Senate Finance Subcommittee on Rising Medical Costs

Interim Report

January, 2003

COMMITTEES:
NATURAL RESOURCES, VICE-CHAIRMAN
SUB-COMMITTEE ON AGRICULTURE
FINANCE
REDISTRICTING
JURISPRUDENCE

ROBERT DUNCAN
STATE SENATOR
DISTRICT 28

January 9, 2003

The Honorable Rodney Ellis
Chair, Senate Finance Committee
P.O. Box 12068
Austin, Texas 78711

Dear Chairman Ellis:

The Senate Finance Subcommittee on Rising Medical Costs submits this report regarding our charge. We thank you for the opportunity to investigate this very important issue.

The Subcommittee has outlined a series of options for the 78th Legislature to consider while developing the 2004-2005 state budget.

Respectfully submitted,

Robert Duncan, Chair

Senator Carlos Truan

Senator Gonzalo Barrientos

Senator Judith Zaffirini

Senator Troy Fraser

Senator Steve Ogden

Senator Todd Staples

1001 MAIN STREET
SUITE 608
LUBBOCK, TEXAS 79401
(806) 762-1122
FAX (806) 749-2828

1790 LEE TREVINO DRIVE
SUITE 209
EL PASO, TEXAS 79936
(915) 629-8880
FAX (915) 629-8881

CAPITOL OFFICE:
ROOM GE.7
P.O. BOX 12068
AUSTIN, TEXAS 78711
(512) 463-0128
(800) 322-9538
FAX (512) 463-2424
TDD 1-800-735-2989

1330 EAST 8TH STREET
SUITE 322
ODESSA, TEXAS 79761
(915) 334-8898
FAX (915) 334-8868

401 AUSTIN
SUITE 101
BIG SPRING, TEXAS 79720
(915) 268-9909
FAX (915) 268-9899

Committees
Education, Vice Chair
Finance

Judith Zaffirini
State Senator, District 21
President Pro Tempore, 1997

Committees
Administration
Redistricting

January 13, 2003

The Honorable
Senator Robert Duncan
Chair, Senate Finance Subcommittee
on Rising Medical Costs
P.O. Box 12068
Austin, Texas 78711

Dear Chair Duncan:

Thank you for your leadership and hard work in developing the Senate Finance Subcommittee on Rising Medical Costs Interim Report. I especially appreciate your listing the options submitted to our committee as possible solutions, rather than your developing recommendations that would have resulted in divided votes. This approach is modeled in other reports, including the one issued by the Joint Interim Committee on Health Services. Clearly, as the 78th Legislature faces critical funding challenges, all options suggested by advocates, agencies and legislators must be evaluated.

Facing budget shortfalls, a slowly recovering national economy and a sluggish job market, we must be mindful of the effects that some of these options could have. It is during such economic instability that some low-income Texans may most need the support of strong safety nets such as Medicaid and CHIP. Accordingly, we must understand the long-term effects that some of the options presented in this report could have as we continue to strive to improve the health of the people of Texas.

May God bless you.

Very truly yours,

Judith Zaffirini

Judith Zaffirini

Capitol Office: P.O. Box 12068 • Austin, Texas 78711 • 512/463-0121 • Fax 512/475-3738 • Dial 711 For Relay Calls
South District Office: P.O. Box 627 • Laredo, Texas 78042-0627 • 956/722-2293 • Fax 956/722-8586
North District Office: 12702 Toepperwein Road #214 • San Antonio, Texas 78233 • 210/657-0095 • Fax 210/657-0262

Texas Senate Committee on Finance

Interim Subcommittee on Rising Medical Costs

Interim Report

Table of Contents

Introduction

The Senate Finance Subcommittee on Rising Medical Costs operated under the direction of the following charge issued by Lieutenant Governor Bill Ratliff:

> *Study the issue of rising medical costs and its impact on the state budget, including health and human services, correctional managed health care, education and state employee benefits. The Subcommittee may review private pay insurance. The Subcommittee's report should recommend ways to control cost increases and identify best practices and opportunities for savings.*

The subcommittee held three hearings. The first two focused on state agencies whose budgets are affected significantly by rising health care costs. The final hearing sought comment from private sector stakeholders. In each of theses hearings, the subcommittee asked the agencies to provide a funding chart and lists of top medical procedures and pharmaceuticals. These documents were intended to supply a similar method of comparing expenditures and cost drivers. This information can be found as Attachments D-J.

Rising health care costs are a significant issue for most states, the federal government, private industry, and individual citizens. Twenty-four states report that Medicaid and other health care expenditures are over budget through the early months of FY 2003, according to the National Conference of State Legislatures. All state agencies reviewed by this subcommittee are requesting additional funding for the upcoming biennium to address deficits and rising costs.

State spending on health care programs in Texas has been increasing steadily for the past several years. Since 1998, state expenditures on health care have increased from $10.9 billion annually to $16.8 billion, a 53.2 percent increase. This represents an infusion of close to $6 billion new dollars for health care in Texas in just four years. This trend of increased funding is projected to continue for the foreseeable future.

Thirty-six percent of the state's growth in spending was related to increases in medical costs and prescription drug spending, according to the Legislative Budget Board. The remaining 64 percent was attributable to increases in participation levels or people served.

To control these escalating costs, all state health plans have implemented various cost management techniques. These initiatives include formulary restrictions, utilization reviews, cost sharing, and administrative adjustments. Some have worked better than others. Despite these efforts, exponential growth in rising health care expenditures has merely slowed.

As the state's population continues to grow and as new medical technologies emerge, it will be an ongoing challenge to manage the state's health care costs. However, without workable solutions the viability of many state programs is at risk.

There is no question the growth in health care-related costs will be a focus during the 78th legislative session because this growth contributes significantly to projected budget shortfalls. However, each of these health care programs enjoys the support of strong and influential constituencies. It is likely that any initiatives designed to substantially control growth or costs in these programs will be subject to stiff political opposition. Further, court challenges to prevent or delay implementation of any reductions may be expected. The key challenge for the 78th Legislature will be to find general and political consensus.

This report provides a variety of options that address each of the health care cost drivers. These options were provided to the subcommittee and are presented only as possible solutions. The committee takes no position as to the viability or feasibility of these suggestions. The 78th Legislature will face a challenging session with budget shortfalls and growing needs. It is the hope of the subcommittee that these suggestions will provide framework and guidance for the difficult choices ahead.

Medicaid

Background

Medicaid is a federal/state program that pays health care expenses for low income people who meet certain eligibility guidelines. Each state has a unique Medicaid program with minimum coverage levels for certain populations and income levels established by federal regulations. The states are allowed to expand their individual Medicaid programs as they are able to fund. Texas, a state considered conservative with expansion programs, spends approximately 70 percent ($22.7 billion to maintain current services for 2004-2005) of its Medicaid appropriation from general revenue to meet minimum federal mandates. The Texas Medicaid program covers acute care services such as physician and medical professional services, inpatient and outpatient hospital services, lab and x-ray services, and pharmaceuticals. Approximately 62 percent of the recipients are under the age of 21. (See Exhibit 1.1)

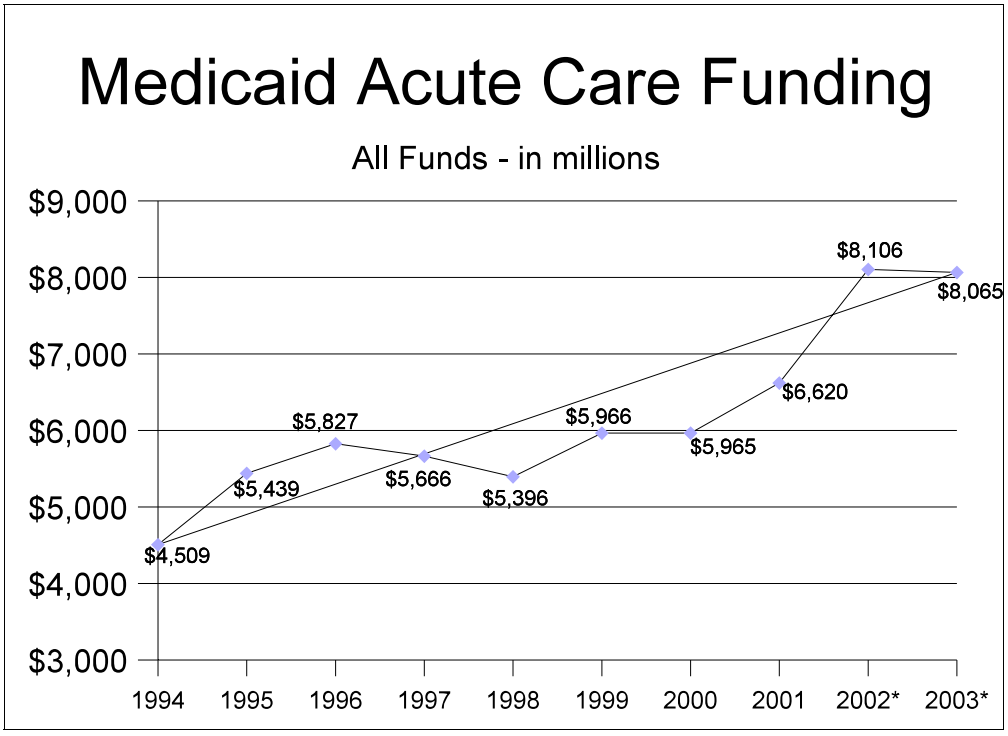


Exhibit 1.1

Estimates for FY 2002-2003 are based on SB 1 Medicaid Appropriations for Texas Department of Health and Health and Human Services Commission --only 11 months of premiums are appropriated for FY 2003).

State Method of Finance

Funding for Medicaid has grown in recent years, from $4.5 billion in 1994 to $8.1 billion in 2003 in All Funds. Moreover, in 2001, the 77th Legislature made an emergency appropriation of $489.9 million in General Revenue to cover 2000-2001 Medicaid funding shortfalls due to caseload growth and increases in the cost of services and prescription drugs. The Health and Human Services Commission (HHSC) projects the 78th Legislature will face requirements for an additional $417.3 million General Revenue in supplemental appropriations, once again to cover a funding shortfall anticipated for the 2002-2003 biennium.

Federal Method of Finance - Federal Medical Assistance Percentage (FMAP)

The Medicaid program is a state/federal partnership. Almost 60 percent of the Texas Medicaid program is funded through federal Medicaid assistance. The federal share is not static, but is derived annually from a formula based on each state's average per capita income compared to the nation's average per capita income for the three most recent calendar years. This formula is called the Federal Medical Assistance Percentage (FMAP). The formula for computing the FMAP is shown in Exhibit 1.2.

$$\mathbf{FMAP = 1 - (.45 * (X^2 / Y^2))},$$

where:
X = 3 year (most recent calendar years) average of Texas per capita income, and
Y = 3 year (most recent calender years) average of US per capita income,
both as provided by the Bureau of Economic Analysis.

Exhibit 1.2

The FMAP is designed to provide a 55 percent matching share to states with average per capita personal income. However, the minimum FMAP is 50 percent and the matching rate for U.S. territories is statutorily set at 50 percent. The maximum FMAP is 83 percent, but no state has exceeded 80 percent since the 1960s.[1]

In recent years, the Texas FMAP percentage has declined from 61.36 percent in 2000 to 59.99 percent in 2003 because Texas' average income has increased relative to the nation's average income. (See Exhibit 1.3) However, for 2004, the Texas FMAP will rise from 59.99 percent to 60.22 percent. Nationally, 27 states will receive an increase in the FMAP percentage in FY 2004

[1] Federal Funds Information for States, **Issues Brief 2002-2005 Final FY 2004 FMAPs,** September 24, 2002.

and 11 will experience declines.[2] A possible reason for the significant number of states receiving increases may be attributable to total national income growing only 3.3 percent in calendar year 2001, the slowest annual growth rate since 1958.

In the current biennium, 2002-2003, the Texas FMAP ranked 26th and 27th, respectively, among all of the states and territories. In 2004 Texas will rank 26th. The Texas FMAP funding level ranking is notable given that Texas is ranked 10th in the percentage of people living under the federal poverty level among all the states.[3] The poverty level is a key factor since it is the primary eligibility requirement for Medicaid. However, poverty level is <u>not</u> a factor in determining the FMAP.

As the FMAP changes, Texas experiences changes in its level of funding for Medicaid. HHSC estimates for FY 2004-2005 a full 1 percent change in the FMAP would roughly entail a $150 to $160 million change in general revenue requirements for Texas. Over the last two biennia, the FMAP changes for the second year of the biennium have required an estimated $113.4 million in additional general revenue funds ($81.9 million for 2000-2001, and $31.5 million for 2002-2003).

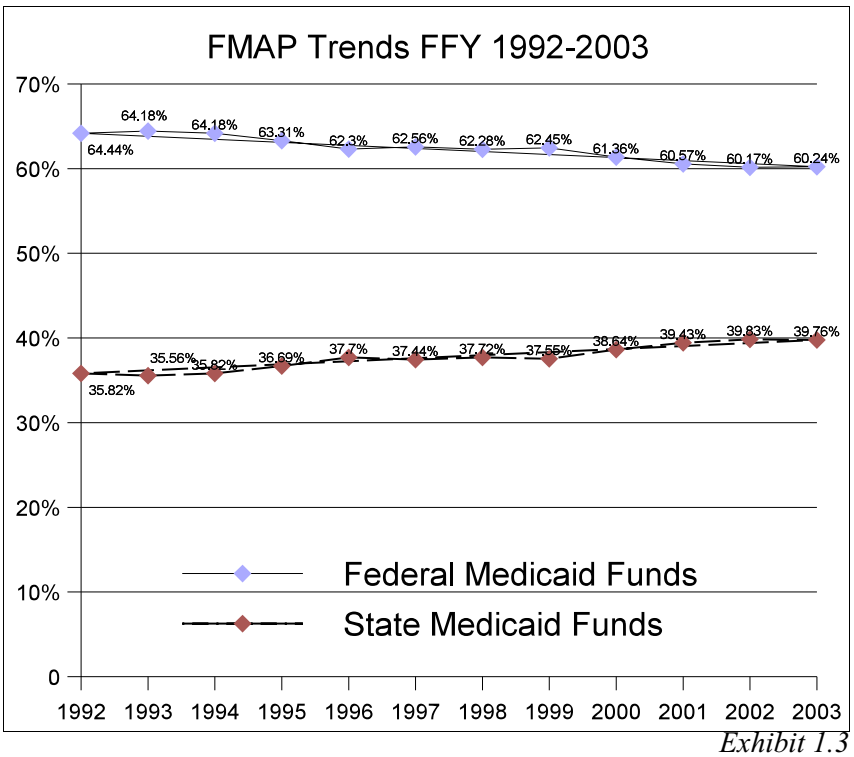


Exhibit 1.3

[2]Id.

[3]Based on U.S. Census Bureau Report, March Current Population Survey (2002)

Cost Containment Initiatives

Joint Medicaid Working Group

During the 77th Legislative Session, Senate Finance and House Appropriations committees created a Joint Medicaid Working Group to address the rising costs of the Medicaid program. From that work, HHSC was directed to find $205 million in general revenue savings from the Texas Medicaid program. These initiatives, laid out in Senate Bill 1, Rider 33, included

- administrative reorganization and streamlining;
- competitive pricing for certain services; creating co-payments;
- aggressive utilization review; and
- a variety of federal waivers.

The changes must be implemented by the end of FY 2003. Some of these initiatives were abandoned and substituted with savings located in other areas of the Medicaid budget. To date, only $5 million in savings have been realized with $136.9 million projected savings for the remainder of the biennium. However, HHSC reports that, with additional savings found outside Rider 33 initiatives, (including Medicaid administrative contract revisions, hospital cost savings and improvements in drug benefit management), the total projected savings are claimed by HHSC to be $216.6 million for 2002-2003. (See attached summary of cost savings initiatives, Attachment A.)

To address the rising cost of prescription drugs, HHSC has implemented $60.1 million worth of cost containment measures in the Vendor Drug Program. (See Exhibit 1.4)

Medicaid Pharmaceutical Savings Initiatives

Initiative	FY 02-03
Move to "Best Price" Structure for Drug Pricing in Medicaid Reimbursement formula change due to statewide audit	**$15.9 million**
Establish Sliding-Scale Co-payments	**$2.3 million**
Increase Utilization Review Activities through PGMs or in-house	
• Edits added to DUR[4] claim rejections for Drug Interaction, High Dosage, Therapy Duplications	$0.6 million
• Maximum Daily Dose Limits	$2.8 million
• Maximum Monthly Dose and Gender and Age Limits	$0.7 million
• Increase early refill edit from 50% to 75%	$1.2 million
• Review recipients on multiple medications	$0.0 million
	$5.3 million
• Audit-related Reduction in Drug Prices effective May and July 2001	$11.0 million
• New MAC[5] related to Federal Upper Limit price changes effective Jan. 2002	$1.6 million
• New MACs related to drugs going off patent protection	$16.4 million
• New May '02 MACs not included above	$0.5 million
• New MACs with narrow therapeutic classes	$0.5 million
• Rebated for drugs dispensed in physician's offices	$0.2 million
• Physician education and utilization management	$6.4 million
	$36.6 million
TOTAL MEDICAID PHARMACEUTICAL SAVINGS	**$60.1 million**

Exhibit 1.4

[4]DUR - Drug Utilization Review

[5]MAC - Maximum Allowable Cost

Cost Drivers

The most significant cost drivers in the Texas Medicaid program, as identified by HHSC, are increased cost due to caseload growth and inflation and expanded utilization of the pharmacy benefit program. Additionally, the unique challenges and costs of the dually eligible (Medicaid and Medicare eligible) population contribute to the growth of the Medicaid budget, mostly through pharmacy benefits.

Entitlement Program

Medicaid is an "entitlement" program. As a condition for receiving the federal match (FMAP), Texas is obligated to provided minimum mandated services to any individual who qualifies at the federal minimum and requests services. The Texas Medicaid program is more or less a minimum benefit program, that does not consist of numerous expansion populations and services. Therefore, the state is hindered in its flexibility to manage program costs. States with large optional populations and services are better able to address their Medicaid budget crises by managing expansion populations and services. However, Texas does not have this flexibility simply because there are few optional populations or services where budget cuts could potentially occur. Assuming the cost saving measures in Senate Bill 1 during the 77th Legislature are implemented, options for further administrative savings in Texas will be more challenging.

Texas Medicaid covers children, single parents, pregnant women and poor/low-income elderly or disabled individuals. Of those populations, only pregnant women, long term care and the medically needy are optional populations to which Texas has expanded coverage beyond the federal minimum. The federal/state funding allocation for these programs is set forth in Exhibit 1.5.

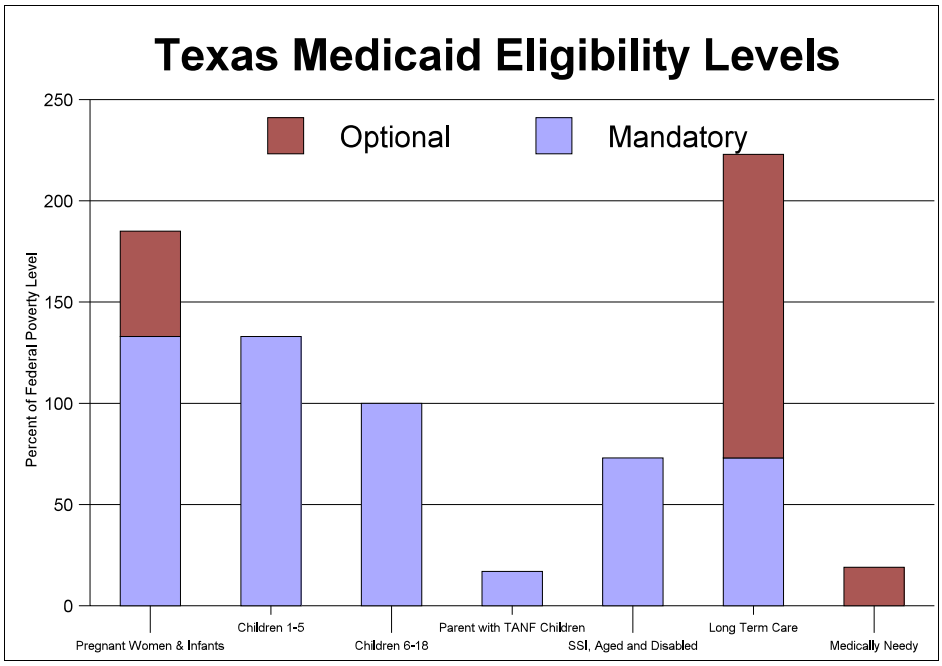


Exhibit 1.5

Caseload Growth

As of November 2002, the average monthly enrollment in the Texas Medicaid program was 2,376,193. The average monthly caseload has increased since FY 2000 and is projected to continue to increase during the 2004-2005 biennium. During this time of recent growth, caseload numbers have surpassed the level appropriated for FY 2002-2003. Forecast updates now project caseload growth for 2002-2003 to surpass budgeted levels by 227,645 clients for a total cost of $417.3 million that will be requested in a supplemental appropriation.

In FYs 1998-2002, legislative appropriations were insufficient to fund caseload growth for Medicaid. Supplemental appropriations were required in each session to cover this forecasting shortfall. The actual caseload growth for those years surpassed both the requested and appropriated levels. However, in response to projected growth, the legislative appropriation actually exceeded the agency's requested amount for caseload growth during 2002-2003. Nevertheless, caseload has grown even larger than the appropriated level of growth.[6] The average number of Medicaid recipients for the final year of 2002-2003 is expected to require a supplemental appropriation of $417.3 million.

[6]See *Selected HHS Caseloads Compared to Appropriated Caseloads, FY 1998-2003 agency document.* Attachment B.

The average monthly caseload is expected to reach 2.8 million participants in FY 2005. (See Exhibit 1.6) This is an increase of 18.4 percent from FY 2003. In the appropriations request for 2004-2005, HHSC is requesting $1.54 billion to address this projected caseload growth.

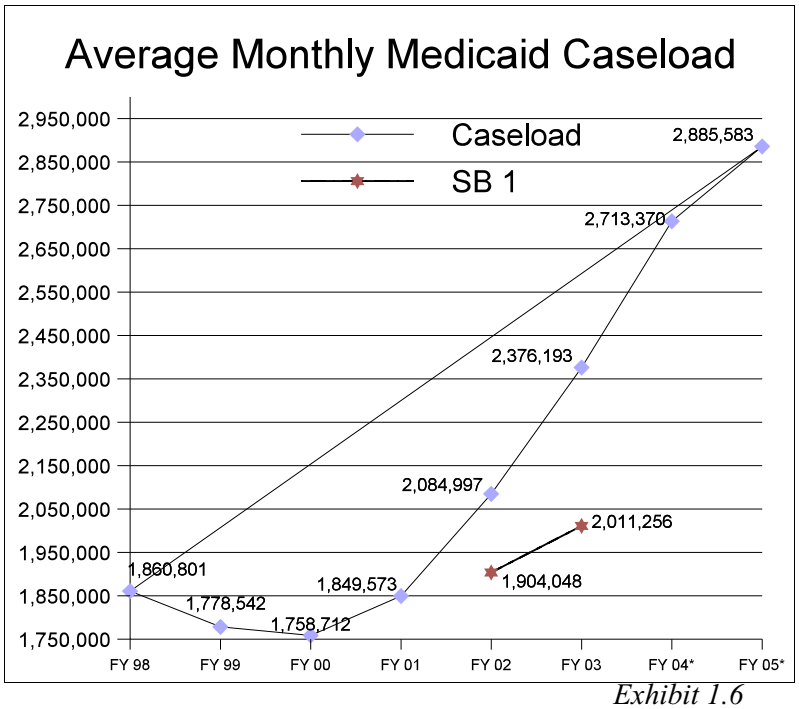


Exhibit 1.6

According to the Kaiser Commission on Medicaid and the Uninsured, the national rate of growth for the total number of individuals enrolled in state Medicaid programs doubled from 4.9 percent in 2000 to 9.8 percent in 2001.[7] All 50 states and the District of Columbia experienced caseload growth in Medicaid programs ranging from a low of 0.2 percent in Oregon to a high of 28.5 percent in Arizona. Texas' growth was 8.2 percent.

Forecasting Medicaid caseload has proven frustrating for both HHSC and the Legislature.[8] Medicaid caseloads are projected using time-series models. These forecasts for both caseload and program costs are produced for each individual population group included in the program. HHSC provides

[7]Kaiser Commission on Medicaid and the Uninsured, Medicaid Enrollment in 50 States, December 2001 Data Update.

[8]For a detailed examination of the forecasting methodologies for HHSC programs, please see the Senate Finance Subcommittee Report on Health and Human Services Demand, November 2002, by Senator Judith Zaffirini.

raw data for client enrollment and cost data is provided from reports of claims paid by National Heritage Insurance Company (NHIC) and paid pharmacy claims from the Medicaid Vendor Drug Program (VDP). HHSC applies various factors and time-series models to determine which model performs more accurately. Adjustments are made monthly and re-run quarterly to adjust for any changes.

Texas' biennial legislative schedule provides unique challenges in accurately forecasting caseload growth appropriations. The time-series models used by HHSC are more statistically reliable for 6 to 18 months. Therefore, any unpredictable factor, such as an economic downturn that may impact poverty level, can skew caseloads from the time-series forecasts. To address the reliability of Medicaid forecasting, HHSC has implemented checks and balance systems to ensure the most accurate forecasts possible. HHSC contracts with an outside consultant for additional input regarding forecasts and methodology. Also, NHIC produces independent forecasts for Medicaid. Finally, HHSC provides caseload, expenditure data and forecasts to the LBB and the Governor's Office for further review and input.

Legislative Expansions

Recent legislative action has also impacted actual and projected caseload growth. Senate Bill 43, enacted in the 77th Legislature, simplified the eligibility process and guarantees a six-month continuous coverage for children, effective as of Feb. 1, 2002. Another provision of Senate Bill 43, effective June 1, 2003, provides 12 month continuous eligibility for children. The impact of Senate Bill 43 on enrollment are included in the current HHSC caseload projections for 2004-2005. The 12-month continuous eligibility represents $400 million of the funding request for the Medicaid program. HHSC projects this would impact 194,000 clients in FY 2004 and 204,000 clients in FY 2005

Other legislative measures that have affected caseload growth include Senate Bill 532, 77th Legislature, to expand Medicaid coverage for women diagnosed with breast and cervical cancer[9] and Senate Bill 51, 77th Legislature, to offer Medicaid coverage for certain foster adolescents who have aged out of the Medicaid children eligibility categories. HHSC identified $1.1 million in state funding from administrative savings to use for implementation of Senate Bill 532. Senate Bill 51 was estimated to cost $822,000. However, that cost estimate was based on the state serving 849 clients - to date they have only served 700 which could reduce the expenditures.

Other factors affecting caseload growth included an extended outreach effort by the state associated with enrollment outreach for the CHIP program and federally mandated outreach programs for Medicaid. When CHIP was implemented in 2000, an extensive outreach campaign was waged to

[9]The Breast and Cervical Cancer Program is located at the Texas Department of Health and the federal portion is funded by the federal Centers for Disease Control.

enroll eligible children in the program. In fact, in FY 2002-2003, Texas succeeded in enrolling more children in CHIP faster than any other state in the country. Often, when parents apply for CHIP, they learn that they are ineligible because they meet the federal poverty level requirements for the Medicaid program.

Pharmaceutical Benefit Cost Increases

In Texas, the Medicaid pharmaceutical program is administered by the Vendor Drug Program (VDP), which was implemented in 1971. The VDP operates under federal guidelines. The Medicaid reimbursements must be sufficient to provide access to the same extent as it is available to the general public, and provider fees must be reasonable. Payments to pharmacies for ingredient costs must be the state's best price estimate of pharmacies' acquisition costs for the drugs dispensed.[10] The federal Omnibus Budget Reconciliation Act of 1990 (OBRA '90) requires that states offer an open formulary in exchange for Medicaid pharmaceutical rebates.[11]

The Center for Medicaid and Medicare (CMS) determines the rebate amounts; states apply the national rebate amounts to use rates and perform the rebate billing and collection function. Texas' Medicaid rebate collections for this biennium are $125.4 million for FY 2002 and $140.5 million for FY 2003.

Pharmaceutical price inflation and increased utilization have impacted all health care costs across the nation. The federal government estimates that prescription drug prices will increase an average of 12.6 percent per year over the next 10 years. If that projection is accurate, the Texas Medicaid Vendor Drug Program's biennial expenditures will grow from $3.36 billion in FY 2002-2003 to roughly $7.6 billion in FY 2010-2011.

In addition to inflation, the VDP is paying for growing levels of utilization. Providers are prescribing more drugs. The Vendor Drug Program will pay for 6.4 million more prescriptions, a 18.8 percent increase, from FY 2003 to FY 2005. The projected annual total for FY 2005 is 40.25 million prescriptions. (See Exhibit 1.7) As of August 2001, the 2004-2005 VDP costs are projected to be $780 million (GR) greater than FY 2002-2003 appropriation levels.

---

[10] "Best Price" generally means the lowest price available from drug manufacturers to wholesalers or retain pharmacy providers, HMOs or other entities within a retail class of trade.

[11] "Open Formulary" in the context of the VDP, broadly describes the availability of various prescription drugs covered by the program for Medicaid clients. In the VDP substantially every product of a drug manufacturer that signs a rebate agreement and participates in the Medicaid drug rebate program is covered, as required by federal law.

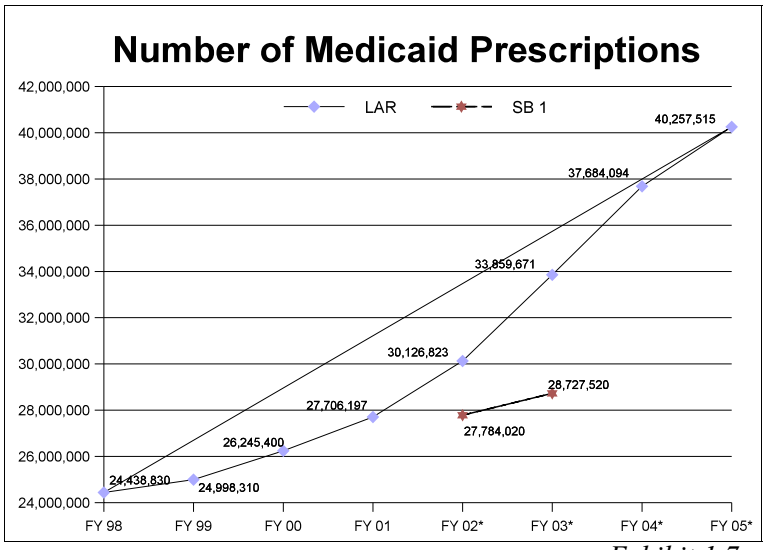


Exhibit 1.7

Much of the increase in the VDP has been attributed to increased utilization, newer and more expensive products, and price increases for existing products. (See Exhibit 1.8)

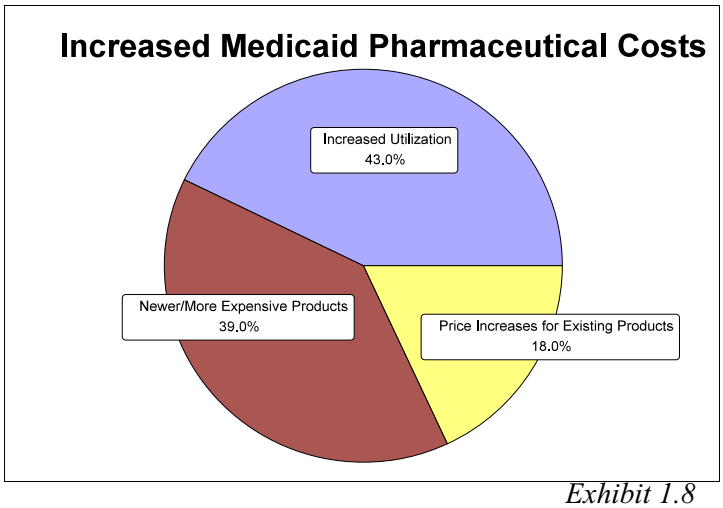


Exhibit 1.8

Dual Eligibles

To reduce the state Medicaid expenditures, the state pays Part A and Part B Medicare premiums for various eligible individuals. Beneficiaries then receive services covered by Medicare. State expenditures are impacted by caseload size (for the premium) and by the amount of the Medicare premium determined (increased) by the federal government. Approximately 63 percent of FY 2002-2003 cost increase projected for this Medicaid strategy is due to increases in Medicare premiums. The remaining 37 percent is attributable to caseload growth. The agency estimates FY 2002-2003 cost to be $1.1 billion, All Funds, and $417.9 million, General Revenue.

A key factor impacting this program's state funding levels is the lack of a pharmaceutical benefit in the federal Medicare program. Texas pays for all the drug costs for these individuals. These costs could be alleviated if the federal government created and funded a pharmaceutical program for all Medicare patients.

Funding Needs for 2004-2005 Biennium Summary

For 2004-2005, the Health and Human Services Commission is requesting $2,647.2 million over 2002-2003 levels to fund Medicaid caseload growth and increased cost. Of that total number, $417.3 million is in the agency's base bill as a supplement to the 2002-2003 biennium shortfall and $1,538.5 million addresses caseload growth. Additionally, the program will need $691.4 million to fund the caseload growth at the current level of service. (See Exhibit 1.9)

Additional General Revenue Requested to Maintain Medicaid Current Services in FY 2004-2005 over 2002-2003 Levels

(Dollars in Millions)

Base			
FY 2002-2003	Supplemental Funding	$ 417.3	
FY 2004-2005	Caseload Growth	1,538.5	
		$ 1,955.8	
Exceptional Items			
FY 2004-2005	Program Cost Increase	$ 691.4	
Total Requested for FY 2004-05			**$2,647.2**
(as of August 2002)			Greater than 2002-2003

Exhibit 1.9

Medicaid Cost Management Options

Through the process of taking testimony and examining issues relating to rising medical costs, a number of cost management concepts emerged or were presented. Below, is a summary of some of the options suggested. The committee takes no position as to the viability or feasibility of these suggestions.

FMAP

As the FMAP rate is set today, federal funding is skewed away from states such as Texas because the formula values average income rather than poverty levels. Like many other large states, Texas has areas of enormous wealth that offer a misleading picture that overshadows the reality of the pockets of our poor families Our average income is somewhat lower than the national average, but our ratio of poverty is significantly higher.

The federal Medicaid guidelines dictate that states accept clients based on a family's federal poverty level. Therefore, the method of financing based on income doesn't give an accurate depiction of how many people will actually apply and qualify for Medicaid. Federal aid to state Medicaid programs should be based on a state's poverty level - the actual factor used for qualifying for the program - not its wealth. With such a change, Texas' FMAP would increase by 10 percent. (see Attachment C) The state should consider working with its Congressional delegation to push a change in the FMAP formula.

Enhanced FMAP Border Zone

The most current definition of the border set by the Texas legislature includes a 43-county area. The Texas/Mexico border region has experienced a 25 percent increase in population. This dramatic population increase gave rise to a number of health concerns. Border residents along the entire U.S. border suffer from diseases such as diabetes, Tuberculosis, hepatitis and cancer at higher levels than other parts of the United States, yet this region does not have an adequate health infrastructure. Residents on both sides of the border are also exposed to a number of health hazards, including poor water quality, pesticides, contamination of fish and air pollution. A shortage of nurses, doctors and other health practitioners compound the problems faced by border communities in attempting to serve the large number of uninsured, under-insured and undocumented persons.

Further, the Texas border includes some of the poorest counties in the nation. Estimates of the population living below poverty for Texas counties in 1999 include figures as high as 50.9 percent for Starr County and 41.8 percent for Zavala County. The state average for that year was 15.4 percent.

In addition, medical providers along the Texas/Mexico border serve a disproportionate number of Medicaid clients while being reimbursed at the same rates as providers in the rest of the state.

Because Medicaid is such a large portion of their caseload, they are unable to offset the costs of Medicaid patients with other higher paying, non-Medicaid patients.

Enhancing the FMAP for Medicaid in the border areas to reflect the *region's* average per capita income would improve access to services by increasing the supply of services through increased reimbursements to providers in those areas. This targeted enhancement would offset the effects of the FMAP loss on a statewide level.

Medicaid Simplification

The final portion of Senate Bill 43 goes into effect June 2003 with 12 month continuous eligibility for children. The cost associated with this implementation is estimated to be $400 million dollars. Advocates for Medicaid simplification assert that allowing children to be continuously enrolled saves money in the Medicaid program in the end because the recipients receive continuous health care rather than sporadic, and sometimes emergent, health care. Depending on the Legislature's ability to assess where the greater savings are found, the following are options:

- Eliminate the 12-month continuous eligibility phase of the legislation
- Delay the final 12 month continuous eligibility phase of the legislation until the state is better able to fund the changes.
- Proceed with Senate Bill 43, as written, anticipating future savings from continuous eligibility for children.

Vendor Drug Program Restricted Pharmaceutical Formulary

A number of states have received approval from Health and Human Services Secretary Tommy Thompson to create a restricted formulary for their pharmaceutical program. These programs allow the states to establish a restricted formulary that sets preferences or implements prior authorization levels for pharmaceutical companies that agree to rebates or assistance programs for the state. Creating the ability to more effectively contract with pharmaceutical companies has the potential to provide some measure of controlling the escalation of prescription drug costs.

Currently, Pharmaceutical Research and Manufacturers of America (PhRMA) has a lawsuit pending against the federal and state governments' approval of such initiatives.

Competitive Hospital Contracting in Urban Areas

In urban areas where greater options may exist for hospital services, competitive bidding for a single Medicaid hospital designation would allow the state greater negotiating power with hospitals' health care costs.

Limit Services to Optional Populations

Adjusting the state plan's optional population and services could significantly reduce expenditures.

Disease Management

Encourage HHSC to investigate possible disease management programs for Medicaid.

- Diabetes
- Cardiovascular
- Asthma

Potentially partner with pharmaceutical companies to pool information, resources and low income assistance programs.

CHIP

Background

The Children's Health Insurance Program (CHIP) provides health insurance for children younger than 19 whose household income does not exceed 200 percent of the poverty level and who are ineligible for Medicaid. CHIP is an insurance program in which the state contracts with various health plans to provide services in return for a premium. The program is financed by a federal grant, state appropriations and premiums paid by the policyholder families. CHIP enrollees receive health care and dental care from participating health plans, medical groups and dentists.

The Federal Balanced Budget Act dedicated nearly $50 billion over 10 years to CHIP. In July 1998, Texas implemented Phase I of its CHIP program. CHIP Phase I provided Medicaid to children aged 15 to 18 in households whose income is under 100 percent of the Federal Poverty Level (FPL). The federal government had already mandated the phase-in of coverage for these children, but Texas had not yet completed its phase-in when CHIP was created. Phase I of CHIP existed from July 1998 through September 2002. Average monthly enrollment in Federal Fiscal Year (FFY) 1998 was 17,500 and in FFY 1999 was 34,800. In FFY 2000, monthly average enrollment was 25,300 and dropped to 13,900 in FFY 2001. Monthly enrollment for CHIP Phase I in FFY 2002 is expected to be less than 5,000. Implementing legislation for Phase II of CHIP[12] was passed during the 76th Legislature. However, Texas did not begin enrolling children until May 2000. Development of the Texas program was delayed because federal authorization for CHIP came in 1997 – after the Texas Legislature had adjourned.

Since Texas began enrolling children in May 2000, total funding (state and federal) has increased from $78.3 million to $806.5 million in 2003. As of November 2002, CHIP enrollment had reached 503,748 children. (See Exhibit 2.1)

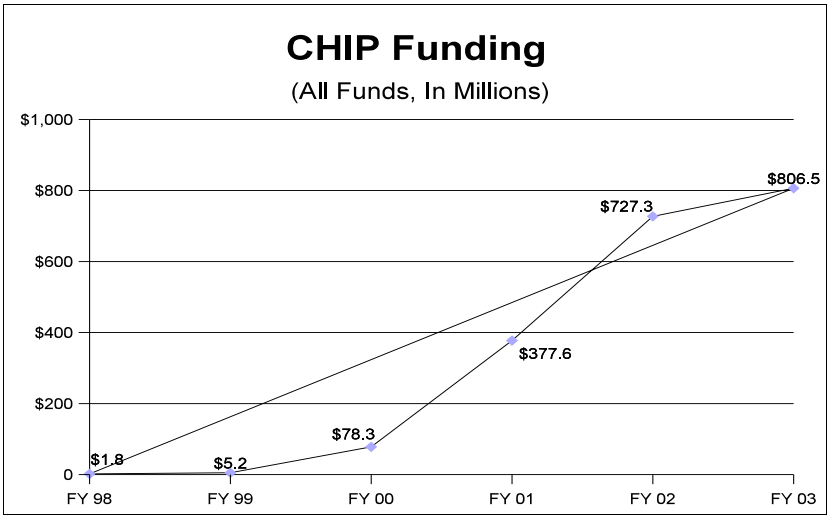


Exhibit 2.1

[12]CHIP Phase II is the program described in the first paragraph of this section.

Federal Method of Finance - Enhanced Federal Medical Assistance Percentage (FMAP)
Similar to Medicaid, CHIP is a federal/state cost share program. However, the rate of the federal contribution is significantly greater for CHIP than Medicaid. The federal share of the CHIP program is based on the Enhanced FMAP formula.[13] Under the Enhanced FMAP formula, the federal share of funding is increased by reducing the state's contribution by 30 percent of its FMAP state share.[14]

2004 Enhanced FMAP Example:
39.78 - (39.78 * .30) = 27.85 Enhanced FMAP rate for the state with 39.78 percent being Texas' 2004 FMAP share

Enhanced FMAP levels in Texas:

Federal Fiscal Year	Enhanced CHIP FMAP	Medicaid FMAP
1998	73.60%	62.28%
1999	73.72%	62.45%
2000	72.95%	61.36%
2001	72.40%	60.57%
2002	72.12%	60.17%
2003	71.99%	59.99%
2004	72.15%	60.22%

As would be the case in Medicaid, any change in the FMAP will result in increases or decreases in the level of federal funding that impact the state's CHIP contribution levels. (See Exhibit 2.2)

State Method of Finance
The method of finance for the state appropriation is a combination of general revenue and general revenue dedicated tobacco receipts. Texas received an initial lump payment from the tobacco settlement that was distributed to counties and the state. Since that time, the state receives annual payments pursuant to the lawsuit agreement. Those funds are deposited each December into the General Revenue Fund and given an identifying number for tracking purposes. Texas' annual tobacco settlement payment is $580 million, subject to adjustments.[15] As written in the CHIP enabling legislation, CHIP has first draw on all tobacco monies, subject to the appropriations process.

