NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 199, Third Edition, Sections 4.5, 4.7, & 7.

SHORT TITLE: Managed Care Patients' Bill of Rights

SPONSOR(S): Sen. Wellons

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: Only three sections of the bill affect the Teachers' and State Employees' Comprehensive Major Medical Plan. These sections are:

Section 4.5. Health Plan External Review. Standard and expedited external review procedures are established for insurers to assure that covered individuals have the opportunity for an independent review of coverage decisions made by the insurers. Independent reviews will be conducted by the North Carolina Department of Insurance, which would assign a request for external review to a qualified independent review organization. Insurers would be required to pay the Department of Insurance for the costs incurred by the Department in conducting the review. Requests can be made for an external review of a noncertification decision by an insurer within 60 days after exhausting internal grievance opportunities, unless the internal appeals are waived by an insurer. "Noncertification" means a determination that an admission, availability of care, continued stay, or other health care services have been reviewed, and based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard of coverage in emergency situations, and the requested service is denied, reduced, or terminated. Noncertification does not however apply to decisions rendered solely on the basis that a service is not a covered service. After reviewing a case, a review organization would either uphold or reverse a noncertification decision within 45 days after receipt of a request for a standard review or within a period set by the Department of Insurance for an expedited review when the life or health or ability to regain maximum function of an insured is jeopardized. The review decision would be binding upon insurers.

For members of the Teachers' and State Employees' Comprehensive Major Medical Plan, an external review can be made after a Plan member has exhausted second level internal review opportunities. The section applies to utilization review activities of the Plan's self-insured indemnity program and to alternative health maintenance organization (HMO) coverages offered by the Plan, whether insured or self-insured. The section also applies to the Health Insurance Program for Children which is administered by the Plan.

Section 4.7. Health Plan Liability. Managed care entities would be subject to liability for damages for their harm to an insured caused by their failure to exercise ordinary care. Managed care entities are insurers that have systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered to their insured. Ordinary care is the degree of care that, under the same or similar circumstances, a managed care entity would have used under ordinary prudence at the time a health care decision is made. Managed care entities would be liable for the decisions of its employees, agents, and other representatives over which they have sufficient influence or control. Before an action can be brought

against a managed care entity, an insured must have exhausted all administrative remedies and appeals, including external review procedures. An insured who has been found to have been harmed by a managed care entity is entitled to recover actual or nominal damages plus allowable punitive damages equal to the greater of three times the amount of compensatory damages or $250,000.

The section applies to the managed care components of the Plan's self-insured indemnity program and to alternative health maintenance organization (HMO) coverages offered by the Plan on a self-insured basis. The section also applies to the managed care components of the Health Insurance Program for Children which is administered by the Plan. The Plan's maximum liability for each tort claim occurrence is $500,000.

Section 7. Responsibilities of State Employee Health Benefit Plan's Executive Administrator. The State Employee Health Benefit Plan's managed care practices used for cost management programs are subject to:

G.S. 58-3-191: Disclosure of Managed Care Requirements. Insurers are required to give insureds an explanation of utilization review criteria used, reasons for denial of recommended treatments, formularies and prior approvals required for prescription drugs, and criteria used for determining experimental treatments, procedures, or tests.

G.S. 58-3-221: Access to Restricted Access Prescription Drugs. Coverage is provided for restricted access drugs and devices when an insured's physician certifies that an alternative non-restricted access drug on a closed formulary is ineffective in treating the insured's medical condition or is detrimental to the insured's health

G.S. 58-3-223: Access to Medical Specialists. When an insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, coverage for an extended or standing referral to contracting specialists and sub-specialists, or non-contracting specialists and sub-specialists when contracting professional are not reasonably available, for up to 12 months is provided with consultation of a primary care physician. An insured is not penalized financially for use of non-contracting specialists and sub-specialists when contracting specialists and sub-specialists are not reasonably available.

G.S. 58-3-235: Medical Specialists as Primary Care Physicians. When an insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, a specialist may be designated by the insured as a primary care physician.

G.S. 58-3-240: Pediatricians as Primary Care Physicians for Children. Contracting pediatricians may be chosen by insureds as primary care providers for children.

G.S. 58-3-245: Provider Directory Disclosure. Printed or electronic directories of health care providers available to insured are required of insurers at least annually.

G.S. 58-3-250: Benefit Payment Obligation Disclosure. An insurer must disclose how benefits are calculated and the financial obligations of all parties involved in a medical service, including which party is responsible for filing claims and how much of health care provider's charge is above an insurer's allowance and how much is required to be paid by an insured.

G.S. 58-3-265: Prohibition on Medical Care Provider Incentives. An insurer is prohibited from providing any financial or other incentive to contracting health care providers for denying, reducing, withholding, limiting, or delaying medically necessary and appropriate individual health care services.

