

**GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2005**

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**HOUSE BILL 1059  
Committee Substitute Favorable 5/31/05  
Third Edition Engrossed 6/1/05  
Senate Rules and Operations of the Senate Committee Substitute Adopted 7/20/06  
Fifth Edition Engrossed 7/21/06**

Short Title: State Health Plan Changes. (Public)

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Sponsors:

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Referred to:

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March 31, 2005

A BILL TO BE ENTITLED

1  
2 AN ACT TO MAKE CHANGES TO THE TEACHERS' AND STATE EMPLOYEES'  
3 COMPREHENSIVE MAJOR MEDICAL PLAN; TO CLARIFY ENROLLMENT  
4 IN THE PPO OPTIONAL PROGRAM ESTABLISHED PURSUANT TO PART 2  
5 OF ARTICLE 3 OF CHAPTER 135 OF THE GENERAL STATUTES; AND TO  
6 AUTHORIZE THE EXECUTIVE ADMINISTRATOR AND BOARD OF  
7 TRUSTEES OF THE TEACHERS' AND STATE EMPLOYEES'  
8 COMPREHENSIVE MAJOR MEDICAL PLAN TO PERMIT A CERTAIN  
9 NUMBER OF LOCAL GOVERNMENTS OPTIONAL COVERAGE UNDER THE  
10 PLAN.

11 The General Assembly of North Carolina enacts:

12 **SECTION 1.(a)** Cost-Saving Initiatives. – Coverage of Over-the-Counter  
13 Medications. – Notwithstanding any other provision of law to the contrary, the  
14 Executive Administrator and Board of Trustees may authorize coverage for  
15 over-the-counter medications as recommended by the Plan's pharmacy and therapeutics  
16 committee. In approving for coverage one or more over-the-counter medications, the  
17 Executive Administrator and Board of Trustees shall ensure that each recommended  
18 over-the-counter medication has been analyzed to ensure medical effectiveness and Plan  
19 member safety. The analysis shall also address the financial impact on the Plan. The  
20 Executive Administrator and Board of Trustees may impose a co-payment to be paid by  
21 each covered individual for each packaged over-the-counter medication. The Executive  
22 Administrator and Board of Trustees may adopt policies establishing limits on the  
23 amount of coverage available for over-the-counter medications for each covered  
24 individual over a 12-month period. Prior to implementing policy and co-payment  
25 changes authorized under this section, the Executive Administrator and Board of

1 Trustees shall submit the proposed policies and co-payments to the Committee on  
2 Employee Hospital and Medical Benefits for its review.

3         **SECTION 1.(b)** Incentive Programs. – For the purposes of helping Plan  
4 members to achieve and maintain a healthy lifestyle without impairing patient care, and  
5 to increase cost effectiveness in Plan coverage, the Executive Administrator and Board  
6 of Trustees may adopt programs offering incentives to Plan members to encourage  
7 changes in member behavior or lifestyle designed to improve member health and  
8 promote cost-efficiency in the Plan. Participation in one or more incentive programs is  
9 voluntary on the part of the Plan member. Before adopting an incentive program, the  
10 Executive Administrator and Board of Trustees shall conduct an impact analysis on the  
11 proposed incentive program to determine (i) whether the program is likely to result in  
12 significant member satisfaction, (ii) that it will not adversely affect quality of care, and  
13 (iii) whether it is likely to result in significant cost savings to the Plan. The impact  
14 analysis may be conducted by a committee of the Plan, in conjunction with the Plan's  
15 consulting actuary, provided that the Plan's medical director participates in the analysis.  
16 An approved incentive plan may provide for a waiver of deductibles, co-payments, and  
17 coinsurance required under this Article in order to determine the effectiveness of the  
18 incentive program in promoting healthy lifestyles for members and increasing  
19 cost-effectiveness to the Plan. The Executive Administrator and Board of Trustees shall,  
20 before implementing incentive programs authorized under this section, submit the  
21 proposed programs to the Committee on Employee Hospital and Medical Benefits for  
22 review.

23         **SECTION 2.(a)** Technical Changes. – G.S. 135-40.5(g) reads as rewritten:

24         "(g) Prescription Drugs. – The Plan's allowable charges for prescription legend  
25 drugs to be used outside of a hospital or skilled nursing facility are to be determined by  
26 the Plan's Executive Administrator and Board of Trustees. The Plan will pay allowable  
27 charges for each outpatient prescription drug less a copayment to be paid by each  
28 covered individual equal to the following amounts: pharmacy charges up to ten dollars  
29 (\$10.00) for each generic prescription, twenty five dollars (\$25.00) for each preferred  
30 branded prescription, and forty dollars (\$40.00) for each preferred branded prescription  
31 with a generic equivalent drug, and fifty dollars (\$50.00) for ~~each~~ each nonpreferred  
32 branded or generic prescription not on a formulary used by the Plan. ~~prescription.~~