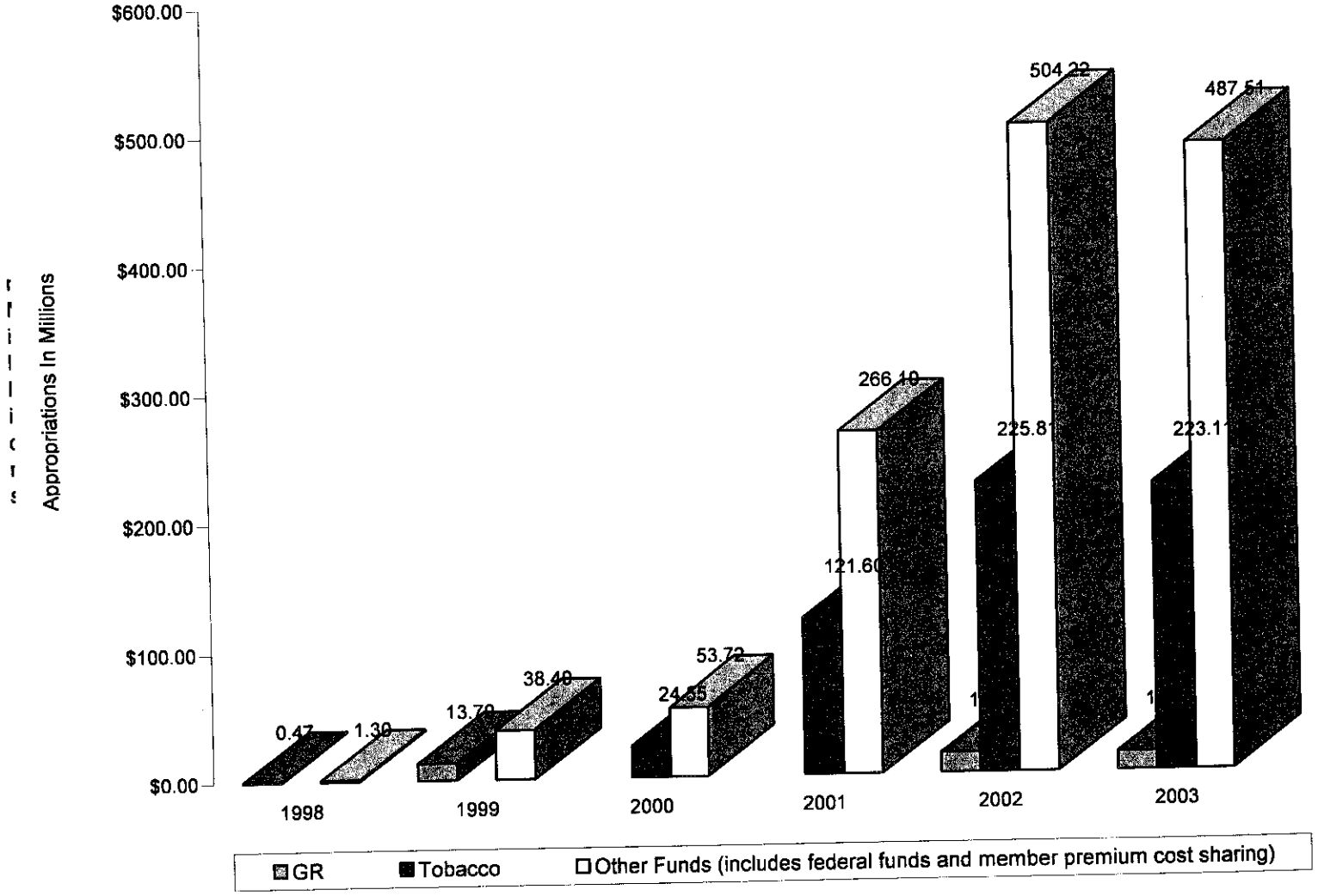
---

[13]The FMAP is figured annually based on each state's average income compared to the nation's average income for the three most recent calendar years. Refer to Medicaid portion of this report for further information.

[14]Federal Funds Information for States, **Issue Brief 2002-2005 Final FY 2004, FMAPs**, September 24, 2002.

[15]Adjustments are made, pursuant to the settlement agreement, based on tobacco sales, volume and inflation.

Exhibit 2.2 CHIP Funding



Federal Fund Lapse

As of October 2002, Texas faced the possibility of lapsing approximately $285 million in unspent federal CHIP funds. This lapse is due primarily to Texas' inability to implement and rollout the program until May 2000.

Federal CHIP allocations are appropriated in 10 year cycles (FFY 1998 - FFY 2007). Then any one year's allocation is available to the state for a total of three federal fiscal years.[16]

The Texas CHIP program was created in 1997 and funding began in 1998. Because Texas has a biennial legislature, timing became a factor in prompt spending of federally appropriated funds. Texas received its largest allocation of federal funding in 1998, and smaller allocations in subsequent years. This funding scheme goes contrary to the reality of the program. States were given large appropriations at the outset when there was little enrollment. Then the funding decreased over time as the program matured and enrollment grew, therefore, more funding was needed.

This current funding loss is reflective of Texas' unspent funds from the year 2000. The front-loading of federal funds made it difficult for Texas – and most other states – to spend its first three years of allocations. Almost 40 states had funds left over from the 1998 and 1999 allocations, and a similar number may face the same problem as Texas with their fiscal year 2000 funding.

This potential lapse does not affect current services under the CHIP program. However, it could be felt in the out years, FFY 2006 and 2007 (the end of the current ten year allocation period), if caseload growth and program costs continue to escalate. HHSC estimates the FY 2000 funds will be the final funds the state will be not able to spend during stipulated years.

Historically, Texas has lapsed funds as follows:

Allocation Year	Federal Funds Spent	Federal Funds Lapsed
1998	$310 million	$170 million
1999	$234 million	$324 million

The law dictating the period of time states had to spend a year's allocation was amended to allow 1998 funds to be available for two more years and 1999 funds for one more year. Action from the federal government extending the time in which states can spend 2000 funds has not occurred. However, President Bush has asked Congress to allow states to keep all funding from 1998 and 1999 until 2006. Also, Senators John D. Rockefeller (D-W.Va) and Lincoln Chafee (R-RI) have proposed legislation to send lapsed funds to states that have been more successful in spending the CHIP funds.

[16] "Available" meant that (for a state with unexpended funds) only a portion of the unexpended funds for those years was available. The rest was redistributed to states that had spent all of their allocations.

Cost Containment Initiatives

Similar to Medicaid, CHIP was also the subject of the joint Senate/House Article 2 Working Group during the 77th Legislative Session. Several cost containment features were discussed and implemented as a result of solutions developed in that process.

Two initiatives were implemented: the Vendor Drug Program carve out; and increase of co-payment amounts.

Vendor Drug Program Carve Out

Beginning in March 2002, HHSC "carved out" the CHIP prescription benefit from each of the CHIP health plans . Now all pharmaceutical needs of the CHIP program are served through the Medicaid Vendor Drug Program (VDP)[17], combining the CHIP pharmaceutical program with the VDP. Combining the VDP increased purchasing power and bargaining position of the state because HHSC is in a better position than individual plans to negotiate prices with the pharmaceutical companies.

Prior to the change, CHIP clients were subject to common pharmaceutical cost containment strategies, such as restricted formularies and prior authorization, that may have been implemented by the individual plans. Now, CHIP clients only pay a co-payment for pharmaceuticals purchased through the VDP. Based on data projections for 2002, it appears this change reduced per member per month drug costs from $14.49 to $12.93. HHSC estimates a total 2002-2003 biennial savings to the state to be approximately $4.14 million.

Another benefit of combining the CHIP pharmaceutical benefit program with the VDP was the ability of HHSC to negotiate Medicaid level rebates with pharmaceutical companies for CHIP drugs purchased through the VDP. CHIP drug manufacturer rebates were negotiated with the understanding that CHIP would have the same open formulary used by Medicaid.[18] In exchange, manufacturers would provide rebates to the CHIP program at the rate of 21 percent. The estimated rebate revenue for FY 2002 is $110,000 and for FY 2003 is $4,344,079.

Currently, these rebates are deposited into the General Revenue Fund. HHSC does not have authority to roll them back into the program to offset costs. HHSC would need authority from the Legislature or the Governor's Office and the Legislative Budget Board to harness the rebates.

---

[17]HHSC adjusted the plans' reimbursement rates to account for the removal of the costs associated with the drug benefit.

[18]In the context of the Medicaid Vendor Drug Program, "open formulary" describes the availability of various prescription drugs covered by the program for Medicaid clients. In the Vendor Drug Program, substantially every product of a drug manufacturer that signs a rebate agreement and participates in the Medicaid drug rebate program is covered and available to clients, as required by federal law.

CHIP Co-Payments

CHIP program has implemented a co-payment schedule to encourage appropriate utilization. In March 2002, the CHIP co-payment schedule for emergency room visits and prescription drugs was increased and deductibles were replaced with an inpatient hospital admission co-pay.
(See Exhibit 2.3)

CHIP co-payment schedule

Federal Poverty Level	Below 100%	101% - 150%	151% - 185%	186% - 200%
Office Visit Co-pay	$0	$2	$5	$10
Emergency Room Visit	$3	$5	$50	$50
Generic Prescription	$0	$0	$5	$5
Brand Name Prescription	$3	$5	$20	$20
Facility Co-Pay	$0	$25 per inpatient hospital admission	$50 per inpatient hospital admission	$100 per inpatient hospital admission
Annual Enrollment Fee	$0	$15	$15 (first month's premium)	$18 (first month's premium)
Monthly Family Premium	$0	$0	$15	$18
Annual Cost Sharing Caps	$100 per family	$100 per family	5% of annual income	5% of annual income

Exhibit 2.3

Cost Drivers

CHIP is a relatively new program with evolving processes and adjustments, and reliable data regarding cost drivers is still developing. Similar to most health care systems in the nation, CHIP costs are typically driven by enrollment growth, increase in the cost of services, and rising prescription drugs costs due to inflation and utilization. Despite declines in the rate of enrollment growth and savings achieved in carving out the pharmaceutical benefit, premium rates have continued to increase.

Premium Rates

Under the CHIP program, changes in program costs due to utilization, provider rates and general inflation are reflected in the premium rate. The premium rate is based upon actuarial projections and costs for each member of the plan and is similar to the premium paid for group health insurance.

The initial premium rating period covered the period beginning May 1, 2000, through September 30, 2001. Because CHIP was a new program with no historical data, premiums for the first year of operation were determined based on target rates developed largely on Medicaid fee-for-service experience, and data from the Texas Uniform Group Insurance Program and other commercial plans.

According to the health plans, the premium rates developed for the first year were insufficient to cover losses experienced by the plans. During the second year, Oct. 1, 2001, through Sept. 30, 2002, rates were negotiated with each individual health plan based on actual experience of the plan.

For appropriations for the 2004-2005 biennium, HHSC is assuming a 6 percent annual increase for benefit costs, including utilization and inflation. In order to maintain current services for the level of anticipated caseload growth and projected increase in benefit costs, HHSC is requesting $62.9 million in GR over 2002-2003 levels. (See Exhibit 2.4)

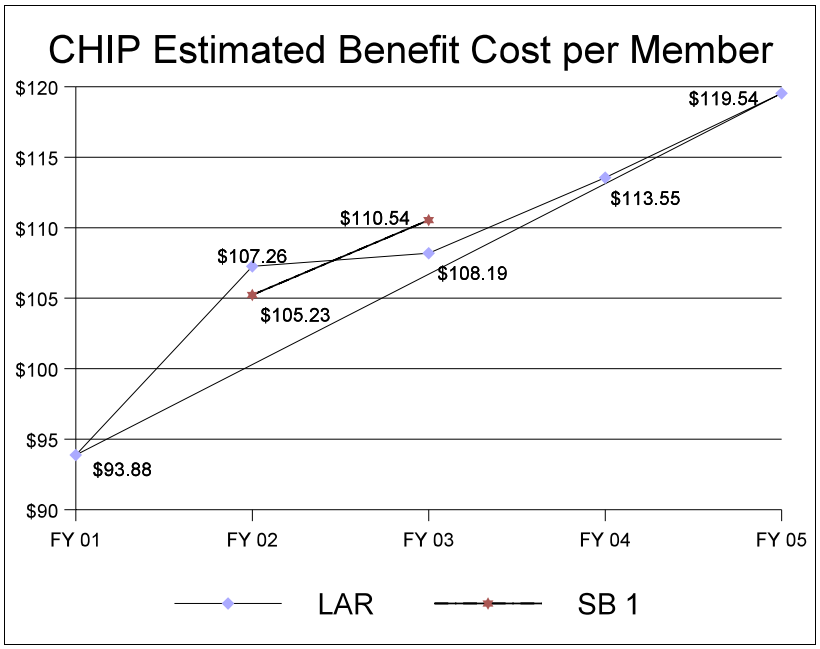


Exhibit 2.4

Caseload Growth

Texas began the 2002-2003 biennium enrolling more children in CHIP faster than any other state in the country. As of November 2002, CHIP enrollment had reached 503,748 children. (See Exhibit 2.5) HHSC estimates it will need a supplemental appropriation of $31.4 million, two-thirds of the total CHIP deficit, to address caseload growth for 2002-2003. However, it appears that caseload growth rates are leveling off, which should provide some relief in budget pressures for the future.

In forecasting budget requests for the 2004-2005 biennium, HHSC has assumed a 1 percent per year rate of caseload growth. At this level of growth, funding increases over the last biennium attributed to caseload growth will total $6.5 million (out of $62.9 million request) .

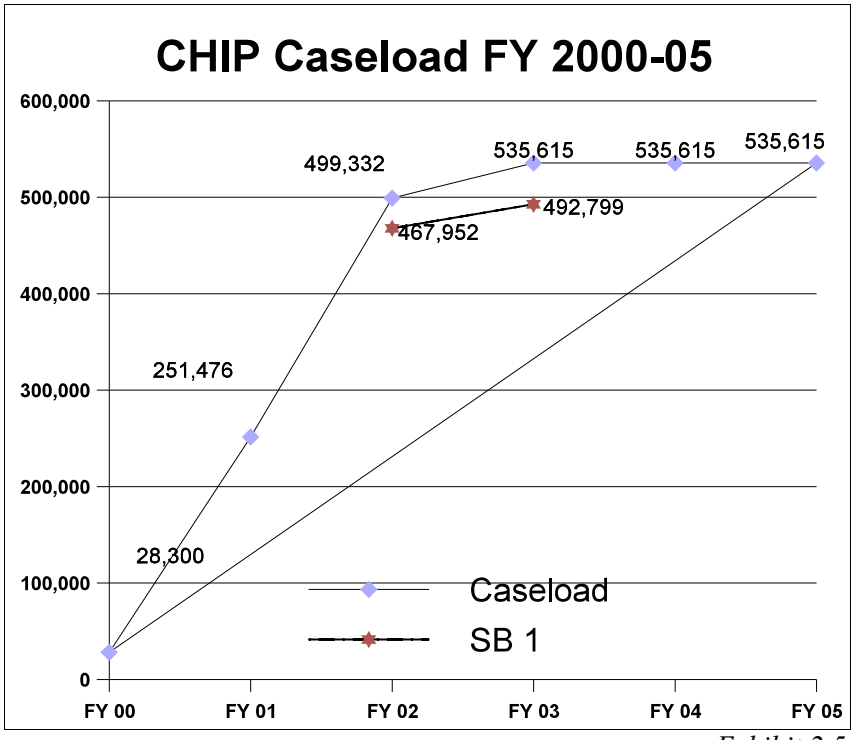


Exhibit 2.5

Pharmaceutical Benefit

With an estimated cost increase of 17 percent per year, prescription drugs act as a crucial component in the rise of health care services costs for CHIP. While under the health plans, the increases in drug costs were a combination of increased utilization and increased cost per member. However, with the recent move of the pharmaceutical benefit to the Vendor Drug Program (VDP), data is not available to accurately identify which of those two components is the more significant cost driver.

HHSC testified the costs of pharmaceuticals will continue to increase due to inflation, but the agency will have a greater ability to control many costs now that the pharmaceutical benefit is under the VDP rather than the CHIP health plans. HHSC has utilized a series of administrative interventions to control the costs of pharmaceuticals. They have implemented a pharmacy management system, enhanced surveillance of potential fraud and abuse, clinical guidelines for improved efficiency, and increased drug utilization review.

It is the hope of HHSC that the benefits of carving out the pharmaceutical drugs, in addition to the CHIP rebates, will help minimize the affects of drug cost increases on the program. This program change has been in place since March 2002, and more time will be needed to see the true impact on CHIP costs.

Funding Needs for 2004-2005 Biennium Summary

The Health and Human Services Commission is requesting $94.3 million over 2002-2003 levels to fund CHIP caseload growth and increased cost. Of that total number, $31.4 million is in the agency's base bill to supplement the 2002-2003 biennium shortfall and $62.9 million as an exceptional item request to address cost and caseload growth for 2004-2005. (See Exhibit 2.6)

Additional General Revenue Requested to Maintain CHIP Current Services in FY 2004-2005 over 2002-2003 Levels

Base	
FY 2002-2003 Supplemental Funding	$31.4 million
Exceptional Items	
FY 2004-2005 Program Cost & Caseload Increase	$62.9 million
Total Requested for FY 2004-05	**$ 94.3 million**
(as of August 2002)	greater than 2002-2003

Exhibit 2.6

CHIP Cost Management Options

Through the process of taking testimony and examining issues relating to rising medical costs, a number of cost management concepts emerged or were presented. Below, is a summary of some of the options suggested. The committee takes no position as to the viability or feasibility of these suggestions.

Pharmaceutical Drugs

- Give the HHSC the authority to spend the CHIP rebate funds on the CHIP program that are currently being placing into the General Revenue Fund.
- The creation of a restricted formulary or three tiered co-payment structure for prescription drugs could establish some cost containment for prescription drug use in CHIP.

Premium Rate Growth

The HHSC should report to Senate Finance the savings individual health plans may have experienced with implementation of cost saving measures: removal of the pharmaceutical benefit and introduction of utilization control measures. The number of patients - or at least the cost levels of services - should have been reduced with a utilization controlling co-payment system. HHSC rate setting for CHIP plans should accurately reflect cost savings the state has provided for the plans.

Caseload Growth

As previously discussed, the stabilized CHIP caseload growth does not appear to continue to present a budgetary challenge. CHIP is a successful state program that is attaining its goal of providing low cost insurance to the children of Texas. The cost drivers that continue to impact this program are issues experienced by the entire system of health care. Therefore, the following options may not be best considered as first options, as caseload growth impact on the budget has lessened. However, the approaching legislative session may present itself with budgetary shortfalls and the following are possible options to curtail further growth in the program.

- Delayed Enrollment
  Health care services begin as soon as a child is approved for the program. Delaying enrollment one to two months from eligibility determination could aid in slowing caseload growth for the program.

- Limited Open Enrollment Periods
  At the present time, children can apply for CHIP at any time during the year. Similar to the state employee system, CHIP could move to an annual or semi-annual enrollment period. Certain qualifying events, such as losing Medicaid coverage, could serve as an exemptions.

- Cap Enrollment
  If funds are not available for the new growth in CHIP, the HHSC could cap enrollment with currently enrolled children and begin a waiting list.

- Reduce 12 months Continuous Eligibility
  Many children's family income status changes throughout the year. Increasing the number of opportunities for the state to assess income levels could slow caseload growth.

Benefit Reduction

- Elimination of the CHIP Dental Benefit
  CHIP provides a limited dental benefit with a $300 annual cap on therapeutic services. Eliminating or reducing this benefit could provide some cost savings.

- Reduce CHIP Benefit Package
  Under federal law, the CHIP benefit package must be the same as or the equivalent of one of three benefit packages: the federal employees standard Blue Cross/Blue Shield PPO plan; coverage offered and generally available to state employees in Texas; or coverage offered by the HMO in the state with the largest insured commercial, non-Medicaid enrollment. Alternatively, the CHIP package can be one that is approved by the Secretary of Health and Human Services.

  Theoretically, the greatest room for adjustment in the current CHIP benefit package would be through an amendment to the state plan under this last option. The current CHIP package was determined to be actuarially equivalent to both the state employee plan and the largest insured commercial HMO in the state. To what extent the benefits in CHIP could be reduced without the state being out of compliance with the actuarial equivalency requirement in federal law is unclear. There are no standards for this option and it is unclear how much less comprehensive the package could be and still garner Secretarial approval.

  However, the Health and Human Services Commission could investigate the possible limits of benefit reduction that would not compromise our status as actuarially equivalent.

State Employee Health Care

Employees Retirement System of Texas (ERS)

Background

The Texas Employees Uniform Group Insurance Program (UGIP) was established by the 64th Legislature in 1975 to provide high quality health insurance and other optional coverage for state employees, retirees, and eligible dependents. Today, the program offers three major options of health coverage. Two self-funded programs are administered by Blue Cross/Blue Shield of Texas: HealthSelect, a self-funded, point-of-service, managed care health plan offers both in-network and out-of-network benefits; and HealthSelect Plus, a self-funded health maintenance organization. The third health care option is provided through contract with private health maintenance organizations who provide a variety of health-care alternatives.

Levels of benefits and premiums for the two self-funded plans are set by the ERS board. Private HMOs must submit bids and/or applications meeting certain benefit and premium specifications set forth by the ERS board as well. HMOs are admitted to the program only if they bring a cost savings to the program.

Premium costs for active state employees enrolled in any UGIP health plan are covered 100 percent from date of employment to the date of termination. In addition, fully vested retirees may enroll in UGIP health plans. For these participants, the state covers 100 percent of premium costs. Dependents of active employees and retirees are also eligible for enrollment in UGIP health plans. For these dependent participants, the state covers 50 percent of the premium costs.

During the past 23 years, enrollment in the program has naturally increased as employees have retired and the state's population has grown. Along with that growth is the 1993 decision to include employees and staff at Texas' colleges and universities. In addition, members of executive boards have also been added. Today, UGIP enrollment includes about 530,000 employees, retirees, and dependents. More than 57 percent of those participants are enrolled in HealthSelect; 31 percent use HealthSelect Plus; and 12 percent are enrolled in one of the participating private HMOs (see Exhibit 3.1).

The UGIP health plans are primarily funded through a combination of state and employee contributions. For FY 2002, these two elements provided $1.38 billion in revenue with the state funding $1.1 billion (81 percent) of the total. While the state's proportional share of funding has remained relatively constant since 1998, the total dollars appropriated have increased dramatically. Since 1998, the state's contribution has jumped 60 percent, requiring an additional $419 million. Over that same time period, employee contributions have risen almost 50 percent, generating an additional $86.3 million.

Despite these dramatic increases in funding, expenditures have consistently outdistanced contributions. Since 1998, UGIP has had an average annual shortfall of $71.6 million. To offset this difference, the program has typically utilized investment income, hospital/formulary refunds, and subsidized from its reserve fund. Prior to 1998, funding sources were sufficient to cover funding requirements and accumulate a reserve. The UGIP reserve fund peaked at $249 million at the end of FY 1997.

Since that time, general sources of revenue have been insufficient to cover costs and the reserve fund balance has dwindled. Requiring $50 million per year on average to balance expenditures, the reserve fund was expected to be depleted by the end of FY 2002. State law does require ERS to request the funding necessary to maintain a reserve adequate to pay 60 days of claims. As a result, ERS' current LAR requests $221.5 million for that purpose (see Exhibits 3.2, 3.3 and 3.4).

To help control the costs driving much of this demand for addition revenue, ERS has implemented many cost containment initiatives, including prior authorization requirements; financial incentives for using network benefits; and utilization of a pharmacy benefit manager (see Exhibit 3.5). Even with these and other changes to benefits, UGIP health plans continue to be comparable with group insurance programs offered by cities, counties, and private industry around the state (see Exhibit 3.6).

In addition to the cost containment initiatives, ERS (in conjunction with BlueCross/BlueShield) has instituted an aggressive claims payment review process. In FY 2002, $2.7 billion in payments were reviewed for ineligible charges, such as:

- duplicate claims
- non-covered services
- charges for which there was incomplete documentation
- charges incurred when coverage was not in effect
- charges incurred in facilities not under contract
- charges for services not medically necessary; and
- amounts in excess of benefit maximums

Of the payments reviewed, 21 percent were identified as ineligible, which saved the program $582.5 million.

All cost-saving initiatives employed by ERS, however have served only to slow the exponential growth in rising health care expenditures**.** Since 1998, UGIP health plan expenditures have increased 54 percent or $494 million even though enrollment has increased only six percent.

Cost Drivers

There are several factors driving this increase in spending. Increased utilization has played a role. However, with enrollment in UGIP health plans growing only slightly each year (around 1 percent annually), many of the increases in this area relate to participants accessing their benefits more frequently. Since 1998, the number of non-prescription, health claims for each participant in HealthSelect has increased from 11.4 claims per participant to 12.67 claims. This is an increase of 11 percent. By the end of FY 2005, the numbers are expected to increase by 12 percent, pushing claims up to 14.25 annually for each participant (see Exhibit 3.7).

Growth in pharmaceutical utilization has been a factor as well. The number of HealthSelect prescriptions for each participant has risen almost 21 percent since 1998; each participant's annual prescription needs have jumped from 12.8 prescriptions to 15.5 prescriptions in just four years. By the end of FY 2005, this number is expected to grow another 20 percent, taking pharmaceutical claims up to 18.46 prescriptions for each participant annually (See Exhibit 3.8).

Some of these trends may be attributed to higher consumer awareness and education. Radio, television, print publications and the Internet are all utilized extensively today by individuals to educate themselves about the latest in health care technologies. In addition, health care marketers use these media to reach out to potential consumers. With a health care consuming public more savvy about the latest trends in medical care and prescription drug efficacy, doctors are facing more specific requests for courses of diagnosis and treatment.

Dramatic increases in some of the underlying costs of the services being accessed is likely a main culprit behind the escalation in health care spending. Since 1998, UGIP claims costs per participant (excluding prescriptions drugs) have increased more than 40 percent for HealthSelect and almost 43 percent for HealthSelect Plus. This has brought the average monthly claims costs per participant from $217.36 to $304.34 for HealthSelect, and from $243.60 to $347.40 for HealthSelect Plus. These dollar figures are expected to grow an additional 34 percent and 31.6 percent, respectively by the end of FY 2005 (see Exhibits 3.9 and 3.10).

Similar to changes in general medical benefit costs, prescription drug benefit costs have also grown significantly. In 1998, average monthly pharmaceutical claims cost per HealthSelect participant were $73.47. For FY 2002, that number was up 35.2 percent to $99.32. By the end of FY 2005, it is expected to increase another 72.8 percent, taking the cost to $171.62 annually for each participant's pharmaceutical needs. The total increase comes to 134 percent since 1998. The numbers are equally as dramatic for HealthSelect Plus. From 1998 to 2002, pharmaceutical claims cost per member increased 44 percent. And similar to HealthSelect, they too are expected to increase another 72.8 percent by the end of the coming biennium (See Exhibits 3.9 and 3.10).

One of the factors driving these increases has been growth in the rates charged for pharmaceuticals. For example, in 1998, the average payment per HealthSelect prescription was $37.75. For 2002 the price had increased 11 percent, up to $41.92. By FY 2005, it is projected that the average plan payment per prescription will be $59.58, an increase of another 42 percent (see Exhibit 3.11).

In addition, general health care reimbursement rates - including those of hospitals and physicians - have recently begun to increase. Requests for increases in reimbursement rates have been met to avoid the threatened exodus of large groups of providers. This was required for UGIP to maintain its broad network. However, the result has been growth, such as a 40 percent increase to the Baylor Hospital System; a 12 percent increase to the Presbyterian System, and double digit increases to the HCA hospitals. In addition, general health providers have seen 4 percent to 5 percent reimbursement rate increases each year (see Exhibit 3.12).

EXHIBIT 3.1
ERS Health Plan
Average Monthly Participation in All Health Plans

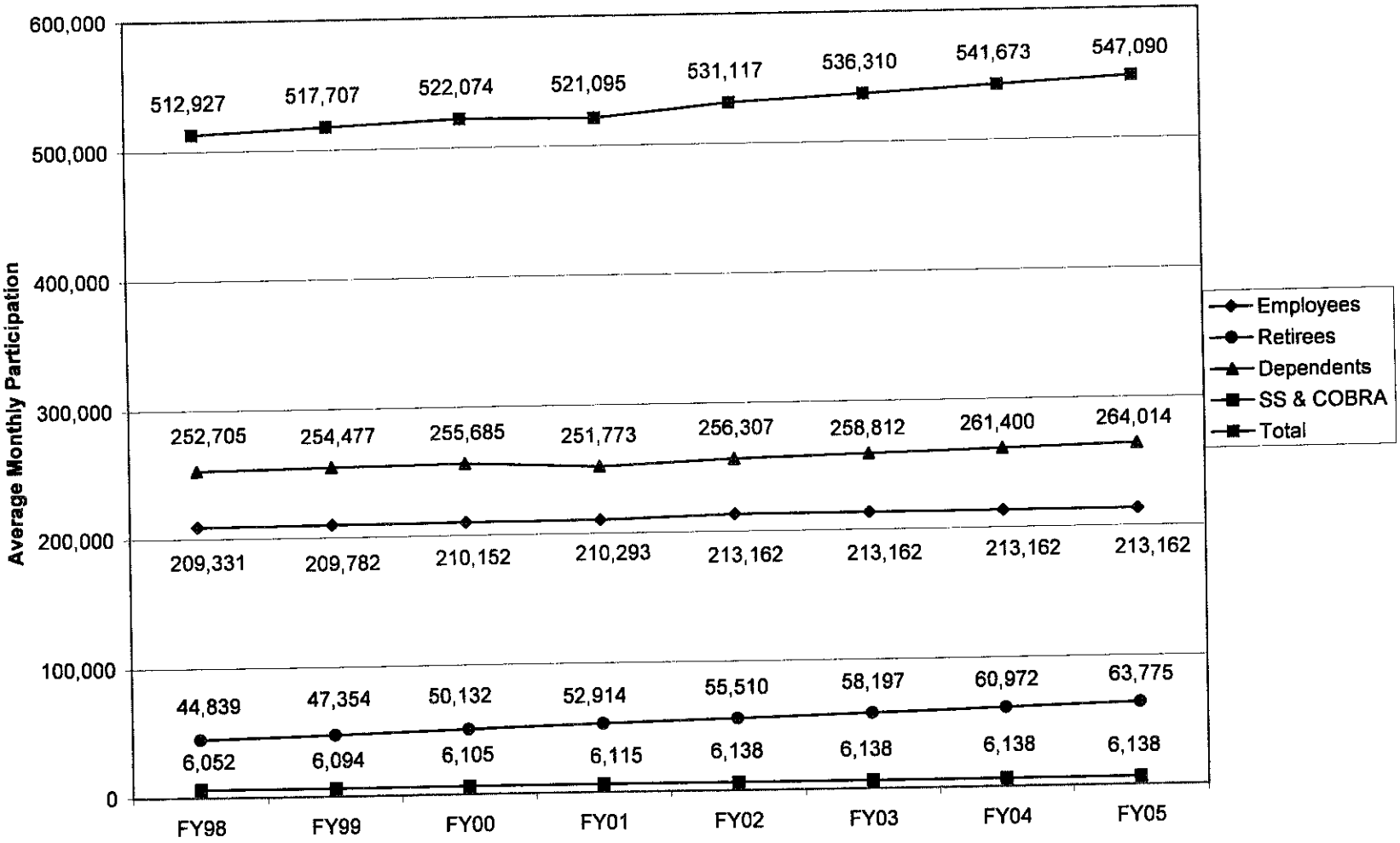


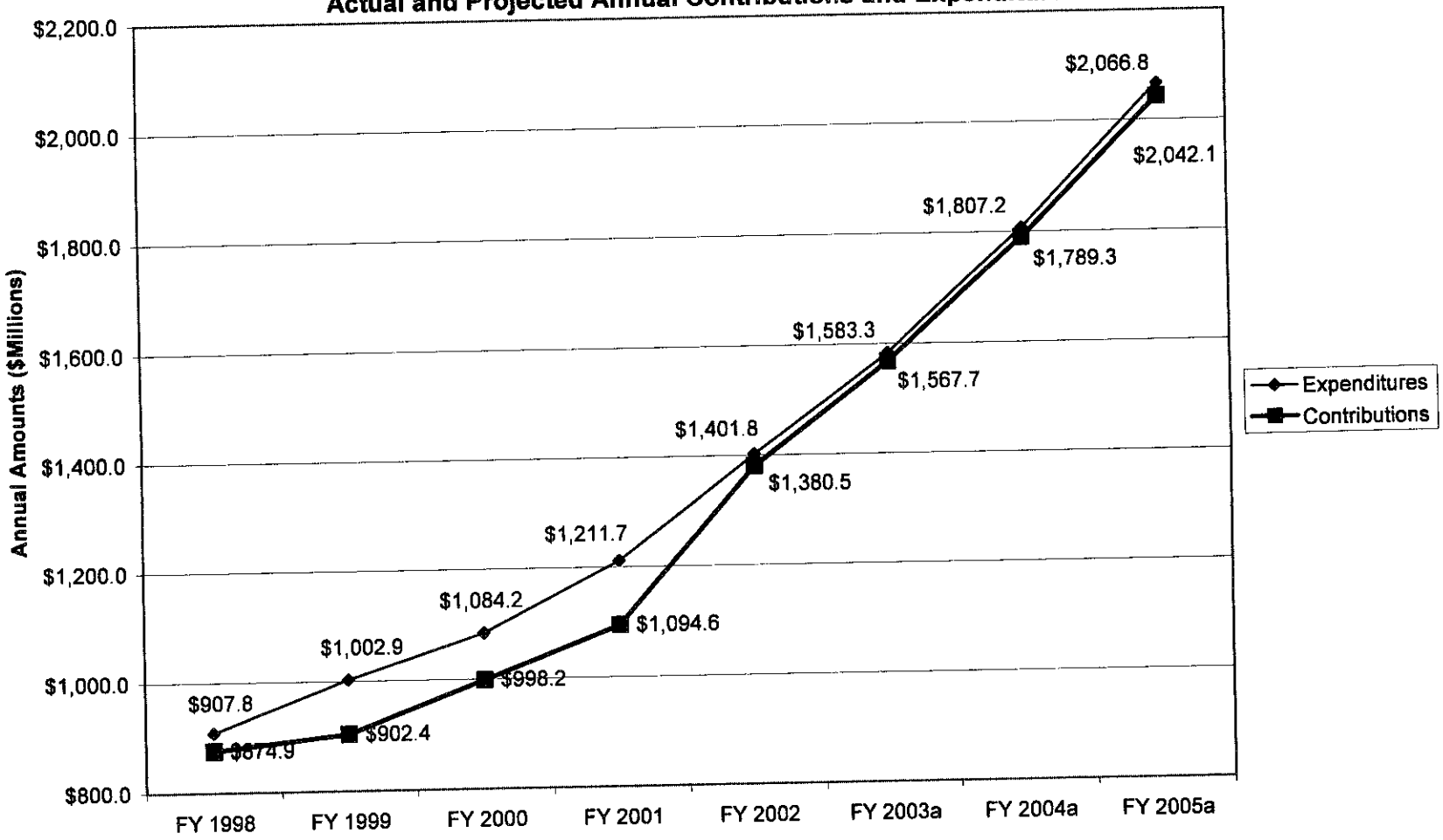
EXHIBIT 3.2
ERS Health Plan Financial History
($Millions)

	Actual FY 1998	Actual FY 1999	Actual FY 2000	Actual FY 2001	Estimated FY 2002	Projected FY 2003[a]	Projected FY 2004[a]	Projected FY 2005[a]
Health Plan Expenditures:								
HealthSelect	$504.5	$579.6	$650.9	$747.0	$837.3	$1,077.3	$1,223.9	$1,392.8
HealthSelect Plus	64.5	103.0	139.5	245.0	430.3	333.0	373.6	419.9
HMOs	338.8	320.3	293.8	219.7	134.2	173.0	209.7	254.1
Total, Health Plan Expenditures	$907.8	$1,002.9	$1,084.2	$1,211.7	$1,401.8	$1,583.3	$1,807.2	$2,066.8
Percent Change	3.8%	10.5%	8.1%	11.8%	15.7%	12.9%	14.1%	14.4%
Method of Finance:								
State Contribution	$699.6	$717.3	$798.3	$867.8	$1,118.9	$1,270.4	$1,450.0	$1,654.8
Employee Contribution	175.3	185.1	199.9	226.8	261.6	297.3	339.3	387.3
Subtotal, Contribution Revenue	$874.9	$902.4	$998.2	$1,094.6	$1,380.5	$1,567.7	$1,789.3	$2,042.1
Percent Change	2.2%	3.1%	10.6%	9.7%	26.1%	13.6%	14.1%	14.1%
Contribution Shortfall	-$32.9	-$100.5	-$86.0	-$117.1	-$21.3	-$15.6	-$17.9	-$24.7
Other Funding Sources:								
Hospital/Formulary Refunds	$4.0	$7.0	$7.2	$7.6	$18.5	$15.0	$15.0	$15.0
Net Investment Income[b]	21.6	17.5	16.2	11.6	3.8	-0.8	-0.3	0.0
Reserve Fund	7.3	76.0	62.6	97.9	-1.0	1.4	3.2	9.7
Total, Other Funding Sources	$32.9	$100.5	$86.0	$117.1	$21.3	$15.6	$17.9	$24.7
Reserve Fund Balance	$236.0	$171.1	$116.1	$18.3	$19.3	$17.9	$14.7	$5.0

[a]Expenditure and revenue amounts assume current level of benefits and 1% annual growth in membership.

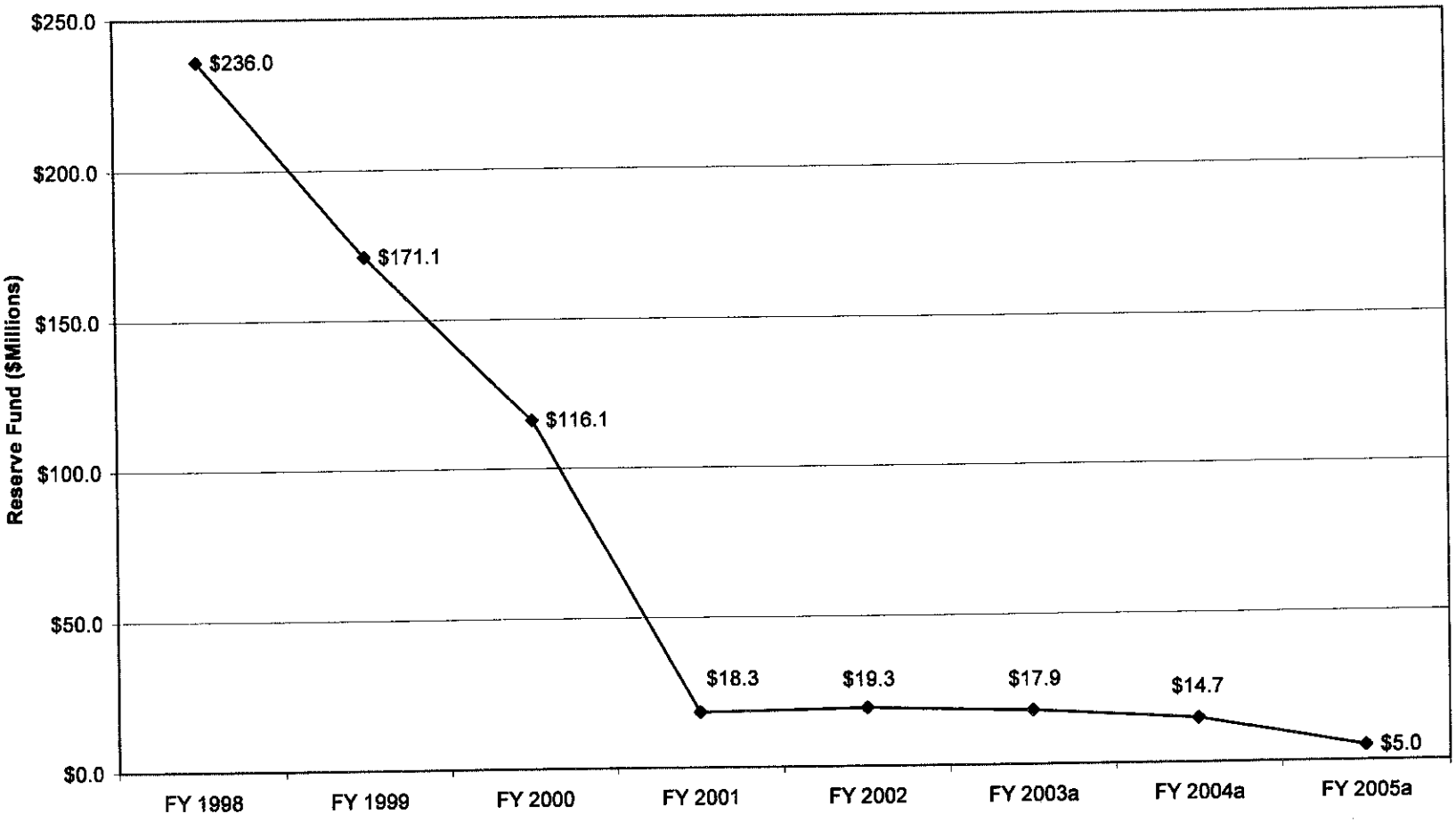
[b]Net investment income represents the excess of investment income over ERS operating expenses related to the insurance program.

EXHIBIT 3.3
ERS Health Plan Financial History
Actual and Projected Annual Contributions and Expenditures



a Expenditure and contribution amounts assume current level of benefits and 1% annual growth in membership.

EXHIBIT 3.4
ERS Health Plan Financial History
Actual and Projected Reserve Fund Balances



a Assumes current level of benefits and 1% annual growth in membership.

