GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

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SENATE BILL 540

Short Title: State Emp. Health Plan Changes. (Public)

Sponsors: Senator Murphy.

Referred to: Pensions and Retirement.

April 10, 1991

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR TECHNICAL AND OTHER CLARIFYING CHANGES IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-39.4A(f) reads as rewritten:

"(f) The Executive Administrator may employ such clerical and professional staff, and such other assistance as may be necessary to assist the Executive Administrator and the Board of Trustees in carrying out their duties and responsibilities under this Article. The Executive Administrator may also negotiate, renegotiate and execute contracts with third parties in the performance of his duties and responsibilities under this Article; provided any contract negotiations, renegotiations and execution with a Claims Processor or with an optional prepaid hospital and medical benefit plan or with a preferred provider of institutional or professional hospital and medical care shall be done only after consultation with the Committee on Employee Hospital and Medical Benefits."

Sec. 2. G.S. 135-39.5 reads as rewritten:

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

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

(1) Supervising and monitoring of the Claims Processor.

(2) Providing for enrollment of employees in the Plan.

(3) Communicating with employees enrolled under the Plan.
(4) Communicating with health care providers providing services under the Plan.
(5) Making payments at appropriate intervals to the Claims Processor for benefit costs and administrative costs.
(6) Conducting administrative reviews under G.S. 135-39.7.
(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.
(20) Determine administrative and medical policies that are not in direct conflict with Part 3 of this Article upon the advice of the Claims Processor and upon the advice of the Plan's consulting actuary when Plan costs are involved.

(21) Supervise the payment of claims and all other disbursements under this Article, including the recovery of any disbursements that are not made in accordance with the provisions of this Article."

Sec. 3. 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. 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 provisions of G.S. 57B-11 shall not apply to any optional prepaid hospital and medical benefits plans provided for by the Executive Administrator and Board of Trustees.~~ 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. 4. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits."

Sec. 5. G.S. 135-39.7 reads as rewritten:

"**§ 135-39.7. Administrative review.**

If, after exhaustion of internal appeal handling as outlined in the contract with the Claims Processor any person is aggrieved, the Claims Processor shall bring the matter to the attention of the Executive Administrator and Board of Trustees, which may make a binding decision on the matter in accordance with procedures established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written summary of the decisions made pursuant to this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a decision,

and to any other parties requesting a written summary and approved by the Executive Administrator and Board of Trustees to receive a summary immediately following the issuance of a decision."

Sec. 6. G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts 2 and 3 of this Article. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other parties requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

Sec. 7. G.S. 135-39.10 reads as rewritten:

"**§ 135-39.10. Meaning of 'Executive Administrator and Board of Trustees'.**

Whenever in this Article the words 'Executive Administrator and Board of Trustees' appear, they mean that the Executive Administrator shall have the power, duty, right, responsibility, privilege or other function mentioned, after consulting with the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical ~~Plan, or its Executive Committee.~~ Plan."

Sec. 8. G.S. 135-40.1 is amended by adding a new subdivision to read:

"(7.1) Experimental/Investigational Medical Procedures. – The use of any treatment, procedure, facility, equipment, drug, device, or supply not recognized as having scientifically established medical value nor accepted as standard medical treatment for the condition being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor, nor any such items requiring federal or other governmental agency approval not granted at the time services were rendered. The Executive Administrator and Board of Trustees may overturn the advice of the Claims Processor upon convincing evidence from the American Medical Association, North Carolina Medical Society, the United States Health Care Financing Administration, medical technological journals, and other major United States insurers of health care expenses on a consensus of medical value and accepted standard medical treatment."

Sec. 9. Effective October 1, 1982, G.S. 135-40.3(b) is amended by adding a new subdivision to read:

"(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled or not adding dependents when first eligible after an employee's retirement may enroll later on the first of any following month, but

will be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section."

Sec. 10. G.S. 135-40.3(b) is amended by adding a new subdivision to read:

"(4) Employees and dependents reenrolled within 12 months after a termination of enrollment, regardless of the employing units involved, shall not be considered as newly-eligible employees or dependents for the purposes of waiting periods and preexisting conditions. Employees and dependents transferring from optional prepaid plans in accordance with G.S. 135-39.5B; employees and dependents immediately returning to service from an employing unit's approved periods of leave without pay for illness, injury, educational improvement, workers' compensation, parental duties, or for military reasons; employees and dependents immediately returning to service from a reduction in an employing unit's work force; retiring employees and dependents reenrolled in accordance with G.S. 135-40.3(b)(3); formerly-enrolled dependents reenrolling as eligible employees; formerly-enrolled employees reenrolling as eligible dependents; and employees and dependents reenrolled without waiting periods and preexisting conditions under specific rules and regulations adopted by the Executive Administrator and Board of Trustees in the best interests of the Plan shall not be considered reenrollments for the purpose of this subdivision. Furthermore, employees accepting permanent, full-time appointments who had previously worked in a part-time or temporary position and their qualified dependents shall not be covered by waiting periods and preexisting conditions under this division provided enrollment as a permanent, full-time employee is made when the employee and his dependents are first eligible to enroll."

