NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 1005, Fourth Edition

SHORT TITLE: The Current Operations & Capital Improvements Appropriations Act of 2001 (Sections 32.20 (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), and (s))

SPONSOR(S): Representatives Redwine, Easterling, Oldham, Thompson, and Wright

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: According to available information from the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan, the Plan's self-insured indemnity program needs over $927 million in additional financial support to remain solvent and maintain minimum claim stabilization reserves for the 2001-2003 biennium. This amount of additional financial support is a net requirement for the biennium after realizing $192.708 million in reduced outpatient prescription drug claim costs from the program's pharmacy benefit manager according to the Plan ($86.876 million in 2001-2002 and $105.832 million in 2002-2003). This additional financial support can come from additional premium income, additional sources of income, reductions in payments to health care providers, a reduction in benefits provided to members of the program, a reduction in the number of members covered by the program, or from a combination of these avenues. A breakdown of this required additional financial support is:

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

From these requirements can be deducted the additional funding provided by this Act in the way of premiums paid on behalf of teachers, state employees, and retired employees by employing agencies and the State Retirement Systems:

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

This additional premium financing is equivalent to a 30% across-the-board premium rate increase effective October 1, 2001. The Plan's Executive Administrator has the statutory authority to set the premium rates for the spouses and dependent children of teachers, state employees, and retired employees who elect to pay for parent and child and family coverage. If the Executive Administrator were to increase the premium amounts

paid by employees and retired employees for their family members by 30% across-the-board effective October 1, 2001, he says that the additional premium income to the program will be:

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

After realizing the additional premium income provided by this Act and the anticipated premium income to be provided by the Plan's Executive Administrator, the program's financial condition would still be in a deficit position. However, the Plan's Executive Administrator reports that he can reduce payments to the providers of health care by the following amounts during the 2001-2003 biennium:

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

Assuming that the Plan's Executive Administrator is able to realize the full amount of claim cost savings that he maintains from cuts in payments to hospitals and physicians, the Plan's self-insured indemnity program would still continue to be in a deficit situation. Consequently, the Plan's Executive Administrator has recommended cuts in the benefits to members of the Plan's self-insured indemnity program. The net amount of these recommended benefit reductions for the 2001-2003 biennium is:

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

The special provisions contained in the referenced sections of this Act reflect the amount of the benefit reductions recommended by the Plan's Executive Administrator. Subsections (a), (b), & (e) increase the program's annual deductible from $250 to $350 per individual and from $750 to $1,050 per employee and child(ren) or employee and family contracts; (b) requires the program to honor a member's assignment of benefits to non-network providers of health care services and requires the program to contract with network hospitals within 10 days after delivery of an executed contract; (c) & (l) eliminate required second surgical opinions; (d) increases outpatient prescription drug copayments for each prescription from $15 to $25 for branded drugs, from $20 to $35 for branded drugs with generic equivalents, and from $25 to $40 for non-formulary or non-preferred formulary drugs, sets a $2,500 annual limit on copayments paid by members of the program, continues the program's open formulary for drugs, and requires prior approval for growth hormone, weight loss, and anti-fungal drugs; (e) & (l) increase the program's maximum annual out-of-pocket for the 20% coinsurance paid by members of the program from $1,000 to $1,500 with an annual limit of $4,500 per employee and child(ren) or employee and family contract; (f) clarifies that hospital inpatient costs include speech and occupational therapy; (g) & (k) eliminate 30 days of skilled nursing facility care following a hospitalization and limits coverage for stays to 100 days per year for each medical condition; (h) & (j) provide coverage for therapeutic shoes for diabetes and other high-risk conditions up to $350; (i) increases coverage for cardiac rehabilitation from $650 annually to the greater of $1,800 or charges for 90 days within 6 months after a hospital discharge or other qualifying event for cardiac conditions; (k) requires prior approval for varicose vein surgery, botulinium toxin, and growth hormone, weight loss, and anti-fungal outpatient prescription drugs; (l) , (n), & (o) increase the hospital inpatient copayment from $75 to $100, add a $50

