NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 1207

SHORT TITLE: Eligibility for State Health Benefits.

SPONSOR(S): Rep. Bill Culpepper

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 allows former Plan members who have been excluded from coverage for filing fraudulent claims to be reinstated in the Plan upon a cessation of coverage for five years and upon full and complete restitution to the Plan for all fraudulent claims amounts.

EFFECTIVE DATE: When it becomes law.

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 for the General Assembly's Fiscal Research Division, Hartman & Associates, estimate that the bill will not materially increase the cost to the Plan's indemnity program. The only concern expressed by both actuaries was the likelihood of adverse selection against the Plan by fraudulent filers at the time of reinstatement since they would have been out of the Plan for at least five years.

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 nine HMOs currently covering about 25% of the Plan's total population in 66 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, 1998, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	192,800	74,400	267,200
Active Employee Dependents	107,400	52,200	159,600
Retired Employees	91,600	6,700	98,300
Retired Employee Dependents	15,600	1,300	16,900
Former Employees & Dependents with Continued Coverage	2,700	700	3,400
Total Enrollments	410,100	135,300	545,400
Number of Contracts			
Employee Only	217,400	55,100	272,500
Employee & Child(ren)	30,600	16,500	47,100
Employee & Family	38,400	9,900	48,300
Total Contracts	286,400	81,500	367,900
Percentage of Enrollment by Age			
29 & Under	27.0%	44.3%	31.3%
30-44	20.2	26.5	21.7
45-54	20.8	18.5	20.2
55-64	14.6	8.0	13.0
65 & Over	17.4	2.7	13.8
Percentage of Enrollment by Sex			
Male	39.5%	39.2%	39.5%
Female	60.5	60.8	60.5

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1998, the self-insured program started its operations with a beginning cash balance of $334.1 million. Receipts for the year are estimated to be $590 million from premium collections, $20 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $625 million in receipts for the year. Disbursements from the self-insured program are expected to be $720 million in claim payments and $19 million in administration and claims processing expenses for a total of $739 million for the year beginning July 1, 1998. For the fiscal year beginning July 1, 1999, the self-insured indemnity program is expected to have an operating cash balance of over $220 million with a net operating loss of $185 million for the 1999-2000 fiscal year. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of $35 million with a net operating loss of $270 million for the 2000-2001 fiscal year. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 1999-2001 biennium

without increases in its current premium rates or a reduction in existing benefits 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 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 2-3% of its number of active employee dependents each year, whereas the number of enrolled retiree dependents is assumed to grow 1-2% from year to year. Investment earnings are based upon a 5-6% 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 Indemnity Plan's Fraudulent Claim Filers: Based upon information provided by the Plan, only about six Plan members have been excluded from coverage for filing fraudulent claims. A large majority of these claims involved reimbursement to Plan members for outpatient prescription drugs. Since the time that such claims were determined to be fraudulent, the Plan has taken steps to try to prevent the possibility of future occurrences of fraudulent claims involving outpatient prescription drugs.

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, Proposed Draft Legislation, March 26, 1999, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, Proposed Draft Legislation, March 29, 1999, 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.

TECHNICAL CONSIDERATIONS: None.

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DATE: Tuesday, April 20, 1999

Signed Copy Located in the NCGA Principal Clerk's Offices