank	Indication	Rxs	Patients
ST/PA/DQM	2	CANCER	153	37
ST/PA/DQM	6	MULTIPLE SCLEROSIS	69	18
ST/PA/DQM	9	INFLAMMATORY CONDITIONS	51	11
ST/PA	15	ALPHA 1 DEFICIENCY	13	2
ST/PA/DQM	19	PULMONARY HYPERTENSION	33	9
PA/DQM	17	OSTEOPOROSIS	53	17
N/A	24	IRON TOXICITY	6	1
PA	33	LOW BLOOD PRESSURE	10	2
ST/PA/DQM	11	MENTAL/NEURO DISORDERS	3	1
PA	10	ANTICOAGULANT	120	74
Total Top 10:			511	

# Patient Stratification

## Patient Care Needs

Smoking Cessation, Allergies, Constipation/Anti-diarrheals, Topical Antifungal / Anti-bacterial infection treatment

### Acute

Colds & Flu, Strep Throat, Ear Infection, Headache, Sprains

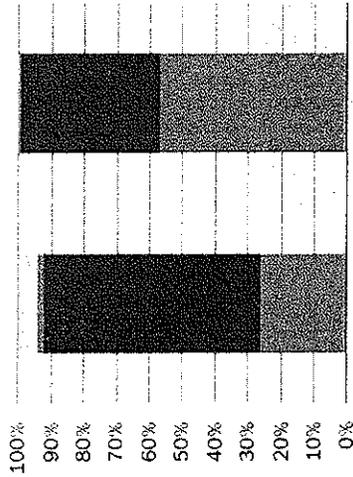
### Chronic

Heart Disease, Diabetes, Arthritis, High Blood Pressure, High Cholesterol, Dementia, Back Pain

### Complex

Multiple Chronic Conditions such as Heart Failure & Diabetes, Cancer, AIDS, Multiple Sclerosis, Metabolic Syndrome

Patient Stratification



Well 5.77% 0.08%  
 Acute 1.85% 0.20%  
 Chronic 66.51% 42.85%  
 Complex 25.86% 56.87%

- 92.4% of the population are Chronic or Complex patients and represent 99.7% of Plan Cost in the current period

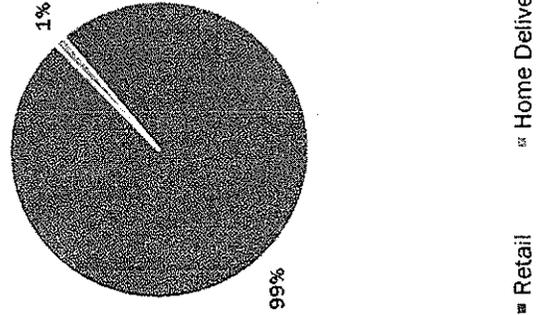
	Well	Acute	Chronic	Complex	Total
Members	492	158	5,671	2,205	8,526
Members %	5.8%	1.9%	66.5%	25.9%	100.0%
Plan Cost %	0.1%	0.2%	42.8%	56.9%	100.0%
Member Age (Avg.)	71.5	71.0	75.9	74.5	74.8
Days of Therapy/Member	2.0	37.0	629.5	1,142.9	715.1
GFR %	61.7%	86.6%	89.3%	85.4%	87.6%
Home Delivery Utilization	0.0%	0.0%	0.7%	1.4%	1.0%

GFR % calculated with Unadjusted Rx's

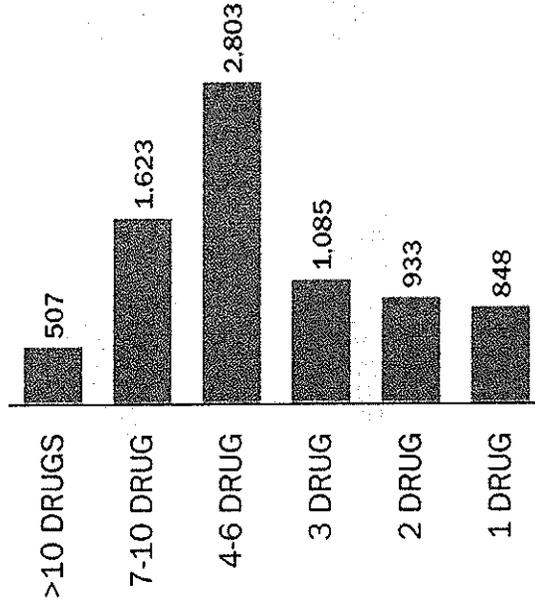
# Channel Management: Home Delivery

- 98.8% of your Plan Cost for maintenance drugs is filled at retail

Plan Cost by Delivery Channel  
(Maintenance Drugs)



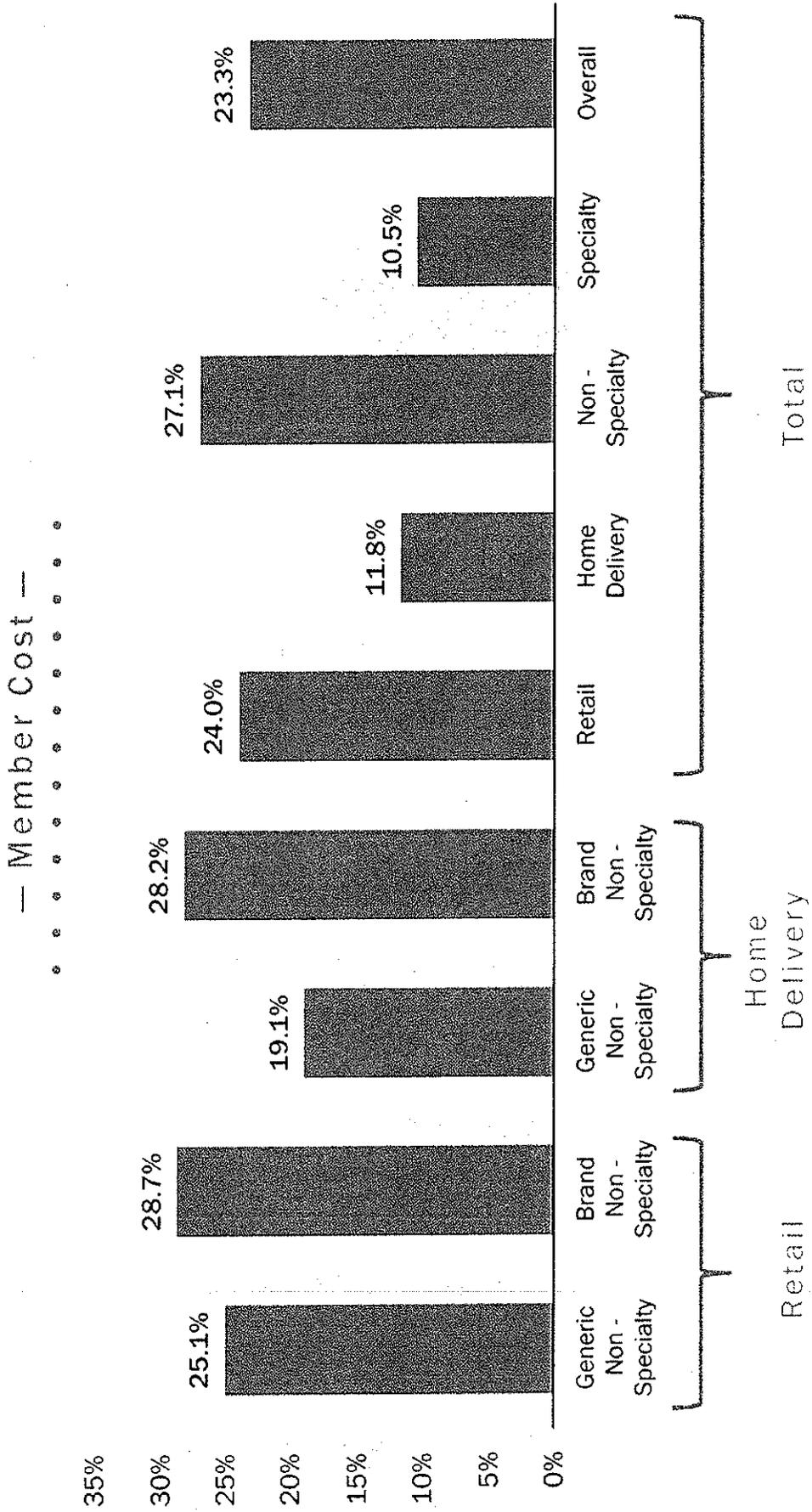
Number of Patients by Number of  
Retail Maintenance Drugs\*



Slide excludes Specialty drugs

# Trend Components: Member Cost

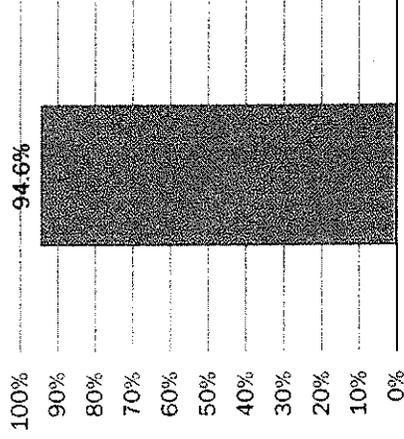
• In the current period, Member Cost was 23.3%.



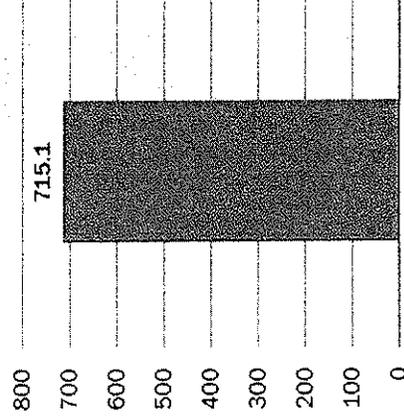
# Utilization

- Utilization is a measurement of the number of people using the plan and when they do, for how long
- Utilization is measured in days per member
- Days per member is a function of the patient per member ratio and days per patient

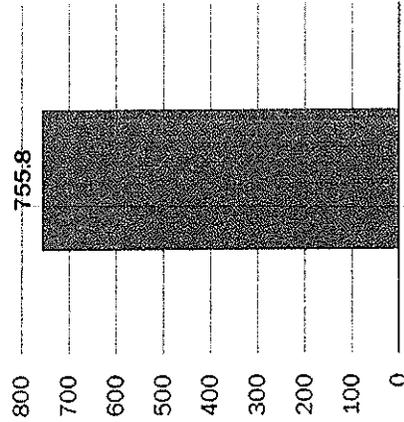
Patients/Member



Days/Member

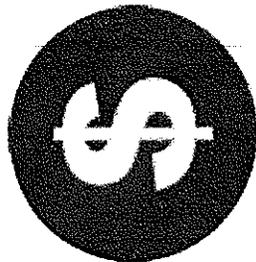


Days/Patient



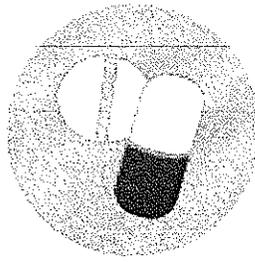
---

# Executive Summary



## Plan Performance

- ✓ Generic Fill Rate 87.6%
- ✓ Specialty Drugs Accounted for 26.4% of Pharmacy Costs
- ✓ Member Cost Share 23.3%



## Clinical Cost Drivers

- ✓ Diabetes, Cancer, High Blood Cholesterol, High Blood Press/Heart Disease, Asthma, represented 50.5% of total pharmacy spend.
- ✓ 4 of the 10 top drugs were for Specialty Medications.

## NDPERS EGWP Premium

- The Current 2016 EGWP Premium is \$82.00.
- NDPERS may choose from several plan design, formulary or network options to lower premium increases for 2017. Recommended Option: 4 – Maintains current plan design and move to a Closed Formulary.
- Premium Amounts based on final 2017 National Average Subsidy amounts.

	<b>Retail</b>	<b>Home Delivery</b>
<b>Tier</b>	<b>Three-Month (90-day) Supply</b>	<b>Three-Month (90-day) Supply</b>
<b>Tier 1:</b>		
<b>Generic Drugs</b>	\$5 copayment plus 15% coinsurance	\$5 copayment plus 15% coinsurance
<b>Tier 2:</b>		
<b>Preferred Brand Drugs</b>	\$15 copayment plus 25% coinsurance	\$15 copayment plus 25% coinsurance
<b>Tier 3:</b>		
<b>Non-Preferred Brand Drugs</b>	\$25 copayment plus 50% coinsurance	\$25 copayment plus 50% coinsurance

<p><b>Coverage Gap stage</b></p>	<p>Under your plan, you reach the Coverage Gap stage once your total yearly drug costs reach \$3,310. During this stage, your cost-sharing amounts for generic and brand-name drugs will remain the same until your yearly out-of-pocket drug costs reach \$4,850.</p>
<p><b>Catastrophic Coverage stage</b></p>	<p>After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,850, you will pay <b>the greater of 5% coinsurance or:</b></p> <ul style="list-style-type: none"> <li>• a \$2.95 copayment for covered generic drugs (including brand drugs treated as generics)</li> <li>• a \$7.40 copayment for all other covered drugs.</li> </ul>

Existing premiums \$82  
 Increase \$8.33  
 Approx: 10.16%

	<b>Scenario 1: Current Plan Design, Formulary &amp; Network</b>
Deductible	\$0
Initial Coverage	Same as Current
Coverage Gap	All
<hr/>	
2017 Premium Estimate PMPM*	\$90.33

Existing premiums \$82

Increase \$8.33

Approx: 10.16%

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 2: Same as Current Plan Design, Formulary & Network. Adc \$100 Deductible
Deductible	\$0	\$100
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	All
2017 Premium Estimate PMPM*	\$90.33	\$86.73

Existing premiums \$82

Increase \$7.73

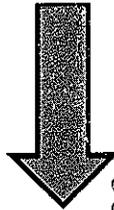
Approx: 5.76%

Existing premiums \$82  
 Increase \$8.33  
 Approx: 10.16%

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 4: Same Plan Design & Network. Move to a Closed Formulary
Deductible	\$0	\$0
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	All
2017 Premium Estimate PMPM*	\$90.33	\$88.95

Existing premiums \$82  
 Increase \$6.95  
 Approx: 8.48%

	<b>Retail</b>	<b>Home Delivery</b>
<b>Tier</b>	<b>Three-Month (90-day) Supply</b>	<b>Three-Month (90-day) Supply</b>
<b>Tier 1:</b>		
<b>Generic Drugs</b>	\$5 copayment plus 15% coinsurance	\$5 copayment plus 15% coinsurance
<b>Tier 2:</b>		
<b>Preferred Brand Drugs</b>	\$15 copayment plus 25% coinsurance	\$15 copayment plus 25% coinsurance
<b>Tier 3:</b>		
<b>Non-Preferred Brand Drugs</b>	\$25 copayment plus 50% coinsurance	\$25 copayment plus 50% coinsurance



Existing premiums \$82  
 Increase \$8.33  
 Approx: 10.16%

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 3: Same as Current Plan Design, Formulary & Network. Coverage Gap option is Generic Only
Deductible	\$0	\$0
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	Generic Only
2017 Premium Estimate PMPM*	\$90.33	\$81.29

