Fiscal Note
Proposed Permanent Rule Amending Fees for Medical Compensation

Basic Information

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Rules Proposed for Amendment:	Rule 04 NCAC 10J .0103 Fees for Institutional Services (See proposed rule text in Appendix 1)
Statutory Authority:	G.S. §§ 97-25; 97-26; 97-80(a); S.L. 2013-410

Impact Summary

State Government:	Yes
Local Government:	Yes
Private Sector:	Yes
Substantial Economic Impact:	Yes

Description of the Proposed Rule

04 NCAC 10J .0103 provides a schedule of maximum reimbursement rates for institutional medical providers participating in the workers' compensation system. This rulemaking amends the rule with respect to the maximum reimbursement rates for ambulatory surgery centers ("ASCs"). The rule sets reimbursement rates at a percentage of the amount the Centers for Medicare and Medicaid Services ("CMS") would pay for services. CMS regularly updates and publishes its fee schedule. The rule, as amended, will provide a maximum reimbursement rate of 200% for institutional services that are eligible for payment by CMS when performed at an ASC. Additionally, for institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but are not eligible for payment by CMS if performed at an ASC, the amended rule sets a maximum reimbursement rate of 135%.

Necessity for the Proposed Rule

The North Carolina Industrial Commission ("the Commission") was directed by Session Law 2013-410 to revise its medical fee schedule. Session Law 2013-410 instructed the Commission to base these revisions on the applicable CMS payment methodologies. Session Law 2013-410

specifically granted the Commission authority for an expedited rulemaking process. This exempted the Commission from the North Carolina Administrative Procedure Act's ("the APA") fiscal note requirement, as set forth in N.C. Gen. Stat. § 150B-21.4, in developing the fee schedule. Subsequently, the permanent rule, effective April 1, 2015, was challenged on the alleged basis that the rule was not adopted in conformance with the permanent rulemaking requirements of the APA. Specifically, the litigation hinges on the lack of a fiscal note and whether the General Assembly's fiscal note exemption in Session Law 2013-410 applies to fee provisions for services performed at ASCs. This litigation is currently pending on appeal to the N.C. Court of Appeals.

The Commission is statutorily mandated to adopt by rule a schedule of maximum fees for medical compensation provided in workers' compensation claims. The fee schedule must be adequate to ensure (1) the proper standard of care for injured workers, (2) reasonable reimbursement to providers, and (3) cost containment for payers. *See* N.C. Gen. Stat. § 97-26. Due to the pending litigation, there is uncertainty for payers and providers regarding both past and prospective medical costs and the potential for imbalance among the three factors underpinning the fee schedule. This amended rule will provide certainty for all industry stakeholders, including employers, insurers, and medical providers, regarding medical costs prospectively.

It will also provide balance in the fee schedule by basing reimbursement to ASCs on the CMS fee schedule, similar to other institutions covered by the rule, at percentage rates that reflect the goals laid out in N.C. Gen. Stat. § 97-26. If the Commission is unable to adopt this rule, one category of institutional medical providers—ASCs—would potentially receive reimbursement based on an old percentage-of-charges method, leading to increased medical costs and/or the routing of surgeries away from ASCs, and preventing the Commission from fulfilling its statutory obligation to keep medical costs balanced and affordable.

Adopting this amended rule will ensure that the Commission remains in compliance with the General Assembly's direction to create Medicare-based compensation systems, while also addressing feedback from the medical provider community regarding certain procedures not covered by the current rule.

Introduction and Background:

The North Carolina Industrial Commission is a statutory creation of the General Assembly tasked with administering the Workers' Compensation Act ("the Act") and adjudicating all cases arising thereunder. Pursuant to N.C. Gen. Stat. § 97-26, the Commission is required to adopt by rule a schedule of maximum fees for medical compensation resulting from the treatment of workers' compensation injuries. In complying with this statutory requirement, the Commission must consider and balance three competing interests. First, the Commission must ensure that injured workers are provided the standard of services and care intended by the Act. Second, any promulgated fee schedule must ensure that providers are reimbursed reasonable fees for providing these services. Finally, the Commission must ensure that medical costs are adequately contained.

On July 25, 2013, the North Carolina General Assembly passed Session Law 2013-410. Section 33.(a) of that Session Law directed the Commission to revise its physician and hospital medical fee schedule. Specifically, with respect to the schedule of maximum fees for physician and

hospital compensation, the Commission was instructed to adopt a fee schedule based on the applicable Medicare payment methodologies. In order to expedite this process, the Session Law also granted the Commission an exemption from the now-repealed certification requirement and the fiscal note requirement as required under the APA.

In order to carry out the General Assembly's mandate set forth in Session Law 2013-410, s. 33.(a), the Commission engaged in rulemaking to adopt new rules and amend existing rules in accordance with the APA. On November 17, 2014, the Commission gave notice of its intention to adopt Rules 04 NCAC 10J .0102 and .0103 and to amend Rules 04 NCAC 10J .0101 and .0102. This notice was published in Volume 29, Issue 10 of the North Carolina Register. Based on the Session Law, specifically with regard to the General Assembly's stated exemptions, the Commission did not obtain a fiscal note. The Commission held a public hearing on December 17, 2014, and accepted written comments on the proposed rules through January 16, 2015. The proposed rules were approved by the Rules Review Commission on February 19, 2015, and entered into the North Carolina Administrative Code on April 1 and July 1, 2015, respectively.

On October 1, 2015, six months after the rule went into effect, the Commission received a Request for Declaratory Ruling challenging the rules' validity based on the lack of a fiscal note as applied to ambulatory surgery centers. The Commission issued its Declaratory Ruling denying the relief requested on December 14, 2015. Following a petition for judicial review of the declaratory ruling, Judge Paul Ridgeway of the Wake County Superior Court ruled in favor of the petitioner, finding that the fiscal note exemption in the Session Law did not apply to rulemaking for ASCs, and therefore, the Commission did not substantially comply with the APA when it amended the fee schedule provisions for ambulatory surgery centers. The impact of the Superior Court Judge's ruling is to invalidate the revised fee schedule provisions that apply to ASCs back to the original effective date of April 1, 2015.

With the invalidation of the ASC-specific provisions of 04 NCAC 10J .0103(g) and (h), the reimbursement rates for ASCs would revert to the provisions in place prior to the effective date of April 1, 2015.

Upon the Commission's Motion to Stay, the August 9, 2016 decision was stayed by the Wake County Superior Court allowing the current 04 NCAC 10J .0103 to remain in effect pending appeal to the North Carolina Court of Appeals. This stay was granted on September 2, 2016. Litigation over this rule is currently pending before the North Carolina Court of Appeals. However, even with the stay, considerable uncertainty remains within the North Carolina workers' compensation system.

At present, under the April 1, 2015 rule, the fee schedule provisions provide a maximum reimbursement rate, for institutional services provided at an ASC, of 200% of the Medicare ASC facility-specific amount. See Appendix 2, 04 NCAC 10J .0103(g) and (h). Because these provisions of the rule are currently in effect by application of the Stay, it is this rule that is evaluated as the baseline for purposes of this fiscal note.

If the Commission takes no rulemaking action, the outcome of the appellate court case leaves two possible outcomes. First, a favorable decision from the Court of Appeals would leave the April 1,

2015 rule in place, resulting in no change from the baseline scenario. The proposed rule amendment differs from the April 1, 2015 permanent rule because it addresses the procedures CMS will reimburse if performed at an outpatient hospital but not if performed at an ASC. Because of the differing demographics for the CMS and workers' compensation populations, the Commission proposes to include fee provisions in the rule that will guide reimbursement for procedures performed at ASCs for which they would not be reimbursed by CMS.

