NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 435

SHORT TITLE: State Health Plan Technical Amendments/AB

SPONSOR(S): Rep. Jerry Dockham

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, Other State Employer Receipts, Premium Payments for Dependents by Active and Retired Teachers and State Employees, and Premium Payments for Coverages Selected by Eligible Former Teachers and State Employees.

BILL SUMMARY: The bill is the recommendation of the Executive Administrator and Board of Trustees of the Plan for changes in the Plan's indemnity program. Most of the bill involves codification of administrative policies previously adopted by the Plan into the Plan's statutes. Consequently, these changes do not involve changes in the Plan's claim costs. However, a few of the recommendations do involve claim costs to the indemnity program if they are enacted.

Before describing the cost items, a review of the administrative and clarifying changes requested to be codified into the statutes follows. These changes are already in use by the Plan. The words "benefit or benefits" are defined to mean a service covered by the program (Sec. 1).
Since radial keratotomy procedures are not covered by the program, other related surgeries to correct vision when performed in lieu of corrective lenses are also excluded from coverage (Sec 5). Coinsurance amounts paid by Plan members are calculated on the lower of diagnostic related grouping (DRG) amounts paid for inpatient hospitalizations or a hospital's charges for the admission (Sec. 7). Clarification is made on waiting periods for preexisting health condition exclusions so that waiting periods are not applied whenever enrollments are made within 30 days after eligibility to enroll or re-enroll (Secs. 16, 28, 29). Clarification of non-contributory premium statutes is requested to make employees on approved leaves of absence with pay, on approved workers' compensation leaves, and on approved family and medical leave eligible for continued non-contributory premiums (Sec. 17). The State Retirement System is designated the health benefit representative for retired employees and their dependents (Sec. 18). To be eligible to continue participation in the Plan, former members of the General Assembly who do not commence retirement are required to continue their coverage within 30 days after their last term of office (Sec. 19). Spouses of surviving dependents are not eligible for coverage under the Plan nor are dependent children if they were not covered at the time of a Plan member's death (Sec. 20). Dependents of blind vendors are not eligible for coverage under the Plan since federal rulings have determined that the vendors were contractors and not employees of the State (Sec. 21). Eligibility for permanent-hourly employees of state agencies is repealed since the employee classification has been discontinued (Sec. 22).

Clarification is made of the statutes that dependent children of deceased former members of the General Assembly and deceased beneficiaries of the State's Disability Income Plan are eligible for coverage if covered at the time of the Plan member's death (Sec. 23). Employees eligible for coverage as a dependent and as an employee on a fully contributory basis are permitted the lower premium rate (Sec. 24). Disability Income Plan beneficiaries are allowed to continue coverage on a fully contributory basis when they complete five years of retirement service credit (Sec. 25). Disability Income Plan beneficiaries with less than five years of retirement service credit along with their eligible dependents are allowed to continue coverage under the Plan on a fully contributory basis (Sec. 26). Surviving dependents of deceased Plan members are allowed to continue coverage beyond 90 days following a member's death but will be subject to preexisting health condition limitations (Sec. 27). Plan members wishing to change coverage under the Plan's indemnity program are required to notify health benefit representatives or the Plan within 30 days of the effective date of the change (Secs. 29, 30, 31). Medicare-eligible employees who choose Medicare to be the primary payer of health benefits and lose their eligibility for the program's group health benefits are allowed to convert to a non-group plan of health benefits offered by the indemnity program (Sec. 32). Changes in continuation coverage provided to employees and dependents who lose eligibility for Plan benefits are requested to comply with federal law (Secs. 33, 34, 35). Certified physical therapy and certified occupational therapy assistants are allowed to provide physical and occupational therapy respectively (Secs. 36, 37). Foot surgeries, argon laser trabeculoplasty, and radioallergosorbent tests are covered under the indemnity program without prior approval (Secs. 38, 39). Conformity with federal preexisting health condition limitations are also included provided not more than 63 days separate health coverages (Sec. 40).

Sections 2, 3 and 4 of the bill redefine experimental and investigational procedures that are excluded from coverage under the Plan's indemnity program. The program's current definition has not been able to withstand legal challenges which is the reason for the requested change. Section 4 further excludes from the program's coverage complications arising from noncovered services.

Section 8 of the bill deals with the indemnity program's pre-certification of inpatient hospital admissions. The program's current policies provide that failure of a Plan member to secure a certification or the Plan's denial of a requested certification results in a claim payment penalty of 50% of the admission's expenses up to $500 per admission. The Plan's experience has been that, on occasion, Plan members are glad to pay a penalty of only $500 for uncertified admissions in order to have the balance of the claim paid. Under the Plan's recommendation, the entire expense of the claim would be denied to the extent that the expenses were not medically necessary or appropriate.

Section 10 of the bill requires that skilled nursing facility care benefits be medically necessary and that skilled nursing care be provided on a continuing daily basis to patients who otherwise would require continual hospital confinement.

