NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 1038

SHORT TITLE: No Abortions under State Health Plan

SPONSOR(S): Rep. Capps

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

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

BILL SUMMARY: The bill would remove abortions from coverage of the Teachers' and State Employees' Comprehensive Major Medical Plan. The bill applies to the Plan's self-insured indemnity program and any alternative coverage provided by health maintenance organizations (HMOs) offered by the Plan.

EFFECTIVE DATE: When the bill becomes law.

ESTIMATED IMPACT ON STATE: Both the consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, project the bill to have additional cost for the Plan's self-insured indemnity program based upon the number of foregone abortions expected to result in additional cost to the program for the deliveries and newborn care of babies. A comparison of the net cost increases is:

Delivery	Fiscal Year 2001-02		Fiscal Year 2002-03	
Percentage	Aon	Hartman	Aon	Hartman
25%	$283,408	$301,120	$378,036	$390,252
50%	$1,543,766	$1,572,129	$2,082,479	$2,037,479
75%	$2,813,258	$2,843,137	$3,775,085	$3,684,706

Aon Consulting consequently projects the cost of the bill to be $1.5 million for fiscal year 2001-02 and $2.1 million for fiscal year 2002-03. Both actuaries projected the cost of abortion expenses saved by the bill for fiscal year 2001-02 to be some $1.2 million and $1.3 million for fiscal year 2002-03.

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., $250

annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. 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 beginning cash balance of $188 million. Receipts for the year are estimated to be $929 million from premium collections, $10 million from investment earnings, and $8 million in risk adjustment and administrative fees from HMOs, for a total of $947 million in receipts for the year. Disbursements from the self-insured program are expected to be $1.085 billion in claim payments and $31 million in administration and claims processing expenses for a total of $1.116 billion for the year beginning July 1, 2000. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $19 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, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from 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 will be reduced from $4.00 to $1.50 per prescription. In addition, ingredient prices for pharmacies will be 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.

Assumptions for Indemnity Plan's Abortion and Maternity Claims: The latest data provided by the Plan for abortion expenses shows the following claims experience for the Plan's self-insured indemnity program for three calendar years:

	No. of Cases	Billed Charges	Allowed Charges	Paid Claims
Calendar Year 1999				
Employees	358	$943,950	$861,048	$646,591
Spouses	73	182,558	166,081	99,278
Total	431	$1,126,508	$1,027,129	$745,869
Calendar Year 1998				
Employees	350	$839,275	$750,738	$570,788

Spouses	57	168,034	151,376	82,968
Total	407	$1,007,309	$902,114	$653,756
Calendar Year 1997				
Employees	340	$787,797	$723,427	$554,073
Spouses	52	105,020	96,997	56,598
Total	392	$892,817	$820,424	$610,671

Hospital (DRG) claims for the Plan's self-insured indemnity program for calendar year 2000's delivery and newborn care reveal that normal vaginal deliveries and cesarean sections with and without complications and high risk vaginal deliveries and cesarean sections with and without complications had average charges of $4,305, average allowed charges of $3,657, and average paid charges of $3,176 for 3,318 admissions. Hospital (DRG) claims for newborn care for the same period showed average charges of $3,060, average allowed charges of $2,597, and average paid charges of $2,404 for 2,749 admissions. Average professional charges for 2,904 inpatient hospital admissions for vaginal deliveries and cesarean deliveries for fiscal year 1999-2000 in the Plan's self-insured indemnity program amounted to some 75% of the average amount of hospital charges.

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, House Bill 1038, May 7, 2001, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, House Bill 1038, May 1, 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

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