Existing premiums \$82  
 Increase \$-.71  
 Approx: -.8%

	<b>Retail Three-Month (90-day) Supply</b>	<b>Home Delivery Three-Month (90-day) Supply</b>
<b>Tier 1: Generic Drugs</b>	\$5 copayment plus 15% coinsurance	\$5 copayment plus 15% coinsurance
<b>Tier 2: Preferred Brand Drugs</b>	\$15 copayment plus 25% coinsurance	\$15 copayment plus 25% coinsurance
<b>Tier 3: Non-Preferred Brand Drugs</b>	\$25 copayment plus 50% coinsurance	\$25 copayment plus 50% coinsurance

<b>Coverage Gap stage</b>	Under your plan, you reach the Coverage Gap stage once your total yearly drug costs reach \$3,310. During this stage, your cost-sharing amounts for generic and brand-name drugs will remain the same until your yearly out-of-pocket drug costs reach \$4,850.
<b>Catastrophic Coverage stage</b>	After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach \$4,850, you will pay <b>the greater of 5% coinsurance or:</b> <ul style="list-style-type: none"> <li>• a \$2.95 copayment for covered generic drugs (including brand drugs treated as generics)</li> <li>• a \$7.40 copayment for all other covered drugs.</li> </ul>

Existing premiums \$82  
 Increase \$8.33  
 Approx: 10.16%

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 5: Same as Current Plan Design & Formulary. Move to a Preferred Network
Deductible	\$0	\$0
Initial Coverage	Same as Current	Same as Current
Coverage Gap	All	All
<hr/>		
2017 Premium Estimate PMPM*	\$90.33	\$89.86

Existing premiums \$82  
 Increase \$7.86  
 Approx: 9.59%

Existing premiums \$82  
 Increase \$8.33  
 Approx: 10.16%

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 6: Current Network & Formulary. Move to CMS Defined Standard Plan Design.
Deductible	\$0	\$400
Initial Coverage	Same as Current	CMS Defined Standard (25%)
Coverage Gap	All	CMS Defined Standard Minimum
2017 Premium Estimate PMPM*	\$90.33	\$68.26

Existing premiums \$82  
 Increase \$13.74  
 Approx: -16.76%

	Scenario 1: Current Plan Design, Formulary & Network	Scenario 2: Same as Current Plan Design, Formulary & Network. Add \$100 Deductible	Scenario 3: Same as Current Plan Design, Formulary & Network. Coverage Gap option is Generic Only
Deductible	\$0	\$100	\$0
Initial Coverage	Same as Current	Same as Current	Same as Current
Coverage Gap	All	All	Generic Only
<hr/>			
2017 Premium Estimate PMPM*	\$90.33	\$86.73	\$81.29
	Scenario 4: Same Plan Design & Network. Move to a Closed Formulary	Scenario 5: Same as Current Plan Design & Formulary. Move to a Preferred Network	Scenario 6: Current Network & Formulary. Move to CMS Defined Standard Plan Design.
Deductible	\$0	\$0	\$400
Initial Coverage	Same as Current	Same as Current	CMS Defined Standard (25%)
Coverage Gap	All	All	CMS Defined Standard Minimum
<hr/>			
2017 Premium Estimate PMPM*	\$88.95	\$89.86	\$68.26

# NDPERS RETIREE BENEFITS COMMITTEE

August 16, 2016

## MINUTES

\* - Present

**BOARD MEMBERS:** \*Yvonne Smith

**STAFF:** \*Sparb Collins, \*Bryan Reinhardt, \*Kathy Allen, \*Rebecca Fricke,  
\*Sharon Schiermeister,

**Guests:**

**Interest Groups:** \*Bill Kalanek - AFPE/NASW, Stuart Savelkohl - NDPEA

**Membership Representatives:**

\*Dave Zentner, \*Weldee Baetsch, David Gunkel, \*Bill Lardy,

\*Ron Leingang \*Howard Sage, \*Denae Kautzman

Fort Union Room (moved from Sakakawea Room)

### Minutes

9:05 – Sparb started the meeting and covered the presentation. ESI sent utilization statistics for the retiree EGWP. The data is for the first six months of 2016. The plan will renew on Jan 1<sup>st</sup>, 2017. The group asked if there were statistics on rejected claims for new specialty drugs. There were not, NDPERS staff just got the ESI information yesterday. The slides moved to the topic of the renewal of the EGWP for 2017. The present plan monthly cost would increase from \$82 to \$90.33 (10.16%). ESI gave several plan design options to consider that would shift costs and reduce the premium increase.

#1 – Current plan \$90.33

#2 – Add a \$100 deductible \$86.72, the \$3.61 savings (\$43.32 per year) for potential \$100 cost

#3 – Allow only generics in the coverage gap \$81.29, big savings but may be hardship for some

#4 – Closed formulary \$88.95, \$1.38 savings, not much savings but may be hardship for some

#5 – Preferred network \$89.86, \$.47 savings, not much but may be hardship for some

#6 – Change to standard plan benefits \$68.26, big savings, but at this level of coverage it would probably be best to unbundle the plan.

Additional questions were asked:

Number of members with less than \$3,310 in costs?

How many reach and go through the "doughnut hole"?

Number of members that use preferred brand drugs?

Can we ID users of nonformulary drugs where a formulary drug is available?

Discussion followed if members would leave the plan with a 10% increase. Since the plan is still bundled with the medical side, the thought was not many would leave. Time is coming fast and if the plan were to go to bid, it would have to be done in the next few weeks.

The retiree group felt the NDPERS Board should continue with the current plan and pass along the \$90.33 premium. They also thought efforts should be made to target high cost members and nonformulary RX users with education on alternatives. The #3 and #4 options should be studied.

Rebecca noted that CMS changes now make it possible to add nonformulary generic drugs into the 3<sup>rd</sup> tier (higher cost sharing) instead of the 1<sup>st</sup> tier (generic cost sharing). This would involve 52 NDPERS members and would result in no premium cost reduction. The group felt this should not be done since it is a small number of members and there would be no cost savings. Maybe a reach out could be made to these members letting them know a change might be made in the future and if any lower cost alternative medications are available.

10:15 – Adjourn

## Memo

**Date:** August 17, 2016  
**To:** NDPERS Board  
**From:** Josh Johnson and Pat Pechacek, Deloitte Consulting LLP  
**Subject:** EGWP Renewal Review

NDPERS staff asked that Deloitte Consulting LLP, review the Express Scripts, Inc. (ESI) 2017 EGWP renewal rates for reasonableness and appropriateness.

On July 29, 2016, the Centers for Medicare and Medicaid Services (CMS) released the national average monthly bid amount for Standard Part D and the Base Beneficiary Premium for 2017. ESI receives payments from CMS based on these bidding averages. CMS payments to ESI account for a large percentage of the overall needed premium and factor into the overall renewal. The national average monthly bid amount for Part D coverage decreased to \$61.08 from \$64.66 in 2016, and the Part D base beneficiary premium increased to \$35.63 from \$34.10 in 2016.

On April 4, 2016, CMS announced an annual 2016 trend on Medicare Part D payments of 6.99%, however, prior year trend was underestimated by 4.55%, yielding an expected 2017 increase of 11.75%.

Deloitte actuaries are seeing EGWP rate increases frequently in the 10%-12% range and national survey data and pharmacy benefit managers are citing projected trends from approximately 8%-12% depending on the source. The most frequent reason cited for increased trend is the increase in specialty medication utilization and price.

### Proposed ESI Rates and Plan Designs

2016 rate is \$82 per member per month

2017 Plan Design	2017 Rate	Increase	Savings
1) Current design, network & formulary	\$90.33	10.2%	
2) Add \$100 deductible	\$86.73	5.8%	-4.0%
3) Coverage gap generic only	\$81.29	-0.9%	-10.0%
4) Change to a closed formulary	\$88.95	8.5%	-1.5%
5) Change to a preferred network	\$89.86	9.6%	-0.5%
6) Change to CMS minimum design	\$68.26	-16.8%	-24.4%



Official Professional Services Sponsor

To: NDPER\$ Board  
Subject: EGWP Renewal Review  
Date: August 17, 2016  
Page 2

Based on emerging market trends gathered from Deloitte actuaries, national survey data and CMS trend estimates, the proposed 10.2% increase to maintain the current plan design, network and formulary is reasonable.

Deloitte would be happy to conduct a more detailed analysis of ESI's underlying renewal calculations should the board require it, and pending receipt of detailed experience data including underlying claims experience, underwriting trend assumptions, estimated drug rebates, anticipated loss ratios, CMS payment estimates, etc.

## Memo

**Date:** September 6, 2016

**To:** NDPERS Board

**From:** Brian Collender, FSA, MAAA and Megan Partida, ASA, MAAA - Deloitte Consulting LLP

**Subject:** EGWP Renewal Pricing Review

Pursuant to your request, Deloitte Consulting LLP (“Deloitte Consulting”) has reviewed the Express Scripts, Inc. (ESI) 2017 EGWP renewal rates pricing methodology and assumptions for reasonableness and appropriateness. Based on the procedures performed, we believe that ESI used appropriate and acceptable actuarial methods and employed reasonable assumptions in using those methods.

### Methodology & Assumptions

We reviewed the pricing methodology provided by ESI in file [NDPERS – 2017 ESI Claim Projection\_EGWP.pdf]. The pricing methodology utilized by ESI in the 2017 rate development appears reasonable. Actual NDPERS claims and member months is used to calculate a per member per month (PMPM) claims cost. The PMPM is projected forward using trend cost assumptions and assumed changes in discounts from the base period to the projection period. The plan paid portion PMPM is calculated by removing estimated member cost sharing, costs paid by pharmaceutical manufacturers, and prescription drug rebates. The 2017 gross premium is calculated by utilizing the 2017 anticipated loss ratio. Finally, Centers for Medicare and Medicaid Services (CMS) payments to ESI for Direct Subsidy and Federal Reinsurance are removed from the gross premium to arrive at the final calculated member premium.

#### *Base Data*

ESI’s 2017 rate development uses NDPERS allowed claims incurred between January 1, 2016 and April 30, 2016 and exposed member months associated with those claims as the base data allowed claims PMPM. We note that four months of data is utilized because ESI does not have historic data prior to 2016. While the increase in 2016 allowed claims appears high compared to the 2013-2014 allowed claims utilized in the 2016 rate development, 2014-2015 trends and 2015-2016 trends were high in the industry due to high cost specialty drugs. Therefore, the 2016 allowed claims do not appear unreasonable compared to historical information and industry trends.

For 2018 rate development, we recommend ESI use a full calendar year of data to account for seasonality and movement through the CMS benefit phases. Utilizing the full calendar year 2016 data for 2018 pricing is also in line with CMS prescribed guidance for Medicare Advantage and Prescription Drug Plan pricing.

#### *Assumptions*

ESI uses reasonable assumptions to adjust the base data to 2017 in their 2017 rate development calculation. We reviewed the following assumptions with commentary below:

- Trend and Pricing Changes – We understand that trend and pricing changes includes utilization trend, Average Wholesale Price (AWP) or cost trend, and discount changes. We reviewed the underlying utilization and AWP trends provided by ESI and find the assumptions reasonable and in line with published industry reports. While the discount changes were not provided, we understand these are favorable and reduce the ultimate member premium.
- Member Cost Share and Manufacturer Discount PMPM – The member cost share and manufacturer discount as a percentage of allowed claims has increased from the 2016 rate development, which lowers member premium. The percentage of member cost share and manufacturer discount as a percentage of allowed claims appears reasonable.
- Estimated 2017 Rx Drug Rebate PMPM – The estimated 2017 rebate is reasonable and in line with our expectations of ESI rebate contracts. We have seen instances where plans will trade-off lower discounts for higher rebates if that appears to benefit the group. While the rebates appear competitive this may be something to discuss with ESI in the future for 2018 rate development. Actuarial modeling should be performed to determine if renegotiation of contracted discounts and rebates could provide savings to member premium.
- 2017 Anticipated Loss Ratio – The 2017 anticipated loss ratio is higher in 2017 rate development than 2016 rate development. The higher loss ratio decreases member premium, so is beneficial in the rate development. The assumed loss ratio in pricing of 88.1% is greater than the minimum required loss ratio of 85.0% per CMS regulation. Further, the 88.1% appears competitive based on industry expectations.
- CMS Payments to ESI – We understand that the CMS payments to ESI include the Direct Subsidy and the Federal Reinsurance Subsidy. Based on the CMS released 2017 national average monthly bid amount and base beneficiary premium, and 2016 NDPERS risk score, the projected Direct Subsidy provided by ESI is in line with our expectations. We note that the Federal Reinsurance as a percentage of allowed claims is on the low end of our expectations given the assumption used in prior year rate development. However, the population appears healthy given the 2016 risk score and members are provided full coverage through the gap, so it is not unreasonable that the assumption is low as fewer claims may fall above the Federal Reinsurance threshold. For 2018 rate development, the actual Federal Reinsurance received for 2015 and 2016 should be utilized to refine the assumption to ensure the assumption is in line with actual received Federal Reinsurance Subsidy payments.
- Formulary and Utilization Management – We note that there are no assumptions included in the rate development for savings from enhanced utilization management (UM) or formulary management. Typically, plans can generate savings by implementing more effective UM and formulary changes year-over-year. We understand from ESI that NDPERS has the standard ESI Employer Group Waiver Plan (EGWP) UM and additional programs were not included due to potential member disruption concerns. We also understand that closing the formulary was discussed but it was ultimately decided against proceeding with this strategy. For 2018 rate development, formulary and UM changes could be discussed as a way to potentially reduce member premium.

## Conclusions

Based on our review, we believe reasonable and appropriate actuarial methodologies and assumptions were utilized by ESI in the 2017 rate development. We recommend enhancements and refinements be made for 2018 rate development as ESI will have a calendar year of historical allowed claims and member months and actual payments received from CMS for this population. We recommend NDPERS to consider contract negotiations for pharmacy rebates and discounts to determine if better rebates with fewer discounts would benefit their rate development. We also recommend NDPERS and ESI consider formulary and utilization management techniques to help lower member premium.

## Attachment 3

# Sanford to leave DakotaCare after negotiations with Avera fall through

Jonathan Ellis, jonellis@argusleader.com 7:58 a.m. CDT August 24, 2016

Sanford Health(Photo: logo)

Sanford Health says it will leave DakotaCare next year after Sanford and Avera Health Plans failed to reach a deal in which Sanford could offer a broad health plan that included Avera's physicians.

The decision will affect thousands of consumers who will open enroll for health insurance later this year, and it ensures that only one health insurer – Wellmark – will be able to offer a broad insurance network in South Dakota that includes most of the state's health providers.

And it means that consumers in some communities might have to drive longer distances for in-network care or that longstanding health providers will suddenly no longer be in DakotaCare's network.

Laurie Gill, the commissioner for the South Dakota Bureau of Human Resources, notified the state's more than 12,000 employees – the biggest member group in DakotaCare – that Sanford's decision does not require immediate changes.

“We will work with our partners to continue to provide services for our members and will keep you informed as new information becomes available,” Gill wrote.

The decision was set in motion last year when Avera bought DakotaCare, which offered the only other broad network plan in the state. Avera's acquisition meant it owned an insurance plan that offered access to Sanford's providers. Prior to the acquisition, Avera's health plan generally did not include networks with Sanford providers, and Sanford did not offer plans with Avera providers.

Earlier this year, Sanford officials say they approached Avera about extending access to Sanford Health Plans to Avera physicians, a move that would have created a third broad network plan in the state and one that would have put Sanford on an equal footing with Avera's DakotaCare plan. But Avera countered with a proposal that Sanford buy an equity share in DakotaCare.

Paul Hanson, the executive vice president of Sanford Health, said Sanford balked at Avera's proposal based on philosophical and regulatory concerns. Hanson said he didn't think it was

realistic for two competing health systems to own an insurance company, and he said the move might have raised anti-trust problems with the two owning a single insurer.

