REPORT OF THE

LEGISLATIVE SELECT COMMITTEE ON

STATE EMPLOYEE HEALTH INSURANCE

NORTH CAROLINA GENERAL ASSEMBLY

JUNE 11, 1991

NORTH CAROLINA GENERAL ASSEMBLY

June 11, 1991

The Honorable Daniel T. Blue, Jr.
Speaker of the House
North Carolina House of Representatives
State Legislative Building
Raleigh, North Carolina

The Honorable Henson P. Barnes
President Pro Tempore of the Senate
North Carolina State Senate
State Legislative Building
Raleigh, North Carolina

Dear Speaker Blue & President Pro Tempore Barnes:

The Legislative Select Committee on State Employee Health Insurance that you appointed earlier in this legislative session herewith makes its report to you as was adopted today by the Committee. The Committee began its deliberations by reviewing various options for dealing with the State Employee Health Benefit Plan's initial estimated need for an additional $187 million for 1991-92 and $250 million for 1992-93, over and above the current year's funding of over $455 million in premiums. Of these needed amounts, $116 million would be required from the General Fund for 1991-92 and $155 million for 1992-93. Some of the options reviewed by the Committee included:

(1) Increasing the Plan's deductible paid by Plan members from $150 to $300 per year;

(2) Increasing the Plan's copayments paid by Plan members after satisfaction of the deductible from 10% up to $300 per year to 25% up to $1,500;

(3) Adding a $15 per visit copayment paid by Plan members for physicians office, home, or nursing home visits;

(4) Adding a $50 copayment paid by Plan members for each emergency room hospital visit when admission to a hospital does not immediately follow;

(5) Limiting outpatient prescription drug reimbursements to 90% of average wholesale price;

(6) Increasing the Plan's copayments paid by Plan members for outpatient prescription drugs from $2 per generic and $3 per branded prescription to $10 and $15 respectively;

(7) Subrogating the Plan's claims to third party injury awards;

(8) Increasing the Plan's deductible paid by Plan members from $150 to $250 per year for employees earning $15,000 to $24,999 annually, to $300 for employees earning $25,000 to $39,999 annually, and to $500 for employees earning $40,000 and more annually;

(9) Contracting with preferred hospital providers for discounts in exchange for the Plan's business;

(10) Requiring non-Medicare eligible retirees to pay part of their own premiums since Medicare-eligible retirees are required to pay their Medicare Medical Benefit (Part B) premiums;

(11) Requiring new retirees with 5 to 14 years of service to pay 50% of their individual premiums and new retirees with 15 to 19 years of service to pay 25% of their individual premiums;

(12) Requiring all employees and retirees to pay up to $25 per month for their individual coverage; and

(13) Requiring all employees to pay 1.55% o their salary or retirement benefit for their individual coverage.

In addition, the Committee looked at the components of the Plan's estimated 17% annual increase in current benefit claim costs for each year of the 1991-93 biennium along with the estimated causes for the cost increases. The Committee further reviewed the Plan's current amount of cost containment activities amounting to over $176 million annually. Of particular interest to the Committee were comparisons between the Plan's current benefit design with those offered by other large employers in the State. Actuarial estimates put the State Plan's current benefit design at 31%-37% greater than Plan's current premiums if they were provided in the private sector through insurance contracts. Conversely, the Plan's current premiums would purchase benefits with a $500 deductible and a 20% member copayment up to $3,000 per year through a private sector insurance contract.

