NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 822 (Second Edition)

SHORT TITLES: State Self-Funded Health Plan (HMO)

SPONSOR(S): Sen. Rand

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts, premium payments for dependents by active and retired teachers and State employees, and premium payments for coverages selected by eligible former teachers and State employees.

BILL SUMMARY: Section 1: The section allows the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan, after consulting with the Legislative Committee on Employee Hospital and Medical Benefits, to adopt any arrangement for offering health maintenance organization (HMO) alternatives to members of the Plan, including ones underwritten by the State. The Plan has, since 1986, provided HMO alternatives with HMOs assuming all of the risk for the coverages offered. HMOs have further been required to compensate the Plan for administrative costs and for enrolling members of the Plan with more favorable risk factors.

The Plan's Executive Administrator says he intends to offer, under the bill, a self-insured HMO alternative to the Plan's self-insured indemnity program under the following circumstances: (a) the Plan will competitively select open-access HMOs that will be required to have a viable health care provider network in all of the State's 100 counties; (b) the HMOs will be provided an administrative fee no greater than the fee paid to the claims processing contractor for the Plan's self-insured indemnity program (Blue Cross & Blue Shield of North Carolina); (c) monthly premiums will be the same as the monthly premiums for the Plan's self-insured indemnity program; (d) most benefits will be actuarially 5-10% better than the benefits of the Plan's self-insured indemnity program with member cost-sharing limited to copayments; (e) outpatient prescription drug benefits and mental health and substance abuse benefits will be carved-out and will continue to be managed by the self-insured indemnity program's pharmacy benefit manager (AdvancePCS) and mental health case manager (Value Options); (f) a point-of-service option in which HMO members can use out-of-network providers in exchange for higher copayments will not be offered: and (g) conversion to non-group benefits upon a member's termination of eligibility for group benefits will be provided by the selected HMOs on an insured arrangement.

Section 2: The section allows the Plan's Executive Administrator to conduct a pilot program in a county that has at least 10,000 members of the Plan to measure the potential cost savings and patient care improvements from medical management by local providers of health care services.

Sections 3, 3.1, 3.2, and 3.3: The sections transfer a long-term care benefit program from the Plan to the Department of State Treasurer.

Section 4: The section makes the terms of any contract, including reimbursement rates, between the Plan and hospitals, hospital authorities, physicians, a pharmacy benefit manager, or any other provider of medical services under the Plan confidential and not a public record under state law. Only the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Executive Administrator, and members of the Joint Legislative Health Care Oversight Committee would have sole and exclusive access to the contracts.

Section 5: The section clarifies that the Plan's allowable charges for private duty nursing services are the lesser of the Plan's usual, customary, and reasonable allowances or 90% of the daily semi-private rate at skilled nursing facilities.

Section 5.1: The section provides for the reimbursement of services to clinical pharmacist practitioners who are approved by the North Carolina Board of Pharmacy and North Carolina Medical Board. Clinical pharmacist practitioners became a new level of pharmacy in North Carolina in July, 2000, with rules promulgated by the Board of Pharmacy and Medical Board in April, 2001. These pharmacists have advanced training and work collaboratively with licensed physicians to implement pre-determined agreements for drug therapy such as aminoglycoside dosing, anti-coagulation management, theophylline dosing, pain management, refill programs, and disease management programs for chronic diseases such as asthma and diabetes.

Sections 6, 7, 8, 9, 10, and 11: The sections permit employees, retired employees, and their spouses and dependent children to choose reduced coverage under the Plan's self-insured indemnity program in order to get lower monthly premiums. The sections apply only to persons for whom Medicare is not the primary payer of health benefits. Employees and retired employees would have the same reduced levels of coverage that would be chosen for spouses and dependent children. Premiums paid to the Plan by employers for employees and retired employees would however remain the same under each coverage option. A comparison between the self-insured program's standard and reduced levels of coverage under the sections is:

	Standard Coverage	Reduced Coverage
Annual Deductible Per Person	$350	$500
Maximum Annual Deductible Per Family	$1,050	$1,500
Coinsurance Paid by Members	20%	30%
Maximum Annual Coinsurance Per Person	$1,500	$2,000
Maximum Annual Coinsurance Per Family	$4,500	$6,000
Copayment for Professional Services Paid by Members	$15	$25
Annual Deductible for Prescription Drugs Per Person	None	$50

All other benefits of the two levels of coverage remain the same as provided under the standard coverage. Premiums paid by employees and retired employees for the coverage of their spouses and dependent children would increase an estimated 8% over 2000-2001 amounts under the reduced level of coverage as opposed to a 30% increase under the standard level of coverage. Premiums paid by employees and retired employees for the coverage of their dependent children only would be reduced by an estimated 4% under the reduced level of coverage as compared to 2000-2001 rates as opposed to a 30% increase under the standard level of coverage.

Section 8: The section also provides coverage for erectile dysfunction up to three dosages of medication per month. Drugs that are affected are Viagra, Caverject, Muse, and Edex.

Section 12: The section requires an election of contributory coverage by employees who have had 12 months of non-contributory coverage following an elimination of a job because of a reduction in funds supporting the job within 90 days after the last day of non-contributory coverage.

EFFECTIVE DATE: Sections 3, 3.1, 3.2, and 3.3 become effective July 1, 2002. Sections 6, 7, 8, 9, 10, and 11 become effective January 1, 2002. The other sections become effective when they become law.

ESTIMATED IMPACT ON STATE: Self-Insured HMO: The consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Aon Consulting, says that the Plan will design a self-insured HMO that will be cost neutral to the State. Aon Consulting further states that the cost savings to the State will come from greater discounts from an HMO's network of institutional and professional health care providers, notwithstanding the fact that changes in utilization management may result in an increase or decrease in cost to the State. In any event, Aon Consulting concludes that the bill results in the risk of adverse experience being transferred to the State by an HMO. The consulting actuary for the General Assembly's

Fiscal Research Division, Hartman & Associates, states that the financial impact of the bill is currently indeterminable, but that a considerable amount of uncompensated risk will be transferred from the commercial HMO market and Plan members selecting an HMO option to the State. Factors related to this observation include: inconclusive evidence that splitting the Plan's self-insured efforts into two parts will generate savings not realized by the Plan in total, the likelihood that Plan members will self-select the self-insured option most advantageous at the time which will result in an overall cost increase to the Plan, the likelihood of a viable health care provider network and HMO option with higher benefits in all of the State's 100 counties is quite uncertain, the addition of another self-insured option to the Plan will likely create additional administrative costs to the Plan, the addition of another self-funded option will likely result in increased total claims processing fees since the indemnity program's claims processor's fees are based upon a minimum enrollment to adequately cover fixed expenses, and with the State's anticipation of subjecting managed care plans to malpractice liabilities and increased defensive medical practices, the commercial HMO industry will in all likelihood transfer all of the increased costs for protection against these liabilities and defensive medical practices to the State rather than to its owners and other books of business.

Pilot Program for Local Management of Health Care Services: The Plan's consulting actuary, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, both state that the financial impact of the pilot program is indeterminable. Hartman and Associates further notes that to the extent that local management's costs duplicate those included in the indemnity program's claims processors' fees, the Plan's total administrative expense would be expected to increase.

Transfer of Long-Term Care Program to the Department of State Treasurer: The Plan's consulting actuary, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, do not see any financial impact to the Plan for the transfer.

Confidentiality of Provider Contracts: The Plan's consulting actuary, Aon Consulting, states that the Plan could see cost increases up to 25% without the confidentiality of provider contracts. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the confidentiality of provider contracts to have a significant financial impact.

Allowable Charges for Private Duty Nursing Set at Lesser of UCR or 90% of Daily Semi-Private Rates at Skilled Nursing Facilities: The Plan's consulting actuary, Aon Consulting, states that the change should result in minimal cost savings. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the change to have a significant financial impact.

Clinical Pharmacist Practitioners Added as Providers of Health Care Services: The Plan's consulting actuary, Aon Consulting, expects the addition to have a negligible cost. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the addition to have a significant financial impact.

