NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 439

SHORT TITLE: Enhanced State Employee Health Benefits

SPONSOR(S): Representative George Miller

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

BILL SUMMARY: Enhances the benefits under the indemnity program of the Teachers' and State Employees' Comprehensive Major Medical Plan as follows:

Wellness: (a) Covers routine diagnostic examinations at 100% of allowable charges up to $150 per member per year, in addition to 100% of allowable charges for immunizations, without application of the Plan's $250 annual deductible and 20% coinsurance up to $1,000 annually paid by beneficiaries; allowable charges in excess of $150 per member per year would continue to be covered by the Plan subject to the current annual deductible and coinsurance limitations paid by Plan members. (b) Reduces the minimum age at which Plan members can receive annual routine diagnostic examinations covered by the Plan from 55 to 50; Plan members age 40 to 49 would continue to be able to get routine diagnostic examination coverage every other year. (c) Empowers the Plan's Executive Administrator and Board of Trustees to implement and operate a preventive health promotion and education program to reduce claim costs associated with catastrophic and other illnesses and injuries identified by the Plan.

Lifetime Maximum Benefits: Eliminates the program's $1,000,000 lifetime maximum benefit retroactively so that Plan members who have had claims denied because of the limit can have their denied claims adjudicated.

Case Management: Empowers the Plan's Executive Administrator and Board of Trustees to establish and operate a managed, individualized care program for high-risk maternity cases and other high-cost treatment cases for acute and chronic illnesses and injuries identified by the Plan.

Outpatient Prescription Drugs: Provides maximum allowable charges for outpatient prescription drugs at 90% of drugs' average wholesale price (AWP) plus a pharmacy dispensing fee of $5.50 per prescription. The program's current allowable charges for

outpatient prescription drugs are 90% of the drugs' average wholesale price (AWP) less a $5.00 per prescription copayment to be paid by Plan members for brand name drugs purchased with generic equivalents.

Transplants: Provides coverage for bone marrow transplants in the treatment of breast and ovarian cancer as well as for multiple myeloma.

EFFECTIVE DATE: July 1, 1995, except for removal of the program's maximum lifetime benefit which is retroactive to July 1, 1992, a year after the program's previous $500,000 lifetime maximum benefit was increased to $1,000,000.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical Plan and its claims processor, the consulting actuary for the Plan, Alexander & Alexander Consulting Group, Inc., and the consulting actuary of the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, both estimate the additional cost to the Plan for the 1995-96 fiscal year to be $19.1 million. However, the Plan's consulting actuary has quantified claim cost savings to the program for 1996-97 from the bill's case management provisions at $3.3 million. The consulting actuary of the General Assembly's Fiscal Research Division acknowledges that claim cost savings from case management activities will occur by the 1996-97 fiscal year but was unable to quantify the amount of the savings. In addition, the consulting actuary for the General Assembly's Fiscal Research Division estimates additional claim costs from the bone marrow transplants for ovarian cancer and multiple myeloma to be about $1.2 million more than estimated by the Plan's consulting actuary.

Using the more conservative and cautious estimates of the consulting actuary of the General Assembly's Fiscal Research Division, the bill's impact upon the Plan is expected to result in the following additional costs to the Plan's indemnity program: $19,150,000 in fiscal year 1995-96 and $27,850,000 in fiscal year 1996-97. For outlying years, using claim cost trend increases of 10% annually adopted by both consulting actuaries, additional costs to the Plan from the bill are estimated to be $30,635,000 for fiscal year 1997-98, $33,699,000 for fiscal year 1998-99, and $37,069,000 for fiscal year 1999-2000.

No additional General or Highway Fund appropriations would be required for the bill until the 1997-99 biennium, because of accumulated reserves in the Plan's indemnity program based upon current premiums and anticipated claim costs. By the 1997-99 biennium, claim cost savings from the bill's case management activities should be fully quantified, however.

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-insured indemnity type of program which covered all

employees, retired employees, eligible dependents of employees and retired employees, and 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. 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 seven HMOs currently covering about 16% of the Plan's total population in about 70 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, 1994, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,200	43,700	246,900
Active Employee Dependents	117,500	33,600	151,100
Retired Employees	78,500	3,300	81,800
Retired Employee Dependents	14,000	800	14,800
Former Employees & Dependents with Continued Coverage	2,600	400	3,000
Total Enrollments	415,800	81,800	497,600
Number of Contracts			
Employee Only	211,800	30,700	242,500
Employee & Child(ren)	32,800	10,200	43,500
Employee & Family	39,100	6,400	45,500
Total Contracts	283,700	47,300	331,000
Percentage of Enrollment by Age			
0-29	29.1%	43.8%	31.5%
30-44	23.8	29.3	24.7
45-54	18.8	17.1	18.5
55-64	12.8	7.0	11.9
65+	15.5	2.8	13.4
Percentage of Enrollment by Sex			
Male	40.0%	40.3%	40.1%