Hanson said the decision means that Sanford will have to develop new insurance plans that will be attractive and competitive in the new marketplace. It also means that Sanford, at least in the short-term, will lose millions of dollars by leaving DakotaCare.

“Is it going to be easy? No. This is going to be a long road, but it’s the high road for us to take,” Hanson said.

Rob Bates, the senior vice president of Avera Health, called Sanford’s decision to leave DakotaCare “unfortunate,” and one meant to cause “maximum noise in the marketplace.” He predicted that it would be disruptive to some of DakotaCare’s members.

Bates said that Avera offered ownership stakes in DakotaCare to Sanford and other health providers across the state. Avera bought DakotaCare with the intent of preserving a broad-network plan that was owned by more than just Avera. He said Sanford rejected multiple offers to buy into DakotaCare, and he said he didn’t agree that there were anti-trust problems with Sanford and Avera owning DakotaCare.

Bates also said Avera could not come to terms with Sanford about allowing Avera providers to participate in Sanford’s plans because Sanford’s terms and conditions were too “onerous,” a charge that Sanford officials dismissed.

Ultimately, Sanford said that it will provide continuity of care for DakotaCare members who are undergoing treatment for various ailments when the change occurs



# QUARTERLY STATEMENT

Attachment 4

AS OF MARCH 31, 2016  
OF THE CONDITION AND AFFAIRS OF THE

## SANFORD HEALTH PLAN

NAIC Group Code 01246 , 01246 NAIC Company Code 95683 Employer's ID Number 91-1842494  
(Current Period) (Prior Period)

Organized under the Laws of South Dakota , State of Domicile or Port of Entry South Dakota

Country of Domicile United States

Licensed as business type: Life, Accident & Health [  ] Property/Casualty [  ] Hospital, Medical & Dental Service or Indemnity [  ]  
 Dental Service Corporation [  ] Vision Service Corporation [  ] Health Maintenance Organization [  ]  
 Other [  ] Is HMO Federally Qualified? Yes [  ] No [  ]

Incorporated/Organized 07/30/1997 Commenced Business 01/01/1998

Statutory Home Office 300 Cherapa Place, Suite 201 , Sioux Falls, SD, US 57103  
(Street and Number) (City or Town, State, Country and Zip Code)

Main Administrative Office 300 Cherapa Place, Suite 201 Sioux Falls, SD, US 57103 605-328-6868  
(Street and Number) (City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Mail Address PO Box 91110 , Sioux Falls, SD, US 57109-1110  
(Street and Number or P.O. Box) (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 300 Cherapa Place, Suite 201 Sioux Falls, SD, US 57103 605-328-6868  
(Street and Number) (City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Internet Web Site Address www.sanfordhealthplan.org

Statutory Statement Contact Kristen B. Lunt 605-328-6868  
(Name) (Area Code) (Telephone Number) (Extension)  
Kristen.Lunt@sanfordhealth.org 605-328-6811  
(E-Mail Address) (FAX Number)

### OFFICERS

Name	Title	Name	Title
<u>Kelby K. Krabbenhoft</u>	<u>Chief Executive Officer</u>	<u>Rich G. Adcock</u>	<u>Executive Vice President</u>
<u>Kirk J. Zimmer</u>	<u>President</u>	<u>Jeff D. Sandene</u>	<u>Chief Financial Officer</u>

### OTHER OFFICERS

DIRECTORS OR TRUSTEES			
Name	Name	Name	Name
<u>Clayton Van Balen MD</u>	<u>Denise Myhre</u>	<u>Marlin Overman</u>	<u>Sheila Beermann</u>
<u>Craig Lambrecht MD</u>	<u>Robert St. Michel</u>	<u>Steve Watkins</u>	<u>Lori Devries</u>
<u>Kimberly Elbers</u>	<u>Dwight W. Thompson</u>	<u>Larry Heidebrink</u>	<u>Rich G. Adcock</u>

State of South Dakota ss  
 County of Minnehaha

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions and Accounting Practices and Procedures* manual except to the extent that: (1) state law may differ, or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Kirk J. Zimmer Jeff D. Sandene  
 President Chief Financial Officer

Subscribed and sworn to before me this  
 day of \_\_\_\_\_

- a. Is this an original filing? Yes [  ] No [  ]
- b. If no:
1. State the amendment number
  2. Date filed
  3. Number of pages attached

Monica Begeman, Notary Public South Dakota  
 09/01/2021

STATEMENT AS OF MARCH 31, 2016 OF THE SANFORD HEALTH PLAN

ASSETS

	Current Statement Date			4 December 31 Prior Year Net Admitted Assets
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	
1. Bonds	79,877,179		79,877,179	58,194,921
2. Stocks:				
2.1 Preferred stocks	923,901		923,901	925,889
2.2 Common stocks	28,286,367		28,286,367	27,794,516
3. Mortgage loans on real estate:				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate:				
4.1 Properties occupied by the company (less \$ _____ encumbrances)			0	0
4.2 Properties held for the production of income (less \$ _____ encumbrances)			0	0
4.3 Properties held for sale (less \$ _____ encumbrances)			0	0
5. Cash (\$ _____ 52,738,497 ), cash equivalents (\$ _____ 0 ) and short-term investments (\$ _____ 42,692,189 )	95,430,686		95,430,686	81,862,272
6. Contract loans (including \$ _____ premium notes)			0	0
7. Derivatives	0		0	0
8. Other invested assets	1,958,342		1,958,342	1,934,586
9. Receivables for securities			0	0
10. Securities lending reinvested collateral assets			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	206,476,474	0	206,476,474	170,712,184
13. Title plants less \$ _____ charged off (for Title insurers only)			0	0
14. Investment income due and accrued	1,418,449		1,418,449	1,056,327
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	815,972	41,027	774,945	7,062,486
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$ _____ earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums (\$ _____ ) and contracts subject to redetermination (\$ _____ )	9,517,823		9,517,823	12,959,456
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	6,107,389		6,107,389	4,113,557
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans	5,871		5,871	8,148
18.1 Current federal and foreign income tax recoverable and interest thereon	383,405		383,405	383,405
18.2 Net deferred tax asset			0	0
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software	1,698,676	1,294,772	403,904	440,900
21. Furniture and equipment, including health care delivery assets (\$ _____ )	1,070,310	1,070,310	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	14,598		14,598	25,579,034
24. Health care (\$ _____ 585,547 ) and other amounts receivable	7,193,020	6,598,701	594,319	706,074
25. Aggregate write-ins for other-than-invested assets	366,019	366,019	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	235,068,005	9,370,828	225,697,176	223,021,571
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28. Total (Lines 26 and 27)	235,068,005	9,370,828	225,697,176	223,021,571
<b>DETAILS OF WRITE-INS</b>				
1101.			0	0
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0
2501. Prepaid expenses	366,019	366,019	0	0
2502.				
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	366,019	366,019	0	0

2

## LIABILITIES, CAPITAL AND SURPLUS

	Current Period			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$ ..... reinsurance ceded)	91,554,370	6,056,806	97,611,177	105,424,023
2. Accrued medical incentive pool and bonus amounts			.0	.0
3. Unpaid claims adjustment expenses		2,767,000	2,767,000	2,505,000
4. Aggregate health policy reserves including the liability of \$ ..... for medical loss ratio rebate per the Public Health Service Act		41,992,754	41,992,754	39,567,493
5. Aggregate life policy reserves			.0	.0
6. Property/casualty unearned premium reserve			.0	.0
7. Aggregate health claim reserves			.0	.0
8. Premiums received in advance		12,920,512	12,920,512	4,796,856
9. General expenses due or accrued		21,404,475	21,404,475	13,496,029
10.1 Current federal and foreign income tax payable and interest thereon (including \$ ..... on realized gains (losses))			.0	.0
10.2 Net deferred tax liability		144,320	144,320	144,320
11. Ceded reinsurance premiums payable			.0	.0
12. Amounts withheld or retained for the account of others			.0	.0
13. Remittances and items not allocated			.0	.0
14. Borrowed money (including \$ ..... current) and interest thereon \$ ..... (including \$ ..... current)			.0	.0
15. Amounts due to parent, subsidiaries and affiliates		3,185,672	3,185,672	2,035,097
16. Derivatives		.0	.0	.0
17. Payable for securities			.0	.0
18. Payable for securities lending			.0	.0
19. Funds held under reinsurance treaties (with \$ ..... authorized reinsurers, \$ ..... unauthorized reinsurers and \$ ..... certified reinsurers)			.0	.0
20. Reinsurance in unauthorized and certified (\$ ..... ) companies			.0	.0
21. Net adjustments in assets and liabilities due to foreign exchange rates			.0	.0
22. Liability for amounts held under uninsured plans			.0	.0
23. Aggregate write-ins for other liabilities (including \$ ..... current)	.0	.0	.0	.0
24. Total liabilities (Lines 1 to 23)	91,554,370	88,471,540	180,025,911	167,968,819
25. Aggregate write-ins for special surplus funds	XXX	XXX	.0	7,579,721
26. Common capital stock	XXX	XXX	.0	.0
27. Preferred capital stock	XXX	XXX	.0	.0
28. Gross paid in and contributed surplus	XXX	XXX	137,525,989	137,525,989
29. Surplus notes	XXX	XXX	.0	.0
30. Aggregate write-ins for other-than-special surplus funds	XXX	XXX	(1,041,658)	(1,065,414)
31. Unassigned funds (surplus)	XXX	XXX	(90,813,065)	(88,987,544)
32. Less treasury stock, at cost:				
32.1 ..... shares common (value included in Line 26 \$ ..... )	XXX	XXX	.0	.0
32.2 ..... shares preferred (value included in Line 27 \$ ..... )	XXX	XXX	.0	.0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	45,671,266	55,052,752
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	225,697,176	223,021,571
<b>DETAILS OF WRITE-INS</b>				
2301. ....			.0	.0
2302. ....			.0	.0
2303. ....			.0	.0
2398. Summary of remaining write-ins for Line 23 from overflow page	.0	.0	.0	.0
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	0	0	0	0
2501. Health insurer fee	XXX	XXX		7,579,721
2502. ....	XXX	XXX		.0
2503. ....	XXX	XXX		.0
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	.0	.0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	0	7,579,721
3001. Investment in insurance subsidiary	XXX	XXX	(1,041,658)	(1,065,414)
3002. ....	XXX	XXX		.0
3003. ....	XXX	XXX		.0
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	.0	.0
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	(1,041,658)	(1,065,414)

## STATEMENT OF REVENUE AND EXPENSES

	Current Year To Date		Prior Year To Date	Prior Year Ended December 31
	1 Uncovered	2 Total	3 Total	4 Total
1. Member Months	XXX	412,185	180,759	1,135,662
2. Net premium income (including \$ non-health premium income)	XXX	203,665,690	112,235,092	612,610,693
3. Change in unearned premium reserves and reserve for rate credits	XXX		0	0
4. Fee-for-service (net of \$ medical expenses)	XXX	145,515	142,402	577,306
5. Risk revenue	XXX		0	0
6. Aggregate write-ins for other health care related revenues	XXX	0	0	0
7. Aggregate write-ins for other non-health revenues	XXX	0	0	0
8. Total revenues (Lines 2 to 7)	XXX	203,811,205	112,377,494	613,187,998
<b>Hospital and Medical:</b>				
9. Hospital/medical benefits		84,693,549	54,707,602	313,743,837
10. Other professional services		58,897,705	23,946,697	156,746,599
11. Outside referrals		10,371,429	4,859,012	28,223,826
12. Emergency room and out-of-area		13,182,731	8,325,852	41,209,936
13. Prescription drugs		25,608,747	12,092,932	87,101,993
14. Aggregate write-ins for other hospital and medical	0	0	0	0
15. Incentive pool, withhold adjustments and bonus amounts			0	0
16. Subtotal (Lines 9 to 15)	0	192,754,161	103,932,094	627,026,191
<b>Less:</b>				
17. Net reinsurance recoveries		1,247,128	1,299,768	8,830,328
18. Total hospital and medical (Lines 16 minus 17)	0	191,507,032	102,632,326	618,195,862
19. Non-health claims (net)			0	0
20. Claims adjustment expenses, including \$ 2,932,892 cost containment expenses		5,634,012	2,211,375	15,958,786
21. General administrative expenses		12,919,833	7,540,297	16,955,035
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only)		2,425,261	0	38,581,000
23. Total underwriting deductions (Lines 18 through 22)	0	212,486,138	112,383,998	689,690,684
24. Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(8,674,934)	(6,504)	(76,502,686)
25. Net investment income earned		1,239,014	286,656	2,871,221
26. Net realized capital gains (losses) less capital gains tax of \$		(235)	(1,790)	(84,416)
27. Net investment gains (losses) (Lines 25 plus 26)	0	1,238,779	284,866	2,786,804
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$ ) (amount charged off \$ )]			0	0
29. Aggregate write-ins for other income or expenses	0	17,857	11,428	131,232
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	(7,418,297)	289,791	(73,584,649)
31. Federal and foreign income taxes incurred	XXX		299,000	(341,527)
32. Net income (loss) (Lines 30 minus 31)	XXX	(7,418,297)	(9,209)	(73,243,122)
<b>DETAILS OF WRITE-INS</b>				
0601.	XXX		0	0
0602.	XXX			
0603.	XXX			
0698. Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX	0	0	0
0701.	XXX		0	0
0702.	XXX		0	0
0703.	XXX		0	0
0798. Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799. Totals (Lines 0701 through 0703 plus 0798) (Line 7 above)	XXX	0	0	0
1401.			0	0
1402.			0	0
1403.			0	0
1498. Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499. Totals (Lines 1401 through 1403 plus 1498) (Line 14 above)	0	0	0	0
2901. Other Revenue (Expense)		17,857	11,428	131,232
2902.			0	0
2903.				
2998. Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999. Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)	0	17,857	11,428	131,232

4

## STATEMENT OF REVENUE AND EXPENSES (Continued)

	1	2	3
	Current Year To Date	Prior Year To Date	Prior Year Ended December 31
<b>CAPITAL &amp; SURPLUS ACCOUNT</b>			
33. Capital and surplus prior reporting year.....	55,052,752	24,097,466	24,097,466
34. Net income or (loss) from Line 32.....	(7,418,297)	(9,209)	(73,243,122)
35. Change in valuation basis of aggregate policy and claim reserves.....		0	0
36. Change in net unrealized capital gains (losses) less capital gains tax of \$.....	95,855	22,503	(1,396,846)
37. Change in net unrealized foreign exchange capital gain or (loss).....		0	0
38. Change in net deferred income tax.....		0	(1,914,320)
39. Change in nonadmitted assets.....	(2,082,800)	(1,056,976)	(2,408,249)
40. Change in unauthorized and certified reinsurance.....	0	0	0
41. Change in treasury stock.....		0	0
42. Change in surplus notes.....	0	0	0
43. Cumulative effect of changes in accounting principles.....		0	0
44. Capital Changes:			
44.1 Paid in.....		0	0
44.2 Transferred from surplus (Stock Dividend).....		0	0
44.3 Transferred to surplus.....		0	0
45. Surplus adjustments:			
45.1 Paid in.....		0	110,512,771
45.2 Transferred to capital (Stock Dividend).....	0	0	0
45.3 Transferred from capital.....		0	(2,000,000)
46. Dividends to stockholders.....		0	0
47. Aggregate write-ins for gains or (losses) in surplus.....	23,756	921,512	1,405,051
48. Net change in capital and surplus (Lines 34 to 47).....	(9,381,486)	(122,170)	30,955,286
49. Capital and surplus end of reporting period (Line 33 plus 48)	45,671,266	23,975,297	55,052,752
<b>DETAILS OF WRITE-INS</b>			
4701. Investment in insurance subsidiary.....	23,756	921,512	1,405,051
4702. ....		0	0
4703. ....		0	0
4798. Summary of remaining write-ins for Line 47 from overflow page.....	0	0	0
4799. Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)	23,756	921,512	1,405,051