copayment for hospital outpatient and ambulatory surgical facility services with allowable charges exceeding $500, increase the hospital emergency room copayment from $50 to $100, increase the physician office visit copayment from $10 to $15, add a $15 copayment for visits to other professional providers of health care services, and add a $15,000 annual limit on coinsurance out-of-pockets expenses per employee and child(ren) or employee & family contract for use of non-network providers; (m) increases the program's maximum lifetime benefit from $2 million to an unlimited amount; (p) requires compliance with the State's laws on prompt payment to providers of medical services beginning January, 2002; (q) requires advance written notice to interested persons on proposed rules and regulations; and (r) requires development of a prospective payment system for hospital outpatient and ambulatory surgical facility services and a medical fee schedule for professional providers of medical services by January, 2003, for implementation no sooner than July, 2003.

With the additional premium income provided by this Act and expected to be provided by the Plan's Executive Administrator, and the cuts in payments to hospitals and physicians and the benefit reductions recommended by the Plan's Executive Administrator, the Plan's self-insured indemnity program is projected to end the 2001-2003 biennium with a cash balance of $102.4 million of which only $3.7 million would not be obligated, according to the Plan.

It must be noted that the data on the amount of financial support included in this Summary comes from the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan and not from the General Assembly's Fiscal Research Division nor from its consulting actuary.

EFFECTIVE DATE: All subsections are effective July 1, 2001, except for subsection (p) which becomes effective January 1, 2002.

ESTIMATED IMPACT ON STATE: Based upon information provided by the Plan, its consulting actuary, Aon Consulting, estimates that the referenced provisions of the bill will result in a net cost reduction to the Plan's self-insured indemnity program of $113.1 million in fiscal year 2001-2002 and $147.8 million in fiscal year 2002-2003 for a total net cost reduction for the 2001-2003 biennium of $260.9 million. Aon Consulting's estimate has $121.2 million in total cost reductions for 2001-2002 and $159.8 million for 2002-2003 for a total of $281 million for the biennium. Aon Consulting's estimate has a total increase in the program's cost of $8.1 million in 2001-2002 and $12 million in 2002-2003 for a total increase in cost for the biennium of $20.1 million. Based upon information available from the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, estimates the referenced provisions of the bill will result in a net cost reduction to the Plan's self-insured indemnity program of $128.4 million in fiscal year 2001-2002 and $167.5 million in fiscal year 2002-2003 for a total net cost reduction of $295.9 million for the 2001-2003 biennium. Hartman and Associates' estimate has $130.6 million in total cost reductions for 2001-2002 and $170.7 million for 2002-2003 for a total of $301.3 million for the biennium. Hartman and Associates' estimate has a total increase in the program's cost of $2.2 million in 2001-2002 and $3.2 million in 2002-2003 for a total increase in cost for the biennium of $5.4 million.

The differences in the cost reduction estimates between Aon Consulting and Hartman and Associates are:

	2001-2002		2003-2003	
	Aon Consulting	Hartman & Associates	Aon Consulting	Hartman & Associates
Increased Deductibles	$25.4 Million	$32.1 Million	$32.7 Million	$39.2 Million
Increased Coinsurance Out-of-Pocket	$14.1 Million	$26.2 Million	$21.9 Million	$37.5 Million
Increased Drug				

