

SUMMARY
S287 – CSLN-9
STATE HEALTH PLAN

FUNDS (Part One, pages 1-2)

Appropriate \$250,000,000 for 2008-2009 [from Savings Reserve]

Appropriate \$154.7 million 2009-2010; \$326.9 million 2010-2011

BENEFIT changes:

Eliminate PPO Plus effective July 1, 2009 (Section 2(a), p. 2)

Healthy Lifestyles Initiative: (Section 2(b), pp. 2-3)

Smoking cessation:

January 1, **2011**, all members are enrolled in 70/30 plan. If at the time of enrollment the member attests that the member and the member's adult covered dependents are nonsmokers then, upon attestation, the member may enroll in the 80/20 plan.

Weight management:

January 1, **2011**, all members are enrolled in the 70/30 plan. If at the time of enrollment the member is a nonsmoker and meets the weight management requirements the member may choose to enroll in the 80/20 plan. If the member is a nonsmoker but does not meet the weight requirements the member may enroll in the 80/20 plan **if** the member is enrolled in a Plan-approved weight management program, or, **if** the member's physician certifies in writing that the member has a condition that prevents the member from attaining the weight requirement.

The Plan must provide education and training to assist members in complying with smoking cessation and weight management requirements.

Prescription drug co-payments (Section 2(c) pp. 3-4)

No increase for generics (\$10)

\$35 for preferred brand **w/o generic** (\$5 increase)

\$55 for non-preferred branded (\$5 increase)

Branded w/generic – members pays generic co-pay (\$10) **plus** the difference between the Plan's cost for the generic and the Plan's cost for the branded drug.

No coverage for drugs for sexual dysfunction, hair growth, and non-medically necessary drugs used for cosmetic purposes. (Section 2(c), p. 4, lines 36-39)

Prohibits re-packaging by the vendor. (Section 2(c), pp. 4, lines 43-48)

Specialty drugs (Section 2(c) p4.) Specialty medications are covered biotech medications and other medications designated by the Plan that generally have unique uses for the treatment of complex diseases, require special dosing or administration, require special handling, are typically prescribed by a specialist provider, and exceed \$400 cost to the Plan. Examples of these medications are those prescribed for such conditions as Hemophilia, or are Growth Hormone drugs or certain drugs prescribed for rheumatoid arthritis.

The member may:

- a. Purchase the drug from a "specialty pharmacy vendor" under contract

with the Plan; however, any retail pharmacy to dispense a specialty drug at the same price as determined by the specialty drug vendor; and

- b. Pay a co-payment in the amount of 25% of the Plan's cost of the drug but not more than \$100. For example, if the Plan's cost of the drug is \$1,000, 25% of \$1,000 is \$250 but the member would only be required to pay \$100.

c.

Deductibles/co-pays/coinsurance changes (Section 2(e), pages 5-6)

These amounts go into effect July 1, 2009. They differ in the Basic and Standard plans. Deductibles and coinsurance listed are for member-only coverage. Dependent coverage is 3x the member-only amounts.

Basic Plan (70/30)		Standard Plan (80/20)
\$800	in-network annual deductible	\$600
\$1,600	out-of-network annual deductible	\$1,200
\$3,250	in-network coinsurance	\$2,750
\$6,500	out-of-network coinsurance	\$5,500
\$30	in-network primary care (primary care amount applies to chiropractic services)	\$25
\$70	for in-network specialist care	\$60
\$250	for inpatient co-pay (in-network and out-of-network)	\$200
\$30	for PT/OT/ST	\$25
\$75 (no change)	urgent care	\$75 (increased from \$50)

Premium increase for contributory (dependent) coverage – 10%. (Sec. 2(g), p.6)

The Plan does not charge a premium for member-only coverage.

Eliminate coverage for routine eye exams – Effective 1/1/2010 (Sec.2(d), p. 5.)

Extend sunset on no-limitation on **occupational, physical, and speech therapies**. (Sec. 5(e), p.10)

Pharmacy benefit savings. (Sec. 2(h), pp. 6-7)

The language in this section replaces that in the 2nd edition pertaining to retail pharmacy networks and mail-order. Under this section there would be reductions in pharmacy reimbursements expected to yield \$18,000,000 in savings to the Plan in the first year (2009-2010) and \$20,000,000 in savings in the second year (2010-2011).

If the savings are greater than these amounts the Plan will adjust the reimbursements accordingly. If the savings do not reach 105% of the savings specified, the pharmacy reimbursement reduction will remain. The Plan will review the savings achieved every six months. Within 60 days of determining the savings achieved, the Plan will report the results to the Committee on Employee Hospital and Medical Benefits. Members will not be required to choose between a network pharmacy and mail-order.

TECHNICAL and conforming changes:(pp. 7-12)

Clarifies dependent coverage (p. 7-8)

Requires eligibility audit to ensure all covered dependents are eligible for coverage (p. 8)

Authorizes programs to address utilization abuse (p. 9)

Changes to employer contribution rates (pp. 11-12)

NC Health Choice (pp 8-9):

Delays effective date of coverage for over-the-counter meds

Authorizes subrogation

Technical correction re purchase of extended coverage

Makes the contracts between the Plan and BC/BS and its pharmacy benefit manager a public record except that information that is competitive, proprietary, or trade secret shall be redacted from the contract before releasing it. (pp. 10-11).

Calendar year. (pp.11-12) Secs. 5(g) and (h).

Effective January 1, 2011, Plan moves to calendar year. This move necessitates changes to deductibles and co-payment amounts for the six month period July 1, 2010 through December 31, 2010. Deductible and co-payment amounts will revert to annual amounts enacted in this act beginning January 1, 2011.

Blue Ribbon Task Force (pp.13-14) Section 7.

Establishes a Task Force to review governance and other matters pertaining to the SHP.

EFFECTIVE DATE.

3/25/gw