EXHIBIT 3.5 ERS Cost Containment Initiatives	
1993	Required primary care physicians to manage medical care
	Negotiated discounted payments to network providers
	Implemented out of pocket cost incentives to use network providers
1996	Restructured the retail pharmacy network
1997	Introduced mail order prescription drug program
	Negotiated reduced reimbursement rates to certain physicians
1998	Increased generic and name brand prescription drug copayments
	Implemented reduction in hospital reimbursement rates
	Eliminated early refills of prescription drugs
1999	Negotiated 2-year contract for competitively bid HMOs
	Standardized HMO physician copayment
2000	Converted to independent pharmacy benefit manager for HealthSelect
	Increased HealthSelect and HealthSelect Plus brand drug copayments
	Increased HealthSelect out of network deductibles
2001	Implemented 3-tier prescription drug program
	Increased prescription drug copayments
	Eliminated retail maintenance drug benefit
	Implemented specific drug quantity limits
2002	Required prior authorization on certain prescription drugs
	Expanded use of quantity limits on prescription drugs
2003	Continued HealthSelect Plus only in major metropolitan areas
	Froze enrollment in HealthSelect Plus

EXHIBIT 3.6
Comparison of HealthSelect's Benefit Schedule To Other Entities' POS/PPO Plans

Plan Description	Texas HealthSelect	City		County			Private Industry				
		Austin	Houston	Dallas	Travis	Harris	HEB	SW Airlines	IBM	Motorola	Dell
	90%/10%	90%/10%	60%/40%	90%/10%	90%/10%	100%	90%/10%	85%/15%	100%	90%/10%	80%/20%
Employer Pays											
Employee only	100%	100%	90%	96%	100%	100%	80%	100%	80%	87%	80%
Dependents	50%	50%	82%	71%	0%	50%	80%	2%	80%	87%	80%
Retirees	100%	See note (1)	See note (2)	See note (3)	80%	100%	See Note (4)	$0	0%	$0	0%
Retiree Dependents	50%	50%	See note (2)	See note (3)	0%	50%	See Note (4)	$0	0%	$0	0%
Waiting Period for Coverage	None	None	90 days	1 full month	None	3 full months	None	30 days	None	None	None
Calendar Deductible	None	$200	$500	$250	$150	$650	$200	$150	None	None	$500
Office Visit Co-payments											
Primary Care	$15	$15	$20	$20	$15	$10	$0	85%/15%	$15	$10	$15
Specialist	$15	$15	$20	$20	$15	$10	$0	85%/15%	$15	$10	$15
Calendar Year Stop Loss	$500	$2,000	$1,000	$2,000	$1,500	$1,500	$1,700	$2,000	$1,500	$2,000	$1,000
Hospital (addl. Co-pay or ded.)											
Inpatient											
Co-Pay	$0	$0	85% to $400	$0	$100	$100	$0	85%/15%	90%	$0	$200
Deductible	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$500
Outpatient											
Co-Pay	$0	$0	85% to $400	$20	$0	$0	$0	85%/15%	90%	$0	$0
Deductible	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$200
Emergency Room											
Co-Pay	$50	$75	$150	$50	$50	$40	$0	85%/15%	$50/90%	$0	$75
Deductible	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drug Benefit											
Separate Deductible	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0
Co-pay-Retail	$5/$20/ $35	$5/$15/$30	$10/20	See Note (5)	$5/$15/$35	$2/20% brand	$5/$13/$23	$7/$15/$30	20% to $25	$10/$20/$40	$7/$15/$30
Co-pay-Mail	$10/$40/$70	$10/$30/$60	$20/$40	See Note (5)	$10/$30/$70	$4/20% brand	$5/$18/$33	$15/$30/$60	20% to $25	$15/$30/$60	$14/$30/$60
Annual Drug Max	None	None	None	None	None	None	None	$750 PP/Pyr	None	None	None
Lifetime Drug Max	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lifetime Maximum Benefit	Unlimited	$1,000,000	$1,500,000	$1,000,000	$2,000,000	Unlimited	$1,000,000	$2,000,000	Unlimited	$2,000,000	Unlimited
Out of Network Benefits:											
Individual Deductible	$500	$750	$500	500	$750	$300	$4,700	75%	$300	90% of R&C*	$1,000
Family Deductible	$1,500	$2,250	$1,500	No Limit	$2,500	$1,500	$14,100	75%	$900	90% of R&C*	$2,000
Stop Loss	$1,500	$10,000	$5,000	No Limit	$2,500	$1,700	$14,100	75%	$2,500	90% of R&C*	$2,000
Co-Insurance Level	70%	60%	60%	70%	70%	80%	70%	75%	70%	90% of R&C*	70%
Lifetime Maximum	$1,000,000	$1,000,000	$1,500,000	$1,000,000	$2,000,000	Unlimited	$1,000,000	$2,000,000	$1,000,000	$2,000,000	Unlimited

* R&C- Reasonable and Customary

Note (1). City of Austin retirees receive a premium contribution based on years of service. With 20 years service, the city pays $90.00 for retirees under age 65 and $45.00 for retirees over age 65. Medicare is required.

Note (2). City of Houston's contribution is approximately 63% for retiree only and 56% for retirees and dependents up to age 65.

Note (3). Dallas County pays 30% of retiree and 30% of dependent contribution for all retirees under age 65.

Note (4). Company makes a contribution for retirees under age 65 if they were hired prior to 1972. At age 65, coverage is cancelled. Retirees hired after 1972, have very limited employer contribution, if any.

\

Note (5). Dallas County has a 3 tier drug copay of $5/$15/$35 for formulary drugs. For non-formulary drugs, the participant pays the copay plus 50% of the drug cost up to $50.00.

EXHIBIT 3.7
ERS Health Plan
Actual and Projected HealthSelect Claims
Excluding Pharmacy Claims

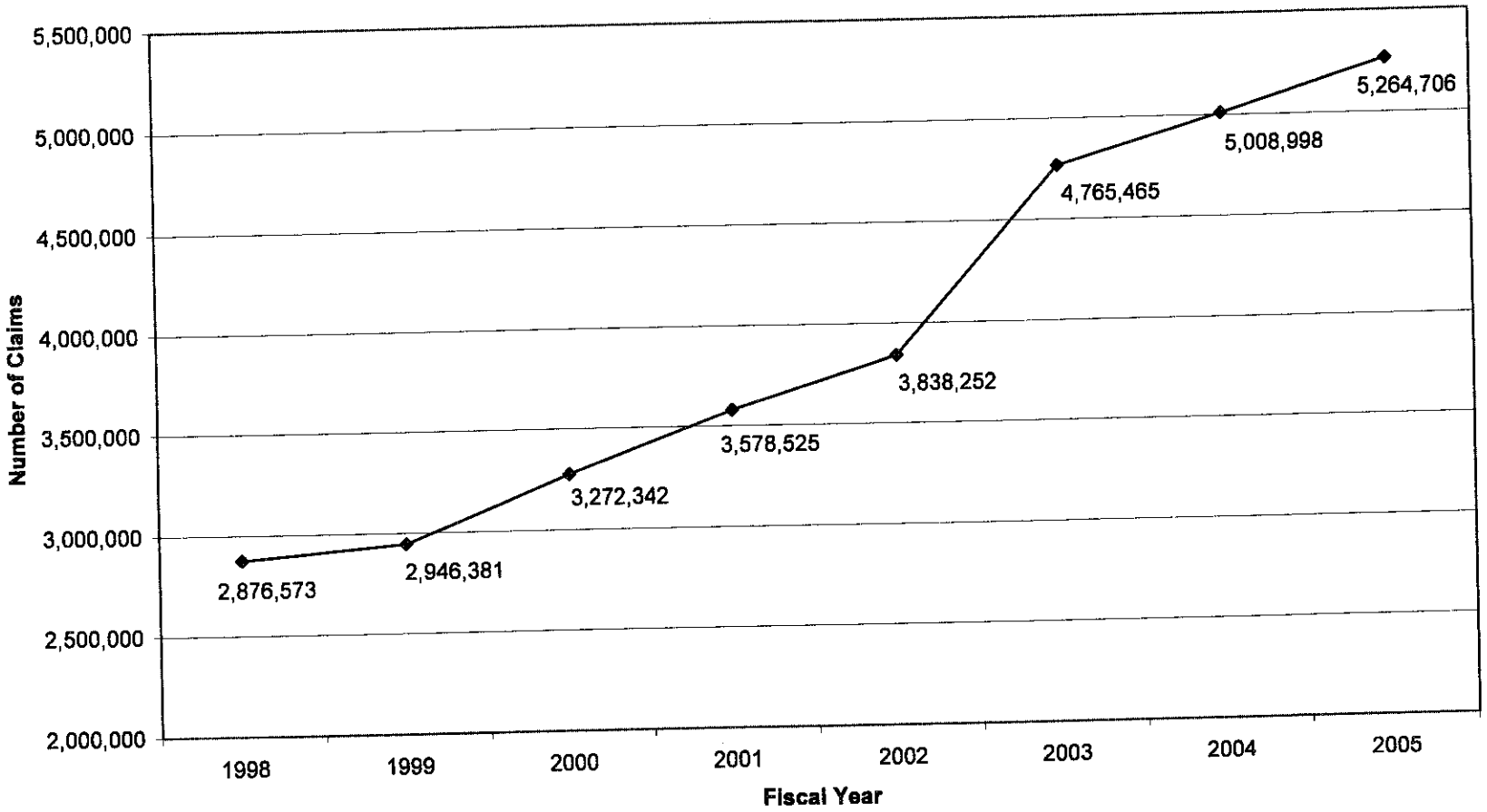


EXHIBIT 3.8
Employees Retirement System
Actual and Projected HealthSelect Prescriptions

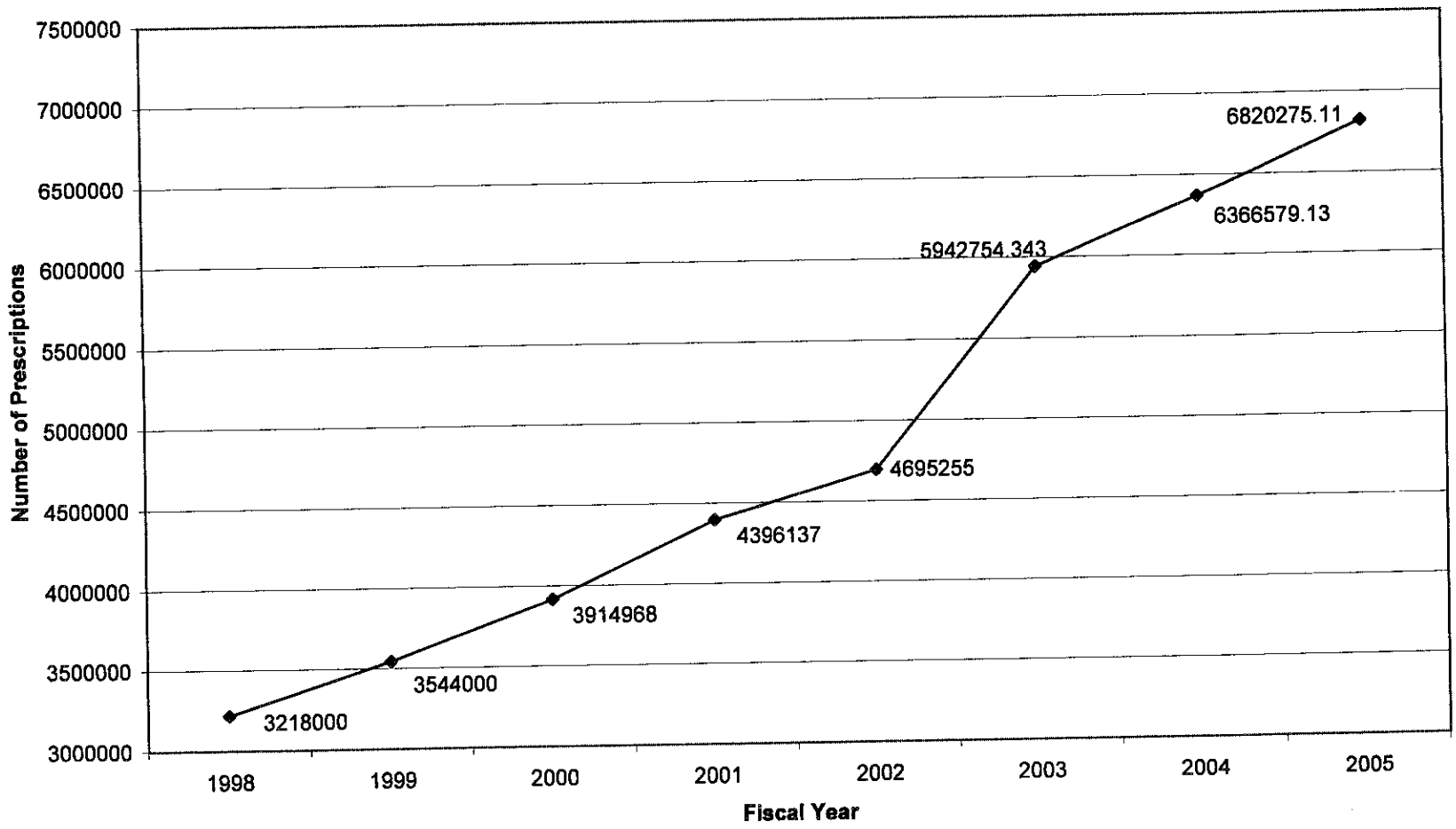


EXHIBIT 3.9
ERS Health Plan
Actual and Projected HealthSelect Benefit Cost

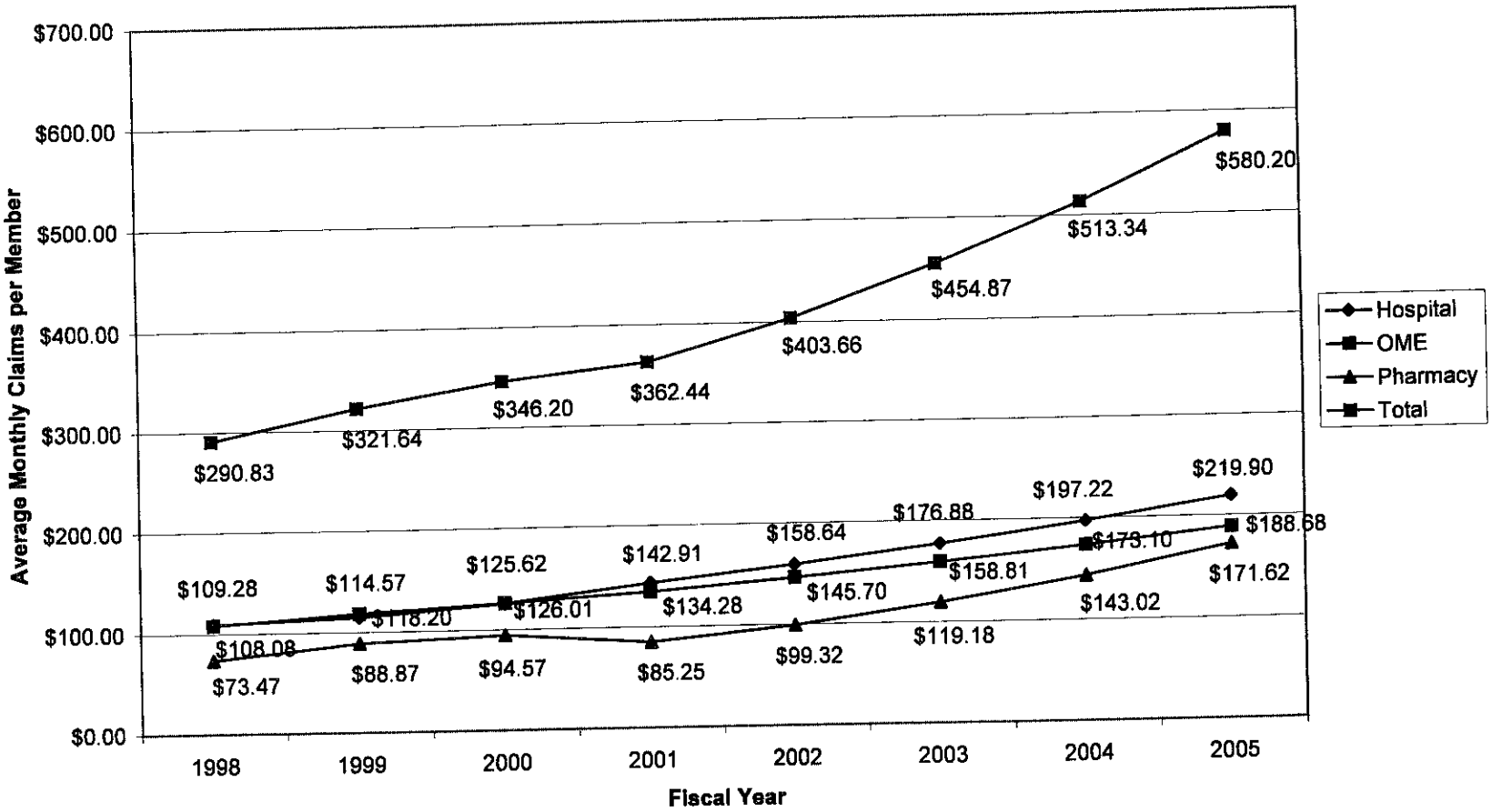


EXHIBIT 3.10
ERS Health Plan
Actual and Projected HealthSelect Plus Benefit Cost

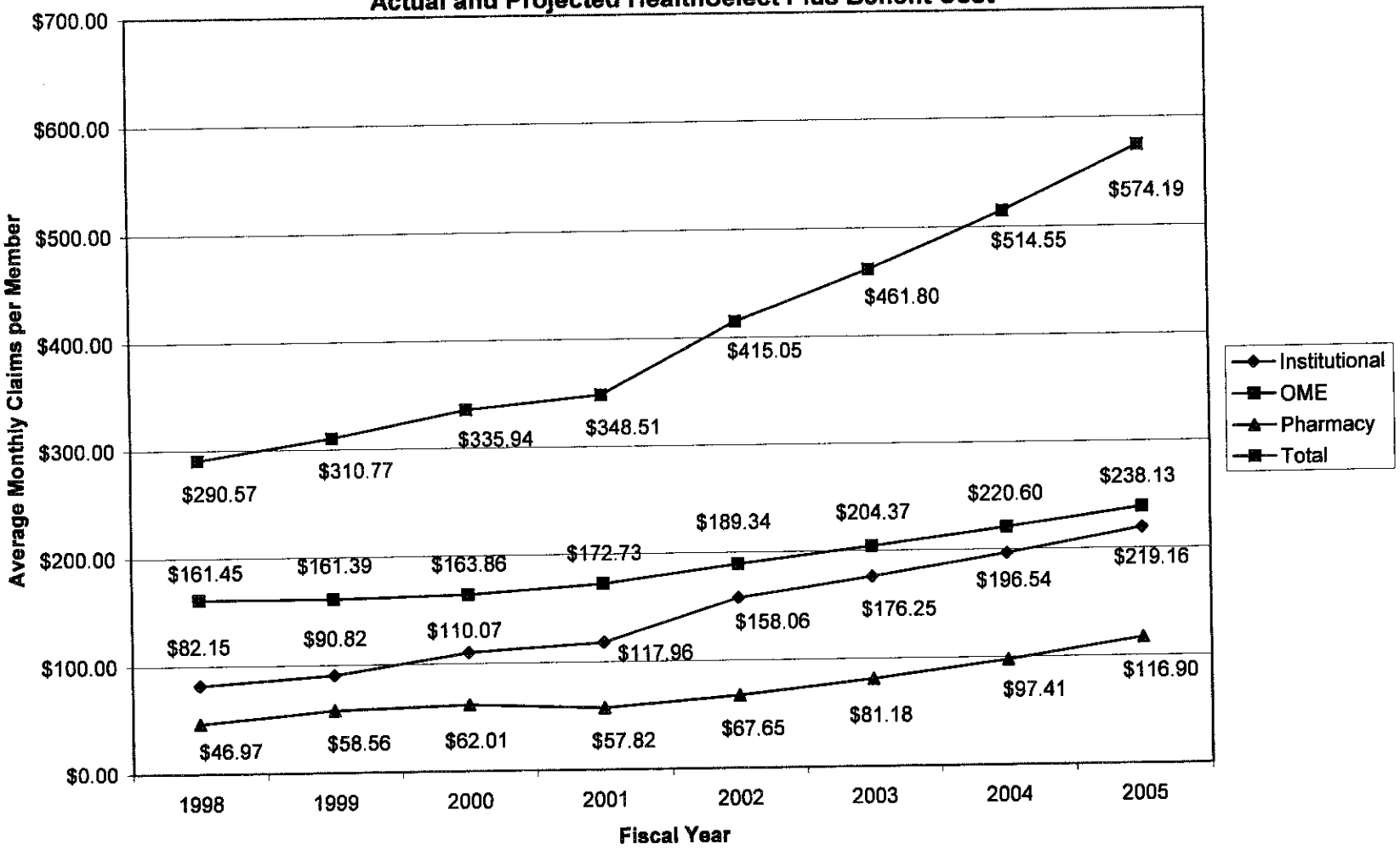


EXHIBIT 3.11
Employees Retirement System
Actual and Projected Average Plan Payments
Per HealthSelect Prescription
(Net of Member Copayment)

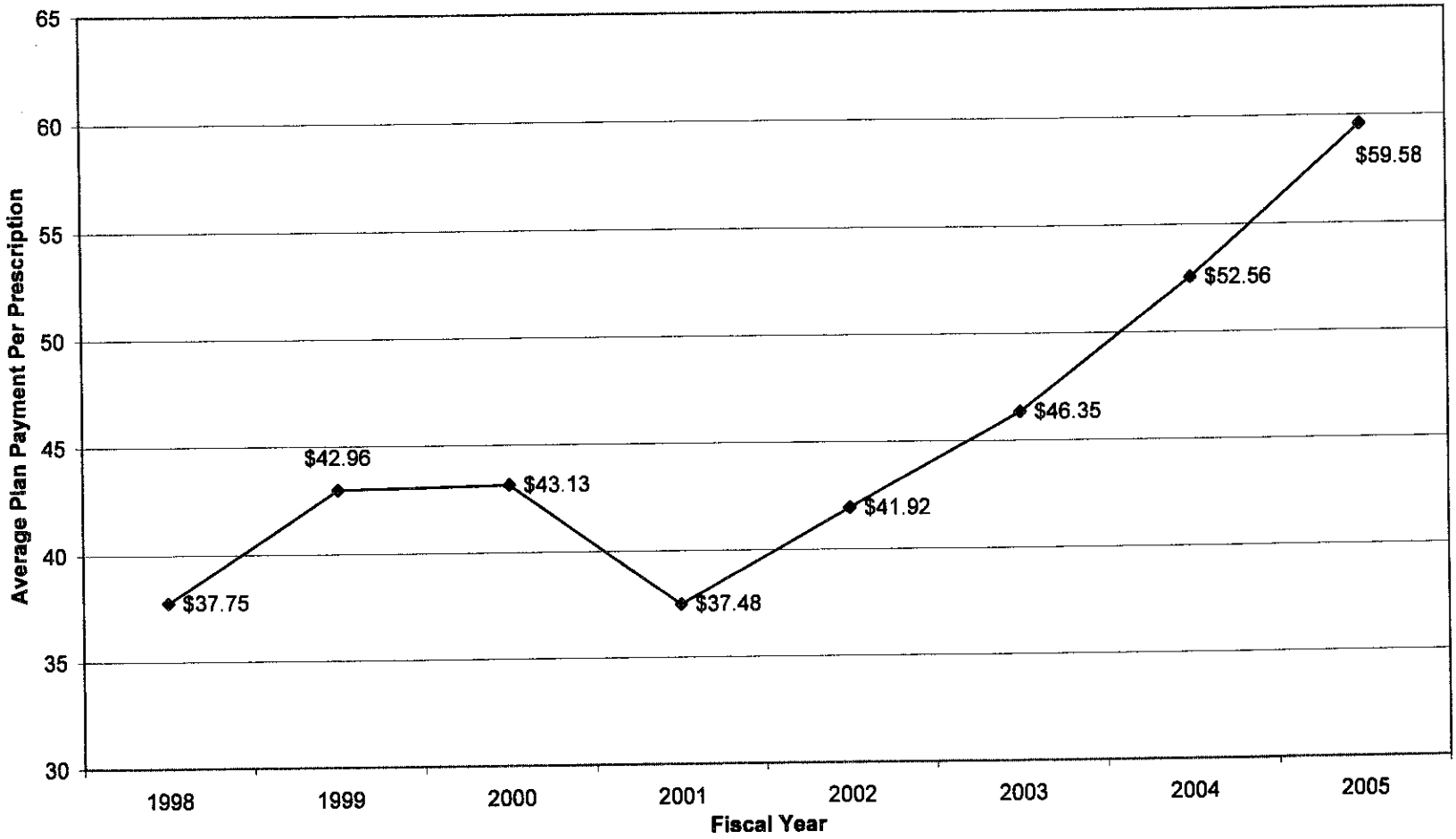


EXHIBIT 3.12
Discussion of Increased Reimbursement Rates for Health Care Services

There are two general categories of forces that drive the cost of the ERS health plans higher. The first is the increased utilization of health care services, e.g., more hospital admissions, more visits to the physician's office, more surgeries, etc. The second includes those factors which result in increases in the payments that the plan makes for a unit of health care services, e.g., payments for a hospital admission, payments for a visit to the physician's office, etc. The second category is the subject of this discussion. For this purpose, the discussion will focus on the rising cost of hospital services and the services that are included in the category referred to as other medical expenses (OME), which is comprised of professional provider services, lab, x-ray and pathology, durable medical equipment and supplies, etc. This discussion does not include an analysis of the inflationary forces driving increases in the cost of pharmacy benefits.

Generally, the average payment for a hospital admission actually decreased during most of the 1990's as a result of changes in the way that hospitals were reimbursed and the highly competitive environment that existed at the height of the managed care era. This situation began to reverse itself during FY 2000 when a number of hospitals across the state began to demand higher reimbursement rates and, in some cases, significant revisions in the manner in which they were compensated. The hospitals backed up their demands with threats to leave the network. This aggressive behavior coincided with the decline of managed care, the consolidation of hospitals and a new emphasis on maximizing consumer choice.

Although the HealthSelect/HealthSelect Plus administrator was generally able to renegotiate hospital contracts that included rates below the initial demands of the hospitals, they had little choice but to ultimately agree to increases, a number of which were quite significant, in order to maintain the networks. In some cases they also found it necessary to agree to changes in methodology which made it more difficult to control hospital charges. This has resulted in significant increases in plan payments for both inpatient and outpatient hospital services under both HealthSelect and HealthSelect Plus. Examples of increases include a 40% increase to the Baylor System, a 12% increase to the Presbyterian System, double digit increases to the HCA hospitals and increases to dozens of others. In most cases the renegotiated increases include automatic annual inflationary adjustments. While demands for hospital rate increases are not currently as numerous or as high as they have been over the last few years, requests for more moderate increases continue to be common. Over the last two years, increases in unit costs, primarily driven by reimbursement rate changes, have been the primary factor contributing to the increase in plan payments for hospital services.

Unit cost increases have not been as volatile for the OME component of the plan. They have been more stable over the last five years, averaging in the range of 4-5% per year, without any major disruptions in the networks. This is the result of relatively stable contracts with professional providers and, in some cases, the extensive work of the administrator in rebuilding networks in areas in which physician groups have terminated contracts over rate disputes. Although there have been some high profile demands for higher reimbursement from physician groups in various parts of the state, these have generally been resolved with more moderate increases than those that have been required to maintain the hospital networks.

It is important to note that in the case of both hospital and OME costs, changes in the mix of services that are provided also contribute to unit cost inflation. The providers control changes in the mix of services and such changes generally result in an increase in unit costs. For example, the average hospital admission increases in cost from year to year both due to changes in reimbursement rates and as a result of the provision of more and/or different services, each of which carries its own separate charge. Changes in the mix of services are difficult to manage in an environment in which health care management has been discouraged.

Other State Employee Health Coverage

Background

Under pressure of rapidly rising health care costs, all academic institutions of higher education were given the opportunity to join ERS' Uniform Group Insurance Plan (UGIP) in 1993. At that time, only the University of Texas and Texas A&M University opted not to join UGIP. The two primary reasons given for not opting in were that the two programs had a long history of self-insurance, and they both had their own health related institutions to help provide health care for their employees.

Independence of the UT & A&M group insurance programs was predicated on the idea that the two systems would be able to provide comparable or superior health care benefits to their employees at costs roughly equivalent to UGIP for similar benefits.

Funding for the two programs is based on dollar figures ERS-UGIP anticipates will be needed to cover costs for participants. This methodology results in an appropriation that has the potential for yielding more dollars than might otherwise be needed to provide comparable coverage to UGIP. For example, all three programs cover 100 percent of premiums for the employee/retiree only. UT and A&M, however, have typically received enough state funding to allow premium coverage for spouses and dependents well in excess of the 50 percent UGIP covers.

Until last session, both UT and A&M had rider language in the General Appropriations Act (GAA) indicating legislative intent that the state cover 80 percent of spouse and dependent premiums. This was based on the level of benefit the state appropriation yielded several biennia ago when UT & A&M health plans were less expensive than UGIP. As costs rose, however the legislature failed to meet the threshold. The rider was dropped from the 2002-03 GAA. Today the state funds 57 percent of spouse and dependent premiums for UT and 67 percent for A&M.

In addition to these differences, UGIP, UT and A&M also differ on general benefit coverage as well. UGIP premiums are generally higher, however, UT & A&M have higher deductibles, co-payments, and out-of pocket maximums which allow them to keep their premiums down (see Exhibit 3.13).

The University of Texas Employee Group Insurance Plan (UT-EGIP)

The UT System health care program covers approximately 141,000 participants throughout 15 component institutions and System Administration Office. Of those, approximately 78,000 are employee or retirees, and 63,000 are spouses or dependents. Similar to UGIP, growth in

participation in UT-EGIP has remained relatively modest having only increased around 5 percent since 1998.

As mentioned above, funding for UT-EGIP is based on projected cost estimates for ERS-UGIP and the estimated number of participants the program will have in the coming biennium. For FY 2002, UT-EGIP received $138.3 million in general revenue. This represents an increase of 82.7 percent since FY 1998.

State appropriated funds, however, comprise only around 35.7 percent of total program revenues. Employee premiums, system and component institution contributions, and investment income are used to balance the ledger. An additional $248.9 million was generated from these sources in FY 2002. This amount was up 53.5 percent over FY 1998. All totaled, program revenues have increased nearly 63 percent in five years.

To meet these growing demands, UT-EGIP has also utilized reserve fund balances to offset expenditures. Since 1998, a reserve fund balance that was $36.2 million has been depleted. Having utilized over $48 million since that time, at the end of FY 2001 UT-EGIP reported a reserve fund deficit of nearly $12 million.

To control some of these escalating costs, UT-EGIP has implemented many of the same cost containment initiatives used by UGIP. This has included increased co-payments, deductibles, and out-of-pocket limits, as well as implementation of a 3-tier formulary and disease management programs. In addition, UT-EGIP has recently enacted a Mandatory Generic Substitution program in which participants are required to pay the full difference in price for a brand drug when an appropriate generic is available. This new feature is expected to save the program more than $1 million in the current biennium.

UT-EGIP also recently selected a new administrator for its self-funded PPO. This resulted in a savings of $1.7 million in administrative fees, greater efficiency in plan administration, and more favorable provider contracts.

Texas A&M Employee Group Insurance Plan (A&M-EGIP)

The Texas A&M health care program covers approximately 57,000 throughout its component institutions. Of those, approximately 29,000 are active employees or retirees, with nearly 28,000 being spouses or dependents. Similar to both UGIP and UT-EGIP, growth in participation in the A&M program has remained relatively modest, having only grown around 7 percent since 1998.

Similar to UT-EGIP, funding for A&M-EGIP is based on projected cost estimates for ERS-UGIP and the estimated number of participants the program will have in the coming biennium. For FY 2002, A&M-EGIP received $71.9 million in general revenue. This represents an increase of 62 percent since FY 1998.

State appropriated funds, however, comprised only around 55 percent of total program revenues. Employee premiums, system and components institution contributions, and investment income are used to balance the ledger. An additional $57.6 million was generated from these sources in FY 2002. This amount was up 42.5 percent over FY 1998. All totaled, program revenues have increased nearly 52.9 percent in five years.

To help control these escalating costs, A&M-EGIP has implemented many of the same cost containment initiatives used by UGIP & UT-EGIP. This has included increased co-payments, deductibles, and out-of-pocket limits. This reflects one of the central tenets of A&M-EGIP: those who utilize the benefits should pay more of the costs than those who do not use the benefits. As a result, A&M-EGIP has looked to hold down out-of-pocket premium costs and asked those who utilize the plan's benefits to pay more of the costs at the time of service. In addition, A&M-EGIP has implemented a 3-tier formulary, mandatory generic substitution, and aggressive prior authorization programs on their prescription drug program.

Similar to UGIP, both UT-EGIP and A&M-EGIP attribute most of the increases in spending within their programs to two major factors: generally higher utilization of benefits driven largely by an aging population and a more savvy health care consuming populace; and higher costs of services driven by such things as advances in technology, higher operating expenses, and rapidly increasing prescription drug costs.

EXHIBIT 3.13
COMPARISON OF (SELF-FUNDED) HEALTH PLAN PROVISIONS
(REFLECTS MARCH 1, 2003 A&M CARE CHANGES)

	UT SELECT Network, In-Area	A&M CARE 350 Network, In-Area	HEALTHSELECT (HS) Network, In-Area
Out of Service Area Restrictions	Urgent Care: BCBS network (nationwide) - $250 deductible + 15% of allowed Non-network - $500 deductible + 35% of allowed Emergency Care: $75 copay	Urgent Care: BCBS network (nationwide) - $350 deductible + 20% of allowed Non-network - $700 deductible + 50% of allowed Emergency Care: $350 deductible + 20% of allowed	Urgent Care: BCBS network (nationwide) - 10% of allowed Non-network - $500 deductible + 30% of allowed Emergency Care: $50 copay + 10% of allowed
Deductibles	$250/person $750/family	$350/person $1,050/family	None
Out of Pocket Maximum	$1,750/person $5,250/family	$3000/person	$500/person
In-Hospital Care	$250 deductible + 15% of allowed	$350 deductible + 20% of allowed	10% of allowed
Emergency Room	$75 copay	$350 deductible + 20% of allowed	$50 copay + 10% of allowed
Surgery	$250 deductible + 15% of allowed	$350 deductible + 20% of allowed	10% of allowed
Office Visits/ Outpatient Surgery	$20 copay/family care doctor $25 copay/specialist	$20 copay; certain expensive surgeries $350 deductible + 20% of allowed	$15 copay
Prescription Drugs	Retail: up to 30-day supply Generic $10 Preferred $25 Non-Preferred $40 Mail: up to 90-day supply Generic $20 Preferred $50 Non-Preferred $80	$50 deductible then Retail: up to 30-day supply Generic $10 Preferred $25 Non-Preferred $50 Mail: up to 90-day supply Generic $20 Preferred $50 Non-Preferred $100	Retail: up to 30-day supply Generic $5 Preferred $20 Non-Preferred $35 Mail: up to 90-day supply Generic $10 Preferred $40 Non-Preferred $70
Vision	Illness-related eye exams only, same as office visit copay. Routine vision care is an optional coverage.	$20 copay; one exam per year	$15 copay; one exam per year
Dental	Accidental injuries to normal, healthy teeth covered; $250 deductible + 15% of allowed All other dental services are covered by an optional dental plan.	Accidental injuries to normal, healthy teeth covered; $350 deductible + 20% of allowed All other dental services are covered by an optional dental plan.	Accidental injuries to normal, healthy teeth covered; 10% of allowed All other dental services are covered by an optional dental plan.
Mental Health	Inpatient: Maximum 30 days $250 deductible + 15% of allowed Outpatient: Maximum 20 visits $20 copay/family care doctor $25 specialist Serious Mental Illness covered the same as any other illness	Inpatient: Maximum 30 days $350 deductible + 20% of allowed Outpatient: Maximum 40 visits $20 copay Serious Mental Illness covered the same as any other illness	Inpatient: Maximum 30 days First 15 days – 10% Second 15 days – 30% Outpatient: Maximum 30 visits 10% of allowed (out of pocket max does not apply) Serious Mental Illness covered the same as any other illness
Premium Cost (Employee/State)	Employee Only $0/$319.11 Employee & Spouse $124.14/$498.98 Employee & Children $129.84/$439.45 Employee & Family $244.48/$619.32	Employee $0/$297.90 Employee & Spouse $63.37/$468.82 Employee & Children $31.45/$412.34 Employee & Family $96.26/$583.28	Employee Only $0/$306.61 Employee & Spouse $176.30/$482.91 Employee & Children $118.04/$424.66 Employee & Family $294.34/$600.96

State Employee Health Care - Cost Management Options

Through the process of taking testimony and examining issues relating to rising medical costs, a number of cost management concepts emerged or were presented. Below, is a summary of some of the options suggested. The committee takes no position as to the viability or feasibility of these suggestions.

- Consider requiring newly hired state employees to wait 30, 60 or possibly 90 days from date of employment before they are eligible for coverage under one of the state's health care plans. Waiting periods are not uncommon in either the public or private arenas.

- Consider reducing the state's premium contributions for newly hired part-time employees working between 20 and 39 hours per week and their dependents . The state currently pays 100 percent of these employee premiums and 50% of their dependent premiums without regard to number of hours worked.

- Consider reducing or eliminating the state's premium contributions for executive board members and their dependents. The state currently pays 100 percent of executive board member premiums and 50% of their dependent premiums. For most of these individuals, their state service is not a full-time job.

- Consider requiring all state prescription drug plans to include a mandatory generic substitution program where participants are required to pay the full difference in price for a brand drug when an appropriate generic is available. UT-EGIP recently implemented this provision and is expected to save more than $1 million in the current biennium.

- Consider indexing the state's level of premium contribution for future retirees and their dependents to the employee's number of years of service. For retirees with at least 10 years of service, the state currently pays 100 percent of the retiree's premiums and 50% of their dependent's premiums regardless of the number of years of service beyond the 10 year mark. Savings for this proposal would vary widely depending on how it was structured and to whom it was applied. In addition, this option would provide added longevity incentive for state employees.

- Consider changing the methodology by which funding for UT-EGIP and A&M-EGIP is determined. Currently, these programs receive funding based on ERS-UGIP cost projections. The legislature may want to consider requiring these two programs to justify their own appropriations. By doing so, the state could better ensure that each program is funded appropriately.

- Consider requiring all state employee health programs to institute an aggressive claims payment review process like ERS. In FY 2001, ERS-UGIP reviewed $2.3 billion in payments for ineligible charges. This resulted in $440.9 million in savings. This process could be replicated in the state's other programs as well.

- Consider changing state employee health care program to a defined contribution plan, where the state would pay a specific amount to employees for the purpose of purchasing health coverage. Employees would be given a choice of state health plans with different levels of benefits. Any differences in the amount the state provided and actual premium costs would be born by the employee. Under this type of plan the state's cost would be more easily controlled and employees would be empowered with more control over their health care dollars.

Teacher Retirement System of Texas

Background

The Teacher Retirement System of Texas was established by a constitutional amendment passed in 1936 to provide retirement programs for public education employees. Today, one of the most significant benefits administered by TRS is its health care program. Composed of two major programs, TRS-Care offers comprehensive group health benefits for eligible retired Texas public school employees and their eligible dependents. TRS-Active Care provides health coverage to public school employees in eligible school districts and their dependents.

TRS-CARE

Created in 1985, TRS-Care currently provides health care benefits to more than 150,000 retirees and dependents and includes retirees of public schools, charter schools and education service centers. TRS-Care offers three levels of coverage. TRS-Care 1 & 2 provide catastrophic coverage with relatively high deductibles and payment limits. TRS-Care 1 is designed for those retirees not covered by Medicare, while TRS-Care 2 covers those who do receive Medicare benefits. Both plans are offered at no cost to the retiree. However, a contribution is required for coverage of dependents. Today, almost 40,000 retirees and dependents participate in both TRS-Care 1 and 2.

TRS-Care 3 is the largest retiree health care program offered by TRS. This program offers more than 100,000 enrollees a comprehensive health care program and a pharmacy benefit to all retirees. Both retirees and dependents pay premiums to participate in the program, which offers lower deductibles and out-of-pocket limits than TRS-Care 1 or 2 (see Exhibit 4.1). Premiums for participants in TRS-Care 3 were last increased in FY 2000.

For those participants covered under Medicare, TRS-Care acts as a coordinated benefit. Once the participant reaches age 65, Medicare becomes the primary coverage and typically pays 80 percent of claims. TRS-Care then pays 80 percent of the remainder, and the difference goes to the participant. However, for participants younger than 65, TRS-Care is the usually the only source of coverage. In addition, because no Medicare prescription drug plan yet exists, TRS-Care is the lone source of prescription drug coverage.

While participation in TRS-Care 1 & 2 has remained relatively constant during the past several years, enrollment in TRS-Care 3 has grown steadily. This trend is expected to continue as many teachers approach retirement eligibility. By 2005, it is projected that more than 30,000 additional retirees and dependents could be enrolled in TRS-Care 3. This would represent an increase of nearly 30 percent in just 3 years (see Exhibit 4.2).

TRS-Care 1, 2 and 3 have historically been funded through a combination of state, member, and retiree contributions, as well as investment income. Since the inception of the program, active TRS members have contributed one quarter of one percent of their salaries to support the program. For 2002, this generated $47.5 million (8 percent of total revenue) which accounted for 10 percent of expenditures. However, just 10 years ago, this funding mechanism generated almost 17 percent of total program revenue and accounted for 21.5 percent of program expenses. The trend is expected to worsen over the next biennium, with member contributions projected to only cover around five percent of program expenses in FY 2005 (see Exhibit 4.3).

The other legislatively established funding mechanism is the state's contribution. Originally set at 0.35 percent of public education covered payroll, this percentage moved to one half of one percent (0.5 percent) by 1989 - where it remains today. During the past 10 years this component has generated an average of about 35 percent of revenue and covered almost 30 percent of the cost. However, it is projected by the end of the 2004-05 biennium the state's regular contribution will only cover 11 percent of projected costs (see Exhibit 4.3).