On the other hand, if the Commission takes no rulemaking action and receives an unfavorable decision upholding the invalidation of the current ASC fee provisions, the rule in effect prior to April 1, 2015, would be reinstated. This older fee schedule, which was in place for charges prior to April 1, 2015, was structured to reimburse providers at a percentage of the charges billed by the provider. The former rule language states that ASC services are reimbursed at 67.15% of the billed charges. Additionally, implants are paid at no greater than invoice cost plus 28%.

The second scenario would result in a very disproportionate reimbursement model for one type of institutional provider, cause imbalance in the workers' compensation system, and contradict the Commission's understanding of the General Assembly's intent in its 2013 Session Law, which directs the Commission to transition to a Medicare-based fee schedule model. The effect of this result would be both retroactive and prospective. ASCs would be able to request payment adjustments on all bills dating back to April 1, 2015. ASCs would also be able to control the rate of their compensation going forward because it is based on the billed charges that they set, while all other institutional provider types would continue to be reimbursed at a percentage of the schedule based on CMS payment rates.

In order to limit the period of time subject to retroactive payment adjustments in the event of an invalidation of the current ASC fee provisions and to provide certainty for the insurance community, providers, and employers going forward, the Commission is engaging in permanent rulemaking to amend the challenged April 1, 2015 ASC fee provisions. The Commission maintains its position that it is not required to obtain a fiscal note in order to do permanent rulemaking regarding fees for ASCs. However, this fiscal note has been prepared in light of the August 9, 2016 decision and the pending appeal before the Court of Appeals.

The proposed amendments to 04 NCAC 10J .0103 differ from the April 1, 2015 permanent rule because the Commission received input from various stakeholders indicating the need to set reimbursement rates for ASCs for procedures CMS will reimburse if performed at an outpatient hospital but not if performed at an ASC. Because of the demographics of the population served by CMS, many procedures that could normally be performed in ASCs are required to be performed in outpatient or inpatient hospitals. Because those demographic considerations do not necessarily apply to the workers' compensation population, the Commission proposes to add fee provisions in the rule that will guide reimbursement for certain procedures performed at ASCs for which ASCs would not be reimbursed by CMS.

Impact of the Proposed New Rule

1. Costs to the State through the Commission:

   - Once adopted, the proposed rule amendments may impose some minimal opportunity costs on the State through the Commission. Medical providers and payers are not required to send bills to the Commission for review, but the Commission will assist parties in determining the correct reimbursement. The Commission also has a medical fee dispute resolution procedure. Because the proposed amendments include a change to the current rule, there may be increased requests for assistance or disputes filed until the workers' compensation community becomes familiar with the new rule. However, the Commission believes that the current staff of two in the Medical Fees Section will be able to handle the increased temporary workload, though there may be a temporary unquantifiable increase in response time due to increased workload.

   - To the extent that the Commission is an employer, it could experience workers' compensation claims which would be subject to the new rule. The May 2, 2017 NCCI *Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule* attached as Appendix 3 indicates that the proposed rule amendments would result in a negligible decrease in costs for services furnished at ASCs.

2. Costs to payers, including self-insured employers:

   - The costs to payers captures both private sector insurance carriers and self-insured employers. Approximately 24.2% of workers' compensation costs in North Carolina are paid by self-insured employers, including the State, local government units, and private employers.[1] All of State government, many local government entities, and a minority of private sector employers are self-insured, and thus bear the cost of workers' compensation benefits directly as payers.

   - There could be some initial costs to all payers, including self-insured employers, in implementing the amended rule because it requires the determination of reimbursement for various ASC services using either the CMS ASC fee schedule or the CMS Outpatient Prospective Payment System ("OPPS") fee schedule. The baseline rule does not contain a provision for payment for certain ASC services based on the CMS OPPS fee schedule. Therefore, there could be some initial costs to reprogram any reimbursement-related software and to train employees on the changes in the amended rule. The Commission reached out to the payer community to get a sample of these costs. One carrier that processes its medical bills in-house reported that the costs included 2.5 days for a full-time employee at $65-$75 per hour for the initial analysis and one day at $85 per hour for the programming. The carrier termed this one-time cost of approximately $2,000 "not significant." The Commission is also aware that

[1] See *Workers' Compensation: Benefits, Coverage, and Costs*, October 2016, National Academy of Social Insurance, Table 8, Workers' Compensation Benefits Paid by Type of Coverage, and State, 2014, page 23, at http://www.nasi.org/sites/default/files/research/NASI_Workers_Comp_Report_2016.pdf.

several major carriers and third-party administrators use third-party medical bill review companies to carry out medical bill reimbursement duties. One such bill review company estimates that it would take 145-150 hours for programming at an hourly rate of $200. This large nationwide workers' compensation billing review system expects the cost to be approximately $28,000-$30,000. With such contrasting input, the Commission is unable to definitively quantify this potential cost uniformly to all payers with any accuracy or consistency.[2]

3. Costs to the State and the private sector as ambulatory surgery centers:

   - The State has limited, indirect exposure through any ASCs owned, controlled, and/or operated by the University of North Carolina. Because the analysis conducted by NCCI (Appendix 3) suggests that total losses to ASCs will be negligible and these centers occupy only a small portion of the ASC market, the proposed rule amendments will result in *de minimis* losses to the State. It is assumed that the State as an ASC will share in a small portion of all costs estimated to impact ASCs.

   - In North Carolina, payments for ASC services represent 4.8% of total medical payments in workers' compensation cases, or $45,700,000, in 2015. See Appendix 3.

   - The proposed rule amendments are projected by NCCI to result in an estimated impact to ASC services of -0.1% when compared to the current baseline rule, which totals -$45,700. According to the Division of Health Service Regulation's May 2017 facility listing for ambulatory surgical facilities licensed by the State, there are 118 licensed ASCs in North Carolina.[3] Subtracting the ASCs dedicated to endoscopy, gastroenterology, and OB/GYN services left 43 licensed ASCs likely to provide services in workers' compensation cases. The projected loss amount of -$45,700 can be divided by 43 ASCs for an average loss of -$1,063 per ASC from the proposed rule amendments.[4] It is possible that not all 43 ASCs identified will provide services in workers' compensation cases.

   - Adoption of the proposed rule amendments may result in potential future costs or lost profits for ASCs if the August 9, 2016 decision is ultimately upheld in the higher courts, invalidating the current rule. First, the proposed rule amendments, if adopted, would limit the past ASC bills subject to potential recalculation and readjustment to the old

[2] Because the temporary rule in effect from January 1, 2017, to March 21, 2017 was exactly the same as the proposed rule amendments, payers, including self-insured employers, have already made this adjustment once. Therefore, the cost may be somewhat mitigated as employees have been recently trained and the correct way to reprogram the software has already been determined once.

[3] The 118 ASCs listed appeared to be primarily free-standing ASCs not associated with hospitals. The Commission reviewed the Division of Health Service Regulation's May 2017 list of hospitals licensed by the State of North Carolina. The hospital list gives a count of operating rooms, classifying them as inpatient or ambulatory surgery or shared, but it was not possible to tell whether the hospitals had actual ambulatory surgery centers on their campus or attached to the hospital. It appeared that the term ambulatory surgery must also mean outpatient surgery because there were no counts for outpatient surgery operating rooms.

