GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

S **D**

SENATE DRS75345-LN-197A (3/13)

Short Title:	State Health Plan Changes.	(Public)
Sponsors:	Senator Rand.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE LAW PERTAINING TO THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Effective January 1, 2009, G.S. 135-40.1(7b) is repealed.

SECTION 1.(b) Effective January 1, 2009, G.S. 135-40.1 is amended by adding the following new subdivision in alphabetical order to read:

"(1c) Calendar year. – The period beginning on January 1 and ending on December 31 of the same year."

SECTION 1.(c) Effective January 1, 2009, the Revisor of Statutes shall delete the term "fiscal year" wherever it appears in Parts 1 through 3 of Article 3 of Chapter 135 of the General Statutes and substitute the term "calendar year."

SECTION 2. G.S. 135-40.8(c2) reads as rewritten:

"(c2) Notwithstanding any other provision of this Article, the Plan does not pay the first two hundred dollars ($200.00) of allowable emergency room charges when admission to a hospital pursuant to the emergency room use does not immediately follow. ~~This subsection shall apply only when less costly alternative means of emergency medical care are reasonably available as determined by the Executive Administrator and Board of Trustees.~~ The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs."

SECTION 3.(a) G.S. 135-40.3(a)(3) reads as rewritten:

"(3) Employees not enrolling or adding dependents when first eligible in accordance with G.S. 135-40.1(7) may enroll later on the first of any following month but will be subject to a 12-month waiting period for a preexisting health ~~condition, except employees who elect to change their coverage in accordance with rules adopted by the Executive~~

~~Administrator and Board of Trustees for optional prepaid hospital and medical benefit plans.~~

SECTION 3.(b) G.S. 135-40.3(b)(3) and (b)(5) read as rewritten:

"(b) Waiting Periods and Preexisting Conditions. –

…

(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.~~month.

…

(5) To administer the 12-month waiting period for preexisting conditions under this Article, the Plan must give credit against the 12-month period for the time that a person was covered under a previous plan if the previous plan's coverage was continuous ~~to a date not more than 63 days before the effective date of coverage.~~ without a break of more than 63 days in the 12 months prior to the person's effective date. As used in this subdivision, a "previous plan" means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement."

SECTION 3.(c) G.S. 135-40.11(d) reads as rewritten:

"(d) No benefits will be paid by this Plan for any expenses incurred or treatment received after cessation of coverage as provided in subsections (a) or (b) of this ~~section, except that in the event of hospital confinement at that time, hospitalization benefits as described in G.S. 135-40.6 will continue to the extent provided therein.~~section."

SECTION 4. G.S. 135-40.13A(a) reads as rewritten:

"(a) The Plan shall have the right of subrogation upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party. A liable third party shall not include the Plan member's underinsured motorist policy. The Plan member shall do nothing to prejudice these rights. The Plan has the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. Notwithstanding any other provision of law to the contrary, the recovery limitation set forth in G.S. 28A-18-2 shall not apply to the Plan's right of subrogation of Plan members."

SECTION 5. G.S. 135-40.1(3) reads as rewritten:

"(3) Dependent Child. – A natural, legally adopted, or foster child of the employee and/or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday.

A foster child is covered (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the Claims Processor accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of, the child(ren), are not eligible participants.

Coverage may be extended beyond the 19th birthday under the following conditions:

a. If the dependent is a full-time student, between the ages of 19 and 26, who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction. <u>At the Plan's sole discretion, coverage may be extended for a period of 12 months from the date of withdrawal from the school or accredited college for dependent full-time students who withdraw from the school or college due to a documented serious medical condition.</u>

b. The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-40.1(3)a.

Dependent children of firemen, rescue squad workers, and members of the national guard are subject to the same terms and conditions as are other dependent children covered by this subdivision."

SECTION 6. G.S. 135-40.2(b)(5) reads as rewritten:

"(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:

…

(5) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of G.S. 135-40.2(a)(6), Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within ~~30~~ 90 days of the member's death."