The third and most substantial program funding element is retiree premiums. Although not statutorily set, retiree premiums have composed about 41 percent of program revenue for the past 10 years. This has historically covered around 40 percent of the costs. However, similar to the other two funding elements, retiree premiums will only cover about 22 percent of program costs by the end of the 2004-05. Retiree premiums have not increased since FY 2000, and the TRS LAR request is based on no anticipated increases to retiree premiums (see Exhibit 4.3).

Until 1993, these three funding components generated enough annual revenue to cover expenditures associated with the program and allow the TRS Health Care Trust Fund to develop a surplus. Those funds were invested over the years to generate additional revenue for the program. Investment income held solid in the 1990's, averaging about $15.5 million each year (see Exhibit 4.3).

However, in 1993 the three major funding elements failed to generate sufficient revenue to cover costs. For the first time, investment income was used to balance the ledger. In spite of this initial funding imbalance, the Trust Fund balance continued to grow, peaking in 1995 at almost $235 million. Three years later, even using all investment income available, the TRS-Care programs did not have sufficient revenue to cover costs. This funding deficit has existed since 1996, and the Trust Fund balance has dwindled. Any remaining balances in the fund are projected to be gone by the end of FY 2003 (see Exhibit 4.4 & 4.5).

In 2001, all available revenue, including investment income and fund balances, were insufficient to cover costs. TRS-Care required a supplemental appropriation outside the designed funding elements for the first time since its creation. To cover expenses, the 76th Legislature appropriated an additional $76 million. Last session, the Legislature was again asked to

appropriate additional funds to meet costs. As a result, the current budget contains an additional $410 million in General Revenue. For the coming biennium, it is expected that TRS-Care will need an additional $1.15 billion to meet projected expenditures (see Exhibit 4.3, 4.4 and 4.5).

In an ongoing effort to control the expenditures side of the ledger, TRS has implemented a number of cost containment efforts over the years. Increasing deductibles and coinsurance, pre-certification requirements, implementation of a statewide hospital and physician network, and a mandatory generic differential payment for brands are some of the measures employed by TRS (see Exhibit 4.6).

Cost Drivers

Recent trends in escalating health care costs can be attributed to a number of factors. One major cause has been a dramatic increases in enrollment. Growth in participation in TRS-Care 1 & 2 has been flat for the past 5 years with enrollment hovering at around 40,000. TRS-Care 3, however, has seen large increases and is projected to experience more of the same. As of June 2002, TRS-Care 3 enrollment was over 100,000. This is an increased of 8.7 percent over June 2001 numbers, and an increase of more than 20 percent since June 2000. TRS is expecting enrollment to increase at 7.5 percent each year of the next biennium. This will add about 30,000 new enrollees to the program by the end of 2005.

Perhaps the more significant factor, however, has been the growth in TRS-Care 3 among enrollees not covered by Medicare. Participation by those carrying Medicare coverage has grown steadily during the past four years at around 4 percent each year. During that same period, enrollment of those not covered by Medicare has grown almost 40 percent with the largest surge in FY 2002 when participation grew by 16.4 percent. This trend may be attributed to a number of factors, including a surge in the number of new, younger retirees. TRS members may begin accessing benefits once their age plus years of experience equals 80. Therefore, teachers who are 55 years old with 25 years teaching experience may retire and begin accessing benefits.

Overall growth in TRS-Care participation has been a major driver, but it is the cost of care associated with these programs pushing the expenditures. Since 1998, TRS-Care medical claims cost (excluding prescription drugs) have grown 85 percent, rising from $156.5 million to $290.4 million each year. However, projections show medical claims cost may increase $324 million (112 percent) between now and the end of FY 2005. While less in total dollars, the percentage increases associated with prescription drug costs are also dramatic. Already having increased 115 percent since 1998, projections have pharmaceutical costs rising another 122 percent by the end of FY 2005 (see Exhibits 4.2 and 4.3).

While some of this growth can be attributed to expansion in participation, most has been caused by general increases in medical and prescription drug costs. In 1998, an average participant cost

TRS-Care $1,293 for medical claims and $630 for pharmaceuticals. By the end of 2002, those number had increased 57 percent and 82 percent, respectively. Projections show that during the next three years, we can anticipate medical costs to jump 73 percent and pharmaceutical costs to rise another 82 percent. This would bring average costs per participant up to $3,518 for medical and $2,084 for prescription drugs (see Exhibits 4.2 and 4.3).

One of the most significant factors driving medical and pharmaceutical cost seems to be the growth among TRS-Care 3 participants not covered by Medicare. These participants have costs associated with them far exceeding those receiving Medicare benefits. In FY 2001, members receiving Medicare benefits cost TRS-Care $2,353 each year, while non-Medicare participants cost $5,922 each. This represents a difference of more than 151 percent. Although the trend is projected to improve slightly, by FY 2004 the difference will be near 94 percent with Medicare participants costing $3,736 each year and non-Medicare participants costing $7,242**.**

Finally, increased utilization has also had an impact on cost. In addition to increases driven by enrollment trends, participant use has grown exponentially. In 1998, TRS enrollees averaged 22.42 prescriptions; 2.16 days of inpatient care; and 10.94 outpatient visits; three years later, these figures had increased 13.2 percent; 7.9 percent; and 27 percent, respectively. Patient awareness, direct to consumer marketing, and advances in new technologies have each helped perpetuated this trend.

EXHIBIT 4.1
TRS-*Care*
Comparison of Benefit Levels

Benefit Level	TRS-*Care* 1	TRS-*Care* 2	TRS-*Care* 3
Medical Services	Same	Same	Same
Pharmacy Services	TRS-*Care* 1 and 2 pay Rx claims like medical claims		Rx Program
Individual deductible	$4,500	$1,800	$240
Family deductible	$9,000	$3,600	$480
Individual Co-pay limit	$5,000	$5,000	$5,000
Family Co-pay limit	$10,000	$10,000	$10,000
Individual out-of-pocket limit	$9,500	$6,800	$5,240
Family out-of-pocket limit	$19,000	$13,600	$10,480
Lifetime maximum coverage	Unlimited	Unlimited	Unlimited
Premium Examples:			
Retiree w/Medicare Premium	n.a.	$0	$67
Retiree w/o Medicare Premium	$0	n.a.	$162
Participants including dependents	17,400	22,400	100,300

EXHIBIT 4.2
TEACHER RETIREMENT SYSTEM
TRS-Care Medical and Rx Information
1993 to 2001 *with Projections through 2005*

	Average Participants During Year	TRS-Care Health Care Claims			% Increase		% of Total Claims		Annual Cost per Participant		
		Medical	Rx	Total	Medical	Rx	Medical	Rx	Medical	Rx	Total
1993	100,241	101,627,864	40,700,513	142,328,376			71.4%	28.6%	$1,014	$406	$1,420
1994	104,855	108,284,693	45,712,060	153,996,753	6.6%	12.3%	70.3%	29.7%	$1,033	$436	$1,469
1995	109,235	122,054,551	50,782,093	172,836,644	12.7%	11.1%	70.6%	29.4%	$1,117	$465	$1,582
1996	112,373	135,982,304	57,074,921	193,057,225	11.4%	12.4%	70.4%	29.6%	$1,210	$508	$1,718
1997	116,559	148,823,489	62,530,982	211,354,471	9.4%	9.6%	70.4%	29.6%	$1,277	$536	$1,813
1998	121,084	156,537,913	76,256,158	232,794,071	5.2%	21.9%	67.2%	32.8%	$1,293	$630	$1,923
1999	125,190	184,398,533	93,459,890	277,858,423	17.8%	22.6%	66.4%	33.6%	$1,473	$747	$2,219
2000	130,289	203,029,971	110,903,247	313,933,218	10.1%	18.7%	64.7%	35.3%	$1,558	$851	$2,410
2001	136,721	250,691,898	139,774,848	390,466,745	23.5%	26.0%	64.2%	35.8%	$1,834	$1,022	$2,856
2002	*143,049*	*290,367,170*	*164,286,824*	*454,653,994*	15.8%	17.5%	*63.9%*	*36.1%*	*$2,030*	*$1,148*	*$3,178*
2003	*152,323*	*374,199,453*	*213,810,409*	*588,009,862*	28.9%	30.1%	*63.6%*	*36.4%*	*$2,457*	*$1,404*	*$3,860*
2004	*162,811*	*479,093,485*	*278,539,174*	*757,632,659*	28.0%	30.3%	*63.2%*	*36.8%*	*$2,943*	*$1,711*	*$4,653*
2005	*174,702*	*614,574,647*	*363,997,296*	*978,571,943*	28.3%	30.7%	*62.8%*	*37.2%*	*$3,518*	*$2,084*	*$5,601*

Key Assumptions for 2003 through 2005:

	Care 1	Care 2	Care 3
Medical costs will increase by 14% per year			
Rx costs will increase by 20% per year			
Membership will increase each year by the following:			
Members with Medicare	0.0%	0.0%	3.0%
Dependents with Medicare	16.3%	8.7%	7.5%
Members without Medicare	0.0%	2.3%	15.0%
Dependents without Medicare	1.7%	3.0%	20.0%

Note: Fiscal year 2002 is based on actual for 11 months and projected for one month.

EXHIBIT 4.3
TEACHER RETIREMENT SYSTEM
TRS-Care Financial History -- Incurred Basis
Actual 1985 to 2001 *with Projections through 2005*

		REVENUES							EXPENDITURES					
	Beginning Balance	Retiree Premiums	1/2% - State Contributions	Supplemental Appropriations	Member Contributions	Investment Income	Total Revenue	% Increase	For Claims	Claims Processing	Internal Administ	Total Expenditures	% Increase	Ending Balance
1985	-										362,371	362,371		18,084,976
1986	-	-		250,000	17,625,194	572,153	18,447,347							
1987	18,084,976	22,617,624	25,931,680		18,522,629	2,568,998	69,640,931		58,033,670	3,552,911	389,025	61,975,606		25,750,301
1988	25,750,301	23,948,600	31,357,632		19,598,520	5,703,832	80,608,584	15.75%	28,599,321	4,130,071	484,684	33,214,076	-46.41%	73,144,809
1989	73,144,809	25,428,632	37,420,711		20,789,215	8,802,914	92,441,472	14.68%	48,385,034	4,650,730	561,343	53,597,107	61.37%	111,989,174
1990	111,989,174	37,556,561	44,369,915		22,184,958	13,098,835	117,210,269	26.79%	70,007,884	6,497,731	689,120	77,194,735	44.03%	152,004,708
1991	152,004,708	46,563,787	47,277,743		23,638,871	15,801,047	133,281,448	13.71%	111,380,270	7,269,406	988,623	119,638,299	54.98%	165,647,857
1992	165,647,857	56,395,797	50,392,512		25,196,592	17,314,372	149,299,273	12.02%	108,137,647	7,957,901	904,659	117,000,207	-2.21%	197,946,923
1993	197,946,923	65,154,653	54,029,406		27,014,703	17,181,190	163,379,952	9.43%	142,328,376	9,107,944	959,415	152,395,735	30.25%	208,931,140
1994	208,931,140	80,128,944	56,912,083		28,456,041	16,467,438	181,964,506	11.38%	153,996,753	10,742,076	926,752	165,665,581	8.71%	225,230,065
1995	225,230,065	89,006,331	59,849,850		29,924,925	16,841,673	195,622,779	7.51%	172,836,644	11,393,649	826,198	185,056,491	11.70%	235,796,353
1996	235,796,353	82,622,236	63,634,087		31,817,043	16,818,747	194,892,113	-0.37%	193,057,225	12,491,199	1,102,379	206,650,803	11.67%	224,037,663
1997	224,037,663	87,657,784	67,616,395		33,808,197	16,202,440	205,284,816	5.33%	211,354,471	12,880,395	1,217,059	225,451,925	9.10%	203,870,554
1998	203,870,554	91,390,173	72,210,190		36,105,095	15,260,517	214,965,975	4.72%	232,794,071	12,748,881	1,867,797	247,410,749	9.74%	171,425,780
1999	171,425,780	96,474,107	76,488,424		38,244,213	9,762,741	220,969,485	2.79%	277,858,423	13,232,423	1,672,773	292,763,619	18.33%	99,631,646
2000	99,631,646	120,227,960	85,505,637		42,738,069	6,923,485	255,395,151	15.58%	313,933,218	14,682,301	2,154,826	330,770,345	12.98%	24,256,452
2001	24,256,452	131,213,445	90,152,467	76,248,101	45,059,393	5,824,134	348,497,540		390,466,745	16,017,167	2,220,596	408,704,508		(35,950,516)
2002	*(35,950,516)*	*150,352,957*	*95,075,320*	*285,515,036*	*47,537,660*	*7,063,791*	*585,544,764*		*454,653,994*	*16,738,354*	*2,331,630*	473,723,978		75,870,270
2003	*75,870,270*	*167,667,939*	*100,304,463*	*124,661,063*	*50,152,231*	4,621,407	*447,407,103*		*588,009,862*	*18,728,292*	*2,448,212*	609,186,365		(85,908,993)
2004	*(85,908,993)*	*187,578,724*	*105,821,208*		*52,910,604*	*2,384*	*346,312,921*		*757,632,659*	*21,034,052*	*2,570,622*	781,237,333		(520,833,405)
2005	*(520,833,405)*	*210,512,833*	*111,641,375*		*55,820,687*	-	*377,974,895*		*978,571,943*	*23,716,000*	*2,699,153*	1,004,987,096		(1,147,845,606)
														521,000,000
										Supplement Request for 2004				627,000,000
										Supplement Request for 2005				
											Total			1,148,000,000

EXHIBIT 4.4
TRS-Care
Historical Funding

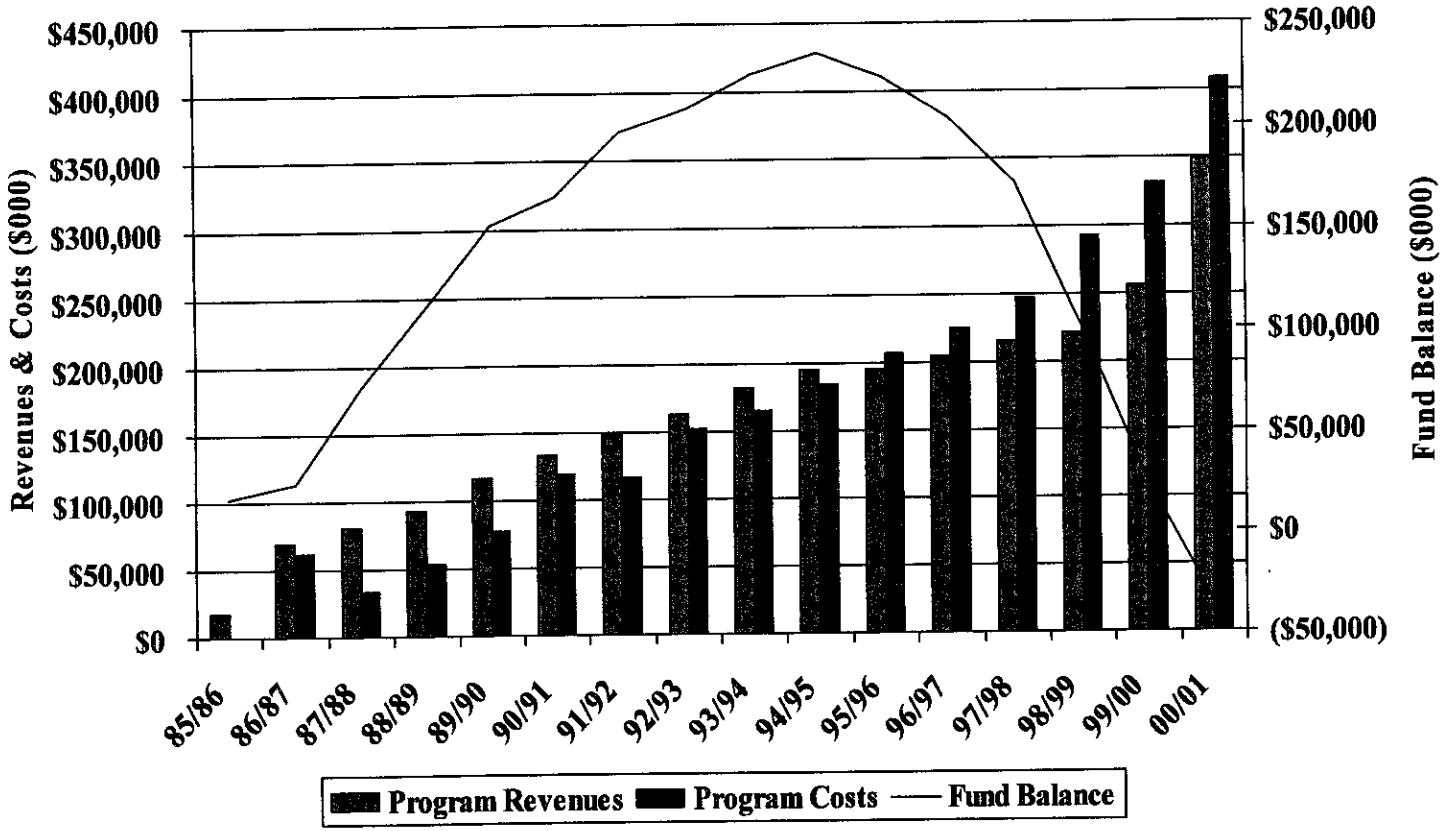


EXHIBIT 4.5

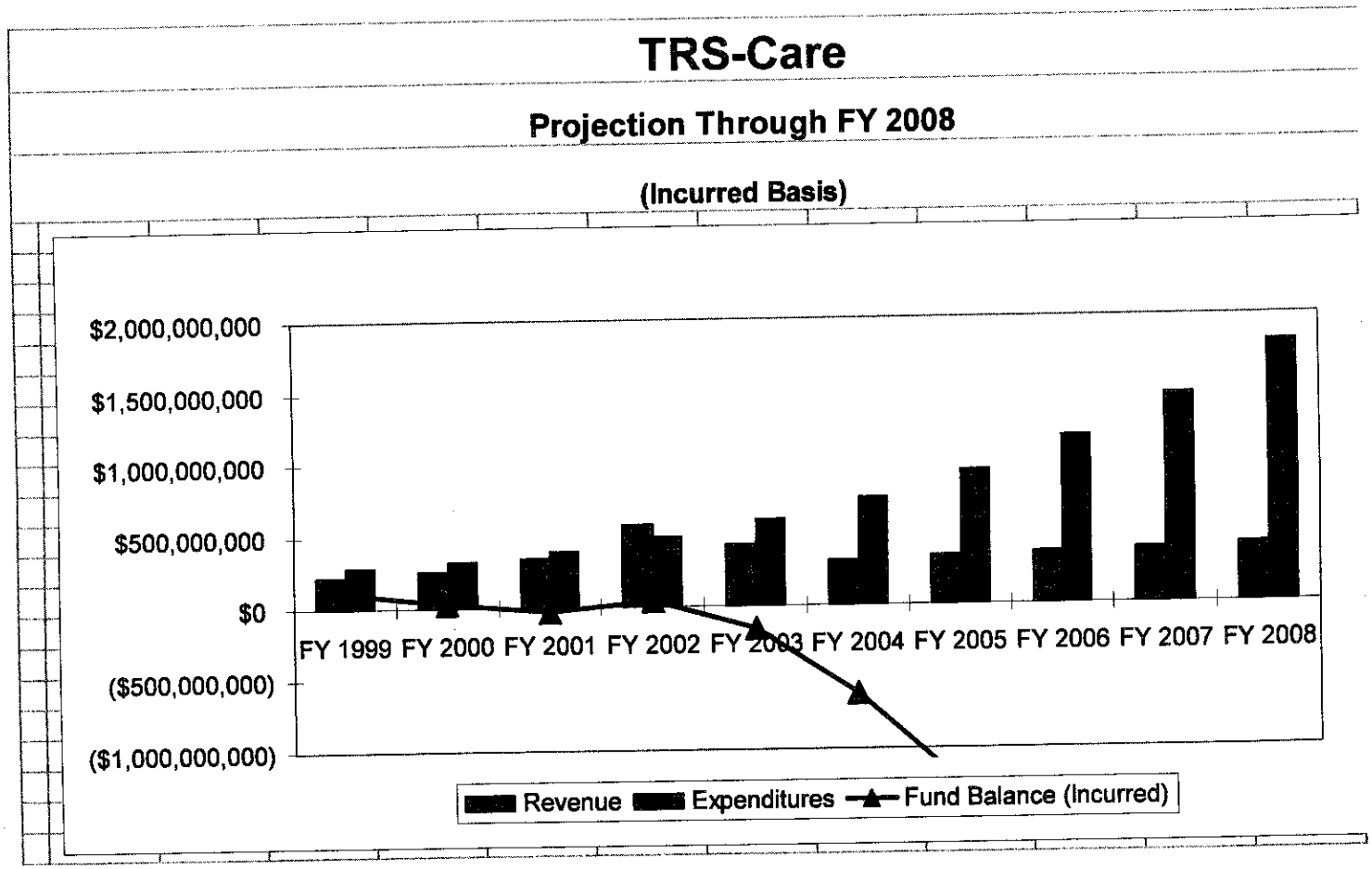

TRS-Care
Projection Through FY 2008
(Incurred Basis)
$2,000,000,000
$1,500,000,000
$1,000,000,000
$500,000,000
$0
($500,000,000)
($1,000,000,000)
FY 1999 FY 2000 FY 2001 FY 2002 FY 2003 FY 2004 FY 2005 FY 2006 FY 2007 FY 2008
Revenue
Expenditures
Fund Balance (Incurred)

EXHIBIT 4.6 TRS-Care Cost Containment Initiatives	
1989-90	Implemented mandatory pre-certification for certain outpatient services
1990-91	Expanded outpatient pre-certification
1991-92	Increased deductibles
	Increased maximum coinsurance limit
1992-93	Increased deductibles
	Increased maximum coinsurance limit
	Established retail pharmacy network
1993-94	Increased deductibles
	Increased maximum coinsurance limit
	Implemented a statewide hospital network
1994-95	Increased deductibles
	Increased maximum coinsurance limit
	Implemented a statewide physician network
1996-97	Increased discounts in hospital and physician networks
1997-98	Increased discounts in hospital and physician networks
	Implemented drug card program with mandatory generic differential payment for brands
1998-99	Increased discounts in hospital and physician networks
1999-00	Increased mail order drug co-payments
2001-02	Increased mail order drug co-payments
	Limited Chiropractic visits to 20 per year
	Negotiated more favorable prescription drug discounts in conjunction with TRS-Active Care program

TRS-ACTIVE CARE

Created by the 77th Legislature, TRS-Active Care was established to provide a statewide health care benefits program for employees of school districts, charter schools, regional education service centers, and other educational districts. The program went into effect Sept.1, 2002. School districts with 500 or fewer employees (more than 80 percent of the state's districts) were required to participate in the program, while those having between 501 and 1,000 employees were presented the option of joining. In its first year of operation, some 930 entities opted to participate in TRS-Active Care. More than 150,000 district employees are covered.

Those participating in TRS-Active Care are provided three choices of coverage. Plan 1 provides basic coverage. It uses deductibles and coinsurance as its primary benefit, and is offered at no expense to the employee. Plan 2 provides greater benefits offering lower deductibles and coinsurance. In addition, certain services such as office visits and prescription drugs are covered through co-payment. Plan 2 is provided at virtually no cost to the employee. Plan 3 offers the most comprehensive coverage. It provides both network and non-network benefits with most network benefits provided through low co-payment. For this plan, the employee pays $91 a month with the state and school district paying the difference.

Funding for the teacher health care program is provided by a variety of sources. Through TRS, $1,000 per year ($83.33 a month) is allocated to each active school employee, whether or not the employee participates in either the state program or a local district insurance program. These funds may be used to pay for additional employee coverage, dependent coverage, or taken as compensation, depending on the employee's choice. In addition, all districts, whether participating in the state insurance program or not, receive a monthly contribution via the Texas Education Agency of $75 per employee covered by either the state program or a local district program. Finally, every district must contribute at least an additional $150 monthly toward participating employees healthcare cost. Any difference in cost beyond the $308 provided by the state and school district may be covered by the district. Otherwise it is the employee's responsibility.

Because the program has been up and running for less than a year, hard data to support trends in rising costs are limited. With program design very similar to others administered by TRS and ERS, it is safe to assume trends affecting those plans will also drive similar increases in expenditures in TRS-Active Care. However, because funding for the program is strictly defined, the state's exposure to any increases in health care costs have been limited. Only the number of active teachers and staff employed by school districts in the state of Texas will affect the amount of money needed to fund the state's portion of the plan. TRS projections anticipate a 3 percent annual employee growth during the 2004-05 biennium. This will equate to around $18 million per year more needed to fund TRS' portion of Active Care.

TRS - Cost Management Options

Through the process of taking testimony and examining issues relating to rising medical costs, a number of cost management concepts emerged or were presented. Below, is a summary of some of the options suggested. The committee takes no position as to the viability or feasibility of these suggestions.

- Consider limiting participation in TRS-Care 3 of new retirees until they reach the age of 65. Participants between retirement age and 65 are on average the most expensive to the program. This approach would seek to limit that cost by offering them access to only TRS-Care 1 and 2 until age 65. An alternate approach to this option would be to require TRS-Care 3 participants under 65 to pay 100% of the premium difference between TRS-Care 1 or 2 and that of TRS-Care 3.

- Consider indexing premium contributions for all TRS-Care 3 participants on their years of service. Currently, the state pays all but $67 of a retiree's monthly premium for those who have Medicare, and all but $162 for those who do not. This is done without regard to the retiree's number of years of service. Savings for this proposal would vary widely depending on how it was structured and to whom it was applied. In addition, this option would provide added longevity incentive for teachers.

- Consider adjusting TRS-Care's method of finance by increasing the contribution levels for active employees, retirees and the state. The contribution levels of retirees and active teachers have changed relatively little (if at all) over the life of the program. This proposal would look to update the funding elements so as to provide a sufficient funding from all sources. The Legislature may also want to consider creating a contribution requirement for school districts, who currently provide no financial support to the program. An additional approach would be to establish a cap or limit on the state's supplemental appropriation for this program and require any necessary increases in funding to be generated by active teachers, retirees, and school districts.

- Consider changing TRS-Care to a defined contribution plan, where retirees would receive a specific amount of money for the purpose of purchasing health coverage. Retirees would be given a choice of state health plans with different levels of benefits. Any differences in the amount the state provided and actual premium costs would be born by the retiree. Under this type of plan the state's cost would be more easily controlled and retirees would be empowered with more control over their health care dollars.

- Consider requiring the implementation of a 3-tiered prescription drug co-payment program. TRS-Care currently has a 2-tiered prescription drug co-payment program.

- Consider requiring both TRS-Care and TRS-Active Care to institute an aggressive claims payment review process. In FY 2002, ERS-UGIP reviewed $2.7 billion in payments for ineligible charges. This resulted in $582.5 million in savings. This process could be replicated in the TRS programs as well.

Texas Department of Criminal Justice Correctional Managed Health Care

Background

The Texas Correctional Managed Health Care (CMHC) partnership represents a unique collaboration between the Texas Department of Criminal Justice (TDCJ) and two of the state's leading health science centers, the University of Texas Medical Branch at Galveston (UTMB) and the Texas Tech Health Center (TTUHSC). The three entities joined forces in 1993 to form the Correctional Managed Health Care Committee, a group charged with increasing access, improving quality and containing the costs of treating inmate medical needs.

The committee is composed of two representatives appointed by each partners' respective president or executive director. One representative of each partner must be a physician. Effective in FY 2000, the committee expanded to include three members appointed by the governor (two of whom must be physicians). The nine-member body contracts on behalf of TDCJ with the health science centers to provide a full range of health care services. Both universities have established a correctional health care organization, which includes a medical director and a chief administrative officer.

The committee oversees and coordinates all inmate health care services, and it provides a representative forum for decision-making in terms of overall health care policy, allocation of resources and assignment of responsibilities. Committee representatives are empowered by their respective organizations to represent them on health care matters and make decisions that are binding on their organizations.

Cost Drivers

Appropriations for TDCJ Correctional Managed Health Care have slowly increased from $296.6 million in 1996 to $343.4 million in 2003. (See Exhibit 5.1) An incarcerated population continually presents unique funding challenges and health care is not an exception. Most concepts of rising medical costs in the free world are quite different than those factors affecting the cost of health care for the prison population. The rising cost of medication is common, but the diseases and needed drugs are dramatically different. Major cost drivers for TDCJ Correctional Managed Health Care include the aging population of the inmates; altered standards of care for Hepatitis C, HIV and psychiatric medications; pharmacy costs; and expansion/service capacity issues.

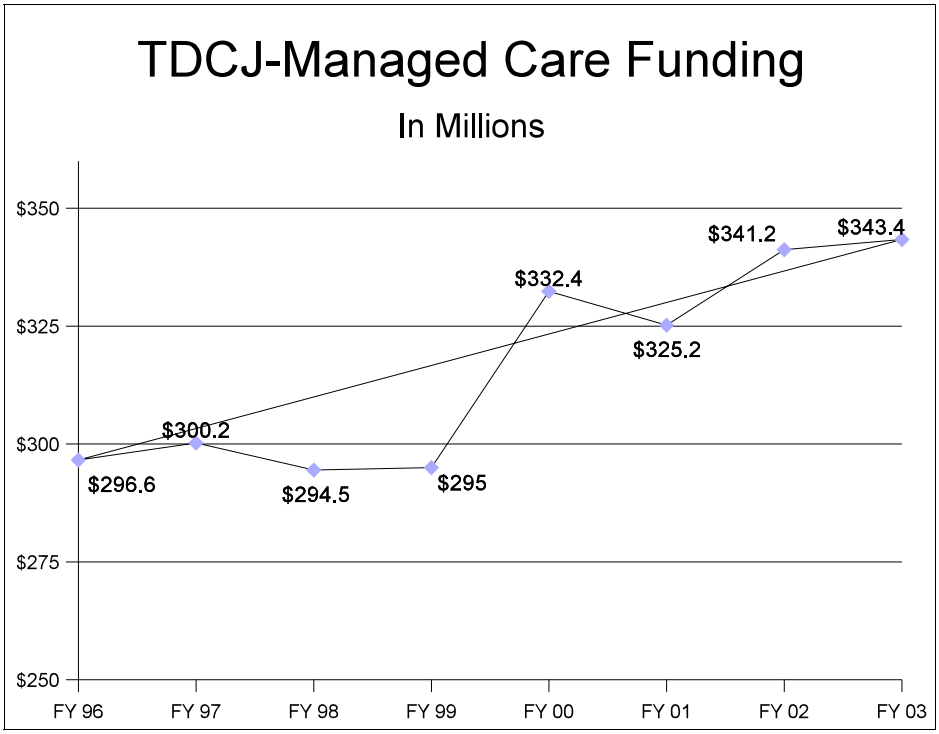


Exhibit 5.1

Aging of Inmate Population

In just two years, the number of offenders 55 and older has increased by 13.6 percent. Elderly offenders access health care services more often than young inmates and the services they require are more expensive. For example, while comprising 4.7 percent of the service population, offenders 55 and older account for 18 percent of billed charges for hospitalization. Elderly offenders average more than $4,000 average in billed hospital charges each year compared to about $500 per year for younger offenders. In addition, elderly offenders average more than 10 outpatient encounters with medical staff per month compared to less than two such encounters for younger offenders

It is a common debate as to whether the state should continue to incarcerate inmates who are frail and elderly. These aged and unwell inmates are considered by many to be of no threat to the public; keeping them in the prison system only increases costs to the state for their expensive health care. The Legislature has created a special parole option for elderly and infirm inmates. Texas allows for the release of an inmate on medically recommended intensive supervision (previously referred to as special needs parole) if:

- the Texas Council on Offenders with Mental Impairments (TCOMI), in cooperation with the Correctional Managed Health Care Committee, identifies the inmate as being elderly, physically handicapped, mentally ill, terminally ill, mentally retarded, or having a condition requiring long-term care;
- a parole panel determines that, based on the inmate's condition and a medical evaluation, the inmate does not constitute a threat to public safety; and
- TCOMI, in cooperation with TDCJs parole division, has prepared for the inmate a medically recommended intensive supervision plan that requires the inmate to submit to electronic monitoring, places the inmate on super-intensive supervision, or otherwise ensures appropriate supervision of the inmate.

Individuals convicted of an aggravated offense are not eligible for medically recommended supervision. As a condition of release, these former inmates must remain under the care of a physician and in a medically suitable placement.

The 77th Legislature expanded the list of conditions eligible for medically recommended intensive supervision to include conditions requiring long-term care. The amended statute took effect Sept. 1, 2001.

During FY 2000, 115 referrals were presented to the Board of Pardons and Paroles (BPP) for release under these provisions. Of these referrals, 49 were approved (42.6 percent). During FY 2001, 186 referrals were presented to BPP and 47 were approved (25.3 percent). Under the expanded list of conditions authorized by the 77th Legislature, 178 referrals have been presented

to the BPP and 42 (23.6 percent) have been approved during the first six months of fiscal year 2002.[19]

A key component of this program is, once released under this provision, these inmates are able to access a health care, third-party-payer, such as Medicaid or Medicare.

Changing Standards of Care

Hepatitis C and HIV
As medical research and technologies identify new medications, new treatment therapies and new diagnostic techniques, costs to the program increase. When treatment protocol is adjusted for diseases prevalent in the prison population, the costs to the state increase dramatically.

On average, 2,397 inmates, or 1.8 percent of the prison population are HIV positive. HIV antiretroviral drugs alone accounted for $14.7 million, or 40 percent, of CMHC total drug costs. In 1997 there was an alteration in HIV drug therapies which has increased the overall cost of treating inmates that are HIV+.

- FY 1996: $1.23 million for 1876 patients
- FY 1997: $3.93 million for 2101 patients
- FY 1998: $7.54 million for 2393 patients
- FY 1999: $12.29 million for 2520 patients
- FY 2000: $15.24 million for 2574 patients
- FY 2001: $15.75 million for 2481 patients
- FY 2002: $14.7 million for 2397 patients

TDCJ estimates that about 18,000 inmates, about 13.7 percent, have been identified as testing positive for the Hepatitis C virus. However, studies show that 28.8 percent of incoming offenders test positive for Hepatitis C indicating there is a likelihood of a much larger number of offenders needing treatment in the future. These inmates are monitored in a chronic clinic program. From this program, specialists examine and evaluate the inmates' eligibility for drug therapy. At current funding levels, about 300 patients are receiving Interferon and Ribavarin drug therapy. The costs of providing this care have increased in the last two biennia.

- FY 1999: $250,000
- FY 2000: $560,827
- FY 2001: $955,959
- FY 2002: $1,416,432

[19]Report provided by the Legislative Budget Board in response to a request from Sub-committee members during the February 26, 2002 hearing.

The National Institutes of Health (NIH) June 2002 Draft Consensus Development Conference Statement for Hepatitis C treatment indicates a significant change in Hepatitis C disease management.[20] The NIH statement recommends:

- initiation of therapy earlier in the disease's progression;
- use of newer pegylated Interferon in combination with Ribavirin;
- increased use of genotyping and liver biopsy for therapeutic decision-making; and
- emphasizes the need for additional research into special Hepatitis C populations such as those in institutional settings.

CMHC has requested $5.967 million and $11.613 million for FY 2004-2005 respectively to address the anticipated needs for the newly adopted consensus standard for Hepatitis C.

Psychiatric Medications

Passed by the 77th Legislature, Senate Bill 636 called for a study on implementing Texas Medication Algorithm Project (TMAP) within the TDCJ patient population. TMAP is a public and academic collaborative effort within the Texas Department of Mental Health and Mental Retardation (MHMR) designed to develop, implement and evaluate an algorithm-driven treatment philosophy for major adult psychiatric disorders treated in the Texas public mental health sector. TMAP is a treatment philosophy for the medication management portion of care. A result of this project has been the development of medication treatment guidelines for three major psychiatric disorders:

- schizophrenia;
- major depressive disorder; and
- bipolar disorder.

Preliminary estimates on implementing such a level of care to the prison population indicate costs would increase by about 220 percent ($16 million) each year. TDCJ has included a costs study pilot project study as an exceptional item appropriations request at $2.25 million for 2004-2005.

Additionally, the move toward new generation medications as the recommended treatment for prison inmates increases CMHC program costs.

Pharmacy Costs

Pharmacy costs for CMHC are expected to increase by double digit percentages. Cost increases are being driven primarily by changes in utilization due to newer therapies and changes in standards of care rather than by inflation of prices. HIV related drugs account for about 40

[20]NIH Consensus Statements are prepared by a non-advocate, non-Federal panel of experts, based on presentations, questions and statements, and deliberations.

percent of those total drug costs. CHMC drug costs in FY 2001 were $39.9 million and represented about 12.5 percent of total health care costs.

The 77th Legislature's Senate Bill 347 required a good faith effort by CMHC parties [21] to participate in the federal 340B drug pricing program, which provides for pharmaceutical drugs to be purchased for a lower cost. CMHC sought and gained approval in April 2002 from the federal government for the UTMB sector that constitutes 78 percent of the prison population. If access to the federal 340B drug pricing program continues, it should help to minimize expected pharmacy cost increases independent of increases associated with changes in standard of care.

Due to the cost offset from using 340B drug prices, CMHC is not requesting an increase in funding for drug costs in FY 2004-2005 over the estimated 2002-2003 amounts other than their anticipated funding need to address the Hepatitis C treatment change.

Facility Expansion/Service Capacity

The 77th Legislature authorized expansion of the Rural Medical Facility at the Montford Unit. The expansion will provide 44 beds to accommodate hospitalization and specialty care needs for prisoners in West Texas on site rather than in local hospitals. This facility expansion in FY 2005 will require $1.748 million for operational funding once the facility construction is completed. This cost is listed in the agency's exceptional item request.

CMHC plans to increase dialysis capacity and move female, dialysis patients to the Carole Young Medical Complex. This complex was constructed with dialysis space and plumbing, but they need to build the dialysis stations and employ appropriate staff to operate as a dialysis center. The costs associated with this project are $1.06 million in FY 2004 and $842,000 in FY 2005. These costs are listed in the agency's exceptional item request.

[21] CMHC parties include University of Texas Medical Branch (UTMB), the Texas Department of Criminal Justice (TDCJ), and the Texas Tech University Health Sciences Center.

Correctional Managed Health Care Cost Management Options

Through the process of taking testimony and examining issues relating to rising medical costs, a number of cost management concepts emerged or were presented. Below, is a summary of some of the options suggested. The committee takes no position as to the viability or feasibility of these suggestions.

- consider more regional providers for delivering constitutionally adequate health care services to reduce associated costs

When discussing the costs of providing health care to the prison population it is important to recognize there is value to providing adequate medical services to this population. In terms of the larger public health issue, it is key to remember that the overwhelming majority of prisoners will eventually be released back to the communities. If we as a state do not maintain adequate health care for inmates, those health problems will eventually become a free population problem - for example, to local hospitals or jails. Additionally, curbing the spread of prisoners' diseases into the community should be of utmost concern. Addressing the medical needs of offenders while they are incarcerated represents an important public health and risk management opportunity that should not be overlooked.

A second consideration for funding the correctional health care program adequately is that states are required constitutionally to provide health care services to offenders. We also know from the *Ruiz* litigation that the costs involved in not providing the constitutionally required level of care and the consequences of the lack of care, subsequent litigation, and intrusion of the courts to enforce the required care will far exceed the costs of having provided the care in the first place and will likely be more intrusive into the state's operation of its prison system.

As a state we must remember to frame any cost management for CMHC in terms of these issues.

Selected Health Care Stakeholders Testimony

At the final hearing on September 5, 2002, the subcommittee invited health care stakeholders to testify and share information, concerns and suggestions regarding rising health care costs. The subcommittee heard from:

- Texas Department of Insurance,
- Texas Association of Business,
- Texas Hospital Association,
- Texas Medical Association
- Texas Association of Health Plans,
- Pharmaceutical Research and Manufacturers of America (PhRMA)
- Genentech

Each of these industry groups spoke of the trends and factors that are impacting their abilities to be effective participants in the health care realm. The subcommittee also heard from the Texas Department of Insurance.

Texas Department of Insurance

At the request of the subcommittee, Texas Insurance Commissioner Jose Montemayor testified regarding the status of medical malpractice insurance and health maintenance organizations (HMOs).

Regarding medical malpractice insurance in Texas, the Commissioner provided the following information:

- Medical malpractice reforms of 1993 and 1995 resulted in rate rollbacks of 17.2 percent.
- The number of companies actively writing medical malpractice coverage in Texas has declined in the last year from 17 to five companies.
- Around 6,500 physicians will have to find new coverage in the coming year because of companies withdrawing of otherwise non-renewing policies.
- To help with decreases in availability, JUA has "modernized" policies to offer broader coverage.
- Rates have increased on average around 63 percent since 1999 with one company increasing rates as much as 117 percent and JUA increasing rates only around 3 percent.
- Losses increased approximately 15 percent between 1996-2000 enough to cause rates to double.
- Frequency of claims in Lower Rio Grande Valley (primarily Hidalgo County) increased at a rate of 60 percent per year. As a result, claims severity has declined 25 percent for the area.
- Claims severity in other parts of the state, such as San Antonio and Dallas, has increased significantly.

- The number of claims per 100 insured physicians is up slightly in most areas of the state yet still well below 50 claims. In the Rio Grande Valley, the numbers of claims exceeds 350.
- Cost per reported claim is up significantly. In San Antonio and Dallas, costs are almost double the state average.
- On average, medical malpractice rates in Texas are highest in Hidalgo, Cameron, and El Paso counties, and lowest in Lubbock, Travis and Webb counties.
- Medical malpractice insurance in Texas is the least profitable for insurance companies, compared with the other top 15 states.

Regarding the health maintenance organization industry in Texas, the Commissioner provided the following information:

- Since the 4th quarter of 1995, the Texas HMO industry has incurred losses.
- In the first two quarters of 2002, Texas HMOs posted profits once again.
- Single service HMOs continue to be profitable.
- Statutory requirements relating to minimum net worth, risk-based capital, and premium deficiency reserves have all helped the HMO industry bounce back in Texas by prohibiting financially questionable business practices as a method of gathering market share.
- Although we now compare favorably to other states in profitability, we still lag four to six quarters behind most other states.
- TDI practices aggressive monitoring of financial condition, and intervenes early when problems are detected to get companies on "get well" plan.
- Texas had a net gain of HMOs last year.
- TDI is monitoring companies for promptness in claims processing and takes appropriate action when necessary.

