NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: Senate Bill 451

SHORT TITLE: Pharmacists' Patient Drug Care Act.

SPONSOR(S): Sen. Rand

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

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

BILL SUMMARY: The bill allows members of the Teachers' and State Employees' Comprehensive Major Medical Plan to have their outpatient prescription drugs filled and their corresponding outpatient prescription drug benefits redeemed by any pharmacy operating within the State that is willing to accept the Plan's claim payments regardless of whether or not a pharmacy has a provider agreement with the Plan. The bill applies to the Plan's self-insured indemnity program and to the Plan's alternative coverages through health maintenance organizations (HMOs). Pharmacies willing to accept the Plan's payments will assess members of the Plan purchasing a drug any difference between the price of the drug at the time of purchase and the allowable amount to be paid by the Plan. The Plan is required to pay all pharmacies willing to accept the Plan's claim payments in a uniform manner regardless of whether or not a provider agreement is involved with the Plan.

EFFECTIVE DATE: July 1, 2001.

ESTIMATED IMPACT ON STATE: The consulting actuary for the Teachers' and State Employees' Comprehensive Major Medical Plan, Aon Consulting, estimates the cost of the bill to the Plan to be $107 million for fiscal year 2001-02 and $147 million for fiscal year 2002-03. This estimate is based upon the assumption that the bill "…provides an incentive to Plan members to not use the pharmacy network…" and "…that there will be no contracting pharmacies under the bill…." Aon Consulting's estimate is based upon members of the Plan not being required to pay a copayment per prescription. Aon Consulting did not attempt to price any other cost alternatives under the bill.

The consulting actuary for the General Assembly's Fiscal Research Division, Hartman and Associates, estimates the cost of the bill under various conditions:

(1) If the Plan's contract with AdvancePCS, its pharmacy benefit manager, remains in force, the bill would not result in any additional costs to the Plan or Plan members.

(2) If the Plan's contract with AdvancePCS does not remain in force, the bill's cost will be determined by the Plan's Executive Administrator and Board of Trustees. These costs would be offset by the $500,000 performance guarantee in the Plan's contract with AdvancePCS upon AdvancePCS' default and any additional compensation for damages that may result from the contract default. The estimated costs from actions by the Plan's Executive Administrator and Board of Trustees to set allowable charges would be expected to fall within the following ranges:

   (a) If the Executive Administrator and Board of Trustees set allowable charges at the same rates that are in the Plan's contract with AdvancePCS, the additional costs are estimated to be:

	2001-02	2002-03
To the Plan	$114,835,000	$124,975,000
To Plan Members	$13,536,000	$27,188,000

These additional costs result from pharmacies not accepting the Plan's payments as payment in full and the Plan loses its copayments paid by Plan members and Plan members are balanced-billed for the difference between charges and allowed charges.

(b) If the Executive Administrator and Board of Trustees continue the Plan's prescription drug pricing in effect for the 2000-01 fiscal year, the Plan would suffer the following loss of savings from AdvancePCS contract rates:

	2001-02	2002-03
To the Plan	$47,040,000	$53,795,000

(c) If the Executive Administrator and Board of Trustees reduce allowable charges lower than the AdvancePCS contract rates to compensate for a loss of copayments paid by Plan members, the additional costs are estimated to be:

	2001-02	2002-03
To Plan Members	$128,371,000	$152,164,000

Of course, the Plan's Executive Administrator and Board of Trustees could set allowable charges anywhere within the limits of the foregoing range of 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 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 $1.101 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 the Indemnity Program's Outpatient Prescription Drug Claims: 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%
<u>Generic Drugs</u>					
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%
<u>Compounded Drugs</u>					
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%

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.

Effective July 1, 2001, the Plan's self-insured indemnity program will set allowable charges for outpatient prescription drugs. These allowable charges have been set by the program's contract with AdvancePCS, its contractual pharmacy benefit manager. Beginning in July, 2001, the program will, by contract, pay AdvancePCS a dispensing fee of $1.50 for each prescription drug and the following ingredient prices: AWP-15% for brand drugs and AWP-55% (MAC discount) for generic drugs. Advance PCS will pay pharmacies whatever is agreed to by the pharmacies. AdvancePCS, by complying with the program's Bid Solicitation, has to have agreement with 97% of the 1,800-1,900 pharmacies operating within North Carolina. By clarification of its bid solicitation proposal to the program, AdvancePCS has further stated that it will "…offer a network in North Carolina that will represent approximately 99% of the available pharmacies in the state." The Plan's contract with AdvancePCS runs from December 1, 2000, through November 30, 2003, with an extension for two one-year periods at the option of the Plan. Pricing under the contract is however guaranteed only through November 30, 2003. Contract termination can be made upon written agreement of the Plan and AdvancePCS, by the Plan for failure to comply with the contract upon 30 days' advance written notice, by the Plan in its best interests upon 180 days' advance written notice, by the Plan for a lack of funds to carry out the contract or for a change in the Plan's need for services under the contract, and by the Plan if AdvancePCS becomes insolvent. AdvancePCS is subject to a $500,000 performance guarantee to the Plan for a determination of default under the contract. Based upon the latest usable detailed claims data provided by the Plan for the program during October-November, 2000, it is estimated that the program will see a reduction in outpatient prescription drug claim costs of $45-$50 million for fiscal year 2001-02 from a reduction in allowable charges for prescription drugs in its contract with AdvancePCS plus another $8-$9 million in manufacturer rebates guaranteed by AdvancePCS of $1.40-$1.70 per prescription and $5-$10 million in claim cost reductions from utilization review of drugs by AdvancePCS. For fiscal year 2002-03, a reduction of $60 million could be realized from a reduction in drugs' allowable charges over the 2001-02 fiscal year plus the same amount of manufacturer rebates and claim cost reductions from utilization review that is expected for the 2001-02 fiscal year.

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, Senate Bill 451, April 6, 2001, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 451, March 29, 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.
-Outpatient Prescription Drug Claims Data and North Carolina Pharmacy Data Provided by the Teachers' and State Employees' Comprehensive Major Medical Plan and its Claims Processor, Blue Cross & Blue Shield of North Carolina.
-North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan's Bid Solicitation for Pharmacy Benefit Management Services, issued August 2, 2000.
-Advance Paradigm, Inc.'s Proposal to the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan's Bid Solicitation for Pharmacy Benefit Management Services, dated September 6, 2000.
-AdvancePCS's October 5, 2000, Letter from Mr. Geoffrey C. Kilgore, Regional Vice President, to Mr. Harold Wright, Deputy Executive Administrator of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, Clarifying it's Proposal to the Plan Pursuant to an October 3, 2000, Meeting with Proposal Finalists.
-Contract between the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and Advance Paradigm, Inc., for the Plan's Pharmacy Benefit Management Program, dated December 1, 2000.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION 733-4910

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DATE: April 10, 2001.

Signed Copy Located in the NCGA Principal Clerk's Offices