G.S. 58-50-30: Discrimination on Selection of Medical Care Providers Prohibited.

An insured may select duly-licensed and contracting optometrists, podiatrists, certified clinical social workers, certified substance abuse professionals, licensed professional counselors, dentists, chiropractors, psychologists, pharmacists, certified fee-based practicing pastoral counselors, advanced practice nurses, and physician assistants to provide covered services within their scopes of practice. These medical professionals cannot be denied a provider contract solely on the basis of license or certification, or on the basis that medical professionals lack hospital privileges unless hospital privileges could be reasonably expected.

G.S. 58-67-88: Continuity of Care. When a provider contract is terminated with an HMO, coverage can be continued for treatment by the terminated provider for special ongoing medical conditions. For a terminal illness in which an insured has a life expectancy of 6 months or less, coverage can be continued for life. For pregnancy, coverage can be continued through 60 days of postpartum care. For scheduled surgery, organ

transplantation, and other inpatient care, coverage can be continued through 90 days of follow-up care following discharge. For other medical conditions, coverage can be continued for 90 days.

These statutory requirements would apply to the Plan's self-insured indemnity program and to alternative health maintenance organization (HMO) coverages offered by the Plan, whether insured or self-insured. The requirements also apply to the Health Insurance Program for Children which is administered by the Plan.

EFFECTIVE DATE: Sections 4.5 and 4.7 become effective March 1, 2002. Section 7 becomes effective when it becomes law.

ESTIMATED IMPACT ON STATE: The estimated impact upon the Teachers' and State Employees' Comprehensive Major Medical Plan is:

External Review**:** Based upon information provided by the Comprehensive Major Medical Plan for Teachers' and State Employees, the Plan's consulting actuary, Aon Consulting, estimates the additional cost of external review to the Plan's self-insured indemnity program for fiscal year 2001-02 to be $218,000, and $373,000 for fiscal year 2002-03. These additional costs assume that the program experiences 90-110 second level grievances per year, and that 50% or 50-55 of these grievances will be requested for external review. At a range of average appeal costs of $2,855 to $3,555, these 50-55 cases assumed to request external review is estimated to cost $157,000 to $190,000 per year. In addition, Aon Consulting expects about 10% of the cases involved in external review to be decided in favor of the members of the program requesting external reviews. These 4 to 6 cases per year are estimated to cost the program an additional $160,000 to $240,000. Total costs of external review are estimated to be of $317,000 to $430,000 per year, with a mid-point cost of $373,000 per year. Based upon the same information provided by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, estimates the additional costs to the Plan to be $310,000 for fiscal year 2001-02 and $590,000 for fiscal year 2002-03. Hartman and Associates estimates the same number of cases for external review as Aon Consulting, but expects a higher average cost for reviews decided in favor of the program members requesting the reviews. However, since external review activities do not become effective until March 1, 2002, pro-rated costs for fiscal year 2001-02 are estimated by Aon Consulting to be $62,000 and by Hartman and Associates to be $88,000.

Liability: Based upon information provided by the Plan and studies by consulting firms, research organizations, managed care entities, and governmental agencies, Aon Consulting estimates the additional costs from exposure to liability claims to be $3,800,000 for the managed care components of the Plan's self-insured indemnity program and $4,700,000 for the Plan's proposed self-insured HMO for the 2002-03 fiscal year. Based upon similar information, Hartman and Associates estimates the additional costs from the Plan's exposure to liability claims to be $3,420,000 for the managed care components of the Plan's self-insured indemnity program and $4,688,000 for the Plan's proposed self-insured HMO.

In summary, Aon Consulting estimates the total cost to the Teachers' and State Employees' Comprehensive Major Medical Plan to be $66,000 for fiscal year 2001-02 and $8,873,000 for fiscal year 2002-03. Hartman and Associates estimates the total cost to be $88,000 for fiscal year 2001-02 and $8,698,000 for fiscal year 2002-03. The Executive Administrator of the Plan says that an additional amount not to exceed $200,000 per year will be needed by the Plan and its claims processing contractor to further comply with the provisions of the bill. These estimated additional costs to the Plan should not require any additional General Fund or Highway Fund appropriations for the Plan during the 2001-03 biennium. The reason is that the benefit changes enacted by the General Assembly and signed into law by the Governor effective July 1, 2001, will produce savings to the Plan of $265.4 million for the 2001-03 biennium according to Aon Consulting. The amount of savings that the Plan said it needed from benefit reductions for the 2001-03 biennium amounted to $242.8 million, leaving a working balance for the Plan during the biennium of $22.6 million which is sufficient to cover the estimated additional cost to the Plan from external review, liability, and administrative items.