Optional Benefit Levels for Lower Monthly Premiums: Although the draft legislation does not specify that the optional benefit levels would incorporate a preferred provider organization (PPO) structure, the Plan's consulting actuary, Aon Consulting, specifies that the low option premium rates are predicated on a PPO format for an approximate 10% reduction in rates. The low option's monthly rates would be:

Contract	Employer	Employee	Total
Employee & Child(ren)	$244.37	$112.64	$357.01
Employee & Family	$244.37	$304.38	$548.75

Under a PPO structure, the Plan selects certain hospitals, physicians, and other providers of health care services for which Plan members will receive expected benefits. Use of hospitals, physicians, and other providers of health care services by Plan members other than the ones selected by the Plan will result in members paying a coinsurance rate of 50% up to $7,000 per person per year with no annual contract

maximum amount. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, did not calculate the amount of the lower premiums.

Three Monthly Dosages for Erectile Dysfunction Drugs: The Plan's consulting actuary, Aon Consulting, expects the change in outpatient prescription drug coverage to have an additional cost of $147,000 for fiscal year 2001-02 and $600,000 for fiscal year 2002-03. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the change in coverage to have a significant financial impact.

Election Time for Contributory Continuation Coverage Following Job Losses: The Plan's consulting actuary, Aon Consulting, expects negligible cost savings from the change in eligibility. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, does not expect the change in eligibility to have a significant financial impact.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan only had a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $350 annual deductible, 20% coinsurance up to $1,500 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Beginning in July, 2000, firefighters, rescue squad workers, and members of the National Guard and their eligible dependents were allowed to voluntarily participate in the Plan on a fully contributory basis, provided they were ineligible for any other type of group health benefits and had been without such benefits for at least six months. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. All other types of premium in the indemnity program are fully contributory. The Plan's Executive Administrator has set the premium rates for firefighters, rescue squad workers, and members of the National Guard and their families at 47% more than the comparable rates charged for employees, retired employees, and their families. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with three HMOs currently covering about 9% of the Plan's total population in 24 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 2000, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	248,518	28,822	277,340
Active Employee Dependents	134,795	17,376	152,171
Retired Employees	104,305	3,185	107,490
Retired Employee Dependents	17,936	594	18,530
Former Employees & Dependents with Continued Coverage	2,865	381	3,246
Firefighters, Rescue Squad Workers, National Guard Members & Dependents	3	-	3

Total Enrollments	508,422	50,358	558,780
Number of Contracts			
Employee Only	270,322	23,223	293,545
Employee & Child(ren)	38,775	6,006	44,781
Employee & Family	45,764	3,026	48,790
Total Contracts	354,861	32,255	387,116
Percentage of Enrollment by Age			
29 & Under	28.0%	41.6%	29.2%
30-44	20.9	26.6	21.4
45-54	21.3	19.2	21.1
55-64	14.5	9.2	14.0
65 & Over	15.4	3.4	14.3
Percentage of Enrollment by Sex			
Male	39.1%	36.9%	38.9%
Female	60.9	63.1	61.1

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 2000, the self-insured program started its operations with a cash balance of $188 million. Receipts for the year were $930.5 million from premium collections, $9.9 million from investment earnings, and $8.4 million in risk adjustment and administrative fees from HMOs, for a total of $948.8 million in receipts for the year. Disbursements from the self-insured program were $1.056 billion in claim payments and $29.2 million in administration and claims processing expenses for a total of $1.085 billion for the year beginning July 1, 2000. For the fiscal year beginning July 1, 2001, the self-insured indemnity program began the year with a cash balance of only $51 million. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in its current premium rates or a reduction in existing benefits or payments to health care providers or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, mental health case management, pharmacy benefit management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from formularies, and fraud detection) are maintained and improved where possible. Of particular note in these cost containment strategies is that the program's contract with its pharmacy benefit manager, AdvancePCS, calls for a further reduction in claim payments for outpatient prescription drugs for the 2001-03 biennium. Effective July 1, 2001, dispensing fees for pharmacies were reduced from $4.00 to $1.50 per prescription. In addition, ingredient prices for pharmacies were reduced from 90% to 85% of average wholesale price (AWP) for branded drugs and from maximum allowable charges (MAC) by the federal Health Care Financing Administration (HCFA) or 80% of AWP to 45% of AWP for generic drugs. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $187.98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family contract dependents. Claim cost trends are expected to increase 12% annually. Total enrollment in the program is expected to increase about 3% annually over the next two years due to enrollment losses from alternative HMOs. The number of

