GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

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SENATE BILL 795

Short Title: State Employee Health Changes. (Public)

Sponsors: Senators Royall; Odom, Parnell, Plyler, Rauch, and Sherron.

Referred to: State Personnel.

April 5, 1989

1 A BILL TO BE ENTITLED
2 AN ACT TO MAKE CHANGES IN THE TEACHERS' AND STATE EMPLOYEES'
3 COMPREHENSIVE MAJOR MEDICAL PLAN TO CONFORM WITH
4 FEDERAL INTERNAL REVENUE CODE REQUIREMENTS, TO ELIMINATE
5 SPECIAL PREEXISTING CONDITION REQUIREMENTS FOR CONGENITAL
6 DEFECTS, CLEFT PALATE, AND SPEECH THERAPY, TO DETECT AND
7 PREVENT FRAUD, AND TO CORRECT PREVIOUS STATUTORY
8 LANGUAGE.
9 The General Assembly of North Carolina enacts:
10 Section 1. G.S. 135-39.5 reads as rewritten:
11 **"§ 135-39.5. Powers and duties of the Executive Administrator and Board of**
12 **Trustees.**
13 The Executive Administrator and Board of Trustees of the Teachers' and State
14 Employees' Comprehensive Major Medical Plan shall have the following powers and
15 duties:
16 (1) Supervising and monitoring of the Claims Processor.
17 (2) Providing for enrollment of employees in the Plan.
18 (3) Communicating with employees enrolled under the Plan.
19 (4) Communicating with health care providers providing services under
20 the Plan.
21 (5) Making payments at appropriate intervals to the Claims Processor for
22 benefit costs and administrative costs.
23 (6) Conducting administrative reviews under G.S. 135-39.7.
24 (7) Annually assessing the performance of the Claims Processor.

(8) Preparing and submitting to the Governor and the General Assembly cost estimates for the health benefits plan, including those required by Article 15 of Chapter 120 of the General Statutes.

(9) Recommending to the Governor and the General Assembly changes or additions to the health benefits program and health care cost containment programs, together with statements of financial and actuarial effects as required by Article 15 of Chapter 120 of the General Statutes.

(10) Working with State employee groups to improve health benefit programs.

(11) Repealed by Session Laws 1985, c. 732, s. 9.

(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-260.6.

(13) Requiring bonding of the Claims Processor in the handling of State funds.

(14) Repealed by Session Laws 1985, c. 732, s. 7.

(15) In case of termination of the contract under G.S. 135-39.5A, to select a new Claims Processor, after competitive bidding procedures approved by the Department of Administration.

(16) Notwithstanding the provisions of Part 3 of this Article, to formulate and implement cost-containment measures which are not in direct conflict with that Part.

(17) Implementing pilot programs necessary to evaluate proposed cost containment measures which are not in direct conflict with Part 3 of this Article, and expending funds necessary for the implementation of such programs.

(18) Authorizing coverage for alternative forms of care not otherwise provided by the Plan in individual cases when medically necessary, medically equivalent to services covered by the Plan, and when such alternatives would be less costly than would have been otherwise.

(19) Establishing and operating a hospital bill audit program and a fraud detection program."

Sec. 2. Effective January 1, 1989, G.S. 135-40 reads as rewritten:

"§ 135-40. Undertaking.

(a) The State of North Carolina undertakes to make available a Comprehensive Major Medical Plan (hereinafter called the 'Plan') ~~to~~ exclusively for the benefit of its employees, retired employees and certain of their dependents which will pay benefits in accordance with the terms hereof. The Plan shall have all of the powers and privileges of a corporation and shall be known as the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan. The Executive Administrator and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan.

(b) The Plan benefits will be provided under contracts between the State and the Claims Processor selected by the State. Claims Processor refers to the administrator,

third party administrator or other party contracting with the State to administer the Plan benefits. Such contracts shall include the substance of G.S. 135-40.1 through G.S. 135-40.13 and the description of Plan in the request for proposal, and shall be administered by the respective Claims Processor of the State which will determine benefits and other questions arising thereunder. The contracts necessarily will conform to applicable State laws. If any of the provisions of G.S. 135-40.1 through G.S. 135-40.13 and the request for proposals must be modified for inclusion in the contract because of State laws, such modification will be made.