Female	60.0	59.7	59.9

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July, 1994, the self-insured program started its operations with a beginning cash balance of $287.1 million. Receipts for the year are estimated to be $597 million from premium collections, $20 million from investment earnings, and $6 million in risk selection and administrative fees from HMOs, for a total of $623 million in receipts for the year. Disbursements from the self-insured program are expected to be $545 million in claim payments and $18 million in administration and claims processing for a total of $563 million for the year beginning July, 1994. For the fiscal year beginning July, 1995, the self-insured indemnity program is anticipated to have an operating cash balance of over $347 million with a net operating gain of $60 million for the 1994-95 fiscal year. For the next few years, the self-insured indemnity program is 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 1997-98 or 1998-99 fiscal years. 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, and fraud detection) are maintained and improved where possible. Current non-contributory premiums 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 about 10% annually. Total enrollment in the program is expected to increase about one-half of one percent (0.5%) annually. Growth in the number of enrolled active employees is expected to be a little less than 1% annually, whereas the growth in the number of retired employees is assumed to be a little more than 4% per year. The program is expected to lose about 2% 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 Bill's Impact on the Plan's Self-Insured Indemnity Program: The Executive Administrator and claims processor, Blue Cross and Blue Shield of North Carolina, for the Teachers' and State Employees' Comprehensive Major Medical Plan provided the following data upon which actuarial notes have been prepared. This data included the amount of allowable charges for wellness benefits, including immunizations, subjected to the indemnity program's deductible and

coinsurance for 1992-93 ($3,992,836) and 1993-94 ($4,314,747). The indemnity program also has 34,500 members aged 50-54. Other data included three members of the indemnity program that have already reached their current $1,000,000 lifetime maximum benefit as of December 31, 1994, with another dozen members with lifetime maximum benefits exceeding $750,000, and another forty-six members having exceeded $500,000 in lifetime benefits. As for outpatient prescription drug coverage by the indemnity program, data provided include 3,151,360 prescriptions processed for 1993-94, of which 407,143 were branded drugs with generic equivalents. The indemnity program's average percentage reimbursement during the same year for branded drugs was 64.7% of allowed charges, 61.5% for generic drugs, and 51.3% for branded drugs with generic equivalents. Over the past two years, the indemnity program has experienced three cases of multiple myeloma and two cases of ovarian cancer with costs per case ranging from $80,000 to $410,000. Incidence rates for these two diseases has been estimated from 5-10 cases annually with an average cost of $175,000 - $250,000 per case. North Carolina's mortality statistics for the two diseases applied to the indemnity program's affected population could indicate incidence rates twice the rates used by the Plan.

The average costs for preventive health promotion and education programs are about 1.0% of claim costs in large employer plans having such programs, with ranges from 0.5% to 2.0%. Claim cost savings from case management of high-risk maternity cases and other high-cost cases of acute and chronic care can be as much as 2.0% of claim costs. Such information was compiled during the 1993 Legislative Session's Government Performance Audit Committee (GPAC) activities.

SOURCES OF DATA:

- Actuarial Note, Dilts, Umstead & Dunn, House Bill 439, April 17, 1995, original of which is one file in the General Assembly's Fiscal Research Division.

- Actuarial Note, Alexander & Alexander Consulting Group, Inc., House Bill 439, April 7, 1995, 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.

- Cost and demographic data provided by the Teachers' and State Employees' Comprehensive Major Medical Plan and its claims processor, Blue Cross and Blue Shield of North Carolina.

- North Carolina Detailed Mortality Statistics, 1991-93, State Center for Health and Environmental Statistics, North Carolina Department of Environment, Health and Natural Resources.

- Actuarial Notes, Dilts, Umstead & Dunn, May 27, 1993, and Alexander & Alexander Consulting, June 8, 1993, House Committee Substitute for House Bill 300, GPAC - State Employee Health Benefits, with Selected Claims Data for High-Risk Pregnancy, Cancer, and other Chronic Diseases and Conditions, 1989-92.

TECHNICAL CONSIDERATIONS: The Plan's Executive Administrator and consulting actuary have recommended that Section 5 of House Bill 439 be rewritten to read:

"Sec. 5. G.S. 135-40.6(6)i. is rewritten to read:

"i. No benefits are payable for organ transplants not listed in G.S. 135-40(6)(5)a, nor will benefits be payable for surgical procedures or organ transplants determined in the opinion of the Claims Processor to be experimental, except that coverage is provided for bone marrow transplants in the treatment of breast cancer, ovarian cancer, and multiple myeloma."

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