33         Allowable charges shall not be greater than a pharmacy's usual and customary  
34 charge to the general public for a particular prescription. Prescriptions shall be for no  
35 more than a 34-day supply for the purposes of the copayments paid by each covered  
36 individual. By accepting the copayments and any remaining allowable charges provided  
37 by this subsection, pharmacies shall not balance bill an individual covered by the Plan.  
38 A prescription legend drug is defined as an article the label of which, under the Federal  
39 Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal Law  
40 Prohibits Dispensing Without Prescription." Such articles may not be sold to or  
41 purchased by the public without a prescription order. Benefits are provided for insulin  
42 even though a prescription is not required. The Plan may use a pharmacy benefit  
43 manager to help manage the Plan's outpatient prescription drug coverage. In managing  
44 the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit

1 manager shall not provide coverage for erectile dysfunction, growth hormone,  
2 antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically  
3 necessary to the health of the member. The Plan and its pharmacy benefit manager shall  
4 not provide coverage for growth hormone and weight loss drugs and antifungal drugs  
5 for the treatment of nail fungus and botulinum toxin without approval in advance by the  
6 pharmacy benefit manager. Any formulary used by the Plan's Executive Administrator  
7 and pharmacy benefit manager shall be an open formulary. Plan members shall not be  
8 assessed more than two thousand five hundred dollars (\$2,500) per person per fiscal  
9 year in copayments required by this subsection."

10 **SECTION 2.(b)** Prior Approval. – G.S. 135-40.6A(b) is amended by adding  
11 the following new subdivision to read:

12 ...

13 "(b) The Executive Administrator and Board of Trustees may establish procedures  
14 to require prior medical approvals for the following services:

15 ...

16 (12) Bone Anchored Hearing Aids (BAHA) surgically implanted for the  
17 treatment of hearing loss."

18 **SECTION 3.** Personnel. – For the purpose of improving efficiency and  
19 cost-effectiveness of Plan operations, the Executive Administrator and Board of  
20 Trustees of the North Carolina State Health Plan may create 13 new full-time positions,  
21 10 of which shall be subject to the State Personnel Act under G.S. 126-5, and three of  
22 which shall be exempt from the State Personnel Act under G.S. 126-5(c). The Executive  
23 Administrator and Board of Trustees may use up to seven hundred ninety-four thousand  
24 two hundred seventy-eight dollars (\$794,278) of available funds to support these  
25 positions.

26 **SECTION 4.(a)** Enrollment Clarification. – G.S. 135-39.5B is amended by  
27 adding the following new subsection to read:

28 "(c) Enrollment in an optional program established pursuant to subsection (b) of  
29 this section shall not constitute enrollment in the comprehensive major medical plan as  
30 established in Part 3 of this Article."

31 **SECTION 4.(b)** G.S. 135-39.5(12) reads as rewritten:

32 "(12) Determining basis of payments to health care providers, including  
33 payments in accordance with G.S. 58-50-56. The Comprehensive  
34 Major Medical Plan and optional plans and programs adopted pursuant  
35 to G.S. 135-39.5B shall comply with G.S. 58-3-225."

36 **SECTION 5.(a)** G.S. 135-40.13A reads as rewritten:

37 "**§ 135-40.13A. Liability of third person; right of subrogation; right of first**  
38 **recovery.**

39 (a) Whenever the Plan pays benefits for hospital, surgical, medical, or  
40 prescription drug expenses, with respect to any Plan member, the Plan shall be  
41 subrogated, to the extent of any payments under the Plan, to all of the Plan member's  
42 rights of recovery against liable third parties, regardless of the entity or individual from  
43 whom recovery may be due. The Plan shall have the right of subrogation upon all of the  
44 Plan member's right to recover from a liable third party for payment made under the

1 Plan, for all medical expenses, including provider, hospital, surgical, or prescription  
2 drug expenses, to the extent those payments are related to an injury caused by a liable  
3 third party. The Plan member shall do nothing to prejudice these rights. The Plan has  
4 the right to first recovery on any amounts so recovered, whether by the Plan or the Plan  
5 member, and whether recovered by litigation, arbitration, mediation, settlement, or  
6 otherwise. Notwithstanding any other provision of law to the contrary, the recovery  
7 limitation set forth in G.S. 28A-18-2 shall not apply to the Plan's right of subrogation of  
8 Plan members.

9 (b) If the Plan is precluded from exercising its right of subrogation, it may  
10 exercise its rights of recovery ~~to the extent allowed by law.~~ pursuant to  
11 G.S. 135-40.13(g). If the Plan recovers damages from a liable third party in excess of  
12 the claims paid, any excess will be paid to the member, less a proportionate share of the  
13 costs of collection.