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 Indemnity Plan's Appeals Process and Managed Care Entities: The internal appeals process for the Teachers' and State Employees' Comprehensive Major Medical Plan starts with a Plan member's inquiry to the Plan's claims processing contractor or case/benefit manager. The inquiry can be made by telephone or in writing for information on the status of a claim, the reason for a claim decision, administrative issues or general information about the benefits and provisions of the Plan. Inquiries generally involve eligibility criteria, enrollment procedures, Medicare benefits, claim submission procedures, benefit payments, and claim denials. An inquiry may be followed by an appeal of a benefit decision or administrative matter. An appeal is a formal written request of the Plan's claims processing contractor or case/benefit manager to review a decision involving a benefit determination or claim denial. An appeal is made only when the inquiry process is exhausted. The Plan has three levels of internal appeal. The Plan's claims processing contractor or case/benefit manager offers the first and second levels of appeal while the Plan's Executive Administrator and Board of Trustees offer the third level of appeal. An appeal must be submitted within 60 days of receiving a benefit decision or claim denial unless the 60-day time limit is waived by the Plan for extenuating circumstances. The first and second levels of internal appeal may be combined when an appeal is denied because of specific statutory limitations. Second level appeals normally involve new information that was not available during a first level review and may involve the use of independent medical consultants. When a Plan member has a short or tenuous life expectancy and is not likely to survive the time that it takes to complete the internal appeals process, the process may be expedited at the discretion of the Plan and the claims processing contractor or case/benefit manager.

Following the Plan's internal appeals process, a Plan member who is still aggrieved may file an informal contested case petition with the State's Office of Administrative Hearings where an administrative law judge may issue a recommended decision or order. A recommended decision or order is returned to the Plan for concurrence. The Plan's Executive Administrator can concur with the recommended decision or order or not concur. The decision of the Plan's Executive Administrator is final and may be further appealed by a Plan member to superior court for judicial review. In a separate action, an aggrieved Plan member could file a tort claim with the North Carolina Industrial Commission citing negligence on the part of any officer, employee, involuntary servant or agent of the Plan while acting within the scope of his or her office, employment, service, agency or authority. Upon a finding of negligence, the Commission may award damages, including medical and other expenses, up to a cumulative amount of $500,000 per occurrence.

For the last three calendar years, the Plan's self-insured indemnity program has had 65 second level grievances in 1998, 91 in 1999, and 79 in 2000. Of this 235 total number of second level grievances, 110 were further appealed to the Plan's Executive Administrator and Board of Trustees for a further appeal percentage of some 47%. Appeal costs are estimated to range from $300 reported by the Department of Insurance to $5,500 reported by the claims processing contractor of the Plan's self-insured indemnity program, Blue Cross and Blue Shield of North Carolina.

The Plan's managed care efforts have included the managed care components of the Plan's self-insured indemnity program and alternative coverages by alternative health maintenance organizations (HMOs). The managed care 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.

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. However, none of the State's HMOs responded to a Request for Proposals from the Plan to continue fully-insured HMO options for Plan members

past September 30, 2001. Consequently, the Plan's Executive Administrator says he intends to offer a self-insured HMO alternative to the Plan's self-insured indemnity program under the following circumstances: (a) the Plan will competitively select only one open access HMO that will be required to have a viable health care provider network in all of the State's 100 counties; (b) the HMO 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 HMO on an insured arrangement. Due to the time required to establish a self-insured HMO option, the Plan is not intending to have the option available until July 1, 2002. Consequently, effective July 1, 2002, the Plan is estimated to have the following enrollments and annual premium base:

	Indemnity Program	Self-Insured HMO	Plan Total
Estimated Membership	410,000	150,000	560,000
Estimated Annual Premiums	$1,023,386,000	$348,614,000	$1,372,000,000

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, Proposed Amendment to House Health Committee Substitute for Senate Bill 199, August 14, 2001, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Proposed Amendment to House Health Committee Substitute for Senate Bill 199, August 15, 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.

-Actuarial Note, Hartman & Associates, Senate Bill 218, March 28, 2001, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 218, March 294, 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.

-Actuarial Note, Hartman & Associates, Senate Bill 822, May 10, 2001, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 822, April 24, 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.

-Actuarial Note, Hartman & Associates, House Committee Substitute for Senate Bill 1005, Sections 32.20(a) through (s), June 21, 2001, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, House Committee Substitute for Senate Bill 1005, Sections 32.20(a) through (s), June 21, 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.

-Actuarial Note, Hartman & Associates, Senate Committee Substitute for Senate Bill 1005, Sections 32.20(a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), and (p), May 25, 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 1005, Sections 32.20(a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), and (p), May 28, 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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DATE: August 20, 2001

Signed Copy Located in the NCGA Principal Clerk's Offices