enrolled active employees is expected to show a 3% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 5% per year. The program is expected to have an increase in the number of active employee dependents and retiree dependents of 2% per year. Investment earnings are based upon a 6% return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

In response to the Plan's financial condition, the Plan has said it needs the following amounts for its self-insured indemnity program to remain solvent during the 2001-2003 biennium:

	($Million)	
2001-2002	2002-2003	Biennium
$382.258	$545.032	$927.290

Of these requirements, Governor Easley recommended the following amounts of additional premium income to be paid on behalf of teachers, state employees, and retired teachers and state employees:

Employer Financing ($Million)	2001-2002	2002-2003	Biennium
General Fund	$150.000	$200.000	$350.000
Highway Fund	7.000	9.000	16.000
Other Employer Funds	30.945	41.176	72.121
Total	$187.945	$250.176	$438.121

The General and Highway Fund parts of this additional premium income are included in both the House and Senate versions of the Appropriation Act for the 2001-2003 biennium. This additional premium income is equivalent to a 30% across-the-board increase in rates effective October 1, 2001. With this increase in premium financing for teachers, state employees, and retired teachers and state employees, premiums for these individuals will continue to be non-contributory. The Plan's Executive Administrator sets the premium rates for spouses and dependent children covered under the Plan by teachers, state employees, and retired teachers and state employees. A 30% across-the-board increase in these premiums effective October 1, 2001, will generate additional premium income paid by employees:

	2001-2002	2002-2003	Biennium
Employee Financing ($Million)	$49.960	$66.477	$116.437

In addition to these amounts of additional premium income for the Plan for the biennium, the Plan's Executive Administrator says he will reduce the program's payments to hospitals and physicians by the following amounts:

Reduced Provider Payments ($Million)	2001-2002	2002-2003	Biennium
Additional 20% Discount on Hospital Outpatient Charges	$19.174	$26.985	$ 46.159
Additional 3.45% Discount on Hospital Inpatient Charges	5.725	7.554	13.279
Additional 13% Discount on Charges for Non-Primary Care Physician Services	23.683	46.766	70.449
Total	$48.582	$81.305	$129.887

Even after a reduction in payments to hospitals and physicians, the program still would need additional financial support. This remaining support comes in the form of benefit reductions. Benefits in the program

have not been reduced since 1991. To remain solvent, the benefit reductions would have to equal the following amounts:

	($Million)	
2001-2002	2002-2003	Biennium
$95.771	$147.074	$242.845

Changes in the benefits of the Plan's self-insured indemnity program were enacted by the General Assembly and signed into law by the Governor effective July 1, 2001.

Assumptions for the Plan's HMO Offerings: Summary data for the Plan's HMO offerings during the last 10 years shows:

	2000	1999	1998	1997	1996	1995	1994
No. of HMOs	3	11	10	12	12	7	7
No. of Counties Covered	24	66	66	90	84	73	72
Most Counties Covered by an HMO	22	39	36	62	61	56	56
Member Copayments							
Inpatient	$75	None	None	None	None	None	None
Emergency Room	$50	None	None	None	None	None	None
Office Visit	$10-$30	$10-$20	$10-$15	$10-$20	$5-$20	$10-$20	$10-$20
Prescrip. Drug	$5-$20	$5-$40	$5-$40	$5-$20	$5-$20	$5-$10	$5-$10
Monthly Premium Over Indemnity Plan							
Individual	$71-$78	$30-$61	$21-$82	$14-$62	$14-$49	$13-$44	$26-$41
Parent/Child	$135-$148	$65-$119	$46-$152	$34-$117	$33-$94	$33-$85	$43-$80
Family	$211-$229	$103-$187	$73-$237	$55-$183	$53-$201	$52-$134	$56-$126
(Non-Medicare Only)							
HMO Memb. Ages							
<30	20,932	51,043	59,945	63,877	57,965	47,445	35,793
Plan Penetration	12.8%	30.8%	35.2%	38.0%	35.1%	29.6%	22.8%
30-44	13,414	33,504	35,897	39,060	36,235	30,750	23,994
Plan Penetration	11.2%	28.0%	30.3%	32.7%	29.9%	25.2%	19.5%
45-54	9,693	24,054	24,962	26,153	23,092	18,816	14,009
Plan Penetration	8.2%	21.0%	22.6%	24.6%	22.7%	19.5%	15.2%
55-64	4,627	10,659	10,852	10,812	9,161	7,412	5,754
Plan Penetration	5.9%	14.3%	15.3%	16.3%	14.5%	12.1%	9.7%
65>	1,692	3,482	3,635	3,618	3,170	2,716	2,270
Plan Penetration	2.1%	4.5%	4.8%	5.0%	4.5%	3.9%	3.4%
Total	50,358	122,742	135,291	143,520	129,623	107,139	81,820
Plan Penetration	9.0%	22.2%	24.8%	26.9%	24.8%	21.1%	16.4%
HMO Memb. Types							
Employees	28,822	70,681	74,413	78,462	70,454	57,898	43,717
Plan Penetration	10.4%	25.8%	27.8%	29.9%	27.4%	23.0%	17.7%

Employ. Depend.	17,376	44,369	52,163	56,361	51,767	43,330	33,606
Plan Penetration	11.4%	28.7%	32.7%	35.6%	33.1%	28.3%	22.2%
Retirees	3,185	5,712	6,682	6,400	5,441	4,390	3,338
Plan Penetration	3.0%	5.6%	6.8%	6.8%	6.1%	5.1%	4.1%
Retiree Depend.	594	1,165	1,334	1,304	1,169	978	738
Plan Penetration	3.2%	6.6%	7.9%	8.2%	7.5%	6.4%	5.0%
Former Memb.	381	815	699	993	792	543	421
Plan Penetration	11.7%	22.0%	20.1%	27.3%	22.7%	16.5%	13.9%
Total	50,358	122,742	135,291	143,520	129,623	107,139	81,820
Plan Penetration	9.0%	22.2%	24.8%	26.9%	24.8%	21.1%	16.4%
HMO Contract Types							
Individual	23,223	54,059	55,100	57,538	51,777	41,134	30,705
Plan Penetration	7.9%	19.0%	20.2%	21.7%	20.1%	16.5%	12.7%
Parent/Child	6,006	14,644	16,564	17,155	14,476	13,261	10,223
Plan Penetration	13.4%	31.7%	35.1%	37.1%	32.6%	29.9%	23.7%
Family	3,026	8,182	9,864	10,767	10,126	8,247	6,373
Plan Penetration	6.2%	17.1%	20.5%	22.8%	21.6%	18.0%	14.0%
Total	32,255	76,885	81,528	85,460	76,379	62,642	47,301
Plan Penetration	8.3%	20.3%	22.2%	23.9%	21.9%	18.4%	14.3%

	1993	1992	1991
No. of HMOs	6	6	4
No. of Counties Covered	50	46	22
Most Counties Covered by an HMO	24	22	22
Member Copayments			
Inpatient	None	None	None
Emergency Room	None	None	None
Office Visit	$5-$20	$5-$20	$5-$15
Prescrip. Drug	$5-$10	$5-$10	$5-$10
Monthly Premium Over Indemnity Plan			
Individual	$24-$41	$17-$29	$8-$19
Parent/Child	$45-$81	$28-$61	$9-$40
Family	$63-$128	$36-$97	$5-$53
(Non-Medicare Only)			
HMO Memb. Ages			
<30	31,581	28,458	22,288
Plan Penetration	20.7%	19.0%	15.0%
30-44	21,773	20,301	16,258
Plan Penetration	17.6%	16.3%	12.9%
45-54	11,649	9,702	7,079
Plan Penetration	13.4%	11.9%	9.3%
55-64	4,818	4,141	3,257
Plan Penetration	8.4%	7.4%	5.9%
65>	1,977	1,644	1,302

