GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

H **1**

HOUSE BILL 796

Short Title: Prescription Drugs/Competition. (Public)

Sponsors: Representatives Crawford, Howard, Blue (Cosponsors), Cole, Black, Sherrill, G. Wilson, Hiatt, Watson; Aldridge, Allred, Baddour, Baker, Bonner, Brown, Buchanan, Cansler, Church, Culpepper, Fox, Gamble, Goodwin, Grady, Hill, Hurley, Jeffus, Justus, Kiser, Mercer, Morris, Mosley, Nye, Preston, Redwine, Rogers, Russell, Sexton, Smith, and Wilkins.

Referred to: Insurance.

April 3, 1997

A BILL TO BE ENTITLED

AN ACT TO PROMOTE COMPETITION, CHOICE, AND AVAILABILITY IN THE PURCHASE OF PRESCRIPTION DRUGS AND PHARMACEUTICAL SERVICES.

The General Assembly of North Carolina enacts:

Section 1. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-37A. Prescription drugs and pharmaceutical services benefits.**

(a) This section applies only to health benefit plans that provide benefits for prescription drugs and pharmaceutical services.

(b) The purposes of this section are:

(1) To promote competition among and continued availability of retail pharmacies who redeem benefits for prescription drugs and pharmaceutical services provided to consumers by a health benefit plan or insurance certificate.

(2) To prohibit anticompetitive restrictions in pharmacy provider contracts between a pharmacy and a health benefit plan, insurer or third-party administrator.

(3) To enable a pharmacy to establish without restriction its prices for both prescription drugs and pharmaceutical services, as well as to control its hours of operation.

(4) To further ensure that consumers may redeem prescription drug and pharmaceutical services benefits allowed by a health benefit plan or an insurer at the pharmacy of the beneficiary's choice.

(5) To continue to enable a health benefit plan, insurer or third-party administrator to establish prescription drug and pharmaceutical services benefits it provides to its beneficiaries or insureds, so long as in so doing it does not interfere with the right of the pharmacy to establish its own price or charge for the drug or service.

(c) As used in this section:

(1) 'Benefit' or 'benefits' means a benefit for either prescription drugs or pharmaceutical services, or both, provided by a health benefit plan or an insurer.

(2) 'Drug' or ‘prescription drug' means any substance subject to the Federal Food, Drug and Cosmetic Act, 21 U.S.C. G.S. 301-395, as amended.

(3) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; coverage provided by an employer under G.S. 97-93; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to the act provided under federal law or regulation. ‘Health benefit plan' does not mean accident only insurance, or credit insurance, or disability income insurance.

(4) Insurer' means any entity that provides or offers a health benefit plan, including, but not limited to, an entity subject to Article 49, Article 65, or Article 67 of this Chapter.

(5) 'Pharmacy' means a pharmacy required by Article 4A of Chapter 90 of the General Statutes to be registered with the North Carolina Board of Pharmacy. Unless otherwise expressly provided in this section, the term 'pharmacy' also means a pharmacy that redeems benefits under a health benefit plan, insurer, or third-party administrator through a pharmacy provider contract or otherwise.

(6) 'Pharmacy provider contract' means a contract or agreement between a pharmacy and a health benefit plan, an insurer or a third-party administrator under which the pharmacy agrees to redeem prescription drug and pharmaceutical services benefits provided by a health benefit

plan or insurer to the subscribers or beneficiaries of the plan or health insurance certificate.

(7) 'Third-party administrator' means a person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums, or adjusts or settles claims in connection with a health benefit plan.

(d) Notwithstanding G.S. 58-51-37, a health benefit plan, insurer, third-party administrator, or other entity shall not, directly or indirectly, restrict or prohibit a pharmacy from establishing its charge or price for prescription drugs and pharmaceutical services, or both, or its hours of operation.

(e) Subject to the provisions of this section, a benefit for prescription drugs or pharmaceutical services or both may be redeemed by the beneficiary at any pharmacy of the beneficiary's choice.

(f) A health benefit plan, insurer, third-party administrator, or other person or entity providing benefits may not, directly or indirectly, restrict, induce, or financially coerce the beneficiary's choice of pharmacy.

(g) Notwithstanding G.S. 58-51-37, if the charge or price established by the pharmacy for a prescription drug or pharmaceutical service, or both, is greater than the benefit allowed by the health benefit plan or insurer for the drug or service, then the beneficiary is responsible for paying the pharmacy the difference between the benefit and the charge or price of the pharmacy for the prescription drug or pharmaceutical service, or both.

(h) A health benefit plan, insurer, or third-party administrator shall not restrict or prohibit, directly or indirectly, a pharmacy from charging the beneficiary for services rendered by the pharmacy that are in addition to charges for the drug, for dispensing the drug, or for patient counseling. Any provision of a pharmacy provider contract that restricts a pharmacy from charging and collecting for the additional service or services is unenforceable to the extent of the conflict.