[4] See footnote 3. The loss amount per ASC would likely be much smaller if hospital-owned ASCs were included in the calculation.

percentage-of-charges fee provisions to those for dates of service between April 1, 2015, and the effective date of the amended rule. Second, ASC reimbursements for dates of service on or after the effective date of the proposed rule would not be subject to the outcome of the pending litigation and would not revert to the percentage-of-charges model. See the Uncertainties and Risk Analysis section below for more detail.

4. Costs to Employees and Injured Workers:

   - The proposed amended rule provisions could change the location where injured workers receive certain medical services. The location of care affects the total cost of these medical services, and thus affects the costs borne by employees and injured workers. However, it is not possible to provide an accurate forecast of regulatory-driven changes in patient care settings. In the NCCI *Analysis* (Appendix 3), NCCI calculated the impact of the proposed amended rule provisions using bills for ASC services provided in 2015 (the most current complete year of data available) assuming no change in the number or type of procedures or the place they were performed under the proposed new reimbursement rates. The proposed rule differs from the baseline rule in that it specifies that procedures performed at ASCs for which they could not be reimbursed by CMS will be reimbursed at 135% of the CMS OPPS rate. If the true experience has been that patients were in fact getting these procedures done in other treatment settings in 2015, with this proposed rule amendment to clarify maximum reimbursement rates for procedures without a designated CMS ASC rate, it is possible that there will be a shifting of these procedures to ASCs. Alternatively, if the true experience is that ASCs were performing these procedures but negotiating reimbursement at more than the 135% of the CMS OPPS rate prior to receiving rule clarity, it is possible that ASCs will lose revenue for these procedures. In this case, it is possible that there will be a shifting of these procedures away from ASCs to other care settings.

   - Certain ASCs could choose to provide fewer services in workers' compensation cases based on the projected negligible decrease in revenue from the proposed rule amendments to the baseline rule. The Commission cannot predict this potential behavior or quantify its effect with any accuracy.

5. Benefits to the State through the Commission:

   - The Commission is an employer under the umbrella of the State's self-insurance program. Each division of the State pays for its workers' compensation losses from its division budget. To the extent that the proposed rule amendments result in a decrease in medical costs and greater certainty regarding ongoing medical costs, the State will receive these benefits through the Commission.

6. Benefits to payers, including self-insured employers:

   - Based on the NCCI *Analysis* (Appendix 3), there would be a decrease in costs for ASC services as a result of the proposed rule amendments when compared to the April 1,

2015 baseline. Although the decrease is estimated to be negligible, any decrease in costs is a benefit to payers, including self-insured employers. For payers, this would translate to reduced costs for medical care, as well as more administrative certainty of costs going forward.

- The amended rule will decrease the amount of uncertainty payers, including self-insured employers, have regarding prospective medical costs due to the pending litigation. ASC reimbursements for dates of service on or after the effective date of the proposed rule would not be subject to the outcome of the pending litigation and would not revert to the percentage of charges model. Better certainty will likely create efficiencies because they will be able to set reserves for future benefits more accurately and not have to set aside extra funds for increases in future medical costs in the event that the litigation regarding the April 1, 2015 rule is not resolved in the Commission's favor.

7. Benefits to the State and the private sector as ambulatory surgical centers:

   - The proposed rule amendments would bring ASCs several benefits. First, the proposed rule addresses stakeholder concerns brought forward by ASCs that there are certain procedures that can be performed for the workers' compensation population at ASCs that are not paid under the CMS ASC fee schedule. This has been addressed in the proposed rule amendments, which provide that ASCs are to be reimbursed at 135 percent of what Medicare would pay for those procedures pursuant to its outpatient hospital fee schedule.

   - Second, the certainty that a new permanent rule will bring to other stakeholders is also a benefit to ASCs.

8. Benefits to Employers:

   - For purchasers of workers' compensation insurance policies, these proposed rule amendments could result in a net reduction in premiums through lower medical costs and a lower risk of rate hikes to cover larger retrospective payments to ASCs. If the Commission is not successful on appeal, the ASC reimbursement rates will revert to a percentage-of-charges basis, increasing future workers' compensation costs for employers and payers. ASCs will also be eligible for retrospective payments from employers, at the old percentage of billed charges rate, for procedures performed since April 1, 2015. The potential retrospective payment amount is highly uncertain, estimated to exceed $10M.

   - Completing the rulemaking process again in advance of the appeal decision will avoid the former, much higher ASC reimbursement rates from being reinstated prospectively and limit the amount of time subject to retrospective payments, should the court invalidate the current rule provisions. To the extent that costs to insurers are passed on to employers, employers will benefit from the proposed rule amendments by avoiding the effects of a substantial increase in future medical costs on their premiums. The

future medical benefits cost increases under a percentage-of-charges model are not quantifiable. See the Uncertainties and Risk Analysis section below for more detail.

Alternatives Analysis

Baseline: The baseline rule used for the fiscal impact analysis is the April 1, 2015 version of 04 NCAC 10A .0103. See Appendix 2. Pursuant to that rule, the current reimbursement methodology for services provided by ASCs is 200% of what CMS would pay for the services. As explained above, this provision of the rule was challenged and invalidated, but the August 9, 2016 decision invalidating the rule was stayed pending the Commission's appeal of the decision. Therefore, the rule remains in place at the time of writing.

In considering amending the baseline rule, the Commission requested the analysis of four alternative amendments. The NCCI *Analysis* (Appendix 3) provided a forecast of the fiscal effect of each alternative on the workers' compensation system.

- Alternative 1: This alternative was chosen for the proposed rule amendments because it has a very minimal projected impact of -0.1% on ASC costs, described as a negligible decrease in overall workers' compensation system costs, and it improves on the baseline rule by adding certain procedures included under the CMS OPPS fee rule. This alternative is a good choice because this rulemaking is an effort to put a new permanent rule in place for the reasons explained in Necessity section above, not to make significant changes to costs to payers or providers. This alternative is similar to the baseline rule in that it would allow reimbursement of services provided by ASCs at 200% of what CMS would pay for those services that are deemed payable in the CMS ASC fee schedule. For those services that CMS does not pay ASCs to perform, but does pay outpatient hospitals to perform, ASCs would be reimbursed at 135% of what CMS would pay under its outpatient hospital fee schedule. This second provision involving the CMS outpatient fee schedule was included in response to stakeholder feedback received by the Commission in past public comment proceedings. N.C. Gen. Stat. § 97-26(c) allows for payment of any procedure not covered by the fee schedule either by agreement or at the "usual, customary, and reasonable charge" ("UCR") for the service. Therefore, the payment rules of CMS that relate to the older population they serve do not restrict what procedures ASCs can perform for workers' compensation. However, expanding the number of procedures with fees set by the fee schedule will assist the payer and ASC community by not requiring them to negotiate or determine a UCR charge for procedures not listed in the CMS ASC fee rule.

- Alternative 2: This alternative reflects a potential decrease from 200% to 175% for services paid under the CMS ASC fee schedule, but it reflects the addition of a rate of 135% for those procedures that are performed at an ASC but are paid by CMS under the OPPS fee schedule. Because the Commission was concerned that allowing 135% of the CMS OPPS fee schedule for certain procedures performed at ASCs might inflate medical costs, the Commission requested an analysis of a rule alternative with a slightly lower ASC rate of 175%. This alternative was not selected for proposal because it resulted in a projected -$2 million change in workers' compensation costs, which would reflect a benefit for payers, but a loss for ASCs.