Texas Association of Business

Texas' health care crisis is characterized by premium increases, unaffordable coverage, reduced availability, and the largest percentage of uninsured working citizens in the United States, according to Texas Association of Business (TAB) testimony and *Texas Health Insurance Crisis, 2002 Report.* In 2002, Texas employers are faced insurance premium increases averaging 25 percent compared to the national average of 15 percent. TAB said the rise in health care is driven by state coverage mandates, health care fraud, medical liability insurance rates, and pharmaceutical costs.

In a national survey, of 300 surveyed companies, initial results indicate that business officials claim the cost of health care coverage has reached the point where it threatens the survival of their businesses. TAB fears if businesses are forced to choose between the livelihood of their

company and health coverage, the employees' health care needs will be sacrificed. The number of small employers in Texas offering health insurance has dropped by 18 percent since 1996.[22]

TAB indicated that "excessive" legislative mandates and bureaucratic regulations contribute to the current crisis. Texas is one of only eight states with 40 or more health care mandates in statute. The majority of states have between 20 and 40 health care mandates.[23] TAB said these mandates restrict consumers' ability to purchase affordable insurance customized to their needs, and health insurers shoulder the additional cost of providing mandated coverage that may or may not be needed by the entire insured population.

TAB published a report outlining legislative solutions to address rising health care costs in Texas. That report can be found at http://www.txbiz.org/Gov_issues/health_care/Docs/SolutionsExecutiveSummary.html

Texas Hospital Association

The Texas Hospital Association testimony centered on a survey conducted by the association in August 2002. This survey was sent to more than 400 of their member hospitals. They received 108 responses representing 125 hospitals, which account for approximately 50 percent of all the acute care hospital expenditures in Texas. The survey looked at two aspects of rising health care costs for hospitals - factors that caused a decline in revenue and factors that increase hospitals' expenses.

Declining Revenue

The rising cost of the uninsured/charity care and changes in governmental reimbursement methodology (Medicare and Medicaid) have considerable impact on hospital revenue decline. Lack of prompt reimbursement from managed care prayers, changes in managed care requirements, declining investment earnings, and competition from other providers were identified as having a moderate impact on hospital revenue.

Increasing Expenses

Workforce shortage and professional liability coverage were identified as issues that increase hospital expenses. Issues that have a moderate impact on hospital expenses included changes in government reimbursement methodology (Medicare and Medicaid); increased capital requirements; administrative/regulatory compliance; increased supply costs due to newer technology; increased patient volume; and increased patient acuity .

---

[22] *TAB Texas Health Insurance Crisis, 2002 Report*

[23] Id.

Other Findings
During the past three years, hospital expenses have increased approximately 26 percent. Some expense items grew dramatically. For example, contract labor for direct patient care increased 126 percent and professional liability insurance premiums increased 101 percent.

Finally, almost 60 percent of responding hospitals believe financial conditions for their hospital will deteriorate this year. Some 25 percent believe their total margin will be significantly less this year than last year.

Along with the association, the subcommittee invited a rural and an urban hospital to provide insight to the unique challenges they face.

Mr. John Simms, CEO of Trinity Medical Center in Brenham, listed the following as cost drivers for his hospital:

- manpower shortage - this factor is specifically challenging for a rural provider where the labor pool is smaller than in an urban setting;
- professional liability insurance premiums;
- trauma and emergency medical services;
- administrative and regulatory compliance; and
- revenue factors, such as reduced governmental reimbursements.

Ms. Sally Jeffcoat, President and CEO of CHRISTUS Health Gulf Coast, testified on behalf of urban hospitals. Ms. Jeffcoat listed the following cost drivers for her hospital:

- workforce shortage;
- contract staffing cost increases;
- supply costs;
- pharmaceutical costs
- professional liability premiums;
- employee health insurance;
- increase in voluntary free care; and
- revenue reductions due to governmental reimbursement changes.

Texas Medical Association
The Texas Medical Association testimony focused on an article, *Why Are Health Care Costs Rising*, prepared for the association by Laura Stevens and Teresa M. Waters, PhD. This article attributes the rising medical costs to:

- aging population - as the population ages, medical costs also rise because the aging population uses more services;
- advancements in medical technology - while valuable for increasing quality and length of life, technological advances come at a very high cost;
- rising pharmaceutical costs;

- increasing consumerism - today's consumers are much more knowledgeable regarding health care, which can impact the amount of health care individuals require and expect;
- one-time savings of managed care companies - many cost reductions that occurred in the 1990's were only immediate savings, which did not address the systemic problems that may have existed; and
- cyclical nature of hospital and physician pricing.

Texas Association of Health Plans

Gary Goldstein, MD, CEO Humana Central Texas, testified on behalf of the Texas Association of Health Plans. Dr. Goldstein identified cost drivers as legislative mandates, medical liability insurance premiums and fraud.

Further, he testified that medical costs are increasing faster than inflation due to expanded coverage; technological advances; pharmacy costs; HMOs are not managing costs; and a lack of true market based competition. In order to remain competitive, insurance companies need to cover administrative costs and other overhead and profit. These cost drivers combined create a cost growth greater than inflation, and limits insurance companies' ability to offer an affordable product.

Pharmaceutical Research and Manufacturers of America (PhRMA)

At the request of the subcommittee, PhRMA provided testimony regarding the role of pharmaceuticals in rising medical costs. Testifying on behalf of PhRMA was Eugene Kolassa, Associate Professor, Department of Pharmacy, University of Mississippi, Merrill Mathews, Visiting Scholar, Institute for Policy Innovation, and Thomas Hardaway, Director of State Affairs, Pharmaceutical Research and Manufacturers of America (PhRMA)

PhRMA provided the following testimony:

- The 2001 and 2002 reports by Families USA entitled Off the Chart: Pay, Profits and Spending by Drug Companies and Profiting from Pain: Where Prescription Drug Dollars Go are factually challenged and predicated on the belief that for-profit businesses should not be involved in the development or sale of pharmaceutical products.
- Pharmaceuticals are priced based on value brought to the market place. Today, new pharmaceuticals typically are replacing older drugs and therapies, and usually result in overall healthcare cost savings.
- Generally, medical costs have increased because people are living longer and dying of more costly ailments.
- Had pharmaceuticals been less available, overall costs would have risen faster.
- The state can look to save money by limiting pharmaceutical spending, but it will end up spending it elsewhere like on hospitals and nursing homes.

- For low income populations, the state should look to encourage the most cost effective and least invasive treatments. Open access to all pharmaceuticals (including both generics and brands) is best way to accomplish this.
- Restricted formularies typically don't save money, but end up costing more.
- Of the 14.7 percent increase in spending on pharmaceuticals nationwide, 8.7 percent was the result of higher utilization.
- In 2000, pharmaceutical companies spent on average $964 million on research and development for every newly approved drug.
- For most companies, research and development spending exceeds combined expenditures on marketing and providing free samples.
- PhRMA lawsuit against Florida, Michigan, and Maine is based on claim that states' formularies violate federal law requiring access to all company products for those who agree to provide a 15 percent rebate on prescription drug prices or offer their best price.
- Although not opposed to all preferred drug lists, utilization review, disease management, and case management are better ways to control costs.
- State should consider tapping institutions of higher education to engage in "academic detailing" wherein graduate level pharmacy students identify and consult with doctors whose prescribing patterns deviate from clinical pathways.
- Differences in drug prices between the USA, Canada and Mexico are largely attributable to variances in the value the US dollar relative to local currencies. In addition, both the Mexican and Canadian governments are more involved in negotiating prices.
- Publication of "best prices" is difficult because that amount is not typically calculated until after rebates have been applied. In addition, "best prices" change from quarter to quarter.

Genentech, Inc.

At the request of the committee, Genentech, Inc., provided testimony regarding ideas on how that state could control some of its rising pharmaceutical costs. Testifying on behalf of Genentech was Todd Kaufman, Director of State Government Affairs.

Genentech provided the following testimony:

- Most appropriate way to control prescription drug costs within the state's budget is through a single preferred drug list.
- Restrictive formularies can be enhanced through the use of supplemental rebates charged to manufacturers who want to have one or more of their products included on the formulary.
- Value added programs, where companies agree to provide disease management programs that generate guaranteed savings (ie. if the level of savings promised is not generated, the company pays the difference), have also proven successful in helping control cost.

- Prior authorization can also be a valuable tool, but should adhere to four main principals:
  1.) decision making process must be prompt;
  2.) decisions must be driven by medical need;
  3.) there must be a fair and open appeals process; and
  4.) there should be a minimum burden to providers

- Florida is probably the state to look to for direction on how best to structure some of these concepts.

Attachment A

Medicaid Cost Containment Strategies Summary - December 23, 2002

Rider 33 Strategies	Required GR Savings	Projected 02-03	To Date
Statewide Managed Care Rollout of TANF Population	$17.9 million	See Hospital Cost Savings	See Hospital Cost Savings
Mandatory SSI Population Participation in Managed Care	$6.1 million	See Hospital Cost Savings	See Hospital Cost Savings
Case Management for Complex Cases	$3.0 million	$3.0 million	$3.0 million
Selective Contracting for Impatient Services in Urban Areas	$24.5 million	See Hospital Cost Savings	See Hospital Cost Savings
Best Prices Structure for Medicaid Drugs	$22.0 million	$13.1 million	$0.0
Require Supplemental Rebates in Selected Therapeutic Categories	$14.0 million	See CHIP Rebates	See CHIP Rebates
Reduce Outlier Payment Percentage	$6.1 million	See Hospital Cost Savings	See Hospital Cost Savings
Competitive Pricing for DME	$7.3 million	$4.2 million	$0.0
Vision Care	$1.0 million	$.4 million	$0.0
Expand Health Insurance Premium Payment System (HIPPS)	$3.2 million	$3.2 million	$2.5 million
Establish Sliding Scale Co-payments	$3.0 million	$7.5 million	$0.0
Use Title XIX Trust Fund Balance	$60.0 million	$88.0 million	$0.0
Increase Drug Utilization Review	$6.0 million	$11.7 million	$4.4 million
Pilot Automatic Drug Dispensing Machines in Nursing Homes	$3.2 million	$0.0	$0.0

Savings Due to CHIP	$18.8 million	$5.8 million	$2.3 million
Lowest Contract Price/Medicaid Pricing for All Retail Drug Purchases	$3.0 million	$0.0	$0.0
Medicaid Waiver for Psycotrophics	$5.9 million	$0.0	$0.0
SUBTOTAL: Rider Strategies	**$205 million**	**$136.9 million**	**$5.0 million**

Savings from Additional Strategies	Required GR Savings	Projected 02-03	To Date
Medicaid Administrative Contract Revisions		HHSC is calculating the estimated cost savings of this initiative	$7.4 million
Hospital Cost Savings		$48.5 million	$1.5 million
CHIP Manufacturer Rebates		$3.3 million	$.2 million
Additional Improvements in Drug Benefit Management		$30.2 million	$8.5 million
TOTAL PROJECTED SAVINGS 02-03		**$231.3 million**	

Selected HHS Caseloads Compared to Appropriated Caseloads

FY1998-2003

Program/ Fiscal Year	Requested	Appropriated	Actual/ Projected	Difference (approp. vs. actual)	% Difference (approp. vs. actual)	Difference (requested vs. actual)	% Difference (requested vs. actual)
HHSC- Medicaid Caseload							
1998	2,043,613	1,944,020	1,860,804	-83,216	-4.28%	-182,809	-8.95%
1999	2,099,135	1,929,551	1,778,542	-151,009	-7.83%	-320,593	-15.27%
2000	1,757,834	1,719,409	1,785,693	66,284	3.86%	27,859	1.58%
2001	1,709,988	1,704,879	1,849,573	144,694	8.49%	139,585	8.16%
2002	1,887,863	1,904,048	2,084,997	180,949	9.50%	197,134	10.44%
2003	1,932,642	2,011,256	2,376,193	364,937	18.14%	443,551	22.95%
HHSC - CHIP Caseload							
1998							
1999							
2000		96,553	28,300	-68,253	-70.69%		
2001		280,811	251,476	-29,335	-10.45%		
2002	467,952	467,952	492,688	24,736	5.29%	24,736	5.29%
2003	492,799	492,799	514,035	21,236	4.31%	21,236	4.31%
DHS - TANF Caseload							
1998	549,952	543,885	474,891	-68,994	-12.69%	-75,061	-13.65%
1999	528,818	523,217	370,069	-153,148	-29.27%	-158,749	-30.02%
2000	325,951	348,087	341,396	-6,691	-1.92%	15,445	4.74%
2001	291,728	312,514	349,856	37,342	11.95%	58,128	19.93%
2002	364,072	361,225	358,742	-2,483	-0.69%	-5,330	-1.46%
2003	371,353	364,476	365,619	1,143	0.31%	-5,734	-1.54%
DHS - Nursing Homes Caseload							
1998	65,522	65,522	63,817	-1,705	-2.60%	-1,705	-2.60%
1999	65,116	65,116	63,630	-1,486	-2.28%	-1,486	-2.28%
2000	64,991	64,991	61,605	-3,386	-5.21%	-3,386	-5.21%
2001	65,082	65,082	62,002	-3,080	-4.73%	-3,080	-4.73%
2002	64,072	64,072	60,885	-3,187	-4.97%	-3,187	-4.97%
2003	64,009	64,009	60,437	-3,572	-5.58%	-3,572	-5.58%
MHMR - Community ICF-MR Average # Persons							
1998	7,226	7,624	7,490	-134	-1.76%	264	3.65%
1999	7,226	7,624	7,623	-1	-0.01%	397	5.49%
2000	7,626	7,627	7,713	86	1.13%	87	1.14%
2001	7,627	7,627	7,694	67	0.88%	67	0.88%
2002	7,644	7,644	7,476	-168	-2.20%	-168	-2.20%
2003	7,644	7,644	7,476	-168	-2.20%	-168	-2.20%
MHMR - State Hospital Daily Census							
1998	2,670	2,575	2,370	-205	-7.96%	-300	-11.24%
1999	2,670	2,575	2,265	-310	-12.04%	-405	-15.17%
2000	2,456	2,456	2,356	-100	-4.07%	-100	-4.07%
2001	2,456	2,456	2,394	-62	-2.52%	-62	-2.52%
2002	2,273	2,235	2,281	46	2.06%	8	0.35%
2003	2,273	2,237	2,309	72	3.22%	36	1.58%

Program/ Fiscal Year	Requested	Appropriated	Actual/ Projected	Difference (approp. vs. actual)	% Difference (approp. vs. actual)	Difference (requested vs. actual)	% Difference (requested vs. actual)
MHMR - State School Average Monthly Number of Enrollments							
1998	5,423	5,213	5,433	220	4.22%	10	0.18%
1999	5,248	5,038	5,298	260	5.16%	50	0.95%
2000	5,382	5,457	5,433	-24	-0.44%	51	0.95%
2001	5,307	5,457	5,345	-112	-2.05%	38	0.72%
2002	5,425	5,425	5,133	-292	-5.38%	-292	-5.38%
2003	5,425	5,425	4,962	-463	-8.53%	-463	-8.53%
PRS - Foster Care Caseload							
1998	11,912	11,804	10,843	-961	-8.14%	-1,069	-8.97%
1999	12,131	12,306	10,981	-1,325	-10.77%	-1,150	-9.48%
2000	11,878	11,897	12,006	109	0.92%	128	1.08%
2001	12,226	12,242	12,769	527	4.30%	543	4.44%
2002	12,964	13,028	14,002	974	7.48%	1,038	8.01%
2003	13,405	13,527	14,774	1,247	9.22%	1,369	10.21%

Note: Requested amounts do not reflect changes in legislation passed after the request is made. For example, the impact of SB43, 77th Legislature is not included in the requested amounts for Medicaid.

FMAP Determination: Traditional Formula Based on Per Capita Personal Income Versus Alternative Formula Based on Percent of Population Living in Poverty (Selected States)

	Estimated Traditional FMAP Based on a Per Capita Personal Income Formula *	Estimated Alternative FMAP Based on a Percent of Population Living in Poverty Formula * *	Estimated Difference in FMAP (Alternative Versus Traditional Formula)
Texas	60.2%	70.5%	10.3%
Arizona	65.0%	57.9%	-7.1%
California	50.0%	61.9%	11.9%
Florida	56.4%	50.0%	-6.4%
Georgia	59.0%	50.0%	-9.0%
Illinois	50.0%	50.0%	0.0%
Massachusetts	50.0%	50.0%	0.0%
Michigan	56.4%	50.0%	-6.4%
Minnesota	50.0%	50.0%	0.0%
New Jersey	50.0%	50.0%	0.0%
New Mexico	73.1%	83.0%	9.9%
New York	50.0%	68.6%	18.6%
North Carolina	61.0%	55.1%	-6.0%
Oregon	59.2%	52.9%	-6.4%
Pennsylvania	54.6%	50.0%	-4.6%
Washington State	50.0%	50.0%	0.0%

* Income data were averaged for 1997-1999 period. Data are from the U.S. Department of Commerce, Bureau of Economic Analysis (BEA).

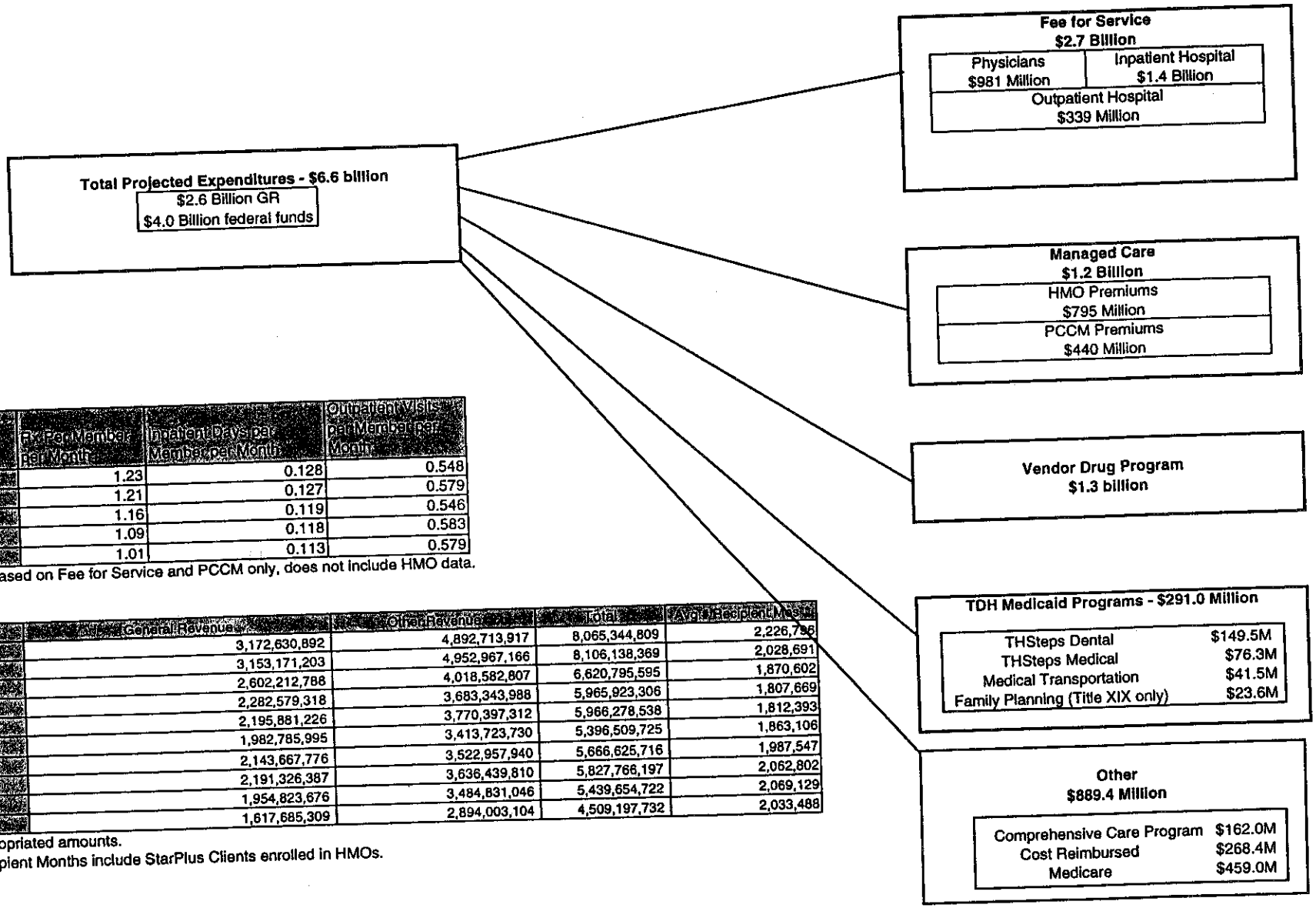
* * Poverty data are for 1998-2000 period. Data are from the U.S. Census Bureau, March Current Population Survey (CPS).

Analysis By:

Research and Forecasting Department
Texas Health and Human Services Commission
April of 2002

Attachment C

Medicaid Acute Care FY 2001



Year	Rx Per Member per Month	Inpatient Days per Member per Month	Outpatient Visits per Member per Month
2001	1.23	0.128	0.548
2000	1.21	0.127	0.579
1999	1.16	0.119	0.546
1998	1.09	0.118	0.583
1997	1.01	0.113	0.579

Note: Based on Fee for Service and PCCM only, does not include HMO data.

Year	General Revenue	Other Revenue	Total	Avg # Recipient Months**
2003	3,172,630,892	4,892,713,917	8,065,344,809	2,226,796
2002*	3,153,171,203	4,952,967,166	8,106,138,369	2,028,691
2001	2,602,212,788	4,018,582,807	6,620,795,595	1,870,602
2000	2,282,579,318	3,683,343,988	5,965,923,306	1,807,669
1999	2,195,881,226	3,770,397,312	5,966,278,538	1,812,393
1998	1,982,785,995	3,413,723,730	5,396,509,725	1,863,106
1997	2,143,667,776	3,522,957,940	5,666,625,716	1,987,547
1996	2,191,326,387	3,636,439,810	5,827,766,197	2,062,802
1995	1,954,823,676	3,484,831,046	5,439,654,722	2,069,129
1994	1,617,685,309	2,894,003,104	4,509,197,732	2,033,488

* Appropriated amounts.

**Recipient Months include StarPlus Clients enrolled in HMOs.

Attachment D

Health and Human Services Commission

Medicaid Vendor Drug Program

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures - Pre-Rebate	Estimated Expenditures - After Rebate	Actual prescriptions filled	Total costs column divided by #Rx column	Estimate based on most common Qty dispensed		Actual cost per tab or cap (based on most common quantity dispensed):		OTC	Generic Equivalent
				Total Costs	Total Costs	#RX	$/RX	Units per RX	Unit	Unit Cost	Effective Date		
1	ZYPREXA	Atypical Antipsychotic	Eli Lilly & Co	$52,286,118	$44,818,424	169,836	$263.89	58	ea	$7.77	12/17/01	No	No
2	RISPERDAL	Atypical Antipsychotic	Janssen	$44,377,739	$36,334,533	262,233	$138.56	56	ea	$2.37	06/19/01	No	No
3	PRILOSEC	Gastric Acid Inhibitor Anti-ulcer	AstraZenica LP	$32,198,694	$25,392,598	237,243	$107.03	36	ea	$3.70	01/09/02	No	No
4	CELEBREX	Anti-inflammatory	Pharmacia	$30,427,616	$21,940,793	272,161	$80.62	55	ea	$2.30	11/20/01	No	No
5	PREVACID	Gastric Acid Inhibitor Anti-ulcer	Tap Pharmaceuticals	$23,964,840	$16,491,085	206,633	$79.81	32	ea	$3.71	01/10/02	No	No
6	CLARITIN	Antihistimine	Schering Corp	$20,244,795	$14,155,338	288,188	$49.12	33	ea	$2.22	12/14/01	No	No
7	AUGMENTIN	Antibiotic	Smithkline Beecham	$20,188,144	$13,028,035	332,885	$39.14	100	ea	$0.63	01/15/02	No	No
8	LIPITOR	Cholesterol lowering agent	Warner-Lambert Co.	$18,309,439	$15,874,137	164,621	$96.43	47	ea	$1.88	01/03/02	No	No
9	DEPAKOTE	Anticonvulsant	Abbott Laboratories	$16,931,942	$13,465,349	143,750	$93.67	105	ea	$1.53	01/14/02	No	No
10	ZOLOFT	Antidepressant	Pfizer-Roerig	$16,607,972	$14,560,321	190,237	$76.54	39	ea	$2.02	01/09/02	No	No

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures - Pre-Rebate	Estimated Expenditures - After Rebate	Actual prescriptions filled	Total costs column divided by #Rx column	Estimate based on most common Qty dispensed		Actual cost per tab or cap (based on most common quantity dispensed):		OTC	Generic Equivalent
				Total Costs	Total Costs	#RX	$/RX	Units per RX	Unit	Unit Cost	Effective Date		
1	HYDROCODONE W/ACETAMINOPHEN	Analgesic	Various Generic Mfg.	$5,584,104	$5,290,880	535,715	$9.88	39	ea	$0.07	N/A	No	Yes
2	IBUPROFEN	Anti-inflammatory	Various Generic Mfg.	$5,019,043	$4,615,248	490,774	$9.40	170	ml	$0.10	N/A	No	Yes
3	ALBUTEROL SULFATE	Bronchodilator	Various Generic Mfg.	$5,739,167	$5,356,828	424,749	$12.61	174	ml	$0.14	N/A	No	Yes
4	TYLENOL	Analgesic	McNeil Pharmaceutical	$3,703,767	$3,432,819	420,692	$8.16	160	ml	$0.04	02/13/98	Yes	Yes
5	ZITHROMAX	Antibiotic	Pfizer, Inc.	$14,568,999	$13,009,603	402,204	$32.35	22	ml	$1.24	01/14/02	No	No
6	FUROSEMIDE	Diuretic	Various Generic Mfg.	$2,636,401	$2,580,960	395,758	$6.52	48	ea	$0.03	N/A	No	Yes
7	AUGMENTIN	Antibiotic	Smithkline Beecham	$20,188,144	$13,028,035	332,885	$39.14	100	ml	$0.63	01/15/02	No	No
8	AMOXICILLIN	Antibiotic	Various Generic Mfg.	$2,247,109	$2,187,446	303,876	$7.20	149	ml	$0.02	N/A	No	Yes
9	CLARITIN	Antihistimine	Schering Corp	$20,244,795	$14,155,338	288,188	$49.12	33	ea	$2.22	12/14/01	No	No
10	CELEBREX	Anti-inflammatory	Pharmacia	$30,427,616	$21,940,793	272,161	$80.62	55	ea	$2.30	11/20/01	No	No

Health and Human Services Commission - Medicaid Procedures

Top 10 Inpatient Medical Procedures by Expenditure (FY 2001)

Rank	Diagnosis Related Group Code Description	Total Dollars	# of DRG Claims	$ per DRG Claim	Diagnostic Related Group
1	Vaginal Delivery without Complicating Diagnoses	$135,842,352.65	78,191	$1,737.31	373
2	Extreme Immaturity or Respiratory Distress Syndrome, Neonate	$114,941,136.07	2238	$51,358.66	386
3	Cesarean Section without complications	$77,543,836.41	27,982	$2,771.20	371
4	Normal Newborn	$48,173,180.25	102,509	$469.94	391
5	Liver transplant	$47,567,184.31	743	$64,020.44	483
6	Psychosis (Inpatient tests, therapy and room and board required to stabilize a client suffering from psychosis)	$41,279,932.17	9,252	$4,461.73	430
7	Prematurity w Major Problems	$39,384,110.64	2769	$14,223.23	387
8	Cesarean Section with complications	$37,494,886.72	9,798	$3,826.79	370
9	Full Term Neonate with Major Problems	$33,519,159.63	8,479	$3,953.20	389
10	Bronchitis & Asthma Age 0-17	$32,336,212.42	11,797	$2,741.05	098

Top Ten Inpatient Medical Procedures by Volume (FY 2001)

Rank	Diagnosis Related Group Code Description	Total Dollars	# of DRG Claims	$ per DRG Claim	Diagnostic Related Group
1	Normal Newborn	$48,173,180	102,509	$469.94	391
2	Vaginal Delivery without Complicating Diagnoses	$135,842,353	78,191	$1,737.31	373
3	Cesarean Section without complications	$77,543,836	27,982	$2,771.20	371
4	Vaginal Delivery w Sterilization &/or D&C	$21,640,475	13,239	$1,634.60	374
5	Bronchitis & Asthma Age 0-17	$32,336,212	11,797	$2,741.05	098
6	Neonate w Other Significant Problems	$12,116,602	11,115	$1,090.11	390
7	Cesarean Section with complications	$37,494,887	9,798	$3,826.79	370
8	Psychosis (Inpatient tests, therapy and room and board required to stabilize a client suffering from psychosis)	$41,279,932	9,252	$4,461.73	430
9	Full Term Neonate with Major Problems	$33,519,160	8,479	$3,953.20	389
10	Vaginal Delivery with Complicating Diagnoses	$21,640,475	7,881	$2,745.90	372

Health and Human Services Commission -Medicaid Procedures

Top 25 Outpatient Medical Procedure Codes by Volume (FY2001)

Rank	Procedure Code Description	Use	Total Dollars	# of Procedures	$ per Procedure
1	EMERGENCY ROOM (CHARGE FOR ROOM)	Emergency room facility use charge.	$62,984,954.69	800,204	$78.71
2	CLINIC VISIT FEE (OUTPATIENT)	Outpatient clinic facility use charge.	$20,020,921.54	531,089	$37.70
3	ORAL AND TOPICAL MEDICATIONS USED IN THE EMERGENCY ROOM		$8,324,969.48	446,395	$18.65
4	MISCELLANEOUS SUPPLIES	Medical supplies provided in an emergency room or outpatient clinic	$11,968,300.84	425,615	$28.12
5	RURAL HEALTH ENCOUNTER	Rural health clinic services including physician or other health care professional	$18,478,614.46	319,639	$57.81
6	AUTOMATED HEMOGRAM	Diagnostic laboratory procedure	$2,997,333.70	288,265	$10.40
7	HOME HEALTH AGENCY, PRIVATE DUTY NURSING, PER HOUR	Private duty nurses for children enrolled in the Comprehensive Care Program	$80,058,243.90	243,830	$328.34
8	IV EQUIPMENT (OUTPATIENT) (TO INCLUDE TRAYS)		$5,568,498.83	165,193	$33.71
9	URINALYSIS, AUTO W/SCOPE	Diagnostic laboratory procedure	$618,575.79	145,816	$4.24
10	BASIC METABOLIC PANEL	Diagnostic laboratory procedure	$1,254,136.13	119,418	$10.50
11	SPEECH/HEARING THERAPY		$12,978,591.89	117,797	$110.18
12	COMPREHENSIVE METABOLIC PANEL	Diagnostic laboratory procedure	$1,537,346.18	115,847	$13.27
13	CHEST X-RAY		$7,392,355.00	112,608	$65.71
14	OBSERVATION ROOM	Room charge for patients not requiring hospital admission but requiring a period of observation of less than 24 hours	$12,683,810.24	108,624	$116.77
15	THERAPEUTIC EXERCISES	Exercises related to physical or occupational therapy	$8,791,086.69	104,065	$84.48
16	THERAPEUTIC ACTIVITIES	Treatments provided by physical or occupational therapists, such as electrostimulation, ultrasound and infrared treatments.	$9,982,140.33	96,476	$103.47
17	RURAL HEALTH ENCOUNTER	Rural health clinic services, including physician or other health care professional	$5,768,223.24	81,303	$70.95
18	AUTOMATED HEMOGRAM	Diagnostic laboratory procedure	$903,609.41	79,345	$11.39
19	URINE CULTURE/COLONY COUNT		$844,644.31	77,830	$10.85
20	FQHC ENCOUNTER	Federally Qualified Health Center services, including physician or health care professional	$6,432,640.36	59,116	$108.81
21	TREATMENT ROOM IN ER		$3,718,688.29	57,998	$64.12
22	URINALYSIS, AUTO, W/O SCOPE		$157,559.61	52,618	$2.99
23	PROTHROMBIN TIME	Diagnostic laboratory procedure to measure blood clotting time	$253,740.54	47,961	$5.29
24	DRUGS UNCLASSIFIED INJECTION	Miscellaneous drugs that do not have a specific billing code	$2,043,408.86	46,475	$43.97
25	BLOOD CULTURE FOR BACTERIA		$609,057.30	43,826	$13.90

Note: Data are reported for Fee for Service and Primary Care Case Management but not for Medicaid HMOs.

Shading indicates which of the most billed medical codes are actual procedures as opposed to other outpatient costs billed to Medicaid.

Source:Vision 21

Date:2/13/01

Top 25 Outpatient Medical Procedure Codes by Paid Amount (FY2001)

Rank	Procedure Code Description		Total dollars	# of procedures	$/Claim
1	HOME HEALTH AGENCY, PRIVATE DUTY NURSING, PER HOUR	Private duty nurses for children enrolled in the comprehensive care program	$80,058,243.90	243,830	$328.34
2	EMERGENCY ROOM (CHARGE FOR ROOM)	Emergency room facility use fee	$62,984,954.69	800,204	$78.71
3	CLINIC VISIT FEE (OUTPATIENT)	Outpatient clinic facility use charge	$20,020,921.54	531,089	$37.70
4	RURAL HEALTH ENCOUNTER	Rural health clinic services including physician or health care professional	$18,478,614.46	319,639	$57.81
5	SPEECH/HEARING THERAPY		$12,978,591.89	117,797	$110.18
6	OBSERVATION ROOM	Room charge for patients not requiring hospital admission but requiring a period of observation of less than 24 hours	$12,683,810.24	108,624	$116.77
7	MISCELLANEOUS SUPPLIES	Medical supplies provided in an emergency room or outpatient clinic	$11,968,300.84	425,615	$28.12
8	THERAPEUTIC ACTIVITIES	Treatments provided by physical or occupational therapists, such as electrostimulation, ultrasound and infrared treatments.	$9,982,140.33	96,476	$103.47
9	CT HEAD/BRAIN W/O DYE	Diagnostic radiological procedure	$9,651,021.05	23,717	$406.92
10	THERAPEUTIC EXERCISES	Exercises related to physical or occupational therapy	$8,791,086.69	104,065	$84.48
11	ORAL AND TOPICAL MEDICATIONS USED IN THE EMERGENCY ROOM		$8,324,969.48	446,395	$18.65
12	CHEST X-RAY		$7,392,355.00	112,508	$65.71
13	FQHC ENCOUNTER	Federally qualified health center services including physician or health care professional	$6,432,640.36	59,116	$108.81
14	ECHO EXAM OF PREGNANT UTERUS	Diagnostic radiological procedure	$5,911,859.82	42,055	$140.57
15	RURAL HEALTH ENCOUNTER	Rural health clinic services including physician or health care professional	$5,768,223.24	81,303	$70.95
16	IV EQUIPMENT (OUTPATIENT) (TO INCLUDE TRAYS)		$5,568,498.83	165,193	$33.71
17	MRI BRAIN W/O&W DYE		$3,929,568.86	4,561	$861.56
18	TREATMENT ROOM IN ER		$3,718,688.29	57,998	$64.12
19	THSTEPS DENTAL SERVICES		$3,432,661.24	6,746	$508.84
20	CT PELVIS W/DYE		$3,120,314.86	6,300	$495.29
21	CT ABDOMEN W/DYE		$3,094,245.51	5,755	$537.66
22	AUTOMATED HEMOGRAM	Diagnostic laboratory procedure	$2,997,333.70	288,265	$10.40
23	SKILLED NURSING VISIT TO INCLUDE "INCIDENTAL SUPPLIES" USED DURING VISIT, PER VISIT		$2,861,071.09	28,626	$99.95
24	ECHO EXAM OF PELVIS	Diagnostic radiological procedure	$2,657,787.81	18,770	$141.60
25	OPERATING ROOM (CHARGE FOR THE ROOM)		$2,651,925.39	12,065	$219.80

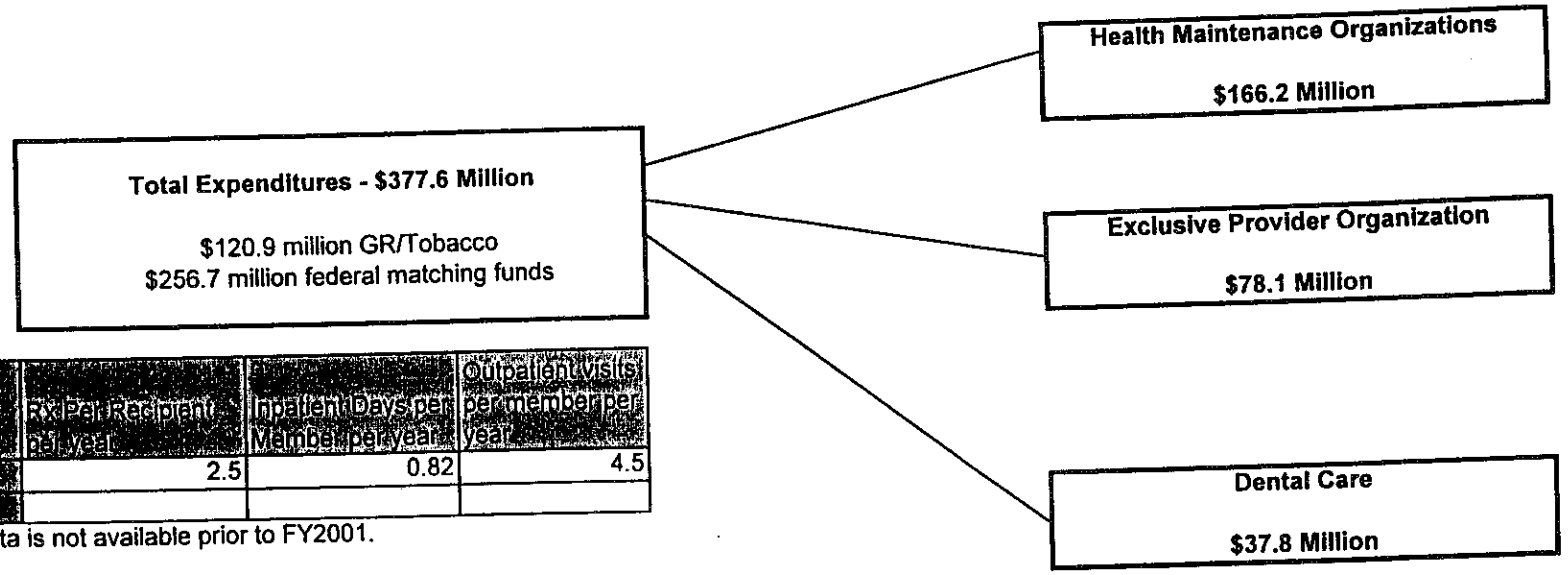
Note: Data are reported for Fee for Service and Primary Care Case Management but not for Medicaid HMOs.
Shading indicates which of the most billed medical codes are actual procedures as opposed to other outpatient costs billed to Medicaid.

Source:Vision 21
Date: 2/13/01

Health & Human Services Commission
Vendor Drug Program Expenditures for FY 2001
Top Ten Drugs by Volume (Includes dosage detail)

nk	Brand Name	Drug	Manufacturer	Use	# Claims	Amount Paid (Pre Rebate)	Approx. Amt. Paid after Rebate	Total Quantity	Avg. Rx Amt. Paid	Avg. Rx Qty	Unit	Average Unit Cost (WEAC)	Unit Cost Eff. Date	OTC	Generic Equiv.
		HYDROCODONE W/APAP 2.5/500MG			2,276	$26,867	$25,829	90,656	11.35	39.83	ea	0.16		No	Yes
		HYDROCODONE/APAP 5/500 TAB			257,459	$1,719,094	$1,668,653	9,980,360	6.48	38.76	ea	0.07		No	Yes
		HYDROCODONE/APAP 7.5/500 TB			86,445	$1,032,567	$978,920	4,784,161	11.32	55.34	ea	0.16		No	Yes
		HYDROCODONE/APAP 7.5/650 TB			8,254	$90,394	$86,497	443,357	10.48	53.71	ea	0.13		No	Yes
		HYDROCODONE/APAP 7.5/750 TB			100,854	$1,076,328	$1,021,570	5,801,074	10.13	57.52	ea	0.13		No	Yes
		HYDROCODONE/APAP 10/500 TAB			32,375	$738,014	$668,903	2,678,206	20.66	82.72	ea	0.36		No	Yes
		HYDROCODONE/APAP 10/660 TAB			29,795	$506,357	$470,186	2,334,774	15.78	78.36	ea	0.22		No	Yes
		HYDROCODONE W/APAP ELIXIR			18,257	$396,466	$370,322	5,112,978	20.28	280.06	ml	0.07		No	Yes
1	HYDROCODONE W/ACETAMINOPHEN	Total	Various Generic Mfg.	Analgesic	535,715	$5,584,104	$5,290,880		9.86						
		IBUPROFEN 100MG/5ML SUSP			306,826	$3,707,874	$3,344,895	52,053,783	10.90	169.65	ml	0.10		No	Yes
		IBUPROFEN 200MG TABLET			6,181	$12,654	$12,067	314,470	1.95	50.88	ea	0.03		Yes	Yes
		IBUPROFEN 400MG TABLET			55,657	$368,711	$360,963	2,502,122	6.49	44.96	ea	0.04		No	Yes
		IBUPROFEN 600MG TABLET			60,514	$426,417	$414,885	2,821,923	6.86	46.63	ea	0.06		No	Yes
		IBUPROFEN 800MG TABLET			61,596	$503,387	$482,438	3,443,088	7.83	55.90	ea	0.09		No	Yes
2	IBUPROFEN	Total	Various Generic Mfg.	Anti-inflammatory	490,774	$5,019,043	$4,615,248		9.40						
		ALBUTEROL .83MG/ML SOLUTION			180,863	$3,740,864	$3,440,313	31,527,164	19.02	174.32	ml	0.14		No	Yes
		ALBUTEROL 5MG/ML SOLUTION			77,873	$733,122	$683,937	2,013,980	8.78	25.86	ml	0.35		No	Yes
		ALBUTEROL SULF 2MG/5ML SYRP			157,500	$1,204,245	$1,173,826	21,091,288	7.45	133.91	ml	0.02		No	Yes
		ALBUTEROL SULFATE 2MG TAB			4,740	$32,243	$31,209	304,665	6.58	64.28	ea	0.05		No	Yes
		ALBUTEROL SULFATE 4MG TAB			3,773	$28,694	$27,542	259,450	7.30	68.76	ea	0.06		No	Yes
3	ALBUTEROL SULFATE	Total	Various Generic Mfg.	Bronchodilator	424,749	$5,739,167	$5,356,828		12.61						
		CHILD TYLENOL 80MG TAB CHEW			7,663	$62,636	$57,642	648,718	7.52	84.66	ea	0.08	02/13/98	Yes	Yes
		CHILDREN'S TYLENOL 160MG/5ML			186,032	$1,664,470	$1,549,825	29,722,537	8.33	159.77	ml	0.04	02/13/98	Yes	Yes
		INFANT'S TYLENOL 100MG/ML			150,945	$1,323,189	$1,231,016	4,156,503	8.16	27.54	ml	0.22	02/13/98	Yes	Yes
		TYLENOL 325MG TABLET			20,464	$139,999	$112,299	1,600,822	5.49	78.23	ea	0.17	03/23/99	Yes	Yes
		TYLENOL JR 160MG TAB CHEW			9,379	$93,919	$87,278	456,944	9.31	48.72	ea	0.15	03/23/99	Yes	Yes
		TYLENOL ARTHRITIS			3,519	$39,209	$35,944	362,602	10.21	103.04	ea	0.09	03/23/99	Yes	Yes
		TYLENOL E-R 650MG CAPLET SA			767	$8,345	$7,647	74,197	9.97	96.74	ea	0.09	09/01/97	Yes	Yes
		TYLENOL EX-STR 500MG			41,923	$372,000	$351,167	3,640,419	8.38	86.84	ea	0.06	09/01/97	Yes	Yes
4	TYLENOL	Total	McNeil Pharmaceutical	Analgesic	420,692	$3,703,767	$3,432,819		8.16						
		ZITHROMAX 1GM POWDER PACKET			3,195	$83,073	$74,941	3,575	23.46	1.12	gm	18.96	01/14/02	No	No
		ZITHROMAX ORAL SUSP 100MG/5ML			87,019	$2,970,720	$2,658,812	1,518,524	30.53	17.45	ml	1.72	01/14/02	No	No
		ZITHROMAX ORAL SUSP 200MG/5ML			159,334	$5,031,341	$4,508,273	3,503,544	28.29	21.99	ml	1.24	01/14/02	No	No
		ZITHROMAX 250MG TABLET			151,322	$6,218,441	$5,540,486	925,539	36.61	6.12	ea	6.10	01/14/02	No	No
		ZITHROMAX 600MG TABLET			1,295	$264,757	$229,181	20,241	176.97	15.63	ea	14.65	01/14/02	No	No
		ZITHROMAX I.V. 500MG VIAL			39	$668	-$90	286	-2.32	7.33	ea	22.09	01/14/02	No	No
5	ZITHROMAX	Total	Pfizer, Inc.	Antibiotic	402,204	$14,568,999	$13,009,603		32.35						

Children's Health Insurance Program - FY 2001



Year	Rx Per Recipient per year	Inpatient Days per Member per year	Outpatient Visits per member per year
2001	2.5	0.82	4.5
2000			

Note: Data is not available prior to FY2001.

