GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

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HOUSE BILL 439

Short Title: Enhanced State Empl. Health Ben. (Public)

Sponsors: Representatives G. Miller; Hunt, Buchanan, and Redwine.

Referred to: Public Employees.

March 9, 1995

A BILL TO BE ENTITLED

AN ACT TO ENHANCE THE BENEFITS PROVIDED UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. (a) G.S. 135-40.5 is amended by adding two new subsections to read:

"(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent (100%) of 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 50 years, and once a year for covered individuals age 50 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. The maximum amount payable under this subsection for a covered individual is one hundred fifty dollars ($150.00) per fiscal year.

(f) Immunizations. – The Plan will pay one hundred percent (100%) of allowable charges for immunizations for the prevention of contagious diseases as generally accepted medical practices would dictate when directed by an attending physician."

(b) G.S. 135-40.6(8)s. reads as rewritten:

"s. 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~~ 50 years, and once a year for covered individuals age ~~55~~ 50 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. ~~The maximum amount payable under this subdivision is one hundred fifty dollars ($150.00) per fiscal year.~~"

(c) G.S. 135-40.6(8)t. is repealed.

Sec. 2. (a) G.S. 135-39.5 is amended by adding two new subdivisions to read:

"(22) Implementing and operating a preventative health promotion and education program to reduce the claim costs associated with catastrophic and other illnesses and injuries identified by the Plan.

(23) Establishing and operating managed, individualized care programs for high-risk maternity cases and other high-cost treatment cases for acute and chronic illnesses and injuries identified by the Plan."

(b) G.S. 135-40.7 is amended by adding a new subdivision to read:

"(16b) Charges incurred but not approved by the Plan under managed, individualized care programs established by the Executive Administrator and Board of Trustees."

(c) G.S. 135-40.8(d) reads as rewritten:

"(d) Where a network of qualified preferred providers of ~~inpatient and outpatient hospital care~~ institutional and professional medical care and services is reasonably available for use by those individuals covered by the Plan, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year per covered individual in addition to the general

coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

Sec. 3. G.S. 135-40.6(8)a. reads as rewritten:

"a. Prescription Drugs: The Plan's maximum allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility are ninety percent (90%) of the average wholesale ~~price. A dispensing fee for qualified providers shall be determined by the 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 provider dispensing fee set by the Executive Administrator and Board of Trustees.~~ price plus a dispensing fee of five dollars and fifty cents ($5.50) per prescription for qualified providers. 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."

Sec. 4. G.S. 135-40.9 reads as rewritten:

"**§ 135-40.9. Maximum benefits.**

The Plan has no maximum lifetime benefit for ~~each~~ a covered ~~individual will be one million dollars ($1,000,000).~~ individual."

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

"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, heart, corneal, bone marrow, lung, heart-lung, pancreas, and kidney. The Plan's coverage for bone marrow transplants shall include transplants in the treatment of breast and ovarian cancer as well as multiple myeloma. 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. The Executive Administrator and Board of Trustees may limit the Plan's reimbursement for selected organ transplants to amounts

that would otherwise be allowed in accordance with G.S. 135-40.4."

Sec. 6. This act becomes effective July 1, 1995, except that Section 4 becomes effective July 1, 1992.