## CASH FLOW

	1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
<b>Cash from Operations</b>			
1. Premiums collected net of reinsurance	223,902,777	93,547,593	651,830,994
2. Net investment income	1,409,325	549,925	3,312,108
3. Miscellaneous income	223,687	(231,606)	726,484
4. Total (Lines 1 to 3)	225,535,789	93,865,911	655,869,586
5. Benefit and loss related payments	205,834,014	94,481,341	597,652,360
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		0	0
7. Commissions, expenses paid and aggregate write-ins for deductions	10,363,265	9,025,584	23,713,462
8. Dividends paid to policyholders		0	0
9. Federal and foreign income taxes paid (recovered) net of \$ tax on capital gains (losses)	0	0	(459,609)
10. Total (Lines 5 through 9)	216,197,280	103,506,925	620,906,212
11. Net cash from operations (Line 4 minus Line 10)	9,338,510	(9,641,013)	34,963,374
<b>Cash from Investments</b>			
12. Proceeds from investments sold, matured or repaid:			
12.1 Bonds	2,573,743	515,136	6,164,890
12.2 Stocks	0	0	24,577
12.3 Mortgage loans	0	0	0
12.4 Real estate	0	0	0
12.5 Other invested assets	0	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	0	0
12.7 Miscellaneous proceeds	0	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	2,573,743	515,136	6,189,467
13. Cost of investments acquired (long-term only):			
13.1 Bonds	6,261,234	1,527,305	6,439,422
13.2 Stocks	394,007	0	29,203,286
13.3 Mortgage loans	0	0	0
13.4 Real estate	0	0	0
13.5 Other invested assets	0	921,512	0
13.6 Miscellaneous applications	0	1,790	1,790
13.7 Total investments acquired (Lines 13.1 to 13.6)	6,655,241	2,450,607	35,644,498
14. Net increase (or decrease) in contract loans and premium notes	0	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(4,081,499)	(1,935,471)	(29,455,031)
<b>Cash from Financing and Miscellaneous Sources</b>			
16. Cash provided (applied):			
16.1 Surplus notes, capital notes	0	0	0
16.2 Capital and paid in surplus, less treasury stock	0	0	64,326,990
16.3 Borrowed funds	0	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0	0
16.5 Dividends to stockholders	0	0	0
16.6 Other cash provided (applied)	8,311,403	574,888	(2,692,131)
17. Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	8,311,403	574,888	61,634,858
<b>RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS</b>			
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	13,568,414	(11,001,597)	67,143,201
19. Cash, cash equivalents and short-term investments:			
19.1 Beginning of year	81,862,272	14,719,071	14,719,071
19.2 End of period (Line 18 plus Line 19.1)	95,430,686	3,717,474	81,862,272

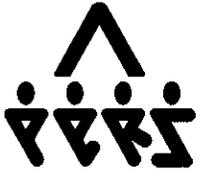
6

STATEMENT AS OF MARCH 31, 2016 OF THE SANFORD HEALTH PLAN

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1 Total	3 Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	Group							
Total Members at end of:										
1. Prior Year	129,667	6,914	100,975	1,755	0	0	90	0	19,933	0
2. First Quarter	139,062	17,073	100,052	1,764	0	0	127	0	20,046	0
3. Second Quarter	0	0	0	0	0	0	0	0	0	0
4. Third Quarter	0	0	0	0	0	0	0	0	0	0
5. Current Year	0	0	0	0	0	0	0	0	0	0
6. Current Year Member Months	412,185	48,157	300,358	5,266			411		57,973	
Total Member Ambulatory Encounters for Period:										
7. Physician	116,706	10,381	69,428	14,649			87		22,161	
8. Non-Physician	109,410	10,085	72,865	9,196			97		17,165	
9. Total	226,116	20,466	142,293	23,847	0	0	184	0	39,326	0
10. Hospital Patient Days Incurred	8,922	1,119	4,021	1,322			2		2,458	
11. Number of Inpatient Admissions	2,325	282	1,240	334			1		488	
12. Health Premiums Written (a)	205,129,151	17,311,189	117,709,822	882,034			230,989		68,985,117	
13. Life Premiums Direct	0									
14. Property/Casualty Premiums Written	0									
15. Health Premiums Earned	205,129,151	17,311,189	117,709,822	882,034			230,989		68,985,117	
16. Property/Casualty Premiums Earned	0									
17. Amount Paid for Provision of Health Care Services	199,319,879	12,681,792	116,830,057	901,921			168,720		68,737,389	
18. Amount Incurred for Provision of Health Care Services	192,754,161	17,594,501	109,421,695	973,976			177,280		64,586,709	

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$



**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](mailto:NDPERS-info@nd.gov) • [www.nd.gov/ndpers](http://www.nd.gov/ndpers)

# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 7, 2016  
**SUBJECT:** Telehealth Bill

At the May 2015 Board meeting we reviewed that the following bill which was passed this last session:

---

## HB 1038

- Passed
- Telemedicine
- PERS already covered telemedicine

---

At the August 2015 meeting we reviewed a presentation from Sanford on the bill (Attachment 1)

## HB1038 Telehealth Overview

North Dakota Health Information Network  
Telehealth Workgroup  
July 20, 2015

Section 54-03-28 (2) (c) states:

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 system's 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 bill's mandate.

This section requires PERS to:

1. 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.
2. The public employees retirement system shall append to the bill a report regarding the effect of the mandated coverage or payment on the system's health insurance programs.
3. The report must include a recommendation on whether the coverage or payment should continue

In compliance with this section, to date PERS Board has:

1. Approved the introduction of Proposed Bill #17.01 (Attachment 2)
2. Had Deloitte prepare a review (Attachment 3)

Yet to be done is for the Board to prepare its recommendations on the bill. In doing so the Board could:

1. Base its recommendation on the Deloitte review
2. Invite interested parties to comment on the Deloitte review at the regular September meeting or in writing by the meeting and consider those comments in preparing the final recommendations.
3. Share those recommendations with the Employee Benefits Programs Committee.

Staff is seeking your direction on how to proceed now that the bill has been introduced and the Deloitte review is completed.

Board Action Requested

Determine how to proceed with the last phase of the Telehealth Bill

## **HB1038 Telehealth Overview**

North Dakota Health Information Network  
Telehealth Workgroup  
July 20, 2015

### **Our discussion today...**

- Overview of HB1038
- Legislative process and timeline
- Eligibility
- Covered Services
- Coding & Reimbursement
- Q&As

## HB1038

- Require the coverage of telemedicine for NDPERS
- Amendments adopted include:
  - adding definitions for “distant site” and “originating site”
  - reimbursements may be established through negotiations
  - In addition, a provision was struck that would prohibit special cost-sharing for services provided through telemedicine.

3

## HB1038

- Services still subject to medical necessity
- Services subject to normal deductible, coinsurance and copayment amounts
- The bill will expire June 30, 2017 unless the expiration is reversed as a result of recommendations of a study.

4

## Legislative Process and Timeline

- Oct. 2015 – PERS develops study outline
- March 2016 – PERS submits bill draft to the Employee Benefits Committee
- Aug/Sept 2016 – Report is submitted to Employee Benefits Committee

5

## Facility Eligibility

We follow CMS eligibility standards for facilities:

- Practitioner Office
- Hospital (inpatient or outpatient)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Dialysis Centers (hospital or CAH-based)
- Skilled Nursing Facility
- Community Mental Health Center

## Practitioner Eligibility

We follow CMS eligibility standards for practitioners:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse-midwife
- Clinical nurse specialist
- Clinical psychologist
- Clinical social worker
- Registered dietician or nutrition professional

## Covered Services

- Services must be medically necessary and appropriate
- Evaluation, management and consultation services
  - Synchronous – interactive audio/video visit
  - Asynchronous - store-and-forward evaluation
- Telemonitoring – monitoring patients at a distance who are at risk for an acute episode
  - Cardiac conditions, COPD, diabetes, mental health/substance abuse

## Examples of Covered Services

- Office or outpatient visits
- Consultations (office, Internet-based, outpatient, emergency room)
- Follow-up inpatient consultations
- Pharmacologic management
- Neurobehavioral status exam
- Individual and group medical nutrition therapy
- Individual and group health and behavior assessment and intervention

## Minimum Requirements

- Services must be medically necessary and appropriate
- A permanent record of telemedicine communication must be maintained as part of patient medical record
- Provider must receive appropriate informed patient consent for telemedicine
- Services must be under control of consulting practitioner

## Non-Covered Services

- Non-HIPAA compliance communication
- Transmission fees, per-minute – reported by HCPCS procedure code T1014.
- Services for diagnoses excluded by a Member's Benefit Policy
- Services not medically appropriate or necessary.
- Installation or maintenance of any telecommunication devices or systems
- Provider-initiated e-mail

11

## Non-Covered Services

- Appointment scheduling
- A service that would similarly not be charged for in a regular office visit
- Reminders of scheduled office visits
- Requests for a referral
- Consultative message exchanges with an individual who is seen in the provider's office immediately afterward
- Clarification of simple instructions

12

## Coding & Reimbursement

### Coding

- Billable CPT codes will be provided on website and within Provider Manual
- Must use modifiers:
  - GT – live video encounters
  - GQ – store-and-forward encounters
- Reimbursement is according to your current negotiated professional agreement rates

## Questions?

Thank you for your time.

2

Sixty-fifth  
Legislative Assembly  
of North Dakota

**BILL NO.**

Introduced by

(At the request of the Public Employees Retirement System)

1 A BILL for an Act to create and enact section 26.1-36-09.15 of the North Dakota Century Code,  
2 relating to individual and group health insurance coverage of telehealth services; and to amend  
3 and reenact section 54-52.1-04.13 of the North Dakota Century Code, relating to public  
4 employees retirement system uniform group insurance coverage of telehealth services.

5 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

6 **SECTION 1.** Section 26.1-36-09.15 of the North Dakota Century Code is created and  
7 enacted as follows:

8 **26.1-36-09.15. Coverage of telehealth services.**

9 **1. As used in this section:**

- 10 **a. "Distant site" means a site at which a health care provider or health care facility is**  
11 **located while providing medical services by means of telehealth.**
- 12 **b. "Health care facility" means any office or institution at which health services are**  
13 **provided. The term includes hospitals; clinics; ambulatory surgery centers;**  
14 **outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted**  
15 **living facilities; laboratories; and offices of any health care provider.**
- 16 **c. "Health care provider" includes an individual licensed under chapter 43-05,**  
17 **43-06, 43-12.1 as a registered nurse or as an advanced practice registered**  
18 **nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42,**  
19 **43-44, 43-45, 43-47, 43-58, or 43-60.**
- 20 **d. "Originating site" means a site at which a patient is located at the time health**  
21 **services are provided to the patient by means of telehealth.**
- 22 **e. "Policy" means an accident and health insurance policy, contract, or evidence of**  
23 **coverage on a group, individual, blanket, franchise, or association basis.**

- 1           f. "Store-and-forward technology" means electronic information, imaging, and  
2           communication that is transferred, recorded, or otherwise stored in order to be  
3           reviewed at a distant site at a later date by a health care provider or health care  
4           facility without the patient present in real time. The term includes telehome  
5           monitoring and interactive audio, video, and data communication.
- 6           g. "Telehealth":
- 7           (1) Means the use of interactive audio, video, or other telecommunications  
8           technology that is used by a health care provider or health care facility at a  
9           distant site to deliver health services at an originating site and that is  
10           delivered over a secure connection that complies with the requirements of  
11           state and federal laws.
- 12           (2) Includes the use of electronic media for consultation relating to the health  
13           care diagnosis or treatment of a patient in real time or through the use of  
14           store-and-forward technology.
- 15           (3) Does not include the use of audio-only telephone, electronic mail, or  
16           facsimile transmissions.
- 17           2. An insurer may not deliver, issue, execute, or renew a policy that provides health  
18           benefits coverage unless that policy provides coverage for health services delivered  
19           by means of telehealth which is the same as the coverage for health services  
20           delivered by in-person means.
- 21           3. Payment or reimbursement of expenses for covered health services delivered by  
22           means of telehealth under this section may be established through negotiations  
23           conducted by the insurer with the health services providers in the same manner as the  
24           insurer with the health services providers in the same manner as the insurer  
25           establishes payment or reimbursement of expenses for covered health services that  
26           are delivered by in-person means.
- 27           4. Coverage under this section may be subject to deductible, coinsurance, and  
28           copayment provisions.
- 29           5. This section does not require:
- 30           a. A policy to provide coverage for health services that are not medically necessary,  
31           subject to the terms and conditions of the policy;

- 1           b. A policy to provide coverage for health services delivered by means of telehealth  
2           if the policy would not provide coverage for the health services if delivered by  
3           in-person means;
- 4           c. A policy to reimburse a health care provider or health care facility for expenses  
5           for health services delivered by means of telehealth if the policy would not  
6           reimburse that health care provider or health care facility if the health services  
7           had been delivered by in-person means; or
- 8           d. A health care provider to be physically present with a patient at the originating  
9           site unless the health care provider who is delivering health services by means of  
10           telehealth determines the presence of a health care provider is necessary.

11           **SECTION 2. AMENDMENT.** Section 54-52.1-04.13 of the North Dakota Century Code is  
12 amended and reenacted as follows:

13           **54-52.1-04.13. ~~(Effective through July 31, 2017)~~ Insurance coverage**Coverage of  
14 telehealth services.