Year	General Revenue	Tobacco Funds	Other Funds	Total	Recipient Months
2003	16,822,935	248,587,014	541,102,859	806,512,808	573,984
2002	15,797,619	219,985,056	491,562,682	727,345,357	534,921
2001		120,961,216	256,691,780	377,552,996	282,260
2000		25,201,443	53,067,989	78,269,432	64,493
1999	13,708,399		38,434,618	52,143,017	33,851
1998	469,426		1,308,902	1,778,328	13,829

Notes:
1. Recipient months include CHIP I, CHIP II, Legal Immigrants, Spillover and SKIP.
2. Other funds include federal matching funds and member premium cost sharing.
3. FY02-03 data is projected.

Attachment E

CHIP Medical Procedures

Top 10 Inpatient Medical Procedures by Unit Cost (FY 2001)

Rank	Procedure Name	Description	Unit Cost*	# of Procedures	Total Dollars
1	Professional charges hospital care	Professional fees for providing care to children during admission to the hospital.	$72,323	2,230	$161,279,287
2	Emergency room use	Cost of use of the emergency room itself.	$22,724	1,666	$37,858,784
3	Intensive Care	Cost of care provided when the child is admitted to an Intensive Care Unit.	$27,569	794	$21,889,992
4	Radiology diagnostic	Cost of Medical Imaging ("Radiology") studies done during an inpatient admission.	$17,884	2,741	$49,021,195
5	Semi-private room and board	Cost of room shared with another patient; includes basic staff and support services.	$14,381	1,964	$28,245,070
6	Laboratory/pathology	Cost of blood tests, chemistries, tissue specimen handling during an inpatient admission.	$14,696	2,401	$35,284,856
7	Private room and board	Cost of private room; includes basic staff and support services.	$14,255	3,380	$48,180,311
8	Respiratory Therapy	Cost of therapies administered by Respiratory Therapists to improve lung function and breathing.	$3,756	12,171	$45,714,276
9	Anesthesia	Cost of providing relief from pain during surgery and painful procedures.	$3,553	6,477	$23,012,781
10	Medical surgical supplies	Cost of medically related supplies, e.g., sutures, special dressings, suctioning kits, etc.	$2,147	34,085	$73,180,154

*The unit cost represents the charges associated with the hospital stay during which this service or supply was dispensed. It is not the unit cost of the particular procedure. The Health Plans do not supply the Institute with their reimbursement information. Therefore, calculations had to be based on the dollar amount associated with that hopitalization. The dollar amounts associated with the hospitalization are based on the average charges in Texas times the relative DRG weight for that stay.

CHIP Medical Procedures

Top Ten Inpatient Medical Procedures by Volume (FY 2001)

Rank	Procedure Name	Description	Unit Cost*	# of Procedures	Total Dollars
1	Pharmacy	Cost of Drugs and Medicines	$973	89,368	$86,949,702
2	Medical Surgical Supplies	All supplies and equipment used to treat patients while they are in the hospital.	$2,147	34,085	$73,180,154
3	Respiratory Therapy	Treatments provided by professional Respiratory Therapists to improve breathing. Commonly used in asthma.	$3,756	12,171	$45,714,276
4	Anesthesia	Professional services to provide relief of pain for surgery and painful procedures.	$3,553	6,477	$23,012,781
5	Operating Room Services	Cost of staffing and using the Operating Room.	$2,349	5,421	$12,733,929
6	Recovery Room	Cost of staffing and using special facility to allow patients to safely recover after anesthesia/surgery	$6,218	3,398	$21,127,099
7	Private room and board	The basic cost of the hospital room and the attendant staff and services	$14,255	3,380	$48,180,311
8	Pulmonary function test	Tests of lung function and breathing	$4,903	3,190	$15,639,135
9	Radiology diagnostic	X-Ray and other medical imaging tests. Typically includes MRI, ultrasound, etc.	$17,884	2,741	$49,021,195
10	Laboratory/pathology	Cost of all blood tests, chemistries, tissues specimen handling.	$14,696	2,401	$35,284,856

*The unit cost represents the charges associated with the hospital stay during which this service or supply was dispensed. It is not the unit cost of the particular procedure. The Health Plans do not supply the Institute with their reimbursement information. Therefore, calculations had to be based on the dollar amount associated with that hopitalization. The dollar amounts associated with the hospitalization are based on the average charges in Texas times the relative DRG weight for that stay.

CHIP Medical Procedures

Top Outpatient Procedures by Cost (FY01)

Rank	Procedure		# of Units	Unit Cost*	Total Cost
1	Outpatient office visit	Physician fee related to the evaluation and management of a patient during an office visit	735,003	$35.98	$26,444,067
2	Emergency room visit professional charges	Physician fee component of an emergency room visit.	62,863	$47.39	$2,979,273
3	Oronasal repair	Physician fee for repair of lacerations (cuts) in the area of the mouth and face.	7,343	$265.68	$1,950,888
4	Outpatient consultation	Physician fee for a medical consultation. Typically billed by a specialist on a first patient visit.	23,680	$77.65	$1,838,834
5	Hemogram and platelet count, differential WBC count	Complete blood count, including all circulating blood cell types.	23,679	$77.56	$1,836,543
6	Thoracentesis	Drainage of fluid or air from the chest cavity.	21,502	$67.10	$1,442,865
7	Abcess drainage	Drainage of an abcess.	26,243	$53.71	$1,409,570
8	Opthamology visit	Professional fees of MD or DO physicians specializing in the medical and surgical diagnosis and treatment of diseases of the eye.	22,062	$58.78	$1,296,856
9	Psychotherapy visit	Professional services for treating behavioral health conditions.	14,388	$59.10	$850,350
10	Coccygeal fracture	Diagnosis and treatment of broken tailbone.	9,240	$90.83	$839,223

Note: Outpatient charges are based on Texas Medicaid fee schedule. CHIP health plans do not provide actual paid amounts.

CHIP Medical Procedures

Top Outpatient Procedures by Volume (FY01)

Rank	Procedure	Description	# of Units	Unit Cost*	Total Cost
1	Outpatient office visit	Fees charged by physicians for visits to their offices for care outside of the hospital.	735,003	$35.98	$26,444,067
2	Emergency room visit professional charges	Fees charged by physicians providing care in the Emergency Department of a hospital.	62,863	$47.39	$2,979,273
3	Allergy skin test	Tests that inject substances into the skin surface to test for allergic reactions.	54,917	$2.52	$138,665
4	Immunization	Cost of providing required childhood vaccinations against disease, according to nationally recognized standards .	39,419	$15.55	$612,950
5	Medical surgical supplies	Cost of supplies for medical and minor surgical care as an outpatient, e.g., casts, splints, sutures.	39,136	$15.55	$608,549
6	Strep A pathology	Tests for Group A Streptococcal infection, most commonly, testing for "strep throat."	32,562	$16.58	$539,878
7	Additional vaccine - two or more toxoid vaccines	Costs related to giving more than one vacciniation at a visit. This is often required.	28,665	$15.55	$445,741
8	Allergy professional services	Physician fees related to the diagnosis and treatment of allergic conditons.	26,490	$4.29	$113,642
9	Abcess drainage	Physician fee for opening and removing infected material from an abcess.	26,243	$53.71	$1,409,570
10	Hemogram and platelet count, differential WBC count	Complete blood count, including all circulating blood cell types.	23,679	$77.56	$1,836,543

Note: Outpatient charges are based on Texas Medicaid fee schedule. CHIP health plans do not provide actual paid amounts.

Heath & Human Services Commission

Children's Health Insurance Program

Top 10 Drugs by Expenditure (FY 2001)				Expenditures*	Number of Prescriptions	Total costs column divided by #Rx column	Average per RX or estimate based on most common Qty dispensed**	Actual cost per tab or cap**		
Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Units per RX	Unit Cost	OTC	Generic Equivalent
1	CLARITIN****	Allergies	Schering	$15,374,018	229,034	$67.13	N/A	N/A	No	No
2	AUGMENTIN	Antibiotic	SK Beecham	$6,274,547	94,457	$66.43	N/A	N/A	No	No
3	CEFZIL	Antibiotic	BM Squibb	$5,548,463	93,505	$59.34	N/A	N/A	No	No
4	ZYRTEC****	Antihistamine	Pfizer	$4,514,715	105,190	$42.92	N/A	N/A	No	No
4	IBUPROFEN	Fever reduction	Alpharma	$3,883,986	328,639	$11.82	N/A	N/A	Yes	Yes
5	NASONEX	Allergies	Schering	$3,382,928	71,782	$53.40	N/A	N/A	No	No
6	ZITHROMAX****	Antibiotic	Pfizer	$5,279,909	154,480	$34.18	N/A	N/A	No	No
7	AMOXIL	Antibiotic	SK Beecham	$1,107,947	71,100	$15.58	N/A	N/A	No	Yes
8	TRIMOX	Antibiotic	Apothecon	$931,001	121,099	$7.69	N/A	N/A	No	Yes
9	ALBUTEROL	Asthma	Warrick	$775,681	71,278	$10.88	N/A	N/A	No	Yes
10	AMOXICILLIN	Antibiotic	Teva	$683,276	91,247	$7.49	N/A	N/A	No	Yes

Top Ten Drugs by Volume (FY 2001)				Expenditures*	Actual prescriptions filled	Total costs column divided by #Rx	Average	Actual cost per tab or cap**		
Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Package Size	Unit Cost	OTC	Generic Equivalent
1	IBUPROFEN	Fever reduction	Alpharma	$3,883,986	328,639	$11.82	100mg Sus	N/A	No	Drug is generic
2	CLARITIN****	Allergies	Schering	$15,374,018	229,034	$67.13	Liquid/Tabs	N/A	No	No
3	ZITHROMAX****	Antibiotic	Pfizer	$5,279,909	154,480	$34.18	Liquid/Tabs	N/A	No	No
4	TRIMOX	Antibiotic	Apothecon	$931,001	121,099	$7.69	150ml Sus	N/A	No	Yes
5	ZYRTEC****	Antihistimine	Pfizer	$4,514,715	105,190	$42.92	Liquid/Tabs	N/A	No	No
6	AUGMENTIN	Antibiotic	SK Beecham	$6,274,547	94,457	$66.43	100ml/5ml Sus	N/A	No	No
7	CEFZIL	Antibiotic	BM Squibb	$5,584,463	93,505	$59.72	100ml/5ml Sus	N/A	No	No
8	AMOXICILLIN	Antibiotic	Teva	$683,276	91,247	$7.49	150ml/5ml Sus	N/A	No	Yes
9	NASONEX	Allergies	Schering	$3,832,928	71,782	$53.40	17gm	N/A	No	No
10	ALBUTEROL	Asthma	Warrick	$775,681	71,278	$10.88	90mcg Aer	N/A	No	Yes

*CHIP costs are based on data reported by health plans.

**Units per prescription and, therefore, unit costs are not provided to the program by the health plans.

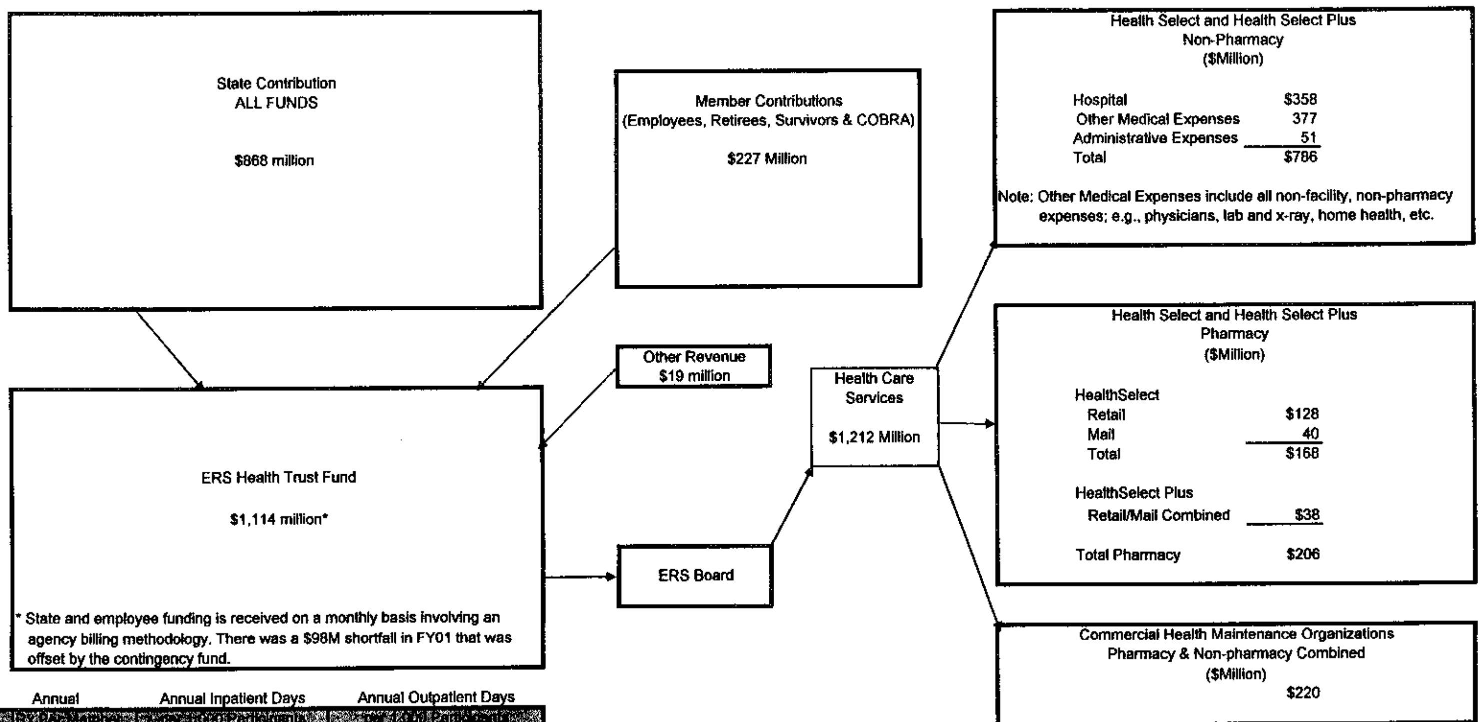
***Co-pays vary by income. Co-pay as % is not available.

****Products in this group are combined. Example: Suspension and tablets.

Attachment F

Employees Retirement System (FY 2001)

Health Plan



Year	Annual Rx Per Member	Annual Inpatient Days per 1,000 Participants	Annual Outpatient Days per 1,000 Participants
2001	15.11	642	1,299
2000	14.42	604	1,225
1999	16.02	576	1,069
1998	14.99	639	997
1997	13.94	580	883

	$ Million					*Minus COBRA & Nominees
Year	State (All Funds)	Member Contributions	[illegible]	[illegible]	Total	[illegible]
2003	$1,241.7	$291.2	$15.4	$7.6	$1,555.9	518,565
2002	1,105.5	258.9	14.3	1.0	1,379.7	518,565
2001	867.8	226.8	19.2	97.9	1,211.7	516,858
2000	798.3	199.9	23.4	62.6	1,084.2	516,900
1999	717.3	185.1	24.5	76.0	1,002.9	511,585
1998	699.6	175.3	25.6	7.3	907.8	506,145
1997	684.9	170.9	24.7	0.0	880.5	497,741
1996	685.6	171.4	22.7	0.0	879.7	494,883
1995	641.9	172.6	15.1	0.0	829.6	491,815
1994	571.1	161.3	7.7	0.0	740.1	469,244

Employees Retirement System (All Pharmacies)

Top 10 Drugs by Expenditure (FY 2001)				Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Either average per RX or Estimate based on most common Qty dispensed for the agent	Actual cost per tab or cap include date completed:			
Rank	**Drug Name**	**Use**	**Manufacturer**	**Total Costs**	**#RX**	**$/RX**	**Units per RX**	**Unit Cost**	**OTC**	**Generic Equivalent**	**St. Copay %**
1	Prilosec	gastrointestinal	AstraZeneca	$12,579,039	82,814	$151.90	44.530	$3.41	no	no	85.7%
2	Lipitor	cardiovascular	Parke-Davis	$9,128,847	107,899	$84.61	41.408	$2.04	no	no	74.4%
3	Zocor	cardiovascular	Merck	$6,738,582	56,169	$119.97	41.231	$2.91	no	no	81.7%
4	Claritin	antihistamine	Schering	$5,793,216	82,764	$70.00	41.339	$1.69	no	no	71.1%
5	Celebrex	analgesic (nsaids)	Searle	$5,494,173	55,741	$98.57	53.398	$1.85	no	no	78.7%
6	Vioxx	analgesic (nsaids)	Merck	$4,086,149	47,287	$86.41	39.941	$2.16	no	no	76.0%
7	Prozac	antidepressant	Dista	$3,874,369	33,237	$116.57	48.930	$2.38	no	yes	81.7%
8	Prevacid	gastrointestinal	TAP	$3,421,765	26,490	$129.17	40.228	$3.21	no	no	72.3%
9	Glucophage	antidiabetic	Bristol-Myers Sq	$2,992,339	42,970	$69.64	91.934	$0.76	no	yes	69.1%
10	Premarin	hormone,estrogen	Wyeth-Ayerst	$2,884,643	114,252	$25.25	40.398	$0.62	no	no	20.7%

Top Ten Drugs by Volume (FY 2001)				Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Average	Actual cost per tab or cap include date completed:			
Rank	**Drug Name**	**Use**	**Manufacturer**	**Total Costs**	**#RX**	**$/RX**	**Units per Rx**	**Unit Cost**	**OTC**	**Generic Equivalent**	**St. Copay %**
1	Premarin	hormone,estrogen	Wyeth-Ayerst	$2,884,643	114,252	$25.25	40.398	$0.62	no	no	20.7%
2	Lipitor	cardiovascular	Parke-Davis (Pfizer)	$9,128,847	107,899	$84.61	41.408	$2.04	no	no	74.4%
3	Hydrocodone	analgesic		$905,036	91,278	$9.92	49.931	$0.20	no	yes	61.8%
4	Prilosec	gastrointestinal	AstraZeneca	$12,579,039	82,814	$151.90	44.530	$3.41	no	no	85.7%
5	Claritin	antihistamine	Schering	$5,793,216	82,764	$70.00	41.339	$1.69	no	no	71.1%
6	Zocor	cardiovascular	Merck	$6,738,582	56,169	$119.97	41.231	$2.91	no	no	81.7%
7	Celebrex	analgesic (nsaids)	Searle	$5,494,173	55,741	$98.57	53.398	$1.85	no	no	78.7%
8	Norvasc	cardiovascular	Pfizer	$2,799,223	51,122	$54.76	41.545	$1.32	no	no	62.2%
9	Zithromax	antibiotic	Pfizer	$1,744,126	51,095	$34.13	8.778	$3.89	no	no	48.3%
10	Allegra	antihistamine	Aventis	$2,784,975	50,763	$54.86	50.603	$1.08	no	no	64.0%

Notes:

1. FY2001 experience for the HealthSelect plan only.
2. All pharmacies is retail and mail order pharmacies combined
3. Actual expenditures equals ingredient cost. Dispensing fees are not included. Rebate amount is estimated by applying uniform rebate percentage to all drugs.
4. Experience for an individual drug will be reported for all strengths combined.
5. St. Copay% is calculated by dividing the total plan cost (total cost less member copayment for each drug) by the total cost of drug. Total Cost is defined as ingredient cost plus dispensing fee less estimated rebate.
6. Use will be the standard description in Physician's Desk Reference 2001.
7. Generics of some strengths of Prozac and Glucophage available after 2001 plan year.

Employees Retirement System (Retail Pharmacies)

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Either average per RX or Estimate based on most common Qty dispensed for the agent	Actual cost per tab or cap include date completed:	OTC	Generic Equivalent	St. Copay %
				Total Costs	#RX	$/RX	Units per RX	Unit Cost			
1	Prilosec	gastrointestinal	AstraZeneca	$8,384,426	69,596	$120.47	34.200	$3.52	no	no	84.6%
2	Lipitor	cardiovascular	Parke-Davis (Pfizer)	$5,834,771	89,294	$65.34	31.023	$2.11	no	no	72.1%
3	Claritin	antihistamine	Schering	$4,353,662	74,121	$58.74	34.897	$1.68	no	no	69.0%
4	Zocor	cardiovascular	Merck	$4,214,967	45,972	$91.69	30.458	$3.01	no	no	79.9%
5	Celebrex	analgesic (nsaids)	Searle	$3,832,528	48,069	$79.73	42.131	$1.89	no	no	76.9%
6	Vioxx	analgesic (nsaids)	Merck	$2,926,337	41,232	$70.97	31.819	$2.23	no	no	74.2%
7	Prozac	antidepressant	Dista	$2,848,259	29,339	$97.08	40.013	$2.43	no	yes	80.4%
8	Prevacid	gastrointestinal	TAP	$2,632,671	23,796	$110.64	33.720	$3.28	no	no	70.7%
9	Zoloft	antidepressant	Pfizer	$2,200,897	31,792	$69.23	34.869	$1.99	no	no	73.6%
10	Allegra	antihistamine	Aventis	$2,161,785	46,067	$46.93	42.457	$1.11	no	no	61.8%

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Average	Actual cost per tab or cap include date completed:	OTC	Generic Equivalent	St. Copay %
				Total Costs	#RX	$/RX	Units per Rx	Unit Cost			
1	Premarin	hormone,estrogen	Wyeth-Ayerst	$1,941,363	95,805	$20.26	31.124	$0.65	no	no	18.1%
2	Hydrocodone	analgesic	various	$868,311	90,300	$9.62	48.321	$0.20	no	yes	61.2%
3	Lipitor	cardiovascular	Parke-Davis (Pfizer)	$5,834,771	89,294	$65.34	31.023	$2.11	no	no	72.1%
4	Claritin	antihistamine	Schering	$4,353,662	74,121	$58.74	34.897	$1.68	no	no	69.0%
5	Prilosec	gastrointestinal	AstraZeneca	$8,384,426	69,596	$120.47	34.200	$3.52	no	no	84.6%
6	Zithromax	antibiotic	Pfizer	$1,733,529	51,047	$33.96	8.749	$3.88	no	no	48.1%
7	Celebrex	analgesic (nsaids)	Searle	$3,832,528	48,069	$79.73	42.131	$1.89	no	no	76.9%
8	Allegra	antihistamine	Aventis	$2,161,785	46,067	$46.93	42.457	$1.11	no	no	61.8%
9	Zocor	cardiovascular	Merck	$4,214,967	45,972	$91.69	30.458	$3.01	no	no	79.9%
10	Norvasc	cardiovascular	Pfizer	$1,967,189	44,067	$44.64	32.822	$1.36	no	no	59.9%

Notes:

1. FY2001 experience for the HealthSelect plan only.
2. Retail pharmacies only.
3. Actual expenditures equals ingredient cost. Dispensing fees are not included. Rebate amount is estimated by applying uniform rebate percentage to all drugs.
4. Experience for an individual drug will be reported for all strengths combined.
5. St. Copay% is calculated by dividing the total plan cost (total cost less member copayment for each drug) by the total cost of drug. Total Cost is defined as ingredient cost plus dispensing fee less estimated rebate.
6. Use will be the standard description in Physician's Desk Reference 2001.
7. Generics of some strengths of Prozac and Glucophage available after 2001 plan year.

Employees Retirement System (Mail Order Pharmacy)

Top 10 Drugs by Expenditure (FY 2001)				Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Either average per Rx or Estimate based on most common Qty dispensed for the agent	Actual cost per tab or cap include date completed:			
Rank	**Drug Name**	**Use**	**Manufacturer**	**Total Costs**	**#RX**	**$/RX**	**Units per Rx**	**Unit Cost**	**OTC**	**Generic Equivalent**	**St. Copay %**
1	Prilosec	gastrointestinal	AstraZeneca	$4,194,613	13,218	$317.34	98.920	$3.21	no	no	88.2%
2	Lipitor	cardiovascular	Parke-Davis (Pfizer)	$3,294,075	18,605	$177.05	91.248	$1.94	no	no	78.7%
3	Zocor	cardiovascular	Merck	$2,523,616	10,197	$247.49	89.797	$2.76	no	no	84.8%
4	Celebrex	analgesic(nsaids)	Searle	$1,661,645	7,672	$216.59	123.995	$1.75	no	no	82.8%
5	Claritin	antihistamine	Schering	$1,439,554	8,643	$166.56	96.592	$1.72	no	no	77.7%
6	Vioxx	analgesic(nsaids)	Merck	$1,159,812	6,055	$191.55	95.250	$2.01	no	no	80.6%
7	Prozac	antidepressant	Dista	$1,026,110	3,898	$263.24	116.044	$2.27	no	yes	85.4%
8	Premarin	hormone,estrogen	Wyeth-Ayerst	$943,281	18,447	$51.13	88.562	$0.58	no	no	26.8%
9	Glucophage	antidiabetic	Bristol-Myers Sq	$923,049	5,883	$156.90	214.338	$0.73	no	yes	75.2%
10	Norvasc	cardiovascular	Pfizer	$832,034	7,055	$117.94	96.029	$1.23	no	no	68.0%

Top Ten Drugs by Volume (FY 2001)				Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Average	Actual cost per tab or cap include date completed:			
Rank	**Drug Name**	**Use**	**Manufacturer**	**Total Costs**	**#RX**	**$/RX**	**Units per Rx**	**Unit Cost**	**OTC**	**Generic Equivalent**	**St. Copay %**
1	Lipitor	cardiovascular	Parke-Davis (Pfizer)	$3,294,075	18,605	$177.05	91.248	$1.94	no	no	78.7%
2	Premarin	hormone,estrogen	Wyeth-Ayerst	$943,281	18,447	$51.13	88.562	$0.58	no	no	26.8%
3	Prilosec	gastrointestinal	AstraZeneca	$4,194,613	13,218	$317.34	98.920	$3.21	no	no	88.2%
4	Zocor	cardiovascular	Merck	$2,523,616	10,197	$247.49	89.797	$2.76	no	no	84.8%
5	Claritin	antihistamine	Schering	$1,439,554	8,643	$166.56	96.592	$1.72	no	no	77.7%
6	Celebrex	analgesic (nsaids)	Searle	$1,661,645	7,672	$216.59	123.995	$1.75	no	no	82.8%
7	Prempro	hormone	Wyeth-Ayerst	$507,034	7,589	$66.81	83.229	$0.80	no	no	43.7%
8	Prinivil	cardiovascular	Merck	$587,556	7,520	$78.13	99.434	$0.79	no	no	51.9%
9	Norvasc	cardiovascular	Pfizer	$832,034	7,055	$117.94	96.029	$1.23	no	no	68.0%
10	Vioxx	analgesic (nsaids)	Merck	$1,159,812	6,055	$191.55	95.250	$2.01	no	no	80.6%

Notes:

1. FY2001 experience for the HealthSelect plan only.
2. Mail order pharmacy only.
3. Actual expenditures equals ingredient cost. Dispensing fees are not included. Rebate amount is estimated by applying uniform rebate percentage to all drugs.
4. Experience for an individual drug will be reported for all strengths combined.
5. St. Copay% is calculated by dividing the total plan cost (total cost less member copayment for each drug) by the total cost of drug. Total Cost is defined as ingredient cost plus dispensing fee less estimated rebate.
6. Use will be the standard description in Physician's Desk Reference 2001.
7. Generics of some strengths of Prozac and Glucophage available after 2001 plan year.

HEALTHSELECT PLUS - TOTAL

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Units per RX	Unit Cost	OTC	Generic Equivalent	St. Copay %
1	PRILOSEC	GASTRIC ACID SECRETION REDUCERS	ASTRA	$ 2,486,881	16,779	$ 148.21	42	$ 3.52	no	no	89%
2	LIPITOR	LIPOTROPICS (CONTINUED 1)	PARKE DAVIS	$ 2,407,850	28,643	$ 84.06	39	$ 2.14	no	no	78%
3	CLARITIN	ANTIHISTAMINES (CONTINUED 1)	SCHERING	$ 1,402,444	19,775	$ 70.92	42	$ 1.69	no	no	75%
4	ZOCOR	LIPOTROPICS	MERCK HUMAN HEALTH	$ 927,830	7,887	$ 117.64	37	$ 3.17	no	no	72%
5	PREVACID	GASTRIC ACID SECRETION REDUCERS	TAP	$ 917,138	7,146	$ 128.34	39	$ 3.31	no	no	75%
6	AUGMENTIN	PENICILLINS	SMITHKLINE BEECHAM	$ 907,713	12,779	$ 71.03	49	$ 1.44	no	no	78%
7	ZOLOFT	SEROTONIN SPECIFIC REUPTAKE INHIBITOR (SSRIS)	ROERIG	$ 898,750	10,856	$ 82.79	42	$ 1.99	no	no	79%
8	GLUCOPHAGE	HYPOGLYCEMICS, BIGUANIDE TYPE (NON-SULFONYLUREAS)	MEAD JOHNSON	$ 876,508	11,811	$ 74.21	89	$ 0.83	no	metformin hydrochloride	76%
9	VIOXX	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE	MERCK HUMAN HEALTH	$ 862,037	10,131	$ 85.09	38	$ 2.26	no	no	80%
10	ALLEGRA	ANTIHISTAMINES (CONTINUED 2)	MARION MERRELL DOW	$ 839,066	14,275	$ 58.78	48	$ 1.22	no	no	69%

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Package Size	Unit Cost	OTC	Generic Equivalent	St. Copay %
1	LIPITOR	LIPOTROPICS (CONTINUED 1)	PARKE DAVIS	$ 2,407,850	28,643	$ 84.06	39	$ 2.14	no	no	78%
2	PREMARIN	ESTROGENIC AGENTS	WYETH-AYERST	$ 699,100	26,949	$ 25.94	39	$ 0.66	no	no	22%
3	CLARITIN	ANTIHISTAMINES (CONTINUED 1)	SCHERING	$ 1,402,444	19,775	$ 70.92	42	$ 1.69	no	no	75%
4	SYNTHROID	THYROID HORMONES	BOOTS	$ 321,975	18,774	$ 17.15	38	$ 0.45	no	no, not AB rated	1%
5	ZITHROMAX	MACROLIDES	PFIZER	$ 592,247	17,765	$ 33.34	9	$ 3.53	no	no	48%
6	ZESTRIL	HYPOTENSIVES, ACE INHIBITORS	ZENECA	$ 639,130	17,648	$ 36.22	41	$ 0.87	no	no	46%
7	PRILOSEC	GASTRIC ACID SECRETION REDUCERS	ASTRA	$ 2,486,881	16,779	$ 148.21	42	$ 3.52	no	no	89%
8	HYDROCODON	ANALGESICS,NARCOTICS	WATSON LABS	$ 113,059	15,026	$ 7.52	39	$ 0.19	no	HYDROCODONE W/AC	58%
9	ALLEGRA	ANTIHISTAMINES (CONTINUED 2)	MARION MERRELL DOW	$ 839,066	14,275	$ 58.78	48	$ 1.22	no	no	69%
10	AUGMENTIN	PENICILLINS	SMITHKLINE BEECHAM	$ 907,713	12,779	$ 71.03	49	$ 1.44	no	no	78%

Notes:

1. FY 2001 experience for the HealthSelect Plus plan only.
2. All pharmacies is retail and mail order pharmacies combined.
3. Actual expenditures equals ingredient cost. Dispensing fees are not included. Rebate amount is estimated by applying uniform rebate percentage to all drugs.
4. Experience for an individual drug will be reported for all strengths combined.
5. St. Copay % is calculated by dividing the total plan cost (total cost less member copayment for each drug) by the total cost of drug. Total Cost is defined as ingredient cost plus dispensing fee less estimated rebate,
6. Use will be the standard description in Physician's Desk Reference 2001.
7. Generics of some strengfths of Prozac and Glucophage available after 2001 plan year.
8. Total Costs = Ingredient Cost less rebate
9. $/RX = Total C/#RX
10. Units per Rx = Metric Decimal Quantity/#Rx
11. Unit Cost = TC/Decimal Quantity
12. St. Copay % = Plan Pay/Total Cost
13. Rebate percentage to all drugs is 3.4%

Total

5/8/02

HEALTHSELECT PLUS - RETAIL

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Units per RX	Unit Cost	OTC	Generic Equivalent	St. Copay %
1	PRILOSEC	GASTRIC ACID SECRETION REDUCERS	ASTRA	$1,745,709	14,578	$119.75	33.61	$3.56	no	no	88%
2	LIPITOR	LIPOTROPICS (CONTINUED 1)	PARKE DAVIS	$1,632,870	24,524	$66.58	30.75	$2.17	no	no	76%
3	CLARITIN	ANTIHISTAMINES (CONTINUED 1)	SCHERING	$1,120,755	18,169	$61.68	37.50	$1.64	no	no	74%
4	AUGMENTIN	PENICILLINS	SMITHKLINE BEECHAM	$907,448	12,776	$71.03	49.30	$1.44	no	no	78%
5	PREVACID	GASTRIC ACID SECRETION REDUCERS	TAP	$728,863	6,561	$111.09	33.21	$3.34	no	no	73%
6	ZOLOFT	SEROTONIN SPECIFIC REUPTAKE INHIBITOR (SSRIS)	ROERIG	$720,691	9,978	$72.23	35.93	$2.01	no	no	78%
7	ZOCOR	LIPOTROPICS	MERCK HUMAN HEALTH	$689,979	7,033	$98.11	30.67	$3.20	no	no	69%
8	PAXIL	SEROTONIN SPECIFIC REUPTAKE INHIBITOR (SSRIS)	SMITHKLINE BEECHAM	$687,075	9,370	$73.33	33.91	$2.16	no	no	78%
9	ALLEGRA	ANTIHISTAMINES (CONTINUED 2)	MARION MERRELL DOW	$670,856	13,114	$51.16	41.30	$1.24	no	no	67%
10	VIOXX	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE	MERCK HUMAN HEALTH	$660,866	9,180	$71.99	31.35	$2.30	no	no	78%

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Package Size	Unit Cost	OTC	Generic Equivalent	St. Copay %
1	LIPITOR	LIPOTROPICS (CONTINUED 1)	PARKE DAVIS	$1,632,870	24,524	$66.58	30.7514679	$2.17	no	no	76%
2	PREMARIN	ESTROGENIC AGENTS	WYETH-AYERST	$493,879	23,265	$21.23	31.4360628	$0.68	no	no	17%
3	CLARITIN	ANTIHISTAMINES (CONTINUED 1)	SCHERING	$1,120,755	18,169	$61.68	37.4990368	$1.64	no	no	74%
4	ZITHROMAX	MACROLIDES	PFIZER	$592,246	17,765	$33.34	9.43861525	$3.53	no	no	48%
5	SYNTHROID	THYROID HORMONES	BOOTS	$245,132	16,299	$15.04	30.5213817	$0.49	no	no	1%
6	ZESTRIL	HYPOTENSIVES, ACE INHIBITORS	ZENECA	$456,656	15,471	$29.52	33.2630728	$0.89	no	no	41%
7	HYDROCODONE W/ACETAMINOPHEN	ANALGESICS,NARCOTICS	WATSON LABS	$109,826	14,949	$7.35	38.3797578	$0.19	no	HYDROCODONE W/ACETAMINOPHEN	57%
8	PRILOSEC	GASTRIC ACID SECRETION REDUCERS	ASTRA	$1,745,709	14,578	$119.75	33.6103718	$3.56	no	no	88%
9	ALLEGRA	ANTIHISTAMINES (CONTINUED 2)	MARION MERRELL DOW	$670,856	13,114	$51.16	41.30456	$1.24	no	no	67%
10	AUGMENTIN	PENICILLINS	SMITHKLINE BEECHAM	$907,448	12,776	$71.03	49.3015811	$1.44	no	no	78%

HEALTHSELECT PLUS - MAIL ORDER

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Units per RX	Unit Cost	OTC	Generic Equivalent	St. Copay %
1	LIPITOR	LIPOTROPICS (CONTINUED 1)	PARKE DAVIS	$ 774,980	4,119	$ 188.15	90.64	$ 2.08	no	no	83%
2	PRILOSEC	GASTRIC ACID SECRETION REDUCERS	ASTRA	$ 741,172	2,201	$ 336.74	98.54	$ 3.42	no	no	92%
3	CLARITIN	ANTIHISTAMINES (CONTINUED 1)	SCHERING	$ 281,690	1,606	$ 175.40	92.62	$ 1.89	no	no	82%
4	PRAVACHOL	LIPOTROPICS	E.R. SQUIBB & SONS	$ 266,514	1,175	$ 226.82	89.69	$ 2.53	no	no	87%
5	ZOCOR	LIPOTROPICS	MERCK HUMAN HEALTH	$ 237,851	854	$ 278.51	89.91	$ 3.10	no	no	79%
6	GLUCOPHAGE	HYPOGLYCEMICS, BIGUANIDE TYPE (NON-SULFONYLUREAS)	MEAD JOHNSON	$ 221,649	1,241	$ 178.60	219.67	$ 0.81	no	metformin hydrochloride	82%
7	PREMARIN	ESTROGENIC AGENTS	WYETH-AYERST	$ 205,220	3,684	$ 55.71	89.45	$ 0.62	no	no	35%
8	VIOXX	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE	MERCK HUMAN HEALTH	$ 201,170	951	$ 211.54	98.05	$ 2.16	no	no	86%
9	PREVACID	GASTRIC ACID SECRETION REDUCERS	TAP	$ 188,274	585	$ 321.84	101.00	$ 3.19	no	no	82%
10	ZESTRIL	HYPOTENSIVES, ACE INHIBITORS	ZENECA	$ 182,474	2,177	$ 83.82	99.36	$ 0.84	no	no	58%

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX	Package Size	Unit Cost	OTC	Generic Equivalent	St. Copay %
1	LIPITOR	LIPOTROPICS (CONTINUED 1)	PARKE DAVIS	$ 774,980	4,119	$ 188.15	90.64	$ 2.08	no	no	83%
2	PREMARIN	ESTROGENIC AGENTS	WYETH-AYERST	$ 205,220	3,684	$ 55.71	89.45	$ 0.62	no	no	35%
3	SYNTHROID	THYROID HORMONES	BOOTS	$ 76,843	2,475	$ 31.05	90.22	$ 0.34	no	no, not AB rate	3%
4	PRILOSEC	GASTRIC ACID SECRETION REDUCERS	ASTRA	$ 741,172	2,201	$ 336.74	98.54	$ 3.42	no	no	92%
5	ZESTRIL	HYPOTENSIVES, ACE INHIBITORS	ZENECA	$ 182,474	2,177	$ 83.82	99.36	$ 0.84	no	no	58%
6	PREMPRO	ESTROGENIC AGENTS	WYETH-AYERST	$ 143,742	1,961	$ 73.30	83.60	$ 0.88	no	no	51%
7	CLARITIN	ANTIHISTAMINES (CONTINUED 1)	SCHERING	$ 281,690	1,606	$ 175.40	92.62	$ 1.89	no	no	82%
8	NORVASC	CALCIUM CHANNEL BLOCKING AGENTS	PFIZER	$ 163,307	1,306	$ 125.04	93.93	$ 1.33	no	no	73%
9	GLUCOPHAGE	HYPOGLYCEMICS, BIGUANIDE TYPE (NON-SULFONYLUREAS)	MEAD JOHNSON	$ 221,649	1,241	$ 178.60	219.67	$ 0.81	no	metformin hydrocloride	82%
10	PRAVACHOL	LIPOTROPICS	E.R. SQUIBB & SONS	$ 266,514	1,175	$ 226.82	89.69	$ 2.53	no	no	87%

