GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

H **1**

HOUSE BILL 772*

Short Title: State Health Plan Modifications. (Public)

Sponsors: Representatives Easterling, Culp; Adams, Alexander, Barnes, Buchanan, Earle, Edwards, Fitch, Gamble, Hensley, Hunt, Luebke, McLaughlin, Michaux, G. Miller, Nye, Oldham, Redwine, Richardson, Russell, Sexton, Thompson, Warner, Womble, and Yongue.

Referred to: Rules, Calendar, and Operations of the House.

April 6, 1995

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN BY ALIGNING THE FISCAL YEAR AND THE CALENDAR YEAR OF THE PLAN AND HMOS, PROVIDING LIMITED CONTRIBUTIONS FOR EMPLOYEES WHO HAVE LOST THEIR JOBS DUE TO A REDUCTION IN FORCE, ALLOWING RIF'D EMPLOYEES TO PURCHASE COVERAGE FROM THE STATE PLAN, PROVIDING PARTIAL CONTRIBUTION TOWARD DEPENDENT COVERAGE, ALLOWING MATERNITY BENEFITS TO ELIGIBLE DEPENDENTS, INCREASING THE WELLNESS BENEFIT, CHANGING THE PRESCRIPTION DRUG REIMBURSEMENT FORMULA, PLACING THE PENALTY FOR NOT SEEKING CERTIFICATION WITH THE RESPONSIBLE PARTY, ALLOWING FOR IMPROVED BENEFITS WHEN ONE INCISION IS USED FOR MORE THAN ONE PROCEDURE, OMITTING THE OFFICE VISIT COPAY FOR RETIREES ON MEDICARE, COVERING ORAL SURGERY NECESSITATED BECAUSE OF MEDICAL TREATMENT, AND TO DOUBLE THE LIFETIME MAXIMUM BENEFIT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-39.5B reads as rewritten:

"**§ 135-39.5B. Prepaid plans.**

The Executive Administrator and Board of Trustees may, after consultation with the Committee on Employee Hospital and Medical Benefits, provide for optional prepaid hospital and medical benefits plans. Benefits offered under such optional plans shall be comparable to those offered under the ~~Plan.~~ Plan and the same fiscal year shall be used. The amounts of State funds contributed for such optional plans shall not be more than the amounts contributed for each person eligible under G.S. 135-40.2 on a noncontributory Employee Only basis, with the person selecting an optional plan paying any excess, if necessary. The amount of State funds contributed to such optional plans shall also not exceed the amount of an optional plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees are authorized to assess and collect fees from participating optional plans provided by this section for administrative purposes and for risk management purposes. Such fees may be based upon the enrollees' risk factors and the number and types of contracts enrolled by each participating optional plan, and may be collected by the Plan in a manner prescribed by the Executive Administrator and Board of Trustees. In no instance shall benefits be paid under Part 3 of this Article for persons enrolled in an optional prepaid hospital and medical benefit plan authorized under this section on and after the effective date of enrollment in the optional prepaid plan, except in cases of continuous hospital confinement approved by the Executive Administrator."

Sec. 2. (a) G.S. 135-40.1(7a) reads as rewritten:

"(7a) Fiscal Year. – The period beginning ~~July 1 and ending on June 30 of the succeeding~~ January 1 and ending on December 30 of the same calendar year."

(b) Notwithstanding G.S. 135-40.1(7a), the period July 1, 1995, through December 31, 1995 is a fiscal year for the purpose of Article 3 of Chapter 135 of the General Statutes. For the fiscal year established by this subsection, any dollar amounts set for a fiscal year under that Article shall be applied as half that amount.

Sec. 3. G.S. 135-40.2 reads as rewritten:

"**§ 135-40.2. Eligibility.**

(a) The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of G.S. 135-40.3:

(1) All permanent full-time employees of an employing unit who meet the following conditions:

a. Paid from general or special State funds, or

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more

hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

(1a) Permanent hourly employees as defined in G.S. 126-5(c4) who work at least one-half of the workdays of each pay period.

(2) Retired teachers, State employees, members of the General Assembly, and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985.

(2a) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

(3) Repealed by Session Laws 1985 (Reg. Sess., 1986), c. 1020, s. 29(b).

(3a) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(4) Members of the General Assembly.

(5) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

(6) All employees who lost their jobs due to a reduction in force and are eligible for reemployment consideration as provided by G.S. 126-7.1, who were covered under subdivision (1) of this subsection immediately before their termination.

(b) The following person shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of G.S. 135-40.3:

(1) Repealed by Session Laws 1983, c. 761, s. 255.

(2) Former members of the General Assembly who enroll before October 1, 1986.

(2a) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

(3a) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(3b) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

(4) All permanent part-time employees (designated as half-time or more) of an employing unit who meets the conditions outlined in subdivision (a)(1)a above, and who are not covered by the provisions of G.S. 135-40.2(a)(1).

(4a) Permanent hourly employees as defined in G.S. 126-5(c4) who work less than one-half of the workdays of each pay period.