(c) Payroll deduction shall be available for coverage under this Part or under G.S. 135-39.5B of amounts not paid by the State.

(d) Notwithstanding any other provisions of the Plan, the Executive Administrator and Board of Trustees are specifically authorized to use all appropriate means to secure tax qualification of the Plan under any applicable provisions of the Internal Revenue Code of 1954 as amended. The Executive Administrator and Board of Trustees shall furthermore comply with all applicable provisions of the federal Internal Revenue Code, as amended, to the extent that such compliance is not prohibited by this Article."

Sec. 3. G.S. 135-40.1(2) reads as rewritten:

"(2) Deductible. – Deductible shall mean an amount of covered expenses during a ~~calendar~~ fiscal year which must be incurred after which benefits (subject to the deductible) becomes payable. The deductible for an employee, retired employee and/or his or her dependents shall be one hundred fifty dollars ($150.00) for each ~~calendar~~ fiscal year.

The deductible applies separately to each covered individual in each ~~calendar~~ fiscal year, subject to an aggregate maximum of four hundred fifty dollars ($450.00) per family (employee or retiree and his or her covered dependents) in any ~~calendar~~ fiscal year.

If two or more family members are injured in the same accident only one deductible is required for charges related to that accident during the benefit period."

Sec. 3.1. G.S. 135-40.1(17) reads as rewritten:

"(17) Retired Employee (Retiree). – Retired teachers, State employees, and members of the General Assembly who are receiving monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina, so long as the retiree is enrolled. On and after January 1, 1988, a ~~retired~~ retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree."

Sec. 4. G.S. 135-40.2 is amended by adding a new subsection to read:

"(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 and Board of Trustees or by a court of competent jurisdiction that said 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. 4.1. Effective September 1, 1987, G.S. 135-40.2(a) reads as rewritten:

"(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, and members of the General Assembly.

(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), effective January 1, 1988.

(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."

Sec. 5. Effective July 1, 1986, G.S. 135-40.6 is amended by deleting "up to a maximum of three hundred dollars ($300.00) out-of-pocket per calendar year", and substituting "up to a maximum of three hundred dollars ($300.00) out-of-pocket per fiscal year".

Sec. 5.1. G.S. 135-40.6(1) reads as rewritten:

"(1) In-Hospital Benefits. – The Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room accommodation, including bed, board and general nursing care, but not

1 to exceed the charge for semi-private room or ward accommodations,
2 or the rate negotiated for the Plan.
3 The Plan will pay the following covered charges, when charged by a
4 hospital, for each confinement.
5 a. Intensive and cardiac nursing care.
6 b. All recognized drugs and medicines for use in the hospital.
7 c. Radiation services, including diagnostic x-rays, x-ray therapy,
8 radiation therapy and treatment.
9 d. Clinical and pathological laboratory examinations.
10 e. Electrocardiograms and electroencephalograms.
11 f. Physical therapy.
12 g. Intravenous solutions.
13 h. Oxygen and oxygen therapy, plus the use of equipment.
14 i. Dressings, ordinary splints, plaster casts and sterile supplies.
15 j. Use of operating, delivery, recovery and treatment rooms and
16 equipment.
17 k. Routine nursery charges, if the mother is eligible to receive
18 maternity benefits.
19 l. Anesthetics and the administration thereof by the hospital's
20 employee anesthesiologist.
21 m. Devices or appliances surgically inserted within the body.
22 n. Processing and administering of blood and blood plasma.
23 o. Children ~~who are born under the coverage type (2), (3), or (5), as~~
24 ~~outlined in G.S. 135-40.3(d), and who remain continuously covered~~
25 are entitled to benefits for treatment of illnesses or congenital
26 defect, incubation or isolette care, and treatment of prematurity
27 or postmaturity.
28 If the mother is a covered individual, benefits are provided
29 for the newborn's circumcision and routine nursery care.
30 p. When a covered individual is admitted to or transferred to a
31 section of a hospital providing ambulant, convalescent, or
32 rehabilitative care, benefits are provided up to the average
33 number of days of service for treatment of the particular
34 diagnosis or condition involved, or more if medical necessity
35 requires.
36 q. The Plan pays benefits for laboratory testing and administration
37 of blood provided to a covered individual.
38 When a covered individual is the recipient of transplanted
39 organs or bones, benefits are provided for services to the donor
40 which are directly and specifically related to the transplantation.
41 r. Thirty days per fiscal year are provided for inpatient treatment
42 of mental illness. Readmission for this condition within 365
43 days of last discharge shall be considered a single confinement.
44 When furnished to a patient in a skilled nursing facility, 30 days