Copayments	$57.8 Million	$48.5 Million	$72.0 Million	$63.7 Million
100 Day Limit Per Condition on Skilled Nursing Facility Care	$1.5 Million	$0.3 Million	$2.0 Million	$0.4 Million
Second Surgical Opinions Eliminated	$0.3 Million	$0.4 Million	$0.4 Million	$0.5 Million
Prior Approval of Botox/Anti-Fungal Drugs	$0.5 Million	$0.3 Million	$0.7 Million	$0.4 Million
Increased Office Visit Copayments	$4.7 Million	$5.7 Million	$6.6 Million	$7.0 Million
Copayments for Visits to Other Professionals	$7.7 Million	$8.1 Million	$10.7 Million	$10.4 Million
Increased Hospital Inpatient Copayments	$0.8 Million	$0.8 Million	$1.1 Million	$1.0 Million
Hospital Outpatient Copayments Added	$7.2 Million	$6.8 Million	$10.0 Million	$9.0 Million
Increased Hospital Emergency Room Copayments	$1.2 Million	$1.4 Million	$1.7 Million	$1.6 Million
Total	$121.2 Million	$130.6 Million	$159.8 Million	$170.7 Million

The differences in the cost increase estimates between Aon Consulting and Hartman and Associates are:

	2001-2002		2003-2003	
	Aon Consulting	Hartman & Associates	Aon Consulting	Hartman & Associates
Increased Lifetime Benefit	$6.4 Million	$1.4 Million	$10.0 Million	$2.1 Million
Annual Limit on Drug Copayments	$1.7 Million	$0.8 Million	$2.0 Million	$1.1 Million
Total	$8.1 Million	$2.2 Million	$12.0 Million	$3.2 Million

The projection of Aon Consulting for the increased lifetime benefit is based upon Aon's proprietary rating manual and claimant distributions. The projection of Hartman and Associates is based upon the Society of Actuaries' Group Medical Insurance Large Claims Database Collection and Analysis Report.

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 Changes in the Indemnity Plan's Benefits:

Overall Finances: Since the benefits in the Plan's self-insured indemnity program have not suffered any reductions since July 1, 1991, with an overall premium increase of only once since that time (30% increase in October, 1999), an overview of the program's financial condition for the last six years shows:

($ Million)	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
BEGINNING BALANCE	$193.205	$287.088	$348.944	$368.255	$384.924	$334.140	$234.145
RECEIPTS							
Premiums Due	$596.526	$601.680	$587.139	$574.459	$569.901	$592.920	$765.552
Plus: Receivables (Prior)	$0.162	$0.100	$0.103	$0.770	$0.291	$0.276	$0.194
Sub-Total	$596.688	$601.780	$587.242	$575.229	$570.192	$593.196	$765.746
Less: Receivables (Current)	$0.100	$0.103	$0.770	$0.291	$0.276	$0.194	$0.263
Premium Receipts							
Employees	$352.709	$355.357	$341.011	$328.462	$321.901	$334.388	$432.624
Retirees	$108.897	$113.039	$117.259	$121.477	$125.550	$131.759	$170.560