- Alternative 3: This alternative reflects the request of certain ASCs that all services performed by ASCs in workers' compensation cases be reimbursed at 200% of the CMS OPPS fee schedule. This alternative was not selected for proposal because it reflects a potential +$12 million increase in costs to the workers' compensation system. While this alternative would provide a benefit to ASCs, it would be a significant cost to payers. Based on the Commission's review of states that allow payment to ASCs under the CMS OPPS fee schedule, such a rule would also be significantly above the average reimbursement rate of 127%.

- Alternative 4: This alternative would allow all services provided at ASCs that are included for payment in the CMS OPPS and ASC fee rules to be reimbursed at 135% of the CMS OPPS fee rule. The procedures allowed by CMS to be performed in ASCs are also included in the CMS OPPS fee rule. The Commission requested an analysis of this rule alternative because there are states that use only the CMS OPPS fee rule as their basis for reimbursement of both ASCs and outpatient hospitals. As stated above, the average rate applied to the CMS OPPS fee schedule for services provided at ASCs is 127%. The result of the analysis indicated a negligible decrease in workers' compensation system costs, with a -1.1% change to ASC-related medical costs. This alternative was not chosen because the -1.1% effect on ASC-related costs was larger than the -0.1% change under the proposed rule amendments, implying a greater loss to ASCs, even if negligible. There are also concerns that basing the fee provisions for ASCs on the CMS OPPS fee rule for all procedures could have unintended consequences if the CMS OPPS fee rule is adjusted in the future for reasons unrelated to ASC services or costs. Such an adjustment could create imbalance in the reimbursement levels between institutional providers in the Commission's fee schedule.

Uncertainties and Risk Analysis

Data Limitations and Behavioral Assumptions

The proposed rule differs from the baseline rule in that it specifies that procedures performed at ASCs for which they could not be reimbursed by CMS will be reimbursed at 135% of the CMS OPPS rate. NCCI's *Analysis* estimated that the proposed changes would result in a -0.1% decline in ASC reimbursements in the year following rule implementation.

NCCI's *Analysis* (Appendix 3) relies on the observed experience in 2015 as the basis for the impact estimates in this fiscal note. NCCI calculated the impact of the proposed amended rule provisions using bills for ASC services provided in 2015 because they are the most current complete year of data available. However, these data limitations are a source of uncertainty.

NCCI is not able to forecast any changes in the number, type, or location of procedures that may have occurred between 2015 and the present day. The maximum reimbursement rate of 67.15% of billed charges was in place for 3 months of 2015; a maximum reimbursement rate of 220% of the CMS ASC rate was in place for the remaining months. In the *Analysis*, NCCI first calculated the expected ASC reimbursements for the procedures completed in 2015, at 200% of the CMS ASC rate (the current fee schedule in effect). Then, NCCI estimated how those reimbursements would change after clarifying the reimbursement rate for certain procedures not reimbursed by CMS at

ASCs. The *Analysis* presents the effect of a price change on the observed procedures in 2015. However, that estimate does not capture any economic or population-driven changes in procedures performed at ASCs that may have occurred in the past two years.

Furthermore, because the analysis applies differing payment methodologies to past procedures, it does not account for any behavioral changes on the part of providers or the insurers and self-insureds regarding the chosen location of patient care for those procedures not reimbursed by CMS at the ASC rate. If the true experience has been that patients were in fact getting these procedures done in other treatment settings in 2015, with this proposed rule amendment to clarify maximum reimbursement rates for procedures without a designated CMS ASC rate, it is possible that there will be a shifting of these procedures to ASCs. Alternatively, if the true experience is that ASCs were performing these procedures but negotiating reimbursement at more than the 135% of the CMS OPPS rate prior to receiving rule clarity, it is possible that ASCs will lose revenue for these procedures. In this case, it is possible that there will be a shifting of these procedures away from ASCs to other care settings. Without experience data, the Commission is not able to quantify a potential shift in patient treatment settings with any accuracy.

If the negligible decrease in costs to payers translates to a minor decrease in profits for ASCs, some ASCs may decide to perform fewer procedures in workers' compensation cases. If more procedures are performed at outpatient or inpatient hospital facilities, there may be an increase in medical costs as CMS generally reimburses outpatient and inpatient hospitals at higher rates than ASCs for the similar services. This difference in CMS payment rates is related to the lower overhead costs experienced by ASCs.[5]

Finally, the Commission cannot predict with confidence this rule's impact on employer behavior or premiums. As detailed by the NCCI analysis, there is minimal difference in cost to the workers' compensation system between the April 1, 2015 rule and the new proposal. The Commission thus cannot predict whether this small difference will result in changes to wages or hiring practices. Nor can the Commission predict whether this small change will place any upward or downward pressure on employer premiums or self-insureds' costs.

Litigation Outcome

Adoption of the new rule does not resolve all uncertainties related to the litigation over the April 1, 2015 rule, which moved the Commission from a percent-of-charges method to a Medicare-based methodology. While the decision of the Wake County Superior Court to stay the August 9, 2016 decision has temporarily preserved the status quo, subsequent litigation may eventually end this stay. The April 1, 2015 rule is in effect until a court ends this stay. If the August 9, 2016 decision is upheld, ASCs may request to be reimbursed under the old percentage of charges method, requiring insurers and self-insured employers to recalculate and compensate these providers retroactively for the difference between what they received under the April 1, 2015

[5] See *Medicare Program: Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008*, 72 FR 42470, 42475, August 2, 2007, at https://www.federalregister.gov/documents/2007/08/02/07-3490/medicare-program-revised-payment-system-policies-for-services-furnished-in-ambulatory-surgical; *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient System*, GAO-07-86, November 30, 2006, at http://www.gao.gov/products/GAO-07-86.

rule and the former method based on percentage-of-charges assessed by the provider.[6] Furthermore, if the court invalidates the current rule, the percentage-of-charges based reimbursement rates would be reinstated for ASCs for any procedures performed from that point forward, barring the adoption of the proposed rule amendments. The Commission is unlikely to know the outcome of this litigation prior to the completion of rulemaking on the proposed rule amendments.

By adopting this rule, Commission can put a firm boundary on the end of this period of uncertainty over retrospective bill calculations and prospective repayment.

- Retrospective reimbursement: By adopting the proposed rules, the Commission will limit the period of time for which employers would be responsible for retrospective payments to ASCs in the event that the August 9, 2016 decision is upheld on appeal. The period under which these charges would have to be recalculated ranges from the adoption of the April 1, 2015 rule until the date the Commission formally adopts and implements a new rule.

    - NCCI analyses conducted in 2014 and 2016 estimated the impact on ASC reimbursements of, first, the change from 67.15% of charges to 220% of the CMS ASC rate, and then the later change from 220% of the CMS rate to 200% of the CMS rate (the baseline rule).[7] The ASC reimbursement losses presented in the NCCI analyses are not an accurate estimate of the total retrospective payments that employers and payers would be required to make in the event that the August 9, 2016 decision is upheld on appeal. At the time of the analyses, NCCI did not have current claims data or certain knowledge of changes to Medicare payment rates. NCCI is not able to forecast changes in the number or type of claims, or market-driven shifts in patient treatment settings. Therefore, these analyses do not represent the true changes in reimbursements experienced by ASCs. However, they can provide an estimate of the order of magnitude of the potential retrospective payments. Based on the NCCI analyses, the Commission makes a conservative estimate that retrospective payments could exceed $10M in total.