Plan Penetration	3.1%	2.6%	2.2%
Total	71,798	64,246	50,184
Plan Penetration	14.8%	13.6%	10.8%
HMO Memb. Types			
Employees	38,324	34,784	26,903
Plan Penetration	15.9%	14.8%	11.8%
Employ. Depend.	29,663	26,499	20,945
Plan Penetration	19.9%	18.0%	14.0%
Retirees	2,781	2,212	1,680
Plan Penetration	3.5%	3.0%	2.3%
Retiree Depend.	673	523	434
Plan Penetration	4.6%	3.6%	3.0%
Former Memb.	357	228	222
Plan Penetration	12.8%	8.7%	6.7%
Total	71,798	64,246	50,184
Plan Penetration	14.8%	26.9%	10.8%
HMO Contract Types			
Individual	26,682	24,132	18,385
Plan Penetration	11.4%	10.7%	8.6%
Parent/Child	9,057	7,848	6,023
Plan Penetration	21.7%	19.3%	15.1%
Family	5,599	5,164	4,311
Plan Penetration	12.4%	11.4%	9.1%
Total	41,338	37,144	28,719
Plan Penetration	12.9%	11.9%	9.5%

This summary data is based upon statistics on December 31st of each year. For the same ten-year period, the Plan assessed HMOs a monthly administrative fee of $1.00 per contract and the following monthly risk selection fees per affected enrollee in the HMOs:

Age of Enrollee	1991-1997	1998-2000
2 and Under	None	$12.00
3-4	None	$12.00
5-19	$12.00	$12.00
20-29	$18.00	$18.00
30-39	$16.00	$16.00
40-49	$6.00	$2.00
50 and Over	None	None

The total amount of fees collected by the Plan from HMOs have been:

	($Million)		($Million)
Year	Fees	Year	Fees
1990-1991	$3.139	1995-1996	$7.697
1991-1992	$3.477	1996-1997	$13.365
1992-1993	$4.813	1997-1998	$16.803
1993-1994	$5.778	1998-1999	$16.473
1994-1995	$6.104	1999-2000	$14.516

An additional factor expected to impact the bill is the availability of primary care physicians on a statewide basis within North Carolina. According to 1999 information provided by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, there are eight counties within the State that have less than 5 family practitioners, general practitioners, and internists. These same counties had an October, 2000, enrollment of over 7,000 members of the Plan. Another nine counties have 5 but less than 10 family practitioners, general practitioners, and internists. The Plan had another 11,000 enrollees in these counties as of October, 2000. As far as OB/Gyn physicians are concerned, twenty-eight counties within the State do not have an OB/Gyn practitioner. These counties had an enrollment of over 38,000 members in the Plan in October, 2000. Another seventeen counties in the State have one but less than three OB/Gyn physicians. The Plan had an enrollment of over 55,000 in these counties in October, 2000. Furthermore, twenty-four counties within the State do not have a pediatrician. The Plan had an enrollment of 31,000 members in these counties in October, 2000. Another sixteen counties have one but less than three pediatricians. The Plan had an enrollment of over 42,000 members in these counties in October, 2000.