Dependents	$131.394	$129.522	$124.228	$121.040	$118.686	$122.842	$157.675
Former Members	$3.588	$3.759	$3.974	$3.959	$3.779	$4.013	$4.624
Sub-Total	$596.588	$601.677	$586.472	$574.938	$569.916	$593.002	$765.483
Less: Refunds	$1.053	$1.451	$1.006	$0.839	$1.294	$1.295	$1.641
Total Net Premiums	$595.535	$600.226	$585.466	$574.099	$568.622	$591.707	$763.842
Investment Earnings	$16.081	$21.843	$24.931	$25.471	$24.354	$20.464	$15.241
Average Annual Yield	6.1%	6.4%	6.4%	6.3%	6.2%	6.0%	5.9%
Long Term Care Fees						$0.006	$0.017
HMO Fees	$5.778	$6.104	$7.697	$13.365	$16.803	$16.473	$14.516
Total Receipts	$617.394	$628.173	$618.094	$612.935	$609.779	$628.650	$793.616
TOTAL BEGINNING BALANCE AND RECEIPTS	$810.599	$915.261	$967.038	$981.190	$994.703	$962.790	$1,027.761
DISBURSEMENTS							
Claim Receipts	$1,191.185	$1,293.920	$1,421.994	$1,431.975	$1,561.104	$1,779.548	$2,016.299
Plus: Payables (Prior)	$7.232	$5.998	$10.009	$9.165	$10.899	$13.718	$15.583
Sub-Total	$1,198.417	$1,299.918	$1,432.003	$1,441.140	$1,572.003	$1,793.266	$2,031.882
Less: Deductibles	$72.252	$82.222	$111.969	$89.069	$90.106	$96.851	$97.575
Copayments	$63.673	$89.413	$92.789	$94.526	$102.850	$114.795	$174.055
Coordination of Benefits	$306.962	$336.103	$381.565	$396.309	$449.379	$513.490	$550.578
Non-Covered Charges	$231.814	$221.744	$247.831	$263.264	$264.848	$334.009	$373.100
Payables (Current)	$5.998	$10.009	$9.165	$11.830	$13.718	$15.583	$8.079
Claim Payments							
Employees	$272.789	$289.531	$312.305	$294.382	$312.939	$346.092	$410.692
Retirees	$112.395	$132.844	$142.236	$155.322	$174.758	$201.581	$240.441
Dependents	$125.336	$131.153	$126.576	$128.195	$154.551	$161.689	$168.364
Former Members	$7.198	$6.899	$7.567	$8.243	$8.854	$9.176	$8.998
Sub-Total	$517.718	$560.427	$588.684	$586.142	$651.102	$718.538	$828.495
Less: Refunds	$10.063	$10.711	$6.580	$6.825	$7.558	$8.100	$8.402
Total Net Claims	$507.655	$549.716	$582.104	$579.317	$643.544	$710.438	$820.093
Administration	$3.335	$3.620	$3.653	$3.776	$1.374	$1.299	$1.309
Claims Processing	$12.521	$12.981	$13.026	$13.173	$15.645	$16.908	$18.340
Total Disbursements	$523.511	$566.317	$598.783	$596.266	$660.563	$728.645	$839.742
ENDING BALANCE	$287.088	$348.944	$368.255	$384.924	$334.140	$234.145	$188.019
NUMBER OF CLAIMS (000)							
Beginning Inventory	32.8	26.9	46.5	35.6	46.4	57.3	59.7
Claims Received	5,390.4	5,904.4	5,779.4	5,817.1	6,260.8	6,712.2	8,086.5
Claims Processed	5,396.4	5,884.8	5,790.3	5,806.3	6,249.9	6,709.8	8,111.4
Ending Inventory	26.8	46.5	35.6	46.4	57.3	59.7	34.8
Paid Claims	5,204.0	5,701.2	5,613.1	5,686.4	6,124.2	6,577.1	7,922.6
Paid Adjustments	69.0	79.2	83.7	84.1	89.3	103.4	141.3

Total Paid Claims	5,273.0	5,780.4	5,696.8	5,770.5	6,213.5	6,680.5	8,063.9
Average Claim Payment	$98	$97	$103	$102	$105	$108	$108
AVERAGE NUMBER OF MEMBERS (000)							
Employees	201.7	203.1	196.3	187.8	184.3	190.9	201.3
Retirees	75.7	78.7	81.5	84.5	87.2	91.5	96.1
Dependents							
Employee	119.1	117.4	111.3	105.2	102.1	105.6	109.3
Retiree	14.0	14.1	14.2	14.4	14.7	15.5	16.3
Total Dependents	133.1	131.5	125.5	119.6	116.8	121.1	125.6
Former Members	2.3	2.5	2.6	2.6	2.5	2.6	2.6
Total Membership	412.8	415.8	405.9	394.5	390.8	406.1	425.6
AVERAGE NUMBER OF CONTRACTS (000)							
Employee Only	207.3	211.7	210.3	207.8	208.2	216.8	229.6
Employee & Child(ren)	32.8	32.9	31.5	29.9	29.2	30.2	31.3
Employee & Family	39.5	39.0	37.6	36.5	36.5	38.1	39.4
Total Number of Contracts	279.6	283.6	279.4	274.2	273.9	285.1	300.3

Most of the changes in the program's benefits since July 1991, have been benefit increases. The major increases in these benefits have been an $150 annual wellness benefit and an outpatient prescription drug card benefit, each without application of the program's annual deductible and coinsurance requirements, and coverage for reconstructive breast surgery following a mastectomy.