- Prospective reimbursement: Because the litigation over the April 1, 2015 rule would only apply to payments made between the adoption of the April 1, 2015 rule and its proposed replacement, by adopting these proposed rule amendments the Commission will provide certainty to payers and providers for medical reimbursement rates. This certainty is an inherent goal of the Commission's schedule of fees for medical compensation. However, the potential impacts associated with avoiding a reinstatement of the percentage-of-charges fee schedule cannot be determined due to lack of experience data about future injuries and costs. Further, NCCI indicated that fee schedules that are strictly based on charges rather than a fixed maximum provide a maximum reimbursement rate that changes with inflationary measures that are not subject to regulatory

[6] Of course, if the August 9, 2016 decision is reversed on appeal, there will be no period for which providers will have to make retroactive payments.

[7] See Appendix 4 for the December 4, 2014 NCCI analysis and go to www.ic.nc.gov/NCCINCRBAnalysis.pdf for the September 19, 2016 NCCI Analysis.

action. Consequently, a change in rules reflecting a percentage of charges is not measurable at a fixed point in time. As such, NCCI would not estimate a price impact for medical fee schedule changes that are purely based on charges.

Summary of economic impact

Compared to the baseline under the April 1, 2015 rule, payers in the North Carolina workers' compensation system, including both insurers and self-insured employers, stand to benefit from the proposed rule amendments by reducing uncertainty regarding retroactive and prospective medical costs based on the ongoing litigation regarding the April 1, 2015 rule and minor savings on medical costs as they can be projected at this time. If the proposed rule is adopted, ASCs will be limited in the amount of retroactive reimbursement they may receive if the August 9, 2016 decision is upheld. ASCs would also receive a negligible decrease in revenue under the amended rule from its effective date. However, under the amended rule, ASCs will benefit from clarity regarding the reimbursement rates for certain procedures.

APPENDIX 1

Rule 04 NCAC 10J .0103 is proposed for amendment as follows:

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments. An institutional facility may only be reimbursed for hospital outpatient institutional services pursuant to this Paragraph and Paragraphs (c), (d), and (f) of this Rule if it qualifies for payment by CMS as an outpatient hospital.

(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:

(1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

(c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:

(1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

(d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.

(e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows:

(1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.

(2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.

(3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

(f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:

(1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.

(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.

(3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the ~~Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective~~ most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment ~~System~~ Systems reimbursement formula and ~~factors~~ factors, including all Hospital Outpatient Prospective Payment and Ambulatory Surgical Center

Payment Systems Addenda, as published annually in the Federal Register and on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html ~~("the Medicare ASC facility-specific amount").~~ ("the OPPS/ASC Medicare rule"). An ASC's specific Medicare wage index value as set out in the OPPS/ASC Medicare rule shall be applied in the calculation of the maximum allowable amount for any institutional service it provides. ~~Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical Procedures for CY 2015, and Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, as published in the Federal Register, or their successors.~~

(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:

~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.~~

~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.~~

~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.~~

(1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.

(2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.

(i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.

(j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.

(k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.

(l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

History Note: *Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;*
Eff. April 1, ~~2015.~~ 2015;
Amendment Eff. October 1, 2017.

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments.

(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:

(1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

(c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:

(1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

(d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.

(e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows:

(1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.

(2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.

(3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

(f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:

(1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.

(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.

(3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical Procedures for CY 2015, and Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, as published in the Federal Register, or their successors.

(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:

(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.

(i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.

(j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.

(k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.

(l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

History Note: *Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;*
Eff. April 1, 2015.

ANALYSIS OF ALTERNATIVES TO THE NORTH CAROLINA AMBULATORY SURGICAL CENTER FEE SCHEDULE PROPOSED TO BE EFFECTIVE OCTOBER 1, 2017

The North Carolina Industrial Commission has requested that NCCI estimate the impact on workers compensation system costs under four reimbursement alternatives for Ambulatory Surgical Center (ASC) services. NCCI estimates that the fee schedule alternatives would result in an overall impact between -0.1% (-$2.0M[1]) and +0.6% (+$12.0M) on North Carolina workers compensation system costs, if adopted.

The following table summarizes the alternatives and includes the estimated impacts.

Maximum Reimbursement for ASC	(A) Estimated Impact on ASC Services	(B) ASC Share of Medical Costs (SY 2015)	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Medical Costs as % of Overall Workers Compensation Benefit Costs (Eff. 10/1/2017)	(E) Estimated Impact on Overall Workers Compensation System Costs (C) x (D)
200% of Medicare ASC Payment Rate with 135% of Medicare Outpatient Prospective Payment System (OPPS)	-0.1%	4.8%	Negligible decrease	48.5%	Negligible decrease
175% of Medicare ASC Payment Rate with 135% of Medicare OPPS	-5.0%		-0.2%		-0.1% (-2.0M)
200% of Medicare OPPS	+27.6%		+1.3%		+0.6% (+12.0M)
135% of Medicare OPPS	-1.1%		-0.1%		Negligible decrease

[1] The estimated dollar impact is the percentage impact(s) displayed multiplied by 2015 written premium of $1,963M from NAIC Annual Statement data for North Carolina. This figure includes self-insurance, but not the policyholder retained portion of deductible policies, or the adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be between $-2M and $+12M, where data on self-insurance is approximated using the National Academy of Social Insurance's October 2016 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2014."

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ANALYSIS OF ALTERNATIVES TO THE NORTH CAROLINA AMBULATORY SURGICAL CENTER FEE SCHEDULE PROPOSED TO BE EFFECTIVE OCTOBER 1, 2017

Summary of Proposed Medical Fee Schedule Changes

The North Carolina Industrial Commission has requested that NCCI estimate the impact on workers compensation system costs from a change to the maximum reimbursement rate of 200% of the 2017 Medicare ASC facility specific amounts as of January 1, 2017. The following fee schedule alternatives for reimbursement for institutional services provided by ASCs, proposed to be effective October 1, 2017 are listed below:

1. Maximum reimbursement rate of 200% of the 2017 Medicare ASC facility specific amount and a maximum reimbursement rate of 135% of the OPPS facility specific amount for institutional services performed at an ASC that are eligible for payment if performed at an outpatient hospital facility, but would not be eligible for payment under Medicare rules if performed at an ASC.

2. Maximum reimbursement rate of 175% of the 2017 Medicare ASC facility specific amount and a maximum reimbursement rate of 135% of the OPPS facility specific amount for institutional services performed at an ASC that are eligible for payment if performed at an outpatient hospital facility, but would not be eligible for payment under Medicare rules if performed at an ASC.

3. Maximum reimbursement rate of 200% of the 2017 Medicare Outpatient facility specific amount

4. Maximum reimbursement rate of 135% of the 2017 Medicare Outpatient facility specific amount

Actuarial Analysis of Proposed Medical Fee Schedule Changes

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
    a. Compare the prior and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
    b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

2. Estimate the price level change as a result of the proposed fee schedule
    a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.

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i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
The formula used to determine the percent realized for fee schedule increases is 80% x (1.10 + 1.20 x (price departure)).

3. Estimate the share of costs that are subject to the fee schedule
    a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for North Carolina for Service Year 2015.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes.