~~(5) The spouses and eligible dependent children of enrolled employees, retirees, and members of the General Assembly.~~

(6) Blind persons licensed by the State to operate vending facilities under contract with the Department of Human Resources, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

(7) Repealed by Session Laws 1985 (Reg. Sess., 1986), c. 1020, s. 29(j).

(8) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(9) Repealed by Session Laws 1987, c. 857, s. 11.1.

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, or member of the General Assembly, provided the child was covered at the time of death of the retiree, teacher, State employee, or member of the General Assembly (or was in posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. Any eligible spouse or dependent child of a person eligible under subdivision (8) of this subsection if the spouse or dependent child was enrolled before October 1, 1986.

(11) All employees who lost their jobs due to a reduction in force and who are not covered by subdivision (a)(6) of this section.

(12) All dependents of persons covered by either subdivision (a)(6) of this section or subdivision (11) of this subsection.

(b1) The spouses and eligible dependent children of enrolled employees, retirees, and members of the General Assembly shall be eligible for coverage under the Plan, on a partial contributory basis, with fifty dollars ($50.00) per month contribution by the employer toward Employee and Child(ren) coverage under G.S. 135-40.3(d)(2) or toward Employee and Family coverage under G.S. 135-40.3(d)(3).

(c) No person shall be eligible for coverage as an employee or retired employee and as a dependent of an employee or retired employee at the same time. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.

(d) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes, provided the former employee has at least five years of retirement membership service at the time of disability, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on the same basis as a retired employee. Such coverage shall terminate as of the end of the month in which such former employee is no longer eligible for disability retirement benefits or disability income benefits pursuant to Article 6 of this Chapter.

(e) Employees on official leave of absence without pay may elect to continue this group coverage at group cost provided that they pay the full employee and employer contribution through the employing unit during the leave period.

(f) For the support of the benefits made available to any member vested at the time of retirement, their spouses or surviving spouses, and the surviving spouses of employees who are receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina Art Society, Inc., and the North Carolina Symphony Society, Inc., each association, organization or board shall pay to the Plan the full cost of providing these benefits under this section as determined by the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan. In addition, each association, organization or board shall pay to the Plan an amount equal to the cost of the benefits provided under this section to presently retired members of each association, organization or board since such benefits became available at no cost to the retired member.

(g) An eligible surviving spouse and any eligible dependent child of a deceased retiree, teacher, State employee, or member of the General Assembly shall be eligible for group benefits under this section without waiting periods for preexisting conditions provided coverage is elected within 90 days after the death of the former plan member.

(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan."

Sec. 4. G.S. 135-40.3(d) reads as rewritten:

"(d) Types of Coverage Available. – There are three types of coverage which an employee or retiree may elect.

(1) Employee Only. – Covers enrolled employees only. Maternity benefits are provided to employee only.
(2) Employee and Child(ren). – Covers enrolled employee and all eligible dependent children. ~~Maternity benefits are provided to the employee only.~~
(3) Employee and Family. – Covers employee and spouse, and all eligible dependent children. ~~Maternity benefits are provided to employee or enrolled spouse.~~
(4), (5) Repealed by Session Laws 1985 (Regular Session, 1986), c. 1020, s. 5(b)."

Sec. 5. G.S. 135-40.5 is amended by adding a new subsection to read:

"(e) Wellness Benefit. – The Plan will pay one hundred percent (100%) of usual, reasonable, and customary charges, up to three hundred dollars ($300.00) per year, per covered individual, for prenatal care and routine diagnostic examinations. Allowable charges for routine diagnostic examinations and tests, including Pap smears, breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 55 years, and once each year for covered individuals age 55 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements."

Sec. 6. G.S. 135-40.5 is amended by adding a new subsection to read:

"(f) Prescription Drugs. – Benefits are provided for prescription legend drugs used outside of a hospital or skilled nursing facility. 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.

The Executive Administrator and Board of Trustees may contract with prescription drug providers to establish a preferred provider network where reimbursement is made directly to participating providers. The design, adoption, and implementation of such preferred provider contracts and networks are not subject to the requirements of Chapter 143 of the General Statutes, provided that all prescription drug providers will have an opportunity to contract with the Plan if they meet the contract requirements.

The Plan's maximum allowable payment shall be the lesser of one hundred percent (100%) of average wholesale price or the price established by the preferred provider network less a copayment by the Plan member per prescription of five dollars ($5.00) for generic drugs, ten dollars ($10.00) for brand name drugs without a therapeutic generic

equivalent, and fifteen dollars ($15.00) for brand name drugs with a therapeutic generic equivalent for each 30-day supply of a drug."

Sec. 7. G.S. 135-40.6(8)a. is repealed.