Sections 14 and 15 of the bill remove the maximum benefit limitations for coverage of chemical dependency under the Plan's self-insured indemnity program. These limits for each covered individual are $8,000 per fiscal year, $25,000 for a lifetime, and $200 per day except for medical detoxification treatment. Removal of these specialized limits for substance abuse will result in its coverage being limited only to the same deductibles, coinsurance factors, and durational and other limitations as generally affect physical illnesses and injuries. Similar limitations on

other mental health coverages under the Plan's indemnity program were removed by the 1991 Session of the General Assembly effective January 1, 1992. At that time, inpatient mental health benefits were limited to 30 days per year for each covered individual and outpatient treatments were limited to 50 visits and $2,200 in claim payments per year for each person. When these limitations were removed, a managed individualized plan of case-by-case treatment was implemented for mental health benefits, including utilization review and use of available preferred provider networks to contain the expected cost increases from removing the specialized mental health limitations. Sections 14 and 15 of the bill repeat what the 1991 Session of the General Assembly did in requiring that case management be implemented for chemical dependency benefits to contain the cost increases from removing the current limits on substance abuse benefits.

EFFECTIVE DATE: July 1, 1997.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical Plan, the consulting actuary for the Plan, Aon Consulting, estimates that the bill will reduce the indemnity program's claim costs by 0.48% to 0.68%.

However, using a midpoint value of 0.58%, the Plan's consulting actuary projects the savings to the Plan's indemnity program to be $2,784,000 for 1997-98 and $4,007,000 for 1998-99. The consulting actuary for the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, estimates that the bill will reduce the indemnity program's claim costs by $1,790,000 in 1997-98 and $2,916,000 in 1998-99. The major differences between the two actuarial projections involve chemical dependency, denial of inpatient hospital claims not certified, and excluding coverage for complications arising from non-covered services. For chemical dependency, the consulting actuary for the Plan projects that case management activities will reduce claim costs by the amount of increased chemical dependency claims from removal of the dollar limits. The consulting actuary for the Fiscal Research Division projects that the costs for removal of the chemical dependency limits will exceed the savings realized from case management by $359,000 for 1997-98 and that 1998-99 will be the first year that the savings from case management will generally equate to the increased costs from removing the substance abuse limits. Such was the Plan's experience in 1992 regarding mental health benefit limits and case management. The largest single difference between the actuarial projections involves savings estimated from denial of inpatient hospitalization claims when the admission is not certified. The estimates from the Fiscal Research Division's consulting actuary were lower than those from the Plan's consulting actuary by $514,000 in 1997-98 and $889,000 in 1998-99. The lower estimate from the Fiscal Research Division's consulting actuary was due to a decreasing rate of inpatient hospital admissions being experienced by most major medical plans. With these declining inpatient admissions rate, more and more inpatient admissions will become more justified as being medically necessary and appropriate. The remaining difference between the actuarial projections involves the estimated savings from excluding claim payments for complications arising from non-covered services. The estimated savings projected by the Fiscal Research Division's consulting actuary were lower than those of the Plan's consulting actuary by $121,000 in 1997-98 and $161,000 in 1998-99. Using a combined projection from the two actuarial firms based upon the estimates of the Plan's consulting actuary for all items of savings except for the denial of uncertified inpatient hospital claims and the impact of changes upon chemical dependency claims, both of

which incorporate the work of the Fiscal Research Division's consulting actuary, produces an estimated savings to the indemnity program of $1,911,000 for 1997-98 and $3,118,000 for 1998-99.

Further using this combined projection, additional savings in the indemnity program for outlying years are expected to be $3,367,000 for 1999-2000, $3,636,000 for 2000-01, and $3,927,000 for 2001-02.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with twelve HMOs currently covering about 25% of the Plan's total population in about 85 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1996, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	186,400	70,400	256,800
Active Employee Dependents	104,700	51,800	156,500
Retired Employees	84,400	5,400	89,800
Retired Employee Dependents	14,400	1,200	15,600
Former Employees & Dependents with Continued Coverage	2,700	800	3,500
Total Enrollments	392,600	129,600	522,200
Number of Contracts			

Employee Only	206,300	51,800	258,100
Employee & Child(ren)	29,900	14,500	44,400
Employee & Family	36,600	10,100	46,700
Total Contracts	272,800	76,400	349,200
Percentage of Enrollment by Age			
29 & Under	27.3%	44.7%	31.6%
30-44	21.6	28.0	23.2
45-54	20.0	17.8	19.5
55-64	13.8	7.1	12.1
65 & Over	17.3	2.4	13.6
Percentage of Enrollment by Sex			
Male	39.8%	40.0%	39.8%
Female	60.2	60.0	60.2