(i) A health benefit plan, insurer, or third-party administrator shall not do any act which promotes or recommends, directly or indirectly, one pharmacy, group of pharmacies, or other entity over any other pharmacy, group of pharmacies, or other entity, as a source for redeeming benefits to beneficiaries under a health benefit plan, when the purpose of the act is to influence a beneficiary's choice of pharmacy or when the health benefit plan, insurer, or third-party administrator has a financial interest in the choice of pharmacy or in the redeemed benefit transaction. Acts prohibited under this subsection include, but are not limited to:

(1) Reimbursing one pharmacy, group of pharmacies, or other entity for benefits at a reimbursement rate different from that allowed to another pharmacy, or group of pharmacies, or other entity under the plan for the identical prescription drugs or pharmaceutical services, or both, covered by the benefit; or

(2) Directly or indirectly influencing, or attempting to influence, a beneficiary's choice of pharmacy through communications to the

beneficiary where an opinion or judgment is expressed as to what a pharmacy's charge or price should be, or as to what a beneficiary's co-payment difference should be; or

(3) By agreement or otherwise, recommending, requiring, coercing or inducing a beneficiary to redeem a benefit at a particular pharmacy, group of pharmacies, or other entity.

(j) The health benefit plan or the insurer shall inform all beneficiaries under the plan that benefits may be redeemed at any pharmacy which the beneficiary chooses. This information shall be communicated through reasonable means on a timely basis and at regular intervals. This information shall also be included in the written summary or description of the health benefit plan or insurance, as well as other written communications furnished to beneficiaries where benefits are mentioned. If the health benefit plan, insurer, or third-party administrator furnishes to a beneficiary the names of pharmacies where benefits may be redeemed, then all pharmacies in the county or area of the State where the beneficiary resides must be included.

(k) A pharmacy eligible to redeem benefits under a health benefit plan may announce and advertise that eligibility in a commercially reasonable manner.

(l) Penalties:

(1) The Commissioner of Insurance shall not approve any health benefit plan or policy providing prescription drug or pharmaceutical services benefits that does not conform to the provisions of this section.

(2) Any provision of a health benefit plan that is executed, delivered, or renewed or otherwise contracted for in this State that is in conflict with any provision of this section shall be void, to the extent of the conflict.

(3) Any provision of a pharmacy provider contract between a health benefit plan, or insurer, or third-party administrator, or other person subject to the provisions of this section and a pharmacy, or pharmacist licensed under Article 4A of Chapter 90 of the General Statutes, that is in conflict with this section is void to the extent of the conflict.

(4) A violation of this section creates a civil cause of action for damages or injunctive relief in favor of any person, pharmacy, or other entity aggrieved by the violation.

(5) The Commissioner of Insurance shall investigate and sanction any person, health benefit plan, insurer, third-party administrator, or other person that violates the provisions of this section, pursuant to Chapter 58 and other applicable law.

(6) A health benefit plan or insurer or third-party administrator, or other person that violates this section shall be subject to the provisions of G.S. 58-2-70 concerning civil penalties, restitution and summary suspension of license or certificate; provided, however, if pursuant to G.S. 58-2-70(d), monetary civil penalties are directed by the Commissioner, for the purposes of this section, these penalties shall not be less than one

thousand dollars ($1,000) per day, nor more than ten thousand dollars ($10,000) per day.

(7) If the Commissioner has reason to believe that a health benefit plan, insurer, third-party administrator, or other person or entity has failed to comply, the Commissioner shall issue and serve upon the person or entity a statement of the charges in that respect and a notice of hearing to be held at the time and place fixed in the notice, which shall not be less than 10 days after the date of service of the notice. If, after hearing, the Commissioner finds that the person or entity is in violation of this section, the Commissioner shall reduce the finding to writing and issue and serve upon the person or entity an order requiring the person or entity to cease and desist from engaging in the violation. A person or entity required to cease and desist pursuant to this section may obtain a review of the cease and desist order in accordance with the procedures set forth in G.S. 58-63-35.

(8) The Commissioner of Insurance shall have the authority granted by this Chapter to enforce violations of this section, including additional authority provided in this section.

(9) The Attorney General shall bring such actions as are necessary to enforce or prevent violations of this section, either through representation of the Commissioner of Insurance or otherwise."

Section 2. If any provision of this act or the application of this act to any person or circumstance is held invalid, the other provisions or applications of this act shall be given effect without the invalid provisions or applications.

Section 3. This act applies to every health benefit plan as defined in Section 1 of this act that is delivered, issued for delivery, or renewed on or after October 1, 1997. For purposes of this act, renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

Section 4. This act becomes effective October 1, 1997.