GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2001

SENATE BILL 824
RATIFIED BILL

AN ACT PERTAINING TO BENEFITS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN; AND TO HOSPITAL RATES UNDER WORKERS' COMPENSATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Effective July 1, 2002, 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:

…

(26) Increasing annually the amount of the annual deductible and annual aggregate maximum deductible. The increase shall be established by determining the ratio of the CPI-Medical Index to such index one year earlier. If the ratio indicates an increase in the CPI-Medical Index, then the amount of the annual deductible and annual aggregate maximum deductible may be increased by not more than the percentage increase in the CPI-Medical Index. As used in this subdivision, the term 'CPI-Medical Index' means the U.S. Consumer Price Index for All Urban Consumers for Total Medical Care."

SECTION 1.(b) G.S. 135-40.1(2) reads as rewritten:

"(2) Deductible. – Deductible shall mean an amount of covered expenses during a 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 ~~two hundred fifty dollars ($250.00)~~ three hundred fifty dollars ($350.00) for each fiscal year.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family (employee or retiree and his or her covered dependents)~~employee and child(ren) or employee and family coverage contract in any 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."

SECTION 1.(c) G.S. 135-40.4(a) reads as rewritten:

"(a) In the event a covered person, as a result of accidental bodily injury, disease or pregnancy, incurs covered expenses, the Plan will pay benefits up to the amounts described in G.S. 135-40.5 through G.S. 135-40.9.

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to both a ~~two hundred fifty dollars ($250.00)~~three hundred fifty dollar ($350.00) deductible for each covered individual to

an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family~~ employee and child(ren) or employee and family coverage contract and coinsurance of 80%/20%. There is a limit on out-of-pocket expenses under the second part.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may contract with providers of institutional and professional medical care and services to established preferred provider networks. The design, adoption, and implementation of such preferred provider contracts and networks are not subject to the requirements of Chapter 143 of the General Statutes, provided that for any hospital preferred provider network all hospitals will have an opportunity to contract with the Plan if they meet the contract requirements. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make reports as requested to the President of the Senate, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such preferred provider contracts. The Executive Administrator and Board of Trustees shall implement a refined diagnostic-related grouping or diagnostic-related grouping-based reimbursement system for hospitals as soon as practicable, but no later than January 1, 1995."

SECTION 1.(d) G.S. 135-40.5(d) is repealed.

SECTION 1.(e) 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, ~~fifteen dollars ($15.00)~~ twenty-five dollars ($25.00) for each branded prescription, and ~~twenty dollars ($20.00)~~thirty-five dollars ($35.00) for each branded prescription with a generic equivalent drug, and ~~twenty-five dollars ($25.00)~~ forty dollars ($40.00) for each branded or generic prescription not on a formulary used by the Plan. 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 1.(f) The first paragraph of G.S. 135-40.6 reads as rewritten:

"The ~~following~~ benefits provided in this section are subject to a deductible of ~~two hundred fifty dollars ($250.00)~~ three hundred fifty dollars ($350.00) per covered

individual to an aggregate maximum of ~~seven hundred fifty dollars ($750.00)~~ one thousand fifty dollars ($1,050) per ~~family~~ employee and child(ren) or employee and family coverage contract per fiscal year and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered individual up to a maximum of one thousand ~~dollars ($1,000)~~ five hundred dollars ($1,500) out-of-pocket per fiscal ~~year:~~year. The aggregate maximum out-of-pocket required of individuals covered by this section shall not be more than four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year."

SECTION 1.(g) G.S. 135-40.6(1)f. reads as rewritten:

"(1) In-Hospital Benefits. – The Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room accommodations, including bed, board and general nursing care, but not to exceed the charge for semiprivate room or ward accommodations, or the rate negotiated for the Plan. Under the DRG reimbursement system, the coinsurance shall be based on the lower of the DRG amount or charges.

The Plan will pay the following covered charges, when charged by a hospital, for each confinement.

…

f. ~~Physical~~ Physical, speech, and occupational therapy."

SECTION 1.(h) G.S. 135-40.6(3) reads as rewritten:

"(3) Skilled Nursing Facility Benefits. – The Plan will pay benefits in a skilled nursing facility licensed under applicable State laws for not more than 100 days per fiscal year for the same reason, as follows:

After discharge from a hospital for which inpatient hospital benefits were provided by this Plan for a period of not less than three days, and treatment consistent with the same illness or condition for which the covered individual was hospitalized, the daily charges will be paid for room and board in a semiprivate room or any multibed unit up to the maximum benefit specified in subsection (1) of this section, less the days of care already provided for the same illness in a hospital. Plan allowances for total daily charges may be negotiated but will not exceed the daily semiprivate hospital room rate as determined by the Plan.

