GENERAL ASSEMBLY OF NORTH CAROLINA

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HOUSE BILL 1059

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Short Title: State Health Plan Changes. (Public)

Sponsors:

Referred to:

March 31, 2005

A BILL TO BE ENTITLED

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

The General Assembly of North Carolina enacts:

SECTION 1.(a) Cost-Saving Initiatives. – Coverage of Over-the-Counter Medications. – Notwithstanding any other provision of law to the contrary, the Executive Administrator and Board of Trustees may authorize coverage for over-the-counter medications as recommended by the Plan's pharmacy and therapeutics committee. In approving for coverage one or more over-the-counter medications, the Executive Administrator and Board of Trustees shall ensure that each recommended over-the-counter medication has been analyzed to ensure medical effectiveness and Plan member safety. The analysis shall also address the financial impact on the Plan. The Executive Administrator and Board of Trustees may impose a co-payment to be paid by each covered individual for each packaged over-the-counter medication. The Executive Administrator and Board of Trustees may adopt policies establishing limits on the amount of coverage available for over-the-counter medications for each covered individual over a 12-month period. Prior to implementing policy and co-payment changes authorized under this section, the Executive Administrator and Board of Trustees shall submit the proposed policies and co-payments to the Committee on Employee Hospital and Medical Benefits for its review.

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

SECTION 2.(a) Technical Changes. – 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~~ each nonpreferred branded or generic ~~prescription not on a formulary used by the Plan.~~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. 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 2.(b) Prior Approval. – G.S. 135-40.6A(b) is amended by adding the following new subdivision to read:

…

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

…

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

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

SECTION 4. Enrollment Clarification. – G.S. 135-39.5B is amended by adding the following new subsection to read:

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

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

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

(a) ~~Whenever the Plan pays benefits for hospital, surgical, medical, or prescription drug expenses, with respect to any Plan member, the Plan shall be subrogated, to the extent of any payments under the Plan, to all of the Plan member's rights of recovery against liable third parties, regardless of the entity or individual from whom recovery may be due.~~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. 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.

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

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

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

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

"(a) When the death of a person is caused by a wrongful act, neglect or default of another, such as would, if the injured person had lived, have entitled him to an action for damages therefor, the person or corporation that would have been so liable, and his or their personal representatives or collectors, shall be liable to an action for damages, to be brought by the personal representative or collector of the decedent; and this notwithstanding the death, and although the wrongful act, neglect or default, causing the death, amounts in law to a felony. The personal representative or collector of the decedent who pursues an action under this section may pay from the assets of the estate the reasonable and necessary expenses, not including attorneys' fees, incurred in pursuing the action. At the termination of the action, any amount recovered shall be applied first to the reimbursement of the estate for the expenses incurred in pursuing the action, then to the payment of attorneys' fees, and shall then be distributed as provided in this section. The amount recovered in such action is not liable to be applied as assets, in the payment of debts or legacies, except as to burial expenses of the deceased, and reasonable hospital and medical expenses not exceeding four thousand five hundred dollars ($4,500) incident to the injury resulting in death, except that the amount applied for hospital and medical expenses shall not exceed fifty percent (50%) of the amount of damages recovered after deducting attorneys' fees, but shall be disposed of as provided in the Intestate Succession Act. The limitations on recovery for hospital and medical expenses under this subsection do not apply to subrogation rights exercised pursuant to

G.S. 135-40.13A. All claims filed for such services shall be approved by the clerk of the superior court and any party adversely affected by any decision of said clerk as to said claim may appeal to the superior court in term time."

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

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

"**§ 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:

…

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

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