NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: House Bill 882

SHORT TITLE: Prescription Drug Pricing/Access

SPONSOR(S): Representative Gene Arnold

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

BILL SUMMARY: The bill would eliminate rebates from pharmaceutical manufacturers and distributors to the Teachers' and State Employees' Comprehensive Major Medical Plan unless the manufacturers and distributors offered the same drugs to all purchasers under the same terms and conditions. The Plan would further be prohibited from participating in any arrangement with a manufacturer or seller that engages in pharmaceutical price discrimination.

EFFECTIVE DATE: October 1, 1995

ESTIMATED IMPACT ON STATE: The consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Alexander & Alexander Consulting Group, Inc., and the consulting actuary for the General Assembly's Fiscal Research Division, Dilts, Umstead & Dunn, both concur that the Plan's indemnity program will lose pharmaceutical manufacturer rebate receipts in the amount of about $300,000 per month beginning in April or May, 1995, on a volume of at least 3,150,000 prescriptions annually, unless the manufacturers offer all pharmaceutical purchasers in the State the same pricing terms and conditions. No additional General or Highway Fund appropriations would be required for the bill until the 1997-99 biennium because of accumulated reserves in the Plan's indemnity program based upon current premiums and anticipated claim costs.

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-insured indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and 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. 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 seven HMOs currently covering about 16% of the Plan's total population in about 70 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, 1994, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,200	43,700	246,900
Active Employee Dependents	117,500	33,600	151,100
Retired Employees	78,500	3,300	81,800
Retired Employee Dependents	14,000	800	14,800
Former Employees & Dependents with Continued Coverage	2,600	400	3,000
Total Enrollments	415,800	81,800	497,600
Number of Contracts			
Employee Only	211,800	30,700	242,500
Employee & Child(ren)	32,800	10,200	43,500
Employee & Family	39,100	6,400	45,500
Total Contracts	283,700	47,300	331,000
Percentage of Enrollment by Age			
0-29	29.1%	43.8%	31.5%
30-44	23.8	29.3	24.7
45-54	18.8	17.1	18.5
55-64	12.8	7.0	11.9
65+	15.5	2.8	13.4
Percentage of Enrollment by Sex			
Male	40.0%	40.3%	40.1%
Female	60.0	59.7	59.9

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July, 1994, the self-insured program started its operations with a beginning cash balance of $287.1 million. Receipts for the year are estimated to be $597 million from premium collections, $20 million from investment earnings, and $6 million in risk selection and administrative fees from HMOs, for a total of $623 million in receipts for the year. Disbursements from the self-insured program are expected to be $545 million in claim payments and $18 million in administration and claims processing for a total of $563 million for the year beginning July, 1994. For the fiscal year beginning July, 1995, the self-insured indemnity program is anticipated to have an operating cash balance of over $347 million with a net operating gain of $60 million for the 1994-95 fiscal year. For the next few years, the self-insured indemnity program is assumed to be able to carry out its operations without any increases in its current premium rates or a reduction in existing benefits until the 1997-98 or 1998-99 fiscal years. This assumption is 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, and fraud detection) are maintained and improved where possible. Current non-contributory premiums rates are $110.08 monthly for employees whose primary payer of health benefits is Medicare and $144.60 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $68.50 monthly for children whose primary payer of health benefits is Medicare and $90.12 monthly for other covered children, and $164.30 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $216.18 per month for other family contract dependents. Claim cost trends are expected to increase about 10% annually. Total enrollment in the program is expected to increase about one-half of one percent (0.5%) annually. Growth in the number of enrolled active employees is expected to be a little less than 1% annually, whereas the growth in the number of retired employees is assumed to be a little more than 4% per year. The program is expected to lose about 2% of its number of active employee dependents each year, whereas the number of enrolled retiree dependents is assumed to show no appreciable change from year to year. Investment earnings are based upon a 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 the Self-Insured Indemnity Program's Outpatient Prescription Drug Claims: On September 13, 1994, the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan entered into a letter of understanding with the indemnity program's claims processor, Blue Cross and Blue Shield of North Carolina (BCBSNC), for the indemnity program to participate in BCBSNC's drug rebate and formulary arrangement with PCS Health Systems, Inc., of Scottsdale, Arizona. Although the letter of understanding was agreed to by both the Plan and BCBSNC, no amendment was made to the claims processing contract between the two parties. The terms of the letter of understanding include:

1. Blue Cross and Blue Shield of North Carolina (BCBSNC) entered into a drug rebate and formulary arrangement with PCS Health Systems, Inc. (PCS). This program provides rebates for the use of prescription drugs pursuant to a prescription drug formulary when PCS has a master rebate arrangement with the manufacturer of the drug used. Rebates are collected on behalf of the Plan pursuant to the BCBSNC contract with PCS based on the Plan's prescription drug claims processed by BCBSNC when reported to PCS by BCBSNC.

2. The Plan pays BCBSNC a fee of two percent (2%) of the rebates paid to BCBSNC which are generated by the Plan's prescription drug claims.

3. It is understood that although as an "administered benefit plan" of BCBSNC the Plan indirectly benefits from the benefits and protections of the PCS rebate arrangement, BCBSNC is not responsible for the performance of PCS and BCBSNC makes no guarantee or representation that the Plan will receive any particular benefit or level of benefit or rebate from the PCS rebate arrangement.

4. Upon receipt, BCBSNC deposits the Plan's rebates, less its administrative fee, directly into the Plan's bank account and accounts to the Plan when the rebates are deposited.

5. Pursuant to the rebate arrangement with PCS, BCBSNC will distribute and maintain a clinical formulary to a sufficient number of the North Carolina providers to support rebate arrangements.

The rebates anticipated being passed through to the Plan from BCBSNC are based upon the following outpatient prescription drug claims experience through July, 1994, for the Plan's indemnity program.

Types of Drugs	1991-92	1992-93	1994-95
Brands without Generic Equivalents			
No. of Prescriptions	935,011	1,618,314	1,584,311
Total Charges	$28,182,099	$62,771,504	$64,442,496
Allowed Charges	$25,619,932	$54,392,752	$56,406,049
Claims Paid	$17,591,037	$35,323,699	$36,485,743
Brands with Generic Equivalents			
No. of Prescriptions	138,584	447,962	407,143
Total Charges	$3,503,900	$12,366,986	$12,369,270
Allowed Charges	$2,729,784	$10,002,392	$10,268,083
Claims Paid	$1,639,366	$4,989,631	$5,265,661
Generics			
No. of Prescriptions	1,974,105	1,067,305	1,159,906
Total Charges	$54,588,863	$13,651,127	$16,292,724
Allowed Charges	$53,532,654	$9,447,019	$12,171,578
Claims Paid	$32,491,600	$5,881,540	$7,482,263

SOURCES OF DATA:

o Actuarial Note, Dilts, Umstead & Dunn, House Bill 882, May 5, 1995, original of which is on file in the General Assembly's Fiscal Research Division.

o Actuarial Note, Alexander & Alexander Consulting Group, Inc., House Bill 882, May 4, 1995, 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.

o Letter of Understanding between the Executive Administrator of the Teacher's and State Employees' Comprehensive Major Medical Plan and Blue Cross and Blue Shield of North Carolina concerning a Formulary Services Agreement with PCS Health Systems, Inc.

o Outpatient prescription drug claim reports provided by the Teachers' and State Employees' Comprehensive Major Medical Plan.

TECHNICAL CONSIDERATIONS: None

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