15           4. As used in this section:

- 16           a. ~~"Distant site" means a site at which a health care provider or health care facility is~~  
17           ~~located while providing medical services by means of telehealth.~~
- 18           b. ~~"Health care facility" means any office or institution at which health services are~~  
19           ~~provided. The term includes hospitals; clinics; ambulatory surgery centers;~~  
20           ~~outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted-~~  
21           ~~living facilities; laboratories; and offices of any health care provider.~~
- 22           c. ~~"Health care provider" includes an individual licensed under chapter 43-05,~~  
23           ~~43-06, 43-12.1 as a registered nurse or as an advanced practice registered~~  
24           ~~nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42,~~  
25           ~~43-44, 43-45, 43-47, 43-58, or 43-60.~~
- 26           d. ~~"Originating site" means a site at which a patient is located at the time health~~  
27           ~~services are provided to the patient by means of telehealth.~~
- 28           e. ~~"Policy" means health benefits coverage under a contract for insurance pursuant~~  
29           ~~to section 54-52.1-04 or under a self-insurance plan pursuant to section~~  
30           ~~54-52.1-04.2.~~

- 1           f. ~~"Store and forward technology" means electronic information, imaging, and~~  
2           communication that is transferred, recorded, or otherwise stored in order to be  
3           reviewed at a distant site at a later date by a health care provider or health care  
4           facility without the patient present in real time. The term includes telehome-  
5           monitoring and interactive audio, video, and data communication.
- 6           g. ~~"Telehealth":~~
- 7           (1) ~~Means the use of interactive audio, video, or other telecommunications~~  
8           technology that is used by a health care provider or health care facility at a  
9           distant site to deliver health services at an originating site; and that is  
10          delivered over a secure connection that complies with the requirements of  
11          state and federal laws.
- 12          (2) ~~Includes the use of electronic media for consultation relating to the health~~  
13          care diagnosis or treatment of a patient in real time or through the use of  
14          store and forward technology.
- 15          (3) ~~Does not include the use of audio only telephone, electronic mail, or~~  
16          facsimile transmissions.
- 17          2. ~~For all policies that become effective after June 30, 2015, and which do not extend~~  
18          past June 30, 2017, the board shall provide health benefits coverage under a policy  
19          that provides coverage for health services delivered by means of telehealth which is  
20          the same as the coverage for health services delivered by in-person means.
- 21          3. ~~Payment or reimbursement of expenses for covered health services delivered by~~  
22          means of telehealth under this section may be established through negotiations  
23          conducted by the board or the board's contractor with the health services providers in  
24          the same manner as the board establishes payment or reimbursement of expenses for  
25          covered health services that are delivered by in-person means.
- 26          4. ~~Coverage under this section may be subject to deductible, coinsurance, and~~  
27          copayment provisions.
- 28          5. ~~This section does not require:~~
- 29          a. ~~A policy to provide coverage for health services that are not medically necessary,~~  
30          subject to the terms and conditions of the policy;

- 1           b. ~~A policy to provide coverage for health services delivered by means of telehealth-~~  
2           ~~if the policy would not provide coverage for the health services if delivered by-~~  
3           ~~in-person means;~~
- 4           e. ~~A policy to reimburse a health care provider or health care facility for expenses-~~  
5           ~~for health services delivered by means of telehealth if the policy would not-~~  
6           ~~reimburse that health care provider or health care facility if the health services-~~  
7           ~~had been delivered by in-person means; or~~
- 8           d. ~~A health care provider to be physically present with a patient at the originating-~~  
9           ~~site unless the health care provider who is delivering health services by means of~~  
10           ~~telehealth determines the presence of a health care provider is necessary.~~

11           The board shall provide health benefits coverage under a contract for insurance pursuant to  
12 section 54-52.1-04 or under a self-insurance plan pursuant to section 54-52.1-04.2 which  
13 provides coverage of health services delivered by means of telehealth in the same manner as  
14 provided under section 26.1-36-09.15.



Deloitte Consulting LLP  
50 South Sixth Street  
Ste 2800  
Minneapolis, MN 55402  
USA  
Tel: 7979709790  
Fax: 97970979  
www.deloitte.com

## Memo

**Date:** August 30, 2016  
**To:** Senator Krebsbach, Chair  
Legislative Employee Benefits Programs Committee  
**From:** Josh Johnson and Pat Pechacek, Deloitte Consulting LLP  
**Subject:** REVIEW OF PROPOSED BILL 17.0120.01000 RELATING TO INSURANCE COVERAGE OF TELEHEALTH SERVICES

The following summarizes our review of the proposed bill.

### OVERVIEW OF PROPOSED BILL

As proposed, this bill would require the medical benefits coverage of services provided by a health care provider by means of telehealth which are the same as medical benefits coverage for the same services provided by a health care provider in-person. There is widespread support for health plan coverage and incentivizing expanded use for telehealth services.

### Telehealth – Deloitte Health Policy Brief

Attached is a copy of a recent health policy brief from Deloitte titled: Realizing the potential of telehealth". The executive summary of that report states:

*Improving digital connectivity between patients and providers is critical to achieving value-based, patient-centered care.*

*Many health care organizations are exploring strategies to leverage technology, including telehealth, to increase consumer engagement and focus on prevention and chronic care management outside the traditional physician office visit. Findings from Deloitte’s 2016 Survey of US Health Care Consumers shows that interest in and use of telehealth is rising. The policy landscape—including payment policy and care provisions across state lines—is evolving to keep up with consumer demand and technology innovations.*

*An aging population, increasing chronic illness, the importance of self-care, accelerating health costs, regulatory reform, and new payment models are driving interest and growth in telehealth.<sup>1</sup> Some recent studies show that*



Official Professional Services Sponsor

To: Senator Krebsbach  
Subject: Telehealth Bill  
Date: August 30, 2016  
Page 2

*telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,<sup>2</sup> while others are concerned about its potential to increase costs in a fee-for-service environment.<sup>3</sup> Under new value-based payment models that reward outcomes (including lower total cost of care) rather than utilization, telehealth may be a cost-effective solution to provide access to care and, ideally, reduce unnecessary hospital care. Given these trends, providers and health plans should continue to monitor the complex and ever-evolving policy landscape around telehealth, and consider adopting targeted strategies for telehealth that encourage self-care and increase medication adherence to realize the clinical and economic benefits.<sup>4</sup>*

*New telehealth policies will likely need to balance potential increased access to services with potential cost increases, as well as payment and licensing changes and what they may mean for provider business models.<sup>5</sup> This policy brief provides an overview of trends in telehealth and consumer interest; the regulatory landscape; and the potential barriers, opportunities, and enablers for telehealth in the coming years. Top-of-mind policies for providers and health plans include:*

- *Current Medicare payment policy and proposed legislation to change it*
- *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its impact on telehealth*
- *Centers for Medicare and Medicaid Services (CMS) initiatives that are encouraging telehealth*
- *Recent Medicaid legislation that encourages telehealth<sup>6</sup> in states and Medicaid managed care*
- *State policy trends, including licensing reciprocity and reimbursement, and examples of state telehealth regulations*

## **CURRENT SCOPE OF COVERAGE IN NDPERS**

Currently, NDPERS covers health services that are delivered by telehealth in the same manner as health services provided in-person. The payment/reimbursement of telehealth services is established through negotiations with health care providers conducted by Sanford Health Plan as NDPERS' contractor. The NDPERS bill, as it stands today, does not cover telehealth services that are not medically necessary or if the policy would not provide coverage if the health services or expenses for health services were provided by in-person means. The NDPERS telehealth bill also does not require a health care provider (like a nurse or doctor) to be physically present with a patient at the originating site unless the health care provider who is delivering health services via telehealth determines that the presence of a health care provider is necessary. NDPERS Telehealth Summary Experience.

Female infertility, behavioral health and sleep apnea were the top three diagnoses for the first year of this program. Telehealth has enabled patients in the rural and outlying areas of the state to continue to see their specialist residing in one of the state's four major

To: Senator Krebsbach  
Subject: Telehealth Bill  
Date: August 30, 2016  
Page 3

cities without having to travel hundreds of miles. Additionally, telehealth has been a means to address the shortage of behavioral health providers in rural areas and has enabled rural members access to behavioral health services.

## **TECHNOLOGY**

There are many different ways in which telehealth can be provided:

- Online, two-way video using a personal computer
- Smart phone
- Other online monitoring systems such as remote cardiac monitoring

The types of telehealth technologies will likely increase over the coming years as telehealth vendors increase. Between 2014 and 2015, the number of vendors selling telehealth technologies increased 23%.

## **NDPERS EXPERIENCE**

Attached is summary of the NDPERS Telehealth Experience prepared by Sanford. You will note in the attached:

- From July 1, 2015 to June 30, 2016 there were 1022 total telehealth claims. telehealth visit and the originating site charge.
- 551 of these claims refer to the professional service, totaling \$63,040.
- 387 of these claims refer to the originating site charge.
- The originating site charge includes being checked in by a nurse and the use of a secure video connection between the member and Physician.
- 74.4% of telehealth claims were between a provider and member/resident who were both in the state of North Dakota
- 8.4% of the telehealth claims were between an ND resident and a MN provider
- 85% of total claims came from 10 types of specialists
- Top 10 Provider Specialties:
  - 1. Reproductive Endocrinology (OB/GYN)- 341 claims
  - 2. Psychiatry- 211 claims
  - 3. Child & Adolescent Psychiatry- 71 claims
  - 4. Psychology- 75 claims
  - 5. Nurse Practitioner (OB/GYN)- 32 claims
  - 6. Sleep Medicine- 26 claims
  - 7. Family Medicine- 19 claims
  - 8. Internal Medicine- 46 claims
  - 9. Clinical Nurse Specialist (Psychiatric/Mental Health)- 27 claims
  - 10. Nurse Practitioner- 26 claims

To: Senator Krebsbach  
Subject: Telehealth Bill  
Date: August 30, 2016  
Page 4

## Savings

As noted in a recent memo from Sanford Health Plan there is the possibility of savings not only for NDPERS members, but also NDPERS as a payor:

- In a 3 year study of high-risk dialysis patients, the patient group that was monitored via remote technology had a significantly lower amount of hospitalizations and hospital days, along with significantly lower hospital and emergency room charges<sup>1</sup>.
- A study of Medicare members who were monitored after discharge from the hospital found a 44% reduction in 30-day readmissions amongst members who were monitored versus the control group<sup>2</sup>.
- Heart failure patients participating in a telemonitoring study had 12% lower total costs<sup>3</sup>.
- A study of a 15-hospital, rural, multi-state ICU telemedicine program found a 37.5% reduction in the number of patients requiring transfer via ambulance or helicopter services. In total, there were 6825 fewer days spent in the ICU by patients, along with 821 fewer hospital days. The reduction in ICU days saved approximately \$8 million, and an additional \$1.25 million saved due to reductions in length of stay<sup>4</sup>.
- A peer-reviewed study in Critical Care Medicine found that continuous, contact-free patient monitoring has the potential to save the US healthcare system up to \$15 billion annually<sup>5</sup>.

---

<sup>1</sup> Dayna E. Minatodani & Steven J. Berman, *Home Telehealth in High-Risk Dialysis Patients: A 3-Year Study*, 19 TELEMEDICINE AND E-HEALTH 520–522, 520-522 (2013).

<sup>2</sup> Jove Graham et al., *Post discharge Monitoring Using Interactive Voice Response System Reduces 30-Day Readmission Rates in a Case-managed Medicare Population*, 50 MEDICAL CARE 50–57, 50-57 (2012), [http://journals.lww.com/lww-medicalcare/abstract/2012/01000/postdischarge\\_monitoring\\_using\\_interactive\\_voice.7.aspx](http://journals.lww.com/lww-medicalcare/abstract/2012/01000/postdischarge_monitoring_using_interactive_voice.7.aspx).

<sup>3</sup> Christopher Tompkins & John Orwat, *A Randomized Trial of Telemonitoring Heart Failure Patients*, 55 JOURNAL OF HEALTHCARE MANAGEMENT 312–322, 312-322 (2010), <http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=af518a72-40b4-425a-95d2-4cb652ac97d4@sessionmgr4009&vid=0&hid=4107> (last visited Aug 16, 2016).

<sup>4</sup> Edward Zawada, Patricia Herr & Deanna Larson, *Impact of an Intensive Care Unit Telemedicine Program on a Rural Health Care System*, 121 HEALTH ECONOMICS 159–170, 159-170 (2009), [https://www.researchgate.net/profile/edward\\_zawada/publication/26262120\\_impact\\_of\\_an\\_intensive\\_care\\_unit\\_telemedicine\\_program\\_on\\_a\\_rural\\_health\\_care\\_system/links/54b98c080cf2d11571a4b58c.pdf](https://www.researchgate.net/profile/edward_zawada/publication/26262120_impact_of_an_intensive_care_unit_telemedicine_program_on_a_rural_health_care_system/links/54b98c080cf2d11571a4b58c.pdf).

<sup>5</sup> Fred Pennic, *STUDY: CONTINUOUS PATIENT MONITORING COULD SAVE HEALTHCARE \$15B* (2016), <http://hitconsultant.net/2016/08/08/study-continuous-patient-monitoring-healthcare/> (last visited Aug 16, 2016).

To: Senator Krebsbach  
Subject: Telehealth Bill  
Date: August 30, 2016  
Page 5

## **OBSERVATIONS AND RECOMMENDATION**

A recent health policy brief released by the Deloitte Center for Health Solutions titled *Realizing the potential of telehealth: Federal and state policy is evolving support telehealth in value-based care models*, supports the position that telehealth has the potential to reduce treatment costs and improve patient access to care. As stated in the policy brief:

*"Telehealth aims to make health care services more accessible to patients so that they can avoid going to the physician's office. Instead, patients can access care any time, via different devices—a web browser, a mobile phone or tablet, or a standalone kiosk in a retail clinic. Telehealth has the potential to improve remote monitoring and self-care strategies and, ultimately, reduce treatment costs by keeping people out of the hospital and emergency room, and reducing physician office visits."*

From reduced restrictions on telehealth through Accountable Care Organizations (ACO's) by the Centers for Medicare and Medicaid Services (CMS) to studies conducted by organizations such as the Agency for Healthcare Research and Quality (AHRQ), the support for expansion of and removal of traditional barriers for coverage of telehealth are prevalent. A recent technical brief from the AHRQ notes that there is sufficient evidence to support the effectiveness of telehealth, including remote monitoring, communication, and counseling for patients with chronic conditions, and psychotherapy as part of behavioral health. The authors conclude that the research focus should shift to how to promote broader implementation and address barriers.

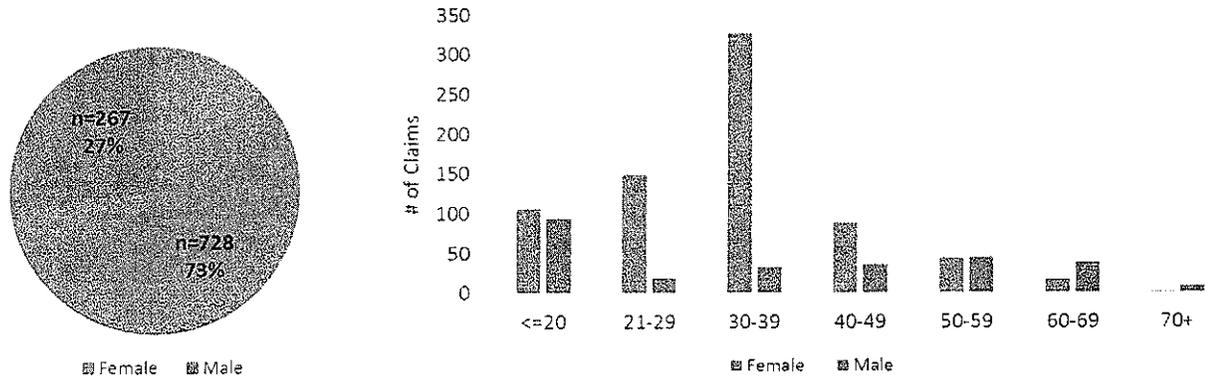
Due to positive results of research and analysis into the effectiveness and potential for cost savings, Deloitte recommends that NDPERS continue coverage of appropriate telehealth services.