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1996, the self-insured program started its operations with a beginning cash balance of $368.3 million. Receipts for the year are estimated to be $580 million from premium collections, $25 million from investment earnings, and $12 million in risk adjustment and administrative fees from HMOs, for a total of $617 million in receipts for the year. Disbursements from the self-insured program are expected to be $595 million in claim payments and $18 million in administration and claims processing expenses for a total of $613 million for the year beginning July 1, 1996. For the fiscal year beginning July 1, 1997, the self-insured indemnity program is expected to have an operating cash balance of over $372 million with a net operating loss of $54 million for the 1997-98 fiscal year. For the fiscal year beginning July 1, 1998, the self-insured indemnity program is expected to have an operating cash balance of $318 million with a net operating loss of $118 million for the 1998-99 fiscal year. The estimated cash balance for the self-insured indemnity program is expected to be $200 million at the end of the 1997-99 biennium. The self-insured indemnity program is consequently assumed to be able to carry out its operations without any increases in its current premium rates or a reduction in existing benefits until the 1999-2000 fiscal year. This assumption is predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $110.08 monthly for employees whose primary payer of health benefits is Medicare and $144.60 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $68.50 monthly for children whose primary payer of health benefits is Medicare and $90.12 monthly for other covered children, and $164.30 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $216.18 per month for other family contract dependents. Claim cost trends are expected to increase 8-10% annually. Total enrollment in the program is expected to decrease about one percent (1.0%) annually due to competition from alternative HMOs. The number of enrolled active employees

is expected to show a 1-2% loss annually, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to lose about 3-4% of its number of active employee dependents each year, whereas the number of enrolled retiree dependents is assumed to show no appreciable change from year to year. Investment earnings are based upon a 6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for the Self-Insured Indemnity Program's Savings from the Bill: During the last three calendar years, the indemnity program denied 12 bone marrow transplant cases that were considered experimental and investigational. However, upon legal challenges, the program paid $1,882,796 in claims for these cases. Also, during this three-year period, the program paid $439,002 in claims from complications arising from non-covered bone marrow transplant, breast implant, and radial keratotomy services. For the same three-year period, the program estimates that it would have saved $225,000 in skilled nursing claim payments had the Plan had clearer definitions of skilled care.

For denial of inpatient hospital claims that were not certified by the program, 893 cases were penalized in calendar year 1996 for $331,532. Claim payments for these same cases were $2,977,836. For calendar year 1995, 995 cases were penalized $366,572 for which $3,389,967 was paid.

For the fiscal year ending June 30, 1996, the Plan's indemnity program paid $1,602,720 in claims related to chemical dependency - $1,011,372 for alcohol abuse and $591,348 for drug abuse. Of the total amount paid, $912,761 was paid for inpatient care, $500,015 was paid for outpatient treatment, $155,590 was paid for partial hospitalizations, and the remaining $34,354 was paid for residential treatment programs. Total charges for these paid claims was $2,877,638. Of the total amount of claim payments made during 1995-96, almost 80% were paid on behalf of the program's active employee group including both employees and their enrolled dependents. This active employee group accounted for 215 inpatient admissions involving 2,519 inpatient days for an average length-of-stay of almost 12 days. For outpatient treatment, the active employee group accounted for 3,909 visits by some 654 patients for an average of 6 visits per patient for the year. In comparison to fiscal year 1994-95 claims experience for substance abuse, 1995-96's experience showed a decrease of over $400,000 in paid claims for a 20% drop. In addition, the active employee group's inpatient admissions fell by over 35% for 1995-96 and the number of inpatient days dropped by over 40%. Outpatient visits for the active employee group for 1995-96 however remained about the same as they were in 1994-95.

Since the inception of the Plan in October, 1982, substance abuse benefits in the Plan's indemnity program have been limited. Through December, 1984, the indemnity program's substance abuse benefits were limited to 30 days per person each year for inpatient care and to 50 visits and $2,200 in claim payments annually for outpatient treatment for each covered individual. In addition, outpatient care was subject to a 20% coinsurance rate paid by enrolled members whereas all other care was subject to a 5% or 10% coinsurance rate. Effective January 1, 1985, these limitations were replaced with a 30-day claim payment limit of $3,000, an annual claim payment limit of $5,000, a lifetime claim payment limit of $15,000, and a $100 daily limit for non-medical detoxification treatment for each person. Effective September 1, 1987, the 30-day limit was increased to $3,900, the annual limit was increased to $6,500, the lifetime limit was increased to $20,000, and the daily detoxification limit was increased to

$130. Effective October 1, 1989, the 30-day limit was eliminated, the annual limit was increased to $8,000, the lifetime limit was increased to $25,000, and the daily detoxification limit was raised to $200. No further changes have been made to these limits since October, 1989. Over the last three years, the indemnity program's records show that $1,457,649 in substance abuse claims have been denied by the program in exceeding these benefit limits.

SOURCES OF DATA:

-Actuarial Note, Dilts, Umstead & Dunn, House Bill 435, April 24, 1997, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Bill 435, April 23, 1997, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: In Section 14, the proposed G. S. 135-40.7B.(c) and (c1) need to be changed by omitting the word "outpatient"; the proposed G. S. 135-40.7B. (c1)(1)g. and h. need to be changed by omitting the phrase "until (sunset date);" the proposed G. S. 135-40.7B. (c1)(1) j. needs to be changed by omitting the phrase "(sunset date)"; and the proposed G. S. 135-40.7B. (c1)(2) g. and h. need to be changed by omitting the phrase "until (sunset date);".

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DATE: April 29, 1997.

Signed Copy Located in the NCGA Principal Clerk's Offices