NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: HB 184

SHORT TITLE: Exempt State Health Plan from APA.

SPONSOR(S): Rep. E. David Redwine.

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 exempts the Comprehensive Major Medical Plan from the rule-making provisions of the State's Administrative Procedures Act. The Plan, however, continues to be subject to the contested case provisions of the Administrative Procedures Act. Furthermore, the Legislative Committee on Employee Hospital and Medical Benefits, which oversees the operations of the Plan, is required to meet at least once each quarter to review the actions of the Plan's Executive Administrator and Board of Trustees. At these quarterly meetings, the Plan is to report any administrative and medical policies which it has adopted, benefit denials resulting from these adopted policies, and benefit denials which have been appealed to the Plan's Board of Trustees.

EFFECTIVE DATE: When the act becomes law by passage of the General Assembly and (1)is signed into law by the Governor, or (2)is not vetoed by the Governor within ten days, or (3)the General Assembly overrides a veto by the Governor.

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, and the consulting actuary of the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, both estimate the administrative cost avoidance to the Plan from not having to comply with the Administrative Procedures Act's rule-making provisions to be $400,000 annually. The Plan's consulting actuary further quantified additional claim cost avoidance to the Plan to be $2,962,000 for the 1996-97 fiscal year assuming an implementation date of April 1, 1997, $12,797,000 for fiscal year 1997-98, and $13,821,000 for fiscal year 1998-99. For outlying years, using a claim cost trend of 8% annually as recommended by the Plan's consulting actuary, additional claim cost avoidance to the Plan from the bill are estimated to be $14,927,000 for fiscal year 1999-2000, $16,121,000 for fiscal year 2000-01, and $17,411,000 for fiscal year 2001-02. The consulting actuary of the General Assembly's Fiscal Research Division acknowledges that claim cost avoidance is possible, as are additional claim costs, but that the financial impact of such cost avoidance or cost increases is subjective and difficult to quantify, resulting in no dollar amount being placed on any claim cost avoidance or increases. The

consulting actuary of the General Assembly's Fiscal Research Division does, however, conclude that if the Plan's medical and administrative rule-making process is placed with a body that does not have a fiduciary responsibility to the Plan, like that placed by statute upon the Plan's Executive Administrator and Board of Trustees, additional claim costs are likely to occur in the Plan. The Plan's consulting actuary bases its quantification of claim cost avoidance on the assumption that compliance with the rule-making provisions of the Administrative Procedures Act will cost the Plan an additional 1.5% to 2.5% of annual claim costs, with 2.0% being selected as a mid-point value. Such an assumption is derived from an evaluation of the following points:

1. If a rule is not in place for certain procedures, the Plan will be required to pay benefits until a rule is implemented, especially in cases involving investigational or experimental medicine and alternative therapies.
2. There may be substantial treatment delays due to the administrative complexities involved in rule making and that delayed treatment causes claims to increase accordingly as the severity of a condition increases.
3. Rules will be required on the correct order of claim payments, resulting in a substantial number of claims required to be paid in an unbundled and upcoded format until an appropriate rule is adopted.

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 Development of Medical and Administrative Policies and Appeals to the Office of Administrative Hearings: The Executive Administrator for the Teachers' and State Employees' Comprehensive Major Medical Plan and its claims processor for the indemnity program, Blue Cross and Blue Shield of North Carolina, have provided the following data upon which actuarial notes have been prepared. The Plan's Executive Administrator and Board of Trustees have adopted administrative and medical policies for the indemnity program covering some 450 different subjects pertaining to medicine, surgery, pathology, radiology, institutional care, and allied health matters. Such policies have been adopted in accordance with the Plan's enabling legislation, G. S. 135-39.8, concerning rules and regulations. Under this statute, the Plan's Executive Administrator and Board of Trustees are required to give written descriptions of its adopted policies on a timely basis to all agencies employing employees enrolled in the Plan, all employing agencies' health benefit representatives, all relevant health care providers affected by a policy, to Plan oversight staffs in the General Assembly's Legislative Services Office and the Governor's Office of State Budget and Management, and to any other parties requesting such information and approved by the Plan. In addition, the Plan's enabling legislation, G. S. 135-39.7, provides for administrative review of claim adjudications which are disputed by an aggrieved member of the Plan's indemnity program. Such disputes are to be settled by a binding decision of the Plan's Executive Administrator and Board of Trustees. Written notices of decisions made by the Plan in this regard are to be sent immediately to those parties receiving descriptions of policies adopted by the Plan. The indemnity program's claims processor is to provide technical medical assistance to the Plan in adopting its administrative and medical policies. The indemnity program's consulting actuary is to provide advice on the costs associated with the Plan's adoption of administrative and medical policies. The Plan has used its own rule-making provisions in lieu of such provisions under the Administrative Procedures Act since the Plan's inception in 1982.

As an indication of the sufficiency of the benefits adopted by the General Assembly for the Plan's indemnity program and the resulting administrative and medical policies adopted by the Plan's Executive Administrator and Board of Trustees, out of some 5,800,000 claim processed by the indemnity program during fiscal year 1995-96, only 63 appeals were made to the Plan's Board of Trustees concerning adjudication of claims. Of these 63 appeals, only 11 were further reviewed by the Office of Administrative Hearings under the Administrative Procedures Act's contested clase provisions. For fiscal year 1994-95,, out of some 5,900,000 claims processed, only 88 appeals were made to the Plan's Board of Trustees with only 8 being further carried to the Office of Administrative Hearings. For fiscal year 1993-94, out of some 5,400,000 claims processed, only 37 appeals were made to the Plan's Board of Trustees with only 12 being carried to the Office of Administrative Hearings.

For the 1995-96 fiscal year, the Plan spent $1,141,000 for administering its indemnity program and alternative HMOs, exclusive of claim processing activities of the indemnity program. For fiscal year 1994-95, these same administrative costs amounted to $1,138,000. For fiscal year 1993-94, administrative costs were $939,000.

SOURCES OF DATA:

-Actuarial Note, Dilts, Umstead & Dunn, House Bill 184, February 26, 1997, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Inc., House Bill 184, February 28, 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.

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Signed Copy Located in the NCGA Principal Clerk's Offices