Credit will be allowed toward private room charges in an amount equal to the facility's most prevalent charge for semiprivate accommodations. Charges will also be paid for general nursing care and other services which would ordinarily be covered in a general hospital. In order to be eligible for these benefits, admission must occur within 14 days of discharge from the hospital.

In order to qualify for benefits provided by a skilled nursing facility, the following stipulations apply:

a. The services are medically required to be given on an inpatient basis because of the covered individual's need for medically necessary skilled nursing care on a continuing daily basis for any of the conditions for which he or she was receiving inpatient hospital services prior to transfer from a hospital to the skilled nursing facility or for a condition requiring such services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he or she was receiving inpatient hospital services,

b. Only on prior referral by and so long as, the patient remains under the active care of an attending doctor and the patient

requires continual hospital confinement without the care and treatment of the skilled nursing facility, and

c. Approved in advance by the Claims Processor.

For facilities not qualified for delivery of services covered by the benefits of Title XVIII of the Social Security Act (Medicare), neither the Plan nor any of its members shall be billed or held liable by such facilities for charges that otherwise would be covered by Medicare."

SECTION 1.(i) G.S. 135-40.6(8)e. reads as rewritten:

"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, not more than three hundred fifty dollars ($350.00) for therapeutic shoes for diabetes and other high-risk conditions, 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 Claims Processor and agreements to rent or purchase shall be between the Claims Processor 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."

SECTION 1.(j) G.S. 135-40.6(8)m. reads as rewritten:

"m. Cardiac Rehabilitation: Charges not to exceed ~~six hundred fifty dollars ($650.00)~~ the lesser of one thousand eight hundred dollars ($1,800) or 90 days 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,~~year. Coverage is limited to patients with Coronary Artery Bypass Graft (CABG), status/post myocardial infarction, Percutaneous Transliminal Coronary Angioplasty (PTCA) or stent, valve replacement, heart transplant, or chronic and disabling angina provided such ~~charges are incurred~~services are provided within six months of the qualifying event and in a medically supervised facility fully certified by the North Carolina Department of Health and Human Services."

SECTION 1.(k) G.S. 135-40.6(9)f. reads as rewritten:

"(9) Limitations and Exclusions to Other Covered Charges. – No benefits are available under this section of the Plan until full utilization is made of similar benefits available under other sections of this Plan.

No benefits will be payable for:

…

f. Eyeglasses or other corrective lenses (except for cataract lenses certified as medically necessary for aphakia persons), hearing aids, braces for teeth, dental plates or bridges or other dental prostheses, air-conditioners, vaporizers, humidifiers, mattresses (other than as supplied with a hospital bed) and specially built shoes (other than attached to artificial limbs or orthopedic ~~braces);~~braces, and other than therapeutic shoes for diabetes or other high-risk conditions);"

SECTION 1.(l) 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);~~Care.
(2) Private Duty ~~Nursing;~~Nursing.
(3) Speech Therapy (unless rendered in an inpatient ~~hospital);~~hospital).
(4) Physical Therapy (in the ~~home);~~home).
(7) Surgical Procedures:
  a. Blepharoplasties
  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.~~Anastomasis
  m. Varicose Vein Surgery.
(8) Subcutaneous injection of "filling" material (Example: zyderm, ~~silicone); and~~ silicone).
(8a) Botulinium toxin.
(9) Suction Lipectomy.
(10) Outpatient prescription drugs requiring prospective review under the Plan's pharmacy benefit management program.
(11) Outpatient prescription drugs for growth hormone, weight loss, and antifungal drugs for the treatment of nail fungus."

SECTION 1.(m) G.S. 135-40.8 reads as rewritten:

"**§ 135-40.8. Out-of-pocket expenditures.**

(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. 135-40.6. ~~The covered individual is then responsible for the remaining twenty percent (20%) until one thousand dollars ($1,000), in excess of the deductible, has been paid out-of-pocket.~~ The remaining twenty percent (20%) is paid by the covered individual until one thousand five hundred dollars ($1,500) per covered individual up to an aggregate of four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year in excess of the deductible has been paid out of pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

~~(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.~~

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first ~~seventy-five dollars ($75.00)~~ one hundred dollars ($100.00) of the room accommodation charge allowable under G.S. 135-40.6(1). Any readmission within 60 days after discharge for the same reason shall be considered the same confinement for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c1) Notwithstanding any other provision of this Article, the Plan does not pay the first fifty dollars ($50.00) of the facility fees and ancillary charges for allowable charges exceeding five hundred dollars ($500.00) per episode of care for hospital outpatient departments and ambulatory surgical facilities under G.S. 135-40.6(4). Readmission within 30 days after discharge for the same reason shall be considered the same episode of care for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c2) Notwithstanding any other provision of this Article, the Plan does not pay the first one hundred dollars ($100.00) 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.