less the days of care already provided for the same illness in a hospital are provided. Additional inpatient treatment, based on individual consideration, may be provided if prior approval is obtained from the Claims Processor.

s. The use of nebulizers when authorized as medically necessary by the attending physician."

Sec. 5.2. G.S. 135-40.6(5) reads as rewritten:

"(5) Surgical Benefits. – The Plan pays the usual, customary and reasonable charges for covered surgical services as follows:

a. Surgery: Cutting procedures, treatment of fractures, transfusions, operative preparation for diagnostic x-ray examinations, surgical implantation radiation sources, major endoscopic examinations, biopsies, surgical sterilization, other standard services and operations.

For the purpose of this subdivision, the term ‘standard services and operations' includes the following organ transplants: liver, corneal, bone marrow, and kidney. All other organ transplants shall be considered nonreimbursable under the Plan. Benefits for the above listed organ transplants shall be payable only in accordance with rules established by the Executive Administrator and Board of Trustees.

b. Anesthesia: Administration of general, spinal block or local anesthesia. Covered services include pre- and postoperative visits, the administration of the anesthetic, fluids and/or blood provided by the anesthesiologist and incidental to the anesthesia, and necessary drugs and materials provided by the anesthesiologist. No benefits are provided for administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant(s).

c. Oral Surgery: Services which are within the scope of practice of both a doctor of medicine and a dentist, such as excision of tumors and lesions of the mouth, treatment of jaw fractures and surgery to correct injuries of the mouth structure other than teeth and their supporting structure. Developmental and congenital orthognathic surgery procedures will be covered under the Plan, provided such surgery is medically necessary, is the only method of treatment which will correct the patient's deformity, is not performed for cosmetic reasons, and is approved in advance by the Claims Processor on the basis of the surgeon's documentation that the correction of the deformity is medically necessary for the maintenance of good physical health.

d. Maternity Care: Independent operative procedures in connection with pregnancy, such as: manipulative obstetrical

delivery, delivery by Caesarean section, removal of ectopic pregnancy, dilation and curettage. Benefits for manipulative obstetrical delivery include use of forceps and/or episiotomy. No benefits are provided for antepartum or postpartum care, except for direct surgical procedures of delivery and surgical treatment.

e. Surgical Assistants: Services of an assistant surgeon when medical judgment requires the services of an assistant surgeon and no hospital-employed doctor in training is available.

f. Multiple Procedures: When multiple or bilateral surgical procedures are performed by the same doctor through separate 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.

g. Cleft Palate: Notwithstanding G.S. 135-40.6(6)a and G.S. 135-40.7(11), medical treatment and care needed by an individual born with cleft palate, including specialized dental and orthodontic care necessitated by the congenital ~~condition, provided that the individual was covered at the time of birth by the Plan or the Predecessor Plan.~~ condition."

Sec. 5.3. G.S. 135-40.6(8) reads as rewritten:

"(8) Other Covered Charges. –

a. Prescription Drugs: Prescription legend drugs in excess of the first two dollars ($2.00) per prescription for generic drugs and brand name drugs without a generic equivalent and in excess of the first three dollars ($3.00) per prescription for brand name drugs for use 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.

b. Private Duty Nursing: Services of licensed nurses (not immediate relatives or members of the participant's household or private duty nursing used in lieu of or as a substitute for hospital staff nurses) ordered by the attending doctor for a condition requiring skilled nursing services. Private Duty Nursing ordered must be approved in advance by the Claims Processor as medically necessary. Allowances for Private Duty Nursing shall not exceed the Plan's usual, customary and reasonable allowances or ninety percent (90%) of the daily semiprivate rate by skilled nursing facilities as determined by the Plan.

c. Home Health Agency Services: Services provided in a covered individual's home, when ordered by the attending physician who certifies that hospital or skilled nursing facility confinement would be required without such treatment and cannot be readily provided by family members. Services may include medical supplies, equipment, appliances, therapy services (when provided by a qualified speech therapist or licensed physiotherapist), and nursing services. Nursing services will be allowed for:

1. Services of a registered nurse (RN); or
2. Services of a licensed practical nurse (LPN) under the supervision of a RN; or
3. Services of a home health aide under the supervision of a RN, limited to four hours a day.