Ambulatory Surgical Center Fee Schedule

In North Carolina, payments for ASC services represent 4.8% of total medical payments. NCCI calculated the percentage change in maximums and the percentage change in reimbursements for ASC services to estimate impacts due to the proposed fee schedule changes. The estimated impacts for the alternatives are calculated as follows:

Alternatives 1 & 2

To calculate the percentage change in maximums for ASC services, NCCI calculates the percentage change in maximum allowable reimbursement (MAR) for each procedure code listed on the fee schedule. For these alternatives, 2017 Medicare OPPS rates are to be utilized only when an applicable outpatient procedure is performed that is not included in the 2017 Medicare ASC fee schedule. The overall change in maximums for ASC services is a weighted average of the percentage change in MAR (proposed MAR / prior MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2015. The prior and proposed maximums are calculated as follows:

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Prior MAR

Prior MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare ASC Payment Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200%

Proposed MAR – ASC or Hospital Outpatient-Based

Proposed MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare ASC Payment Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200% or 175% in the two distinct scenarios or

Proposed MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare OPPS Relative Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 135% in the two distinct scenarios

The overall weighted-average percentage change in maximums for each scenario for ASC services is multiplied by the price realization factor[2] to arrive at the estimated impact on ASC costs. The estimated impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments (4.8%) to arrive at the estimated impact on medical costs. The estimated impact on medical costs is then multiplied by the North Carolina percentage of benefit costs attributed to medical benefits (48.5%) to arrive at the estimated impact on overall workers compensation costs in North Carolina. The estimated impact on ASC services for each alternative is shown in the chart below.

Alternative	Proposed ASC Medicare Multiplier	Proposed OPPS Medicare Multiplier	Percentage Change in MAR	Price Realization Factor	Estimated Impact on ASC Service Costs
1	200%	135%	-0.2%	50%	-0.1%
2	175%	135%	-9.9%	50%	-5.0%

[2] The price realization factor from a fee schedule increase is estimated according to the formula 80% x (1.10 + 1.20 x (price departure)). Due to the volatility observed in the price departure for ASC services in North Carolina, a reliable price departure could not be determined. In such a situation, the price realization factor for a fee schedule increase is assumed to be 80%. The price realization factor for a fee schedule decrease is expected to be 50%.

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Alternative 3 & 4

To calculate the percentage change in maximums for ASC services, NCCI calculates the percentage change in MAR for each procedure code listed on the fee schedule. The overall change in maximums for ASC services is a weighted average of the percentage change in MAR (proposed MAR / prior MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2015. The prior and proposed maximums are calculated as follows:

Prior MAR

Prior MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare ASC Payment Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200%

Proposed MAR – Hospital Outpatient-Based

Proposed MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare OPPS Relative Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200% and 135% in the two distinct scenarios

The overall weighted-average percentage change in maximums for each scenario for ASC services is then multiplied by the price realization factor to arrive at the estimated impact on ASC costs. The estimated impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments (4.8%) to arrive at the estimated impact on medical costs. The estimated impact on medical costs is then multiplied by the North Carolina percentage of benefit costs attributed to medical benefits (48.5%) to arrive at the estimated impact on overall workers compensation costs in North Carolina. The estimated impact on ASC services for each alternative is shown in the chart below.

Alternative	Proposed OPPS Medicare Multiplier	Percentage Change in Reimbursement	Price Realization Factor	Estimated Impact on ASC Service Costs
3	200%	+34.5%	80%	+27.6%
4	135%	-2.2%	50%	-1.1%

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

NCCI estimates that the proposal to adopt a Medicare based fee schedule, effective 4/1/2015, for Hospital Inpatient, Hospital Outpatient, and Ambulatory Surgical Center (ASC) services would result in an impact of -2.9% (-$39.0M[1]) on North Carolina workers compensation system costs.

NCCI estimates that the proposed changes to the fee schedule for professional services, effective 7/1/2015, would result in an impact of +1.4% (+19.0M[1]) on North Carolina workers compensation system costs.

NCCI estimates the combined impact of the proposed 2015 changes on North Carolina workers compensation system costs to be -1.5% (-$20.0M).

Note that the actual rules and fee schedules are not currently available. NCCI will review actual rules when they become available, which may result in a different cost impact. In particular, the 2015 Medicare physician fee schedule was not available at the time of this analysis.

Summary of Proposed Changes

The medical fee schedule changes proposed by the North Carolina Industrial Commission are summarized below.

- **Hospital Outpatient Services**

  The provisions underlying the proposed outpatient fee schedule, proposed to be effective 4/1/2015, are as follows:

  - Services performed in acute care hospitals will be based upon 220% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 67.15% of charges.
  - Services performed in critical access hospitals will be based upon 230% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 73.95% of charges.

[1] Overall system costs are based on NAIC Annual Statement data. The estimated dollar impact is the percentage impact displayed multiplied by 2013 written premium of $1,356M from NAIC Annual Statement data for North Carolina. This figure does not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be $-52M for fee schedule changes effective 4/1/2015 and $+25M for fee schedule changes effective 7/1/2015.
The data on self-insurance is approximated using the National Academy of Social Insurance's August 2014 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2012."

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

- **Hospital Inpatient Services**

  Currently, hospital inpatient services are reimbursed as a discount of charges and Diagnosis Related Group (DRG) maximum reimbursements. The provisions underlying the proposed inpatient fee schedule, proposed to be effective 4/1/2015, are as follows:

  - Services performed in acute care hospitals will be based upon 190% of the Medicare's hospital inpatient payment rates
  - Services performed in critical access hospitals will be based upon 200% of the Medicare's hospital inpatient base rates

- **ASC Services**

  Currently, ASC services are reimbursed at 67.15% of charges. The proposed maximums for ASC services will be based on 190% of Medicare's ASC payment rates.

- **Physician Services**

  The maximum reimbursements underlying the current physician fee schedule are established by the North Carolina Industrial Commission. The provisions underlying the proposed physician fee schedule, proposed to be effective 7/1/2015, are as follows:

  - Update the maximum allowable reimbursements (MARs) to be based on the current Medicare Resource Based Relative Value System (RBRVS)
  - Adopt the following multipliers by service category[2]:

Physician Service Category	Percentage of NC Medicare
Evaluation and Management	140%
Physical Medicine	140%
Emergency Medicine	169%
Neurology	153%
Pain Management	163%
Radiology	195%
Major Surgery	195%
Clinical Laboratory	150%
Other Professional Services	150%

[2] North Carolina Industrial Commission provided NCCI a list of approximately 200 physician services that were classified in the first seven categories listed in the table above. Clinical Laboratory grouping was based on Clinical Laboratory (CLAB) Fee Schedule published by CMS, while the State Specific Codes grouping was based on the Commission Assigned Codes section of the current physician fee schedule available at http://www.ic.nc.gov/ncic/pages/feesched.asp. Following the directive from NC IC, all other physician services with MAR but not listed in any of the aforementioned categories were classified into the Other Professional Services group. To the extent that a more detailed practice category taxonomy is provided to NCCI, the overall weighted-average percentage change in MAR may differ.

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- **Durable Medical Equipment (DME) and Supplies**

  The maximum reimbursements underlying the current DME and Supplies fee schedule are established by the North Carolina Industrial Commission. Under the proposal, these services are to be reimbursed at 100% of those rates established for North Carolina in the Centers for Medicaid and Medicare Services' (CMS) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule.

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Actuarial Analysis of Proposal

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
   a. Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
   b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

2. Estimate the price level change as a result of the proposed fee schedule
   a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
      i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
      ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
      The formula used to determine the percent realized for fee schedule increases is 80% x (1.10 + 1.20 x (price departure)).

3. Determine the share of costs that are subject to the fee schedule
   a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for North Carolina for Service Year 2013.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes.