Top 10 Inpatient Medical ICD-9 Procedures by Expenditure (FY 2001 for ERS HS Product)

Rank	Procedure Name	Use	Total Dollars	# of Admissions	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy w/o mention of thrombolytic agent		$4,774,793	727	$6,568		112
2	Temporary tracheostomy		$2,142,620	64	$33,478		483
3	Incision of adrenal gland		$2,004,483	712	$2,815		371
4	Total knee replacement		$1,900,872	401	$4,740		209
5	Total abdominal hysterectomy		$1,598,564	491	$3,256		359
6	Insertion of endotracheal tube		$1,542,630	23	$67,071		386
7	Continuous mechanical ventilation for 96 consecutive hours or more		$1,262,787	8	$157,848		388
8	Left heart cardiac catheterization		$1,252,020	339	$3,693		125
9	Aortocoronary bypass of three coronary arteries		$1,241,611	90	$13,796		106
10	Aortocoronary bypass of two coronary arteries		$1,107,613	80	$13,845		106

Top Ten Inpatient Medical ICD-9 Procedures by Volume (FY 2001 for ERS HS Product)

Rank	Procedure Name	Use	Total Dollars	# of Admissions	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy w/o mention of thrombolytic agent		$4,774,793	727	$6,568		112
2	Incision of adrenal gland		$2,004,483	712	$2,815		371
3	Complete thyroidectomy		$326,471	632	$517		391
4	Total abdominal hysterectomy		$1,598,564	491	$3,256		359
5	Other manually assisted delivery Assisted spontaneous delivery Crede maneuver		$732,454	445	$1,646		373
6	Episiotomy, Episioproctotomy, Episiotomy with subsequent episiorrhaphy		$679,104	428	$1,587		373
7	Total knee replacement		$1,900,872	401	$4,740		209
8	Left heart cardiac catheterization		$1,252,020	339	$3,693		125
9	Repair of other current obstetric laceration		$516,114	324	$1,593		373
10	Left heart cardiac catheterization		$985,535	253	$3,895		124

Top 10 Outpatient Medical ICD-9 Procedures by Expenditure (FY 2001 for ERS HS Product)

Rank	Procedure Name	Use	Total Dollars	# of Visits	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Hemodialysis		$4,711,086	1,465	$3,216		316
2	Left heart cardiac catheterization		$2,608,798	1,002	$2,604		125
3	Laparoscopic cholecystectomy		$1,949,663	724	$2,693		198
4	Injection or infusion of cancer chemotherapeutic substance		$1,510,956	363	$4,162		410
5	Phacoemulsification and aspiration of cataract		$1,267,729	1,571	$807		39
6	Esophagogastroduodenoscopy [EGD] with closed biopsy		$1,121,392	1,639	$684		183
7	Excision of semilunar cartilage of knee		$961,274	576	$1,669		222
8	Other shunt or vascular bypass		$930,960	1,593	$584		243
9	Endoscopic polypectomy of large intestine		$804,956	1,403	$574		189
10	Colonoscopy		$721,016	1,442	$500		183

Top Ten Outpatient Medical ICD-9 Procedures by Volume (FY 2001 for ERS HS Product)

Rank	Procedure Name	Use	Total Dollars	# of Visits	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Esophagogastroduodenoscopy [EGD] with closed biopsy		$1,121,392	1,639	$684		183
2	Other shunt or vascular bypass		$930,960	1,593	$584		243
3	Phacoemulsification and aspiration of cataract		$1,267,729	1,571	$807		39
4	Hemodialysis		$4,711,086	1,465	$3,216		316
5	Colonoscopy		$721,016	1,442	$500		183
6	Endoscopic polypectomy of large intestine		$804,956	1,403	$574		189
7	Closure of skin and subcutaneous tissue of other sites		$246,218	1,157	$213		281
8	Left heart cardiac catheterization		$2,608,798	1,002	$2,604		125
9	Other mammography		$38,771	751	$52		467
10	Colonoscopy		$406,590	751	$541		189

1. Information on Medicare versus Non-Medicare is not available for the HS claims.

Top 10 Inpatient Medical Procedures by Expenditure (FY 2001 for ERS HSP Product)

Rank	Procedure Name	Use	Total Dollars	# of Procedures	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Low cervical cesarean section		$1,266,927	435	$2,912		D371
2	Single vessel percutaneous transluminal coronary angioplasty (ptca) without mention of thrombolytic agent		$1,046,281	124	$8,438		D112
3	Total abdominal hysterectomy		$820,550	233	$3,522		D359
4	Left heart cardiac catheterization		$749,424	150	$4,996		D125
5	Total knee replacement		$696,876	85	$8,199		D209
6	Insertion of endotracheal tube		$655,117	31	$21,133		
7	Laparoscopic cholecystectomy		$575,332	145	$3,968		D198
8	Other manually assisted delivery		$550,635	303	$1,817		D373
9	Continuous mechanical ventilation for 96 consecutive hours or more		$521,992	14	$37,285		
10	Aortocoronary bypass of three coronary arteries		$514,468	20	$25,723		D106

Top Ten Inpatient Medical Procedures by Volume (FY 2001 for ERS HSP Product)

Rank	Procedure Name	Use	Total Dollars	# of Procedures	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Low cervical cesarean section		$1,266,927	435	$2,912		D371
2	Circumcision		$295,445	413	$715		D391
3	Other manually assisted delivery		$550,635	303	$1,817		D373
4	Prophylactic administration of vaccine against other diseases		$239,699	297	$807		D391
5	Episiotomy		$366,580	235	$1,560		D373
6	Total abdominal hysterectomy		$820,550	233	$3,522		D359
7	Repair of other current obstetric laceration		$273,021	166	$1,645		D373
8	Left heart cardiac catheterization		$749,424	150	$4,996		D125
9	Laparoscopic cholecystectomy		$575,332	145	$3,968		D198
10	Single vessel percutaneous transluminal coronary angioplasty (ptca) without mention of thrombolytic agent		$1,046,281	124	$8,438		D112

Top 10 Outpatient Medical Procedures by Expenditure (FY 2001 for ERS HSP Product)

Rank	Procedure Name	Use	Total Dollars	# of Procedures	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Laparoscopic cholecystectomy		$1,029,082	316	$3,257		
2	Left heart cardiac catheterization		$924,931	252	$3,670		
3	Esophagogastroduodenoscopy (egd) with closed biopsy		$794,151	687	$1,156		
4	Colonoscopy		$439,816	497	$885		
5	Endoscopic polypectomy of large intestine		$343,593	316	$1,087		
6	Excision of semilunar cartilage of knee		$316,471	163	$1,942		
7	Local excision of lesion of breast		$288,350	203	$1,420		
8	Tonsillectomy with adenoidectomy		$262,879	167	$1,574		
9	Myringotomy with insertion of tube		$261,749	211	$1,241		
10	Injection of other agent into spinal canal		$247,047	367	$673		

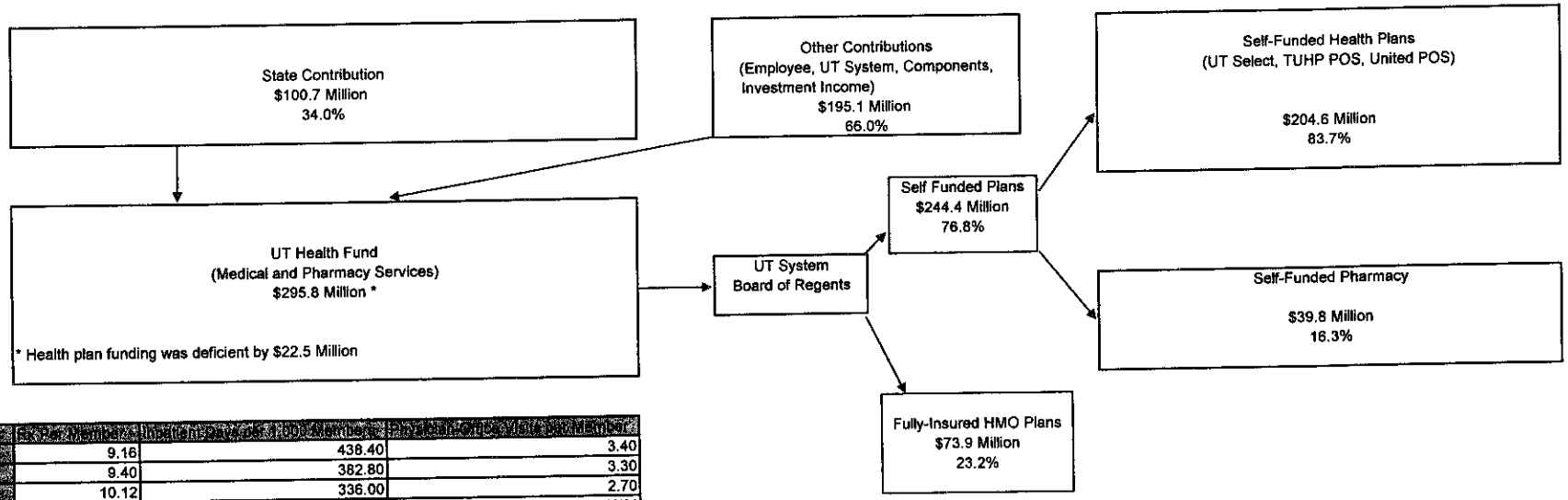
Top Ten Outpatient Medical Procedures by Volume (FY 2001 for ERS HSP Product)

Rank	Procedure Name	Use	Total Dollars	# of Procedures	$ per Procedure (Non-Medicare)	$ per Procedure (Medicare if Applicable)	Diagnostic Related Group
1	Suture of skin and subcutaneous tissue of other sites		$216,662	842	$257		
2	Esophagogastroduodenoscopy (egd) with closed biopsy		$794,151	687	$1,156		
3	Colonoscopy		$439,816	497	$885		
4	Application of splint		$128,877	444	$290		
5	Injection of other agent into spinal canal		$247,047	367	$673		
6	Endoscopic polypectomy of large intestine		$343,593	316	$1,087		
7	Laparoscopic cholecystectomy		$1,029,082	316	$3,257		
8	Injection or infusion of other therapeutic or prophylactic substance		$163,857	258	$635		
9	Left heart cardiac catheterization		$924,931	252	$3,670		
10	Closed biopsy of large intestine (endoscopic)		$236,774	227	$1,043		

1. HMO claims are not required to be grouped by diagnosis. The DRG displayed is the most frequently reported DRG for the corresponding procedure.
2. Information on Medicare versus Non-Medicare is not available for the HMO claims.

Attachment G

The University of Texas (UT) System (FY 2001)



Year	Rx Per Member	Inpatient per 1,000 Members	Physician Office Visits per Member
2001	9.16	438.40	3.40
2000	9.40	382.80	3.30
1999	10.12	336.00	2.70
1998	7.63	N/A*	N/A*
1997	N/A*	N/A*	N/A*

* N/A = Not Available

Year	State Appropriation*	Other Contributions	Total**	Comments
2003	$155,452,454	$279,740,052	$435,192,506	
2002	138,278,288	248,903,657	387,181,945	
2001	100,653,807	218,024,078	318,677,885	
2000	96,215,103	203,698,524	299,913,627	
1999	79,219,551	169,459,419	248,678,970	
1998	75,666,225	162,205,851	237,872,076	
1997	77,151,233	126,399,264	203,550,497	
1996	77,151,233	119,666,431	196,817,664	
1995	86,048,771	104,867,344	190,916,115	
1994	78,290,555	110,386,762	188,677,317	

* Amount budgeted by Texas Legislature

** Total actual revenue received from all sources for funding of UT System health and dental plans

University of Texas System (Self-Funded Plans)*

Top 10 Drugs by Expenditure (FY 2001)				Actual Expenditures (Avg. Wholesale Price minus discounts)	Actual prescriptions (Rx) filled	Total Costs divided by #Rx	Average no. of tabs/caps per RX	Actual cost per tab or cap			
Rank	Brand Name	Use	Manufacturer	Total Costs	#RX	$/RX	Units per RX	Unit Cost	OTC	Generic Equivalent	State Copay %
1	Prilosec	gastrointestinal	AstraZeneca	$2,696,802	13,292	$202.89	60.740	$3.34	no	no	84.9%
2	Lipitor	cardiovascular	Parke-Davis	$2,013,482	17,617	$114.29	56.513	$2.02	no	no	72.9%
3	Claritin	antihistamine	Schering	$1,862,257	21,542	$86.45	50.852	$1.70	no	no	67.8%
4	Zocor	cardiovascular	Merck	$1,590,549	9,478	$167.81	62.668	$2.68	no	no	80.4%
5	Prozac	antidepressant	Dista	$1,200,851	7,771	$154.53	63.787	$2.42	no	yes	81.1%
6	Celebrex	analgesic (nsaids)	Schering	$1,132,222	9,156	$123.66	69.778	$1.77	no	no	76.0%
7	Vioxx	analgesic (nsaids)	Merck	$971,406	8,919	$108.91	50.255	$2.17	no	no	73.5%
8	Zoloft	antidepressant	Pfizer	$900,671	8,541	$105.45	54.152	$1.95	no	no	73.0%
9	Allegra	antihistamine	Aventis	$820,447	11,875	$69.09	65.325	$1.06	no	no	60.1%
10	Glucophage	antidiabetic	Bristol-Myers Sq	$712,999	7,640	$93.32	127.746	$0.73	no	no	72.8%

Top Ten Drugs by Volume (FY 2001)				Actual Expenditures (Avg. Wholesale Price) minus discounts	Actual prescriptions (Rx) filled	Total Costs divided by #Rx	Average	Actual cost per tab or cap			
Rank	Brand Name	Use	Manufacturer	Total Costs	#RX	$/RX	Package Size	Unit Cost	OTC	Generic Equivalent	State Copay %
1	Claritin	antihistamine	Schering	$1,862,257	21,542	$86.45	50.852	$1.70	no	no	67.8%
2	Premarin	hormone,estrogen	Wyeth-Ayerst	$656,217	19,818	$33.11	55.581	$0.60	no	no	16.9%
3	Lipitor	cardiovascular	Parke-Davis	$2,013,482	17,617	$114.29	56.513	$2.02	no	no	72.9%
4	Prilosec	gastrointestinal	AstraZeneca	$2,696,802	13,292	$202.89	60.740	$3.34	no	no	84.9%
5	Zithromax	antibiotic	Pfizer	$460,864	12,759	$36.12	8.904	$4.06	no	no	34.5%
6	Allegra	antihistamine	Aventis	$820,447	11,875	$69.09	65.325	$1.06	no	no	60.1%
7	Prempro	hormone,estrogen	Wyeth-Ayerst	$458,270	10,300	$44.49	53.151	$0.84	no	no	30.6%
8	Zocor	cardiovascular	Merck	$1,590,549	9,478	$167.81	62.668	$2.68	no	no	80.4%
9	Celebrex	analgesic (nsaids)	Schering	$1,132,222	9,156	$123.66	69.778	$1.77	no	no	76.0%
10	Vioxx	analgesic (nsaids)	Merck	$971,406	8,919	$108.91	50.255	$2.17	no	no	73.5%

* Pharmacy Benefits Manager of the self-funded plans was Merck-Medco Managed Care.

Notes:

1. FY2001 experience for self-funded plans only.
2. Retail and mail order pharmacies combined.
3. Actual Expenditures equals ingredient cost. Dispensing fees are not included.
4. State Copay % is calculated by dividing the total plan cost (total cost less member copayment for each drug) by the total cost of drug. Total Cost is defined as ingredient cost plus dispensing fee.

The University of Texas System

UT SELECT (Self-Funded Plan)*

Top 10 Inpatient Medical Procedures by Expenditure (FY 2001)

Rank	Major Diagnostic Category (MDC)	Total Paid	# of Admissions	$ per Admission (Non-Medicare)**	$ per Admission (Medicare if Applicable)**	MDC Code***
1	Circulatory System	$5,508,120	838	$6,573		5
2	Musculoskeletal System	$3,141,934	494	$6,360		8
3	Respiratory System	$2,499,078	402	$6,217		4
4	Digestive System	$2,394,809	465	$5,150		6
5	Pregnancy/Childbirth	$2,055,211	605	$3,397		14
6	Nervous System	$1,553,585	298	$5,213		1
7	Female Reproduction	$1,325,779	262	$5,060		13
8	Newborns/Other Neonates	$1,297,868	419	$3,098		15
9	Hepatobiliary/Pancreas	$1,096,257	149	$7,357		7
10	Kidney/Urinary Tract	$932,932	157	$5,942		11

Top Ten Inpatient Medical Procedures by Volume (FY 2001)

Rank	Major Diagnostic Category (MDC)	Total Paid	# of Admissions	$ per Admissions (Non-Medicare)**	$ per Admission (Medicare if Applicable)**	MDC Code***
1	Circulatory System	$5,508,120	838	$6,573		5
2	Pregnancy/Childbirth	$2,055,211	605	$3,397		14
3	Musculoskeletal System	$3,141,934	494	$6,360		8
4	Digestive System	$2,394,809	465	$5,150		6
5	Newborns/ Other Neonates	$1,297,868	419	$3,098		15
6	Respiratory System	$2,499,078	402	$6,217		4
7	Nervous System	$1,553,585	298	$5,213		1
8	Female Reproduction	$1,325,779	262	$5,060		13
9	Kidney/Urinary Tract	$932,932	157	$5,942		11
10	Hepatobiliary/Pancreas	$1,096,257	149	$7,357		7

Top 10 Outpatient Surgical Procedures by Expenditure (FY 2001)

Rank	Major Diagnostic Category (MDC)	Total Paid	# of Procedures	$ per Procedure (Non-Medicare)**	$ per Procedure (Medicare if Applicable)**	MDC Code****
1	Musculoskeletal System	$3,484,140	4,448	$783		8
2	Digestive System	$2,699,700	2,691	$1,003		6
3	Skin/Breast	$2,430,865	9,102	$267		9
4	Eye	$1,283,418	1,476	$870		2
5	Ear/Nose/Throat	$1,266,378	1,726	$734		3
6	Circulatory System	$1,189,644	693	$1,717		5
7	Female Reproduction	$1,114,397	1,213	$919		13
8	Kidney/Urinary Tract	$718,186	942	$762		11
9	Hepatobiliary/Pancreas	$701,079	199	$3,523		7
10	Nervous System	$627,091	612	$1,025		1

Top Ten Outpatient Surgical Procedures by Volume (FY 2001)

Rank	Major Diagnostic Category (MDC)	Total Paid	# of Procedures	$ per Procedure (Non-Medicare)**	$ per Procedure (Medicare if Applicable)**	MDC Code***
1	Skin/Breast	$2,430,865	9,102	$267		9
2	Musculosketal System	$3,484,140	4,448	$783		8
3	Digestive System	$2,699,700	2,691	$1,003		6
4	Ear/Nose/Throat	$1,266,378	1,726	$734		3
5	Eye	$1,283,418	1,476	$870		2
6	Female Reproduction	$1,114,397	1,213	$919		13
7	Kidney/Urinary Tract	$718,186	942	$762		11
8	Circulatory System	$1,189,644	693	$1,717		5
9	Nervous System	$627,091	612	$1,025		1
10	Factors Influencing Health	$221,923	605	$367		23

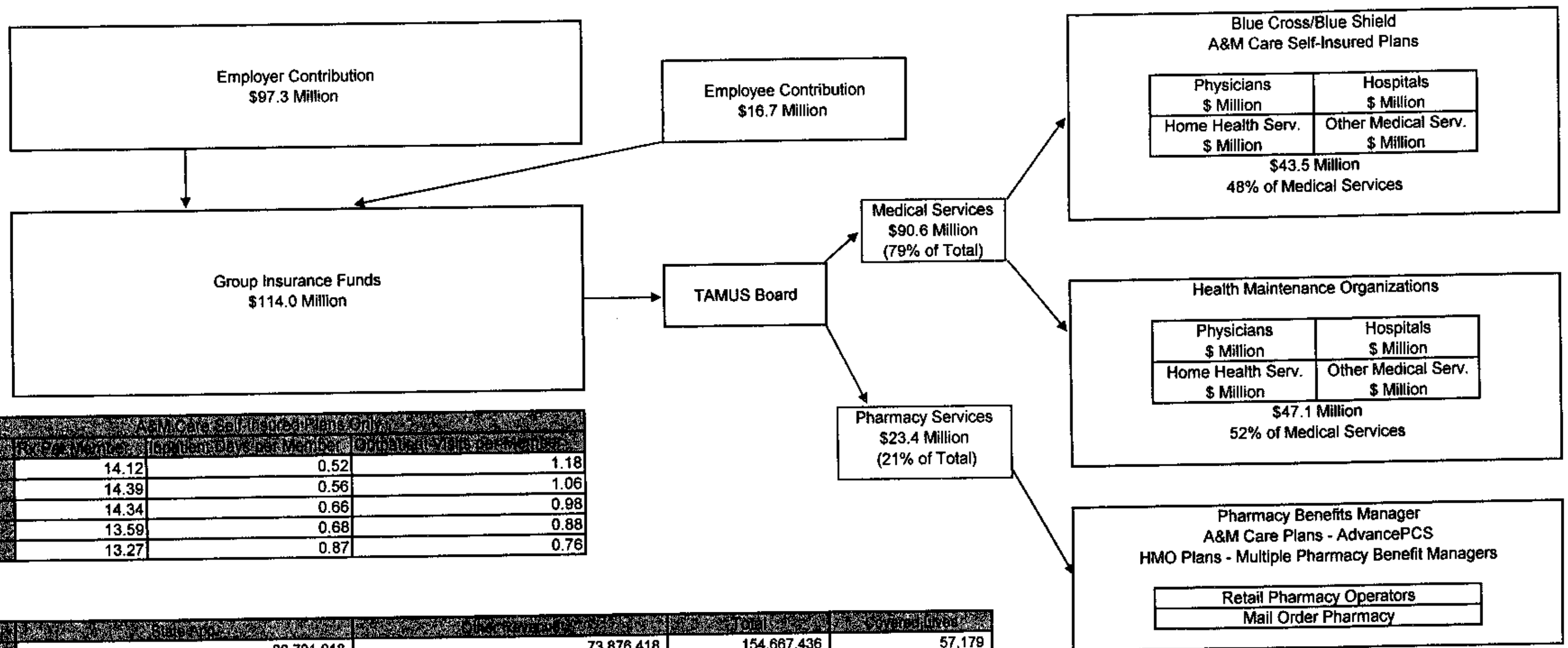
* Claims administrator of self-funded UT SELECT during FY2001 was CIGNA HealthCare.

** CIGNA did not provide sufficient data to categorize Medicare and non-Medicare claims.

*** CIGNA only provided claims data by Major Diagnostic Category (MDC). DRG data was not available.

Attachment H

The Texas A&M University System (FY 2001)



A&M Care Self-Insured Plans Only			
Year	Rx Per Member	Inpatient Days per Member	Outpatient Visits per Member
2001	14.12	0.52	1.18
2000	14.39	0.56	1.06
1999	14.34	0.66	0.98
1998	13.59	0.68	0.88
1997	13.27	0.87	0.76

Fiscal Year	State Appr.	Other Revenue	Total	Covered Lives
2003	80,791,018	73,876,418	154,667,436	57,179
2002	71,865,342	57,594,486	129,459,828	57,432
2001	54,398,721	59,643,751	114,042,472	55,898
2000	51,984,309	52,434,080	104,418,389	55,864
1999	45,294,703	45,263,452	90,558,155	54,908
1998	44,406,570	40,357,334	84,763,904	53,869
1997	40,575,249	42,935,727	83,510,976	52,632
1996	38,148,665	37,221,920	75,370,585	48,651
1995	44,133,398	33,873,893	78,007,291	46,258
1994	40,153,236	33,029,223	73,182,459	45,050

The Texas A&M University System
A&M Care Self-Insured Plans
In Patient and Outpatient Facility by Cost and Volume
Fiscal Year 2001

Top 10 Inpatient Medical Procedures by Expenditure - FY 2001 (Rank DRG by Total Paid, including employee & employer payments)

Rank	DRG Description	Medicare Primary Total Paid*	Non-Medicare Primary Total Paid*	Total Paid*	Medicare Primary Number of Admissions	Non-Medicare Primary Number of Admissions	Total Admissions	Medicare Primary $ Per Admission*	Non-Medicare Primary $ Per Admission*	DRG
1	Extreme Immaturity or Respiratory Distress Syndrome of Neonate	$0.00	$786,818.70	$786,818.70	0	14	14	$0.00	$56,201.34	386
2	Coronary Bypass w/Cardiac Catheterization	$38,048.71	$440,825.62	$478,874.33	19	16	35	$2,002.56	$27,551.60	106
3	Nonextensive OR Procedure Unrelated to Principal Diagnosis	$5,953.70	$417,481.01	$423,434.71	2	5	7	$2,976.85	$83,496.20	477
4	Percutaneous Cardiovascular Procedures	$37,479.65	$285,093.57	$322,573.22	27	25	52	$1,388.14	$11,403.74	112
5	Major Joint and Limb Reattachment Procedures of Lower Extremity	$72,767.65	$235,604.67	$308,372.32	47	19	66	$1,548.25	$12,400.25	209
6	Rehabilitation	$34,910.84	$259,872.06	$294,782.90	22	24	46	$1,586.86	$10,828.00	462
7	Uterine and Adnexa Procedures for Nonmalignancy w/o CC	$22,456.78	$253,684.67	$276,141.45	13	70	83	$1,727.44	$3,624.07	359
8	Extensive OR Procedure Unrelated to Principal Diagnosis	$6,959.79	$262,781.67	$269,741.46	7	13	20	$994.26	$20,213.97	468
9	Major Small and Large Bowel Procedures w/CC	$24,468.31	$218,963.59	$243,431.90	15	15	30	$1,631.22	$14,597.57	148
10	Cardiac Valve Procedures w/Cardiac Catheterization	$6,442.50	$216,310.73	$222,753.23	9	5	14	$715.83	$43,262.15	104

Top 11 Inpatient Medical Procedures by Volume - FY 2001 (By DRG)

Rank	DRG Description	Medicare Primary Total Paid*	Non-Medicare Primary Total Paid*	Total Paid*	Medicare Primary Number of Admissions	Non-Medicare Primary Number of Admissions	Total Admissions	Medicare Primary $ Per Admission*	Non-Medicare Primary $ Per Admission*	DRG
1	Vaginal Delivery w/o Complicating Diagnososes	$0.00	$186,999.70	$186,999.70	0	103	103	$0.00	$1,815.53	373
2	Uterine and Adnexa Procedures for Nonmalignancy w/o CC	$22,456.78	$253,684.67	$276,141.45	13	70	83	$1,727.44	$3,624.07	359
3	Psychoses	$14,926.50	$159,213.09	$174,139.59	10	69	79	$1,492.65	$2,307.44	430
4	Major Joint and Limb Reattachment Procedures of Lower Extremity	$72,767.65	$235,604.67	$308,372.32	47	19	66	$1,548.25	$12,400.25	209
5	Simple Pneumonia & Pleurisy, Age >17 w/CC	$43,286.66	$58,829.19	$102,115.85	47	11	58	$920.99	$5,348.11	089
6	Chest Pain	$20,315.18	$91,170.45	$111,485.63	20	37	57	$1,015.76	$2,464.07	143
7	Specific Cerebrovascular Disorders Except Transient Ischemic Attack	$44,047.73	$99,360.38	$143,408.11	45	12	57	$978.84	$8,280.03	014
8	Heart Failure & Shock	$34,560.86	$55,502.38	$90,063.24	43	12	55	$803.74	$4,625.20	127
9	Percutaneous Cardiovascular Procedures	$37,479.65	$285,093.57	$322,573.22	27	25	52	$1,388.14	$11,403.74	112
10	Cesarean Section w/o CC	$0.00	$142,725.22	$142,725.22	0	46	46	$0.00	$3,102.72	371
11	Rehabilitation	$34,910.84	$259,872.06	$294,782.90	22	24	46	$1,586.86	$10,828.00	462

Top 10 Outpatient Medical Procedures by Expenditure - FY 2001 (Rank Surgical Procedure Code by Total Paid, including employee & employer payments)

Rank	Surgical Procedure Description	Medicare Primary Total Paid*	Non-Medicare Primary Total Paid*	Total Paid*	Medicare Primary Number of Procedures	Non-Medicare Primary Number of Procedures	Total Procedures	Medicare Primary $ Per Procedure*	Non-Medicare Primary $ Per Procedure*	Surgical Procedure Code
1	Hemodialysis	$5,474.52	$319,747.80	$325,222.32	7	104	111	$782.07	$3,074.50	3995
2	Left heart cardiac catheterization	$76,638.22	$157,438.82	$234,077.04	62	48	110	$1,236.10	$3,279.98	3722
3	Laparoscopic cholecystectomy	$19,496.79	$193,531.57	$213,028.36	23	85	108	$847.69	$2,276.84	5123
4	Phacoemulsification & aspiration of cataract	$89,246.88	$100,956.11	$190,202.99	189	67	256	$472.21	$1,506.81	1341
5	Esophagogastroduodenoscopy w/closed biopsy	$42,136.52	$122,087.35	$164,223.87	100	123	223	$421.37	$992.58	4516
6	Colonoscopy	$29,075.53	$127,592.94	$156,668.47	109	173	282	$266.75	$737.53	4523
7	Endoscopic polypectomy of large intestine	$20,742.71	$107,869.11	$128,611.82	63	119	182	$329.25	$906.46	4542
8	Injection or infusion of cancer chemotherapeutic substance	$3,400.90	$110,079.88	$108,842.95	19	48	67	$178.99	$2,293.33	9925
9	Extracorporeal shockwave lithotripsy of kidney, ureter &/or bladder	$13,722.07	$61,449.29	$75,171.36	6	22	28	$2,287.01	$2,793.15	9851
10	Incision of eyelid	$12,522.04	$60,837.67	$73,359.71	16	40	56	$782.63	$1,520.94	806

Top 10 Inpatient Medical Procedures by Volume - FY 2001 (By Surgical Procedure Code)

Rank	Procedure Description	Medicare Primary Total Paid*	Non-Medicare Primary Total Paid*	Total Paid*	Medicare Primary Number of Procedures	Non-Medicare Primary Number of Procedures	Total Procedures	Medicare Primary $ Per Procedure*	Non-Medicare Primary $ Per Procedure*	Surgical Procedure Code
1	Colonoscopy	$29,075.53	$127,592.94	$156,668.47	109	173	282	$266.75	$737.53	4523
2	Phacoemulsification & aspiration of cataract	$89,246.88	$100,956.11	$190,202.99	189	67	256	$472.21	$1,506.81	1341
3	Esophagogastroduodenoscopy w/closed biopsy	$42,136.52	$122,087.35	$164,223.87	100	123	223	$421.37	$992.58	4516
4	Suture of skin and subcutaneous tissue of other sites	$5,048.11	$45,822.26	$50,870.37	49	152	201	$103.02	$301.46	8659
5	Endoscopic polypectomy of large intestine	$20,742.71	$107,869.11	$128,611.82	63	119	182	$329.25	$906.46	4542
6	Injection or infusion of other therapeutic or prophylactic substance	$2,908.03	$60,262.05	$63,170.08	23	98	121	$126.44	$614.92	9929
7	Injection of other agent into spinal canal	$16,704.00	$39,922.96	$56,626.96	51	68	119	$327.53	$587.10	392
8	Hemodialysis	$5,474.52	$319,747.80	$325,222.32	7	104	111	$782.07	$3,074.50	3995
9	Left heart cardiac catheterization	$76,638.22	$157,438.82	$234,077.04	62	48	110	$1,236.10	$3,279.98	3722
10	Laparoscopic cholecystectomy	$19,496.79	$193,531.57	$213,028.36	23	85	108	$847.69	$2,276.84	5123

* Amounts paid by both employer and employee included.

The Texas A&M University System
A&M Care Self-Insured Plans
Top Ten Drugs Ranked by Total Cost
Fiscal Year 2001

Ranked by Total Cost	Drug Name*	Use	Manufacturer	Employee Copayments	Employer Payments	Total Cost	Number of Rxs	Cost Per Rx	Quantity	Units Per Rx	Unit Cost	OTC Available Y / N	Generic Equivalent Available Y / N
1	Lipitor	Treatment of elevated cholesterol	Parke-Davis	179,810	769,995	949,805	9,701	97.91	437,706	45	2.17	N	N
2	Prilosec	Treatment of ulcers and acid reflux	AstraZeneca	90,330	743,761	834,091	5,166	161.46	231,686	45	3.60	N	N
3	Celebrex	Relief from osteoarthritis and rheumatorid arthritis	Pharmacia Corporation	92,494	487,954	580,448	5,203	111.56	295,472	57	1.96	N	N
4	Prevacid	Treatment of duodenal ulcer and erosive esophagitis	TAP Pharmaceuticals	66,360	502,453	568,813	3,418	166.42	168,960	49	3.37	N	N
5	Pravachol	Treatment of elevated cholesterol	Bristol-Myers Squibb	72,885	404,694	477,579	3,746	127.49	182,823	49	2.61	N	N
6	Zocor	Treatment of elevated cholesterol	Merck	109,117	296,060	405,177	3,050	132.84	130,344	43	3.11	N	N
7	Claritin	Relief of seasonal allergic rhinitis	Schering	82,522	310,892	393,414	4,880	80.62	201,394	41	1.95	N	N
8	Vioxx	Relief from osteoarthritis	Merck	70,750	317,313	388,063	4,060	95.58	167,903	41	2.31	N	N
9	Prozac	Treatment of depression and obsessive-compulsive disorder	Eli Lilly	42,807	284,786	327,593	2,448	133.82	131,763	54	2.49	N	Y
10	Fosamax	Treatment of osteoporosis	Merck	72,253	254,869	327,122	3,699	88.44	109,550	30	2.99	N	N

*All strengths and forms are included for each drug. i.e. Lipitor includes 10MG, 20MG, 40MG and 80MG tablets.

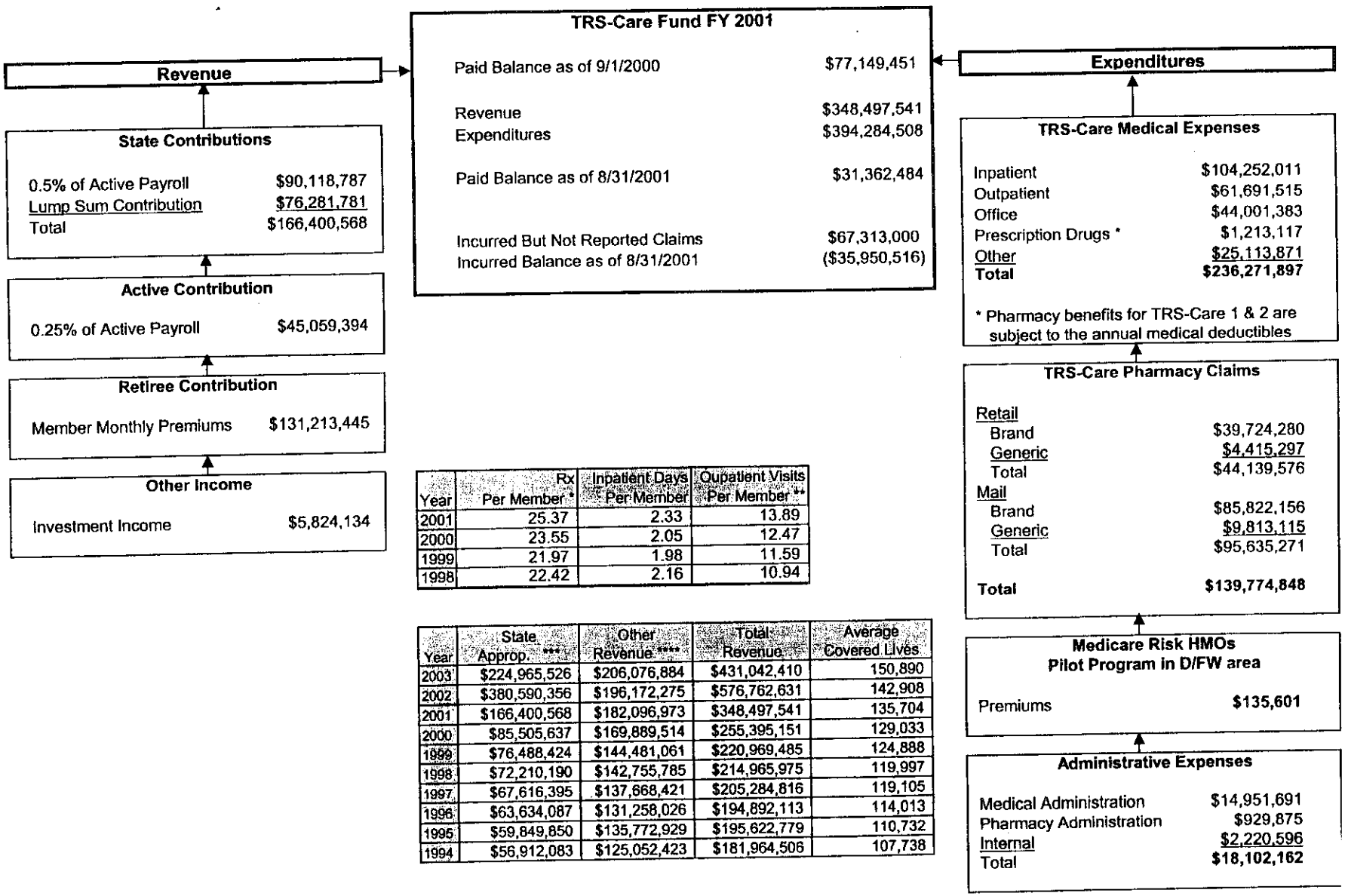
The Texas A&M University System
A&M Care Self-Insured Plans
Top Ten Drugs Ranked by Number of Prescriptions
Fiscal Year 2001

Ranked by # of Rxs	Drug Name*	Use	Manufacturer	Employee Copayments	Employer Payments	Total Cost	Number of Rxs	Cost Per Rx	Quantity	Units Per Rx	Unit Cost	OTC Available Y / N	Generic Equivalent Available Y / N
1	Lipitor	Treatment of elevated cholesterol	Parke-Davis	179,810	769,995	949,805	9,701	97.91	437,706	45	2.17	N	N
2	Celebrex	Relief from osteoarthritis and rheumatorid arthritis	Pharmacia Corporation	92,494	487,954	580,448	5,203	111.56	295,472	57	1.96	N	N
3	Prilosec	Treatment of ulcers and acid reflux	AstraZeneca	90,330	743,761	834,091	5,166	161.46	231,686	45	3.60	N	N
4	Norvasc	Treatment of high blood pressure and angina	Pfizer Labs	88,163	218,490	306,653	4,907	62.49	220,328	45	1.39	N	N
5	Claritin	Relief of seasonal allergic rhinitis	Schering	82,522	310,892	393,414	4,880	80.62	201,394	41	1.95	N	N
6	Vioxx	Relief from osteoarthritis	Merck	70,750	317,313	388,063	4,060	95.58	167,903	41	2.31	N	N
7	Allegra	Relief of seasonal allergic rhinitis	Aventis Pharmaceuticals	69,104	196,181	265,285	4,011	66.14	216,637	54	1.22	N	N
8	Pravachol	Treatment of elevated cholesterol	Bristol-Myers Squibb	72,885	404,694	477,579	3,746	127.49	182,823	49	2.61	N	N
9	Fosamax	Treatment of osteoporosis	Merck	72,253	254,869	327,122	3,699	88.44	109,550	30	2.99	N	N
10	Zoloft	Treatment of depression, obsessive-compulsive disorder and panic disorder	Pfizer	58,557	246,862	305,419	3,529	86.55	146,763	42	2.08	N	N

*All strengths and forms are included for each drug. i.e. Lipitor includes 10MG, 20MG, 40MG and 80MG tablets

Attachment I

Teacher Retirement System Of Texas - TRS-Care Summary - FY 2001



Year	Rx Per Member *	Inpatient Days Per Member	Outpatient Visits Per Member **
2001	25.37	2.33	13.89
2000	23.55	2.05	12.47
1999	21.97	1.98	11.59
1998	22.42	2.16	10.94

Year	State Approp. ***	Other Revenue ****	Total Revenue	Average Covered Lives
2003	$224,965,526	$206,076,884	$431,042,410	150,890
2002	$380,590,356	$196,172,275	$576,762,631	142,908
2001	$166,400,568	$182,096,973	$348,497,541	135,704
2000	$85,505,637	$169,889,514	$255,395,151	129,033
1999	$76,488,424	$144,481,061	$220,969,485	124,888
1998	$72,210,190	$142,755,785	$214,965,975	119,997
1997	$67,616,395	$137,668,421	$205,284,816	119,105
1996	$63,634,087	$131,258,026	$194,892,113	114,013
1995	$59,849,850	$135,772,929	$195,622,779	110,732
1994	$56,912,083	$125,052,423	$181,964,506	107,738

* Includes members in TRS-Care 3 only (Copay drug program)
** Includes outpatient visits and office visits
*** Includes state contribution as % of payroll and lump sum contributions
**** In[illegible]s retiree contributions, active member contributions and investment income

Teacher Retirement System of Texas - TRS-Care - FY 2001 - Top Ten Drugs (Mail & Retail)

