NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 784, Section 1.14

SHORT TITLE: Health Care Reform/HPC

SPONSOR(S): Senator Jim Forrester, Senator Beverly Perdue, Senator Tony Rand

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: Benefits payable under the Teachers' and State Employees' Comprehensive Major medical Plan would be subrogated against recoveries of Plan members in third party personal injury settlements. The maximum amount of recovery available to the Plan would be one-third of the net award.

EFFECTIVE DATE: Effective upon ratification of the bill.

ESTIMATED IMPACT ON STATE: The consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Alexander & Alexander Consulting Group, Inc., and the consulting actuary of the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, both concur in that the bill will not measurably decrease the costs to the Plan, especially following implementation of the change brought about by the bill. Future savings may accrue to the Plan in amounts up to three-tenths of one percent (0.3%) of claim costs, depending upon the costs of securing recoveries. Accrued net claim cost savings of this magnitude would be equal to $1.6 million for the Plan's fiscal year beginning July 1, 1994. Increased amounts could be expected each year thereafter by about 10% annually.

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 Self-Insured Indemnity Program's Claim Recoveries: Subrogation against third party personal injury suits is reportedly extremely rare. Most insurers do not track the savings because they happen so infrequently. Experience of the Teachers' and State Employees' Comprehensive Major Medical Plan is expected to be similar to that of most other insurers. However, Medicaid's subrogation provisions appear to be similar to those under House Bill 289 (G.S. 108A-57). The State Division of Medical Assistance's Third Party Liability Collection Section reports that amounts attributed to subrogation in its total third party liability collections was $4.2 million in 1992-93 and $4.7 million in 1993-94 or about 3% of its total collections from third parties. As a percentage of total expenditures, subrogation collections would be about two-tenths of one percent (0.2%). However, since more than 40% of Medicaid's total medical assistance payments involve long-term care, the portion of Medicaid's subrogated recoveries as a percentage of acute care payments could approximate three-tenths of one percent (0.3%) without excessive costs of collection, similar to Medicaid's low costs through use of the State Attorney General's Office. Three-tenths of one percent (0.3%) of claim costs would equate to about 5% of the Plan's annual claim payments for acute hospital discharges involving injuries and poisonings.

SOURCES OF DATA:

- Actuarial Note, Dilts, Umstead & Dunn, Senate Bill 748, Section 1.14, April 27, 1995, original of which is one file in the General Assembly's Fiscal Research Division.

- Actuarial Note, Alexander & Alexander Consulting Group, Inc., Senate Bill 748, Section 1.14, April 28, 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.

- Acute Care Hospital Admission Rates and Claim Payments by Discharge Classifications provided by the Teachers' and State Employees' Comprehensive Major Medical Plan.

- Data provided by the State Division of Medical Assistance's Third Party Liability Section.

TECHNICAL CONSIDERATIONS: The Teachers' and State Employees' Comprehensive Major Medical Plan suggests that if the Plan is to subrogate, then Senate Bill 784 would need to be amended to add a new section to read:

"Sec. . G.S. 135-40.13 is amended by adding a new section to read:

(h) Right to Reimbursement - By accepting benefits under this Plan, the Plan member shall be deemed to have made an assignment to the State of the right to any recovery by a Plan member from or

on behalf of any third party by judgment, settlement or otherwise to the extent of benefits paid under this Plan for any injury, illness, or sickness of a Plan member for which the third party was responsible. The Plan member shall reimburse the Plan for any amounts so recovered by the Plan member regardless of how the funds recovered are allocated. The Plan will not pay fees or costs associated with any claim or lawsuit without express written consent.

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