Home health services shall be limited to 60 days per fiscal year, except that additional home health services may be provided on an individual basis if prior approval is obtained from the Claims Processor. Plan allowances for home health services shall be limited to licensed or Medicare certified home health agencies and shall not exceed ninety percent (90%) of the skilled nursing facility semiprivate rates as determined by the Plan, or charges negotiated by the Plan.

d. Licensed Ambulance Service: Local ambulance transportation:

To or from a hospital for inpatient care or outpatient accident care;

From a hospital to the nearest facility able to provide needed services not available at the transferring hospital; or

From a hospital to a skilled nursing facility.

The word 'local' means ambulance transportation of not more than 50 miles unless the Claims Processor authorizes ambulance transportation beyond this distance.

e. Prosthetic and Orthopedic Appliances and Durable Medical Equipment: Appliances and equipment including corrective and supportive devices such as artificial limbs and eyes, wheelchairs, traction equipment, inhalation therapy and suction machines, hospital beds, braces, orthopedic corsets and trusses, and other prosthetic appliances or ambulatory apparatus which are provided solely for the use of the participant. Eligible charges include repair and replacement when medically necessary. Benefits will be provided on a rental or purchase basis at the sole discretion of the Administrator and agreements to rent or purchase shall be between the Administrator and the supplier of the appliance.

For the purposes of this subdivision, the term 'durable medical equipment' means standard equipment normally used in an institutional setting which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. Decisions of the Claims Processor, the Executive Administrator and Board of Trustees as to compliance with this definition and coverage under the Plan shall be final.

f. Dental Services: 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) disfunction appliance therapy are limited to cases where the TMJ disfunction 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.

g. Medical Supplies: Colostomy bags, catheters, dressings, oxygen, syringes and needles, and other similar supplies.

h. Blood: Transfusions including cost of blood, plasma, or blood plasma expanders.

i. Physical Therapy: Recognized forms of physical therapy for restoration of bodily function, provided by a doctor, hospital, or by a licensed professional physiotherapist. No benefits are provided for eye exercises or visual training.

j. Inhalation Therapy: When provided by a doctor, hospital, or other organization.

k. Speech Therapy: Speech therapy provided by certified speech therapist. ~~Benefits are provided only in connection with a condition, illness, or injury arising while continuously covered under this Plan.~~

l. Cataract Lenses: Cataract lenses prescribed as medically necessary for aphakia persons, including charges for necessary examinations and fittings. Benefits will be limited to one set of cataract lenses every 24 months for persons 18 years of age or older, and one set of cataract lenses every 12 months for persons less than 18 years of age.

m. Cardiac Rehabilitation: Charges not to exceed six hundred fifty dollars ($650.00) per fiscal year for cardiac testing and exercise therapy, when determined medically necessary by an attending physician and approved by the Claims Processor for patients with a medical history of myocardial infarction, angina pectoris, arrhythmias, cardiovascular surgery, hyperlipidemia, or hypertension, provided such charges are incurred in a medically supervised facility fully certified by the North Carolina Department of Human Resources.

n. Chiropractic Services: Limited to the alignment of the spine and releasing of pressure by manipulation in accordance with the definitions in G.S. 90-143. Maximum benefits for x-rays, manipulations, and modalities shall be one thousand dollars ($1,000) per fiscal year.

o. Foot Surgery: All foot surgery on bones and joints in excess of one thousand dollars ($1,000), except for emergencies, shall require prior approval from the Claims Processor.

p. Outpatient Diabetes Self-Care Programs: Charges, not to exceed three hundred dollars ($300.00) per fiscal year, when determined to be medically necessary by an attending physician and approved by the Executive Administrator and Claims Processor as meeting the standards of the National Diabetes Advisory Board for patients with a medical history of diabetes,

provided such charges are incurred in a medically supervised facility.

q. Necessary medical services provided to terminally ill patients by duly licensed hospice organizations, when directed by the attending physician and approved in advance by the Claims Processor and the Executive Administrator."

