NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: HB 1855 (Second Edition)

SHORT TITLE: State Health Plan Changes

SPONSOR(S): Rep. 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: The Proposed House Committee Substitute for HB 1855 changes the Plan's outpatient prescription benefit, authorizes the Plan to use case management and disease management programs, and allows non-contributory health plan premiums for all retired employees not just those employed prior to October 1, 1995. The proposed changes are listed below by section.

Section 1: Rewrites G.S. 135-40.5(g) to provide the following changes to the Plan's outpatient prescription benefit: reduce the Plan's reimbursement of allowable charges for generic prescription drugs to 40% of Average Wholesale Price (AWP) from the current reimbursement level of 90% of AWP; reduce the dispensing fee paid per prescription to qualified providers for branded and generic prescription drugs to $4.00 per script from the current dispensing fee of $6.00 per script; and, require that allowable charges from providers shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription.

Effective January 1, 2001, the Plan is authorized by the legislation to use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. Any formulary used by the pharmacy benefit manager for the purpose of manufacturer rebates or utilization controls shall be an open formulary. Also, a fourth tier copayment of $25.00 is added for each branded or generic prescription drug not on a formulary used by the Plan.

A pharmacy benefit manager under contract with the Plan may implement dispensing limits, therapeutic and generic substitutions, concurrent reviews for compliance with appropriate clinical protocols, cost effective protocols, contraindications, and prospective reviews for drugs requiring prior approval. A pharmacy benefit manager under contract with the Plan shall be required to maintain continuous and open communications with physicians, pharmacies, and members of the Plan regarding the safest and most efficacious use of outpatient prescription drugs.

Section 2: Rewrites G.S. 135-39.4A(f) to require the Plan's Executive Administrator to consult with the Committee on Employee Hospital and Medical Benefits before executing a contract with a pharmacy benefit manager.

Section 3: Amends G.S. 135-39.5 to authorize the Plan's Executive Administrator and Board of Trustees to implement and administer a case management program for high cost cases, a disease management program for

chronic cases and a pharmacy benefit manager. The contract with the pharmacy benefit manager shall be executed only after competitive bid. This section goes into effect January 1, 2001.

Section 4: Amends G.S. 135-40.6A(b) to require prior approval for prescriptions requiring prospective review by the Plan's pharmacy benefit manager. This section goes into effect January 1, 2001.

Section 5: Amends G.S. 135-40.7 to provide an exclusion from pharmacy benefits for charges excluded by the Plan's pharmacy benefit manager.

Section 6: Rewrites G.S. 135-40.2(a) to provide for non-contributory health plan premiums for all retired employees not just those employed prior to October 1, 1995.

EFFECTIVE DATE: The Act is effective August 1, 2000 unless otherwise stated.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates an overall reduction in claims costs to the Plan's indemnity program to be $38.4 million for 2000-2001 and $67.2 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $28.9 million for 2000-2001 and $46.7 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $33.7 million for 2000-2001 and $57.0 million for 2001-2002.

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 had only 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. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory.
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 nine HMOs currently covering about 25% of the Plan's total population in about 66 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, 1999, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,482	70,681	274,163
Active Employee Dependents	110,453	44,369	154,822
Retired Employees	96,217	5,712	101,929
Retired Employee Dependents	16,374	1,165	17,539
Former Employees & Dependents with Continued Coverage	2,891	323	3,706
Total Enrollments	429,417	122,742	552,159
Number of Contracts			
Employee Only	230,456	54,059	284,515
Employee & Child(ren)	31,626	14,644	46,270
Employee & Family	39,670	8,182	47,852
Total Contracts	301,752	76,885	378,637
Percentage of Enrollment by Age			
29 & Under	26.7%	41.6%	30.0%
30-44	20.1	27.3	21.7
45-54	21.1	19.6	20.8
55-64	14.9	8.7	13.5
65 & Over	17.2	2.7	14.0
Percentage of Enrollment by Sex			
Male	39.4%	37.8%	39.0%
Female	60.6	62.2	61.0

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1999, the self-insured program started its operations with a beginning cash balance of $234.1 million. Receipts for the year are estimated to be $763 million from premium collections, $15 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $793 million in receipts for the year. Disbursements from the self-insured program are expected to be $820 million in claim payments and $24 million in administration and claims processing expenses for a total of $844 million for the year beginning July 1, 1999. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of over $183 million with a net operating loss of approximately $120 million for the 2000-2001 fiscal year. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $63 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 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 voluntary formularies, and fraud detection) are maintained and improved where possible. 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 13% plus annually. Total enrollment in the program is expected to increase about
3-4% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 4-5% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to increase by 1-2% per year the number of active employee dependents and enrolled retiree dependents. Investment earnings are based upon a 5-6% monthly 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 Outpatient Prescription Drug Program:

There are two primary components to be implemented under the Plan's outpatient prescription drug program as proposed in the legislation: 1) A reduction in the rate of reimbursement for allowable charges for generic drugs, a reduced dispensing fee for brand and generic outpatient prescription drugs, and a $25 copayment for non-formulary drugs; and 2) the installation of a pharmacy benefit manager to administer outpatient pharmacy claims under an open formulary with drug utilization review.

The assumptions used to estimate the reduction in allowable charges for prescription drugs include: reducing the Plan's reimbursement of allowable charges for generic prescription drugs to 40% of AWP from the current reimbursement level of 90% of AWP; lowering the dispensing fee paid per prescription to qualified providers for branded and generic prescription drugs to $4.00 per script from the current dispensing fee of $6.00 per script; and, requiring that allowable charges from providers shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. In addition, upon implementation of a pharmacy benefit manager, it assumed that a mail order service will not be implemented by the Plan under its contract with a pharmacy benefit manager.

The assumptions used to estimate claims cost reductions from the implementation of drug utilization review by a pharmacy benefit manager under contract with the Plan are as follows per the Executive Administrator of the Plan: Limit coverage for erectile dysfunction drugs to one tablet or suppository or injection per week; require the dispensing of growth hormones to be subject to prior approval; eliminate coverage of weight loss drugs except for medical conditions involving morbid obesity subject to prior approval for medical necessity; and require infertility treatments to be subject to prior approval and disallow coverage of infertility treatments for artificial means of conception. In addition, the Plan may utilize the following claims management options provided by a pharmacy benefit manager: dispensing limits, therapeutic and generic substitutions, concurrent reviews for compliance with appropriate clinical protocols, cost effective protocols, contraindications, and prospective reviews for drugs requiring prior approval.

Reduction in Allowable Charges -- Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates a reduction in claims costs from reducing the rate of reimbursement for allowable charges for generic drugs, a reduced dispensing fee for brand and generic outpatient prescription drugs, and a $25 copayment for non-formulary drugs

to be $31.5 million for 2000-2001 and $46.7 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $23.5 million for 2000-2001 and $31.3 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $27.5 million for 2000-2001 and $39.0 million for 2001-2002.

Drug Utilization Review Savings -- Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates a net reduction in claims costs from reducing the rate of reimbursement for allowable charges for generic drugs and a reduced dispensing fee for brand and generic outpatient prescription drugs to be $2.9 million for 2000-2001 and $11.0 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $3.0 million for 2000-2001 and $8.8 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $2.95 million for 2000-2001 and $9.9 million for 2001-2002.

Increases in the indemnity program's per capita claim costs for outpatient prescription drugs have been 20.9% for 1998-99, 19.0% for 1997-98, 14.5% for 1996-97, 17.0% for 1995-96, 13.0% for 1994-95 and 13.0% for 1993-94.

Assumptions for Implementing Case Management and Disease Management Programs by the Indemnity Plan:

The Plan's Executive Administrator and Board of Trustees are authorized under the legislation to implement and administer a case management program for high cost cases, and a disease management program for chronic cases. Per the Executive Administrator of the Plan, it is assumed that case management and disease management will be implemented on a voluntary participation basis by Plan members.

Case Management and Disease Management Savings -- Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates a reduction in claims costs to the Plan's indemnity program from case management and disease management programs to be $4.0 million for 2000-2001 and $9.5 million for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates a net reduction in claims costs to the Plan's indemnity program to be $2.5 million for 2000-2001 and $6.6 million for 2001-2002. A combined estimate from the two actuaries on the additional savings to the Plan's indemnity program is $3.25 million for 2000-2001 and $8.1 million for 2001-2002.

Assumptions for Implementing Non-Contributory Retiree Health Premiums by the Indemnity Plan:

The legislation provides for non-contributory health plan premiums for all retired employees not just those employed prior to October 1, 1995. No additional costs or savings were projected due to the elimination of contributory premium requirements for certain retirees. The financial impact of this change is assumed to be negligible.

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, Proposed Committee Substitute for House Bill 1855, June 16, 1999, original of which is on file in the General Assembly's Fiscal Research Division.
-Actuarial Note, Aon Consulting, Proposed Committee Substitute for House Bill 1855, June 16, 2000, 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

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