BDR 57-670
SB 222

EXECUTIVE AGENCY

FISCAL NOTE

AGENCY'S ESTIMATES

Date Prepared: March 20, 2015

Agency Submitting: Public Employees' Benefits Program

Items of Revenue or Expense, or Both	Fiscal Year 2014-15	Fiscal Year 2015-16	Fiscal Year 2016-17	Effect on Future Biennia
Cat 08 Fully Insured Program Costs (Expense)		$2,540,172	$2,895,796	
Cat 12 Self-Insured Claims Costs (Expense)		$5,015,550	$6,018,660	
Total	0	$7,555,722	$8,914,456	0

Explanation (Use Additional Sheets of Attachments, if required)

This agency has reviewed BDR 57-670 which limits co-payments and co-insurance required to be paid for prescription medications. The Public Employees' Benefits Program has determined that this bill will have certain consequences for the plan and its participants as well as a significant fiscal impact. The projected impact for Fiscal Year 2016 and 2017 have been provided. Although a fiscal impact is expected in future biennia, the actual impact cannot be fully determined. The attached documentation explains expected and potential consequences and provides a cost estimate.

Name Roger Rahming

Title Operations Officer

DEPARTMENT OF ADMINISTRATION'S COMMENTS

Date Friday, March 20, 2015

The agency's response appears reasonable.

Name James R. Wells, CPA

Title Interim Director

DESCRIPTION OF FISCAL EFFECT

BDR/Bill/Amendment Number: SB222 (BDR 57-670)

Name of Agency: Public Employees' Benefits Program

Division/Department:

Date: March 19, 2015

SB222 makes the following changes for medical policies ***delivered, issued for delivery or renewal*** on or after July 1, 2015**:**

- Limit any copayment or coinsurance required to be paid for prescription drugs to an amount not greater than $50 per month for a 30-day supply of each prescription drug
- Limit any copayment or coinsurance required to be paid for prescription drugs on an annual basis to an amount not greater than 20 percent of the out-of-pocket maximum specified in the Affordable Care Act
- The limits on coinsurance must apply regardless of whether the amount of the annual deductible has been satisfied, and
- Not all prescription drugs may be placed in a given class within the highest cost tier designated in the health care plan
- If a specialty drug formulary is used, the plan must also include an exceptions process that allows an insured to request an exception to the formulary

There is an exception in Sec. 3., which appears only to deal with chemotherapy, for high deductible plans with reference to the HSA deductibility rules (i.e., 26 U.S.C. §223).

Potential Impact to PEBP

There are three areas of potential impact to PEBP and its members: financial, plan structure/tax, and administrative.

1. **Financial** - Assuming these rules only apply to PEBP's self-funded high deductible plans, estimated annual cost impact ranges from $5-$6 million in plan year 2016 or 3.4-3.9% in additional claims cost. Approximately 20,000 employees (36,000 people) participate in PEBP's self-funded high deductible plans. *Note: the language in Sec. 15. could be interpreted to exempt HMOs from some but not all of these requirements.*

2. **HMOs** - Estimate the financial impact from just the $50/20% limitation to be in the range of 0.6% to 2.6% of premiums, or up to $2.5 million in FY16 and $2.9 million in FY17.

3. **Plan Structure/Tax** – The Bill's rules as they are written will invalidate PEBP's ability to continue to offer Health Savings Accounts (HSAs) to its members. Qualifying high deductible plans must have minimum deductibles and out-of-pocket limits in order to allow members to participate in tax qualifying HSAs. [1]Unless SB222 can exempt HSA-qualifying high deductible plans from all of its requirements, PEBP members will no longer have the tax advantages of Health Savings

[1] In 2004, the IRS looked at similar mandated benefits under state insurance law and concluded that insured plans with those mandates are not qualifying HDHPs and individuals covered under those health plans are not eligible to contribute to HSAs.

Accounts. Shown below are the 2015 HSA qualifying plan requirements compared with the proposed SB222 rules:

Provision	HSA Qualifying Requirements	Proposed SB222 Rules (Rx Only)
Deductible	Minimum of $1,300 (single) Minimum of $2,600 (family)	Maximum of $50/prescription/month
Annual Out-of-Pocket Maximum, including deductibles, copayments, coinsurance	Maximum of $6,450 (single) Maximum of $12,900 (family)	Maximum of $1,320 (single) Maximum of $2,640 (family) (20% of PPACA §1302(c)(1)) each year

The approximate 36,000 PEBP members in the self-funded high deductible plans participating in the HSA will lose the following tax advantages:

- Tax free contributions to HSAs both by employer and by employee
- Tax free interest accumulation
- Tax free distributions to pay for IRS qualified medical expenses
- Tax free distributions to pay insurance premiums while continuing coverage under COBRA, qualified long-term care coverage, coverage while receiving unemployment compensation, any health care coverage for those over age 65 including Medicare (except Medicare supplemental coverage)

In addition, since the HSA also serves as a vehicle for funding wellness incentives, PEBP would need to find another way to fund these $50 monthly incentives for HSA participants.

4. **Administrative** – PEBP is in the process of finalizing rate cards which are expected to be approved at its Board meeting on March 26, 2015. Assuming a July 1, 2015 effective date for PEBP to coincide with our fiscal renewal date, the administrative implications are significant, and cannot reasonably be accomplished by July 1, 2015. Some of the required actions are:

   a. Alternatives to the HSA must be determined (note: HRAs might be considered a reasonable alternative to HSAs, but they do not allow for employee contributions, which would represent a cut in benefits to employees)
   b. The current HSA administrator's contract must be terminated
   c. Communications must be prepared and distributed to all plan members
   d. PEBP's health plan budget, scheduled to be finalized in late March/early April must be recalculated and reapproved by PEBP's Board (a several month process)
   e. The wellness program must be redesigned and re-communicated
   f. PEBP's pharmacy benefit manager, Catamaran, must reprogram its systems to administer the new benefits
   g. PEBP's claim administrator, HealthScope Benefits, must reprogram its systems to administer a lower out-of-pocket limit for non-pharmacy benefits so that the combined pharmacy and non-pharmacy out-of-pocket limits stay within the ACA's overall maximum out-of-pocket limits