Sec. 6. Effective July 1, 1986, G.S. 135-40.6A(b) reads as rewritten:

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

(1) Skilled Nursing Facility Care (after the initial 30 days);
(2) Private Duty Nursing;
(3) Speech Therapy (unless rendered in an inpatient hospital);
(4) Physical Therapy (in the home);
(5) Argon Laser Trabeculoplasty;
(6) Radioallergosorbent Test (RAST);
(7) Surgical Procedures:
a. ~~Elepharoplasties~~ <u>Blepharoplasties</u>
b. Surgery for Hermaphroditism
c. Excision of Keloids
d. Reduction Mammoplasty
e. Morbid Obesity Surgery
f. Penile Prosthesis
g. Excision of Gynecomastia
h. Cochlear Implants
i. Revision of the Nasal Structure
j. Abdominoplasty
k. Fimbrioplasty
l. Tubotubal Anastomasis.
(8) Subcutaneous injection of ‘filling' material (Example: zyderm, silicone); and
(9) Suction Lipectomy."

Sec. 7. Effective July 1, 1986, G.S. 135-40.8(a) reads as rewritten:

"(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays ninety percent ~~(95%)~~ <u>(90%)</u> of the eligible expenses outlined in G.S. 135-40.6. The covered individual is then responsible for the remaining ten percent (10%) until three hundred dollars ($300.00), in excess of the deductible, has been paid out-of- pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses."

Sec. 7.1. Effective October 1, 1986, G.S. 135-40.8(b) reads as rewritten:

"(b) Where a covered individual fails to obtain a second surgical opinion as required under the Plan, the covered individual shall be responsible for fifty percent (50%) of the eligible expenses, provided, however, that no covered individual shall be required to ~~pay~~ <u>pay, in addition to the expenses in subsection (a) above,</u> out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year."

1 Sec. 8. Effective October 1, 1982, G.S. 135-40.10(b) reads as rewritten:
2 "(b) For those participants eligible for Medicare, the State's ~~new~~ Plan will be
3 administered on a 'carve out' basis. The provisions of the ~~new~~ Plan are applied to the
4 charges not paid by Medicare (Parts A & B). In other words, those charges not paid by
5 Medicare would be subject to the deductible and coinsurance of the ~~new~~ Plan just as if
6 the charges not paid by Medicare were the total bill."
7 Sec. 9. G.S. 135-40.11(a) reads as rewritten:
8 "(a) Coverage under this Plan of an employee and his or her surviving spouse or
9 eligible dependent children or of a retired employee and his or her surviving spouse or
10 eligible dependent children shall cease on the earliest of the following dates:
11 (1) The last day of the month in which an employee or retired employee
12 dies. Provided such surviving spouse or eligible dependent children
13 were covered under the Plan at the time of death of the former
14 employee or retired employee, or were covered on September 30,
15 1986, any such surviving spouse or eligible dependent children may
16 then elect to continue coverage under the Plan by submitting written
17 application to the Claims Processor and by paying the cost for such
18 coverage when due at the applicable fees. Such coverage shall cease
19 on the last day of the month in which such surviving spouse or eligible
20 dependent children die, except as provided by this Article.
21 (2) The last day of the month in which an employee's employment with
22 the State is terminated as provided in subsection (c) of this section.
23 (3) The last day of the month in which a divorce becomes final.
24 (4) The last day of the month in which an employee or retired
25 employee requests cancellation of coverage.
26 (5) The last day of the month in which a covered individual enters active
27 military service.
28 <u>(6) The last day of the month in which a covered individual is found to</u>
29 <u>have knowingly and willfully made or caused to be made a false</u>
30 <u>statement or false representation of a material fact in a claim for</u>
31 <u>reimbursement of medical services under the Plan.</u>"
32 Sec. 10. This act shall become effective July 1, 1989, unless otherwise
33 stated.