**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 1991**

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SENATE BILL 1167
Finance Committee Substitute Adopted 7/21/92

Short Title: State Health Plan Prescriptions. (Public)

Sponsors:

Referred to:

June 3, 1992

A BILL TO BE ENTITLED

AN ACT TO CONTROL COSTS IN THE PRESCRIPTION DRUG COVERAGE PART OF THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.4 reads as rewritten:

"**§ 135-40.4. Benefits in general.**

In the event a covered person, as a result of accidental bodily injury, disease or pregnancy, incurs covered expenses, the Plan will pay benefits up to the amounts described in G.S. 135-40.5 through G.S. 135-40.9.

The Plan is divided into ~~two~~ three parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to both a two hundred fifty dollar ($250.00) deductible for each covered individual to an aggregate maximum of seven hundred fifty dollars ($750.00) per family and coinsurance of 80%/20%. The third part covers prescription legend drugs to be used outside a hospital or skilled nursing facility and is subject to and combined with the same deductible per covered individual and aggregate maximum deductibles per family as the second part, and to a coinsurance of 90%/10%. There is a combined limit on out-of-pocket expenses under the second ~~part.~~ and third parts.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may begin the process of negotiating prospective rates of charges that are to be

allowed under the Plan with preferred providers of institutional and professional medical care and services. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make monthly reports to the President of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such prospective rates for allowable charges."

Sec. 2. G.S. 135-40.6(8)a. is repealed.

Sec. 3. Part 3 of Article 3 of G.S. 135 is amended by adding the following new section:

"**§ 135-40.6B. Prescription drugs.**

The Plan pays for prescription legend drugs to be used outside a hospital or skilled nursing facility as follows:

(1) For brand name drugs with a generic equivalent, fifty percent (50%) of the provider's actual charges;

(2) For brand name drugs without a generic equivalent, eighty percent (80%) of the provider's actual charges; and

(3) For generic drugs, eighty percent (80%) of the provider's actual charges.

Charges in excess of the ninetieth percentile of base period charges to the Plan for a particular drug are not covered. If there were no charges to the Plan for a particular drug during the base period, then the maximum eligible charge for that drug shall be ninety percent (90%) of the average wholesale price of that drug.

Covered charges are payable on the basis of ninety percent (90%) by the Plan and ten percent (10%) by the covered individual. Covered charges are subject to and combined with the same deductible per covered individual and aggregate deductible maximum per family per fiscal year, and to the same out-of-pocket maximum that apply to the benefits described in G.S. 135-40.6.

A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: 'Caution: Federal Law Prohibits Dispensing Without Prescription.' Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though prescription is not required.

There is established a peer review committee of 12 persons, six appointed by the Speaker of the House of Representatives and six appointed by the President Pro Tempore of the Senate. Of the appointees of the Speaker, one shall be a State employee, one shall be a member of the North Carolina Medical Society, and four shall be pharmacists. Of the appointees of the President Pro Tempore, one shall be a retired State employee, one shall be a public school teacher, three shall be pharmacists, and one shall be a public member who is not in any of the named categories. Members of the committee shall serve two-year terms commencing July 1, 1992, and biennially thereafter. The committee shall advise the Executive Administrator on the development of the program and review compliance with this section. The committee shall evaluate the extent to which this section has controlled costs for the Plan, the extent to which pharmacists are assisting members of the Plan in reducing their expenses, and the extent

to which prescribers are allowing choice of generic drugs. The committee shall report quarterly to the Executive Administrator and to the Director of the Fiscal Research Division."

Sec. 4. G.S. 135-40.8(a) reads as rewritten:

"**§ 135-40.8. Out-of-pocket expenditures.**

(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in ~~G.S. 135-40.6.~~ G.S. 135-40.6 and ninety percent (90%) of covered charges for prescription legend drugs according to the provisions of G.S. 135-40.6B. The covered individual is then responsible for the remaining twenty percent (20%) of the eligible expenses outlined in G.S. 135-40.6 and for the remaining ten percent (10%) of covered charges for prescription legend drugs as described in G.S. 135-40.6B until one thousand dollars ($1,000), in excess of the deductible, has been paid out-of-pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses."

Sec. 5. This act becomes effective October 1, 1992.