SECTION 7. G.S. 135-40.5(g) reads as rewritten:

"(g) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility are to be determined by the Plan's Executive Administrator and Board of Trustees. The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the following amounts: pharmacy charges up to ten dollars ($10.00) for each generic prescription, twenty five dollars ($25.00) for each preferred branded prescription, and forty dollars ($40.00) for each preferred branded prescription with a generic equivalent drug, and fifty dollars ($50.00) for each nonpreferred branded or generic prescription.

Allowable charges shall not be greater than a pharmacy's usual and customary charge to the general public for a particular prescription. Prescriptions shall be for no more than a 34-day supply for the purposes of the copayments paid by each covered individual. By accepting the copayments and any remaining allowable charges provided by this subsection, pharmacies shall not balance bill an individual covered by the Plan. 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 a prescription is not required. The Plan may use a pharmacy benefit manager to help manage the Plan's outpatient prescription drug coverage. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for ~~erectile dysfunction,~~ growth hormone, antiwrinkle, weight loss, and hair growth drugs unless such coverage is medically necessary to the health of the member. In managing the Plan's outpatient prescription drug benefits, the Plan and its pharmacy benefit manager shall not provide coverage for male and female sexual dysfunction drugs and idiopathic short stature drugs unless such coverage is medically necessary to the health of the member. The Plan and its pharmacy benefit manager shall not provide coverage for growth hormone and weight loss drugs and antifungal drugs for the treatment of nail fungus and botulinium toxin without approval in advance by the pharmacy benefit manager. Any formulary used by the

Plan's Executive Administrator and pharmacy benefit manager shall be an open formulary. Plan members shall not be assessed more than two thousand five hundred dollars ($2,500) per person per fiscal year in copayments required by this subsection."

SECTION 8. G.S. 135-40.3(c)(4) reads as rewritten:

"(c) Dependents of Employees and Retired Employees. –

…

(4) Employees or retired employees who wish to change from family coverage to parent/child(ren) or individual or from parent/child(ren) to individual coverage shall give written notice to their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) that requires a change in contract type. The effective date will be the first of the month following the dependent's ineligibility event. If notification was not made within the 30 days following the dependent's ineligibility event, the dependent will be retroactively removed the first of the month following the dependent's ineligibility event, and the coverage type change will be the first of the month following written notification, except in cases of death, in which case the coverage type change will be made retroactive to the first of the month following the death. If notification was not made within the 30 days following the dependent's ineligibility event, reimbursement of dependent premiums, minus claims paid during the period of ineligibility, will be made from the month following the ineligibility event."

SECTION 9. G.S. 135-40.1(8) reads as rewritten:

"(8) Health Benefits Representative. – The employee designated by the employing unit to administer the Comprehensive Major Medical ~~Plan~~ Plan, including the Indemnity Plan and any optional plans offered pursuant to G.S. 135-39.5B, for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements and remitting group fees. The State Retirement System is the Health Benefits Representative for retired members."

SECTION 10. G.S. 135-40.6(8) reads as rewritten:

"(8) Other Covered Charges. –

…

s. Routine Diagnostic Examinations: Allowable charges for routine diagnostic examinations and tests, including examinations and tests for the screening for the early detection of cervical cancer, breast, colon, rectal, and prostate exams, X rays, 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 50 years, and once a year for covered individuals age 50 years and older and, for examinations and tests for the screening for the early detection of cervical cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. The Plan will pay ~~one hundred percent (100%) of~~ allowable charges for mammograms once per year for covered individuals age 40 years and over, and not more often than once every three years for covered individuals to age 40 years, 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. For the purposes of this sub-subdivision, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration."

SECTION 11.(a) G.S. 135-40.2(a), (a1), 40.2(a2), and 40.2(a3) read as rewritten:

"**§ 135-40.2. Eligibility.**

(a) The following persons are eligible for coverage under the Indemnity Plan, on a ~~noncontributory~~ partially contributory 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. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(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) Notwithstanding the provisions of G.S. 135-40.11, employees formerly covered by the provisions of this section, other than retired employees, who have been employed for 12 or more months by an employing unit and whose jobs are eliminated because of a reduction, in total or in part, in the funds used to support the job or its responsibilities, provided the employees were covered by the Plan at the time of separation from service resulting from a job elimination. Employees covered by this subsection shall be covered for a period of up to 12 months following a separation from service because of a job elimination.