3a

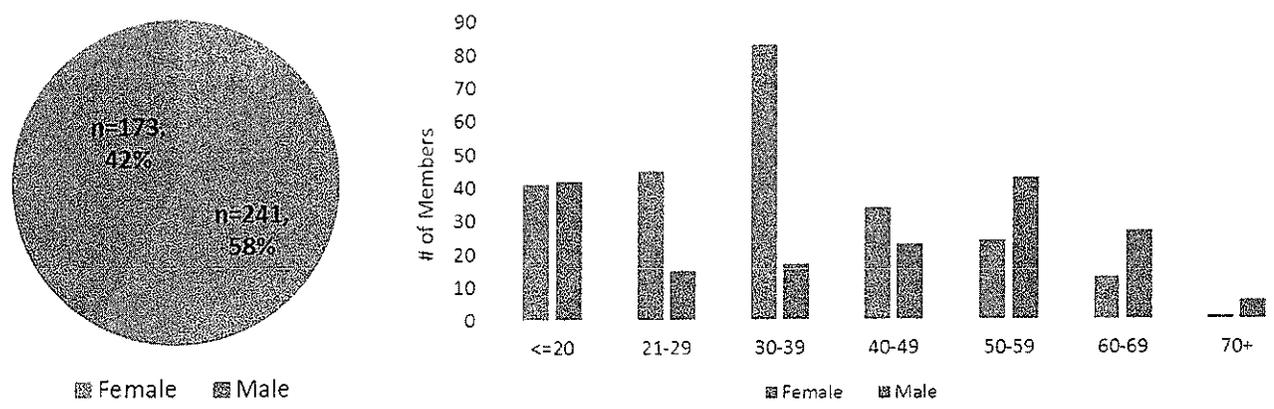
# NDPERS Telehealth Summary

Claims incurred between 7/1/15 and 6/30/16, paid through 8/9/16

### Total Telehealth Claims by Gender and Age Bands

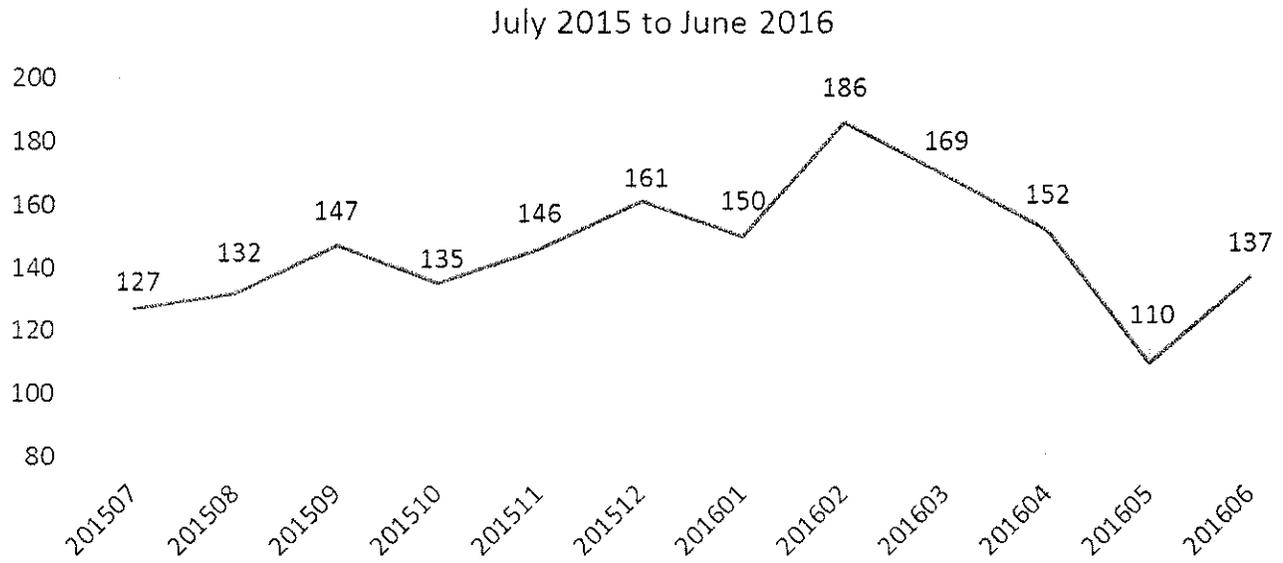


### Total Telehealth Members by Gender and Age Bands



# Claims over Time

Claims incurred between 7/1/15 and 6/30/16, paid through 8/9/16



*Note that May and June claims may not reflect actual volume due to limited runout period*

Member State v Provider State

Provider State	Member State			Grand Total
	MN	ND	SD	
ND	10	801	0	811
MN	12	86	0	98
NULL	0	28	0	28
IL	2	23	0	25
MT	0	25	0	25
SD	3	15	3	21
NE	0	8	0	8
WA	0	1	0	1
IA	0	4	0	4
ID	1	0	0	1
<b>Grand Total</b>	<b>28</b>	<b>991</b>	<b>3</b>	<b>1022</b>

Excludes CPT code 'Q3014'

- 78.4% of the telehealth claims were between a provider and a member (resident) both in the state of North Dakota. 8.4% of the telehealth claims were between a ND resident and a MN provider.

Member State/City v Provider State/City

Count of Claim#	Member City								*MN *SD		Grand Total	
Provider City	GRAND FORKS	BISMARCK	WILLISTON	JAMESTOWN	MINOT	DEVILS LAKE	DICKINSON	Other	ND			
-ND												
BISMARCK		11	19		14		2	11				57
DEVILS LAKE								2				2
DICKINSON							8	7				15
FARGO	143	59	21	46	12	1	25	145	4			456
GRAND FORKS	12	38				30		97	6			183
JAMESTOWN				4				3				7
MINOT			19	9	29			14				71
VALLEY CITY				1				2				3
WILLISTON			1					10	5			16
WEST FARGO								1				1
+MN	2	2	1	10		5	4	62	12			98
+IL	12							11	2			25
+MT			22		1			2				25
+SD		5		2				8	3	3		21
+NE					8							8
+WA								4				4
+FL		1										1
+IA									1			1
+ID		1										1
*NULL						18		10				28
<b>Grand Total</b>	<b>169</b>	<b>117</b>	<b>83</b>	<b>72</b>	<b>64</b>	<b>54</b>	<b>49</b>	<b>384</b>	<b>28</b>	<b>3</b>		<b>1023</b>

Excludes CPT code 'Q3014'

Claims by Provider Specialty

Top 10 Provider Specialties by Total Charged. These top 10 specialties represent 85% of total claims.

<b>Provider Specialty</b>	<b>Claims</b>	<b>Total Charged</b>
REPRODUCTIVE ENDOCRINOLOGY (OBSTETRICS AND GYNECOLOGY)	341	\$57,429
PSYCHIATRY (PSYCHIATRY AND NEUROLOGY)	211	\$55,883
CHILD AND ADOLESCENT PSYCHIATRY (PSYCHIATRY AND NEUROLOGY)	71	\$29,068
PSYCHOLOGIST	75	\$14,824
INTERNAL MEDICINE	46	\$6,102
CLINICAL NURSE SPECIALIST (PSYCHIATRIC OR MENTAL HEALTH)	27	\$5,167
NURSE PRACTITIONER	26	\$5,065
FAMILY MEDICINE	19	\$4,745
NP - OBSTETRICS AND GYNECOLOGY	32	\$4,664
SLEEP MEDICINE (FAMILY MEDICINE)	26	\$4,530
<b>Grand Total</b>	<b>874</b>	<b>\$187,477</b>

*Excludes CPT code 'Q3014'*

Claims by Provider Group

Top 15 Provider Groups by Total Charged. There top 15 providers represent 87% of total claims.

<b>Provider Group</b>	<b>Claims</b>	<b>Total Charged</b>
SANFORD MEDICAL CENTER FARGO PROF	427	\$74,544
ALTRU HEALTH SYSTEM PROFESSIONAL	241	\$35,345
NORTH CENTRAL HUMAN SERVICE CENTER	48	\$20,217
NORTHWEST HUMAN SERVICE CENTER	36	\$17,095
SANFORD CLINIC FARGO REGION	252	\$14,794
CENTER FOR PSYCHIATRIC CARE	104	\$11,761
BADLANDS HUMAN SERVICE CENTER	17	\$7,839
VA MEDICAL CENTER	41	\$7,564
SANFORD BISMARCK	190	\$7,180
NORTHLAND CHRISTIAN COUNSELING CENTER	38	\$6,415
PSYCHIATRY NETWORKS	36	\$4,260
ESSENTIA HEALTH	16	\$3,931
WHITNEY SLEEP DIAGNOSTICS AND CONSULTANTS	42	\$3,906
SANFORD THIEF RIVER FALLS	14	\$3,385
BILLINGS CLINIC	24	\$3,288
<b>Grand Total</b>	<b>1,526</b>	<b>\$221,524</b>

Claims by Diagnosis

Top 15 Diagnoses by Total Charged. These top 15 diagnoses represent 42% of total claims.

<b>Diag 1</b>	<b>Diagnosis Description</b>	<b>Claims</b>	<b>Total Charged</b>
N97.9	Female infertility, unspecified	69	\$12,050
F33.1	Major depressive disorder, recurrent, moderate	35	\$10,704
F41.1	Generalized anxiety disorder	49	\$10,507
N97.0	Female infertility associated with anovulation	52	\$8,512
F90.2	Attention-deficit hyperactivity disorder, combined type	27	\$7,811
F33.9	Major depressive disorder, recurrent, unspecified	24	\$6,571
F84.0	Autistic disorder	14	\$5,533
628	Female infertility associated with anovulation	38	\$5,323
F32.1	Major depressive disorder, single episode, moderate	11	\$5,053
G47.33	Obstructive sleep apnea (adult)(pediatric)	30	\$4,764
F32.9	Major depressive disorder, single episode, unspecified	18	\$4,743
296.32	Major depressive affective disorder, recurrent episode, moderate	11	\$3,648
628.9	Infertility, female, of unspecified origin	22	\$3,307
F90.9	Attention-deficit hyperactivity disorder, unspecified type	13	\$3,187
Z34.01	Encounter for supervision of normal first pregnancy, first trimester	18	\$2,917
<b>Grand Total</b>		<b>431</b>	<b>\$94,627</b>

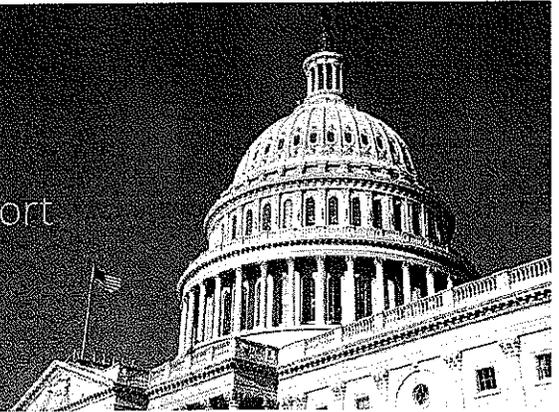
<b>Summary Category</b>	<b>Claims</b>	<b>Total Charged</b>
Female Infertility & Birthing	199	\$32,109
Behavioral Health	202	\$57,755
Sleep Apnea	30	\$4,764
<b>Grand Total</b>	<b>431</b>	<b>\$94,627</b>

*Excludes CPT code 'Q3014'*

## Health Policy Brief

### Realizing the potential of telehealth: Federal and state policy is evolving to support telehealth in value-based care models

Produced by the Deloitte Center for Health Solutions  
and the Deloitte Center for Regulatory Strategy



#### Executive summary

Improving digital connectivity between patients and providers is critical to achieving value-based, patient-centered care.

Many health care organizations are exploring strategies to leverage technology, including telehealth, to increase consumer engagement and focus on prevention and chronic care management outside the traditional physician office visit. Findings from Deloitte's *2016 Survey of US Health Care Consumers* show that interest in and use of telehealth is rising. The policy landscape—including payment policy and care provisions across state lines—is evolving to keep up with consumer demand and technology innovations.

An aging population, increasing chronic illness, the importance of self-care, accelerating health costs, regulatory reform, and new payment models are driving interest and growth in telehealth.<sup>1</sup> Some recent studies show that telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,<sup>2</sup> while others are concerned about its potential to increase costs in a fee-for-service (FFS) environment.<sup>3</sup> Under new value-based payment models that reward outcomes (including lower total cost of care) rather than utilization, telehealth may be a cost-effective solution to provide access to care and, ideally, reduce unnecessary hospital care. Given these trends, providers and health plans should continue to

monitor the complex and ever-evolving policy landscape around telehealth, and consider adopting targeted strategies for telehealth that encourage self-care and increase medication adherence to realize the clinical and economic benefits.<sup>4</sup>

New telehealth policies will likely need to balance potential increased access to services with potential cost increases, as well as payment and licensing changes and what they may mean for provider business models.<sup>5</sup> This policy brief provides an overview of trends in telehealth and consumer interest; the regulatory landscape; and the potential barriers, opportunities, and enablers for telehealth in the coming years. Top-of-mind policies for providers and health plans include:

- Current Medicare payment policy and proposed legislation to change it
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its impact on telehealth
- Centers for Medicare and Medicaid Services (CMS) initiatives that are encouraging telehealth
- Recent Medicaid legislation that encourages telehealth<sup>6</sup> in states and Medicaid managed care
- State policy trends, including licensing reciprocity and reimbursement, and examples of state telehealth regulations

## Telehealth has the potential to reduce treatment costs

Telehealth aims to make health care services more accessible to patients so that they can avoid going to the physician's office. Instead, patients can access care any time, via different devices—a web browser, a mobile phone or tablet, or a standalone kiosk in a retail clinic. Telehealth has the potential to improve remote monitoring and self-care strategies and, ultimately, reduce treatment costs by keeping people out of the hospital and emergency room, and reducing physician office visits.

Chronic disease rates are rising, and mental health issues, including depression, are also affecting millions of Americans. The Department of Health and Human Services (HHS) reports that nearly 80 million Americans live in a mental health professional shortage area. Even in urban environments, transportation, time constraints, and the stigma of mental illness often prevent people from seeking mental health services.<sup>7</sup> Telehealth may help address these situations.

A literature review by Rashid Bashshur looked at the evidence related to three conditions prominent in the Medicare population—congestive heart failure (CHF), stroke, and chronic obstructive pulmonary disease.<sup>8</sup> He found that among CHF patients, telemonitoring (transmitting certain physiologic parameters and symptoms from patients at home to their health care provider) was significantly associated with reductions in mortality, ranging from 15 percent to 56 percent relative to traditional care.<sup>9</sup> Studies have also shown that telestroke services—involving a neurologist and an attending nurse communicating via videoconferencing to evaluate the patient's motor skills, view a computed tomography scan, make a diagnosis, and prescribe

treatment—can help stroke patients without readily available access to stroke specialists. Telestroke services could also reduce mortality roughly 25 percent during the first year after the event.<sup>10</sup>

A recent technical brief from the Agency for Healthcare Research and Quality (AHRQ) found that the evidence on telehealth varies across different clinical conditions and health care functions. The report notes that there is sufficient evidence to support the effectiveness of telehealth in some circumstances, including remote monitoring, communication, and counseling for patients with chronic conditions, and psychotherapy as part of behavioral health. The authors conclude that the research focus should shift to how to promote broader implementation and address barriers; and that future research should focus on the use and impact of telehealth in new health care organizational and payment models.<sup>11</sup>

Finally, though data is limited, there is evidence to suggest economic benefits to telemonitoring compared with usual care. One study using data from five telehealth service vendors found:

- In the commercial market, the average estimated cost of a telehealth visit is \$40 to \$50, compared to the average estimated cost of \$136 to \$176 for in-person acute care.
- Patient issues are resolved during the initial telehealth visit an average of 83 percent of the time.

The study concluded that replacing in-person acute care services with telehealth visits reimbursed at the same rate as a doctor's office visit could save the Medicare program an estimated \$45 per visit.<sup>12</sup>

### What is telehealth?

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care and patient and professional health-related education. Telehealth enables health care providers to connect with patients and consulting practitioners across vast distances. A patient with a chronic disease who uses telehealth may have multiple phone or video sessions with the care team, where health care professionals guide treatment, provide behavioral health support, and monitor progress. See the appendix for definitions of terminology used in this brief.