Assumptions for the Plan's Counties with 10,000 Members and Medical Management Programs: In October, 2000, the Plan had the following counties with an enrollment of at least 10,000 members: Wake (64,232), Mecklenburg (27,108), Guilford (24,576), Orange (19,642), Durham (16,677), Cumberland (15,474), Pitt (15,047), Forsyth (14,660), Buncombe (12,602), Wayne (12,147), Johnston (10,971), and Burke (10,139). The medical management components of the Plan's self-insured indemnity program include mental health case management, pharmacy benefit management, case management for high risk maternity, organ transplants, extended home health, private duty nursing, extended skilled nursing facility stays, extended hospital stays, HIV, metastatic cancer, spinal cord injuries, traumatic brain injuries, and conditions with death expected within 6 months, disease management for diabetes and cardio-vascular disease, pre-admission and length-of-stay certification for hospital inpatient admissions, and prior approval of certain durable medical equipment, extended ambulance services, outpatient physical, occupational, and speech therapies, private duty nursing, skilled nursing facility stays, home care aide services, hospice care, and certain other surgical procedures.

Assumptions for the Plan's Long-Term Care Benefits Program: The Plan has since February, 1998 offered a long-term care benefits program to members of the Plan as well as to retired members of the Local Governmental Employees' Retirement System. These benefits are provided through an insurance contract with MedAmerica Insurance Company. This contract expires December 31, 2003, although the Plan can extend the contract through December 31, 2005. The Plan can cancel this contract upon 180 days notice. Benefits include the following daily amounts for nursing home or home care: $75, $100, $125, or $150. Daily benefits for assisted living facility care are $60, $80, $100, and $120. Inflation protection can be chosen for these daily amounts. Benefit periods can be for 2 years, 3 years, 5 years, or for a lifetime. Elimination periods can be for 30, 60, or 90 days. An option is also available for no elimination period. Other optional features include a return of premium death benefit, a shortened benefit period upon failure to pay premiums, and a 10-year paid in full premium. At the beginning of August, 2001, the Plan had the following coverages issued:

	Employees	Spouses	Children	Parents/G'Parents	Total
State Employees	864	214	10	66	1,154
State Retirees	1,567	453	18	10	2,048
Local Retirees	182	85	1	2	270
Total	2,613	752	29	78	3,472

The annualized premium for these coverages was $4,836,773.

Assumptions for the Plan's Confidential Expenditures: For each of the last six fiscal years, the following expenditures are representative of those that could be confidential and exempt from the State's public record laws.

($Million)

1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01

Cost Categories

Hospital						
Inpatient Room & Board	$8.938	$7.015	$7.353	$8.092	$7.178	$8.242
Inpatient Ancillaries	$14.736	$11.443	$12.301	$13.129	$14.496	$17.203
Inpatient DRGs	$172.081	$135.536	$140.456	$143.044	$144.143	$172.532
Total Inpatient	$195.755	$153.994	$160.110	$164.265	$165.817	$197.977
Outpatient Ancillaries	$103.770	$111.346	$125.213	$146.009	$168.118	$216.646
Total Hospital	$299.525	$265.340	$285.323	$310.274	$333.935	$414.623
Medical, Surgical, Other Professional Services						
Medical	$58.161	$61.915	$67.390	$75.670	$75.139	$88.507
Surgical	$64.025	$64.961	$68.362	$77.346	$87.655	$102.612
Dental	$0.192	$0.219	$0.164	$0.159	$0.199	$0.156
Anesthesia	$11.906	$11.479	$11.219	$11.544	$15.196	$16.335
Pathology	$4.282	$4.485	$5.135	$5.768	$6.783	$8.253
Radiology	$19.363	$20.856	$22.812	$27.487	$34.267	$42.776
Laboratory	$21.374	$23.150	$26.664	$30.596	$37.317	$45.999
Chemotherapy	$2.553	$3.325	$3.504	$4.396	$5.092	$5.899
Inhalation Therapy	$0.038	$0.046	$0.051	$0.071	$0.096	$0.135
Radiation Therapy	$2.976	$3.043	$3.255	$4.369	$5.077	$5.681
Physical Therapy	$0.000	$0.000	$0.000	$1.093	$6.087	$7.648
Speech Therapy	$0.082	$0.071	$0.096	$0.109	$0.146	$0.207
Cardiac Rehabilitation	$0.009	$0.003	$0.000	$0.001	$0.000	$0.000
Chemical Dependency	$0.507	$0.397	$0.379	$0.388	$0.373	$0.398
Diabetes Education	$0.008	$0.010	$0.008	$0.009	$0.007	$0.000
Chiropractic	$5.504	$6.323	$7.012	$7.203	$8.731	$10.719
Podiatry	$0.844	$0.834	$0.973	$1.056	$1.156	$1.410
Other	$4.963	$15.053	$15.792	$15.709	$13.738	$15.451
Total Services	$196.787	$216.170	$232.816	$262.974	$297.059	$352.186
Outpatient Prescription Drugs	$69.626	$77.711	$91.793	$115.001	$172.714	$260.195
Skilled Nursing Facilities	$11.043	$12.418	$12.213	$12.346	$11.069	$9.872
Home Health	$5.972	$5.754	$5.194	$3.592	$3.465	$2.894
Hospice	$0.747	$0.629	$0.571	$0.639	$0.728	$0.872
Private Duty Nursing	$2.082	$1.883	$1.967	$1.839	$1.517	$1.825
Medical Equipment & Supplies	$0.868	$0.938	$0.910	$1.114	$1.102	$1.237
Ambulance Service	$0.051	$0.056	$0.059	$0.025	$0.034	$0.023
Other	$1.983	$5.243	$20.256	$10.734	$6.872	$28.703
TOTAL GROSS CLAIMS	$588.684	$586.142	$651.102	$718.538	$828.495	$1,072.430