(c3) Notwithstanding any other provision of this Article, the Plan does not pay for the first fifteen dollars ($15.00) of allowable charges for each home, office, or skilled nursing facility visit under the provisions of G.S. 135-40.6(7)a. and b., G.S. 135-40.6(4), G.S. 135-40.6(8)e.(IV therapy), i., j., k., n., r., and s., and G.S. 135-40.5(e). The copayment assessed by this subsection shall be assessed only once per person per provider per day and shall not apply to laboratory, pathology, and radiology services. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(d) Where a network of qualified preferred providers of inpatient and outpatient hospital care 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 up to an aggregate of fifteen thousand dollars ($15,000) per employee and child(ren) or employee and family coverage contract per fiscal year 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."

SECTION 1.(n) G.S. 135-40.9 reads as rewritten:

"**§ 135-40.9. Maximum benefits.**

The maximum lifetime benefit for each covered individual will be ~~two million dollars ($2,000,000).~~five million dollars ($5,000,000)."

SECTION 1.(o) G.S. 135-40.6(2)g. is repealed.

SECTION 1.(p) G.S. 135-40.6(7)a. reads as rewritten:

"(7) Medical Benefits. –

a. Services of Doctors. – The Plan pays the usual, reasonable and customary charges for covered inpatient medical (nonsurgical) services. Services are covered if the individual is hospital-confined and is eligible for hospitalization benefits as described in this section. Benefits are provided for exactly the same number of days as the individual is entitled to under this

section, except that medical benefits are provided on both the day of admission and the day of discharge.

In the event a covered individual is treated by two or more co-attending doctors during the same hospital confinement for a medical (nonsurgical) condition, benefits are limited to payment for services provided by the primary attending doctor, except where need is established for supplementary skills for treatment of separate and distinct diagnoses or conditions.

Home, office, and skilled nursing facility visits including (i) charges for injected medications, (ii) inpatient care by attending medical doctors, radiologists, pathologists, and consultants during such time as hospital benefits are paid under any section of this Plan, (iii) care in the outpatient department of a hospital, and (iv) administration of shock therapy (drug or electric) including the services of anesthesiologists provided on an office or hospital outpatient basis for treatment of acute psychotic reaction or severe depression. ~~The Plan does not cover the first ten dollars ($10.00) of allowable charges for each home, office, or skilled nursing facility visit.~~"

SECTION 1.(q) Effective January 1, 2002, G.S. 135-39.5(12) 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:

…

"(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-50-56. The Plan shall comply with G.S. 58-3-225."

SECTION 1.(r) 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, 3, 4, and 5 of this Article. The Executive Administrator and Board of Trustees shall provide 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 persons requesting a written description and approved by the Executive Administrator and Board of Trustees written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a rule or regulation, unless immediate adoption of the rule or regulation without notice is necessary in order to fully effectuate the purpose of the rule or regulation. 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~~ persons requesting a written description and approved by the Executive Administrator and Board of Trustees ~~to receive a description~~ on a timely basis."

SECTION 1.(s) The Plan shall develop as soon as practicable a prospective payment system for the payment of hospital outpatient services and the services of ambulatory surgical facilities. In developing this prospective payment system, the Plan shall make use of the expertise of the North Carolina Hospital Association, including any advisory committees of member hospitals that the Association may name, and ambulatory surgical facilities in this State. In addition, the Plan shall develop as soon as

practicable a medical fee schedule for the payment of professional health care services. The fee schedule shall be developed with the expertise of the North Carolina Medical Society, the North Carolina Academy of Family Physicians, and any other groups of professional medical service providers that the Society may wish to include. Any prospective payment system for hospital outpatient services and the services of ambulatory surgical facilities and a medical fee schedule for the providers of professional medical services shall not be implemented by the Plan before July 1, 2003.

SECTION 2. Notwithstanding G.S. 97-26, payment for medical treatment and services rendered to workers' compensation patients by a hospital on or after July 1, 2001, and before August 1, 2001, shall be equal to the payment the hospital would have received for such treatment and services on June 30, 2001.

SECTION 3. Except as otherwise provided, this act becomes effective July 1, 2001.

In the General Assembly read three times and ratified this the 28th day of June, 2001.

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Beverly E. Perdue
President of the Senate

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James B. Black
Speaker of the House of Representatives

_____
Michael F. Easley
Governor

Approved _____.m. this _____ day of _____, 2001