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Analysis of Proposed Fee Schedule Changes effective 4/1/2015

Hospital Outpatient Fee Schedule

In North Carolina, payments for hospital outpatient services represent 19.3% of total medical payments. To calculate the percentage change in reimbursements for hospital outpatient services, NCCI calculates the percentage change in current reimbursement to proposed reimbursement for each procedure. The overall change in reimbursements for hospital outpatient services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The current and proposed reimbursements are calculated as follows:

Current Reimbursement

For each relevant procedure,

Current Reimbursement = Current Payments x Trend Factor

The current payments by procedure code are obtained from NCCI's Medical Data Call for North Carolina for Service Year 2013. These payments are adjusted to reflect changes from past price levels to the price levels projected to be in effect on the effective date of the hospital outpatient fee schedule. The trend factor is based on the most recent available U.S hospital outpatient component of the medical consumer price index (MCPI) as shown below:

Service Year	Hospital Outpatient MCPI* Change from July of previous year
2011	5.1%
2012	5.0%
2013	4.8%
Average	4.9%

*Source: Bureau of Labor Statistics

A trend factor of 1.087 is applied to hospital outpatient payments for Service Year 2013 to determine the projected payments at the 4/1/2015 price level. This trend factor is calculated in two steps

1. Estimate the yearly Hospital Outpatient MCPI, for service years 2014 and beyond, as the arithmetic three-year average of the observed Hospital Outpatient MCPI for 2011-2013. This average is equal to 4.9% (=[5.1% + 5.0% + 4.8%] / 3).

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2. Raise the value above to the number of years elapsed from the midpoint of service year 2013 (7/1/2013) to the effective date of the fee schedule (4/1/2015), which is 1.75 years.

Therefore, the trend factor from 7/1/2013 to 4/1/2015 is estimated as $1.087 = 1.049^{1.75}$.

Proposed Reimbursement on or after April 1, 2015

For each relevant procedure,

Proposed Reimbursement = [Multiplier * Medicare Payment Rate + Outlier Amount (if applicable) – Multiple Procedure Discounts (if applicable)] x (1+ Price Departure)

Where Multiplier = 220% (for acute care hospitals*)
Price Departure for hospital outpatient services is estimated to be -10%

*Given the relatively small percentage of workers compensation hospital costs attributed to critical access hospitals (these comprise less than 1%) the hospital outpatient analysis is based on MARs for acute care hospitals.

The Medicare Payment Rate is based on the Calendar Year 2015 version of Medicare's Hospital Outpatient Prospective Payment System (OPPS) publication. To estimate the proposed reimbursement effective 4/1/2015, NCCI compares trended payments to discounted fee schedule maximums. In general, NCCI observes that average prices paid are below fee schedule maximums. Based on a combination of actuarial judgment and observations of price departure in states that already have a fee schedule, a price departure of -10% was selected.

The Medicare Hospital Outpatient Prospective Payment System (OPPS) reimbursement rule also contains an additional provision for outlier payments. Under the Medicare OPPS rule, the outlier threshold is met when both of the following rules have been satisfied

1. Trended Charges submitted at the bill level times Cost-to-Charge ratio exceeds 1.75 times the North Carolina Medicare Ambulatory Payment Classification (APC) rate and

2. Trended Charges submitted at the bill level multiplied by the Cost-to-Charge ratio exceeds the North Carolina APC payment rate plus a $3,100 fixed-dollar threshold.

When this threshold is met, Medicare provides for an outlier reimbursement that is calculated as 50 percent of the amount by which the cost of furnishing the procedure exceeds 1.75 times 220% of the Medicare APC payment rate.

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

The table below displays a **hypothetical example** of the calculation of the proposed reimbursement on or after 4/1/2015 for an APC of 0203 (Level IV Nerve Injections).

(1)	(2)	(3)	(4)	(5)	(6)
		= (2) x Cost-to-Charge Ratio	(i) 175% x (1) (ii) (1) + $3,100	=2.2 x 0.5 x [(3) - 1.75 x (1)]	= (1) + (5)
220% of 2015 NC Medicare APC Payment Rate	Total Trended Charge Submitted at the bill level	Total Costs for OPPS procedure	Proposed Outlier Threshold	Proposed Outlier Payment	Total Proposed MAR
$2,992	$ 40,000	$10,520	Threshold (i): $5,236 Threshold (ii): $6,092	$5,284	$8,276

The Cost to Charge ratio (CCR) is obtained from Medicare and is calculated as the simple average of the North Carolina Statewide Urban and Rural CCRs (0.263 = 0.5 x (0.246 + 0.280)).

The calculation for the proposed reimbursements also considers multiple procedure discounts. Under the Medicare OPPS reimbursement rule, multiple procedure discounts are allowed for multiple surgical procedures performed during the same operative session. Primary procedures (the procedure with the highest payment rate) would be reimbursed at 100% of the fee schedule amount, and secondary surgical procedures would be reimbursed at 50% of the fee schedule amount.

The overall weighted-average percentage change in reimbursements for hospital outpatient services is -40.7%.

Since the overall reimbursements for hospital outpatient services decreased, NCCI expects that 50% of the decrease will be realized on hospital outpatient price levels. The impact on hospital outpatient payments after the 50% offset is -20.4%.

The above impact on hospital outpatient payments is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in North Carolina (19.3%) to arrive at the impact on medical costs of -3.9%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical costs in North Carolina (49.5%) to arrive at the estimated impact on overall workers compensation costs in North Carolina of -1.9% (-$26M).

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Hospital Inpatient

In North Carolina, payments for hospital inpatient services represent (13.2%) of total medical payments. To calculate the percentage change in reimbursements for hospital inpatient services, we calculate the percentage change in current reimbursement to proposed reimbursement for each inpatient hospital bill that is reported with a diagnosis related group (DRG) procedure code. The overall change in reimbursements for hospital inpatient services is a weighted average of the percentage change in reimbursements for each bill weighted by the observed payments by bill as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The current and proposed reimbursements are calculated as follows:

Current Reimbursement

For each relevant inpatient hospital bill,

Current Reimbursement = Current Payments x Trend Factor

The current payments are obtained from NCCI's Medical Data Call for North Carolina for Service Year 2013. These payments are adjusted to reflect changes from past price levels to the price levels projected to be in effect on the effective date of the hospital inpatient fee schedule. The trend factor is based on the most recent available U.S hospital inpatient component of the medical consumer price index (MCPI) as shown below:

Service Year	Hospital Inpatient MCPI change from July of previous year
2011	6.8%
2012	5.2%
2013	4.4%
Average	5.5%

*Source: Bureau of Labor Statistics

A trend factor of 1.098 is applied to hospital inpatient payments for Service Year 2013 to determine the projected payments at the 4/1/2015 price level.

This trend factor is calculated in two steps

1. Estimate the yearly Hospital Inpatient MCPI, for service years 2014 and beyond, as the arithmetic three-year average of the observed Hospital Outpatient MCPI for 2011-2013. This average is equal to 5.5% (=[6.8% + 5.2% + 4.4%] / 3)

2. Raise the value above to the number of years elapsed from the midpoint of service year 2013 (7/1/2013) to the effective date of the fee schedule (4/1/2015), which is 1.75 years.

Therefore, the trend factor from 7/1/2013 to 4/1/2015 is estimated as $1.098 = 1.055^{1.75}$.

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Proposed Reimbursement on or after 4/1/2015

For each relevant inpatient hospital bill,

Proposed Reimbursement = [Multiplier x Medicare Payment Rate + Outlier Amount (if applicable)] x (1 + Price Departure)

Where Multiplier = 190% (for acute care hospitals*)
Price Departure for hospital inpatient services is estimated to be -10%

*Given the relatively small percentage of workers compensation hospital costs attributed to critical access hospitals (these comprise less than 1%) the hospital inpatient analysis is based on MARs for acute care hospitals.