Assumptions for the Plan's Use of Clinical Pharmacist Practitioners: According to the Board of Pharmacy, 9 pharmacists have been approved as clinical pharmacist practitioners to date in North Carolina. These pharmacists reside in the following counties: Guilford (4), Buncombe (2), Orange (2), and Rockingham (1).

Assumptions for the Plan's Potential Enrollment for Optional Benefits and Reduced Premiums: The estimated number of employee and child(ren) and employee and family contracts by employee income for the Plan's active employee group as of December 31, 2000, shows:

	Indemnity Program	HMOs	Total
Employee & Child(ren)-Tot.	36,756	5,871	42,627
Earnings less than $29,000	13,915	2,266	16,181
Earnings of $29,000-$35,000	5,562	906	6,468
Earnings of $35,000-$40,000	4,162	678	4,840

Earnings of $40,000-$44,000	4,015	654	4,669
Earnings of $44,000-$50,000	4,089	666	4,755
Earnings over $50,000	5,013	701	5,830
Employee & Family-Tot.	31,945	2,653	34,598
Earnings less than $29,000	10,145	883	11,028
Earnings of $29,000-$35,000	3,716	324	4,040
Earnings of $35,000-$40,000	3,099	270	3,369
Earnings of $40,000-$44,000	3,416	298	3,714
Earnings of $44,000-$50,000	3,667	319	3,986
Earnings over $50,000	7,902	559	8,461

Assumptions for the Plan's Limited Coverage of Erectile Dysfunction Drugs: For the period January through November, 2000, the claims experience for erectile dysfunction outpatient prescription drugs for the Plan's self-insured indemnity program was:

Drug Name	No. of Members	No. of Prescriptions	No. of Pills
Caverject	187	420	2,815
Edex	1	2	12
Edex Cartridge Starter Pack	5	10	29
Edex Patient Pack	20	42	269
Muse	188	354	2,387
Viagra	9,399	27,450	322,815
Total	9,800	28,278	328,327
Average Charge		$107.86	$9.29
Average Allowed Charge		$100.28	$8.64
Average Paid		$84.80	$7.30

For the period January, 1999, through June, 2000, approximately 81% of the number of members of the self-insured indemnity program receiving Viagra pills received 54 or fewer for the 18-month period. However, the remaining 19% accounted for 56% of the total number of pills received.

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, Senate Committee Substitute for Senate Bill 822, September 14, 2001, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Committee Substitute for Senate Bill 822, September 14, 2001, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None.
FISCAL RESEARCH DIVISION 733-4910

PREPARED BY: Sam Byrd

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DATE: September 17, 2001

Signed Copy Located in the NCGA Principal Clerk's Offices