(7) Any member enrolled pursuant to subdivision (1) or (1a) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(8) Employees on approved Family and Medical Leave.

(a2) A school employee in a job-sharing position as defined in G.S. 130-40.3. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the ~~Plan's total noncontributory premiums.~~Plan's maximum annual employer contribution. Individual employees shall pay the balance of the ~~total noncontributory premiums~~ Plan's maximum annual employer contribution not paid by the employing unit.

(a3) Subject to the provisions of G.S. 135-40.3, employees and members of the General Assembly with 10 but less than 20 years of retirement service credit shall be eligible for coverage under the Plan on a partially contributory basis, provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's ~~total noncontributory premiums. Individual retirees shall pay the balance of the total noncontributory premiums not paid by the State.~~maximum annual employer contribution. Individual retirees shall pay the balance of the maximum annual employer contribution not paid by the State."

SECTION 11.(b) G.S. 135-40.2 is amended by adding the following new subsection to read:

"(a4) Persons eligible under G.S. 135-40.2(a) who are enrolled in the optional plan established pursuant to G.S. 135-39.5B(b) are eligible for coverage under the optional plan on a noncontributory basis. The provisions of G.S. 135-39.5B(b) apply to persons eligible under G.S. 135-40.2(a2) and 135-40.2(b) who are enrolled in the optional plan."

SECTION 12.(a) G.S. 135-39.5B(b) reads as rewritten:

"(b) The Executive Administrator and Board of Trustees may, after consulting with the Committee on Employee Hospital and Medical Benefits, adopt an arrangement for an optional hospital and medical benefits program other than the one specified in subsection (a) of this section. The optional program may include one that is purchased or underwritten by the State and may be a PPO or other type optional program. Optional programs under this section are not subject to benefits and cost-sharing requirements under G.S. 135-40.5 through G.S. 135-40.9, except that if a pharmacy benefit is not provided under the optional program, the pharmacy benefit under ~~G.S. 135-40.59(g)~~G.S. 135-40.5(g) shall apply. The Executive Administrator and Board of Trustees may set premium rates for coverage under an optional program on a partially contributory basis, provided that the amounts of State funds contributed for coverage on a partially contributory basis shall not be more than the ~~Plan's total noncontributory premium for Employee Only coverage,~~maximum annual employer contribution as enacted in the Current Operations Appropriations Act, with the person selecting the optional program coverage paying the balance of the partially contributory ~~premium not paid by the Plan. The amount of State funds contributed for purchased optional programs shall not exceed the amount of a purchased optional program's cost for Employee Only coverage.~~premium. Contracts for an optional program under this subsection are not subject to Article 3 of Chapter 143 of the General Statutes. In no instance shall benefits be paid under Part 3 of this Article for persons enrolled in an optional prepaid hospital and medical benefits program authorized under this subsection

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."

SECTION 12.(b) G.S. 135-39.5B is amended by adding the following new subsection to read:

"(c) There are four types of coverage that an employee or retiree may elect under the optional program:

(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) Employee and spouse. – Covers enrolled employee and spouse only. Maternity benefits are provided to employee or enrolled spouse."

SECTION 13. For the purpose of improving efficiency and cost-effectiveness of Plan operations, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may create nine and one-half full-time positions, seven and one-half of which shall be subject to the State Personnel Act under G.S. 126-5, and two of which shall be exempt from the State Personnel Act under G.S. 126-5(c). The Executive Administrator and Board of Trustees may use up to six hundred one thousand five hundred twenty dollars ($601,520) of funds available to support these positions.

SECTION 14. Section 1 of this act is effective when it becomes law. The remainder of this act becomes effective July 1, 2007.