GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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SENATE DRS85166-LN-159 (3/15)

Short Title:	State Health Plan/Medicare Drug Copayments.	(Public)
Sponsors:	Senator Rand.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO CONFORM PRESCRIPTION DRUG COPAYMENTS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO THE MEDICARE MODERNIZATION ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.5(g) reads as rewritten:

"**§ 135-40.5. Benefits not subject to deductible or coinsurance.**

…

"(g) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility are to be determined by the Plan's Executive Administrator and Board of Trustees. The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, twenty-five dollars ($25.00) for each branded prescription, and thirty-five dollars ($35.00) for each branded prescription with a generic equivalent drug, and forty dollars ($40.00) for each branded or generic prescription not on a formulary used by the Plan. Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a 34-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. 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 a prescription is not required. The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription

drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for erectile dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager. Any formulary used by the Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan ~~members~~ members, other than those who are receiving prescription drug coverage under the Medicare Program, shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection. Members who receive prescription drug coverage under the Medicare Program shall not be assessed more than three thousand six hundred dollars ($3,600) per person per fiscal year in copayments required by this subsection. Effective January 1, 2006, Plan members who receive prescription drug coverage under the Medicare Program shall be assessed an out-of-pocket maximum based upon the out-of-pocket maximum required by the Medicare Modernization Act."

SECTION 2. This act becomes effective July 1, 2005.