Outpatient Prescription Drugs: For the last five fiscal years, the Plan's self-insured indemnity program has seen the following claims experience for outpatient prescription drugs:

Type of Drug	1995-96	1996-97	1997-98	1998-99	1999-00
Brand Drugs					
Number of Prescriptions	1,876,122	2,024,409	2,186,890	2,607,203	3,059,079
% Change	5.8%	7.9%	8.0%	19.2%	17.3%
Total Charges	$84,613,583	$98,409,330	$115,927,964	$151,141,686	$208,695,902
% Change	12.2%	16.3%	17.8%	30.4%	38.1%
Total Allowed Charges	$74,410,827	$86,682,862	$101,337,962	$130,642,766	$184,280,875
% Change	12.2%	16.5%	16.9%	28.9%	41.1%
Allowed Charges Applied to Deductible	$14,127,198	$15,264,043	$16,357,937	$19,606,166	$47,647,337
% Change	11.7%	8.0%	7.2%	19.9%	143.0%
Allowed Charges Applied to Coinsurance	$10,818,606	$12,753,872	$15,109,477	$18,693,645	$9,815,126.0
% Change	12.4%	17.9%	18.5%	23.7%	-47.5%
Total Paid	$49,465,023	$58,664,947	$69,870,548	$91,478,498	$126,253,019
% Change	12.3%	18.6%	19.1%	30.9%	38.0%
Average Total Charge	$45.10	$48.61	$53.01	$57.97	$68.22
% Change	6.1%	7.8%	9.0%	9.4%	17.7%
Average Allowed Charge	$39.66	$42.82	$46.34	$50.11	$60.24
% Change	6.1%	8.0%	8.2%	8.1%	20.2%
Average Applied to Deduct.	$7.53	$7.54	$7.48	$7.52	$15.58
% Change	5.6%	0.1%	-0.8%	0.5%	107.1%
Average Applied to Coinsur.	$5.77	$6.30	$6.91	$7.17	$3.21