Sec. 8. G.S. 135-40.6(2)f. reads as rewritten:

"f. Prior to admission for scheduled inpatient hospitalization, the admitting physician shall contact the Plan and secure approval certification for an inpatient admission, including a length of stay, based upon clinical criteria established by the medical community, before any in-hospital benefits are allowed under G.S. 135-40.8(a). Immediately following an emergency or unscheduled inpatient hospitalization, the admitting physician shall contact the Plan and secure approval certification for the admission's length of stay before any in-hospital benefits are allowed under G.S. 135-40.8(a). Effective January 1, 1987, failure to secure certification, or denial of certification, shall result in in-hospital benefits being allowed at the rate maximum amount of out-of-pocket expenses established by G.S. 135-40.8(b). Denial of certification by the Plan shall be made only after contact with the admitting physician and shall be subject to appeal to the Executive Administrator and Board of Trustees. Inpatient hospital admission and length of stay certifications required by this subdivision do not apply to inpatient admissions outside of the United States. Once informed that an employee or individual is a Plan member, hospitals which are contract providers, as described in G.S. 135-40.4, shall be responsible for ensuring that certification is secured. ~~While approval certification for inpatient admissions is required to be initiated by the admitting physician, the~~ The employee or individual covered by the Plan shall be responsible for insuring that the required certification is ~~secured.~~ secured when a hospital which is not a contract provider is used."

Sec. 9. G.S. 135-40.6(5)f. reads as rewritten:

"f. Multiple Procedures: When multiple or bilateral surgical procedures are performed by the same doctor through either separate or same incisions or approaches during the same session, the surgical benefits will be the greater UCR allowance, plus fifty percent (50%) of the lesser UCR allowance. Anesthesia benefits will be the greater UCR allowance.

~~When multiple surgical procedures are performed by the same doctor through the same incision or operative approach, the surgical benefits are limited to the procedure which has the highest UCR allowance.~~

When a surgical procedure is performed in two or more stages, the surgical benefit for the entire procedure is the same as it would be were the procedure performed in one stage (except where otherwise provided in the benefit schedule). This limitation does not apply to anesthesia benefits."

Sec. 10. G.S. 135-40.6(7)a. reads as rewritten:

"a. Services of Doctors. – The Plan pays the usual, reasonable and customary charges for covered inpatient medical (nonsurgical) services. Services are covered if the individual is hospital-confined and is eligible for hospitalization benefits as described in this section. Benefits are provided for exactly the same number of days as the individual is entitled to under this section, except that medical benefits are provided on both the day of admission and the day of discharge.

In the event a covered individual is treated by two or more co-attending doctors during the same hospital confinement for a medical (nonsurgical) condition, benefits are limited to payment for services provided by the primary attending doctor, except where need is established for supplementary skills for treatment of separate and distinct diagnoses or conditions.

Home, office, and skilled nursing facility visits including (i) charges for injected medications, (ii) inpatient care by attending medical doctors, radiologists, pathologists, and consultants during such time as hospital benefits are paid under any section of this Plan, (iii) care in the outpatient department of a hospital, and (iv) administration of shock therapy (drug or electric) including the services of anesthesiologists provided on an office or hospital outpatient basis for treatment of acute psychotic reaction or severe depression. The Plan does not cover the first ten dollars ($10.00) of allowable charges for each home, office, or skilled nursing facility ~~visit.~~ visit, except that this sentence does not apply to retirees on Medicare."

Sec. 11. G.S. 135-40.6(8)f. reads as rewritten:

"f. Dental Services: Oral surgery, including extraction of teeth, necessitated because of medical treatment. Dental surgery and appliances for mouth, jaw, and tooth restoration necessitated because of external violent and accidental means, such as the impact of moving body, vehicle collision, or fall occurring while an individual is covered under G.S. 135-40.3. No benefits are provided in connection with injury incurred in the act of chewing, nor for damage or breakage of an appliance such as bridge or denture being cleaned or otherwise not in normal mouth usage at the time of accident, nor for appliances for

orthodontic treatment when a class of malocclusion, other than orthognathic, or cross bite has been diagnosed. Benefits for temporomandibular joint (TMJ) dysfunction appliance therapy are limited to cases where the TMJ dysfunction has been diagnosed as solely resulting from accidental means as certified by the attending practitioner and approved by the Claims Processor.

Benefits shall include extractions, fillings, crowns, bridges, or other necessary therapeutic and restorative techniques and appliances to reasonably restore condition and function to that existing immediately prior to the accident. Injury or breakage of existing appliances such as bridges and dentures is limited to repair of such appliances unless certified as damaged beyond repair."

Sec. 12. G.S. 135-40.6(8)s. is repealed.

Sec. 13. G.S. 135-40.9 reads as rewritten:

"**§ 135-40.9. Maximum benefits.**

The maximum lifetime benefit for each covered individual will be ~~one million dollars ($1,000,000).~~ two million dollars ($2,000,000)."

Sec. 14. G.S. 135-40.10(b) reads as rewritten:

"(b) For those participants eligible for Medicare, the State's plan will be administered on a 'carve out' basis. The provisions of the plan are applied to the charges not paid by Medicare (Parts A & B). In other words, those charges not paid by Medicare would be subject to the deductible and coinsurance of the Plan just as if the charges not paid by Medicare were the total bill. The first ten dollars ($10.00) of allowable charges for each home, office, or skilled nursing facility visit are not subject to this subsection."

Sec. 15. This act becomes effective July 1, 1995, and applies to any medical services rendered on or after that date.