### Telehealth payment policies are evolving as value-based models grow

**Medicare:** Medicare currently pays for telehealth services when the patient being treated is in a health professional shortage area or in a county that is outside any metropolitan statistical area, as defined by the Health Resources and Services Agency and the US Census Bureau, respectively. The telehealth site must be a medical facility, such as a physician's office, hospital, or rural health clinic, and not the patient's home. Medicare will only pay for "face-to-face" interactive video consultation services in which the patient is present, and does not generally cover store-and-forward applications (the transmission of digital images) as they do not typically involve direct interactions with patients (Medicare does have limited coverage of store-and-forward applications in certain regions). Traditionally, Medicare policy restricts coverage to certain reimbursable codes.<sup>13</sup>

As accountable care organizations (ACOs) and other value-based care (VBC) models increase, CMS is experimenting with expanding telehealth—some newer

CMS initiatives give providers more flexibility to use telehealth. In traditional Medicare, coverage is designed around rural populations with little access to other care. However, proposed legislation and experimental programs through CMS are aiming to ease geographic restrictions, which would allow the originating site to be in a person's home and could encourage remote monitoring for patients with chronic conditions.

Since Medicare often sets the standard for coverage in other public and private programs, some stakeholders are advocating for Medicare to update its policy. In May 2016, a group of individual providers and health systems wrote a letter asking the Congressional Budget Office to examine broader sets of telehealth data—from the commercial population, the US Department of Veterans Affairs (VA), and Medicaid—when generating future cost estimates and analyses of telehealth in Medicare.

### Telehealth is a critical component of VA's journey toward patient-centered care

VA is on a journey to become more patient-centric and focused on improving veterans' health and quality. VA's progress in telehealth is virtually unparalleled in other health systems.<sup>14</sup> Early investments and a commitment to increasing access to specialists, incorporating mental health care into primary care, and an integrated provider-payer system that allows for more fluid data flow all support the department's telehealth program.

VA served over 150,000 beneficiaries with telehealth services in 2012.<sup>15</sup> Telehealth was associated with a 25 percent reduction in number of bed days of care and a 19 percent reduction in hospital admissions across all VA patients using telehealth. Overall, VA estimates average annual savings of \$6,500 for each patient that participated in the telehealth program in 2012, which equates to nearly \$1 billion in system-wide savings. VA has conducted studies that show videoconferencing can be successful in treating post-traumatic stress disorder, and that treating mental health issues via telehealth can be effective when compared to face-to-face visits.<sup>16</sup>

Having access to real-time, synchronous expert care through telehealth may help improve access to care, the patient experience, care delivery, and ultimately, health outcomes.

## No new federal telehealth policy but experimentation is happening

Congress has been slow to move on telehealth: Many bills are in the works, but none have passed. Congress did, however, pass MACRA, which included policies that may encourage greater use of telehealth.<sup>17</sup> The Administration has also been focused on telehealth, implementing demonstrations through CMS and making modifications to Medicare Advantage and Medicaid policies at the federal level. Congressional lawmakers have introduced legislation in both the Senate and the House to change Medicare's policies. Some stakeholders say that these bills (described below) have a low chance of passing in their current form,<sup>18</sup> but that certain parts of the bills' provisions may be incorporated into other policy vehicles, including the Senate Finance Committee's expected legislation to address chronic care.<sup>19</sup>

**MACRA:** MACRA may increase telehealth adoption by both clinicians in Alternative Payment Models (APMs) and those remaining in traditional FFS. In April 2016, CMS released the first major regulation under MACRA.<sup>20</sup> According to the proposed rule on the Merit-Based Incentive Payment System (MIPS), Medicare will reward providers' use of telehealth. MIPS will measure performance in four areas: quality; resource utilization; investment in clinical improvement activities; and electronic health records usage. MIPS identifies telehealth and remote patient monitoring (RPM) as a supporting technology for the care coordination subcategory of the clinical practice improvement area.

Telehealth will likely be a useful tool under MACRA because providers will be required to extend their reach beyond the office setting as they aim for more holistic, quality care that avoids costly and unnecessary services. Additionally, MACRA encourages organizations to enter into new payment and delivery models, which should promote collaboration between health plans and hospitals around telehealth and other technology-based patient services.

MACRA directs the Government Accountability Office to study the potential impact of telehealth and remote monitoring on Medicare, with reports due in spring 2017. Though the law holds many encouraging implications for telehealth, some advocates believe that CMS is still showing hesitancy through asking for more evidence around its use.<sup>21</sup>

**Senate activity:** In early 2016, a bipartisan group introduced legislation to remove barriers to Medicare coverage of telehealth through the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act.<sup>22</sup> The CONNECT Act, endorsed by several medical specialty societies, academic institutions, patient advocacy groups, and technology companies, aims to expand the use of telehealth and RPM services in Medicare. Proponents of the legislation believe it will improve quality of care and save costs by making the delivery of health care, information, and education more accessible. The Act includes video conferencing, RPM services to monitor high-risk patients at home, and store-and-forward technologies.

The CONNECT Act strives to help providers transition to MACRA, MIPS, and APMs by eliminating current telehealth and RPM restrictions around geography and lack of reimbursement for face-to-face visits. The Act would also allow RPM use for certain patients with chronic conditions and include telehealth and RPM as basic benefits in Medicare Advantage, without most of the noted restrictions. In a summary sheet for the media, the senators behind the CONNECT Act state that elements of the Act could save \$1.8 billion over 10 years.<sup>23</sup>

**House activity:** The House of Representatives introduced the Medicare Telehealth Parity Act of 2015, bipartisan legislation designed to expand telehealth services under Medicare. This legislation proposes to remove the geographic barriers under current Medicare law and expand the list of providers and related covered services to categories including occupational, physical, respiratory, speech, and audiology therapy.<sup>24</sup> Access to telestroke and RPM for patients with chronic conditions is also part of the legislation, as is access to home health care for dialysis, hospice, and eligible outpatient mental health and home health services. The changes would be phased in to achieve parity between in-person and telehealth coverage.

**CMS demonstrations:** Several CMS initiatives, including the Comprehensive Primary Care Plus (CPC+) Model, the ACO Next Generation model, the Comprehensive Care for Joint Replacement Model (CCJR), and the Bundled Payment for Care Improvement initiative (BPCI), waive certain restrictions around telehealth services (see Table 1 on the following page). Many telehealth advocates and analysts hope these models will demonstrate the value of telehealth services and thereby lay the groundwork for expanding coverage in Medicare.

**Medicare Advantage:** While most of Medicare's 57 million enrollees are covered by FFS Medicare, 31 percent (around 17 million) are enrolled in a Medicare Advantage (MA) plan.<sup>26</sup> MA plans can choose to pay for and provide telehealth services more broadly—as extra benefits—than Medicare FFS.<sup>27</sup> MA plans finance these benefits through their rebate dollars or by charging beneficiaries a supplemental premium.<sup>28</sup> Despite these flexibilities, most MA plans follow the standard Medicare originating site rule.

Anthem and the University of Pittsburgh Medical Center Health Plan offer telehealth benefits beyond traditional FFS benefits to their Medicare Advantage beneficiaries. Part of their motivation is to enhance the consumer experience and make care more accessible.<sup>29</sup> Humana announced in early 2016 that it would offer some telehealth services to its MA beneficiaries, as well.<sup>30</sup> Finally, the Senate Finance Committee is examining telehealth in MA through its work on chronic care management legislation.<sup>31</sup>

**Medicare Payment Advisory Committee (MedPAC) report: More evidence needed on telehealth's value**

MedPAC is an independent, congressionally-appointed body of stakeholders with expertise in health care services financing and delivery. MedPAC makes recommendations to CMS and Congress on payment policy for private health plans participating in Medicare and health care providers serving Medicare beneficiaries. MedPAC published one paper on telehealth, in November 2015, and wrote a chapter on telehealth in its June 2016 report to CMS.<sup>25</sup> In its most recent report, MedPAC again cited the lack of evidence around quality or overall cost-savings for telehealth services. The report said that telestroke may have the strongest evidence. However, MedPAC acknowledged the difficulty in finding sufficient Medicare data on telehealth, given its low use in Medicare as well as inconsistent academic literature, and stated that more evidence is needed around targeted telehealth interventions for specific populations.

"Many telehealth advocates and analysts hope CMS initiatives and models will demonstrate the value of telehealth services and thereby lay the groundwork for expanding coverage in Medicare."

**Table 1. CMS demonstrations involving telehealth**

Initiative	Description	Telehealth Implications
CPC+	<p>The risk-based primary care initiative aims to accelerate the shift toward value-based reimbursement and emphasizes health IT and chronic care management.</p> <p>The model builds on the Pioneer ACO Model and the Medicare Shared Savings Program. It sets financial targets, enables greater opportunities to coordinate care, and aims to incentivize high quality care.<sup>32</sup></p>	<p>Participating practices will be responsible for giving patients 24-hour access to care and their information, delivering preventive care, engaging with patients and their families, and coordinating care with hospitals and other clinicians, such as specialists. Telehealth might help meet these requirements.</p> <p>Providers may decide to use the incentive payments to invest in telehealth.<sup>33</sup></p>
ACO Next Generation	<p>The model's goal is to test whether strong financial incentives for ACOs, combined with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for original Medicare FFS beneficiaries.<sup>34</sup></p>	<p>CMS waives certain telehealth restrictions for ACOs in this model. Originating telehealth sites do not have to be in rural areas or originate from a medical facility (they can originate from the patient's home).</p> <p>ACOs might use telehealth to reduce avoidable hospital readmission rates and triage patients to urgent care or the physician office instead of using the emergency room (ER).<sup>35</sup></p>
CCJR	<p>This model began April 1, 2016. It tests bundled payment and quality measurement for knee and hip replacement episodes of care. Participating hospitals are financially responsible for the cost and quality of these episodes of care.<sup>36</sup></p>	<p>Under bundled payments, providers have the incentive to use any service they believe can reduce the cost of care and improve quality. This model waives the requirements that the originating site for telehealth services must be in a rural area and be a specified medical facility (they can originate from the patient's home).</p>
BPCI	<p>This voluntary program began in 2013 to test bundled payments in Medicare and their ability to reduce Medicare spend while maintaining or improving quality. Participating organizations assume financial and performance responsibility for episodes of care triggered by a hospital admission.<sup>37</sup></p>	<p>Participating organizations can choose among several waivers, including a telehealth waiver similar to the above programs that eases geographic restrictions, though the originating site cannot be the patient's home.</p>

## Federal policies are expanding telehealth in Medicaid

Two recent federal policies provide opportunities for Medicaid providers to expand their telehealth services.

**Federal Medicaid managed care regulations:** In April 2016, CMS released its largest overhaul of Medicaid managed care requirements in more than a decade.<sup>38</sup> The updated regulations aim to modernize Medicaid managed care, align coverage and quality requirements with other sources of health care coverage, strengthen states' delivery system reform, enhance network adequacy standards, and improve the consumer experience. During the public comment period, several commenters recommended that the final rule include coverage for telehealth. CMS noted these comments and agreed that solutions and services related to telehealth could help improve network adequacy in certain areas.

Under the rule, states are required to develop and make publicly available time and distance network adequacy standards for primary care and several specialties, behavioral health and dental care, as well as hospital care. The rule includes factors states should consider in setting standards, including the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

**Federal policy on use of telehealth in home care:** Also in early 2016, CMS released a final rule updating and clarifying policy around how providers can document Medicaid patients' needs for home health services. These updates have implications for telehealth.<sup>39</sup> CMS' rule allows providers to use face-to-face encounters via telehealth to meet the requirement that a provider sees a patient before ordering home health services. It encourages states to work with the home health provider community to incorporate face-to-face visits in creative and flexible ways, while clarifying that phone calls or emails do not qualify as replacements to the face-to-face encounter.

The rule leaves the states flexibility to define telehealth coverage, including what types to cover, where in the state it can be provided, and how it is to be provided. Several organizations used the public comment period to show their support for telehealth, and, in the final rule, the agency noted its willingness to offer technical assistance to state Medicaid agencies to use telehealth. CMS also noted the need to update Medicaid telehealth guidance, which the agency says is forthcoming.

Policy stakeholders tracking telehealth in Medicaid are largely lauding these recent clarifications and updates. Providers can now examine and appropriately prescribe home health while the patient is remote, which can help streamline processes and maximize resources.

## States telehealth policies are a mix of barriers and incentives

Considerable telehealth oversight takes place at the state level and, in general, states have taken diverse approaches to regulating the services and addressing licensing issues. States regulate telehealth coverage through three major channels, as described in Table 2 on the following page.

Providers seeking to adopt VBC initiatives will likely demand policy changes around telehealth. For example, telehealth could assist physicians operating under payment models that emphasize keeping people out of the hospital. The fact that 16 states have adopted an expedited physician licensure process (the Interstate Medical Licensure Compact) indicates that the shift to VBC is helping to align incentives so that physicians may have an easier time obtaining licenses in multiple states.<sup>40</sup>

"As care delivery models evolve, state policies are progressing to meet consumer and provider demand."

**Table 2. State policy areas around telehealth**

	Description of state policy issue	Examples
<b>Medicaid reimbursement</b>	<p>Medicaid programs in the District of Columbia (DC) and 47 states provide some level of reimbursement for live video, the most traditional telehealth service. Five states offer a full range of services reimbursing for live video, store-and-forward and remote patient monitoring, though the restrictions and limitations vary.</p>	<p>California passed the Telehealth Advancement Act in 2011 to prohibit health plans from requiring a face-to-face visit if a service could be provided via telehealth.</p> <p>This law has led to Medicaid managed care plans reimbursing for a variety of telehealth services including e-consults – electronic communications between a primary care provider and a specialty provider, particularly for patients in medical care homes.</p>
<b>Private insurance parity</b>	<p>Twenty eight states and DC have laws requiring private insurers to reimburse telehealth services at the same rate as in-person services.</p> <p>As payment models evolve toward value-based models, payment parity laws may become less relevant if shared risk and shared savings increase the incentives for plans to encourage the use of telehealth services.</p>	<p>Most states self-insure their state employee health plans, meaning that they would be exempt under traditional private insurer parity requirements.</p> <p>Oregon, however, has amended its parity law to apply to self-insured state plans. Arizona's parity law requires coverage and reimbursement of telehealth services but limits the requirement to rural areas and seven specific services.<sup>41</sup></p>
<b>Licensing and reciprocity</b>	<p>States and licensing boards govern how and where providers can practice. Most states require physicians to be licensed to practice where they are located and some states require providers using telehealth technology across state lines to have a valid state license in the state where the patient is located.<sup>42</sup></p> <p>Medical provider licensing can limit telehealth programs.<sup>43</sup></p>	<p>In 2015, the Texas Medical Board restricted when physicians can use telephones and video services to provide medical care. Physicians must have a pre-existing relationship established in-person to provide services remotely. While the restrictions do not ban telehealth outright they sharply limit its use.</p> <p>Representatives from telehealth groups and the Texas Medical board have been meeting to see if compromise language can be established. Talks are ongoing.<sup>44</sup></p>

Source: Deloitte analysis of state policies around telehealth; and The Center for Connected Health Policy, "State Laws and Reimbursement Policies," <http://cchpca.org>.