The Medicare Payment Rate is based on Calendar Year 2015 version of Medicare Hospital Inpatient Prospective Payment System (IPPS) publication. To estimate the proposed reimbursement effective 4/1/2015, NCCI compares trended payments to discounted fee schedule maximums. In general, NCCI observes that average prices paid are below fee schedule maximums. Based on a combination of actuarial judgment and observations of price departure in states that already have a fee schedule, a price departure of -10% was selected.

Similar to the OPPS outlier example shown previously, Medicare's Hospital Inpatient Prospective Payment System (IPPS) reimbursement rule also contains an additional provision for outlier payments. Under the Medicare IPPS rule, the outlier threshold is met when the cost for a particular case exceeds a fixed-loss threshold which is comprised of the following components:

- Medicare Severity Diagnosis Related Group (MS-DRG) payment for that case (both operating and capital)
- Any Indirect Medical Education (IME),Disproportionate Share Hospital (DSH) and new technology payments
- A fixed loss amount of $24,758

Once this threshold is met, the outlier reimbursement is made at 80% of the hospital's costs in excess of the fixed loss threshold for that case.

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

The table below displays a hypothetical example of the calculation of the proposed reimbursement on or after 4/1/2015 for a DRG of 459 (Spinal Fusion Except Cervical with Major Complications and Comorbidities).

(1)	(2)	(3)	(5)	(6)
		= (2) x Cost-to-Charge Ratio	=1.9 x 0.8 x {(3) – [(1) + $24,758]}	= (1) + (5)
190% of 2015 NC MS-DRG Payment Rate	Total Trended Charge Submitted at the bill level	Total Costs for IPPS procedure	Proposed Outlier Payment	Total Proposed MAR
$21,770	$ 190,000	$68,400	$33,245	$55,015

The Cost to Charge ratio (CCR) is obtained from Medicare and is calculated as the simple average of the North Carolina Statewide Urban and Rural CCRs (0.360 = 0.5 x (0.340 + 0.380))

The overall weighted average percentage change in reimbursements for hospital inpatient services is -18.2%. Since the overall reimbursements for hospital inpatient services decreased, NCCI expects that 50% of the decrease would be realized on hospital inpatient price levels. The impact on hospital inpatient payments after the 50% offset is -9.1%.

The above impact on hospital inpatient costs is then multiplied by the percentage of medical costs attributed to hospital inpatient payments (13.2%) to arrive at the impacts on medical costs of -1.2%. The resulting impact on medical costs is then multiplied by the percentage of North Carolina benefit costs attributed to medical costs (49.5%) to arrive at the impact on North Carolina's overall workers compensation system costs of -0.6% (-$8.0M).

ASC Fee Schedule

In North Carolina, payments for ASC services represent 5.7% of total medical payments. To calculate the percentage change in reimbursements for ASC services, NCCI calculates the percentage change in current reimbursement to proposed reimbursement for each procedure. The overall change in reimbursements for ASC services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013.

The current and proposed reimbursements are calculated in an analogous manner to the hospital outpatient analysis, except that Medicare has no outlier provision under the ASC fee schedule.

The overall weighted average percentage change in reimbursements for ASC services was estimated to be -29.3%.Since the overall reimbursements for ASC services decreased, NCCI expects that 50% of the decrease will be realized on ASC price levels. The impact on ASC payments after the 50% offset is -14.7%.

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The above impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in North Carolina (5.7%) to arrive at the impact on medical costs of -0.8%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical costs in North Carolina (49.5%) to arrive at the impact on overall workers compensation system costs in North Carolina of -0.4% (-$5.0M).

Summary of Impacts

The impacts from the changes to the North Carolina Medical Fee Schedules effective 4/1/2015 are summarized below:

	(A) Estimated Impact on Type of Service	(B) Medical Cost Distribution	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) x (2)
Hospital Inpatient	-9.1%	13.2%	-1.2%	-0.6%
Hospital Outpatient	-20.4%	19.3%	-3.9%	-1.9%
ASC	-14.7%	5.7%	-0.8%	-0.4%
(1) Total Impact on **North Carolina** Medical Costs			**-5.9%**	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in **North Carolina**				49.5%
(3) Total Impact on Overall Workers Compensation System Costs in North Carolina = (1) x (2)				**-2.9%**

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ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Analysis of Proposed Fee Schedule Changes effective 7/1/2015

Physician Fee Schedule

In North Carolina, payments for physician services represent 33.5% of total medical payments. To calculate the percentage change in maximum reimbursements for physician services, NCCI calculates the percentage change in maximum reimbursements for each procedure code. The overall change in maximum reimbursements for physician services is a weighted average of the percentage change in MAR (proposed MAR / current MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013.

The overall weighted-average percentage change in MAR is +10.8%.

The impact by category is shown in the table below.

Physician Practice Category	Cost Distribution	Percentage Change in MAR
Anesthesia	2.9%	+4.1%
Major Surgery	9.0%	-21.7%
Pain Management	1.8%	-25.1%
Radiology	10.0%	-28.1%
Physical Medicine	22.3%	+59.9%
Evaluation and Management	16.3%	+33.5%
Emergency Medicine	2.1%	+35.2%
Clinical Laboratory	1.4%	-11.6%
State Specific Codes	0.2%	0.0%
Other Professional Services	20.4%	-17.6%
Physician Payments with no specific MAR	13.6%	0.0%
Total	**100.0%**	**10.8%**

Since the overall average maximum reimbursement for physicians increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula 80% x (1.10 + 1.20 x (price departure)). The observed price departure for physician payments in North Carolina is -9%. The percentage realized is estimated to be 79% (= 80% x (1.10 + 1.20 x (-0.09)). The impact on physician payments due to the revised physician fee schedule change is +8.5% (= +10.8% x 0.79).

The above impact of +8.5% is then multiplied by the North Carolina percentage of medical costs attributed to physician payments (33.5%) to arrive at the impact on medical costs of +2.8%.

Finally, the above impact of +2.8% is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.1%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +1.3% (+18.0M).

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Durable Medical Equipment (DME)

In North Carolina, payments for DME represent 2% of total medical payments. DME payments are based on 2015 North Carolina adjusted Medicare rates.

The overall change in maximum reimbursements for DME is a weighted average of the percentage change in MAR (proposed MAR / current MAR) by code weighted by the observed payments by code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The overall weighted average percentage change in MAR is estimated to be +10.4%.

Since the overall average maximum reimbursement for DME services increased, the percentage expected to be realized from the fee schedule increase is typically estimated to be 80%. The impact on DME payments due to the revised DME fee schedule change is +8.3% (= +10.4% x 0.80).

The above impact of +8.3% is then multiplied by the North Carolina percentage of medical costs attributed to DME payments (2.0%) to arrive at the impact on medical costs of +0.2%.

The above impact is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.1%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +0.1%(+1.4M).

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ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Summary of Impacts

The impacts from the changes to the North Carolina Medical Fee Schedules effective 7/1/2015 are summarized below:

	(A) Estimated Impact on Type of Service	(B) Medical Cost Distribution	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) x (2)
Physician	+8.5%	33.5%	+2.8%	+1.3%
DME	+8.3%	2.0%	+0.2%	+0.1%
(1) Total Impact on **North Carolina** Medical Costs			**+3.0%**	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in **North Carolina**				48.1%[3]
(3) Total Estimated Impact on Overall Workers Compensation System Costs in North Carolina = (1) x (2)				**+1.4%**

[3] The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes, after adjusting for the medical fee changes assumed to become effective April 1, 2015.

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