GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

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HOUSE BILL 1066

Short Title: Lower Prescription Drug Costs. (Public)

Sponsors: Representative Flaherty.

Referred to: Public Employees.

April 22, 1991

A BILL TO BE ENTITLED

AN ACT TO STIMULATE COMPETITIVE DRUG PRICES FOR STATE INSTITUTIONS AND FOR THE STATE HEALTH PLAN.

The General Assembly of North Carolina enacts:

Section 1. Purchases by State agencies and reimbursements by State agencies for prescription drugs shall be at the lowest available price.

Sec. 2. G.S. 135-40.6(8) reads as rewritten:

"(8) Other Covered Charges. –

a. Prescription Drugs: ~~Prescription legend drugs in excess of the first two dollars ($2.00) per prescription for generic drugs and brand name drugs without a generic equivalent and in excess of the first three dollars ($3.00) per prescription for brand name drugs for use outside of a hospital or skilled nursing facility.~~ <u>Prescription legend drugs as determined by the Executive Administrator and the Board of Trustees.</u> 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.

b. Private Duty Nursing: Services of licensed nurses (not immediate relatives or members of the participant's household or private duty nursing used in lieu of or as a substitute for

hospital staff nurses) ordered by the attending doctor for a condition requiring skilled nursing services. Private Duty Nursing ordered must be approved in advance by the Claims Processor as medically necessary. Allowances for Private Duty Nursing shall not exceed the Plan's usual, customary and reasonable allowances or ninety percent (90%) of the daily semiprivate rate at skilled nursing facilities as determined by the Plan.

c. Home Health Agency Services: Services provided in a covered individual's home, when ordered by the attending physician who certifies that hospital or skilled nursing facility confinement would be required without such treatment and cannot be readily provided by family members. Services may include medical supplies, equipment, appliances, therapy services (when provided by a qualified speech therapist or licensed physiotherapist), and nursing services. Nursing services will be allowed for:

1. Services of a registered nurse (RN); or
2. Services of a licensed practical nurse (LPN) under the supervision of a RN; or
3. Services of a home health aide under the supervision of a RN, limited to four hours a day.

Home health services shall be limited to 60 days per fiscal year, except that additional home health services may be provided on an individual basis if prior approval is obtained from the Claims Processor. Plan allowances for home health services shall be limited to licensed or Medicare certified home health agencies and shall not exceed ninety percent (90%) of the skilled nursing facility semiprivate rates as determined by the Plan, or charges negotiated by the Plan.

d. Licensed Ambulance Service: Local ambulance transportation:

1. To or from a hospital for inpatient care or outpatient accident care;
2. From a hospital to the nearest facility able to provide needed services not available at the transferring hospital; or
3. From a hospital to a skilled nursing facility.

The word 'local' means ambulance transportation of not more than 50 miles unless the Claims Processor authorizes ambulance transportation beyond this distance.

e. Prosthetic and Orthopedic Appliances and Durable Medical Equipment: Appliances and equipment including corrective and

1 supportive devices such as artificial limbs and eyes,
2 wheelchairs, traction equipment, inhalation therapy and suction
3 machines, hospital beds, braces, orthopedic corsets and trusses,
4 and other prosthetic appliances or ambulatory apparatus which
5 are provided solely for the use of the participant. Eligible
6 charges include repair and replacement when medically
7 necessary. Benefits will be provided on a rental or purchase
8 basis at the sole discretion of the Administrator and agreements
9 to rent or purchase shall be between the Administrator and the
10 supplier of the appliance.
11 For the purposes of this subdivision, the term 'durable
12 medical equipment' means standard equipment normally used in
13 an institutional setting which can withstand repeated use, is
14 primarily and customarily used to serve a medical purpose, is
15 generally not useful to a person in the absence of an illness or
16 injury and is appropriate for use in the home. Decisions of the
17 Claims Processor, the Executive Administrator and Board of
18 Trustees as to compliance with this definition and coverage
19 under the Plan shall be final.
20 f. Dental Services: Dental surgery and appliances for mouth, jaw,
21 and tooth restoration necessitated because of external violent
22 and accidental means, such as the impact of moving body,
23 vehicle collision, or fall occurring while an individual is
24 covered under G.S. 135-40.3. No benefits are provided in
25 connection with injury incurred in the act of chewing, nor for
26 damage or breakage of an appliance such as bridge or denture
27 being cleaned or otherwise not in normal mouth usage at the
28 time of accident, nor for appliances for orthodontic treatment
29 when a class of malocclusion, other than orthognathic, or cross
30 bite has been diagnosed. Benefits for temporomandibular joint
31 (TMJ) disfunction appliance therapy are limited to cases where
32 the TMJ disfunction has been diagnosed as solely resulting
33 from accidental means as certified by the attending practitioner
34 and approved by the Claims Processor.
35 Benefits shall include extractions, fillings, crowns, bridges,
36 or other necessary therapeutic and restorative techniques and
37 appliances to reasonably restore condition and function to that
38 existing immediately prior to the accident. Injury or breakage of
39 existing appliances such as bridges and dentures is limited to
40 repair of such appliances unless certified as damaged beyond
41 repair.
42 g. Medical Supplies: Colostomy bags, catheters, dressings,
43 oxygen, syringes and needles, and other similar supplies.

h. Blood: Transfusions including cost of blood, plasma, or blood plasma expanders.

i. Physical Therapy: Recognized forms of physical therapy for restoration of bodily function, provided by a doctor, hospital, or by a licensed professional physiotherapist. No benefits are provided for eye exercises or visual training.

j. Inhalation Therapy: When provided by a doctor, hospital, or other organization.

k. Speech Therapy: Speech therapy provided by certified speech therapist.

l. Cataract Lenses: Cataract lenses prescribed as medically necessary for aphakia persons, including charges for necessary examinations and fittings. Benefits will be limited to one set of cataract lenses every 24 months for persons 18 years of age or older, and one set of cataract lenses every 12 months for persons less than 18 years of age.

m. Cardiac Rehabilitation: Charges not to exceed six hundred fifty dollars ($650.00) 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, provided such charges are incurred in a medically supervised facility fully certified by the North Carolina Department of Human Resources.

n. Chiropractic Services: Limited to the alignment of the spine and releasing of pressure by manipulation in accordance with the definitions in G.S. 90-143. Maximum benefits for x-rays, manipulations, and modalities shall be one thousand dollars ($1,000) per fiscal year.

o. Foot Surgery: All foot surgery on bones and joints in excess of one thousand dollars ($1,000), except for emergencies, shall require prior approval from the Claims Processor.

p. Outpatient Diabetes Self-Care Programs: Charges, not to exceed three hundred dollars ($300.00) per fiscal year, when determined to be medically necessary by an attending physician and approved by the Executive Administrator and Claims Processor as meeting the standards of the National Diabetes Advisory Board for patients with a medical history of diabetes, provided such charges are incurred in a medically supervised facility.

q. Necessary medical services provided to terminally ill patients by duly licensed hospice organizations, when directed by the

1 attending physician and approved in advance by the Claims
2 Processor and the Executive Administrator.
3 r. Occupational Therapy: Recognized forms of occupational
4 therapy provided by a doctor, hospital, or by a licensed
5 professional occupational therapist to restore fine motor skills
6 for the resumption of bodily functions."
7 Sec. 3. This act becomes effective July 1, 1991.