The Committee also heard from associations representing employees (NCAE, NCSEANC) and retirees (NCRGEA) as to what their suggestions would be. And finally, the Committee reviewed the following recommendations of the Plan's Executive Administrator and Board of Trustees to:

(a) Increase the Plan's annual deductible from $150 to $250;

(b) Increase the Plan's copayments from 10% up to $300 per year to 20% up to $1,000;

(c) Add a $50 emergency room hospital copayment when an admission does not follow;

(d) Add a $10 physician office, home, or nursing home copayment per visit;

(e) Limit outpatient prescription drug reimbursements to 90% of average wholesale price plus a copayment equal to a drug dispensing fee to be paid by Plan members;

(f) Implement a preferred provider hospital network with a penalty of 20% up to $5,000 per year to be paid by Plan members for use of non-network hospitals when network hospitals are available;

(g) Subrogate the Plan's claim payment to third party liability awards;

(h) Discontinue 100% Plan reimbursement for outpatient surgeries;

(i) Establish a psychiatric case management program and a Cesarean Section birth education program;

(j) Resume length-of-stay reviews for unscheduled inpatient hospitalizations;

(k) Cover handicapped dependent children under the Plan regardless of whether or not they have been continuously covered by the Plan since birth;

(l) Increase the lifetime maximum benefits under the Plan from $500,000 to $1,000,000.

(m) Cover routine diagnostic examinations, including mammograms and Pap smears, up to $150 per person per year annually for individuals age 55 and over, once every 2 years for individuals age 40 to 55, and once every 3 years for individuals under age 40.

(n) Cover immunizations for the prevention of contagious diseases; and

(o) Require non-Medicare retirees to pay the difference between the Plan's individual Medicare-eligible premium and non-Medicare-eligible premium.

After all of these items were reviewed, your Select Committee on State Employee Health Insurance has today recommended all of the Plan's recommendations by its Trustees with the exception of the foregoing items (g) and (o). In addition the Committee recommended that lung transplants, combination heart-lung transplants, and pancreas transplants be added to the Plan's coverage. The fiscal affects of the Committee's recommendations are summarized as follows, based upon required actuarial notes from both our Fiscal Research Division and the Plan's Executive Administrator:

	Fiscal Years	
	1991-92	1992-93
Additional Funding Requirements for Plan for 1991-93:		
Base Plan	$164,000,000	$238,000,000
HMOs	5,600,000	7,500,000
Total	$169,600,000	$245,500,000
Less: Claim Cost Reductions	59,000,000	99,000,000
Plus: Additional Benefits	11,000,000	15,000,000
Total Plan Requirements	$121,600,000	$161,500,000
Less: Employee Cost for Dependents	26,700,000	35,400,000
Continuation Cost	1,200,000	1,600,000
Employer Cost to State	$ 93,700,000	$124,500,000
- General Fund	$ 75,200,000	$ 99,900,000
- Highway Fund	$ 6,200,000	$ 8,200,000
- Other Funds	$ 12,300,000	$ 16,400,000

These fiscal affects were improved over initial estimates due to $22 million in additional current revenues due the Plan for 1990-91 and 1991-93.

As far as premium increases are concerned, the Plan's Executive Administrator and Board of Trustees had recommended preliminary increases of 53% for individual employees and retirees, 55% for dependent children (from $65 to $101 monthly), and 60% for dependent family members ($152 to $244 monthly). The Committee's actions today will limit these increases to 34% for individual employees and retirees, $25 monthly for dependent children and $65 monthly for dependent family members, without causing the Plan's benefits to be out-of-line with those of other major employers within the State.

In addition to the foregoing recommendations, the Select Committee further recommends that it or the statutory legislative committee that is appointed pursuant to G.S. 135-38 continue to look at more health care cost containment measures between legislative sessions.

Attached are some exhibits of the Select Committee's findings should you desire to review them. In summary, we feel that the Select Committee has certainly fulfilled its expectations and that each and every member of the Committee should be congratulated on its accomplishments.