Sec. 11. G.S. 134-40.3 is amended by adding a new subsection to read:

"(e) Notwithstanding any other provision of this section, no coverage under the Plan shall become effective prior to the payment of premiums required by the Plan."

Sec. 12. G.S. 135-40.5(d) reads as rewritten:

"(d) Second Surgical Opinions. – The Plan will pay one hundred percent (100%) of usual, reasonable and customary charges for one presurgical consultation by a second surgeon or other qualified physician as determined by the Claims Processor and Executive Administrator regarding the performance of nonemergency surgery. The Plan will also pay one hundred percent (100%) of the reasonable and customary charges for diagnostic, laboratory and x-ray examinations required by the second surgeon. Second surgical opinions for tonsillectomy and adenoidectomy procedures may be provided by Board-qualified pediatricians and family practitioners when qualified surgeons are not available to provide second surgical opinions. Should the first two opinions differ as to the necessity of surgery, the Plan will pay one hundred percent (100%) of reasonable and customary charges for the consultation of the third surgeon.

As used in this section and the provisions of G.S. 135-40.8(b), second surgical ~~opinions~~ opinions, and third surgical opinions when the first two opinions differ as to the

necessity of surgery, shall be required for the following procedures otherwise covered by the ~~Plan:~~ Plan as the primary payer of health benefits: hysterectomy, revision of the nasal structure, coronary artery bypass surgery, and surgery on the knee (except in procedures involving ~~orthoscopic~~ arthroscopic surgery when the diagnosis and the surgery can be performed in the same procedure and through the same incision). Second surgical opinions for coronary by-pass surgery may be provided by doctors who are Board-qualified in internal medicine when qualified surgeons are not available to provide a second surgical opinion. The Claims Processor may waive the requirement for obtaining a second surgical opinion required by this subsection or required by G.S. 135-40.8(b) if the location and availability of surgeons qualified to provide second opinions creates an unjust hardship or if the medical condition of the patient would be adversely affected."

Sec. 13. Effective January 1, 1986, G.S. 135-40.6(2) reads as rewritten:

"(2) Limitations and Exclusions to In-Hospital Benefits. –

a. The services of physicians, surgeons and technicians not employed by or under contract to the hospital are not covered.

b. Any admission for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis, if no hospitalization would have been required except for such diagnostic services is not covered. However, benefits are provided at ninety percent (90%) of Plan benefits for diagnostic tests and procedures consistent with the symptoms or diagnosis for which admitted.

c. The Plan will not cover any admission to a hospital prior to the effective date of coverage or beginning prior to the expiration of any waiting period so long as the individual remains continuously in a hospital.

d. Hospitalization for custodial, domiciliary or sanitarium care, or rest cures, is not covered.

e. Hospitalization for dental care and treatment is not covered, except when a hospital setting is medically necessary.

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). 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. While approval certification for inpatient admissions is required to be initiated by the admitting physician, the employee or individual covered by the Plan shall be responsible for insuring that the required certification is secured."

Sec. 14. Effective October 1, 1991, G.S. 135-40.6(2), as amended by Section 13 of this act, reads as rewritten:

"(2) Limitations and Exclusions to In-Hospital Benefits. –

a. The services of physicians, surgeons and technicians not employed by or under contract to the hospital are not covered.

b. Any admission for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis, if no hospitalization would have been required except for such diagnostic services is not covered. However, benefits are provided at ninety percent (90%) of Plan benefits for diagnostic tests and procedures consistent with the symptoms or diagnosis for which admitted.

c. The Plan will not cover any admission to a hospital prior to the effective date of coverage or beginning prior to the expiration of any waiting period so long as the individual remains continuously in a hospital.

d. Hospitalization for custodial, domiciliary or sanitarium care, or rest cures, is not covered.

e. Hospitalization for dental care and treatment is not covered, except when a hospital setting is medically necessary.

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. While approval certification for inpatient admissions is required to be initiated by the admitting physician, the employee or individual covered by the Plan shall be responsible for insuring that the required certification is secured."

Sec. 15. Effective July 1, 1985, G.S. 135-40.7 is amended by adding a new subdivision to read:

"(16a) Charges in excess of negotiated rates allowed for preferred providers of institutional and professional medical care and services in accordance with the provisions of G.S. 135-40.4, when such preferred providers are reasonably available to provide institutional and professional medical care."

Sec. 16. 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, or where a covered individual elects to have a surgery performed that conflicts with a majority opinion of the rendered consultations that the surgery requiring a second or third surgical opinion is not necessary, 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, in addition to the expenses in subsection (a) above out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year."

Sec. 17. Unless otherwise stated, this act is effective upon ratification.