% Change	6.3%	9.3%	9.7%	3.8%	-55.3%
Average Paid Charge	$26.37	$28.98	$31.95	$35.09	$41.27
% Change	6.2%	9.9%	10.3%	9.8%	17.6%
Average % of Charge Paid	58.5%	59.6%	60.3%	60.5%	60.5%
Brand Drugs with Generics					
Number of Prescriptions	374,943	336,173	334,814	306,754	320,154
% Change	-10.3%	-10.3%	-0.4%	-8.4%	4.4%
Total Charges	$12,785,948	$12,313,930	$13,539,502	$13,152,741	$16,069,120
% Change	-4.0%	-3.7%	10.0%	-2.9%	22.2%
Total Allowed Charges	$10,760,774	$10,295,733	$11,412,600	$10,984,534	$13,877,689
% Change	-3.4%	-4.3%	10.8%	-3.8%	26.3%
Allowed Charges Applied to Deductible	$3,621,949	$3,328,113	$3,267,785	$3,220,917	$5,465,724
% Change	-12.8%	-8.1%	-1.8%	-1.4%	69.7%
Allowed Charges Applied to Coinsurance	$1,316,847	$1,264,286	$1,491,598	$1,337,447	$733,622
% Change	1.6%	-4.0%	18.0%	-10.3%	-45.1%
Total Paid	$5,821,978	$5,703,334	$6,653,217	$6,364,850	$7,625,886
% Change	2.2%	-2.0%	16.7%	-4.3%	19.8%
Average Total Charge	$34.10	$36.63	$40.44	$42.88	$50.19
% Change	7.0%	7.4%	10.4%	6.0%	17.1%
Average Allowed Charge	$28.70	$30.63	$34.09	$35.81	$43.35
% Change	7.6%	6.7%	11.3%	5.1%	21.1%
Average Applied to Deduct.	$9.66	$9.90	$9.76	$10.50	$17.07
% Change	-2.8%	2.5%	-1.4%	7.6%	62.6%
Average Applied to Coinsur.	$3.51	$3.76	$4.46	$4.36	$2.29
% Change	13.2%	7.1%	18.5%	-2.1%	-47.4%
Average Paid Charge	$15.53	$16.97	$19.87	$20.75	$23.82
% Change	14.0%	9.3%	17.1%	4.4%	14.8%
Average % of Charge Paid	45.5%	46.3%	49.1%	48.4%	47.5%
Generic Drugs					
Number of Prescriptions	1,476,145	1,550,269	1,612,914	1,763,012	1,882,707
% Change	3.1%	5.0%	4.0%	9.3%	6.8%
Total Charges	$22,937,681	$24,922,520	$27,740,795	$32,374,714	$40,868,165
% Change	6.8%	8.7%	11.3%	16.7%	26.2%
Total Allowed Charges	$18,368,094	$20,227,151	$22,977,094	$27,129,910	$37,744,073
% Change	9.4%	10.1%	13.6%	18.1%	39.1%
Allowed Charges Applied to Deductible	$4,487,481	$4,774,829	$4,693,580	$5,377,187	$14,820,145
% Change	7.7%	6.4%	-1.7%	14.6%	175.6%
Allowed Charges Applied to Coinsurance	$2,525,996	$2,792,401	$3,282,494	$3,755,215	$1,906,143
% Change	9.8%	10.5%	17.6%	14.4%	-49.2%
Total Paid	$11,354,617	$12,659,921	$15,001,020	$17,880,177	$20,938,996
% Change	9.9%	11.5%	18.5%	19.2%	17.1%
Average Total Charge	$15.54	$16.08	$17.20	$18.36	$21.71
% Change	3.5%	3.5%	7.0%	6.8%	18.2%
Average Allowed Charge	$12.44	$13.05	$14.25	$15.39	$20.05
% Change	6.0%	4.9%	9.2%	8.0%	30.3%
Average Applied to Deduct.	$3.04	$3.08	$2.91	$3.05	$7.87
% Change	4.5%	1.3%	-5.5%	4.8%	158.1%
Average Applied to Coinsur.	$1.71	$1.80	$2.04	$2.13	$1.01