### Consumer attitudes about telehealth

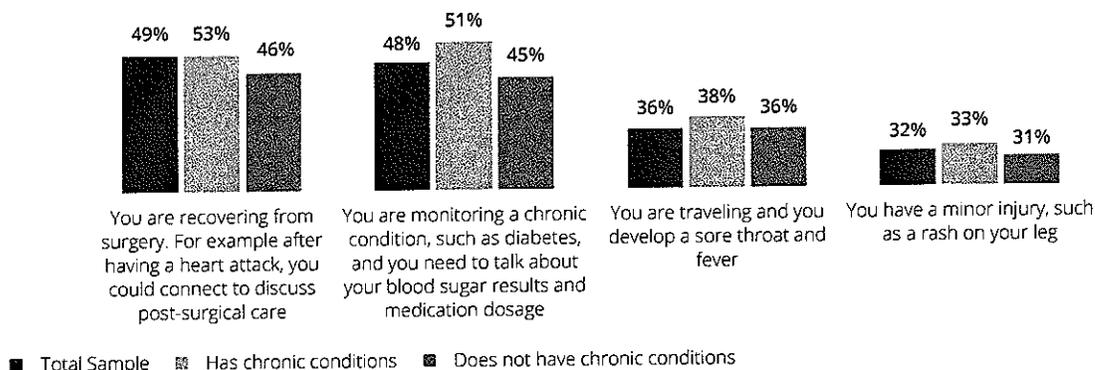
Deloitte's 2016 Survey of US Health Care Consumers<sup>45</sup> shows that consumers are open to telehealth. About half of surveyed consumers, whether they have a chronic condition or not, say they would use telemedicine for post-acute care or chronic condition monitoring. Consumers seem less interested in using telemedicine for acute conditions such as sore throats, rashes, or other minor injuries (Figure 1).

Around one third of surveyed consumers say they have no concerns about using telemedicine. However, 43 percent are concerned about quality of care being

lower than if they saw a provider in person, while 35 percent have privacy and security concerns. Fewer consumers (33 percent) had concerns about the impersonality of telemedicine, while only 15 percent thought the technology would be difficult to learn (Figure 2).

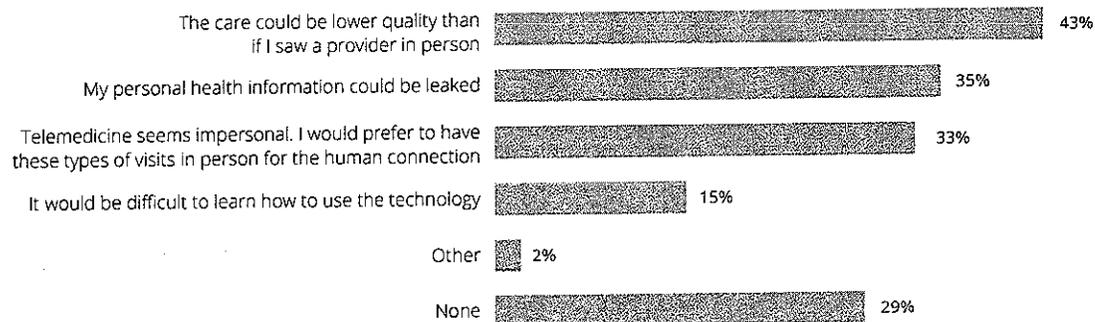
These trends indicate that, similar to banking and retail, health care is not exempt from consumer demand for technology to makes services and information easier to access.

**Figure 1. Likelihood of using telemedicine**



Source: Deloitte Center for Health Solutions 2016 Survey of US Health Care Consumers.

**Figure 2. Barriers to telemedicine use**



Source: Deloitte Center for Health Solutions 2016 Survey of US Health Care Consumers.

## Implications of evolving policies for health care stakeholders

### Health care providers

The American Hospital Association reports that 52 percent of US hospitals were using telehealth in 2013 and another 10 percent were moving toward adopting the platform. A recent policy recommendation from the group includes asking the Senate Finance Committee's Chronic Care Management workgroup to make telehealth the standard of care for people with chronic conditions, rather than a separate path of care alongside traditional in-person visits.<sup>46</sup>

As consumer interest in telehealth continues to grow, and as the federal and state policy landscape evolves to reduce barriers to telehealth, providers may consider investing in telehealth capabilities. In particular, providers may consider strategies for targeted populations who are affected by value-based care models.

Finally, given the complex and ever-evolving policy landscape around telehealth, it would be wise for providers to monitor ongoing federal and state efforts.

### Payers: Health plans and employers

With many health plans developing and investing in capabilities that make health care more convenient and accessible to consumers, it is not surprising that health plan adoption of telehealth is growing. The past year has seen a flurry of activity, with some commercial health plans partnering with telehealth vendors to pilot or expand telehealth services. In addition, more health plans and large employers are interested in incorporating telehealth into their benefit structure.<sup>47</sup> UnitedHealth Group predicts 20 million of its members could access and receive coverage by telehealth providers in the next year; Anthem is expanding its LiveHealth Online program to most individual and employer-based plans, including exchange members in 11 states, and also predicts 20 million members will have telehealth benefits in 2016.<sup>48</sup>

For employers, telehealth may be as much of a human resources topic, used for recruitment and retention, as it is a health care topic. According to a 2015 survey by American Well, one-third of employers offered telehealth in 2015, up from 22 percent in 2014, with 49 percent saying they planned to offer a telehealth benefit in 2016. Reducing medical costs and improving access to care are some of the reasons employers are investing in telehealth; others include employee satisfaction, improving productivity, and attracting new talent.<sup>49</sup>

### Will innovative companies and services beat traditional players to market?

While evidence continues to evolve and accumulate around the ability of telehealth services to meet the health care system's need for cost-effective, quality preventive care and chronic care management, some providers and health plans are interested in meeting consumers where they are.

In the past few years, there has been a proliferation of vendors that offer direct-to-consumer telehealth services. While some consumers may prefer services provided by their physician or health plan, some health care organizations may worry about losing business to these industry disruptors. Meeting consumer demand and innovating their business strategy may be a motivator, beyond cost and quality alone, for broadening telehealth adoption.

Source: Darius Tahir, "Telehealth services surging despite questions of value," *Modern Healthcare*, February 21, 2015

The Affordable Care Act (ACA) requires that health plans serving health insurance exchanges meet standards for network adequacy. As health plans move toward narrower provider networks for exchange plans in order to reduce premiums, telehealth is one important strategy that could help health plans meet network adequacy standards more cost-effectively—and help providers deliver care to underserved areas more efficiently.<sup>50</sup>

Like providers, health plans may want to pay attention to the evolving policy landscape to confirm that their efforts mirror those of CMS and that they are not burdening providers with different requirements. There is an opportunity for health plans to play a leading role in pioneering telehealth strategies, as the federal government will likely continue to look to the commercial market for additional telehealth quality and cost-effectiveness data.

## Appendix

### **Telehealth terminology:**

- **Telehealth vs. telemedicine:** According to the Office of the National Coordinator for Health Information Technology, telehealth refers to a broader scope of remote healthcare services than telemedicine, which refers specifically to remote clinical services. Telehealth can refer to remote nonclinical services, such as provider training and continuing medical education, in addition to clinical services.
- **Synchronous telehealth** requires presence of both parties (may be a patient and a nurse practitioner consulting with a specialist via a live audio/video link, or a clinician and a patient communicating via videoconference) to be communicating in real time.
- **Asynchronous or store-and-forward telehealth** refers to the transmission of digital images, as in radiology or dermatology, for a diagnosis.

## References

1. Harry Greenspun and Sheryl Coughlin, "mHealth in an mWorld: How mobile technology is transforming health care," Deloitte Center for Health Solutions, 2014.
2. Dale H. Yamamoto, "Assessment of the feasibility and cost of replacing in-person care with acute care telehealth services," Alliance for Connected Care, December 2014.
3. Susan D. Hall, "MedPAC concerned increased telehealth reimbursement could lead to unnecessary costs," Fierce Health Care, March 14, 2016.
4. Harry Greenspun, Casey Korba, Sunandan Banerjee, "Accelerating the adoption of connected health," Deloitte Center for Health Solutions, November 2014.
5. Bob Herman, "Virtual reality: More insurers are embracing telehealth," Modern Healthcare, February 20, 2016.
6. Jonah Comstock, "CMS okays telehealth for face-to-face Medicaid visits," Mobihealth News, January 28, 2016.
7. Amy Novotney, "A new emphasis on telehealth," American Psychological Association, June 2011.
8. RL Bashshur et al, "The empirical foundations of telemedicine interventions for chronic disease management," Journal of Telemedicine and e-Health, September 20, 2014.
9. Krista Drobac and Clif Gaus, "Connected care is key to accountable care: The case for supporting telehealth in ACOs," The American Journal of Accountable Care, June 2014.
10. RL Bashshur et al, "The empirical foundations of telemedicine interventions for chronic disease management," Journal of Telemedicine and e-Health, September 20, 2014.
11. AM Totten, DM Womack, KB Eden, MS McDonagh, JC Griffin, S Grusing, and WR Hersh, "Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews." Technical Brief No. 26. AHRQ Publication No.16-EHC034-EF, Agency for Healthcare Research and Quality, June 2016.
12. Dale H. Yamamoto, "Assessment of the feasibility and cost of replacing in-person care with acute care telehealth services," Alliance for Connected Care, December 2014.
13. HHS, CMS, "Medicare Learning Network: Telehealth Services," 2015.
14. Terri Cooper, "A glimpse into the future of health care at VA," Deloitte Center for Health Solutions Health Care Current, April 19, 2016.
15. American Hospital Association, "Telehealth: Helping hospitals deliver cost-effective care," 2016.
16. John Paul Jameson, Mary Sue Farmer, Katharine J. Head, John Fortney, Cayla R. Teal, "VA community mental health service providers' utilization of and attitudes toward telemental health care: The gatekeeper's perspective," The Journal of Rural Health, August 2011.
17. Public Law 114-10 (April 16, 2015)
18. GovTrack.US, S.2484: CONNECT for Health Act.
19. Mark Weideman and Jonathan Nelson, "What digital health should know about the CONNECT Act's effect on telemedicine," Rock Health, March 10, 2016.
20. Public Law 114-10 (April 16, 2015)
21. Dianne Bourque, Thomas S. Crane, Ellen Janos & Sarah Beth S. Kuyers, "MACRA's Advancement of EHR interoperability and telehealth," Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., April 24, 2015.
22. US Congress, S.2484 CONNECT for Health Act, introduced February 2, 2016.
23. Senator Brian Schatz, CONNECT For Health Act one-pager, February 3, 2016.
24. US Congress, H.R. 2948 Medicare Telehealth Parity Act of 2015, introduced July 7, 2015.
25. Medicare Payment Advisory Committee, Reports, 2016.
26. Kaiser Family Foundation, "Medicare Advantage," May 11, 2016.
27. Katie Horton, Mary-Beth Malcarney, Naomi Seiler, "Medicare payment rules and telemedicine," Public Health Report, March-April 2014.
28. Medicare Payment Advisory Committee, Report to the Congress: Medicare and the Health Care Delivery System, June 2016.
29. Phil Galewitz, "Medicare slow to adopt telemedicine due to cost concerns," Health IT News, June 24, 2015.
30. David Pittman, "Major insurer adds telemedicine in Medicare Advantage plans," Politico, January 11, 2016.
31. The United States Senate Committee on Finance, Letter to stakeholders, May 22, 2015.
32. Centers for Medicare and Medicaid Services, Comprehensive Primary Care Model, 2016.
33. Deborah A. Jeffries, "Progress in reimbursement for telehealth and new primary care model," Electronic Health Reporter, May 16, 2016.
34. Patrick Conway, "Building on the success of the ACO model," The CMS Blog, March 10, 2015.
35. Studies have shown that a quarter of all ER visits are for nonemergent care, resulting in otherwise avoidable health costs. Using telehealth to increase appropriate care sites is one strategy of ACO care coordination.
36. Centers for Medicare and Medicaid Services, Comprehensive Care for Joint Replacement Model, 2016.
37. Centers for Medicare and Medicaid Services, Bundled Payments for Care Improvement (BPCI) Initiative: General Information, 2016.
38. Centers for Medicare and Medicaid Services, 42 CFR Parts 431, 433, 438, 440, 457 and 495, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Federal Register, 2016.
39. Ibid.
40. Interstate Medical Licensure Compact, About the Compact, 2016.
41. Latoya Thomas and Gary Capistrant, "State Telemedicine Gaps Analysis: Coverage and Reimbursement," American Telemedicine Association, January 2016.
42. Centers for Medicare and Medicaid Services, Telemedicine, 2016.
43. Ibid.
44. Edgar Walters, "Doctors, telemedicine companies meet to plot new course," The Texas Tribune, June 8, 2016.
45. The Deloitte 2016 Survey of US Health Care Consumers has a nationally representative sample of 3,751 adults.
46. Mark Weideman and Jonathan Nelson, "What digital health should know about the CONNECT Act's effect on telemedicine," Rock Health, March 10, 2016.
47. Brian Dolan and Jonah Comstock, "In depth: The changing relationship of health plans and virtual visit services," Mobile Health News, September 11, 2015.
48. Bruce Japsen, "Health industry dials up telehealth for growth," The Motely Fool, June 11, 2015.
49. Claudia Rimerman, "What do employers want from telehealth: Insights from American Well's 2015 Employer Benchmark Survey," BenefitsPro, February 11, 2016.
50. Sandy Ahn, Sabrina Corlette, and Kevin Lucia, "Can telemedicine help address concerns with network adequacy? Opportunities and challenges in six states," Robert Wood Johnson Foundation and Urban Institute issue brief, April 2016.

## Authors

### Harry Greenspun

Managing Director  
Deloitte Services LP  
hgreenspun@deloitte.com

### Casey Korba

Health Policy Manager  
Deloitte Center for Health Solutions  
Deloitte Services LP  
ckorba@deloitte.com

### Arielle Kane

Senior Business Project Specialist  
Deloitte Center for Health Solutions  
Deloitte Services LP  
arkane@deloitte.com

To download a copy of this report,  
please visit [www.deloitte.com/us/telehealth-policy](http://www.deloitte.com/us/telehealth-policy).

## Acknowledgements

We wish to thank Anne Phelps, Sarah Thomas, Jessica Nadler, Danielle Moon, Julie Barnes, Krista Drobac, Mario Gutierrez, Bernard Harris, Kofi Jones, Claire Cruse, Leslie Korenda, Christina DeSimone, Lauren Wallace, and the many others who contributed their ideas and insights to this project.

### About the Deloitte Center for Health Solutions

The source for health care insights: The Deloitte Center for Health Solutions (DCHS) is the research division of Deloitte LLP's Life Sciences and Health Care practice. The goal of DCHS is to inform stakeholders across the health care system about emerging trends, challenges, and opportunities. Using primary research and rigorous analysis, and providing unique perspectives, DCHS seeks to be a trusted source for relevant, timely, and reliable insights. To learn more, please visit [www.deloitte.com/centerforhealthsolutions](http://www.deloitte.com/centerforhealthsolutions).

### About the Deloitte Center for Regulatory Strategy

The Deloitte Center for Regulatory Strategy provides valuable insight to help organizations in the financial services, health care, life sciences, and energy industries keep abreast of emerging regulatory and compliance requirements, regulatory implementation leading practices, and other regulatory trends. Home to a team of experienced executives, former regulators, and Deloitte professionals with extensive experience solving complex regulatory issues, the Center exists to bring relevant information and specialized perspectives to our clients through a range of media including thought leadership, research, forums, webcasts, and events. To learn more, please visit [www.deloitte.com/centerforregulatorystrategies](http://www.deloitte.com/centerforregulatorystrategies).



This publication contains general information only and Deloitte is not, by means of this publication, rendering accounting, business, financial, investment, legal, tax, or other professional advice or services. This publication is not a substitute for such professional advice or services, nor should it be used as a basis for any decision or action that may affect your business. Before making any decision or taking any action that may affect your business, you should consult a qualified professional advisor.

Copyright © 2016 Deloitte Development LLC. All rights reserved.  
Member of Deloitte Touche Tohmatsu Limited