NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 218

SHORT TITLE: Managed Care Entity External Review.

SPONSOR(S): Sen. Hoyle

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 establishes external review procedures for health plans to assure that individuals covered by the plans have the opportunity for an independent review of coverage decisions made by the plans. Independent reviews will be conducted by the North Carolina Department of Insurance, which would assign a request for external review to an independent review organization. Individuals requesting an independent review would be required to pay a $25 fee to the Department of Insurance for requesting an external review. Health plans would be required to pay the Department of Insurance any remaining costs incurred by the Department in conducting the review. Requests can be made for an external review of a noncertification decision by a plan after exhausting internal grievance opportunities. "Noncertification" means a determination that an admission, availability of care, continued stay, or other health care services have been reviewed, and based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard of coverage in emergency situations, and the requested service is denied, reduced, or terminated. Treatments considered experimental or investigational are also covered under the definition of "noncertification". Noncertification does not however apply to decisions rendered solely on the basis that a service is not a covered service. After reviewing a case, a review organization would either uphold or reverse a noncertification decision. The review decision would be binding. For members of the Teachers' and State Employees' Comprehensive Major Medical Plan, an external review can be made after a Plan member has exhausted second level internal review opportunities. The bill applies to the Plan's self-insured indemnity program and to alternative health maintenance organization (HMO) coverages offered by the Plan.

EFFECTIVE DATE: October 1, 2001.

ESTIMATED IMPACT ON STATE: Based upon information provided by the Comprehensive Major Medical Plan for Teachers' and State Employees, the Plan's consulting actuary, Aon Consulting, estimates the additional cost of the bill to the Plan's self-insured indemnity program for fiscal year 2001-02 to be $218,000, and $373,000 for fiscal year 2002-03. These additional costs assume that the program experiences 90-110 second level grievances per year, and that 50% or 50-55 of these grievances will be requested for external review under the bill. At a range of average appeal costs of $2,855 to $3,555, these 50-55 cases assumed to request external review is estimated to cost $157,000 to $190,000 per year. In addition, Aon Consulting expects about 10% of the cases involved in external review to be decided in favor of the members of the program requesting external reviews. These 4 to 6 cases per year are estimated to cost the program an

additional $160,000 to $240,000. Total costs of the bill are estimated to be of $317,000 to $430,000 per year, with a mid-point cost of $373,000 per year. Based upon the same information provided by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, estimates the additional costs to the Plan to be $310,000 for fiscal year 2001-02 and $590,000 for fiscal year 2002-03. Hartman and Associates estimates the same number of cases for external review as Aon Consulting, but expects a higher average cost for reviews decided in favor of the program members requesting the reviews. A combined estimate from the two actuaries would put the additional cost of the bill to be $265,000 for fiscal year 2001-02 and $482,000 for fiscal year 2002-03.

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 only had 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. Beginning in July, 2000, firefighters, rescue squad workers, and members of the National Guard and their eligible dependents were allowed to voluntarily participate in the Plan on a fully contributory basis, provided they were ineligible for any other type of group health benefits and had been without such benefits for at least six months. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. All other types of premium in the indemnity program are fully contributory. The Plan's Executive Administrator has set the premium rates for firefighters, rescue squad workers, and members of the National Guard and their families at 47% more than the comparable rates charged for employees, retired employees, and their families. 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 three HMOs currently covering about 9% of the Plan's total population in 24 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, 2000, include:

	Self-Insured Indemnity Program	**Alternative HMOs**	**Plan Total**
Number of Participants			
Active Employees	248,518	28,822	277,340
Active Employee Dependents	134,795	17,376	152,171
Retired Employees	104,305	3,185	107,490
Retired Employee Dependents	17,936	594	18,530
Former Employees & Dependents with Continued Coverage	2,865	381	3,246
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	3	-	3
Total Enrollments	508,422	50,358	558,780
Number of Contracts			
Employee Only	270,322	23,223	293,545

Employee & Child(ren)	38,775	6,006	44,781
Employee & Family	45,764	3,026	48,790
Total Contracts	354,861	32,255	387,116
Percentage of Enrollment by Age			
29 & Under	28.0%	41.6%	29.2%
30-44	20.9	26.6	21.4
45-54	21.3	19.2	21.1
55-64	14.5	9.2	14.0
65 & Over	15.4	3.4	14.3
Percentage of Enrollment by Sex			
Male	39.1%	36.9%	38.9%
Female	60.9	63.1	61.1

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2000, the self-insured program started its operations with a beginning cash balance of $188 million. Receipts for the year are estimated to be $930 million from premium collections, $10 million from investment earnings, and $10 million in risk adjustment and administrative fees from HMOs, for a total of $950 million in receipts for the year. Disbursements from the self-insured program are expected to be $1.070 billion in claim payments and $31 million in administration and claims processing expenses for a total of $1.101 billion for the year beginning July 1, 2000. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $37 million. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in its current premium rates or a reduction in existing benefits or payments to health care providers or both. This assumption is further 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 formularies, and fraud detection) are maintained and improved where possible. Of particular note in these cost containment strategies is that the program's contract with its pharmacy benefit manager, AdvancePCS, calls for a further reduction in claim payments for outpatient prescription drugs for the 2001-03 biennium. Effective July 1, 2001, dispensing fees for pharmacies will be reduced from $4.00 to $1.50 per prescription. In addition, ingredient prices for pharmacies will be reduced from 90% to 85% of average wholesale price (AWP) for branded drugs and from maximum allowable charges (MAC) by the federal Health Care Financing Administration (HCFA) or 80% of AWP to 45% of AWP for generic drugs. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $187.98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family contract dependents. Claim cost trends are expected to increase 12% annually. Total enrollment in the program is expected to increase about 3% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 3% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 5% per year. The program is expected to have an increase in the number of active employee

dependents and retiree dependents of 2% per year. Investment earnings are based upon a 6% 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 Indemnity Plan's Second Level Grievances: For the last three calendar years, the Plan's self-insured indemnity program has had 65-second level grievances in 1998, 91 in 1999, and 79 in 2000. Of this 235 total number of second level grievances, 110 were further appealed to the Plan's Executive Administrator and Board of Trustees for a further appeal percentage of some 47%. Appeal costs under the bill range from $300 reported by the Department of Insurance to $5,500 reported by the claims processing contractor of the Plan's self-insured indemnity program, Blue Cross and Blue Shield of North Carolina.

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, Senate Bill 218, March 28, 2001, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, Senate Bill 218, March 294, 2001, 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.
-1998, 1999, and 2000 second level grievance data for the Plan's self-insured indemnity program provided by the Plan.
-Average costs for appealed decisions provided by the Plan from estimates by the Department of Insurance and Blue Cross and Blue Shield of North Carolina.

TECHNICAL CONSIDERATIONS: The bill needs to be amended to make a change in G.S. 135-39.7 as follows:
"If, after exhaustion of internal appeal handling as outlined in the contract with the Claims Processor any person is aggrieved and the case cannot be appealed under the provisions of Article 50 of Chapter 58 of the General Statutes, the Claims Processor shall bring the matter to the attention of the Executive Administrator and Board of Trustees, which may make a binding decision on the matter in accordance with procedures established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written summary of the decisions made pursuant to this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a decision, and to any other parties requesting a written summary and approved by the Executive Administrator and Board of Trustees to receive a summary immediately following the issuance of a decision."

FISCAL RESEARCH DIVISION: 733-4910
PREPARED BY: Sam Byrd

APPROVED BY: James D. Johnson

DATE: April 3, 2001.