Sincerely,

Martin L. Nesbitt, Jr.
Co-Chairman

Wendell H. Murphy
Co-Chairman

Attachments

STATE EMPLOYEE HEALTH BENEFIT PLAN
Component Cost Increases for Claims
($ Million)

Claim Cost Categories	1989-90 Actual Claims	1989-90 % of Total	1990-91 Est. Claims	1990-91 % of Total	1990-91 Ann. Chng.	1990-91 % Ann. Chng.	1990-91 Inflat. % Chng.	1990-91 Other % Chng.
Hospital-Tot.	$214.1	50.6%	$268.3	52.6%	$54.2	25.3%	11.0%	14.3%
Inpat. Tot.	162.0		200.9		38.9	24.0	10.9	13.1
Inpat. R&B	40.3		48.1		7.8	19.4	10.9	8.5
Inpat. Anc.	121.7		152.8		31.1	25.6	10.7	14.9
Outpat. Anc.	52.1		67.4		15.3	29.4	11.2	18.2
Medical, Surgical, Other Prof.	$141.9	33.5%	$169.8	33.3%	$27.9	19.7%	7.5%	12.2%
Outpat. Prescript. Drugs	$ 44.6	10.6%	$ 52.5	10.3%	$ 7.9	17.7%	10.0%	7.7%
Other	$ 22.5	5.3%	$ 19.4	3.8%	$(3.1)	(13.8)%	9.3%	23.1%
TOTAL	$423.1	100.0%	$510.0	100.0%	$86.9	20.5%	9.1%	11.4%

Claim Cost Categories	1991-92 % of Claims	1991-92 Est. Claims	1991-92 Ann. Chng.	1991-92 % Ann. Chng.	1992-93 Est. Claims	1992-93 Ann. Chng.	1992-93 % Ann. Chng.
Hospital-Tot.	52.0%	$310.4	$42.1	15.7%	$363.0	$52.6	16.9%
Inpat. Tot.							
Inpat. R&B							
Inpat. Anc.							
Outpat. Anc.							
Medical, Surgical, Other Prof.	33.0%	$197.0	$27.2	16.0%	$230.3	$33.3	16.9%
Outpat. Prescript. Drugs	10.0%	$ 59.7	$ 7.2	13.7%	$ 69.8	$10.1	16.9%
Other	5.0%	$ 29.9	$10.5	54.1%	$ 34.9	$ 5.0	16.7%
TOTAL	100.0%	$597.0	$87.0	17.1%	$698.0	$101.0	16.9%

Major Causes of Medical Cost Increases

(1)	Inflation	
	(a) General Inflation	30 %
	(b) Medical Inflation	30 %
(2)	Population Changes	
	(a) Increase in Number of Enrollees	2 %
	(b) Aging of Group, Longer Life Spans	3 %
(3)	Improvements in Medical Skills, Facilities, and Technology	15 %
(4)	Cost-Shifting from Uncompensated or Undercompensated Health Care	15 %
(5)	Other Factors (Medical Practice Styles, Cost-Based Third-Party Reimbursements, First-Dollar Coverages)	5 %
	TOTAL	100 %

STATE EMPLOYEE HEALTH BENEFIT PLAN
Cost Containment Cost Reductions for 1989-90

Cost Containment Programs	1989-90 Annual Cost Reductions
A. Pre-Admission Hospital Testing	
-105 Hospital Days Avoided @ $1,334	$ 140,070
B. Pre-Admission Inpatient Hospital & Length-of-Stay Certification	
(1) 96 Admissions Withdrawn (128 Hospital Days Avoided @ $1,334)	$ 170,752
(2) 31 Admissions Denied (167 Hospital Days Avoided @ $1,334)	222,778
(3) 3,549 Hospital Days @ $1,334 Denied on 957 Approved Admissions	4,734,366
(4) 316 Hospital Days Avoided from Denied Length-of-Stay Extensions @ $1,334	421,544
(5) Total	$5,549,440
C. Second Surgical Opinions Required for Coronary Artery By-Pass, Hysterectomy, Knee Surgery, & Revision of Nasal Structure	
(1) 500 Surgeries Not Performed @ $4,450	$2,225,043
(2) 174 Surgeries Not Authorized & Penalized @ $490	85,280
(3) Sub-Total	$2,310,323
(4) Less: Paid Second Opinions (2,102 @ $71)	149,254
(5) Total	$2,161,069
D. Coordination of Benefits with Other Carriers	
(1) Non-Medicare	$ 8,702,000
(2) Medicare	152,914,000
(3) Total	$161,616,000
E. Cost Reduction Contracts with Participating Physicians - Difference Between Medical Inflation & CPI (2.7% Savings on $245.6 million in Billed Charges by 9,300 Contracting Physicians)	$ 6,631,000
F. Hospital Bill Audits	
(1) Actual Recoveries	$ 446,125
(2) Pending Recoveries	100,000
(3) Total	$ 546,125
G. Fraud Detection 175 Cases under Review; 6 Cases Referred to Attorney General for Recoveries of:	$ 68,000
GRAND TOTAL	$176,711,704