% Change	6.5%	5.3%	13.0%	4.7%	-52.5%
Average Paid Charge	$7.69	$8.17	$9.30	$10.14	$11.12
% Change	6.6%	6.2%	13.9%	9.0%	9.7%
Average % of Charge Paid	49.5%	50.8%	54.1%	55.2%	51.2%
Compounded Drugs					
Number of Prescriptions	87	59	62	376	105
% Change	-13.0%	-32.2%	5.1%	506.5%	-72.1%
Total Charges	$4,114	$2,422	$3,116	$14,278	$6,636
% Change	-23.9%	-41.1%	28.7%	358.2%	-53.5%
Total Allowed Charges	$4,046	$2,383	$2,937	$13,664	$6,546
% Change	-24.0%	-41.1%	23.2%	365.2%	-52.1%
Allowed Charges Applied to Deductible	$24	$46	$118	$1,865	$1,393
% Change	-86.4%	91.7%	156.5%	1480.5%	-25.3%
Allowed Charges Applied to Coinsurance	$3,482	$1,230	$1,323	$1,790	$347
% Change	-12.6%	-64.7%	7.6%	35.3%	-80.6%
Total Paid	$540	$1,107	$1,496	$9,989	$4,793
% Change	-53.6%	105.0%	35.1%	567.7%	-52.0%
Average Total Charge	$47.29	$41.05	$50.26	$37.97	$63.20
% Change	-12.6%	-13.2%	22.4%	-24.4%	66.4%
Average Allowed Charge	$46.51	$40.39	$47.37	$36.34	$62.34
% Change	-12.7%	-13.2%	17.3%	-23.3%	71.6%
Average Applied to Deduct.	$0.28	$0.78	$1.90	$4.96	$13.27
% Change	-84.3%	182.6%	144.1%	160.6%	167.5%
Average Applied to Coinsur.	$40.02	$20.85	$21.34	$4.76	$3.30
% Change	0.4%	-47.9%	2.4%	-77.7%	-30.6%
Average Paid Charge	$6.21	$18.76	$24.13	$26.57	$45.65
% Change	-46.7%	202.3%	28.6%	10.1%	71.8%
Average % of Charge Paid	13.1%	45.7%	48.0%	70.0%	72.2%
Total Drugs					
Number of Prescriptions	3,727,297	3,910,910	4,134,680	4,677,345	5,262,045
% Change	2.9%	4.9%	5.7%	13.1%	12.5%
Total Charges	$120,341,326	$135,648,202	$157,211,377	$196,683,419	$265,639,823
% Change	9.2%	12.7%	15.9%	25.1%	35.1%
Total Allowed Charges	$103,543,741	$117,208,129	$135,730,593	$168,770,874	$235,909,183
% Change	9.8%	13.2%	15.8%	24.3%	39.8%
Allowed Charges Applied to Deductible	$22,236,652	$23,367,031	$24,319,420	$28,206,135	$67,934,599
% Change	6.1%	5.1%	4.1%	16.0%	140.9%
Allowed Charges Applied to Coinsurance	$14,664,931	$16,811,789	$19,884,892	$23,788,097	$12,455,238
% Change	10.9%	14.6%	18.3%	19.6%	-47.6%
Total Paid	$66,642,158	$77,029,309	$91,526,281	$115,733,514	$154,822,694
% Change	10.9%	15.6%	18.8%	26.4%	33.8%
Average Total Charge	$32.29	$34.68	$38.02	$42.05	$50.48
% Change	6.1%	7.4%	9.6%	10.6%	20.1%
Average Allowed Charge	$27.78	$29.97	$32.83	$36.08	$44.83
% Change	6.8%	7.9%	9.5%	9.9%	24.2%
Average Applied to Deduct.	$5.97	$5.97	$5.88	$6.03	$12.91
% Change	3.1%	0.1%	-1.6%	2.5%	114.1%
Average Applied to Coinsur.	$3.93	$4.30	$4.81	$5.09	$2.37

% Change	7.8%	9.3%	11.9%	5.7%	-53.5%
Average Paid Charge	$17.88	$19.70	$22.14	$24.74	$29.42
% Change	7.8%	10.2%	12.4%	11.8%	18.9%
Average % of Charge Paid	55.4%	56.8%	58.2%	58.8%	58.3%
Average Annual Per Capita Paid	$172	$197	$234	$283	$350
% Change	17.0%	14.5%	18.8%	20.9%	23.7%

During this same five-year period, the annual number of prescriptions per capita increased from 9.2 in 1995-96 to 12.4 in 1999-2000, an increase of 35%. The annual number of branded prescriptions per capita increased from 5.5 in 1995-96 to 7.9 in 1999-2000, while the annual number of generic prescriptions per capita increased from 3.6 in 1995-96 to 4.4 in 1999-2000, an increase of 22%.

