



STATE HEALTH PLAN UPDATE FUNDING/BENEFIT CHANGES SENATE BILL 287, "State Health Plan \$/Good Health Initiatives"

ANALYSIS:

- North Carolina's comparative benefit ranking with other state health plans for both employee only and family coverage becomes the **WORST IN THE UNITED STATES**, and makes North Carolina the least "family friendly" of all state governments.
- State Health Plan benefits become **less competitive** with private sector health plans, other state health plans and local government plans.
- Half the cost savings are through **benefit reductions at an average annual cost of \$300 per Plan member**.
- Incentives for healthy lifestyles are punitive rather than positive.
- Increases deductibles and co-insurance by a range of 33-100%, with a 50% co-pay increase for specialists.
- **Creates a new co-payment tier for mental health and substance abuses services, chiropractic services, and occupational/physical therapy and speech therapy services requiring a \$45 co-pay in the PPO Standard (80/20) and \$55 in the PPO Basic (70/30).**
- **Dependent premiums increase 8.9% in FY2009-2010 and another 8.9% in FY2010-2011.**
- Premium Payments by the State for employee only coverage increase by an average of 8.9% per year (18.6% compounded for the biennium).
- **Changes the Plan Year** and premium increases from October 1, to July 1 of each year, and continues to require employees to select a Plan option during annual enrollment without knowing premiums and benefits.
- **Requires an independent audit of the Plan**
- **Creates a Blue Ribbon Task Force** to study and compare coverage and costs of the Plan to other State Health Plans in the region, and address issues of cost, quality and access to health care coverage under the State Health Plan. The Task Force shall also consider administrative oversight of the Plan; tiered premium rates for member-only coverage and future retirees based on income or ability to pay; ways to increase dependent coverage including supplements; benefits of a closed drug formulary; calendar year; other issues.

FUNDING

- Appropriates \$250 million dollars from the Rainy Day Fund to pay claims through the end of June 30, 2009.
- Appropriates \$427 million dollars for FY 2009-2011 to fund Plan and administrative expenses.

HEALTH BENEFIT CHANGES

- Eliminates the PPO Plus option on 7/1/09, which lost \$139 million dollars and paid \$1.79 in claims for each \$1 in premium. This only saves \$5 million per year as these members move to the PPO Standard (80/20).
- Implements a Comprehensive Wellness Program with benefit levels based on tobacco use and healthy weight guidelines:
 1. Smoking Cessation program to be implemented effective July 1, 2010
 2. Weight Management program to be implemented effective July 1, 2011
- **Non-Medicare eligible Plan members would be placed in the PPO Basic (70/30) effective July 1, 2010, UNLESS the Plan member and all covered dependents can attest that they do not smoke or use tobacco products, in which case they may move to the PPO Standard (80/20). Sanctions may be imposed for intentional false statements on Plan documents.**
- **Non-Medicare eligible Plan members would be placed in the PPO Basic (70/30) effective July 1, 2011 if they or a covered dependent exceed a body mass index exceeding 40% in 2011 and 35% in 2012. Medical waiver could be granted if certified by the member's medical provider.**
- **Prescription Drug Co-Pays**
 1. Generic Drugs: The current \$10 co-pay remains the same
 2. Preferred Branded Drug without generic equivalent: Increases from \$30-\$35

3. Nonpreferred Branded Drug: Increases from \$50-\$55.
 4. **Preferred branded drug with generic equivalent:** Increase co-pay so member pays the generic co-payment PLUS the difference between the Plan's cost for the generic prescription and the Plan's cost for the branded prescription drug. **Example:** The brand drug costs \$80 for the prescription, but only \$30 for the generic version. Plan member would pay the \$10 generic co-pay + \$50 (difference between brand and generic versions), resulting in Plan member paying \$60 or 75% of the total cost.
 5. **Creates a new Specialty Medication tier for non-cancer drugs exceeding \$400:** Requires a co-pay of 25% of the Plan's cost not to exceed \$100 per 30-day supply.
 6. **Excludes coverage of drugs that have therapeutic equivalents available over-the-counter**
 7. Decreases prescription co-pay level from 34 days to 30 days per prescription
 8. Plan may adopt utilization management procedures for certain drugs.
 9. Requires the Plan to achieve \$38 million in cost savings for the biennium through its existing contract with the Plan's Pharmacy Benefit Manager.
 10. The Plan and its pharmacy benefit manager may implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.
- **Eliminates coverage of routine eye exams effective January 1, 2010.**
 - **Deductible/Co-insurance/Co-Pay Changes**
 1. **PPO Basic (70/30):** Increases annual deductible from \$600-\$800 for individual and from \$1800-\$2,400 per family. Increases in-network co-insurance maximum from \$2,500 to \$3,250 per individual and out-of-network from \$5,000 to \$6,500. Increases in-network primary care office visit from \$25-\$30. Increases specialist office visit co-pay from \$50-\$70. Increases in-patient hospital co-pay from \$200-\$250. Creates a new co-payment tier for mental health and substance abuses services, chiropractic services, and occupational/physical therapy and speech therapy services requiring a \$55 co-pay.
 2. **PPO Standard (80/20):** Increases annual deductible from \$300-\$600 for individual and from \$900-\$1,800 per family. Increases in-network co-insurance maximum to \$2,750 individual and out-of-network maximum to \$5,500. Increases in-network primary care office visit from \$20-\$25. Increases specialist office visit co-pay from \$40-\$60. Increases in-network urgent care copay from \$50 to \$75. Increases in-patient hospital co-pay from \$150-\$200. Creates a new co-payment tier for mental health and substance abuses services, chiropractic services, and occupational/physical therapy and speech therapy services requiring a \$45 co-pay.

DEPENDENT ELIGIBILITY AUDIT (May be extended to active and retired Plan members)

- A State Health Plan audit to determine dependent eligibility for State Health Plan coverage will be conducted in Fiscal Year 2009-10.
- Ineligible dependents will be disenrolled within 10 days of sending written termination notice to the employee.
- The Plan Executive Administrator is authorized to waive requirements to collect from the member reimbursement for claims paid for the ineligible covered individual.
- Future enrollment of dependents will require the Plan member to provide information as required by the Plan to verify dependent's eligibility for coverage.

OTHER

- **Dependent Child:** Change definition to include stepchild of the member who is married to the stepchild's natural parent. To be eligible the stepchild must have its primary residence with the member.
- **Full-time Student Dependents:** In accordance with applicable federal law, coverage of a full-time student that loses full-time status due to illness may be extended for one year from the effective date of the loss of full-time status provided that the student was enrolled at the time of the onset of the illness.
- **Pre-Existing Conditions:** Waiting periods for preexisting conditions administered under GS 135-45.4(d)(5) are subject to applicable federal law.
- For transplant and bariatric medical procedures, the Plan may restrict coverage to certain in-network providers that are designated by the Plan's claims processing contractor.