STATE OF NORTH CAROLINA
THE TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN

November 26, 1990

The Honorable James G. Martin
Governor of North Carolina
State Capital - Capital Square
Raleigh, North Carolina 27601-2905

Dear Governor Martin:

Re: Cost of Current Health Plan on an Insured Basis

I appreciated the opportunity to appear before the Advisory Budget Commission on October 19, 1990 to present the funding needs for the Plan. At that meeting the question was asked that if the State were to purchase the current health plan benefits it provides to its employees through a fully insured arrangement, what would those benefits cost. We asked the Plan's Actuary that question.

Without the carrier accepting a loss, the cost of the plan would need to be 31% to 37% higher than the current cost depending on where the coverage was purchased. We also posed the question of what the benefits might be on an insured basis with the present level of funding. The Actuary's determination was that the current level of funding would purchase an insured plan with a $500 deductible, 20% copayment and a $3,000 out-of-pocket stop loss limit. Those benefit levels should be compared to the current $150 deductible, 10% copayment and $300 out-of-pocket limit.

If I may provide any additional information, please contact me.

Sincerely,

David G. DeVries

David G. DeVries
Executive Administrator

DGD:mrc

STATE EMPLOYEE HEALTH BENEFIT PLAN
1989-90 Claim Cost Overview

	Total Annual Claim Cost Per Capita	Total Annual Claim Cost Per Employee
Employees	$1,120	$1,120
Retirees	$1,275	$ 408
Dependents	$ 753	$ 565
Total	$1,011	$2,093

Employee & Retiree Claim Cost - Percentage of Payroll

	1989-90 State Plan	1989 U. S. Chamber of Commerce		
		Mfg.	Non-Mfg.	Total
Employees	5.10%	7.3%	6.9%	7.1%
Retirees	1.65	1.6	1.2	1.3
Total	6.75%	8.9%	8.1%	8.4%

..ie following is a description of the most prevalent health insurance benefit designs for BCBSNC groups in 1991.

- Deductible

  $200 is the most prevalent level. The second most prevalent is $300.

- Deductibles per Family

  The standard is three.

- Coinsurance

  80/20 is standard.

- Out-of-Pocket Maximum

  $1,000 is the most prevalent. This out-of-pocket maximum does <u>not</u> include the deductible.

- Lifetime Maximum

  $1,000,000 is standard.

- Drug Coverage

  There are two standard types of benefits:

  1. The regular deductible, usually $200, must be met before any drugs are covered. Then there is a two-level copay for generic/name brand drugs of $5/7 or $6/9.

  2. Drugs do not apply to the regular deductible. There is a $5-$10 copay per prescription.

- Psychiatric Coverage

  The standard is to limit the number of inpatient days, usually to 30, or to limit the total dollars. Lifetime maximum dollar limits of $10,000 are now being increased to $25,000. This dollar limit includes outpatient care and is separate from the $1,000,000 lifetime maximum. Outpatient benefits are variable. Most groups cover outpatient visits at 50%. Some groups limit the number of visits to as few as 20, some use a dollar cap ($2,000/year) and others do not specify a separate outpatient limit. The deductible must be met before psychiatric benefits are applicable. The 50% copay for outpatient psychiatric treatment cannot satisfy the out-of-pocket maximum; that is, there is no limit on out-of-pocket psychiatric expenses.