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs *	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX	Average Package Size	Actual cost per tab or cap include date completed: Unit Cost **	OTC	Generic Equivalent	State Copay % ***
1	PRILOSEC	Anti-ulcerant	AstraZeneca	$10,757,851	45,162	$238.21	70.1	$3.40	No	Single Source	93.3%
2	ZOCOR	Cholesterol-lowering	Merck	$10,098,817	53,739	$187.92	67.8	$2.77	No	Single Source	91.5%
3	LIPITOR	Cholesterol-lowering	Pfizer/Warner-Lambert	$6,218,525	47,951	$129.68	62.9	$2.06	No	Single Source	87.7%
4	CELEBREX	Anti-inflammatory	Pharmacia	$5,770,669	38,726	$149.01	81.2	$1.84	No	Single Source	89.3%
5	VIOXX	Anti-inflammatory	Merck	$3,717,752	28,575	$130.11	61.2	$2.13	No	Single Source	87.7%
6	NORVASC	Calcium Channel Blocker	Pfizer	$3,223,346	38,124	$84.55	63.3	$1.34	No	Single Source	81.1%
7	PREMARIN	Hormone Replacement	Wyeth-Ayerst	$2,899,764	75,359	$38.48	64.7	$0.59	No	Single Source	58.6%
8	CLARITIN	Antihistamine	Schering	$2,799,396	24,769	$113.02	55.9	$2.02	No	Single Source	85.8%
9	PREVACID	Anti-ulcerant	TAP	$2,659,117	14,313	$185.78	56.6	$3.28	No	Single Source	91.4%
10	GLUCOPHAGE	Anti - diabetic Agent	Bristol-Myers Squibb	$2,354,288	21,871	$107.64	139.9	$0.77	No	Single Source	85.2%

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs *	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX	Average Package Size	Actual cost per tab or cap include date completed: Unit Cost **	OTC	Generic Equivalent	State Copay % ***
1	PREMARIN	Hormone Replacement	Wyeth-Ayerst	$2,899,764	75,359	$38.48	64.7	$0.59	No	Single Source	58.6%
2	SYNTHROID	Thyroid Replacement	Abbott Laboratories	$1,339,727	64,524	$20.76	62.7	$0.33	No	Single Source	32.1%
3	ZOCOR	Cholesterol-lowering	Merck	$10,098,817	53,739	$187.92	67.8	$2.77	No	Single Source	91.5%
4	LIPITOR	Cholesterol-lowering	Pfizer/Warner-Lambert	$6,218,525	47,951	$129.68	62.9	$2.06	No	Single Source	87.7%
5	PRILOSEC	Anti-ulcerant	AstraZeneca	$10,757,851	45,162	$238.21	70.1	$3.40	No	Single Source	93.3%
6	CELEBREX	Anti-Inflammatory	Pharmacia	$5,770,669	38,726	$149.01	81.2	$1.84	No	Single Source	89.3%
7	NORVASC	Calcium Channel Blocker	Pfizer	$3,223,346	38,124	$84.55	63.3	$1.34	No	Single Source	81.1%
8	FUROSEMIDE	Cardiovascular Agents	Abbott Laboratories	$232,201	35,958	$6.46	68.3	$0.09	No	Generic	19.9%
9	ACETAMINOPHEN-HYDR										
	OCODONE BITARTRATE	Analgesic	Various	$350,159	31,318	$11.18	54.5	$0.20	No	Generic	44.5%
10	ATENOLOL	Cardiovascular Agents	Geneva Pharmaseutic	$611,623	30,765	$19.88	69.3	$0.29	No	Generic	67.6%

* Ingredient cost plus dispensing fees

** Actual average paid during FY 2001 (9/1/00 - 8/31/01)

*** Paid / (Ingredient cost + dispensing fee)

Teacher Retirement System of Texas - TRS-Care - FY 2001 - Top Ten Drugs (Mail)

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs *	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX	Average Package Size	Actual cost per tab or cap include date completed: Unit Cost **	OTC	Generic Equivalent	State Copay % ***
1	PRILOSEC	Anti-ulcerant	AstraZeneca	$ 8,469,354	26,647	$ 317.84	95.8	$ 3.32	No	Single Source	95.0%
2	ZOCOR	Cholesterol-lowering	Merck	$ 8,218,797	34,025	$ 241.55	89.5	$ 2.70	No	Single Source	93.4%
3	LIPITOR	Cholesterol-lowering	Pfizer/Warner-Lambert	$ 4,693,769	25,729	$ 182.43	90.6	$ 2.01	No	Single Source	91.3%
4	CELEBREX	Anti-inflammatory	Pharmacia	$ 4,248,594	19,757	$ 215.04	120.3	$ 1.79	No	Single Source	92.6%
5	VIOXX	Anti-inflammatory	Merck	$ 2,626,117	13,794	$ 190.38	92.6	$ 2.06	No	Single Source	91.6%
6	NORVASC	Calcium Channel Blocker	Pfizer	$ 2,284,005	18,564	$ 123.03	95.6	$ 1.29	No	Single Source	87.0%
7	PREMARIN	Hormone Replacement	Wyeth-Ayerst	$ 2,235,905	44,201	$ 50.58	88.4	$ 0.57	No	Single Source	68.5%
8	CLARITIN	Antihistamine	Schering	$ 1,956,782	11,530	$ 169.71	86.9	$ 1.95	No	Single Source	90.6%
9	GLUCOPHAGE	Anti-diabetic Agent	Bristol-Myers Squibb	$ 1,701,318	10,776	$ 157.88	211.3	$ 0.75	No	Single Source	89.9%
10	PREVACID	Anti-ulcerant	TAP	$ 1,623,681	5,328	$ 304.74	96.7	$ 3.15	No	Single Source	94.8%

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs *	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX	Average Package Size	Actual cost per tab or cap include date completed: Unit Cost **	OTC	Generic Equivalent	State Copay % ***
1	PREMARIN	Hormone Replacement	Wyeth-Ayerst	$ 2,235,905	44,201	$ 50.58	88.4	$ 0.57	No	Single Source	68.5%
2	SYNTHROID	Thyroid Replacement	Abbott Laboratories	$ 970,599	35,069	$ 27.68	89.4	$ 0.31	No	Single Source	42.8%
3	ZOCOR	Cholesterol-lowering	Merck	$ 8,218,797	34,025	$ 241.55	89.5	$ 2.70	No	Single Source	93.4%
4	PRILOSEC	Anti-ulcerant	AstraZeneca	$ 8,469,354	26,647	$ 317.84	95.8	$ 3.32	No	Single Source	95.0%
5	LIPITOR	Cholesterol-lowering	Pfizer/Warner-Lambert	$ 4,693,769	25,729	$ 182.43	90.6	$ 2.01	No	Single Source	91.3%
6	CELEBREX	Anti-inflammatory	Pharmacia	$ 4,248,594	19,757	$ 215.04	120.3	$ 1.79	No	Single Source	92.6%
7	NORVASC	Calcium Channel Blocker	Pfizer	$ 2,284,005	18,564	$ 123.03	95.6	$ 1.29	No	Single Source	87.0%
8	PRINIVIL	Cardiovascular Agents	Merck	$ 1,386,080	16,629	$ 83.35	101.5	$ 0.82	No	Single Source	80.9%
9	ATENOLOL	Cardiovascular Agents	Geneva Pharmaseutica	$ 501,127	15,782	$ 31.75	101.7	$ 0.31	No	Generic	77.1%
10	PREMPRO	Hormone Replacement	Wyeth-Ayerst	$ 1,036,480	14,893	$ 69.60	82.7	$ 0.84	No	Single Source	77.1%

* Ingredient cost plus dispensing fees

** Actual average paid during FY 2001 (9/1/00 - 8/31/01)

*** Paid / (Ingredient cost + dispensing fee)

Teacher Retirement System of Texas - TRS-Care - FY 2001 - Top Ten Drugs (Retail)

Top 10 Drugs by Expenditure (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs *	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX	Average Package Size	Actual cost per tab or cap include date completed: Unit Cost **	OTC	Generic Equivalent	State Copay % ***
1	PRILOSEC	AstraZeneca	AstraZeneca	$ 2,287,164	18,515	$ 123.53	33.1	$ 3.74	No	Single Source	87.1%
2	ZOCOR	Merck	Merck	$ 1,878,273	19,714	$ 95.28	30.5	$ 3.12	No	Single Source	83.2%
3	LIPITOR	Pfizer/Warner-Lambert	Pfizer/Warner-Lambert	$ 1,523,447	22,222	$ 68.56	30.8	$ 2.23	No	Single Source	76.7%
4	CELEBREX	Pharmacia	Pharmacia	$ 1,521,075	18,969	$ 80.19	40.5	$ 1.98	No	Single Source	80.1%
5	VIOXX	Merck	Merck	$ 1,090,925	14,781	$ 73.81	31.8	$ 2.32	No	Single Source	78.3%
6	PREVACID	TAP	TAP	$ 1,035,167	8,985	$ 115.21	32.8	$ 3.51	No	Single Source	86.1%
7	NORVASC	Pfizer	Pfizer	$ 938,398	19,560	$ 47.98	32.6	$ 1.47	No	Single Source	66.7%
8	CIPRO	Bayer	Bayer	$ 871,994	12,943	$ 67.37	17.2	$ 3.92	No	Single Source	76.3%
9	LEVAQUIN	Ortho-McNeil	Ortho-McNeil	$ 845,948	12,341	$ 68.55	9.2	$ 7.44	No	Single Source	76.7%
10	CLARITIN	Schering	Schering	$ 842,035	13,239	$ 63.60	28.9	$ 2.20	No	Single Source	74.9%

Top Ten Drugs by Volume (FY 2001)

Rank	Drug Name	Use	Manufacturer	Actual Expenditures, drug acquisition only minus rebates Total Costs *	Actual prescriptions filled #RX	Total costs column divided by #Rx column $/RX	Average Package Size	Actual cost per tab or cap include date completed: Unit Cost **	OTC	Generic Equivalent	State Copay % ***
1	PREMARIN	Hormone Replacement	Wyeth-Ayerst	$ 661,655	31,158	$ 21.24	31.0	$ 0.68	No	Single Source	25.5%
2	SYNTHROID	Thyroid Replacement	Abbott Laboratories	$ 367,365	29,455	$ 12.47	31.0	$ 0.40	No	Single Source	4.0%
3	ACETAMINOPHEN-HYDRO CODONE BITARTRATE	Analgesic	Various	$ 264,428	28,821	$ 9.17	44.1	$ 0.21	No	Generic	33.8%
4	LIPITOR	Cholesterol-lowering	Pfizer/Warner-Lambert	$ 1,523,447	22,222	$ 68.56	30.8	$ 2.23	No	Single Source	76.7%
5	FUROSEMIDE	Cardiovascular Agents	Abbott Laboratories/(V	$ 91,101	22,045	$ 4.13	39.1	$ 0.11	No	Generic	1.3%
6	ZOCOR	Cholesterol-lowering	Merck	$ 1,878,273	19,714	$ 95.28	30.5	$ 3.12	No	Single Source	83.2%
7	NORVASC	Calcium Channel Blocker	Pfizer	$ 938,398	19,560	$ 47.98	32.6	$ 1.47	No	Single Source	66.7%
8	ACETAMINOPHEN-PROPO XYPHENE NAPSYLATE	Analgesic	Various	$ 287,612	19,248	$ 14.94	44.2	$ 0.34	No	Generic	48.1%
9	CELEBREX	Anti-inflammatory	Pharmacia	$ 1,521,075	18,969	$ 80.19	40.5	$ 1.98	No	Single Source	80.1%
10	PRILOSEC	Anti-ulcerant	AstraZeneca	$ 2,287,164	18,515	$ 123.53	33.1	$ 3.74	No	Single Source	87.1%

* Ingredient cost plus dispensing fees

** Actual average paid during FY 2001 (9/1/00 - 8/31/01)

*** Paid / (Ingredient cost + dispensing fee)

Teacher Retirement System of Texas - TRS-Care FY 2001

Top 10 Inpatient Medical Procedures by Expenditure (FY 2001)

Rank	Diagnosis Related Group Code Description	Total Dollars: Non-Medicare Eligible Episodes	Total Dollars: Medicare Eligible Episodes	Total Dollars: Total	Number of Procedures: Non-Medicare Eligible Episodes	Number of Procedures: Medicare Eligible Episodes	Number of Procedures: Total	$ Per Procedure: Non-Medicare Eligible Episodes	$ Per Procedure: Medicare Eligible Episodes	$ Per Procedure: Total	Diagnostic Related Group
1	209 LOWER EXTREMITYJOINT OR LIMB REATTAC	$2,301,690	$991,371	$3,293,061	181	947	1,128	$12,717	$1,047	$2,919	209
2	127 HEART FAILURE AND SHOCK	$795,492	$795,654	$1,591,146	130	965	1,095	$6,119	$825	$1,453	127
3	116 CARDIAC PACEMAKER IMPLANT	$3,334,312	$909,890	$4,244,201	201	808	1,009	$16,589	$1,126	$4,206	116
4	014 CEREBROVASCULAR DISORDERS	$901,325	$648,260	$1,549,585	103	718	821	$8,751	$903	$1,887	014
5	089 PNEUMONIA	$717,800	$577,996	$1,295,795	86	712	798	$8,347	$812	$1,624	089
6	107 BYPASS, WITHOUT CATHERIZATION	$1,886,190	$504,043	$2,390,233	72	449	521	$26,197	$1,123	$4,588	107
7	462 REHABILITATION	$1,224,040	$862,093	$2,086,132	102	389	491	$12,000	$2,216	$4,249	462
8	088 CHRONIC OBSTRUCTIVE PULMONARY DISEA	$237,220	$297,545	$534,765	51	433	484	$4,651	$687	$1,105	088
9	183 DIGESTIVE DISORDERS	$675,060	$118,961	$794,021	298	182	480	$2,265	$654	$1,654	183
10	174 INTERNAL BLEEDING	$272,920	$272,969	$545,889	42	438	480	$6,498	$623	$1,137	174

Top Ten Inpatient Medical Procedures by Volume (FY 2001)

Rank	Diagnosis Related Group Code Description	Total Dollars: Non-Medicare Eligible Episodes	Total Dollars: Medicare Eligible Episodes	Total Dollars: Total	Number of Procedures: Non-Medicare Eligible Episodes	Number of Procedures: Medicare Eligible Episodes	Number of Procedures: Total	$ Per Procedure: Non-Medicare Eligible Episodes	$ Per Procedure: Medicare Eligible Episodes	$ Per Procedure: Total	Diagnostic Related Group
1	116 PERMANT CARDIAC PACEMAKER IMPLANT	$3,334,312	$909,890	$4,244,201	201	808	1,009	$16,589	$1,126	$4,206	116
2	209 MAJOR JOINT AND LIMB REATTACHMENT	$2,301,690	$991,371	$3,293,061	181	947	1,128	$12,717	$1,047	$2,919	209
3	148 MAJOR BOWEL PROCEDURES	$2,164,673	$500,977	$2,665,650	78	338	416	$27,752	$1,482	$6,408	148
4	483 TRACHEOSTOMY	$1,602,202	$999,135	$2,601,337	24	119	143	$66,758	$8,396	$18,191	483
5	107 BYPASS, WITHOUT CATHERIZATION	$1,886,190	$504,043	$2,390,233	72	449	521	$26,197	$1,123	$4,588	107
6	462 REHABILITATION	$1,224,040	$862,093	$2,086,132	102	389	491	$12,000	$2,216	$4,249	462
7	087 PULMONARY EDEMA AND RESPITORY FAILUI	$386,710	$1,595,176	$1,981,886	26	163	189	$14,873	$9,786	$10,486	087
8	430 PSYCHOSES	$1,543,817	$220,759	$1,764,575	219	127	346	$7,049	$1,738	$5,100	430
9	127 HEART FAILURE AND SHOCK	$795,492	$795,654	$1,591,146	130	965	1,095	$6,119	$825	$1,453	127
10	014 CEREBROVASCULAR DISORDERS	$901,325	$648,260	$1,549,585	103	718	821	$8,751	$903	$1,887	014

Teacher Retirement System of Texas - TRS-Care FY 2001

Top 10 Outpatient Medical Procedures by Expenditure (FY 2001)

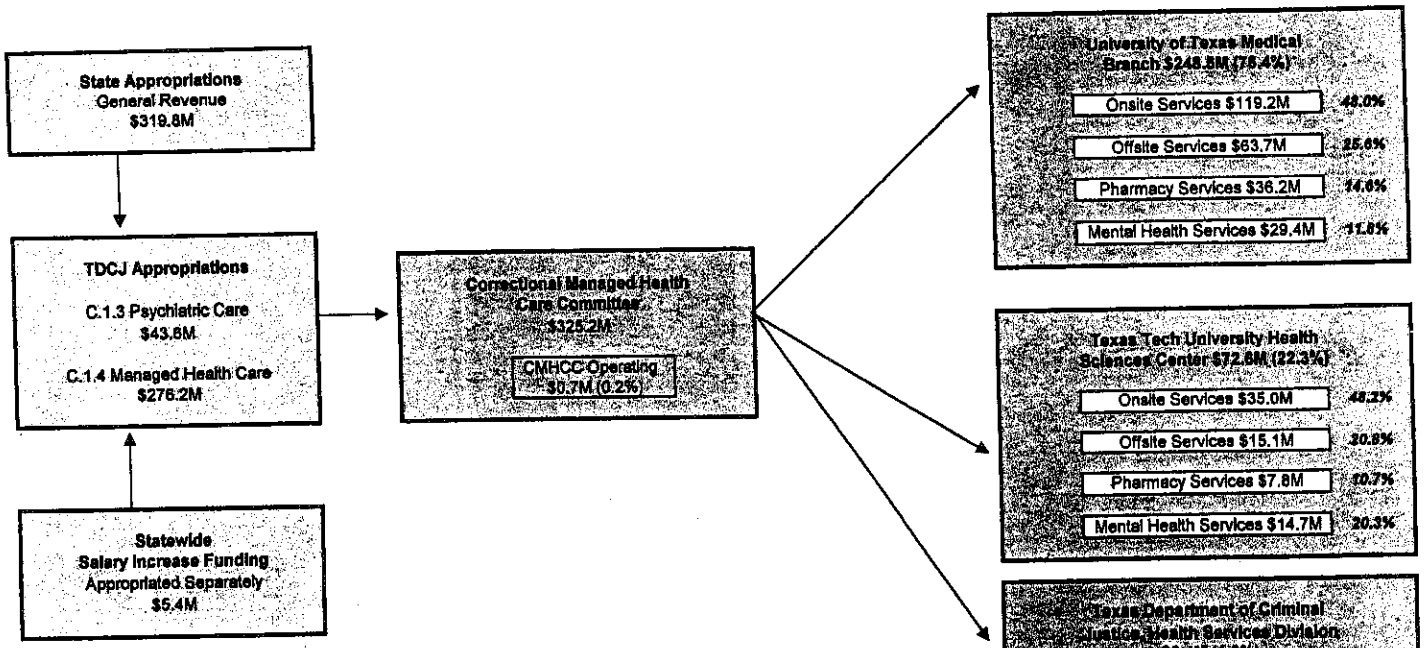
Rank	Procedure Name	Total Dollars: Non-Medicare Eligible Procedures	Total Dollars: Medicare Eligible Procedures	Total Dollars: Total	Number of Procedures: Non-Medicare Eligible Procedures	Number of Procedures: Medicare Eligible Procedures	Number of Procedures: Total	$ Per Procedure: Non-Medicare Eligible Procedures	$ Per Procedure: Medicare Eligible Procedures	$ Per Procedure: Total	Diagnostic Related Group
1	66984 - Cataract Removal W/ Lens Prosthesis Insertio	$325,690	$280,483	$606,174	840	5,446	6,286	$387.73	$51.50	$96.43	
2	45378 - Colonoscopy, Flexible	$341,678	$34,126	$375,803	1,008	1,927	2,935	$338.97	$17.71	$128.04	
3	45385 - Colonoscopy, Flexible; W/ Removal	$221,156	$24,901	$246,057	444	1,054	1,498	$498.10	$23.63	$164.26	
4	99285 - Emergency Dept Visit, 3 Key Components	$109,396	$65,949	$175,345	1,344	5,203	6,547	$81.40	$12.68	$26.78	
5	43239 - Upper GI Endoscopy; W/ Biosopy	$151,703	$18,749	$170,451	638	1,305	1,943	$237.78	$14.37	$87.73	
6	45380 - Colonoscopy, W/ Biosopy	$138,668	$14,304	$152,972	406	806	1,212	$341.55	$17.75	$126.21	
7	88305 - Surgical Pathology	$118,570	$15,676	$134,246	1,863	3,352	5,215	$63.64	$4.68	$25.74	
8	90921 - ESRD Services, Per Month	$87,500	$39,796	$127,296	584	1,035	1,619	$149.83	$38.45	$78.63	
9	99284 - Emergency Dept Visit	$70,083	$34,699	$104,782	1,503	4,736	6,239	$46.63	$7.33	$16.79	
10	47562 - Laparoscopy; Cholecystectomy	$96,160	$8,038	$104,198	164	179	343	$586.34	$44.90	$303.78	

Top Ten Outpatient Medical Procedures by Volume (FY 2001)

Top 10 Outpatient Medical Procedures by Expenditure (FY 2001)

Rank	Procedure Name	Total Dollars: Non-Medicare Eligible Procedures	Total Dollars: Medicare Eligible Procedures	Total Dollars: Total	Number of Procedures: Non-Medicare Eligible Procedures	Number of Procedures: Medicare Eligible Procedures	Number of Procedures: Total	$ Per Procedure: Non-Medicare Eligible Procedures	$ Per Procedure: Medicare Eligible Procedures	$ Per Procedure: Total
1	71020 - Chest Xray - 2 Views (Frontal & Later	$25,831	$7,254	$33,085	2,931	7,424	10,355	$8.81	$0.98	$3.20
2	76092 - Mammography, Bilateral	$28,125	$5,471	$33,596	3,404	5,560	8,964	$8.26	$0.98	$3.75
3	93010 - Electrocardiogram	$14,249	$5,399	$19,647	2,370	6,369	8,739	$6.01	$0.85	$2.25
4	99285 - Emergency Dept Visit	$109,396	$65,949	$175,345	1,344	5,203	6,547	$81.40	$12.68	$26.78
5	66984 - Cataract Removal W/ Lens Prosthesi	$325,690	$280,483	$606,174	840	5,446	6,286	$387.73	$51.50	$96.43
6	99284 - Emergency Dept Visit	$70,083	$34,699	$104,782	1,503	4,736	6,239	$46.63	$7.33	$16.79
7	99283- Emergency Dept Visit	$48,307	$16,986	$65,293	1,660	4,287	5,947	$29.10	$3.96	$10.98
8	99213 - Office/outpatient Visit	$17,679	$12,209	$29,887	1,028	4,243	5,271	$17.20	$2.88	$5.67
9	88305 - Surgical Pathology	$118,570	$15,676	$134,246	1,863	3,352	5,215	$63.64	$4.68	$25.74
10	71010 - Chest Exam; Single View, Frontal	$9,583	$3,742	$13,325	1,262	3,903	5,165	$7.59	$0.96	$2.58

Correctional Managed Health Care
FY 2001 Funding Allocations



State Appropriations		Covered Lives	
2003	$343.4M	2003	133,000
2002	$341.2M	2002	131,575
2001	$325.2M	2001	133,984
2000	$332.4M	2000	135,295
1999	$295.0M	1999	130,894
1998	$294.5M	1998	129,619
1997	$300.2M	1997	125,110
1996	$296.6M	1996	121,601
1995	Data N/A	1995	100,508
1994	Data N/A	1994	73,244

Notes:

Data Not Available: Appropriations data pre-1996 was in completely different appropriations patterns, including direct appropriations to both UTMB and TDCJ, mixed in with security staffing for mental health. Current appropriation pattern established beginning in FY 1996.

Onsite Services: health care services provided onsite at prison facilities including operation of ambulatory care clinics at each facility and infirmary care services at those facilities with infirmaries.

Offsite Services: health care services provided to offenders off prison facility premises including emergency room care, hospitalization, and specialty care.

Pharmacy Services: includes provision of all prescribed medications and provision of most medicine commonly available to non-incarcerated individuals over the counter.

Mental Health Services: complete range of inpatient and outpatient mental health services, including specialized programs for the mentally retarded and for the aggressive mentally-ill offender.

Correctional Managed Care: Top Ten D[illegible] By Expenditure and By Volume

Top 10 Drugs by Expenditure (FY 2001)				Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Either average per RX or Estimate based on most common Qty dispensed for the agent	Actual cost per tab or cap Include date completed: 2/6/02			
Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX*	Units per RX	Unit Cost*	OTC	Generic Equivalent	St. Copay %
1	Nefinavir 250mg	HIV	Agouron	$4,633,336	8,571	$540.58	300	$1.89	no	none	N/A
2	Engerix-B Vaccine	Hepatits B Vaccine	SKB	$3,589,868	231,475	$15.51	1	$21.40	no	none	N/A
3	Lamivudine 150mg	HIV	Glaxowelcome	$3,070,231	14,129	$217.30	60	$3.88	no	none	N/A
4	Stavudine 40mg	HIV	BMS	$2,650,969	11,290	$234.81	60	$4.30	no	none	N/A
5	Efavirenz 200mg	HIV	BMS-DuPont	$1,648,502	5,424	$303.93	90	$3.57	no	none	N/A
6	Zidovudine 300mg	HIV	Glaxowelcome	$1,564,007	6,123	$255.43	60	$4.54	no	none	N/A
7	Sertraline 100mg	Depression	Pfizer	$1,434,002	22,730	$63.09	30	$1.97	no	none	N/A
8	Abacavir 300mg	HIV	Glaxowelcome	$1,199,541	4,069	$294.80	60	$5.22	no	none	N/A
9	Olanzapine 10mg	Psychosis	Lilly	$1,161,627	3,189	$364.26	60	$7.58	no	none	N/A
10	Indinavir	HIV	Merck	$949,556	2,617	$362.84	180	$2.27	no	none	N/A

* TDCJ reclaims unused medication, as a result column G / H will not equal I

Top Ten Drugs by Volume (FY 2001)				Actual Expenditures, drug acquisition only minus rebates	Actual prescriptions filled	Total costs column divided by #Rx column	Average	Actual cost per tab or cap Include date completed: 2/6/02			
Rank	Drug Name	Use	Manufacturer	Total Costs	#RX	$/RX*	Package Size	Unit Cost*	OTC	Generic Equivalent	St. Copay %
1	Engerix-B Vaccine	Hepatits B Vaccine	SKB	$3,589,868	231,475	$15.51	VIAL	$21.40	no	none	N/A
2	Triamterene/HCTZ 50/25	Hypertension	Generic	$57,271	93,704	$0.61	1000/BTL	$0.03	no	yes	N/A
3	Ibuprofen 600mg	Inflamm/pain	Generic	$73,568	93,502	$0.79	500/BTL	$0.05	no	yes	N/A
4	Ranitidine 150mg	GI	Generic	$56,541	77,649	$0.73	500/BTL	$0.03	no	yes	N/A
5	Ibuprofen 800mg	Inflamm/pain	Generic	$82,367	72,451	$1.14	500/BTL	$0.03	no	yes	N/A
6	Aspirin Enteric Coated	Cardiovascular	Generic	$17,665	62,665	$0.28	1000/BTL	$0.01	no	yes	N/A
7	Albuterol Inhaler	Asthma/COPD	Generic	$179,801	61,605	$2.92	INHALER	$3.86	no	yes	N/A
8	Atenolol	Cardiovasvular	Generic	$25,114	58,375	$0.43	1000/BTL	$0.01	no	yes	N/A
9	HCTZ 25mg	Hypertension	Generic	$24,926	56,015	$0.44	1000/BTL	$0.02	no	yes	N/A
10	Antacid 500mg	GI	Generic	$149,054	49,921	$2.99	500/BTL	$0.02	yes	yes	N/A

Rank	Brand Name	Drug	Manufacturer	Use	# Claims	Amount Paid (Pre Rebate)	Approx. Amt. Paid after Rebate	Total Quantity	Avg. Rx Amt. Paid	Avg. Rx Qty	Unit	Average Unit Cost (WEAC)	Unit Cost Eff. Date	OTC	Generic Equiv.
		FUROSEMIDE 10MG/ML AMPUL			557	$4,433	$4,160	6,698	7.47	12.03	ml	0.58		No	Yes
		FUROSEMIDE 10MG/ML SOLUTION			14,063	$193,989	$183,431	1,377,508	13.04	97.95	ml	0.11		No	Yes
		FUROSEMIDE 20MG TABLET			134,436	$816,188	$806,069	5,584,151	6.00	41.54	ea	0.03		No	Yes
		FUROSEMIDE 40MG TABLET			208,844	$1,312,507	$1,289,563	10,076,821	6.17	48.25	ea	0.03		No	Yes
		FUROSEMIDE 40MG/5ML SOLN			113	$2,332	$2,213	27,183	19.59	240.55	ml	0.06		No	Yes
		FUROSEMIDE 80MG TABLET			37,745	$306,953	$295,524	2,205,161	7.83	58.42	ea	0.07		No	Yes
6	FUROSEMIDE	Total	Various Generic Mfg.	Diuretic	395,758	$2,636,401	$2,580,960		6.52						
		AUGMENTIN 125 SUSPENSION			11,081	$372,353	$251,486	1,447,663	22.70	130.64	ml	0.24	01/15/02	No	No
		AUGMENTIN 125 TABLET CHEW			27	$919	$634	693	23.47	25.67	ea	1.18	01/15/02	No	No
		AUGMENTIN 200MG TAB CHEW			607	$25,626	$16,991	14,445	27.99	23.80	ea	1.71	01/15/02	No	No
		AUGMENTIN 200MG/5ML SUSP			76,465	$2,633,683	$1,755,994	7,521,621	22.96	98.37	ml	0.33	01/15/02	No	No
		AUGMENTIN 250 SUSPENSION			21,669	$1,352,426	$876,171	2,990,259	40.43	138.00	ml	0.46	01/15/02	No	No
		AUGMENTIN 250 TABLET			4,593	$277,677	$180,839	113,913	39.37	24.80	ea	2.43	01/15/02	No	No
		AUGMENTIN 250 TABLET CHEW			747	$46,903	$30,606	20,743	40.97	27.77	ea	2.24	01/15/02	No	No
		AUGMENTIN 400MG TAB CHEW			10,704	$774,401	$501,448	239,593	46.85	22.38	ea	3.25	01/15/02	No	No
		AUGMENTIN 400MG/5ML SUSP			121,056	$7,531,568	$4,834,047	12,140,835	39.93	100.29	ml	0.63	01/15/02	No	No
		AUGMENTIN 500MG TABLET			40,589	$2,993,898	$1,918,554	849,084	47.27	20.92	ea	3.62	01/15/02	No	No
		AUGMENTIN 875MG TABLET			45,347	$4,178,691	$2,661,267	897,586	58.69	19.79	ea	4.83	01/15/02	No	No
7	AUGMENTIN	Total	Smithkline Beecham	Antibiotic	332,685	$20,168,144	$13,028,035		39.14						
		AMOXICILLIN 125MG/5ML SUSP			67,429	$444,208	$430,376	9,134,398	6.38	135.47	ml	0.02		No	Yes
		AMOXICILLIN 200MG TAB CHEW			6	$78	$74	150	12.40	25.00	ea	0.36		No	Yes
		AMOXICILLIN 250MG CAPSULE			19,075	$125,206	$123,258	527,208	6.46	27.64	ea	0.05		No	Yes
		AMOXICILLIN 250MG TAB CHEW			11,929	$105,848	$101,522	389,237	8.51	32.63	ea	0.16		No	Yes
		AMOXICILLIN 250MG/5ML SUSP			121,768	$892,790	$870,867	16,133,417	7.15	148.92	ml	0.02		No	Yes
		AMOXICILLIN 400MG TAB CHEW			1,099	$16,833	$16,041	25,046	14.60	23.70	ea	0.43		No	Yes
		AMOXICILLIN 500MG CAPSULE			78,308	$580,371	$567,583	2,068,436	7.25	26.41	ea	0.09		No	Yes
		AMOXICILLIN 500MG TABLET			26	$413	$392	704	15.09	27.08	ea	0.41		No	Yes
		AMOXICILLIN 875MG TABLET			4,236	$81,362	$77,333	82,618	18.26	19.50	ea	0.70		No	Yes
8	AMOXICILLIN	Total	Various Generic Mfg.	Antibiotic	303,876	$2,247,109	$2,187,445		7.20						
		CLARITIN 10MG TABLET			145,366	$10,732,533	$7,467,638	4,738,996	51.37	32.600	ea	2.22	12/14/01	No	No
		CLARITIN 10MG REDITABS			88,763	$7,158,542	$5,008,173	2,762,944	56.42	31.127	ea	2.51	12/14/01	No	No
		CLARITIN 10MG/10ML SYRUP			54,059	$2,353,719	$1,679,527	8,234,812	31.07	152.330	ml	0.26	12/13/01	No	No
5	CLARITIN	TOTAL	Schering Corp	Antihistimine	288,188	$20,244,795	$14,155,338		49.12						
		CELEBREX 100MG CAPSULE			67,760	$5,332,770	$3,860,688	3,980,267	56.98	58.74	ea	1.37	11/20/01	No	No
		CELEBREX 200MG CAPSULE			204,401	$25,094,846	$18,080,106	11,297,680	88.45	55.27	ea	2.30	11/20/01	No	No
10	CELEBREX	Total	Pharmacia	Anti-inflammatory	272,161	$30,427,616	$21,940,793		80.62						

Health & Human Services [redacted]mission
Vendor Drug Program Expenditures for FY 2001
Top Ten Drugs by Expenditure (Includes dosage detail)

Rank	Brand Name	Drug	Manufacturer	Use	# Claims	Amount Paid Pre-Rebate	Approx. Amt. Paid after Rebate	Total Quantity	Avg. Rx Amt. Paid	Avg. Rx Qty	Unit	Avg. Unit Cost	Unit Cost Eff. Date	OTC	Generic Equivalent
		ZYPREXA 2.5MG TABLET			39,693	$6,961,350	$5,984,614	1,582,444	$175.38	40	ea	4.41	12/14/01	No	No
		ZYPREXA 5MG TABLET			53,003	$12,191,869	$10,481,241	2,390,003	$230.02	45	ea	5.11	12/17/01	No	No
		ZYPREXA 7.5MG TABLET			11,199	$2,775,438	$2,344,358	536,248	$247.83	48	ea	5.74	12/14/01	No	No
		ZYPREXA 10MG TABLET			55,438	$24,527,674	$21,005,303	3,237,431	$442.43	58	ea	7.77	12/17/01	No	No
		ZYPREXA 15MG TABLET			9,206	$4,927,603	$4,228,888	425,804	$535.26	46	ea	11.72	12/14/01	No	No
		ZYPREXA 20MG TABLET			1,297	$902,185	$774,021	57,829	$695.59	45	ea	15.83	12/14/01	No	No
1	ZYPREXA	TOTAL	Eli Lilly & Co	Atypical Antipsychotic	169,836	$52,286,118	$44,818,424								
		RISPERDAL 0.25MG TABLET			21,691	$2,612,622	$2,153,749	1,075,857	$120.45	50	ea	2.37	06/19/01	No	No
		RISPERDAL 0.5MG TABLET			61,623	$7,317,194	$6,028,778	3,020,771	$118.74	49	ea	2.37	06/19/01	No	No
		RISPERDAL 1MG TABLET			94,625	$12,582,727	$10,329,988	5,281,981	$132.97	56	ea	2.37	06/19/01	No	No
		RISPERDAL 2MG TABLET			38,318	$8,896,934	$7,255,846	2,311,652	$232.19	60	ea	3.94	06/19/01	No	No
		RISPERDAL 3MG TABLET			27,998	$8,036,715	$6,548,342	1,775,337	$287.05	63	ea	4.66	06/19/01	No	No
		RISPERDAL 4MG TABLET			11,159	$3,805,263	$3,079,165	657,239	$341.00	59	ea	6.14	06/19/01	No	No
		RISPERDAL 1MG/ML SOLUTION			6,819	$1,126,284	$938,665	388,959	$165.17	57	ea	2.68	06/19/01	No	No
2	RISPERDAL	TOTAL	Janssen	Atypical Antipsychotic	262,233	$44,377,739	$36,334,533								
		PRILOSEC 10MG CAPSULE DR			5,655	$658,826	$500,649	214,358	$116.50	38	ea	3.51	01/15/02	No	No
		PRILOSEC 20MG CAPSULE SA			188,591	$25,320,381	$20,006,731	6,845,307	$134.26	36	ea	3.70	01/09/02	No	No
		PRILOSEC 20MG CAPSULE DR			28,128	$3,726,879	$2,945,936	1,006,073	$132.50	36	ea	3.70	01/09/02	No	No
		PRILOSEC 40MG CAPSULE DR			14,461	$2,415,630	$1,877,706	455,107	$167.04	31	ea	5.63	01/15/02	No	No
		PRILOSEC 40MG CAPSULE SA		Gastric Acid Inhibitor	408	$76,978	$61,576	13,945	$188.67	34	ea	5.26	03/22/99	No	No
3	PRILOSEC	TOTAL	AstraZenica LP	Anti-ulcer	237,243	$32,198,694	$25,392,598								
		CELEBREX 100MG CAPSULE			67,760	$5,332,770	$3,860,688	3,980,267	$78.70	59	ea	1.37	11/20/01	No	No
		CELEBREX 200MG CAPSULE			204,401	$25,094,846	$18,080,106	11,297,680	$122.77	55	ea	2.30	11/20/01	No	No
4	CELEBREX	TOTAL	Pharmacia	Anti-inflammatory	272,161	$30,427,616	$21,940,793								
		PREVACID 15MG CAPSULE SA			53,884	$6,356,605	$4,356,034	1,794,411	$117.97	33	ea	3.72	01/10/02	No	No
		PREVACID 30MG CAPSULE SA		Gastric Acid Inhibitor	152,749	$17,608,236	$12,135,051	4,911,926	$115.28	32	ea	3.71	01/10/02	No	No
5	PREVACID	TOTAL	Tap Pharmaceuticals	Anti-ulcer	206,633	$23,964,840	$16,491,085								
		CLARITIN 10MG TABLET			145,366	$10,732,533	$7,467,638	4,738,996	$73.83	33	ea	2.22	12/14/01	No	No
		CLARITIN 10MG REDITABS			88,763	$7,158,542	$5,008,173	2,762,944	$80.65	31	ea	2.51	12/14/01	No	No
		CLARITIN 10MG/10ML SYRUP			54,059	$2,353,719	$1,679,527	8,234,812	$43.54	152	ml	0.26	12/13/01	No	No
6	CLARITIN	TOTAL	Schering Corp	Antihistimine	288,188	$20,244,795	$14,155,338								
		AUGMENTIN 125 TABLET CHEW			27	$919	$634	693	$34.04	26	ea	1.18	01/15/02	No	No
		AUGMENTIN 200MG TAB CHEW			607	$25,626	$16,991	14,445	$42.22	24	ea	1.71	01/15/02	No	No
		AUGMENTIN 250 TABLET CHEW			747	$46,903	$30,606	20,743	$62.79	28	ea	2.24	01/15/02	No	No
		AUGMENTIN 250 TABLET			4,593	$277,677	$180,839	113,913	60.46	25	ea	2.43	01/15/02	No	No
		AUGMENTIN 400MG TAB CHEW			10,704	$774,401	$501,448	239,593	$72.35	22	ea	3.25	01/15/02	No	No
		AUGMENTIN 500 TABLET			40,589	$2,993,898	$1,918,554	849,084	$73.76	21	ea	3.62	01/15/02	No	No
		AUGMENTIN 875MG TABLET			45,347	$4,178,691	$2,881,267	897,586	$92.15	20	ea	4.83	01/15/02	No	No
		AUGMENTIN 125 SUSPENSION			11,081	$372,353	$251,486	1,447,663	$33.60	131	ea	0.24	01/15/02	No	No
		AUGMENTIN 200MG/5ML SUSP			76,465	$2,633,683	$1,755,994	7,521,621	$34.44	98	ea	0.33	01/15/02	No	No
		AUGMENTIN 250 SUSPENSION			21,669	$1,352,426	$876,171	2,990,259	$62.41	138	ea	0.46	01/15/02	No	No
		AUGMENTIN 400MG/5ML SUSP			121,056	$7,531,568	$4,834,047	12,140,835	$62.22	100	ea	0.63	01/15/02	No	No
7	AUGMENTIN	TOTAL	Smithkline Beecham	Antibiotic	332,885	$20,188,144	$13,028,035								

Health & Human Services [redacted]mission
Vendor Drug Program Expenditures for FY 2001
Top Ten Drugs by Expenditure (Includes dosage detail)

Rank	Brand Name	Drug	Manufacturer	Use	# Claims	Amount Paid Pre-Rebate	Approx. Amt. Paid after Rebate	Total Quantity	Avg. Rx Amt. Paid	Avg. Rx Qty	Unit	Avg. Unit Cost	Unit Cost Eff. Date	OTC	Generic Equivalent
		LIPITOR 10MG TABLET			97,263	$8,286,582	$7,170,515	4,555,967	$85.20	47	ea	1.88	01/03/02	No	No
		LIPITOR 20MG TABLET			49,182	$6,862,846	$5,940,454	2,474,547	$139.54	50	ea	2.87	01/11/02	No	No
		LIPITOR 40MG TABLET			17,064	$2,983,072	$2,608,697	968,599	$174.82	57	ea	2.97	11/24/98	No	No
		LIPITOR 80MG TABLET			1,112	$176,940	$154,471	58,130	$159.12	52	ea	2.97	08/16/00	No	No
8	LIPITOR	TOTAL	Warner-Lambert Co.	Cholesterol lowering agent	164,621	$18,309,439	$15,874,137								
		DEPAKOTE 125MG TABLET EC			11,809	$518,920	$421,686	1,145,001	$43.94	97	ea	0.42	01/14/02	No	No
		DEPAKOTE 250MG TABLET EC			65,418	$8,122,053	$4,886,438	7,449,744	$93.58	114	ea	0.83	01/14/02	No	No
		DEPAKOTE 500MG TABLET EC			66,523	$10,290,970	$8,157,225	6,975,301	$154.70	105	ea	1.53	01/14/02	No	No
9	DEPAKOTE	TOTAL	Abbott Laboratories	Anticonvulsant	143,750	$16,931,942	$13,465,349								
		ZOLOFT 25MG TABLET			19,294	$1,489,791	$1,302,180	715,735	$77.22	37	ea	2.02	01/09/02	No	No
		ZOLOFT 50MG TABLET			103,629	$8,634,547	$7,567,055	4,061,571	$83.32	39	ea	2.02	01/09/02	No	No
		ZOLOFT 100MG TABLET			67,233	$6,478,766	$5,686,821	3,026,201	$96.36	45	ea	2.01	01/09/02	No	No
		ZOLOFT 20MG/ML ORAL CONC			81	$4,868	$4,267	5,465	$60.10	67	ml	0.85	01/14/02	No	No
10	ZOLOFT	TOTAL	Pfizer-Roerig	Antidepressant	190,237	$16,607,972	$14,560,321								