14 (c) In the event a Plan member recovers any amounts from a liable third party to  
15 which the Plan is entitled under this section, the Plan may recover the amounts directly  
16 from the Plan member. The Plan has a lien, for not more than the value of claims paid  
17 related to the liability of the third party, on any damages subsequently recovered against  
18 the liable third party. If the Plan member fails to pursue the remedy against a liable third  
19 party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce  
20 liability in the Plan's own name or in the name of the Plan member for the amount paid  
21 by the Plan.

22 (d) In no event shall the Plan's lien exceed fifty percent (50%) of the total  
23 damages recovered by the Plan member, exclusive of the Plan member's reasonable  
24 costs of collection as determined by the Plan in the Plan's sole discretion. The decision  
25 by the Plan as to the reasonable cost of collection is conclusive and is not a "final  
26 agency decision" for purposes of a contested case under Chapter 150B of the General  
27 Statutes. Notice of the Plan's lien or right to recovery shall be presumed when a Plan  
28 member is represented by an attorney, and the attorney shall disburse proceeds pursuant  
29 to this section."

30 **SECTION 5.(b)** G.S. 28A-18-2(a) reads as rewritten:

31 "(a) When the death of a person is caused by a wrongful act, neglect or default of  
32 another, such as would, if the injured person had lived, have entitled him to an action  
33 for damages therefor, the person or corporation that would have been so liable, and his  
34 or their personal representatives or collectors, shall be liable to an action for damages, to  
35 be brought by the personal representative or collector of the decedent; and this  
36 notwithstanding the death, and although the wrongful act, neglect or default, causing the  
37 death, amounts in law to a felony. The personal representative or collector of the  
38 decedent who pursues an action under this section may pay from the assets of the estate  
39 the reasonable and necessary expenses, not including attorneys' fees, incurred in  
40 pursuing the action. At the termination of the action, any amount recovered shall be  
41 applied first to the reimbursement of the estate for the expenses incurred in pursuing the  
42 action, then to the payment of attorneys' fees, and shall then be distributed as provided  
43 in this section. The amount recovered in such action is not liable to be applied as assets,  
44 in the payment of debts or legacies, except as to burial expenses of the deceased, and

1 reasonable hospital and medical expenses not exceeding four thousand five hundred  
2 dollars (\$4,500) incident to the injury resulting in death, except that the amount applied  
3 for hospital and medical expenses shall not exceed fifty percent (50%) of the amount of  
4 damages recovered after deducting attorneys' fees, but shall be disposed of as provided  
5 in the Intestate Succession Act. The limitations on recovery for hospital and medical  
6 expenses under this subsection do not apply to subrogation rights exercised pursuant to  
7 G.S. 135-40.13A. All claims filed for such services shall be approved by the clerk of the  
8 superior court and any party adversely affected by any decision of said clerk as to said  
9 claim may appeal to the superior court in term time."

10 **SECTION 5.(c)** This section is effective when it becomes law and applies to  
11 payments made by the Plan after July 20, 2004, for which reimbursement is sought on  
12 or after the effective date. Subsection (b) of this section applies to wrongful deaths  
13 occurring on or after the effective date of this act.

14 **SECTION 6.** G.S. 135-39.5 is amended by adding the following new  
15 subdivision to read:

16 "**§ 135-39.5. Powers and duties of the Executive Administrator and Board of**  
17 **Trustees.**

18 The Executive Administrator and Board of Trustees of the Teachers' and State  
19 Employees' Comprehensive Major Medical Plan shall have the following powers and  
20 duties:

21 ...

22 (28) To authorize participation in the Plan by an employer, as defined for  
23 local government employers in G.S. 128-21(11), that elects to provide benefits for its  
24 employees and retired employees and their eligible spouses and dependents, and that  
25 meets the requirements of G.S. 135-40.1(6), as amended by Section 31.26 of S.L.  
26 2004-124, except that at any given point in time, there shall be not more than eight  
27 employers, as defined for local government employers in G.S. 128-21(11), participating  
28 in the Plan. The Executive Administrator and Board of Trustees shall have discretion in  
29 selecting local government employers to participate in the Plan. In admitting local  
30 government employers into the Plan, the Executive Administrator and Board of Trustees  
31 shall ensure compliance with the requirements of the Employee Retirement Income  
32 Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1003(b)."

33 **SECTION 7.** Effective Date. – Sections 1, 2, 3, 4, and 6 of this act become  
34 effective July 1, 2006. Section 1 of this act expires July 1, 2009. The limit on the  
35 number of local government employers that may participate in the Plan under  
36 G.S. 135-39.5(28), as enacted in Section 6 of this act, shall include those local  
37 government employers participating in the Plan on June 30, 2006. The remainder of this  
38 act is effective when it becomes law and applies to actions to exercise rights of recovery  
39 under G.S. 135-40.13 or G.S. 135-40.13A commenced on or after that date.