NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 714, Section 5

SHORT TITLE: Coverage for Reconstructive Breast Surgery

SPONSOR(S): Sen. Jim Forrester

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: Section 5 of the bill provides surgical benefits under the Plan for reconstructive breast surgery to nondiseased breasts following a mastectomy resulting from breast cancer or other breast disease such as hyperplasia. Reconstructive surgery on nondiseased breasts is for the purpose of establishing body symmetry when reconstructive surgery on diseased breasts is performed. Reconstruction includes creation of a new breast mound, creation of a new nipple aerola complex, and revisions of previously performed reconstructions. Reconstruction also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of nondiseased breasts.

The Plan's self-insured indemnity program has for some time covered medically necessary mammoplasties for diseased breasts following mastectomies. However, prior approval from the program's claims processor, Blue Cross and Blue Shield of North Carolina, has been required to determine medical necessity before the procedure is performed. The program's medical policies have furthermore considered reconstruction of a nondiseased breast to be cosmetic and not covered by the program.

The Plan's twelve health maintenance organization (HMO) alternatives to the indemnity program are required to have the same coverage for reconstructive breast surgery under Section 3 of the bill as the Plan's indemnity program.

EFFECTIVE DATE: January 1, 1998

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, estimates that mammoplasty coverage for nondiseased breasts following a mastectomy would increase the indemnity program's claim costs by 0.20% to 0.34%. However, using a midpoint value of 0.27%, the Plan's consulting actuary projects the cost to the Plan's indemnity program to be $1,296,000 for 1997-98 and $1,866,000 for 1998-99. The consulting actuary for the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, estimates the cost for covering mammoplasties for nondiseased breasts to be $763,000 for 1997-98 and $3,295,000 for 1998-99. Using the estimate from the consulting actuary of the Fiscal research Division as an upper limit based upon the mastectomy and mammoplasty

experience of the Plan's indemnity program, a combined estimate from the two actuarial projections results in a cost of $1,030,000 for 1997-98 and $2,580,000 for 1998-99. Further using these combined projections, additional costs to the Plan's indemnity program for mammoplasty coverage of nondiseased breasts following a mastectomy for outlying years are expected to be $2,786,000 for 1999-2000, $3,009,000 for 2000-01, and $3,250,000 for 2001-02. Although Section 5 of the bill is expected to produce additional claim costs for the Plan's indemnity program, the program's anticipated reserves for 1997-99 are sufficient to cover the additional costs of the bill without requiring an additional General or Highway Fund appropriation for the 1997-99 biennium.

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
<u>Number of Contracts</u>			
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
<u>Percentage of Enrollment by Age</u>			
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
<u>Percentage of Enrollment by Sex</u>			
Male	39.8%	40.0%	39.8%
Female	60.2	60.0	60.2

<u>Assumptions for the Self-Insured Indemnity Program</u>: 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.

Asssumptions for the Self-Insured Indemnity Program's Mastectomies and Mammoplasties: For the last three calendar years, the indemnity program has averaged covering 466 mastectomies annually. In addition, the program has covered an average of 208 mammoplasties annually for the last three years. Average professional and institutional charges for mammmoplasties were $13,705 in 1996 of which an average of $10,735 was covered by the program. Claim payments by the program for mammoplasties average $9,689 in 1996. The indemnity program has some 236,000 female members, of which 125,000 fall between the ages of 20 and 55. This age band represents the ages at which most mammoplasties are expected to be performed and amounts to some 53% of all of the program's female members.

SOURCES OF DATA:

-Actuarial Note, Dilts, Umstead & Dunn, Senate Bill 714, Section 5, April 22, 1997, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 714, Section 5, April 24, 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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