For the six-month period ending December 31, 2000, the Plan's self-insured indemnity program paid some $104.8 million in outpatient prescription drug claims. An estimated 3,314,482 prescriptions were paid during this same period. Some of the changes in the program's outpatient prescription drug claim payments can be explained by changes in coverage. Beginning in January 1992, the program's claim payments for outpatient prescription drugs were limited to 90% of average wholesale price (AWP) for each drug. Average wholesale price (AWP) is the price that drug manufacturers suggest wholesalers charge retail pharmacies for their products. The payment for these drugs was also subject to the program's overall annual deductible and coinsurance requirements paid by members of the program for all covered services, supplies, drugs, etc. Members of the program were also required to pay the full purchase price at the time of purchase and await reimbursement by the program. Effective January 1, 2000, the program's coverage was changed to a prescription drug card format. Under this change, members of the program were required to pay pharmacies copayments for each prescription drug ranging from $10 for generic drugs to $20 for brand drug with generic equivalents for each 34-day supply of the drug. Pharmacies, in turn, were paid directly by the program for the balance of allowable charges not paid by program members in the way of copayments. Allowable charges were set at 90% of a drug's AWP plus a dispensing fee of $6.00 per prescription. Outpatient prescription drugs were also removed from the program's overall annual deductible and coinsurance requirements paid by members of the program. Effective August 1, 2000, the prescription drug card format was modified to limit allowable charges. Dispensing fees were set at $4.00 per prescription and ingredient pricing for generic drugs was reduced to 80% of AWP for those drugs not subject to maximum allowable charge limits set by the federal Health Care Financing Administration (HCFA) for use by state Medicaid programs. For those generic drugs subject to HCFA maximum allowable charge limits, ingredient pricing was changed to the HCFA limits. The program was also authorized to use a pharmacy benefit management component and an open formulary to further reduce the program's outpatient prescription drug claim costs. Virtually all pharmacies within North Carolina accept the program's payments and member copayments as payment in full for prescriptions.

During the period January through March 2001, the program paid $765,177 in outpatient prescription drug claims for botulinium toxin and anti-fungal conditions according to the program's pharmacy benefit manager, AdvancePCS. The number of prescriptions processed was 22,316. AdvancePCS proposed to charge $7 for each prior approval in its' pharmacy benefit management contract with the program. Approximately 30% of the outpatient prescription drug claims for botulinium toxin and anti-fungal conditions are expected not to receive prior approval.

Skilled Nursing Facility Claims: The Plan's self-insured indemnity program spent the following gross claims amounts for skilled nursing facility care:

	1995-96	1996-97	1997-98	1998-99	1999-2000
Skilled Nursing Facilities ($Million)	$11.043	$12.418	$12.213	$12.346	$11.069

According to the Plan, the following claims were for stays of 30 days or less:

Year	Admissions	Billed	Allowed	Paid	Average Length-of-Stay
1998-99 ($Million)	1,058	$2.072	$1.894	$1.630	17 Days
1999-2000 ($Million)	1,203	$2.499	$2.199	$1.894	16 Days

For stays of more than 30 days, the Plan's claims data shows:

Year	Admissions	Billed	Allowed	Paid	Average Length-of-Stay
1998-99 ($Million)	553	$9.998	$8.180	$7.429	111 Days
1999-2000 ($Million)	574	$9.522	$7.312	$6.871	102 Days

Lifetime Maximum Benefits: When the State created the Plan's self-insured indemnity program in October 1982, the program had a lifetime maximum benefit of $500,000. This lifetime maximum benefit was increased to $1,000,000 effective July 1, 1991, and to $2,000,000 effective January 1, 1994. As of March 30, 2001, the program had only had one member who reached the program's current maximum of $2,000,000, and that maximum was reached in August 1998. As of the same date, only nine members of the program had accumulated benefits of between one and two million dollars, and their claim payments for the last year averaged less than $65,000. Five former members of the Plan's self-insured indemnity program had accumulated lifetime benefits of between one and two millions dollars, but two had cancelled their coverage with the Plan and three transferred their coverage to HMOs offered by the Plan.

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, House Committee Substitute for Senate Bill 1005, 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, 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.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION 733-4910

PREPARED BY: Sam Byrd

APPROVED BY: James D. Johnson

DATE: June 25, 2001

Signed Copy Located in the NCGA Principal Clerk's Offices